

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 TWO

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1 A: It was not.

2 Q: All right. Did Trident make a request to add
3 adverse impact as one of the most important
4 criteria?

5 A: Not to my knowledge.

6 Q: All right. Trident could have made the request
7 to DHEC upon receiving the complete letter that
8 adverse impact is so important, we've got to add
9 it to the list of criteria.

10 A: They could have.

11 Q: DHEC could have said no, yes, but they could
12 have and didn't. All right. Let's look at MUSC
13 Exhibit 10, Bates page 444, back to your slide.
14 Approval of either project will exacerbate the
15 underutilization of Trident. So, that's
16 approval of Roper would exacerbate and/or
17 approval of MUSC would exacerbate, right?

18 A: Correct.

19 Q: All right. Let's look at MUSC 10, Bates page
20 447. I think another one of your slides. All
21 right. I think we've talked about this. This
22 is your access argument, right?

23 A: It is.

24 Q: And you put a little more, I guess, detail here.
25 The point is that the residents of the northern



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ROA_0501

1 portion of this service area can access St.
2 Francis and I presume Mt. Pleasant by taking
3 I526.

4 A: That's true.

5 Q: Because of the Mark Clark, right?

6 A: It is. And, you know, St. Francis is right off
7 of 526 in Charleston County and West Ashley.
8 And the MUSC Radiation Therapy Center is pretty
9 close to 526 on Highway 17 in Mt. Pleasant.

10 Q: Right. And, again, this is if we're comparing
11 -- if we're not considering the existence of
12 Nexton shortening the travel to either West
13 Ashley for the Roper folks or Mt. Pleasant for
14 the MUSC folks, right?

15 A: That's true.

16 Q: MUSC, Exhibit 10, 448. All right. And the last
17 bullet point, \$20 million in healthcare
18 expenditures not needed when Trident has
19 capacity to treat patients. So, that 20 million
20 is the Roper project and the MUSC project added
21 up, right?

22 A: Right. I think Roper was 11 something.

23 Q: And we were 9?

24 A: 9.8 I think.

25 Q: Now, earlier we discussed or mentioned that you



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ROA_0502

1 thought the Roper CON application projections
2 were out there, far out there; is that ---

3 A: Yes.

4 Q: And that's not in the way that Dan would admit
5 that, Dan Westbrook, in like the early 70s, far
6 out. No. You meant they were overly
7 aggressive.

8 A: I do.

9 Q: Not reasonable.

10 A: Correct.

11 Q: All right. And of course in the world of health
12 planning, more conservative planning assumptions
13 and projections are better than overly
14 aggressive or unreasonable ones.

15 A: I think as a rule that's true.

16 Q: Roper's CON application was overly aggressive
17 with respect to projected growth in the number
18 of cancer patients in the service area?

19 A: Yes.

20 Q: They were overly aggressive with respect to the
21 number of linac treatments each patient would
22 receive?

23 A: True.

24 Q: They were overly aggressive with respect to the
25 projected percentage of cancer patients who



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ROA_0503

1 would receive linac.

2 A: That's my recollection.

3 Q: And of course we mentioned the Roper manipulated
4 linac capacity before they filed. Let's look at
5 MUSC -- let's look at some of MUSC's project
6 review slides, MUSC Exhibit 9. These are slides
7 presented by Mr. Levitt. Now, that's, yeah, at
8 the beginning. And let's get to the health
9 planning. And before we dive into any of this,
10 Mr. Levitt's slides contain health planning
11 assumptions and projections that were in his CON
12 application, right?

13 A: They do.

14 Q: And you agree with many of them, right?

15 A: Many is a strong word.

16 Q: Let's see how many. MUSC Exhibit 9, slide ten.
17 This is the idea that 31 percent of MUSC's linac
18 patients come from Moncks Corner, Summerville,
19 North Charleston. You don't dispute that
20 statistic, do you?

21 A: Based on my independent analysis, no.

22 Q: Okay. MUSC Exhibit 9, slide 11, this is -- and
23 we'll focus on the population on the top left.
24 The point here seems to be in the four-county
25 area. The population -- general population is



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ROA_0504

1 projected to increase 8.1 percent in nearly a 25
2 -- a 25 percent increase in the over-65 by 2021.

3 A: That's true.

4 Q: You agree with that, right?

5 A: I do.

6 Q: Let's look at the socioeconomic piece. So,
7 David Levitt here is making the point that folks
8 in Summerville, Moncks Corner, on average have
9 a lower socioeconomic status than folks that
10 live on the Charleston peninsula. You don't
11 dispute that, do you?

12 A: It's a mixed bag. If you look at the peninsula,
13 the peninsula has a pretty strong percentage of
14 patients in that 10,000 to 50,000 range. If
15 you're living on the peninsula, that's not a lot
16 of money to live in downtown Charleston these
17 days. So, you know, you've got about 60 percent
18 of the peninsula population below that 50,000
19 level. You know, so the peninsula is not
20 necessarily a whole lot different from, you
21 know, what's going on in Summerville. In fact,
22 Summerville overall, in terms of below 50,000,
23 is only about 48 percent.

24 Q: I think -- well, how about this. Do you
25 disagree with the general point that peninsula



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ROA_0505

1 folks on average lower socioeconomic status than
2 folks in Berkeley County, Dorchester, and other
3 places? If you do, that's fine.

4 A: On a percentage basis there are a fair number of
5 poor people who live -- or lower income people,
6 I guess is a fairer way to say it, who live on
7 the peninsula. I don't think it's dramatically
8 different from those other areas.

9 Q: It's about the same.

10 A: You have pockets of poverty I think at all ---

11 Q: Oh, sure. I understand the pockets of poverty.
12 We're dealing -- in a health planning we're
13 dealing in averages, right?

14 A: Sure.

15 Q: So, on average higher socioeconomic on the
16 peninsula? If you're not comfortable with that,
17 that's fine.

18 A: I'm not.

19 Q: All right.

20 A: You certainly have more high-end people on the
21 peninsula than you would out there, but ---

22 Q: Greater extremes maybe.

23 A: Yeah, maybe greater extremes is the way to say
24 it.

25 Q: All right. Let's look at MUSC Exhibit 9, slide



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ROA_0506

1 13. All right. And here this is the four-
2 county area we saw a 21 percent growth in cancer
3 cases from '08 to '13, right?

4 A: Yes.

5 Q: A CAGR of 3.9?

6 A: Yes.

7 Q: Compound annual growth rate, right?

8 A: Yeah.

9 Q: Thank you for accepting that.

10 A: I knew what you meant.

11 Q: You don't dispute those numbers, that increase?

12 A: I don't. I presented my own numbers, which were
13 a little bit later period. And my rate of
14 growth was about two percent, but that was based
15 on a later period of time.

16 Q: Understood. MUSC Exhibit 9, slide 13. Let's
17 look at cancer incidence, which I think is right
18 below it. It's Mr. Levitt's slide. Four-county
19 area, 2008 to '13, we saw the cancer incident
20 rate per thousand go up 10 percent.

21 A: We did.

22 Q: CAGR of two percent.

23 A: Right.

24 Q: Do you agree with that?

25 A: I do.



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ROA_0507

1 Q: Let's look at slide 16, please. So, I think we
2 looked at this during your Direct.

3 MR. DAYHUFF: Let's bring the bottom table out, so we
4 can see a little better.

5 Q: This projection uses a CAGR of, I think you said
6 -- I think you rounded to two percent, right?

7 A: Right. It's right around two percent.

8 Q: All right. Does 1.6 percent sound familiar?

9 A: That's about right.

10 Q: And you're comfortable with that. That's the
11 rate of population increase?

12 A: Yeah. I'm comfortable with that in terms of the
13 number of patients. I'm not so comfortable with
14 the number of treatments.

15 Q: That's right. Because you believe that the
16 treatments have, not only been flat, but they've
17 been declining.

18 A: Right.

19 Q: Which we'll talk about later. But with respect
20 to cancer patients, you and David are in
21 agreement here?

22 A: Yeah. I mean, this is not showing patients, so,
23 I mean, I agree that patients are probably going
24 to grow in that 1.6, two percent range. I would
25 think that the treatment numbers are going to



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ROA_0508

1 grow at a lower rate.

2 Q: I see. All right. So, in contrast to Roper's
3 CON application, MUSC's CON application -- well,
4 let me mention one more, I guess. And we don't
5 need a slide for this. What percentage did
6 David use for cancer patients who will need
7 radiation therapy?

8 A: Fifty percent.

9 Q: And is that a percentage that you disagree with?

10 A: It's not. I agree with them.

11 Q: Okay. So, in contrast then to Roper, MUSC's CON
12 application did not use overly aggressive health
13 planning assumptions and projections?

14 A: It did not use as aggressive ---

15 Q: We have the treatments that we'll talk about.

16 A: We do.

17 Q: All right. But with respect to population
18 growth, reasonable cancer incidence rate,
19 reasonable number of percentage of patients who
20 get -- who have cancer who get treatments,
21 reasonable ---

22 A: Yeah. I agree with all of that.

23 Q: Okay. Now, we have walked through the health
24 planning opinions you offered during DHEC's
25 staff review in opposition to MUSC and Roper's



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ROA_0509

1 CON applications. Now, there's some additional
2 opinions we'll get to in a moment. But before
3 we talk about the newer ones, I guess I'd like
4 to recap after you and David presented your
5 opinions to DHEC. Despite Trident's opposition,
6 DHEC approved both CON applications; is that
7 correct?

8 A: Yes.

9 Q: After the DHEC board declined the opportunity to
10 review the matter, Trident filed contested cases
11 in the ALC against MUSC and Roper.

12 A: True.

13 Q: Asking The Court to deny both CON applications.

14 A: True.

15 Q: Did MUSC file contested cases opposing the Roper
16 -- did they file a contested case opposing the
17 Roper CON?

18 A: They did not.

19 Q: All right. Then something interesting happens.
20 Trident and Roper work out a deal, right?

21 A: They did.

22 Q: Trident agreed to drop its opposition to Roper's
23 linac, dismiss its contested case against Roper.
24 And in return Roper dropped its opposition to
25 Trident's FED CON application and dismissed its



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ROA_0510

1 case against Trident's FED.

2 A: That did happen, yes.

3 Q: All right. That deal, I think, was announced in
4 July. We had a motions hearing before we got
5 the contested cases ultimately dismissed, which
6 I'm trying to get over. Roper got a CON for the
7 Berkeley County linac and Trident got a CON for
8 the new FED, right?

9 A: That's my understanding.

10 Q: All right. Recalling our earlier discussion
11 about the attributes of MUSC, Roper, and
12 Trident's cancer programs, as a result of this
13 deal, residents of Berkeley County, Dorchester
14 County, North Charleston got improved geographic
15 access to Roper's cancer care, but they didn't
16 get improved access to MUSC's high quality
17 cancer care with a depth and breadth that
18 neither Roper nor Trident can match; isn't that
19 right?

20 A: That is true. There was no MUSC project
21 approved.

22 Q: Recalling our earlier discussion regarding
23 health planning analysis and assumptions in the
24 Trident and MUSC CON applications, as a result
25 of this deal, Roper, the party whose application



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ROA_0511

1 contained overly aggressive, unreasonable health
2 planning assumptions and projections, got a CON
3 while MUSC, the party with more reasonable or
4 you might say less deficient health planning,
5 still no CON, right?

6 A: That's true. You know, and I had no involvement
7 in that process.

8 Q: This has nothing to do with health planning,
9 does it, what happened here?

10 A: I believe Mr. Gallati said several times this
11 was a business decision.

12 Q: Business decision, yeah. So, as we sit here
13 today, Mr. Gallati's business decision and
14 whoever the CEO of Roper is, is determining the
15 linac services the folks in Berkeley County have
16 right now.

17 A: Well, I think DHEC started that by approving
18 both and ---

19 Q: But Roper and Trident finished it though,
20 perhaps?

21 A: Well, DHEC had to sign off on the deal.

22 Q: All right.

23 **MR. DAYHUFF:** Your Honor, if this is a good time for
24 a short break, ten minutes, five minutes,
25 whatever? Do you want to do ten?



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ROA_0512

1 THE COURT: We can take ten.

2 (Off the Record)

3 THE COURT: We're back on the record.

4 MR. DAYHUFF: Your Honor, are you ready for me to
5 proceed?

6 THE COURT: Go ahead.

7 MR. DAYHUFF: Thank you.

8 Q: All right. Mr. Sullivan, MUSC submitted 2015
9 and 2016 JAR data with its CON application,
10 right?

11 A: True.

12 Q: And what's MUSC's fiscal year?

13 A: June 30.

14 Q: Okay. Through discovery MUSC learned that the
15 2016 JAR over counted treatments slightly,
16 right?

17 A: Yes.

18 Q: Do you remember the numbers? The old JAR was
19 19,221?

20 A: Correct. And the new one was 19,192.

21 Q: Okay. Now, to be at 80 percent of our State
22 Health Planning capacity -- what is our State
23 Health Planning capacity, by the way?

24 A: Eighty percent.

25 Q: The total capacity of all of our linacs.



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ROA_0513

1 A: Well, what you claim it is, is 24,000.

2 Q: Yes. Our State Health Plan capacity, Mr.
3 Sullivan.

4 A: 24,000 is what's in the State Health Plan.

5 Q: All right. And what would we have to achieve in
6 treatments then to be at 80 percent?

7 A: 19,200.

8 Q: All right. Let's look at DX 28. Now, we heard
9 your opinion earlier. What do we have before us
10 right now?

11 A: This is a calculation of utilization rates based
12 on the claim capacity of 24,000 and the actual
13 utilization in '15 and '16.

14 Q: All right. In short, the FY16 number for
15 treatments is the corrected number for MUSC.

16 A: That is true.

17 Q: All right. And at that number we are at 79.97
18 percent. Now, I believe your opinion is we
19 cannot round. There can be no rounding of that
20 to 80. Right?

21 A: Right.

22 Q: And that's based on your understanding of the
23 State Health Plan?

24 A: Right. It's a minimum number, not an
25 approximate number.



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ROA_0514

- 1 Q: Now, I want to set aside the State Health Plan
2 for just a minute. From the perspective of
3 health planning, pure health planning, is there
4 any practical difference between 19,200
5 treatments, the math on 80 percent, and 19,192
6 treatments?
- 7 A: That's not a significant difference from a
8 capacity standpoint.
- 9 Q: Right. Not a material difference with respect
10 to volume, right?
- 11 A: It's not.
- 12 Q: Not a material difference with respect to cost,
13 providing the service, or reimbursement, right?
- 14 A: It's a relatively small difference.
- 15 Q: All right. So, it's not a material difference
16 from a pure health planning perspective?
- 17 A: Yeah. I mean, if you're saying that a provider
18 did eight more treatments in one year than the
19 prior year, that would not be considered a
20 significant change.
- 21 Q: It does not matter. That said, 79.97 cannot be
22 rounded in your opinion to satisfy Standard 7.
- 23 A: Right.
- 24 Q: Despite the immateriality of that difference
25 from a pure health planning perspective.

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ROA_0515

1 A: Right. Because this is not a pure health
2 planning issue. This is an issue related to the
3 standards in the State Health Plan.

4 Q: Well, yeah, I mean, it's -- I understand that.
5 But the State Health Plan is a health planning
6 document, right?

7 A: Right.

8 Q: That's what we're about when we're compiling the
9 State Health Plan, is trying to do good health
10 planning.

11 A: Sure. But, I mean, if you ask me, would a
12 difference of 200 or 300 procedures from -- you
13 know, between two numbers where 20,000 almost at
14 the base, I would say that's not significant
15 either from a health planning perspective. But,
16 again, we're getting farther and farther away
17 then from the 80 percent target.

18 Q: I see. All right. So, even though the State
19 Health Plan is a health planning tool, and from
20 the perspective of pure State Health Planning,
21 there's no material difference between 79.97 and
22 80 with respect to the number of treatments.
23 There still can be no rounding to satisfy
24 Standard 7 in your opinion.

25 A: Right. Because the standard says a minimum of,



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ROA_0516

1 and so that establishes the floor.

2 Q: I understand. Health planners round all the
3 time, right?

4 A: Well, they do for inconsequential purposes.

5 Q: Well, you do for your work, right? You do
6 averages, you round very consequential stuff.

7 A: Well, sure. But the rounding isn't
8 consequential as it relates to the work that ...

9 Q: I see. And it wouldn't surprise you if one of
10 my able assistants found 19 instances of
11 rounding in your work papers in this matter?

12 A: It wouldn't surprise me at all.

13 Q: No. Because we round, right? So, despite the
14 rampant use of rounding in your profession, it
15 doesn't change your mind, there can be no
16 rounding here.

17 A: Well, is that a question? No, I mean, there are
18 different things. I mean, if we're simply
19 trying to present numbers and the magnitude of
20 the numbers has no particular bearing on
21 anything, rounding makes no difference. But
22 when we're dealing with satisfying a specific
23 standard in a regulatory document, I think the
24 numbers have a lot of significance.

25 Q: DHEC does rounding in the State Health Plan,



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ROA_0517

1 correct?

2 A: When it doesn't matter, yes.

3 Q: Only inconsequential rounding. DHEC does
4 rounding in CON decisions. Are you familiar
5 with that?

6 A: I don't know what you're referring to.

7 Q: Are you familiar with any DHEC CON decision
8 wherein there was rounding used as part of the
9 decision making?

10 A: You know, I mean, I -- I mean, rounding is
11 something that anybody who works with numbers is
12 rounding from time to time.

13 Q: Right. And health planners round all the time.
14 DHEC rounds, the State Health Plan rounds,
15 right?

16 A: They do.

17 Q: The difference between 79.97 and 80 is eight
18 treatments, right? Isn't that the math?

19 A: It is.

20 Q: Eight treatments -- well, David Levitt uses 18,
21 right, 18 treatments on average per cancer
22 patient.

23 A: He does.

24 Q: Right? And I think you use 15.

25 A: I think that's more reasonable.



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ROA_0518

1 Q: Well, we'll get to that. But on David's
2 numbers, that's less than half the treatments an
3 average patient gets.

4 A: That's true.

5 Q: But even though eight treatments is less than
6 half the treatments the average patient's going
7 to get, it doesn't even equal one patient, there
8 still can be no rounding here. 79.97 cannot be
9 rounded to 80 in your opinion.

10 MR. THOMAS: I'm going to object, Your Honor. This
11 question has now been asked and answered. I've
12 ticked it off eight times on my pad.

13 MR. DAYHUFF: Different question each time.

14 MR. THOMAS: It's badgering at this point. He's
15 asked if he can round. He's said you can't.
16 He's given at least seven or eight different
17 examples. He's said no in each instance.

18 MR. DAYHUFF: And they're different examples ---

19 MR. THOMAS: And it's getting late.

20 THE COURT: I understand that the examples are
21 different, Mr. Dayhuff, but I believe Mr. Thomas
22 is right. The fundamental question's the same,
23 can you round in this situation? His answer
24 apparently is no. And I don't think you're
25 going to get him to change that answer. You can



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ROA_0519

1 try.

2 **MR. DAYHUFF:** Hope springs eternal, Your Honor.
3 That's fine. I'll move on. I think this
4 question is different, but we'll see.

5 Q: 79.97 can't be rounded. How about 79.98?

6 A: No.

7 Q: 99?

8 A: No.

9 Q: Let's look at Joint Exhibit Number 5, State
10 Health Plan Standard 7. All right. This is in
11 the 2015 State Health Plan. This is the
12 standard that applies to MUSC's linac CON
13 application, right?

14 A: It is.

15 Q: Now, the State Health Plan says that the
16 service, the existing service has operated at a
17 minimum use rate of 80 percent, which we've
18 talked about, of capacity for each of the past
19 two years, right?

20 A: Right.

21 Q: Now, it does not say, by the way, 80 percent is
22 reflected by the past two JARs, right?

23 A: It doesn't.

24 Q: All right. And the State Health Plan, when it
25 wants providers to use -- the State Health



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ROA_0520

1 Planning Committee, when it wants providers to
2 use JARs, it tells us to do it, right?

3 A: Not always.

4 Q: Let's look at Joint Exhibit 6.

5 A: Okay.

6 (Joint Exhibit Number 6 was introduced into the
7 record at this time.)

8 Q: It's the 2017 State Health Plan that I misspoke
9 earlier about calling it the 2016. The 2017
10 State Health Plan applied to Roper's CON
11 application.

12 A: That's true.

13 Q: And Number 6 is the State Health Plan standard
14 that applied to Roper, because they were a newly
15 licensed new service as opposed to an expansion,
16 right?

17 A: Right.

18 Q: And the State Health Plan there says in one of
19 their standards all existing units in the
20 service area have performed at a combined use
21 rate of 80 percent of capacity as evidenced in
22 the most recent joint annual reports, right,
23 JARs?

24 A: That's what it says.

25 Q: So, when the State Health Plan Committee wants



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ROA_0521

1 us to use JARs, they tell us, right?

2 A: I mean, there are other parts of the State
3 Health Plan where it doesn't explicitly say use
4 JAR data, but I've always used JAR data in
5 responding to it.

6 Q: And that's your practice.

7 A: It is.

8 Q: All right.

9 **MR. DAYHUFF:** Let's look at Joint Exhibit 5 again,
10 the State Health Plan Standard 7 again, Dan.

11 Q: All right. And just to be clear, it doesn't say
12 JAR. It also doesn't say the past two fiscal
13 years, right?

14 A: It just says two years.

15 Q: Or the past two calendar years. And you heard
16 Mr. Thomas argue in his opening the past two
17 years means the past two years before you filed
18 the CON application, right?

19 A: Yes.

20 Q: The past two years immediately proceeding the
21 filing of the CON application, right?

22 A: Right.

23 Q: Now, when the State Health Plan committee wants
24 past to mean immediately proceeding, they say
25 so, don't they?



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ROA_0522

1 A: Well, I'm sure they don't in every case, but ...

2 Q: Let's look at Joint Exhibit Number 5, Standard
3 6. All existing units -- and this doesn't apply
4 to MUSC, this is for a new provider. All
5 existing units in the service area have
6 performed at a combined use rate of 80 percent
7 of capacity for the year immediately preceding
8 the filing of the applicant's CON application.
9 That language doesn't appear in Standard 7, does
10 it?

11 A: It doesn't say immediately preceding the filing.

12 Q: Yes. It's past.

13 A: Right.

14 Q: Now, when we reach the Administrative Law Court,
15 as we are here today, the ALC conducts a de novo
16 trial on the CON application at issue, right?

17 A: Correct.

18 Q: The ALC decides whether the CON application
19 should be approved or denied, yes?

20 A: Yes.

21 Q: Considers all the issues raised or considered by
22 DHEC, right?

23 A: Yes.

24 Q: ALC gets to use more recent updated data by
25 which to make its decision.



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ROA_0523

1 A: It has that flexibility, yes.

2 Q: It has that discretion.

3 A: Right.

4 Q: And the ALC can consider data that wasn't
5 available at the time of the DHEC review.

6 A: It can.

7 Q: Right? Generally speaking, it makes good health
8 planning sense to consider more updated data
9 because these CON applications, when they're
10 challenged, take time to progress through the
11 DHEC process and to get to court, right?

12 A: Sure.

13 Q: All right. In your opinion, this Court could
14 consider the most updated information we have in
15 this case?

16 A: It can certainly it, but I don't think it can
17 use that to correct an incorrect decision by
18 DHEC initially.

19 Q: This Court could consider calendar year 2017 and
20 calendar year 2018 data in this case?

21 A: Sure. I think they could consider any prior
22 utilization data.

23 Q: And if MUSC exceeds 80 percent for these two
24 calendar years, MUSC would technically satisfy
25 the 80 percent State Health Plan standard in



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ROA_0524

1 Standard 7?

2 A: I disagree with that.

3 Q: All right. Let's look at your deposition.

4 A: Okay.

5 Q: Christmas present, a late Christmas present.

6 And when you open it, I'd like you to turn to

7 page 170.

8 A: 170?

9 Q: 170.

10 A: Okay.

11 Q: Particularly lines 16 to 23.

12 A: Okay.

13 **MR. DAYHUFF:** Dan, can you put it up on the screen?

14 Q: I'm just going to read it. Just tell me if I

15 misread it. Let's see. Actually let's go to

16 172, Dan.

17 A: Okay.

18 Q: Dan Bupp, Mr. Sullivan. 172, line 8 is where

19 I'm going to start. Are you there? Question:

20 Okay. Start strong. So what about -- so you've

21 already given me your opinion on the calendar

22 year '17, '18, right, which is -- yeah, that

23 would satisfy -- answer: I mean -- question:

24 -- if you conceded -- answer: I mean,

25 technically I think the judge could consider

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ROA_0525

1 that if he chose to. See that? Did I misread
2 that?

3 A: No.

4 Q: All right. Now, let's look back at 170.

5 A: Okay.

6 Q: Where I started before. I'm going to start at
7 12. Question: And we almost always provide
8 updated information on our CON cases in South
9 Carolina, do we not? Answer: Sure. Question:
10 Let me ask you to assume hypothetically that
11 2017 and 2018 calendar year show MUSC at above
12 80 percent. Do they satisfy the State
13 Health Plan -- now I did not say that. I said
14 satisfy and you didn't correct your deposition.
15 We'll leave that aside.

16 A: I usually don't correct the questions, just the
17 answers.

18 Q: Question -- Mr. Thomas: Object to the form.
19 That wasn't a question. Question: In your
20 opinion. Answer: That's a good question.
21 Haven't thought about it. I -- I guess
22 technically, yes.

23 **MR. THOMAS:** Your Honor, I'm going to object to the
24 inflections. First of all ---

25 **MR. DAYHUFF:** That's exactly the way it sounded.



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ROA_0526

1 **MR. THOMAS:** Secondly, Mr. Dayhuff, I guess, is
2 trying to make a point about something that Mr.
3 Sullivan just said, but he didn't use the term
4 hypothetically with Mr. Sullivan in the initial
5 question. So, I just want the record to be
6 clear on that.

7 **MR. DAYHUFF:** I don't know what that objection was.

8 **MR. THOMAS:** It's argumentative.

9 **THE COURT:** He said before you asked the question
10 from the deposition you asked him the question
11 alive and you didn't say hypothetical. That's
12 what his objection is, I think.

13 **MR. THOMAS:** Correct, Your Honor. I'm sorry. I
14 should have been ---

15 Q: I also asked you about 2017, 2018 annualized.

16 A: Right.

17 Q: And you told me no.

18 A: Right.

19 Q: In answer to that, no. Not technically I think
20 the judge could consider it. All right. Now --

21 -

22 A: Could I explain that answer?

23 Q: Maybe on Re-Direct.

24 A: Okay. Sure.

25 Q: No, go ahead. Why not?



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ROA_0527

1 A: When I said technically yes, I think what I was
2 thinking of is could the judge consider it,
3 sure. That's -- what I didn't answer was did I
4 think that that overcame the problem with
5 relying on the incorrect data initially. We
6 were just talking in this hypothetical universe
7 and -- but I think I testified at the time of my
8 deposition and I testified earlier today that
9 the agency relied on the wrong data, came to the
10 wrong decision, and that changed the whole
11 analysis. You can't go back and fix that at
12 this point in time by having later data that
13 says at the time that the application was filed
14 we satisfied the two year prior....

15 Q: I understood your testimony today. Your point
16 was, look, the question before this Court is did
17 DHEC make the right decision back then.

18 A: Right.

19 Q: And you can't fix it.. Well, we're not here --
20 is it your understanding we're here for this
21 Court to decide whether DHEC made the right
22 decision or not?

23 A: Well, I know it's a de novo proceeding.

24 Q: That's right.

25 A: But I think The Court has to take into



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ROA_0528

1 consideration what would be the impact of using
2 later data.

3 Q: It'd be different if The Court was sitting here
4 in a capacity where they review the DHEC
5 decision and decide whether it was supported by
6 substantial evidence. We're here for The Court
7 to decide, within the administrative process,
8 whether a CON application is approved or not,
9 right?

10 A: We are.

11 Q: This Court is in the executive branch. This
12 Court applies the Administrative Procedures Act.
13 This Court is in agency function much like DHEC.
14 Agree?

15 A: It is. If I could explain. If the decision
16 created the situation that we have today, and
17 the decision is that Trident is now the
18 Petitioner, I don't think that this Court can
19 say I'm going to consider, after the fact,
20 utilization data to satisfy what should have
21 been a different decision at that point in time.
22 I think that -- I can't tell the judge what to
23 do. I'm just saying from my health planning
24 perspective what I would be concerned about is,
25 did the applicant meet the requirements of the



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ROA_0529

1 standards at the time they submitted the
2 application? Does the later information that's
3 filed, which I can consider, support that
4 conclusion or not?

5 Q: That is going to be a question for the judge,
6 right?

7 A: Right.

8 Q: And back on your distinguishing the hypothetical
9 world. The reason it was hypothetical when I
10 asked you in December, December 18, 2018, about
11 MUSC's calendar year 2018 data is we didn't
12 know. We had to wait until December ended
13 before we had data.

14 A: I certainly didn't know.

15 Q: Well -- and when I asked you the question, I
16 said assume hypothetically 2017, 2018 calendar
17 years show MUSC at above 80 percent. Do they
18 satisfy, my correction, the State Health Plan in
19 your opinion? That's a good question. I guess
20 technically yes. I don't remember you cabining
21 that or qualifying that in the way you described
22 today.

23 A: I guess I just didn't -- we didn't go there in
24 the deposition. You were just asking me could
25 the Judge consider that and would that



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ROA_0530

- 1 technically be in compliance with the State
2 Health Plan. That would be two prior years.
3 And I was just talking about it in the abstract.
4 But I wasn't talking about the specifics of this
5 particular case.
- 6 Q: And maybe that's my fault. I was pretty focused
7 on that 80 percent and actually proving us, but
8 you thought I was talking generally about what
9 the Judge can consider.
- 10 A: Yeah, I did.
- 11 Q: Okay. Fair enough. All right. So, if the
12 Administrative Law Court were to approve this
13 application today, January 15th -- is it the
14 15th -- 2019, we look back at the past two
15 years, that would be calendar year 2018 and
16 calendar year 2017, before this final
17 administrative approval, MUSC meets Standard 7.
- 18 A: I don't agree that they do because I think the
19 capacities are wrong, but ---
- 20 Q: Setting aside our capacity arguments.
- 21 A: If you accept the 24,000 treatment capacity,
22 then they -- technically they would satisfy the
23 80 percent.
- 24 Q: Right. So, we look back two past years. That's
25 exactly what the State Health Plan says. Now,



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ROA_0531

1 if we ---

2 **MR. THOMAS:** Object -- I'm going to object to that
3 last -- again, that's testifying. That's
4 exactly what it says. He's not asking
5 questions. He's making statements and then
6 leading into another question and it just junks
7 up our record, Your Honor. So, I'd ask that
8 he'd stop.

9 **MR. DAYHUFF:** Those objections junk up our record,
10 Your Honor. But I will attempt to make all my
11 transitions questions.

12 **THE COURT:** All right.

13 **MR. DAYHUFF:** And we really get along. I think it's
14 a long day.

15 **MR. THOMAS:** You think?

16 **MR. DAYHUFF:** Maybe not.

17 **MR. THOMAS:** It's a long day.

18 **MR. DAYHUFF:** Good.

19 **MR. THOMAS:** We get along.

20 **Q:** So, if we were to take your suggestion, I think
21 the answer would be, hey, we got to go re-file,
22 right?

23 **A:** Yes.

24 **Q:** Right. And so, we re-file tomorrow. We would
25 look back to the past two years. You'd be okay



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ROA_0532

1 with calendar year 2018 and 2017?

2 A: I would.

3 Q: And so we'd be back here -- well, wait. First
4 we'd go to the DHEC process where Trident would
5 challenge us ---.

6 A: Or somebody else might also file a competing
7 application.

8 Q: Well, anything is possible, I suppose.

9 A: Yes.

10 Q: And then we'd be back here in a gigantic circle.
11 Why -- does that make any health planning sense?

12 A: It does.

13 Q: Fair enough.

14 A: You have to have standard procedures in the way
15 that you review the applications.

16 Q: Okay. Does that make any sense from the
17 perspective of judicial economy?

18 A: It does, because if you -- you don't want to
19 apply standards that are going to create
20 problems down the road. And I think this type
21 of approach would create additional problems.

22 Q: There are 19 24-month periods between 2015 and
23 2018 -- I may have those dates a little wrong --
24 where we had over 80 percent utilization. Do
25 you recall looking at the document that was put



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ROA_0533

1 on the screen for you earlier today?

2 A: Yes.

3 Q: Does The Court have the discretion to consider
4 those 24-month periods for the purpose of
5 satisfying Standard 7?

6 A: In my view The Court can -- of course The Court
7 can look at that. But as far in my view in
8 terms of approving the application, I think they
9 should stop at the time of the decision in this
10 case by DHEC.

11 Q: Right. Okay. Let's talk about the capacity.

12 A: Okay.

13 Q: The alteration of our capacity. The State
14 Health Plan comes out, what, every two years or
15 so?

16 A: Yeah.

17 Q: Provides health planning standards for
18 facilities and services?

19 A: Depending on the politics, sometimes longer.

20 Q: 2014 was a rough year?

21 A: Yeah.

22 Q: State Health Plan provides inventories,
23 facilities and services, utilization data,
24 right?

25 A: Yes.



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ROA_0534

1 Q: Amended from time to time?

2 A: Yes.

3 Q: The process for amending it?

4 A: There are public hearings.

5 Q: Right. Notice, public hearings. And if a
6 provider wants to amend the State Health Plan,
7 what do they do?

8 A: Sometimes they appear in person at a public
9 hearing. Sometimes they file written comments.

10 Q: Right. And then what happens to those comments?

11 A: They're evaluated by DHEC. And in some cases
12 they're adopted and in some cases they're not.

13 Q: Okay. And it was my understanding that DHEC
14 would look at those proposals and either
15 recommend their approval by the State Health
16 Planning Committee or recommend their denial.
17 Is that your understanding?

18 A: That's right.

19 Q: And the State Health Planning Committee will
20 have the final determination.

21 A: That's true.

22 Q: And then, if the amendment makes it out, the
23 next State Health Plan has that amendment,
24 right?

25 A: Correct.



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ROA_0535

1 Q: And are you aware of any other way to amend the
2 State Health Plan?

3 A: No.

4 Q: All right. One of the things the State Health
5 Plan has it are linear accelerator capacities
6 for linac providers, right?

7 A: They do have that in there.

8 Q: 2015 State Health Plan assigns MUSC a 24,000
9 treatment capacity.

10 A: They do.

11 Q: And you offer the opinion that certain of our
12 linacs should not have the treatment capacity
13 that has been assigned by the State Health Plan.

14 A: I'm not sure if it was assigned by the State
15 Health Plan, but it was published in the State
16 Health Plan just like the erroneous utilization
17 data was published in the State Health Plan.
18 And I think you've always had the -- I mean, my
19 experience is you've always had the ability to
20 question the numbers that are in the State
21 Health Plan. -- And if we could document that
22 something was wrong, then DHEC would take that
23 into consideration.

24 Q: Have you had that experience in a CON case where
25 you have changed a provider's State Health Plan



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ROA_0536

1 capacity through the process of a contested
2 case?

3 A: Let me think about that.

4 Q: Okay.

5 A: I can't recall a specific situation. I know
6 there's been arguments before about how many
7 beds somebody really has. Sometimes the numbers
8 that are published in the State Health Plan are
9 deemed to be inaccurate and there would be
10 different bed configuration that would be
11 counted.

12 Q: But you don't recall a linear accelerator
13 capacity change being effectuated through the
14 contested case process by a CON ...

15 A: I don't. I've only been involved in one South
16 Carolina linear accelerator litigation process.

17 Q: Did it happen in that case?

18 A: It did not.

19 Q: And that's the only one you've been involved in
20 in South Carolina?

21 A: The only one that went to a hearing that I
22 recall.

23 Q: Understood. All right. Now, you criticized
24 Roper for manipulating its linac capacity.

25 A: I did.



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ROA_0537

1 Q: And now you are changing MUSC's linac capacity?

2 A: Well, I'm just looking at the underlying data
3 and suggesting that it's wrong.

4 Q: Let's look at Trident Exhibit 8. I think this
5 will reflect some of your work. So, tell us
6 what we have on the screen here, Mr. Sullivan.

7 A: This was something I did prior to my deposition.

8 Q: That's right. But it would help if we could
9 understand your methodology, I suppose, with it.

10 A: Sure. I mean, basically I was guessing what the
11 capacities were. I didn't know what MUSC was
12 claiming for individual units. And so I looked
13 at the underlying data that was provided to us
14 by MUSC and I believe in this case I looked at
15 2018 fiscal year data and looked at the
16 percentage of IMRT that was provided, and ---

17 Q: And SBRT, right?

18 A: And SBRT. And in this first pass I said I don't
19 what -- you know, eight percent's not a lot of
20 SBRT, but I said I won't argue about that right
21 now and I'll give you 4500. And I thought there
22 should be 5000 on the tomo, 5000 on the 140 and
23 the HCC unit, and then 7000 on the 600CD.

24 Q: All right. And at the time of your deposition
25 do you recall which ones went up and by how



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ROA_0538

- 1 much? Our capacity was 24, so you went up by a
2 total of ---
- 3 A: 2500.
- 4 Q: 2500. So, just -- what went up, again?
- 5 A: Well, I know the -- I know now that -- I think
6 MUSC says that the Varian 600CD has a 5,000
7 capacity.
- 8 Q: Okay.
- 9 A: So, and I said that should be seven. And I
10 believe that the TB140 has a -- MUSC claims a
11 capacity of 4500 and I went up to 5,000 on that.
- 12 Q: All right. So, if I understand this then, you
13 looked at this specialized scan volume that we
14 have in our linacs, concluded some linacs don't
15 do enough of the specialized treatment. And
16 when I say, we're talking about SBRT. That was
17 the reason you made changes, not IMRT. Am I
18 right?
- 19 A: Well, IMRT was the reason I changed the Varian.
- 20 Q: Oh, changed the Varian.
- 21 A: Yeah.
- 22 Q: I'm sorry, right. So, you modified the
23 treatment capacities based on how we actually
24 used them.
- 25 A: Right.

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ROA_0539

1 Q: Does the State Health Plan provide a particular
2 number of IMRT or SBRT that must be performed to
3 entitle a provider to a lower capacity?

4 A: It doesn't. It just says sufficient.

5 Q: And you made the decision about what constitutes
6 sufficient in your opinion.

7 A: I did. I mean, I think Mr. Levitt, your expert,
8 said that 20 to 25 percent wasn't enough. And
9 I don't disagree with that. And I think I
10 testified at my deposition that I thought if you
11 got over 40, that was probably sufficient.

12 Q: And did Mr. Levitt's opinion pertaining to IMRT,
13 SBRT, or both?

14 A: It was in the context of IMRT, but I think it's
15 a fair extension to SBRT as well.

16 Q: And you always agree with Mr. Levitt.

17 A: We agree on a lot of things.

18 Q: Just like Mr. Thomas and I. All right. Just
19 out of curiosity, did you analyze how many
20 specialized treatments, SBRT, IMRT, Trident's
21 linacs do to make sure Trident's not living in
22 a glass house with respect to this issue?

23 A: Did I do that? No. You know, I think that the
24 expectation is that Trident's capacity is going
25 to go up as a result of the replacement of the



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ROA_0540

1 Elekta unit.

2 Q: I'm not worried about the future right now.

3 A: Okay.

4 Q: I'm just wondering if you looked at their
5 utilization to see if -- what their mix of
6 specialized scans and normal scans are.

7 A: I did not.

8 Q: All right. Let's look at the 2016 JAR for
9 Trident.

10 A: Okay.

11 **MR. DAYHUFF:** Do you have that, Mr. Bupp? All right.

12 Is that what we have in front of us? What's
13 that exhibit, Mr. Bupp?

14 **MR. BUPP:** Joint Exhibit 1.

15 **(Joint Exhibit Number 1 was introduced into the**
16 **record at this time.)**

17 Q: Joint Exhibit 1 in front of us. Is that
18 Trident's JAR, Mr. Sullivan?

19 A: For 2016, yes.

20 Q: If we could scroll to where we can look at the
21 types of scans. And you tell Mr. Bupp where he
22 needs to stop for you to see.

23 A: The bottom of -- here we go.

24 Q: All right. What do you see?

25 A: This gives you the total number of treatments up



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ROA_0541

1 here.

2 Q: Okay. Is that the -- all right. 2016, that's
3 the 10,000?

4 A: 10,422.

5 Q: All right.

6 A: And then that number three, it gives you the
7 number of IMRT, GRT treatments and then it has
8 the number of stereotactic treatments.

9 Q: All right. 126 stereotactic treatments.

10 A: Yes. I would agree that's a very small amount.

11 Q: Yeah, that is. Would you agree that Trident
12 should not have -- should we raise Trident's
13 capacities?

14 A: Yeah. I think the Elekta has been in the State
15 Health Plan at 4500. I think that's certainly
16 -- given that low volume of SRS, I would think
17 that that would not justify that having a 4500
18 capacity. I believe that the older unit there,
19 the 2002 unit has a 7,000 capacity. I would
20 agree with that. And the TrueBeam that they got
21 in 2015 has a 5,000. I would agree with that.
22 So, I think the one unit should probably go from
23 4500 to 5,000.

24 Q: So, the stereotactic treatments that are
25 reflected here, do we know how they are spread



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ROA_0542

1 amongst the two units that Trident operates?

2 A: I think I asked that question. I believe those
3 are done on the new TrueBeam.

4 Q: And by new, we mean at that time the one that
5 was installed in 2015?

6 A: Right.

7 Q: Now, let's look at the State Health Plan 2015
8 where it talks about the capacities. And before
9 we leave that, Mr. Sullivan, so that 126 is a
10 lot lower than the TB140's 389, right?

11 A: It is. It's lower.

12 Q: That you changed. All right. Let's look at
13 State Health Plan 2015.

14 **MR. DAYHUFF:** If you could get me a closer on the
15 linac capacity number two, I think. Or number
16 one. Let's look at number two.

17 Q: So, I'm sorry, what treatment capacity did you
18 tell me the -- or maybe you didn't -- the Elekta
19 Synergy S?

20 A: I think it had a 4500.

21 Q: Okay. So, we know, don't we, that the Elekta
22 Synergy S had zero IMRT, IGRT in 2015?

23 A: Sure. I mean, you could give it a 7,000. That
24 wouldn't offend me.

25 Q: And at zero IMRT, IGRT, SBRT in 2016?



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ROA_0543

1 A: It did.

2 Q: At zero at all of those in 2017?

3 A: I agree with that.

4 Q: Why wouldn't it be given a zero ---

5 A: Capacity?

6 Q: --- if it's not operating?

7 A: Because, I mean, it has the capacity, it's just
8 not needed. I mean, you could argue that it
9 should be 7,000. I mean, I think the new
10 TrueBeam that's coming in will both do IMRT and
11 then sufficient number is that it should get a
12 5,000.

13 Q: Or perhaps you could argue that a unit that's
14 not operated at all shouldn't have an assigned
15 capacity.

16 MR. THOMAS: Object to -- Your Honor. That's
17 argumentative and there's no foundation laid.
18 He's already asked and answered the question.

19 MR. DAYHUFF: I'm going to ask you to overrule.

20 THE COURT: Why? Tell me why.

21 MR. DAYHUFF: There didn't need to be a foundation
22 laid to ask this expert about his opinion about
23 whether or not a unit that is not being used
24 could have a zero and not have any capacity
25 under the State Health Plan. That was the



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ROA_0544

1 question.

2 **MR. THOMAS:** He answered it. He said no, it should
3 be 7,000 if you want to give it one. He
4 answered the question. Mr. Dayhuff is asking
5 roundabout questions two and three times.
6 That's why we're still here at 5:20 this
7 afternoon. But he answered the question.

8 **THE COURT:** He did.

9 **MR. DAYHUFF:** Okay. I heard Mr. Thomas' objection
10 and not an answer to the question. That's fine.
11 If he answered it, that's fine.

12 **Q:** All right. Many of the capacities assigned to
13 MUSC's machines were assigned years ago, right?

14 **A:** That's what they contend. I mean, I don't have
15 any personal knowledge, but I did read -- or
16 someone said that the 600CD machine was assigned
17 that capacity in 1999. I have no knowledge of
18 that.

19 **Q:** Well, isn't it generally the process that when
20 you get your CON application, you get a CON and
21 you ask for a capacity and then accept it or
22 not?

23 **A:** I thought that these standards changed since
24 1999 and I don't think that they were assigning
25 capacity -- now, this was a more recent change



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ROA_0545

1 and I don't remember the exact year it changed.
2 But this notion about assigning capacities I
3 don't think was around at the time that that
4 600CD was first approved.

5 Q: Do you know how the MUSC linacs got their
6 capacities and why?

7 A: There apparently was some correspondence with
8 DHEC, but I'm not privy to that.

9 Q: All right. You don't know whether they made an
10 allowance, DHEC made an allowance years ago for
11 teaching or peds or peds sedated? You just
12 don't know?

13 A: Don't know.

14 Q: All right. Let's look at Trident Exhibit 8,
15 Sullivan 31 Revised, I think.

16 A: Right.

17 Q: And this is part of your capacity analysis,
18 right?

19 A: It is.

20 Q: So, if we look at TB140, that's the Mt. Pleasant
21 linac; is that right?

22 A: I believe that's right.

23 Q: And we did 20 SBRT?

24 A: Right.

25 Q: Which you rounded down to zero.



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ROA_0546

1 A: I did round.

2 Q: Yep. That's one of 19. Now, you also, after
3 your deposition, are now changing the capacity
4 the Varian TB41; is that right?

5 A: Yes.

6 Q: Did SBRT of 389.

7 A: It did.

8 Q: And last, but not least, you still are rounding
9 down -- or I'm sorry, changing the capacity of
10 the Varian 600CD; is that right?

11 A: Right. To 7,000.

12 Q: All right. So, you took a linac that's doing 73
13 treatments a year and rounded that to 7,000?

14 A: I didn't round it. I just ---

15 Q: I'm sorry. Assigned a new capacity of 7,000.

16 A: I did.

17 Q: And if you do those things, you increase our
18 treatment capacity at MUSC, you increase our
19 utilization, and we're below 80 percent, right?

20 A: You're below 80 percent in every period, yes.

21 Q: Oh that's right. Because you don't round and
22 you don't accept calendar year. So, this is
23 another reason we are, in your opinion, below --

24 -

25 A: I accept calendar year. I mean, I don't think



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ROA_0547

1 I ever said I don't accept calendar year. I
2 just said that the starting point is to look at
3 the JARs and the JARs happen to be on a fiscal
4 year.

5 Q: I understand. But you don't accept, unless I'm
6 mistaken -- I thought you accepted calendar year
7 when I took your deposition.

8 A: Yeah.

9 Q: You don't accept it as being determinative now
10 of whether this Court could grant the CON
11 application.

12 A: I don't accept future calendar years.

13 Q: Okay. I guess it depends on where we ---

14 A: Right.

15 Q: --- consider now. Are you really opining here
16 that it's appropriate to amend a provider's
17 State Health Plan assigned linac capacity? I
18 mean would that practice comport with the State
19 Health Plan amendment process?

20 A: I've never known the assignment of capacity to
21 really be part of the State Health Plan
22 amendment. It seemed to me that it was a
23 negotiation between the providers and the -- you
24 know, and DHEC.

25 Q: Provider makes a request to DHEC. DHEC



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ROA_0548

1 recommends whether that request to increase or
2 decrease the capacity is accepted. State Health
3 Plan in the next plan approves or does not
4 approve DHEC recommendations. That's the way it
5 works.

6 A: I didn't -- I was not aware that that went
7 before the State Health Planning review.

8 Q: If we adopt your practice to allow CON litigants
9 the opportunity to change elements of the State
10 Health Plan they disagree with, wouldn't that
11 create a lot of chaos within the contested case
12 process?

13 A: I don't think so. I mean, what we're saying
14 here is that providers have -- DHEC, I think,
15 has admitted -- I think Ms. Murdock admitted in
16 her deposition that there was no process for
17 going behind the applicant's -- I mean, not the
18 applicant's -- the provider's suggestion as to
19 what their capacity would be and that they were
20 working towards doing something like that. But
21 when we have concrete evidence that -- for
22 example in Mt. Pleasant -- that only 20 SBRT
23 treatments were provided, why would you think
24 that that deserved a lower capacity when it had
25 virtually no impact on the availability of



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ROA_0549

1 capacity to serve other types of patients? And
2 if you look at the number of treatments that
3 were actually provided in Mt. Pleasant, for
4 example, they provided over 5000 treatments.
5 So, why would a 4500 capacity make sense if you
6 know that they're providing more than that now?

7 Q: Let's look at Joint 5, State Health Plan Section
8 7 again. The last sentence in 7. Can you read
9 that for me, Mr. Sullivan

10 A: If the applicant can justify this proposed
11 annual capacity, then this capacity will be used
12 in CON application calculations, as well as
13 future capacity calculations, for the applicant.

14 Q: So, this standard envisions that, if you get a
15 CON capacity that is approved by DHEC and it's
16 incorporated in the Plan, it's going to be used,
17 absent an amendment to the Plan, for future
18 capacity calculations for that applicant.

19 MR. THOMAS: Object to -- I'm sorry, Your Honor. I
20 know it's late hour, but I'm objecting. He
21 added in there absent an amendment to the Plan.
22 That's not in the language that he was just
23 reading.

24 THE COURT: I understand.

25 MR. DAYHUFF: I can rephrase.



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ROA_0550

1 **THE COURT:** I think that you can read it again
2 without that in there, but ---

3 **MR. THOMAS:** Or it can speak for himself.

4 **THE COURT:** It speaks for itself I think. But I
5 guess the question is, and that's what you're
6 arguing Mr. Dayhuff, is whether, once it's in
7 the Plan, it has to go through a Plan amendment
8 or a Plan creation to be changed.

9 **MR. DAYHUFF:** Correct.

10 **MR. THOMAS:** I don't see that in the language.

11 **THE COURT:** Well, once it gets in the Plan -- that's
12 what this says, it gets in the Plan and it's
13 going to be used until it's changed.

14 **MR. THOMAS:** Well, it just says as well as future
15 capacity calculations for that applicant. It
16 doesn't say unless it's changed.

17 **THE COURT:** Why would you be doing a future capacity
18 calculation unless it's part of the Plan,
19 something you're doing through the Plan?

20 **MR. THOMAS:** Yeah. I guess our argument, you know --
21 -

22 **THE COURT:** And I'm not trying to argue with you.
23 I'm just trying to understand.

24 **MR. THOMAS:** Yeah. And our position is, and I guess
25 we've made it clear, is that, you know, DHEC



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ROA_0551

1 expects you to act -- kind of on the honor
2 system. I'll get into that with Ms. Murdock
3 tomorrow, but ---

4 **THE COURT:** I'm sure you will.

5 Q: If we are able to -- if CON litigants are able
6 to change capacity, change elements of the State
7 Health Plan, I suppose MUSC could do that if
8 there was justification, change elements of the
9 Plan during the CON process in this case?

10 A: Sure. I mean, if they came in and said, this
11 has been a 7,000 capacity unit and we realized,
12 in looking at the data, that we've been doing a
13 lot of IMRT on this unit and we think it should
14 be given a 5,000, I think that's fair game.

15 Q: Right.

16 A: I mean, I think that's -- as we talked about,
17 this is a de novo proceeding. And if we look at
18 the underlying data -- I mean, we want to make
19 the decisions that are most consistent with the
20 definitions in the Plan.

21 Q: Right. So, if we can change the State Health
22 Plan, we have a linac, an old linac that does
23 only TBI, we know that it does 73 procedures,
24 yet it has a four or five -- 4500, 5,000 State
25 Health Plan ---



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ROA_0552

1 A: 5,000.

2 Q: And you give it seven, how about, in light of
3 the fact that it does only TBI, we create
4 through this process, this contested case
5 process, a new State Health Plan standard that
6 more accurately reflects what that does and
7 subtract 7,000 or 5,000 from MUSC's total
8 capacity?

9 A: You could try. I don't think that could work
10 because I think the capacity of it is what the
11 capacity is and that is how many treatments can
12 you do in a given time period.

13 Q: If the healthcare provider believes a linac
14 capacity is in error, you can always apply to
15 DHEC to change capacities and change the State
16 Health Plan.

17 A: You could. But, to be honest, we never knew
18 what the capacities were for these individual
19 units. And we didn't have the underlying data
20 to be able to test whether those were reasonable
21 capacities to be assigned. It was only through
22 the discovery process that we learned what the
23 utilization data looked like and what -- I mean,
24 we didn't know which unit had which capacity.

25 Q: Trident didn't make any requests to DHEC about



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ROA_0553

1 MUSC's capacity or changes to capacity?

2 A: Not to my knowledge.

3 Q: Even if it was legally available to vary from
4 the established State Health Plan amendment
5 process, wouldn't it be better from a health
6 planning perspective not to engage in ad hoc,
7 free-for-all amendments during the contested
8 case process?

9 A: I guess I don't view this as being free-for-all.
10 I guess what this is, is trying to true up, if
11 you will, the capacities based on actual
12 utilization data because we're trying to make
13 judgments about whether an 80 percent standard
14 is met.

15 Q: You changed two of our machines' capacity at the
16 time of your deposition. You came here today
17 and you changed the third of our machine's
18 capacity. Is that right?

19 A: I think I changed one of them less -- or more.

20 Q: Are there going to be any other changes I need
21 to be made aware of?

22 A: No.

23 Q: Great. Now, let's talk about your treatments
24 per patient issue. As I understood earlier
25 David uses 18, you use 15. So, you believe



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ROA_0554

1 David's 18 is not reasonable or overly
2 aggressive?

3 A: Yeah. I think it's high.

4 Q: Let's look at MUSC Exhibit 19.

5 A: Okay.

6 Q: This is our old St. Joseph/Candler linac
7 application, October 20 -- October 10, 2017.

8 A: Sure.

9 Q: We filed our CON application in May of 2017.
10 You assisted on this CON application, right?

11 A: I did.

12 Q: All right. Let's look at the pro forma in here.
13 I think it's 2869. In this CON application you
14 used 20 treatments per patient in Year 1, 20 in
15 Year 2, and 19 in Year 3.

16 A: Right. That's because the actual experience of
17 that applicant, I believe, was 21 treatments
18 historically. And I was assuming it was going
19 to go down over time, so I had a small decline
20 each year in the number of treatments. MUSC's
21 experience is that for the last couple of years
22 they performed less than 15 treatments per
23 patient. And I think the likelihood is that
24 their numbers are going to continue to creep
25 downward. But you look at each individual's



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ROA_0555

1 experience, rather than try to pick a number out
2 of the universe of all providers.

3 Q: You offered the opinion today -- I think you
4 criticized our community support, which is a
5 project review criteria, community need?

6 A: Yeah. I just said I didn't see a lot of
7 community members. I saw a few doctors and then
8 a couple of administrators from outside the
9 service area.

10 Q: All right. But not to cut that short, I
11 suppose. Your opinion is we satisfy that
12 criteria.

13 A: Well, I think you asked me do -- you asked in my
14 deposition do letters of support from doctors or
15 from other individuals and I guess a state
16 representative, does that constitute community
17 support, and I said yes. I'm just saying that
18 I didn't think the community support should be
19 given a lot of weight in the evaluation of these
20 applications.

21 Q: I understand. I don't think it's one of the
22 most important criteria, do you?

23 A: I think it could have been. I mean, if -- you
24 know, I've done a lot of radiation therapy
25 cases. And oftentimes one of the things that



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ROA_0556

1 are present in these radiation therapy cases is
2 an outpouring of letters from patients who are
3 having to travel long distances to get radiation
4 treatment. And that, I think, is persuasive
5 from a health planning standpoint, because you
6 actually have testimonials from individuals who
7 say, this is how hardships were inflicted on me
8 as a result of having to travel long distances.
9 We didn't see any of that in this particular
10 case.

11 Q: We're talking about the project review criterion
12 accepted it, right? Isn't that where the
13 community letters reside, letters?

14 A: It is. It is.

15 Q: You're not telling me that acceptability is
16 generally as important as other criterion like
17 need, financial feasibility, and adverse impact,
18 are you?

19 A: No. I'm not saying -- typically State Health
20 Plan community need are the most important
21 criteria. But I'm saying that sometimes that
22 particular criterion rises up because there's a
23 sufficient ground swell of community support
24 that outlines the scope of a particular problem.
25 And in this case I didn't see that.



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ROA_0557

1 Q: Well, I just want to be clear. Ultimately did
2 you not conclude that, while you don't believe
3 our letters are as many as there should be and
4 from a variety of folks, I suppose, that we
5 satisfy the acceptability community support
6 criteria in 61-15?

7 A: Sure. You demonstrated some community support.
8 I'm just saying it should not be given much
9 weight in the evaluation of this application.

10 Q: In your experience, Trident's a well-managed,
11 profitable hospital?

12 A: It is.

13 Q: Mr. Gallati's the CEO. I imagine he's, in a
14 large part, responsible for that facility being
15 well managed and profitable.

16 A: He's done a good job, based on my knowledge.

17 Q: He's got an MBA, MHA, 30 years of experience in
18 hospital administration, ten at Trident.

19 A: Yes.

20 Q: He's not in the habit of making decisions that
21 harm Trident's bottom line.

22 A: I think in some cases you have to make decisions
23 that harm your bottom line because it serves
24 some greater purpose.

25 Q: Sure. But, if he were in the habit of making



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ROA_0558

1 decisions that harmed Trident's bottom line, he
2 wouldn't have the tenure that he does with HCA,
3 or Trident for that matter.

4 A: Sure. On balance.

5 Q: Right. So, Trident's rad onc service line is
6 profitable today?

7 A: That's my understanding.

8 Q: Certainly in Mr. Galatti's best interest and the
9 hospital's best interest to keep that service
10 line profitable.

11 A: It is.

12 Q: Talked about protecting his oncology service
13 line yesterday.

14 A: He did.

15 Q: Or was that today? Yesterday.

16 A: Yesterday.

17 Q: You concluded that neither the MUSC or Roper CON
18 application for linear accelerators in Berkeley
19 County should be approved in part because
20 approval of those applications would cause
21 Trident adverse impact, material adverse impact,
22 right?

23 A: Yes.

24 Q: In October of 2018 Trident entered into an
25 agreement by which Roper established a linac in



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ROA_0559

1 Beaufort County.

2 A: They did.

3 Q: Which is inconsistent with your health planning
4 analysis.

5 A: It is.

6 Q: It seems to me there could be three things that
7 might explain that. Mr. Gallati and other folks
8 -- you tell me whether any of these are true.
9 Mr. Gallati and other folks at Trident disagree
10 with your analysis that MUSC and Roper CON
11 applications will harm Trident's linac service
12 line.. Is that true?

13 **MR. THOMAS:** Objection, Your Honor.. He's asking Mr.
14 Sullivan to speculate on the decision making by
15 Mr. Gallati and the other administrators at
16 Trident. And this witness has already said that
17 he's not -- he doesn't know exactly why Mr.
18 Gallati made the decision. They also had the
19 ability to cross-examine Mr. Gallati on exactly
20 his decision-making process yesterday with
21 respect to that settlement agreement.

22 **MR. DAYHUFF:** I didn't hear Mr. Sullivan say all of
23 that. I'll try to rephrase.

24 **THE COURT:** Well, in the sense that you're asking him
25 to tell you what Mr. Gallati's mental processes



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ROA_0560

1 were and are, I think it's an inappropriate
2 question. I would sustain the objection.

3 Q: Has Mr. Gallati or anyone else at Trident said
4 to you that the reason they settled that case is
5 they disagree with your analysis about the
6 effect of the Roper application?

7 A: I never heard that.

8 Q: All right. Did Mr. Gallati or anybody else try
9 to tell you, you know, the MUSC and Roper
10 linacs, they're primarily, if not exclusively,
11 going to serve people they already serve, so --
12 did they ever tell you that?

13 A: No. In fact to the opposite. They told me they
14 thought that they would take patients from
15 Trident.

16 Q: So, Mr. Gallati made an uncharacteristic
17 business decision that was going to harm his
18 service line and maybe harm his bottom line?

19 A: I think it will have an impact on his bottom
20 line, a negative one. I can't speak to his
21 thought process. I mean, he explained yesterday
22 that he thought that Roper's project was the
23 lesser of two evils, I believe, because it was
24 deeper into Berkeley County and it was going to
25 be based in a hospital and he thought that it



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ROA_0561

1 would be -- of the two, that he could live with
2 that one more than the MUSC one. But, I mean,
3 I was not privy to those negotiations.

4 Q: Just to be clear, we had a little exchange about
5 a claim that I've seen in a pleading about MUSC
6 and their list of projects and proposed projects
7 and acquisitions and the effect thereof, alleged
8 effect thereof, on maybe financial feasibility
9 of this project. You're not so opining in this
10 case?

11 A: I am not.

12 Q: And there was no such opining by you on that
13 issue before DHEC?

14 A: Well, I mean, many of these projects weren't
15 known at the time of the application. We didn't
16 know about the Berkeley County Hospital. We
17 didn't know about the micro-hospital. We didn't
18 know -- I'm trying to remember all the things
19 that we didn't know about at that point in time.
20 But there was several other projects that MUSC
21 has undertaken that we were not aware of in
22 2017.

23 Q: I'm just asking if you said anything to DHEC
24 about that.

25 A: We did not.



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ROA_0562

- 1 Q: One of my favorite health planners once told me
2 -- that's you -- if a provider has excess linac
3 capacity, shutting down a linac unit makes sense
4 from a health planning perspective. That's
5 generally true, right?
- 6 A: Sure. I mean, if you don't have the volume to
7 support it, it's inefficient to staff a unit
8 that's not being well utilized.
- 9 Q: General conventional health planning notion, if
10 you don't need it, you can shut it down.
- 11 A: Yeah, until you need it.
- 12 Q: Okay. Roper has three linacs. It can serve
13 it's patients with two and does, right?
- 14 A: I think it used to have four and it shut one
15 down and it has -- oh, you mean Roper Hospital,
16 not the Roper system.
- 17 Q: I'm sorry. Did I say Roper? Trident. I'm
18 sorry. I'm getting tired. Trident has CONs for
19 three linacs, operates two.
- 20 A: True.
- 21 Q: Done that since 2015?
- 22 A: Yes.
- 23 Q: Operates at 63 percent of its capacity, State
24 Health Planning capacity?
- 25 A: Based on three units.



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ROA_0563

1 Q: Right. And you had a slide, in fact, that said
2 Roper's doing -- or Trident is doing 40 to 45
3 patients now, could do 100.

4 A: That's true.

5 Q: On three.

6 A: That's true.

7 Q: So, they've got more than twice the capacity
8 they need?

9 A: At the present time.

10 Q: It would make health providing sense for this
11 provider to shut down a unit and turn in its
12 CON.

13 A: I don't think so.

14 Q: Okay. Shutting down a unit comports with the
15 CON acting regulations, including the health
16 planning concept of need, right?

17 A: If you know that a unit's never going to be
18 needed, then that would comport with the
19 concept.

20 Q: Mr. Sullivan, this unit -- they've had three
21 CONs since 2015 and you heard Mr. Clements,
22 right, they've never operated the third.

23 A: Right.

24 Q: Right? And ---

25 A: In part because of technical issues related to



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ROA_0564

1 the fact that the Elekta machine was not
2 compatible with the Varian systems.

3 Q: He testified that they didn't operate all three
4 and you testified they didn't operate all three
5 because they don't have enough patients.

6 A: Right. He also testified that they didn't use
7 that machine because it was too difficult to
8 cross platforms with that machine.

9 Q: If a provider can service its patients on two or
10 three linacs, the third linac is unnecessary --
11 unnecessarily duplicates linacs one and two.

12 A: Well, it didn't at the time that they were
13 approved. And, you know, I think you can go
14 throughout the State of South Carolina and
15 you'll find lots of facilities and services
16 where there is available capacity.

17 Q: You say volumes aren't increasing, right?

18 A: They're not increasing historically; that's
19 correct.

20 Q: Why would they need three?

21 A: Well, let's say for example that one of their
22 machines go down. Then they need the third
23 machine in order to be able to continue to
24 service their patients.

25 Q: Right. The 61-15 criterion redundancy; you get



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ROA_0565

1 an extra machine to make sure, if the ones you
2 need, make sure if those don't operate, you've
3 got one in reserve.

4 A: Trident demonstrated the need for all three
5 machines at the time they were approved. The
6 situation has changed. Their volumes have
7 declined by almost 20 percent. They don't need
8 three machines to meet the capacity now, but
9 there's never been a provision in the CON law
10 that you have to give up the unit or close down
11 beds if you're not using them.

12 Q: Just talking about what one of my favorite
13 health planners told me about good health
14 planning. Now ---

15 MR. THOMAS: Objection. Argumentative. We can just
16 maybe move things along without the gratuitous
17 comments, we might get out of here at some point
18 in time.

19 THE COURT: Speaking of which.

20 MR. DAYHUFF: Oh, we've got three questions left.

21 THE COURT: You've got three questions left?

22 MR. DAYHUFF: Three questions.

23 THE COURT: See if you can do them.

24 MR. DAYHUFF: Oh, I will.

25 Q: Does Trident plan to follow a conventional



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ROA_0566

1 health planning route here and shut down one of
2 its three linacs?

3 A: It's not planning to shut down a linac.

4 Q: All right. And do you know why they're not?

5 A: Yeah. I mean, for the reason I think that Mr.
6 Clements testified to, is they want to have
7 available capacity in the case that one of the
8 machines go down. And then at some point in the
9 distant future, if the volumes go up, they would
10 have the capacity to handle them.

11 Q: And if Trident shuts down a unit, the State
12 Health Plan treatment capacity goes down,
13 utilization goes up, and it becomes easier under
14 our State Health Plan rules for a new linac
15 provider to provide services in the service
16 area.

17 A: That's true.

18 **MR. DAYHUFF:** Nothing further.

19 **THE COURT:** All right.

20 **MR. THOMAS:** I've got a lot of questions, Your Honor.

21 What I'd like to be able to do is go back to my
22 office and try to get them organized.

23 **THE COURT:** I think it's a good time of day for us
24 all to get organized and rested.

25 **MR. THOMAS:** I don't think I'll have -- it'll be long



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ROA_0567

1 tomorrow, but I'll have some -- I've got to
2 clean ...

3 **THE COURT:** Well, we'll adjourn until 10:00 o'clock
4 tomorrow morning.

5 **(Tuesday, January 15, 2019 ended at 5:45 p.m. and**
6 **reconvened on Wednesday, January 16, 2019 at 10:15**
7 **a.m.)**

8 **THE COURT:** We're back on the record in case number
9 18-07-0100. And we are at the Re-Direct for Mr.
10 Sullivan. Mr. Sullivan, I will -- you've
11 already moved into the target area and I will
12 remind you are still under oath, sir.

13 **MR. SULLIVAN:** Yes, sir.

14 **THE COURT:** Mr. Thomas.

15 **MR. THOMAS:** Thank you, Your Honor.

16 **MR. SULLIVAN - REDIRECT EXAMINATION BY MR. THOMAS:**

17 **Q:** Mr. Sullivan, yesterday you were asked about
18 your participation in trying to get six level 3
19 NICU beds for Trident's sister hospital,
20 Summerville Medical Center; do you recall that
21 ---

22 **A:** I do.

23 **Q:** --- line of questioning? Do you recall how many
24 level 3 NICU beds were available in the Health
25 Plan at the time SMC applied?



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ROA_0568

- 1 A: Fourteen, I believe.
- 2 Q: Okay. Now, how many of that 14 -- those 14 beds
- 3 did Summerville request from the Department?
- 4 A: Six.
- 5 Q: Okay. And what was Summerville's -- do you how
- 6 many MUSC was requesting?
- 7 A: Fourteen.
- 8 Q: And do you recall what Summerville's position
- 9 was before the Department?
- 10 A: Yeah. I mean, the position was that, you know,
- 11 there was a need for its project. Summerville
- 12 had no problem with the Department approving
- 13 MUSC either for the remaining beds, the eight
- 14 remaining beds, or, you know, actually we
- 15 believed that there was a way under the State
- 16 Health Plan that they could have approved 14
- 17 beds for Summerville and six beds for -- I mean,
- 18 14 beds for MUSC and six beds for Summerville.
- 19 But MUSC did not agree with that and opposed the
- 20 Summerville project.
- 21 Q: How many level 3 NICU beds does MUSC now have
- 22 after the approval?
- 23 A: I believe 46.
- 24 Q: And so if SMC had been approved for six and MUSC
- 25 would have just gotten eight NICU basinetts, MUSC



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ROA_0569

1 would have had how many NICU basinetts?

2 A: They would have 40.

3 Q: Okay. And what was SMC's -- Summerville Medical
4 Center, that's the SMC -- primary reasoning for
5 applying for level 3 NICU beds?

6 A: It was an access issue. They had what we
7 thought was a critical mass of births that were
8 occurring every year and a material number of
9 patients were having to be transferred -- not
10 only babies, but mothers who were high-risk
11 mothers were having to be transferred to the
12 Medical University... And there were concerns
13 about the safety of transporting critically ill
14 neonates. There were also concerns about access
15 in terms of flooding on the peninsula and so
16 forth that we raised. But that was not deemed
17 by the Department, so MUSC disagreed with our
18 position and the Department ultimately denied
19 the project.

20 Q: Is there any option within a hundred miles of
21 the service area for level 3 NICU beds other
22 than MUSC?

23 A: No.

24 Q: Okay. Now MUSC -- and I believe Mr. Levitt was
25 involved in this, correct me if I'm wrong. But



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ROA_0570

1 on behalf -- Mr. Levitt on behalf of MUSC
2 actually opposed a bed consolidation at
3 Summerville Medical Center when absolutely no
4 beds were being added to the service area. Do
5 you recall that?

6 **MR. DAYHUFF:** Your Honor, I think this line of
7 questioning should go both ways. It was my
8 understanding yesterday that, when I inquired
9 about different CON applications that this
10 witness worked on for Trident in opposition to
11 MUSC, my questioning was limited pursuant to Mr.
12 Thomas' objection. So, I think it needs to go
13 both ways.

14 **THE COURT:** I agree.

15 **MR. THOMAS:** He got to ask about NICU. He got to ask
16 about St. Joseph's -- yes, you did. You asked
17 about St. Joseph's.

18 **THE COURT:** I understand.

19 **MR. THOMAS:** This will be my last one.

20 **THE COURT:** Mr. Thomas, I agree. Mr. Dayhuff we did
21 limit yesterday. And that doesn't mean he can't
22 do it at all. It just means it's limited.

23 **MR. DAYHUFF:** Understood. Thank you.

24 **MR. THOMAS:** This is my last one. I felt two for two
25 is good.



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ROA_0571

1 Q: So, they actually opposed a bed consolidation at
2 Summerville Medical Center. Do you recall that?

3 A: I do.

4 Q: Okay. And was there going to be an increase in
5 the total number of beds as a result of that
6 consolidation?

7 A: It was actually going to be a decrease in the
8 number of beds.

9 Q: Do you have any idea why MUSC opposed that?

10 A: I didn't know at the time. I still don't know.

11 Q: You were asked specifically about tumor boards.
12 Mr. Dayhuff asked you things such as, you know,
13 were you aware of what MUSC had, this that and
14 the other. Do you recall the line of
15 questioning?

16 A: I do.

17 Q: And you heard Mr. Clement's testimony. Is
18 Trident's tumor board for all anatomical sites?

19 A: It is. He said that all types of cancer are
20 discussed at the tumor board.

21 Q: You were asked about access to medical providers
22 being important. Are you aware of any barriers
23 to access that patients have to surgeons,
24 medical oncologists, and radiation oncologists
25 on Trident's medical staff?



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ROA_0572

1 A: I am not.

2 Q: You were asked about the NCI designation. I
3 think Mr. Dayhuff asked you a question
4 regarding, you know, this could be a benefit to
5 folks with rare cancers. Did Dr. Williams
6 indicate that he could not treat patients with
7 rare cancers at Trident on their linear
8 accelerators?

9 A: He said that there were very few patients who
10 could not be treated at Trident. And I think he
11 used the example of patients getting bone marrow
12 transplants.

13 Q: Okay. Now, MUSC -- Mr. Dayhuff brought up, I
14 guess, the Press Ganey scores for MUSC that were
15 referenced by Dr. Jenrette in his deposition.
16 Do you recall what Mr. Clements said about
17 Trident's Press Ganey scores for cancer care?

18 A: Yeah. I believe he said they were all above 90
19 percent.

20 Q: Okay. And Dr. Jenrette was referenced and said
21 that MUSC has very high Press Ganey scores,
22 didn't he?

23 A: He did.

24 Q: And that's without an MUSC Nexton linac,
25 correct?



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ROA_0573

1 A: That's correct.

2 Q: We talked about -- you were asked questions
3 about the quality of care at Nexton and in the
4 context of the overall MUSC system. But do you
5 have any idea who's going to staff that facility
6 in terms of the radiation oncologist?

7 A: I do not. I don't think they've named anybody
8 yet who is going to actually staff it.

9 Q: Do you have any idea what that radiation
10 oncologist's subspecialty will be?

11 A: I do not.

12 Q: Okay. And how many physician FTEs were there
13 listed in the CON application for physicians at
14 the Nexton site?

15 A: One.

16 Q: So, does it stand to reason that, if there's one
17 physician FTE and they specialize in one area,
18 that all the other patients who may not have
19 that type of cancer aren't going to get the
20 benefit of the subspecialty?

21 A: That would be the case. I mean, typically in a
22 freestanding center the radiation oncologist is
23 going to treat all types of cancer. There won't
24 be a subspecialty.

25 Q: And there's not going to be a subspecialist who



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ROA_0574

1 treats SBRT or SRS because they aren't going to
2 have that at Nexton, are they?

3 A: Right. The application says they're not
4 purchasing that equipment.

5 Q: Okay. Mr. Dayhuff talked about the size of
6 MUSC's medical staff. Do you know how many beds
7 MUSC has? And I'm not going to hold you to an
8 exact number.

9 A: It's some number over 600. I can't remember the
10 exact number.

11 Q: Do you know how many beds Trident Medical Center
12 has?

13 A: About 300..

14 Q: Okay. Based on just bed size alone, inpatient
15 bed size, what would you expect to be the size
16 of the medical staff at MUSC relative to the
17 size of the medical staff at Trident?

18 A: Well, I would expect MUSC to be much larger.

19 Q: Would you expect it to be at least double?

20 A: Yeah. I mean, typically and the fact that
21 they're a teaching hospital also, that would
22 also increase the number of staff they would
23 have.

24 Q: Mr. Dayhuff also asked you about the CRCC case
25 in Grand Strand. And I did not object to that



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ROA_0575

1 line of question. But were the CONs deemed
2 competing -- the CRCC CON and the Grand Strand
3 CON for a additional linac deemed competing in
4 that case?

5 A: No.

6 Q: Okay. What was CRCC'S utilization in that case?
7 Again, estimate, not ...

8 A: It was something in the range of 125 percent
9 utilization.

10 Q: Okay. Now, is MUSC anywhere close to 125
11 percent utilization?

12 A: I haven't seen any numbers that would claim
13 that.

14 Q: Okay. Mr. Dayhuff in his questioning of you
15 yesterday continuously used the phrase patients
16 who are choosing MUSC. Is that an accurate
17 portrayal of how patients generally get to high-
18 level ancillary services in any health system?

19 A: Yeah, and I sort of touched on this, but not
20 directly yesterday. Patients for things like
21 radiation therapy or very exotic surgeries
22 typically aren't preselecting a physician or
23 whatever to receive those services, maybe not
24 even a health system. They're seeing a doctor
25 who's farther down the referral chain, a primary



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ROA_0576

1 care physician, a surgeon, a urologist, what
2 have you. And those physicians will make a
3 recommendation to the patient of where they
4 should go. And, you know, in my experience, and
5 there have been studies that have been done,
6 that somewhere between 70 and 80 percent of the
7 time the patients will follow the doctor's
8 recommendation.

9 Q: Wouldn't you think that would be applicable to
10 the case of a doctor whose a medical oncologist
11 at MUSC was treating a patient, they referred
12 them to Trident's radiation therapy center,
13 would there be a 70 or 80 percent chance of that
14 patient going?

15 A: Sure. I mean, if they lived in the area and it
16 was convenient to them and they were told that
17 they could get quality services from MUSC-
18 trained physicians, I think there would be a
19 material number of those patients who would
20 choose to go there.

21 Q: Mr. Dayhuff referenced the hub and spoke system,
22 a kind of healthcare delivery models, yesterday.
23 When did MUSC start developing the hub and spoke
24 system down in the Lowcountry?

25 A: Well, the -- I mean, other than a couple of



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ROA_0577

1 small forays several years ago, there's really
2 been a flurry of activity over the last three or
3 four years.

4 Q: And when did it kind of apply for this spoke,
5 new hospital, in Berkeley County?

6 A: That application, I believe, was in the
7 beginning of 2018.

8 Q: And, you know, from a hub and spoke model
9 system, does the location of the pediatric
10 hospital fall into -- well, first of all,
11 where's the pediatric -- brand new -- I think
12 it's about a 385 million dollar pediatric
13 hospital. Where did MUSC decide to locate that?

14 A: About a block away from the main, you know,
15 hospital where the pediatric services were
16 before. It's basically on the south end of the
17 campus at MUSC.

18 Q: And is that down a very -- kind of almost to the
19 end of the peninsula in Charleston?

20 A: It is. It's close to the Ashley River, right on
21 Calhoun Street.

22 Q: Okay. But not exactly a spoke from the main
23 campus, is it?

24 MR. DAYHUFF: Leading. Objection.

25 Q: Is that a spoke from the main campus?



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ROA_0578

1 A: It's not. I mean, that would be considered a
2 development on the existing campus.

3 Q: So, did MUSC have any issues with making
4 pediatric patients and their parents drive all
5 the way downtown in the flooded and congested
6 streets of Charleston in order to seek this type
7 of care?

8 A: No.

9 Q: How long -- you heard Mr. Gallati's testimony
10 yesterday. How long has Trident been providing
11 healthcare services out to the citizens of
12 Berkeley and Dorchester and North Charleston?

13 A: I think more than 40 years.

14 Q: Okay. Do you have any idea, Mr. Sullivan, kind
15 of on an adjusted for inflation basis, the
16 amount of money Trident has invested in
17 Dorchester, Charleston, and Berkeley County in
18 those four decades?

19 A: I mean, just based on my knowledge of the
20 projects they have, I think we're probably
21 approaching a billion dollars in terms of
22 overall investments.

23 Q: What is the purpose of the CON system, Mr.
24 Sullivan, in terms of providers who make
25 significant investments in a service area?



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ROA_0579

1 A: It's to insure that, when other providers want
2 to provide services in a service area that they
3 don't currently serve, that it's done in an
4 orderly fashion, you know, that there are
5 standards that are followed and that there are
6 documented community needs for the project prior
7 to approving a provider to go into a market
8 where they currently don't have a presence.

9 Q: Okay. And in MUSC, they don't have a presence,
10 a linear -- a cancer presence out in the north
11 area, do they?

12 A: They do not.

13 Q: Mr. Dayhuff asked you several questions about
14 the fact that you and Trident in pleadings noted
15 kind of the data manipulation by Roper in its
16 linac CON application. Do you recall that?

17 A: I do.

18 Q: In terms of MUSC's capacity, if MUSC had
19 presented the Department with correct data
20 regarding its capacity in 2017, would MUSC have
21 been in compliance with the State Health Plan?

22 A: Would not have been.

23 **MR. DAYHUFF:** Objection. If we would have supplied
24 the correct capacity, the correct capacity was
25 in the State Health Plan, the 2015 State Health



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ROA_0580

1 Plan, provided by the State Health Plan.

2 **MR. THOMAS:** He can ask that on Cross, but I'm glad
3 he brought it up.

4 **MR. DAYHUFF:** The question assumes facts not in
5 evidence.

6 **THE COURT:** Well, the problem is, he already answered
7 it by the time you objected.

8 **MR. DAYHUFF:** Well, that's too bad.

9 **MR. THOMAS:** Well, let's do this. Maybe this way --
10 we can get it, Your Honor.

11 **Q:** Would you turn to Joint Exhibit 5?

12 **A:** Sure.

13 **Q:** And we don't necessarily need to put this up on
14 the screen, because they can't prove a negative.
15 Can you show me in -- are you aware of MUSC's
16 capacity number for its linac appearing in the
17 State Health Plan, Mr. Sullivan?

18 **A:** It does not.

19 **Q:** Thank you. And in terms of data manipulation,
20 I'm not accusing of manipulation. But did MUSC
21 provide the Department with the correct fiscal
22 year 2016 utilization in its CON application?

23 **A:** It did not.

24 **Q:** Mr. Sullivan, did the JAR, the joint annual
25 reports, and this is in the capacity line of



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ROA_0581

1 questioning, require the applicants to list the
2 number of treatment types by individual linear
3 accelerator unit?

4 A: The JAR does not ask for that. It just asks for
5 a total for things such as IMRT, IGRT, and
6 stereotactic radiosurgery. Just stereotactic
7 procedures, I think is what it says.

8 Q: So, if an applicant has more than one linear
9 accelerator, is there any way to determine what
10 specialized procedures are being done on each
11 different unit?

12 A: There is not.

13 Q: Okay. How can an affected person get the data
14 to check if sufficient volumes are being
15 performed on a linac unit, other than through
16 discovery in litigation?

17 A: I'm not aware of any way. I mean, you would not
18 have the ability to, you know -- I don't think
19 I could call up MUSC and say, please give me all
20 of your detailed utilization data by machine.
21 I don't think they would be willing to provide
22 that, so I think only through -- you know,
23 through this litigation process that we have
24 access to the underlying data. And DHEC -- I
25 believe, the testimony will be that DHEC does



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ROA_0582

1 not have the underlying data.

2 Q: Okay. You were asked about a hypothetical that
3 was posed to you regarding the 80 percent
4 standard. Was that hypothetical grounded in the
5 context of MUSC's capacity being 26,500
6 treatments?

7 A: It was not.

8 Q: What did you maintain in your deposition was
9 MUSC's actual capacity on its linear accelerator
10 units at your deposition?

11 A: 26,500..

12 Q: Okay. And under any scenario that's been
13 presented thus far in discovery or through the
14 litigation process are you aware of MUSC being
15 over 80 percent if the 26,500 capacity is
16 applied in any past two-year period?

17 A: I mean, I've done that math myself. I've not
18 found any two-year period in which, with a
19 26,500 capacity, MUSC would be over 80 percent.

20 Q: Okay. Now, Mr. Dayhuff asked you several
21 questions about MUSC's Varian 6CD (sic) linac
22 that, I think, only does what are known as total
23 body irradiation or TBI procedures. Do you
24 recall that?

25 A: I do.



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ROA_0583

1 Q: Okay. And I think maybe in 2018 the unit --
2 this is already in evidence -- did about 70
3 procedures in a year. What is the capacity that
4 was assigned to that unit?

5 A: 5,000.

6 Q: Okay. Is it your understanding that other MUSC
7 linac units can perform TBIs?

8 A: I believe Dr. Jenrette testified to that in his
9 deposition.

10 Q: Okay. And I think we've talked about this a
11 little bit. But how long does a TBI procedure
12 take, according to Dr. Jenrette?

13 A: From two and a half to three hours.

14 Q: Okay. So, if the Medical University were to
15 decide that they could -- wanted to do TBIs on
16 the linac that does no stereotactic procedures,
17 you know, how many IMRT and conventional
18 procedures could they do on a unit that does 70
19 TBIs in a year?

20 A: Well, if we -- if you do that math, I mean if
21 you say that there were 70 and the average is
22 three hours in three hours each, that would be
23 210 total hours of treatment time that would be
24 required. And as I testified on Direct, an
25 average linac would have an availability of



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ROA_0584

1. about 2,000 hours a year. So, that would still
2. leave you with 1790 hours to do IMRT, IGRT, you
3. know, other types of procedures. And so, if you
4. can do somewhere between three and four of those
5. an hour, that would give you a capacity of 6500
6. to 7,000 treatments a year to do those other
7. things.

8. Q: So, it's not necessary that MUSC maintains the
9. 6CD (sic) unit, but they do.

10. A: They do. I think it's for convenience. Yes.

11. Q: Should MUSC be required to shut down that unit
12. because it only does 70 treatments a year?

13. A: I don't think so. I mean, I would think they
14. would ultimately want to replace it with
15. something that had a greater capability.

16. Q: Is capacity -- is it your understanding of the
17. State Health Plan in the concept of capacity,
18. how is it tied to utilization?

19. A: Really not at all. Capacity is just what a unit
20. is capable of doing based on the available hours
21. and the number of minutes required for a
22. particular treatment to be delivered. Whether
23. you do 5,000 or five, the capacity of the
24. machine is the same. The fact that MUSC likes
25. to do only 73 procedures on that Varian 600CD,



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ROA_0585

1 doesn't change what the unit's capacity is. The
2 capacity is a constant. And so, you know, I
3 think maybe some of the questions I got, there
4 was some implication that, because they don't do
5 many procedures on there, the machine ought to
6 have a lower capacity. And I guess I just
7 disagree with that.

8 Q: In terms of this concept of, again, capacity in
9 an older unit, are you aware of attempts by MUSC
10 to upgrade the Varian 6CD (sic) linac unit?

11 A: All the depositions I reviewed I didn't see any
12 evidence of that.

13 Q: And are you aware of what -- I mean, Trident's
14 got a 2002 Clinac. Are you aware of any
15 upgrades made to That over time?

16 A: I think Mr. Clements talked about the fact that
17 it had been upgraded over time and it could do
18 a lot of the things that the later TrueBeams can
19 do, such as provide RapidArc technology, which
20 speeds up the treatment process.

21 Q: Now, Mr. Dayhuff, I think, reminded you
22 yesterday that this is a de novo hearing, right?

23 A: He did.

24 Q: Okay. And you heard Ms. Biggers say -- what did
25 you hear her say regarding adverse impact in her



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ROA_0586

1 opening statement regarding the burden of proof?

2 A: Right. I think maybe I counted three times that
3 she said that the burden of proof in this case
4 was on Trident as the Petitioner in this case.

5 Q: Okay. What's your understanding of -- let's
6 scratch that. Mr. Dayhuff stated that chaos
7 could result, and he referenced judicial economy
8 with respect to capacity and some other things.
9 Do you agree with that statement?

10 A: I don't. I think he was -- yeah, I mean I think
11 he was talking about, if we have the ability to
12 challenge the capacities, that would result in
13 chaos. I just don't -- fundamentally disagree
14 with that.

15 Q: Okay. Well, let me ask you something about
16 judicial economy. If MUSC had presented data
17 that showed something less than 80 percent -- we
18 don't know what DHEC would have done. This is
19 somewhat of a hypothetical. But is it possible
20 that MUSC -- if DHEC had denied it, is it
21 possible that MUSC would not have brought a
22 case?

23 A: It's certainly possible. They could have said
24 we'll wait until our numbers get a little higher
25 and we'll come back and file a new application.



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ROA_0587

1 **MR. DAYHUFF:** He doesn't have expert opinion
2 regarding the possibility or what we would or
3 wouldn't do based on a DHEC decision. It's not
4 a proper question or testimony.

5 **THE COURT:** I ---

6 **MR. THOMAS:** Your Honor, I'd like to say that I think
7 it is. I mean, that's one of our tenants in the
8 case is that, you know, that that decision, that
9 the data that we claim is faulty, kind of set
10 off what I would call -- not a domino effect,
11 but, you know, a decision tree, so to speak.
12 That if it went one way, if MUSC knew at the
13 time, okay, that their data was not correct,
14 they may have not even applied for a CON. So,
15 if they knew they were still in the threshold,
16 they may have waited. I'm just asking him if
17 that's a possibility.

18 **THE COURT:** Well, it's certainly a possibility, but
19 insofar as your question, ask him to speculate
20 on what the mental processes that may have
21 occurred. I mean, certainly there are a lot of
22 things that could have happened.

23 **MR. THOMAS:** Sure.

24 **THE COURT:** But when you ask him what they might have
25 done, I just don't see that he has any insight.



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ROA_0588

1 He can talk about what might have happened, but
2 I don't think he can talk about what they might
3 have decided or how they might have decided.

4 **MR. THOMAS:** I think that the questioning on this
5 line is fair because he asked about chaos
6 resulting in judicial economy. So, he's asking
7 my expert to say, hey, if you challenged X, Y,
8 or Z, can this happen? He was fine with asking
9 the question. I'm saying, well, could one, two,
10 or three happen?

11 **MR. DAYHUFF:** I think the could one, two, or three is
12 okay. I think the questioning was asking about,
13 you know, what do you think MUSC ---

14 **THE COURT:** Yeah, that's my point.

15 **MR. THOMAS:** Fair enough.

16 **THE COURT:** To that extent, I would sustain the
17 objection.

18 **MR. THOMAS:** Okay.

19 **Q:** Mr. Sullivan, you know, if MUSC had presented --
20 or knew that it was not in compliance with the
21 80 percent standard because it was under -- was
22 at 79.97, in your expert opinion, what were some
23 of the possibilities that could have happened at
24 that point in time back in June or May of 2017
25 when MUSC applied?



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ROA_0589

1 A: You know, I mean, one outcome potentially was
2 that MUSC would not have submitted their
3 application at that point in time and would have
4 waited until their data supported a two-year
5 historical 80 percent utilization rate. I mean,
6 another possibility, I guess, is they would have
7 filed and argued that you should round up. And
8 if the Department didn't agree with them, they
9 might not have appealed. They might have
10 decided to wait and re-file at a later date when
11 they met the standard.

12 Q: And if they had appealed, who would have the
13 burden of proof in that?

14 A: MUSC would have had the burden.

15 Q: Okay. In terms of judicial economy, there's a
16 possibility that there may not have ever been a
17 legal case, we may not be here today.

18 A: That's certainly a possibility.

19 Q: Mr. Dayhuff asked you about adverse impact. And
20 I don't have too many questions on that for you,
21 but is it your understanding that MUSC is just
22 locating a linear accelerator in the Nexton
23 area?

24 A: That's not my understanding. I mean, Dr.
25 Jenrette, in his deposition, talked about it



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ROA_0590

1 being part of a broader market strategy that
2 included bringing other types of cancer
3 specialists to the market, you know, to
4 potentially in the medical office building there
5 where MUSC was planning to lease space. and he
6 expected there to be a range of cancer
7 specialists locating in the market, which would
8 obviously have an impact on the current referral
9 patterns in the area. For folks who live up
10 there, there would all of a sudden be additional
11 doctors competing for those patients. And those
12 patients would then, instead of going into the
13 Roper or the Trident system, would go into the
14 MUSC system.

15 Q: Okay. Mr. Dayhuff asked you if Trident asked
16 the Department to add the adverse impact
17 criterion to the deemed complete letter. Do you
18 recall that specific question?

19 A: I do.

20 Q: Okay. Have you ever known that request to the
21 Department to add a project review criterion to
22 work?

23 A: My personal experience -- I mean, I've made that
24 request over the years from time to time with
25 various folks in administration at DHEC. And I



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ROA_0591

1 don't recall a single instance where that was
2 granted.

3 Q: Okay. I think Mr. Dayhuff -- if you want to go
4 to Standard 7 in Joint 5.

5 **MR. THOMAS:** VickiLynn, If you want to try to pull it
6 up that would be page six of Joint 5.

7 Q: Okay. Mr. Dayhuff asked you about if Standard
8 7 kind of specifically referenced JAR data for
9 showing each of the past two years. Do you
10 recall that question?

11 A: Yes.

12 Q: Okay. And it's not referenced in Standard 7, is
13 it, that it doesn't say JAR data like maybe one
14 of the other standards says, does it?

15 A: It does not.

16 Q: Okay. What did MUSC use in its CON application
17 to justify the Standard 7 80 percent ratio?

18 A: JAR data for 2016 and 2015.

19 Q: Okay. And that was for fiscal year 2015 and
20 '16?

21 A: That's correct.

22 Q: Okay. And had MUSC used calendar 2016 instead
23 of fiscal year 2016, in your opinion would DHEC
24 have been able to approve the CON application
25 under Standard 7?



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ROA_0592

1 A: They would not have, because I believe that the
2 utilization rate for MUSC in calendar year 2016
3 was below 78 percent.

4 Q: Okay. And if MUSC had presented the rolling 12
5 months, would they have been in compliance with
6 Standard 7 of the State Health Plan?

7 A: No. For any rolling period up until the time of
8 the decision they would not have been in
9 compliance.

10 Q: All right. Let's -- you were asked about this
11 -- under this topic of rounding. And you were
12 asked about a pure health planning perspective
13 and whether rounding does or does not make a
14 difference. Here's my question. If there is no
15 bright line cut off for a minimum threshold, is
16 it possible that there could be different
17 results for different applicants in terms of
18 meeting that standard?

19 A: There could be.

20 Q: Okay. What would that mean in terms of the
21 health planning process' order?

22 A: Well, I mean, it would create a very un-level
23 playing field. You know, one provider may look
24 at the standard and say, well, until I'm, you
25 know, over 80 percent, you know, I mean, I --



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ROA_0593

1 then I can't possibly apply for this. Another
2 provider might come in and say, well, I'm at
3 79.9 and that rounds up to 80. I think that's
4 close enough and I'm going to apply. And so you
5 would have a -- basically a moving target in
6 terms of when a provider would qualify to apply
7 for an exception under the State Health Plan.

8 Q: You could come down to perhaps a health
9 planner's or an attorney's power of persuasion
10 in terms of meeting with the CON director?

11 MR. DAYHUFF: Leading.

12 Q: Could it come down to the power of persuasion of
13 folks meeting with the Department?

14 MR. DAYHUFF: It's still leading.

15 MR. THOMAS: I asked for a yes or no.

16 THE COURT: And he's ---

17 MR. THOMAS: I'm not suggesting ---

18 THE COURT: I'm going to allow that question.

19 A: Yes, it could.

20 Q: Let's see here. I typed up a lot of leading
21 questions last night at 10:00 o'clock, Your
22 Honor. I've got to figure out ---

23 MR. DAYHUFF: What, if any.

24 MR. THOMAS: I know. I know what, if any. That's a

25 ...



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ROA_0594

1 Q: Mr. Sullivan, is there a difference in a
2 provider stating it will perform sufficient
3 volumes at a future date and that provider
4 actually performing sufficient volumes in order
5 to qualify for a capacity standard?

6 A: Yeah. There is a difference.

7 Q: And can you explain what that difference might
8 be?

9 A: Sure. Well, there's -- historical utilization
10 is an objective standard. Projected volumes at
11 some future date, you know, are subject to, you
12 know, changes in the actual circumstances that
13 exist in the market.

14 Q: In terms of these capacity standards in
15 Standards 2, 3, and 4 of the Health Plan, does
16 the State Health Plan provide any guidance as to
17 what the term or phrase sufficient volume means?

18 A: Unfortunately it does not.

19 Q: Okay. And does DHEC kind of rely on the
20 applicant on somewhat of an honor system in
21 terms of maintaining sufficient volume?

22 A: That's my understanding, yes.

23 Q: Mr. Dayhuff asked you questions about the fact
24 that they have this Elekta Synergy unit, the
25 linac unit, that it was not being used from 2015



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ROA_0595

1 forward, but I think Mr. Clement's testimony was
2 that it could be fired up when needed. Do you
3 recall that?

4 A: Yes.

5 Q: Okay. In 2012 Trident applied for that linac
6 TrueBeam. What was its -- do you recall its
7 utilization --

8 MR. THOMAS: Well, can we go to Respondent's 16,
9 please?

10 (Respondent MUSC's Exhibit Number 16 was introduced
11 into the record at this time.)

12 Q: Did you work, Mr. Sullivan, on the 2012
13 application for Trident's TrueBeam?

14 A: I did.

15 Q: Okay.

16 MR. THOMAS: And if we could go to 25, page 25 of
17 that application -- of that exhibit?

18 Q: I'm showing you what's an exhibit within the CON
19 application of Respondent's 16, page 25. What
20 was Trident's utilization on its stated capacity
21 in 2010 of that year?

22 A: It was 115.7 percent.

23 Q: Okay. In 2011 what was it?

24 A: It was 99.2 percent.

25 Q: Okay. Now, if we made the capacity for the



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ROA_0596

1 Elekta at the time instead of 4500 but 5,000,
2 that would have been 12,000. In 2010 and 2011
3 is Trident still above the 80 percent threshold?

4 A: They were.

5 Q: Okay. You may have to get out a calculator for
6 this one, but would they still have been over
7 the 80 percent threshold if both of those units
8 had been assigned a capacity of 7,000?

9 A: I will use my calculator.

10 Q: I figured you would.

11 A: In 2010 for the 14,000 capacity the utilization
12 would have been 95 percent.

13 Q: Okay.

14 A: And then in 2011 it would have been 81.5
15 percent.

16 Q: Okay. So, they're above the 80th percentage.

17 A: Right.

18 Q: Mr. Dayhuff referenced -- asked you questions
19 about whether or not Trident did pediatric
20 sedated radiation therapy during your Cross; do
21 you recall that?

22 A: I do.

23 Q: Is there any indication that MUSC's going to do
24 that type of radiation therapy on peds who are
25 sedated at Nexton?



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ROA_0597

1 A: There's certainly no discussion in the
2 application and the staffing pattern identified
3 in the application did not have an
4 anesthesiologist as part of the staff.

5 Q: And, in fact, are anesthesiologists who work on
6 children actually specialized?

7 A: They are.

8 Q: And is there any indication in the application
9 or otherwise that MUSC's going to perform TBI at
10 Nexton?

11 A: I saw no indication of that.

12 Q: Okay. Now, there's a line of questioning about
13 Trident asking The Court -- is Trident asking
14 The Court to somehow change the State Health
15 Plan with respect to assigned capacities; do you
16 recall that?

17 A: I do.

18 Q: Okay. Is Trident asking The Court to change
19 MUSC's capacity in an artificial sense?

20 A: They are not. I mean, my -- you know, my belief
21 is that -- you know, what I think is the right
22 thing is to make sure that the capacities that
23 are being assigned to MUSC's units are
24 consistent with the State Health Plan, with the
25 specific standards in the State Health Plan that



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ROA_0598

1 are outlined under Criteria 1, 2, and 3.

2 Q: Now, going in the alternative, is MUSC asking
3 The Court to change the Health Plan by accepting
4 -- by having DHEC accept a utilization number of
5 something below the 80 percent threshold?

6 A: They are..

7 Q: If -- Mr. Dayhuff gave you some hypotheticals
8 with respect to, I guess, capacities and certain
9 other things, but if hypothetically it was an
10 applicant who wanted to apply for a new linac
11 and wasn't performing any IMRT on any of its
12 three linacs, but yet had an assigned capacity
13 -- and that had been going on for years, but had
14 an assigned capacity of 15,000 treatments, okay,
15 and decides to apply for a new linac, and was
16 applying because it was at 80 percent of 15,000,
17 would that be an appropriate thing under the
18 State Health Plan in your opinion?

19 A: I believe that would give you the wrong result,
20 you know, certainly from a health planning
21 perspective. Because, in reality, if the
22 capacity was really 7,000 under the State Health
23 Plan definitions, then the applicant would be
24 far below the 80 percent target.

25 Q: 12,000 is nowhere close to 80 percent if the



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ROA_0599

1 actual capacity is 21,000.

2 A: That's true.

3 Q: Would that be a good thing for health planning,
4 Mr. Sullivan?

5 A: In my view it would not.

6 Q: When did Trident find out that MUSC's capacity
7 -- or find out the volumes that MUSC was doing
8 on its linear accelerators with respect to
9 specialized treatments?

10 A: Not until the discovery process started. I
11 mean, the first documents I saw were, what, I
12 believe maybe in November of 2018.

13 Q: Okay. And if The Court doesn't recognize that
14 there could be changes or -- well, strike that.
15 Let me rephrase. Mr. Dayhuff suggested that
16 maybe Trident should have closed down one of its
17 linear accelerators. If Trident did 12,000
18 treatments in 2018, what would its capacity be
19 on just -- State Health Plan capacity for just
20 those two units in 2018?

21 A: 12,000.

22 Q: So, 100 percent?

23 A: Yes.

24 Q: Is having a third unit a bad idea, Mr. Sullivan?

25 A: It is not. You know, I mean, it was -- I mean,



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ROA_0600

1 I don't think you would approve a unit just to
2 have an extra one. But the fact that there was
3 a unit approved and having the ability to have
4 that backup capability will make the service run
5 much more efficiently.

6 Q: And one of Trident's units is how old?

7 A: It is over 16 years old.

8 Q: Okay. And Trident -- could Trident spread its
9 patients out over on all three units?

10 A: It could.

11 Q: Okay. And could it be operating above 50
12 percent on all three of those units if it did
13 that?

14 A: It would.

15 Q: Okay. Is it more or less efficient to treat
16 patients like that?

17 A: My experience in working with radiation therapy
18 providers is you want to operate the units at
19 high utilization rates, because each unit you
20 open requires you to have additional staff
21 available. So, it's less efficient to staff
22 three units than two if your volume only
23 supports two.

24 **MR. THOMAS:** That's all the questions I have for Mr.
25 Sullivan. I'd ask that he be dismissed.



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ROA_0601

1 **MR. DAYHUFF:** Your Honor, I'm assuming then that
2 there's no re-cross, which is fine. I just want
3 to make sure that also goes both ways with Mr.
4 Levitt.

5 **THE COURT:** I understand.

6 **MR. DAYHUFF:** Fair enough.

7 **THE COURT:** Mr. Sullivan, thank you, sir.

8 **MR. SULLIVAN:** Thank you.

9 **THE COURT:** You may go as far as you can get ---

10 **MR. THOMAS:** We'll have a rebuttal case at some
11 point. So, he's been dismissed for the day.
12 Not for -- I'm not releasing him, Your Honor.

13 **MR. DAYHUFF:** It's too late. He's been released.

14 **THE COURT:** He said dismissed. I was not clear on
15 what that might be.

16 **MR. THOMAS:** I apologize. I should have been more --
17 -

18 **THE COURT:** Words are very difficult for me
19 sometimes. So ...

20 **MR. THOMAS:** Yeah. So, the Petitioner rests at this
21 time in its case in chief.

22 **THE COURT:** Ms. Biggers?

23 **MS. BIGGERS:** Your Honor, DHEC has one witness to
24 call in its case in chief. And may I ask for
25 just a brief restroom break before we ---



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ROA_0602

1 **THE COURT:** That would be fine. It's -- let's -- I
2 have no idea where you might have to go -- I
3 think the cleaning crew was moving a little bit
4 late this morning, so if you have to go to
5 another floor -- I think we're okay. So, we can
6 do it in ten minutes?

7 **MS. BIGGERS:** Yes. Thank you, Your Honor.

8 **THE COURT:** Roughly speaking? So, back here at about
9 ten or so -- 11:13. I'll give you an extra 30
10 seconds.

11 (Off the Record)

12 **THE COURT:** Ms. Biggers.

13 **MS. BIGGERS:** Thank you, Your Honor. DHEC calls as
14 its first witness Margaret Murdock.

15 **COURT REPORTER:** Ms. Murdock, please state and spell
16 your first and last name.

17 **MS. MURDOCK:** It's Margaret Murdock, M-A-R-G-A-R-E-T
18 M-U-R-D--O-C-K.

19 **MARGARET MURDOCK,** having been duly sworn, testifies
20 as follows:

21 **MS. MURDOCK - DIRECT EXAMINATION BY MS. BIGGERS:**

22 Q: Ms. Murdock, would you mind repeating your name,
23 again, for the record for testimony?

24 A: Sure. It's Margaret Murdock. I go by Maggie.

25 Q: And where are you employed, Ms. Murdock?



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ROA_0603

1 A: I'm at DHEC. I'm the director of the
2 Certificate of Need Program.

3 Q: How long have you been director of the
4 Certificate of Need Program?

5 A: I've been director of the program since Summer
6 of 2017. I've been with DHEC since May of 2015.
7 Prior to this position, I was a senior
8 consultant in the Certificate of Need Program.

9 Q: And what have been the job responsibilities
10 you've held since that entire time you've worked
11 at DHEC first in that initial position and now
12 as director of the CON Program?

13 A: When I first started as a senior consultant, my
14 primary responsibility was reviewing Certificate
15 of Need applications, assisting with development
16 of the State Health Plan, and providing any sort
17 of research and useful information to the
18 director to assist him and the program and the
19 agency with the furtherance of the Certificate
20 of Need Program. I also was responsible for
21 administering the COPA program, the Certificate
22 of Public Advantage, and I was responsible for
23 interacting with the regulated community,
24 answering questions, providing testimony where
25 needed for various CON-related activities. As



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ROA_0604

1 director, my responsibility is to manage the
2 program itself, including the program staff,
3 oversight of all decision review and application
4 review, oversight of our staff's
5 responsibilities in developing the State Health
6 Plan, and, again, providing information and
7 maintaining dialogue with the regulated
8 community and the public, and providing
9 assistance and information to the rest of the
10 agency and other state agencies regarding
11 Certificate of Need-related and State Health
12 Planning matters.

13 Q: Does -- in your current position do you continue
14 to review CON applications yourself as well?

15 A: Yes, I do.

16 Q: Okay. Can you give us, just briefly for
17 background purposes, tell us what educational
18 degrees you hold post high school?

19 A: Sure. I graduated with a BA from Furman
20 University in 2000 and I received my JD from the
21 University of South Carolina in 2008.

22 Q: And what job experience did you hold in a
23 professional capacity following graduate school
24 and before you started working at DHEC?

25 A: Immediately after law school I worked as an



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ROA_0605

1 associate at Nelson Mullins for about two years.
2 And then after that, I worked with the Wyche Law
3 Firm until -- for the remaining five years or so
4 until I joined DHEC.

5 Q: So, obviously we're here for MUSC's CON
6 application. Can you tell us what was your
7 involvement with the CON application at issue in
8 this case?

9 A: I was the primary reviewer on this case, so it
10 was my -- it was my matter from beginning until
11 now. And so I reviewed the application and the
12 administrative record, all the opposition and
13 response information, and then ultimately made
14 and drafted the decision and participated in all
15 the post-decision administrative review process.

16 Q: Okay. What was your decision on this
17 application?

18 A: It was to grant the Certificate of Need for the
19 addition of MUSC's linear accelerator in
20 Berkeley County.

21 Q: Okay. So, I'll return to the decision in a bit.
22 But let's -- let me ask you to describe for us,
23 what is your typical process in reviewing a CON
24 application when you're the reviewer and going
25 to be making the decision?



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ROA_0606

1 A: Typically I will read the application. I review
2 the entire application once through from
3 beginning to end just to get a sense of the
4 application as a whole. I will make either just
5 some mental notes about what followup matters I
6 might need to address or what questions I have
7 or additional information I might like to
8 request. And after I go through the whole
9 application one time, I go through the State
10 Health Plan and our regulation, in particular
11 the project review criteria, again, just reading
12 through everything to, in essence, sift what
13 I've learned from that initial review of the
14 application through all of the project review
15 criteria and State Health Plan criteria, just,
16 again, to get kind of a sense of the application
17 as a whole and to begin thinking about what
18 project review criteria will be the most
19 important in reviewing the application.

20 Q: Can you describe to us, in your words as the
21 reviewer of the application, what was your
22 understanding of what this project was for; what
23 were they applying for?

24 A: MUSC was applying to add a -- I believe it's a
25 sixth linear accelerator to its fleet, if you



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ROA_0607

1 will. But this one they wanted to put it in
2 Berkeley County at a new facility and establish
3 radiation therapy services closer to a large
4 percentage of its existing patients in Berkeley
5 County. And I believe the total project cost
6 was somewhere under 10 million dollars. I don't
7 know off the top of my head. But basically it
8 was to establish radiation therapy services at
9 a location in Berkeley County by adding a linac,
10 L-I-N-A-C, to its current existing fleet of
11 linacs.

12 Q: Since your time working at DHEC in the CON
13 Program, have you been a primary reviewer for
14 any other CON applications involving linear
15 accelerators apart from the one we're here about
16 today?

17 A: Yes. Other than the one today, I have reviewed,
18 I think, five other ones as the primary
19 reviewer. At least four of them were for the
20 addition of the linac to the service area. And
21 one of them was a project that involved a
22 relocation of a linear accelerator from one --
23 from a hospital to another facility through an
24 exemption. But the project itself required CON
25 review, because there were some additional costs



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ROA_0608

1 associated with the building of the facility
2 that would house that linac.

3 Q: And for just background purposes, can you just
4 briefly tell us why you distinguished the
5 expansion versus relocation where you just
6 mentioned exemption?

7 A: Yes. The relocation project, it was an MUSC
8 application. And MUSC wanted to -- needed to
9 replace one of its linear accelerators. And
10 under the statute and the regulation, MUSC would
11 have been entitled to replace that linac through
12 an exemption. The replacement itself did not
13 require a full CON review and application. But
14 this particular project also involved the
15 construction of a facility and a vault and the
16 cost of all of that, apart from the cost of a
17 linear accelerator, would have been over two
18 million dollars. So, the cost triggered a need
19 for a full CON application review of the
20 building of the facility that would accompany
21 the replacement of the linear accelerator.

22 Q: And you mentioned earlier that your job duties
23 involved a participation -- I'm sorry, I can't
24 remember the exact word you used -- with the
25 process of development of the State Health Plan.



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ROA_0609

1 Can you tell us what your involvement is and --
2 actually first tell us, what is the process for
3 revision of the State Health Plan?

4 A: The process -- and I'll just hit the highlights.
5 Once we decide to open up the State Health Plan
6 for a review or a revision, we convene the State
7 Health Planning Committee, most of whom are
8 appointed by the governor, and staff, myself and
9 my team, will put together a draft of a revised
10 Plan. And the draft will include -- depending
11 on what parts of the Plan we want to revise,
12 we'll include revisions to the standards and/or
13 revisions to the inventories and need
14 calculations. And once we have a working draft,
15 we have to give some notice in the State
16 Register and open up a public comment period, so
17 that the regulated community and the public can
18 review the draft and provide the Department with
19 comments or ask questions or participate however
20 they see fit in coming up with a final draft of
21 the Plan. We will meet -- depending on the
22 extent of the revisions, we will meet sometimes
23 multiple times with the State Health Planning
24 Committee to discuss the proposed revisions.
25 And then once we reviewed all -- once staff has



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ROA_0610

1 reviewed all the public comments, and
2 communications, we will address them and make
3 recommendations or changes or some sort of
4 response to each comment or suggested revision
5 and then we present all of that to the State
6 Health Planning Committee. And the Committee
7 itself reviews the final draft and votes on
8 whether to adopt that plan. Once the State
9 Health Planning Committee approves of a final
10 draft of the plan, then we submit that plan --
11 the staff will submit that plan to the DHEC
12 board and the board will review the plan and
13 ultimately make the decision as to whether or
14 not to adopt the plan or adopt the plan with
15 some revisions as decided by the board. But the
16 board makes the ultimate decision on adoption of
17 a plan. Staff primarily creates the draft and
18 modifies the draft throughout the whole process.

19 Q: So, when you receive, as a reviewer, a CON
20 application to review, do you look at the State
21 Health Plan? And if so, what are you looking
22 for?

23 A: We -- yes, I look at the State Health Plan first
24 to make sure -- to see whether or not the
25 application itself requires review under the



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ROA_0611

1 Plan. There are certain types of applications
2 to which the Plan doesn't directly apply. But
3 if there's a project or a type of service or an
4 application that involves a service that has
5 standards in the Plan, then that project must
6 comply with the applicable standards in the Plan
7 in order to be approved by the Department.

8 Q: And what do you mean by -- you yourself, again,
9 as the reviewer, what do you mean by standards?

10 A: The standards are -- each chapter -- and a
11 chapter typically represents a service. Each
12 chapter has some narrative and then has a list
13 of Certificate of Need standards, which are a
14 combination of either a description of how we
15 calculate need or -- and requirements for each
16 project. Sometimes it's volume requirements,
17 sometimes it's a requirement regarding, you
18 know, certain aspects of the project that must
19 be included in order to be compliant with those
20 standards. But it is a list of applicable
21 requirements associated with that type of
22 project. And so I, as the reviewer, will go
23 through the application and compare it to that
24 list and make sure that the application complies
25 with each and every standard that applies to



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ROA_0612

1 that project. In this case it would have been
2 the chapter that pertains to radiation oncology,
3 specifically linear accelerators, and the
4 Certificate of Needs standards listed as
5 applicable to that type of project.

6 Q: Okay. So, I asked you earlier about your
7 typical process in reviewing a CON application.
8 Let me ask you about -- in that process, does
9 DHEC notify anyone about any project review
10 criteria that they may be paying particular
11 attention to?

12 A: Yes. Our regulation requires us to send a
13 letter to the applicant and any affected persons
14 that have requested that type of notification,
15 we send a letter that we refer to as the deemed
16 complete letter. And by regulation, we're
17 required to list a number of project review
18 criteria that the Department considers the most
19 important in reviewing that specific
20 application.

21 Q: And does the State Health Plan -- if the
22 application is for a service that has CON
23 standards in the State Health Plan, does the
24 State Health Plan mention project review
25 criteria?



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ROA_0613

1 A: Yes. Each chapter of the State Health Plan has
2 a list of important project review criteria
3 that, at the time of drafting the Plan, the
4 Department and State Health Planning Committee
5 and board all agreed were generally -- would
6 generally be important in reviewing that type of
7 project. I think of it as kind of a default
8 suggested list of project review criteria that
9 tend to make sense on the whole for that type of
10 project. That list of project review criteria,
11 however, is not included under the Certificate
12 of Need standards, the specific standards.
13 There are project review criteria and there are
14 standards. And the standards are the
15 requirements that the project must meet in every
16 case in order to be approved. The project
17 review criteria, the list of suggested project
18 review criteria in the State Health Plan, I
19 don't believe is the same as a list of
20 Certificate of Need standards. The project
21 review criteria applicable to a project, that
22 element of review is addressed in the
23 regulation. And we have a process by which the
24 Department chooses those, what we call, the
25 relative importance criteria. And then we put

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ROA_0614

1 those in the deemed complete letter. And even
2 during the review process, if there are
3 circumstances that lead us to determine that we
4 need to adjust or reorder or add or subtract
5 review criteria from that list, we have a
6 mechanism for doing so through the regulation.

7 Q: What is that mechanism that you just referred
8 to?

9 A: If during the review period -- once we've sent
10 the deemed complete letter to the applicant and
11 to the affected parties that have identified
12 themselves, then we will begin review, paying
13 specific attention to those relative importance
14 criteria. And if during the review, for
15 whatever reason, whether it be something that
16 comes up in the application, information that we
17 learned during the review process, information
18 that is provided to us by an affected party or
19 information that we come upon that's available
20 through other means, if it leads us to believe
21 that we need to be looking at different things
22 or more things, then we will -- then we can
23 reorder the project review criteria and send a
24 new letter to the applicant and affected
25 parties, notifying them all that we have



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ROA_0615

- 1 reordered the project review criteria. In which
2 case there's an amount of time after that that
3 the applicant has to respond if the applicant so
4 desires. And then we will issue the decision,
5 making findings specifically on those project
6 review criteria that were listed in the deemed
7 complete letter, either the original or the
8 revised deemed complete letter if we have
9 reordered the project review criteria.
- 10 Q: So, what were the project review criteria that
11 you listed in what you referred to in your
12 testimony as the deemed complete letter in this
13 case?
- 14 A: In this case ---
- 15 Q: And if it will help you, I can give -- you have
16 the DHEC record, DHEC Exhibit 1 should be in a
17 folder in front of you.
- 18 A: Yes.
- 19 Q: And I believe that that -- your letter is on
20 pages CON.369 through 370.
- 21 A: Okay. I know two of the project review criteria
22 were community need and distribution. All
23 right. There it is.
- 24 Q: And looking at this page that's on the screen
25 now, what is that page? What is this?

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ROA_0616

1 A: That's the deemed complete letter.

2 Q: Okay.

3 A: And ---

4 Q: So, let's look at the second page of the letter.

5 A: And that lists compliance with the need outlined
6 in the South Carolina Health Plan. And, again,
7 that's the standard with which the project must
8 comply. We do not have discretion in that
9 regard. The second one listed is Community Need
10 Documentation, then Distribution, after that
11 Medically Underserved Groups, and finally
12 Financial Feasibility.

13 Q: Looking at A again, do you -- and what you just
14 said regarding that, referencing the Plan, what
15 is in your -- as you interpret it and apply it
16 as a reviewer for DHEC, what do you consider to
17 be the need outlined in the South Carolina
18 Health Plan?

19 A: That particular terminology, it probably could
20 be worded better. It really should say
21 compliance with the South Carolina Health Plan,
22 which includes the need outlined in the South
23 Carolina Health Plan. And need outlined in the
24 South Carolina Health Plan can mean different
25 things for different chapters. In a situation



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ROA_0617

1 where you have a finite number of beds that are
2 listed as needed in the Plan, it would include
3 compliance with that -- formula of that
4 calculation. And in the case of -- in this case
5 it means the compliance with the minimum
6 utilization standard in that chapter of the
7 State Health Plan. Compliance with all the
8 standards, but in particular I think that one
9 goes specifically to need, the minimum
10 utilization and then the projected utilization
11 that's required under those standards.

12 Q: And then B through E, as listed in this letter,
13 you said those are other project review
14 criteria, correct?

15 A: Yes. Those are project review criteria that
16 come from our regulation. And under our
17 applicable statute, a project does not
18 necessarily need to comply with every single
19 project review criteria in order to be approved,
20 but it does need to comply with every -- with
21 the State Health Plan, all the standards in the
22 State Health Plan. So, the project -- this
23 project would have had to comply with A. But
24 failure to comply with B through E would not be
25 automatically fatal to approval of the project.



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ROA_0618

- 1 Q: In your experience reviewing CON applications,
2 have you ever chosen different project review
3 criteria for this letter than for -- I'm sorry.
4 You may have answered this before. Let me ask.
5 In this particular case did you identify
6 different project review criteria in this letter
7 than those listed in the State Health Plan under
8 which this application was submitted?
- 9 A: Yes. Well, the lists aren't identical. Some of
10 the project review criteria are the same. I
11 didn't identify all the ones on the list in the
12 State Health Plan. And I think I might have
13 added one that's not on the State Health Plan
14 list. I need to look at the chapter to see.
- 15 Q: If you have that -- I believe the notebook with
16 the green cover on the witness stand in front of
17 you is a Joint Exhibit. So, if you look at
18 Joint Exhibit 5, Roman Numeral IX-6.
- 19 A: There it is, yes. This has a list of seven
20 criteria. And so I did not include Projected
21 Revenues or Projected Expenses or Cost
22 Containment. And then I added Medically
23 Underserved Groups. I think that's it.
- 24 Q: Why did you make the changes that you did for
25 this particular application to that list?

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ROA_0619

1 A: In looking at the application itself and
2 thinking about the service area, the project,
3 the applicant, it's a pretty holistic review of
4 all the circumstances surrounding the --
5 basically the entire administrative record, as
6 it exists at the time, and for a number of
7 reasons, either some criteria would not have
8 seemed as important as others or the criteria in
9 my review of certain project review criteria, I
10 determined that the review of those criteria
11 would cover the elements of some of the other
12 criteria in this list, so that it didn't have to
13 do an independent review of each one. For
14 example, there is an element of projected
15 revenue in analysis of a community -- of the
16 community need project review criteria. That's
17 just one example of some of the crossover in the
18 review. So, I did not -- I didn't feel the need
19 to include everything on this list in the deemed
20 complete letter.

21 Q: The one listed as number one, Compliance with
22 the Need Outline in this Section of the Plan, is
23 that one that was also in your deemed complete
24 letter?

25 A: Yes.



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ROA_0620

1 Q: And then looking at, for example, some of the
2 ones that you did not include in your deemed
3 complete letter with this list, in your opinion
4 did those go to compliance with the need outline
5 in the State Health Plan?

6 A: Could you ask me that again?

7 Q: Sure. So, for the project review criteria that
8 appear in the State Health Plan, which is on our
9 screens we're looking at now, Joint Exhibit 5
10 for linear accelerators, out of the ones listed
11 here that you omitted from your deemed complete
12 letter for this particular application, were
13 there any that, in your opinion as a CON
14 reviewer in how you applied those project review
15 criteria, were actually -- actually went to need
16 outlined in the South Carolina Health Plan?

17 A: If I'm understanding correctly, I did not think
18 that review of the -- I did not think I needed
19 to make findings of the criteria I omitted from
20 the State Health Plan list in order to properly
21 and completely determine compliance with the
22 need outlined in the State Health Plan. Is that
23 -- did I answer ...

24 Q: You answered my question. Thank you. So, let's
25 talk about -- I'm not going to ask you a



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ROA_0621

1 question about every single CON criteria for
2 linear accelerators in the Plan. But the one
3 that has been most discussed so far has been
4 Standard 7. So, if you'll look at CON Standard
5 7 in Joint Exhibit 5, can you tell us what your
6 finding was at the time of your decision
7 regarding compliance -- the application's
8 compliance with this standard?

9 A: At the time I made the decision I determined
10 that the application did comply with Standard 7
11 in this chapter, in chapter ---

12 Q: So, let's start with what -- do you see the
13 sentence referencing 80 percent of capacity for
14 each of the past two years?

15 A: Yes.

16 Q: Okay. Let's start with each of the past two
17 years. What years' data did you review before
18 making your decision?

19 A: I reviewed the -- I believe it was fiscal years
20 2015 and 2016.

21 Q: And if it helps you to look at the DHEC Exhibit
22 1, the application filed, the DHEC record of the
23 application -- tell me first, what is the B(11)
24 question? Is there a typical, a generic way
25 that people refer to the B(11) question?



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ROA_0622

1 A: Yes. B(11) is the need analysis, the need
2 documentation or the need projections.

3 Q: If a CON application involves standards in the
4 plans, where might you see the applicant
5 typically address those standards?

6 A: The applicant typically addresses those
7 standards as part of B(11). We don't require
8 that, but it seems to fit best in an answer to
9 B(11).

10 Q: So, looking at DHEC Exhibit 1, if you --
11 starting with page CON 18. At the very bottom
12 of page CON 18, do you see the bolded wording
13 there?

14 A: Yes.

15 Q: What is that, just generally, what is that that
16 starts with B(11) bolded?

17 A: At the bottom, are you talking about ---

18 Q: I'm sorry, CON 17.

19 A: Okay.

20 Q: Sorry.

21 A: That bolded language is the -- is basically the
22 question or the -- that language comes from the
23 regulation as part of the -- it's one of the
24 questions that the applicant has to answer as
25 part of the application. It's basically



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ROA_0623

1 instructions on how to and what kind of
2 information to include in order to show need.

3 Q: B(11) there -- is that the B(11) question?

4 A: B(11), yes.

5 Q: Okay. So, let's turn to the next page, which
6 now is CON 18. Do you see Figure 4 on CON 18?

7 A: Yes.

8 Q: And can you tell us what -- did you review that
9 information?

10 A: Yes.

11 Q: And to what extent was Figure 4 -- the
12 information of Figure 4, if at all, important to
13 you in making your decision?

14 A: Well, the information in this figure is all part
15 of the analysis that the applicant and the
16 Department needs to do in order to determine
17 what the utilization was for the listed years
18 there. It's a calculation done by determining
19 the capacity of the existing units and then the
20 number of actual treatments performed in order
21 to figure out what percentage of capacity the
22 linear accelerators were used for those years.

23 Q: And you see the heading JAR, J-A-R, all caps?

24 A: Yes.

25 Q: Can you tell us what the JAR is?



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ROA_0624

- 1 A: The JAR is the joint annual report of hospitals.
2 That's a yearly report that is completed by
3 healthcare facilities in South Carolina. Every
4 healthcare facility that has, that requires a
5 Certificate of Need to begin services or to
6 begin a project must fill out an annual -- a
7 joint annual report. It includes different
8 information for different types of facilities.
9 But for radiation therapy facilities, any
10 facility that has a linear accelerator, the JAR
11 includes the number of treatments on all the
12 linear accelerators for that facility for that
13 year.
- 14 Q: Does DHEC have any requirements regarding what
15 year, in terms of a 12-month period, must be
16 included in a JAR?
- 17 A: No. The applicant determines what their JAR
18 year is going to be. It has to be a year, but
19 it can be a fiscal year, it can be a calendar
20 year. And the JAR -- the facility -- there's a
21 part of the JAR that asks for what the reporting
22 year is. And so the reporting facility will
23 include the span of time that's -- for which
24 that -- that that report represents, whatever
25 the 12-month span is.

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ROA_0625

1 Q: And in the course of your job at DHEC in your
2 responsibilities reviewing different
3 information, both in applications and for the
4 State Health Plan, have you reviewed JARs from
5 different facilities over the years?

6 A: Yes.

7 Q: Have -- do they all have the same 12-month time
8 period that they report in their JAR?

9 A: I don't think so, although I don't know for
10 sure. I know that MUSC's JARs, I think, were a
11 July 1st to June 30th year. That was their
12 reported year as indicated on the JAR. But I
13 don't know off the top of my head whether or not
14 everyone else uses that exact same time span.

15 Q: Do you know if everyone considers their fiscal
16 year the same 12-month period?

17 A: I don't know.

18 Q: Is there any requirement in Standard 7 in the
19 State Health Plan for radiation therapy services
20 that talks about whether the two-year period is
21 supposed to be a fiscal year period, calendar
22 year period, or a JAR year period?

23 A: There is no requirement. It only has to be --
24 the standard states that it has to be for each
25 of the past two years.



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ROA_0626

1 Q: What do you, as a reviewer, then look for when
2 you have such an application like this one,
3 you're applying that standard, what do you look
4 for?

5 A: Typically of course I look to see what the
6 applicant has included in the application, which
7 I did here, and I look at the JARs. It's a kind
8 of a standardized way to look at that
9 information. So, that's usually the second
10 place I go. After the application, I'll go to
11 that facility's JAR to see what they reported
12 over the past two years, whatever the two most
13 recent years are that are available. And that's
14 what I did in this case too.

15 Q: When it's time for you to make your decision and
16 you're looking at the past -- that standard past
17 two years, do you have -- does that have any
18 meaning to you in time reference as to
19 application submission versus decision date?

20 A: That means to me -- and I review applications --
21 to me that means the most recent years available
22 at the time I'm making a decision. So, if there
23 is enough intervening time in between submission
24 of an application and the decision, if another
25 JAR report becomes available, if a facility has



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ROA_0627

1 completed a JAR, I will look at that one as the
2 most recent year. Whatever the most recent year
3 that's available to me, that'll be year two.
4 And the year before that will be year one.
5 Sometimes the applicant will submit other years.
6 And that actually has happened before where an
7 applicant submitted an application with older
8 JAR data, but in the intervening time another
9 newer JAR became available and I consider that
10 as the second year.

11 Q: At the time you made this decision, what -- and
12 based on the information in front of you at
13 decision-making time, what was your finding
14 regarding whether or not the application was
15 consistent with Standard 7?

16 A: At the time both the JAR data and the data
17 supplied by the applicant showed that the
18 utilization was more than 80 percent for both
19 2015 and 2016. And those -- that was the most
20 recent data -- those two years were the most
21 recent years of data that were available to me
22 at the time I made the decision.

23 Q: Since the time of the decision and your
24 testimony here today, have you been made aware
25 of anything that -- any changes to the



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ROA_0628

1 information that you reviewed in the
2 application?

3 A: Yes. Shortly before my deposition in this case,
4 MUSC came to us, to the Department, to inform us
5 that there was a need to update the JAR data
6 because there were some inaccuracies that they
7 had discovered. And ultimately for both 2015
8 and 2016 the result of that was a lower number
9 of treatments reported for both of those years,
10 so that one of the years, according to the new
11 data that MUSC brought to us, for that JAR year,
12 one of the years dipped below 80 percent.

13 Q: Do you recall what the number was?

14 A: At the time -- I didn't have the numbers in
15 front of me, but I think at the time the
16 utilization for that year -- and I don't
17 remember if it was '15 or '16, I think it was
18 2015 -- it reduced the utilization from 82.6
19 percent to 79.97. That was the number that
20 sticks in my head.

21 Q: And did they leave any documentation with you
22 when they left the meeting?

23 A: No. They did not leave any documentation.

24 Q: And did you take any written notes at that
25 meeting?



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ROA_0629

1 A: No.

2 Q: Okay. Have you ever, in your experience as a
3 reviewer, been faced with an application where
4 you're looking at Standard 7 and one of the two
5 years, let's say, is 79.97 percent?

6 A: No. I've never faced that situation.

7 Q: So, are you aware of any instance where DHEC has
8 actually issued a decision on what it would do
9 with 79.97, an actual decision?

10 A: No. I'm not aware of any instance that the
11 Department's had to make that kind of
12 determination.

13 Q: Now, since the time that that was brought to you
14 and the time you're sitting here today, have you
15 given any further thought to whether that would
16 have made a difference to you as a reviewer had
17 it been 79.97 at the time of your decision?

18 A: Yes. I have given it some thought, I've
19 discussed it with my team, and our bureau chief,
20 and have an opinion on what I would do if faced
21 with that situation now.

22 Q: What is that?

23 A: I think that if the number -- if the
24 calculations -- well, let me start by saying, if
25 the data showed that there was a number -- a



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ROA_0630

1 utilization number below 80 percent from one of
2 the applicable years, I would contact the
3 applicant to let the applicant know that there
4 was a problem and see -- and start that
5 conversation and see if there was any additional
6 data, any more recent data, or I would give the
7 applicant an opportunity to respond. But if,
8 after that process, I was still faced with a
9 number below 80 percent, I would not round. I
10 would find that that was not compliant.

11 Q: Are you aware of any guidance out there ---

12 A: No.

13 Q: --- that's available to you on this issue?

14 A: I'm not aware of any guidance and I -- again, I
15 have not actually had to make this decision.
16 And so I'm only, just in the intervening time
17 between a couple days before the deposition and
18 now, have discussed kind of a what-would-you-do
19 situation. And generally I think a minimum is
20 a minimum and I'm not, as I sit here today, not
21 comfortable with rounding up. I would -- for a
22 number of reasons. However, that's not to say
23 that in the face of guidance or, you know, a
24 difference decision by The Court, that I
25 wouldn't follow that guidance. Just having --



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ROA_0631

1 if I myself were forced to make that decision
2 right now, I don't think I would round.

3 Q: Are you aware that the two other parties
4 involved in this contested case hearing have
5 differing opinions on this rounding issue?

6 A: Yes. I would be shocked if they didn't.

7 Q: If, at the conclusion of this contested case
8 hearing, there is a finding and conclusion of
9 law from the Administrative Law Court that
10 addresses this issue, what would you consider
11 regarding that for you to encounter this again?

12 A: I would be grateful for the guidance and I would
13 follow it, whatever the guidance is from The
14 Court.

15 Q: Now -- okay. So, we've explored Standard 7.
16 Let's -- and we've looked at the project review
17 criteria that's in the State Health Plan.
18 There's one more thing in the Plan section that
19 I want to talk about, which is the sentence,
20 which I believe is on Roman Numeral IX-6
21 directly below the list of project review
22 criteria. Can you read that sentence aloud for
23 us?

24 A: Yes. It says the benefits of improved
25 accessibility will be equally weighed with the



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ROA_0632

1 adverse effects of duplication in evaluating
2 Certificate of Need applications for this
3 service.

4 Q: Did you consider that sentence in the Plan in
5 your review and decision making on this
6 application?

7 A: Yes, I did..

8 Q: What were your findings or conclusions on that?

9 A: My ultimate conclusion is that the improved
10 accessibility offered by the project was
11 significant enough to mitigate any adverse
12 effects of duplication that might occur with
13 implementation of this project.

14 Q: And what was the basis for that conclusion?

15 A: Well, it was -- a number of things. But
16 specifically this project involved placing a
17 linear accelerator in a county that, to this
18 day, still does not have any linear
19 accelerators, all of Berkeley County. And with
20 this particular service, with radiation oncology
21 and linac treatments, the patient often has to
22 go daily to receive these treatments. So, for
23 this kind of service location is very important
24 with respect to accessibility by the patient.
25 And so the location of this particular project



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ROA_0633

1 was a very weighty factor in my determination
2 that the approved accessibility was significant
3 enough to outweigh any potential adverse
4 impacts. And especially in light of the target
5 population for this project, it's not just that
6 there are no linacs in Berkeley County, it's
7 that MUSC demonstrated that a significant number
8 of their current patients are traveling all the
9 way to downtown Charleston on the almost tip of
10 the peninsula or tip of the peninsula to receive
11 radiation therapy at MUSC. And so these
12 patients are already making significant --
13 spending a significant amount of time traveling
14 to receive these treatments, which are often
15 daily treatments. So, the location was a big
16 factor. I think it might be the most important
17 factor.

18 Q: And one more question before we leave the Plan
19 itself. Have -- and regarding that 80 percent
20 of capacity, looking at -- determining what 80
21 percent is, does that involve looking at what
22 the capacity is for a linear accelerator?

23 A: Yes.

24 Q: And does the Plan have different potential
25 capacities that could be assigned to a linear



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ROA_0634

1 accelerator?

2 A: Yes. And that capacity is identified by the
3 applicant in the application. And then through
4 the review process, the Department -- the
5 reviewer and the Department determines whether
6 or not that capacity is appropriate. And that's
7 part of the final decision, is a finding
8 regarding capacity. And once that decision is
9 made and the certificate's issued, then that is
10 the capacity for that linear accelerator for
11 State Health Planning purposes, unless and until
12 it's changed through the State Health Planning
13 process.

14 Q: In your experience working at DHEC, have you
15 seen any instances where a capacity was changed
16 for a linear accelerator from the capacity in
17 the CON approval application and approval -- and
18 then changed at a later date?

19 A: Yes. I'm aware of one instance. It was one
20 facility and involved more than one unit. Roper
21 had requested a change in capacity for a number
22 of its units by sending a letter to the
23 Department with an explanation as to why Roper
24 thought that that was appropriate. And this is
25 the Roper in Bon Secours St. Francis system.



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ROA_0635

1 And the staff found that there was a compelling
2 reason to change the capacity and so we -- as
3 part of the revision of the subsequent State
4 Health Plan, we included that request and change
5 as part of the draft plan and opened that up --
6 along with all the other proposed changes to the
7 Plan, we opened that up to public comment. And
8 at the end of that process, as part of the State
9 Health Plan revision process, we made the change
10 in capacity for Roper. That's the only instance
11 that I'm aware of, of a capacity change for any
12 linear accelerator that's different from the
13 original approved capacity.

14 Q: Okay. Now, let's look at your decision letter,
15 which in DHEC Exhibit 1 begins on page CON 375.
16 And we've already talked about a number of
17 things at the beginning, so I would like to just
18 bring your attention to where we start with the
19 project review criteria as far as community need
20 documentation.

21 A: Yes.

22 Q: Tell us what was your finding regarding this
23 application and the community need documentation
24 project review criterion?

25 A: I found that the application did comply with



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ROA_0636

1 community need documentation criteria.

2 Q: And can you describe for us your basis for that?

3 A: Yes. The criteria requires certain things,
4 including the clear identification of the target
5 population. MUSC, I found, did clearly identify
6 its target population. As I mentioned before,
7 it was a significant portion of the targeted
8 population for this project was and is MUSC's
9 current patient population. There is a
10 significant percentage of MUSC's radiation
11 therapy patients who are currently driving from
12 the area surrounding the proposed location of
13 the project to the peninsula, to MUSC's facility
14 on the Charleston peninsula, in order to get
15 treatment. And so, that patient population,
16 MUSC's current patient population residing in
17 the area near to the proposed location was a
18 significant portion of MUSC's target population.
19 MUSC also identified some other potential
20 patients as well. And also it made clear
21 projections of utilization. I thought the
22 projections were reasonable, were based on a
23 number of things, including the number of
24 treatments per patient, the likelihood that
25 certain patients from certain areas would travel



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ROA_0637

1 to that facility as opposed to another facility,
2 things like that. And so that's some of the
3 evidence that I thought was sufficient to find
4 the project provided that criteria.

5 Q: Okay. Let's look at the next one, distribution,
6 accessibility. Can you just tell us briefly
7 what was your finding regarding compliance and
8 what was your basis for that?

9 A: I found that the project was compliant with
10 distribution. Some of the highlights of that
11 finding, again, the location was very important.
12 All of the other linear accelerators in the
13 service area, the applicable service area, which
14 is Berkeley County, Dorchester County,
15 Charleston County, and I believe Williamsburg or
16 Colleton. I'm not sure what the last -- anyway
17 all of the linear accelerators in that service
18 area currently in Charleston County. So, from
19 a distribution aspect, having a linac out in the
20 Berkeley County area, which is a rapidly growing
21 area, and, again, as we already discussed, has
22 a significant portion of MUSC's patients already
23 residing there, that was a significant factor in
24 finding compliance with the distribution
25 criteria. There are other elements listed as



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ROA_0638

1 part of that criteria. MUSC had to identify how
2 the patients would have access. Some of the,
3 you know, nondiscrimination-type policies,
4 things like that, which it did include in its
5 application. And then information regarding
6 indigent care. I thought MUSC also included
7 sufficient evidence that it would address
8 indigent care in a way that would make the
9 approval of that project a benefit.

10 Q: Okay. Let's look at the next one, medically
11 underserved groups. What was your finding and
12 just briefly the basis of that?

13 A: The medically underserved groups I found that
14 the application complied with that project
15 review criteria. That addresses how the project
16 and the facility addresses the needs of
17 underserved groups. Underserved groups can
18 include uninsured, underinsured, low income,
19 indigent patients. And based on the information
20 contained in the application regarding the
21 project, specifically MUSC as a whole, I found
22 that the evidence was sufficient to find in
23 compliance with that criteria.

24 Q: And I believe the last one, financial
25 feasibility, what was your conclusion and the



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ROA_0639

1 basis for it?

2 A: I concluded that the project complied with the
3 financial feasibility criteria. That was based
4 on the income statements provided in the
5 application, along with some of the identified
6 assumptions. And the attestation from -- a
7 specific attestation from John Cooper regarding
8 the accuracy of the information in the pro forma
9 and reviewing the financial feasibility, I
10 looked at the project, compared it generally to
11 other similar projects to see if there were any
12 elements of the pro forma or the other financial
13 assumptions, to see if there was anything that
14 raised any significant red flags or jumped out
15 at me as something I needed to follow up on. I
16 didn't see anything that caused me particular
17 concern. And so that's some of the evidence
18 that I used to determine compliance with that
19 criteria.

20 Q: Okay. Well, Ms. Murdock, thank you very much.
21 That concludes my Direct Examination. Thank
22 you.

23 A: Thank you.

24 MR. DAYHUFF: Your Honor, what's your preference?
25 I'm ready to proceed. I would say under 30



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ROA_0640

1 minutes.

2 **THE COURT:** You know, as close as we are, I would
3 still -- we're at 12:20, so pretty close. I
4 think I'd like to have -- let everybody take a
5 lunch break and come back and finish up. And
6 while you're at lunch, you guys can fight over
7 who gets to go first or second.

8 **MR. THOMAS:** I'm going to let him go first.

9 **MR. DAYHUFF:** That's the sound move. I think that's
10 probably right.

11 **THE COURT:** Let's take, what, about an hour and 15,
12 give everybody a chance to eat and then come
13 back and digest your needs. So, we're -- let's
14 see, if I say 1:30, we know we mean 1:35? Okay.
15 All right. We'll be -- we'll adjourn until
16 1:35.

17 **(Off the Record)**

18 **THE COURT:** We are back on the record in case number
19 18-07-0100. And, Mr. Dayhuff ---

20 **MR. DAYHUFF:** I'm ready to go, but we're missing a
21 very crucial ---

22 **THE COURT:** Oh, we seem to be.

23 **MR. DAYHUFF:** --- part of my examination.

24 **MS. BIGGERS:** I apologize, Your Honor, I ---

25 **THE COURT:** Are you going to take over for her?



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ROA_0641

1 MS. BIGGERS: Oh, that's her right there.

2 THE COURT: Okay. Ms. Murdock, you got to catch up.

3 The first two questions have already been asked.

4 MS. MURDOCK: I hope somebody gave a great answer.

5 My apologies.

6 THE COURT: No worries. No worries. All right.

7 You're back on the stand and you're still under
8 oath.

9 MS. MURDOCK - CROSS-EXAMINATION BY MR. DAYHUFF:

10 Q: Good afternoon, Ms. Murdock.

11 A: Good afternoon.

12 Q: All right. During your Direct Examination with
13 Ms. Biggers you discussed the issue of the
14 project review criteria that you chose to put in
15 your deemed complete letter for the MUSC CON
16 application. Do you recall that?

17 A: Yes.

18 Q: All right. I understood you to say that DHEC
19 staff, you, believed you have the discretion to
20 vary from the list of most important project
21 review criterion in the State Health Plan for a
22 service when you're choosing to put stuff in
23 your deemed complete letter.

24 A: Yes.

25 Q: All right. Now, the MUSC CON application for



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ROA_0642

1 the Berkeley County linac, that I referred to as
2 Beaufort County on occasion, it was reviewed
3 simultaneously with another application. Do you
4 recall that?

5 A: Yes.

6 Q: And that was an application by what provider?

7 A: It was an application by Roper for a linear
8 accelerator also in Berkeley County.

9 Q: All right. And the MUSC CON application was
10 reviewed under what State Health Plan, what
11 year?

12 A: It was the Plan adopted in August of 2015.

13 Q: All right. And do you recall what State Health
14 Plan the Roper application, by the nature of the
15 timing of its filing, would have been reviewed
16 under?

17 A: It would have been reviewed under and was
18 reviewed under the subsequent Plan, the 20 --
19 2016-'17 Plan.

20 Q: I think it's '17-'18. Does that sound about
21 right?

22 A: '17-'18 Plan, whatever the subsequent one is to
23 the Plan that the MUSC project was reviewed on.

24 Q: Did your choice of project review criteria, by
25 which you reviewed the Roper application and the



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ROA_0643

1 MUSC application simultaneously, did your choice
2 have something to do with reviewing them
3 together?

4 A: Yes.

5 Q: Explain that, if you would.

6 A: Because they were potentially competing
7 applications, I thought I -- I felt, and still
8 feel, that I was obligated to review them with
9 the same relative importance criteria.

10 Q: All right.

11 A: And I did.

12 Q: Okay. And which party claims that the
13 applications were competing?

14 A: I don't remember exactly. I think Trident did.
15 And I'm not sure -- I don't believe that MUSC
16 did and I'm not sure about Roper.

17 Q: All right. After receiving -- well, the deemed
18 complete letters went to the applicants, Roper,
19 MUSC. And did they also go to the affected
20 parties, Trident?

21 A: Yes.

22 Q: Okay. After those were sent out, did DHEC
23 receive any requests from any of the CON
24 applicants or the affected person -- party,
25 Trident, to add, subtract from, or otherwise



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ROA_0644

1 modify the list of most important criteria that
2 DHEC chose to review these two applications
3 with?

4 A: I don't recall any party specifically asking for
5 that.

6 Q: Okay. If a party would have asked for that,
7 those type requests are something that DHEC
8 considers or not?

9 A: Sure.. We would consider that, yes.

10 Q: All right. We talked about the data, or you
11 talked about the data with Ms. Biggers, that
12 MUSC submitted with its CON application. We
13 submitted 2015 and 2016 JAR data; is that right?

14 A: Yes.

15 Q: All right., And through discovery we learned
16 that 2016 data slightly over-counted treatments?

17 A: Yes.

18 Q: And the number I think that you had in your
19 head, we had it at 80.1 and it went down to 79
20 what?

21 A: I believe it was 79.97.

22 Q: Okay. And did MUSC report that error to you?

23 A: Yes.

24 Q: All right. If I understood you earlier in your
25 testimony about rounding, we've been talking a



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ROA_0645

1 lot about rounding, you do not believe currently
2 DHEC's staff can round to meet the threshold in
3 the State Health Plan, Section 7 -- or Standard
4 7, in the linear accelerator section of the
5 Plant; is that right?

6 A: I don't believe DHEC should round.

7 Q: Okay. At this point, correct?

8 A: At this point.

9 Q: I also understood you to say you were looking
10 for guidance from the Administrative Law Court
11 on this issue.

12 **MR. THOMAS:** Object to the form -- not the form, Your
13 Honor. I think that mischaracterizes her
14 testimony. I don't think that she said that she
15 was looking for guidance from the ALJ. I think
16 she -- in response to Ms. Biggers' question she
17 said she'd be willing to do that, but I don't
18 think she firmly said we're looking for guidance
19 from this Court.

20 **MR. DAYHUFF:** I'll rephrase the question.

21 **THE COURT:** Okay. I don't know why anybody wouldn't
22 be looking for guidance, but that's another
23 issue.

24 Q: Are you, as DHEC staff, looking for guidance
25 from the Administrative Law Court on the issue



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ROA_0646

1 of whether rounding would be appropriate with
2 respect to the State Health Plan Standard 7, or
3 6 for that matter, with respect to linear
4 accelerators?

5 A: At this point, yes, since we're here.

6 Q: If the Administrative Law Court decided that
7 rounding were appropriate, 7.90 and above were
8 appropriate, that was the order that was issued,
9 what would the DHEC staff do going forward?

10 A: DHEC staff would follow that guidance.

11 **MR. DAYHUFF:** Mr. Bupp, could you put up Joint 5,
12 2015 of the State Health Plan, linear
13 accelerator Standard 7?

14 Q: And I want to talk about the past two years.
15 You testified under Direct with Ms. Biggers
16 about the past two years. And here's what I
17 understood you to say or heard you to say, that
18 you view that phrase in the Plan to mean the
19 most recent data available when the decision is
20 made, before the decision is made.

21 A: Yes.

22 Q: All right. Now, you're the person who applies
23 the State Health Plan to CON applications. Is
24 it appropriate for The Court, as part of this
25 case on MUSC's CON application, to look back to



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ROA_0647

1 the past two years, calendar year 2018, calendar
2 year 2017, to determine here and now whether
3 MUSC meets the 80 percent threshold of Standard
4 7?

5 **MR. THOMAS:** I object. That calls for a conclusion
6 of law. She is not the person to make that,
7 Your Honor. You are. You're the person who's
8 going to be making that decision for us. She is
9 not in a position -- she's not a lawyer for the
10 agency. She's not on the stand to testify as to
11 what the law is in a post DHEC review situation.
12 The review stops with her when she does the
13 staff decision and then goes to the DHEC board
14 and, you know, they either decide to take it up
15 or they don't. Then it comes to the final
16 decision of the agency and then we go on and
17 hash it out before you, Your Honor. But she'll
18 never be in a position to make that decision.
19 That is purely a matter of law for The Court.

20 **MR. DAYHUFF:** Mr. Sullivan gave his thoughts on
21 whether that could be done. Ms. Murdock applies
22 the State Health Plan all the time. She can
23 give her thoughts on this as well.

24 **MR. THOMAS:** I don't think so.

25 **THE COURT:** I think the difference is we have, Mr.



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ROA_0648

1 Levitt and Mr. Sullivan, they're experts. We
2 qualified them to give us opinions. I'm not
3 sure that she is qualified to do that.

4 **MR. THOMAS:** And I think Mr. Dayhuff could have
5 certainly objected.

6 **THE COURT:** Ms. Biggers rises too.

7 **MS. BIGGERS:** Your Honor, while it is true that we
8 have not submitted Ms. Murdock as an expert
9 witness, I do believe that, in the vein of the
10 line of question that the expert witnesses were
11 asked, which was for their expert opinion as
12 health planners, I think it's an appropriate
13 question for Ms. Murdock in terms of as a DHEC
14 reviewer. I mean, we certainly have had cases
15 -- doesn't happen often -- but sometimes are
16 remanded from the ALC back to DHEC for some
17 reason to consider something not considered
18 before. I think it's -- within her line as a
19 DHEC reviewer, I think she could answer it in
20 that vein.

21 **MR. THOMAS:** I would respond to that that, as a DHEC
22 reviewer, she is told on a remand what to do by
23 The Court. You know, take this, consider this,
24 you know, go forward with this. But he's
25 asking, you know, directly for a conclusion of



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ROA_0649

1 law, which is an ultimate legal issue in this
2 case.

3 **THE COURT:** Mr. Thomas, I -- this is, I think, a
4 close question. But I think the issue, as it's
5 been posed here, is a question of application of
6 law. It looks to me that that would be
7 something that would come back to DHEC
8 potentially from this Court or some other court.
9 I think that's -- I'm just not sure that she's
10 in a position to answer that question the way
11 it's been put.

12 **MR. DAYHUFF:** Let me try to rephrase it if I may,
13 Your Honor.

14 **Q:** Ms. Murdock, would the Administrative Law
15 Courts, looking back before The Court makes a
16 decision, looking back to calendar year 2018,
17 calendar year 2017, the most recent data we
18 have, to make a determination as to whether MUSC
19 meets the 80 percent threshold in Standard 7,
20 would that defend any DHEC practices that you're
21 aware of?

22 **MR. THOMAS:** Same objection, Your Honor. I don't
23 think she's aware of the DHEC practices because,
24 again, it's not something that she's ever going
25 to be in a position to do without instructions



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ROA_0650

1 from The Court on remand.

2 **MR. DAYHUFF:** I'm certain she's aware of DHEC
3 practices as the director of the CON Program.

4 **THE COURT:** I think the question there is what their
5 practices are.

6 **MR. THOMAS:** Okay. I think he needs to lay some more
7 foundation as to, have you ever been in a
8 situation where The Court has remanded something
9 back to you and has asked you specifically to
10 apply the last two years or have you been ---

11 **MR. DAYHUFF:** That's not my question.

12 **MR. THOMAS:** This is just not -- it's not a scenario
13 she will ever have. It just isn't. It's asking
14 for a conclusion of law from, you know, a non-
15 lawyer for the agency. I know she's probably a
16 licensed attorney, but she doesn't act as such
17 for the agency. It's just a question of law for
18 The Court, and that's a massive issue in this
19 case.

20 **THE COURT:** Well, Mr. Thomas, I do in fact agree with
21 that. I think he's -- Mr. Dayhuff, you're asking
22 her for a legal conclusion. If you could ask
23 her what they've done in the past that's fine.
24 I think you'll find that if a court remands a
25 case, they do what the court tells them to do,



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ROA_0651

1 considers whatever the court asks them to do.
2 The practical question in this case I believe
3 for her would be, what would she do before a
4 case has been appealed to this Court if new
5 information were to come, as this might have,
6 and would they reconsider a decision. Certainly
7 she could answer that question, but I don't
8 think she can say what she would do other than
9 whatever The Court tells her.

10 **MR. DAYHUFF:** So, if this matter were remanded to
11 her, what would she do with respect to ---

12 **THE COURT:** She would do what The Court told her. I
13 don't think there's any -- I don't think you
14 need to ask that question.

15 **MR. DAYHUFF:** Right.

16 **THE COURT:** I hope.

17 **MR. DAYHUFF:** How about this. Let me try again. And
18 then if this doesn't work, I'll move on.

19 **Q:** If we were here today and we submitted you a CON
20 application and you were going to decide that
21 tomorrow, would you rely upon calendar year 2017
22 and calendar year 2018 data from MUSC to
23 determine whether Standard 7 was met?

24 **A:** I would rely on the most recent reliable data
25 available, which I believe in this case is 2018



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ROA_0652

1 and 2017. I believe that relying on the most
2 recent data available is the best way to
3 maintain faithfulness to the purpose and
4 requirements of the CON laws and the State
5 Health Plan.

6 Q: All right. If we were to be subject to Mr.
7 Sullivan's solution in this matter -- and you
8 weren't here for Mr. Sullivan's testimony, but
9 he proposed that what we should do is re-file.
10 If we were to re-file right now, what data would
11 you look at?

12 A: Specifically whatever data was provided to me by
13 the applicant. And I would also look to the
14 most recent available JARs, the most recent
15 complete JARs. I believe in this case the most
16 recent JARs would be -- well, I would look for
17 the most recent data. The most completed JARs,
18 I believe, are still '17 and '16. But I would
19 not -- I don't -- I would not limit the data in
20 which I rely to just JARs. If there's reliable
21 data that's more recent that's available, I
22 would accept that as well.

23 Q: So, if MUSC had calendar year data from 2017 and
24 calendar year through 2018 the end of the year
25 and those showed MUSC at over 80 percent, you



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ROA_0653

1 would consider -- you would consider that data,
2 one?

3 A: Yes.

4 Q: And if they were over 80 percent, what finding
5 would you make under Standard 7?

6 A: That the application was compliant with Standard
7 7, with respect to the minimum utilization. Of
8 course the projection requirements would also
9 need to be met, projecting at least 50 percent
10 utilization.

11 Q: All right. So, if we were to begin again today
12 this entire process, assuming everything else
13 stays the same and we submit that data, we'd be
14 back here?

15 A: Yes. I would approve that application based on
16 that. And I think it's important to recognize
17 that, in a case of an expansion of existing
18 service under 7, under Standard 7, there is
19 language that says for each of the past two
20 years. If we were looking at a new service,
21 there's different language that requires us to
22 look at the JARs. I think there's a difference
23 in the analysis, which is why we have more
24 freedom to use more recent data that's internal
25 to the applicant, for an expansion of an



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ROA_0654

1 existing service, because the analysis is based
2 solely -- for the purpose of compliance with the
3 standard, the analysis is based solely on that
4 applicant's own utilization.

5 Q: All right.

6 A: And that applicant is the owner of all that data
7 to begin with. That's the only way that it gets
8 to the JAR.

9 Q: In your reference to the data, being JAR data,
10 that's in the 2017-'18 Health Plan for new?

11 A: Yes. And that's probably not what -- I don't
12 think that was the language in the 2015 Plan.
13 That's the language we use now..

14 Q: Do you recall the language in the 2015 Plan?

15 A: Not off the top of my head. And they also say
16 that. I don't know.

17 Q: Joint 5, Standard 6. What's the language that's
18 required in 6?

19 A: All right. For 6 it says new radiotherapy
20 services shall only be approved if the following
21 conditions are met. Subsection A, all existing
22 units in the service area have performed at a
23 combined use rate of 80 percent of capacity for
24 the year immediately preceding the filing of the
25 applicant's Certificate of Need application.



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ROA_0655

1 Q: All right. And that's meaningful to you, that
2 distinction between 6 and 7 why?

3 A: The data required for analyzing Standard 6,
4 that's data that has to be collected from all
5 the existing units in the service area. And so
6 there has to -- so, you have to have a
7 standardized way to look at all of that data.
8 If you are looking at different years or
9 different types of data, it's more -- it's more
10 difficult to come up with the same solution
11 every time to be uniform in an application.
12 Again, because it's looking at data, not the
13 applicant's data, but the data of other entities
14 that are not the entities that are contributing
15 to the information supplied in the application.

16 Q: I see. Now Mr. Sullivan, Trident's health
17 planning expert, has opined in this case that
18 it's appropriate to amend a provider's State
19 Health Plan assigned linac capacity at the
20 request of the CON litigant. Now, are aware of
21 the amendments to the capacity he made during
22 his deposition?

23 MR. THOMAS: I'm going to object. Improper
24 foundation and Mischaracterization of Mr.
25 Sullivan's testimony. I don't think he ever



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ROA_0656

1 said that he would amend the State Health Plan.
2 I think his position is and was that, you know,
3 you can look at what their actual utilization
4 is. You can look at what their capacity has
5 stated, which is not in the State Health Plan,
6 by the way, and it was in their CON application.
7 And then, if they're clearly not meeting a
8 sufficient volume, The Court can take notice of
9 that and determine whether or not they actually
10 meet those standards and should be held to those
11 capacities -- those higher capacities, which
12 then makes it easier for them to apply for a new
13 or expanded linear accelerator, Your Honor.
14 That was the position, not that he believed he
15 could amend, through some amendment process, the
16 State Health Plan.

17 **MR. DAYHUFF:** I will rephrase.

18 **Q:** Are you aware of any way -- how can a provider
19 change a capacity in the State Health Plan, a
20 linac capacity?

21 **A:** I believe the linac capacity could only be --
22 after it's already been determined through CON
23 review, I think that the only way to change the
24 capacity of the linear accelerator is to do it
25 through the State Health Planning process.



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ROA_0657

1 Although the capacities of each individual
2 linear accelerator aren't stated specifically in
3 the State Health Plan, they are included in the
4 formula used to make determinations of
5 utilization and relied upon as constants in the
6 calculations that we do in the State Health
7 Plan. So, they are like a mathematical -- you
8 know, an addition or a division, something
9 that's a part of a formula, the linear
10 accelerator capacities are included in the State
11 Health Plan, although they aren't stated
12 specifically and assigned to a specific unit.

13 Q: Are the linear accelerator capacities in the
14 State Health Plan listed by service area,
15 totaled by service area?

16 A: Yes.

17 Q: All right. And if a provider wanted to try to
18 figure out capacities for individual hospitals,
19 they would need to know how many linear
20 accelerators they had and then do math?

21 A: Yes.

22 Q: In the DHEC review process, do you think it
23 would be appropriate in a CON application
24 process for a -- do you think it's appropriate
25 for a affected party to assert that an



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ROA_0658

1 applicant's State Health Plan assigned capacity
2 should be modified for purposes of the DHEC
3 staff review of a CON application?

4 **MR. THOMAS:** Object. Calls for a legal conclusion.

5 **MR. DAYHUFF:** It does not call for a legal
6 conclusion.

7 **MR. THOMAS:** I think it does. That's a question of
8 law.

9 **MR. DAYHUFF:** I asked her if she thinks that it's
10 proper within the DHEC staff review process. It
11 goes to the nature of health planning. Do we
12 have rules? Are we able to change the rules and
13 capacities in each CON application dispute? I'm
14 not asking her about what's happening here. I
15 also think it's chaotic here. I'm asking her if
16 she thinks it would be appropriate as a CON
17 reviewer to have that issue injected into DHEC
18 review of CON applications.

19 **THE COURT:** I think so. I think that's not a legal
20 conclusion. They may decide it's appropriate in
21 this Court or some other court may decide that
22 it's not appropriate. But he's asking what she
23 thinks they can do.

24 **MR. THOMAS:** Okay.

25 **THE COURT:** I'm going to allow that.



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ROA_0659

1 Q: All right.

2 A: I do not think that the DHEC reviewer can change
3 the assigned capacity of a linear accelerator
4 that's not the subject of the application
5 itself. If it's already been approved through
6 the CON process, unless there is some
7 scrivener's error or mistake that is an
8 undisputed mistake, I don't think that the CON
9 reviewer has the authority to change or that the
10 staff or the Department has the authority to
11 change the linear accelerator capacity on a
12 case-by-case basis during the CON review
13 process. I think the only mechanism for doing
14 that is through the State Health Planning
15 process. And if a member of the regulative
16 community felt that any linear accelerator or
17 linear accelerators were assigned a capacity
18 that's not realistic or that should be changed,
19 then anyone in the regulated community or anyone
20 has the opportunity to do so, to make that
21 request during every State Health Planning
22 process.

23 Q: All right. Let's talk about a few of the
24 conclusions in your decision letter with respect
25 to the MUSC CON application. Trident claimed



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ROA_0660

1 that the MUSC and Roper linac CON applications
2 were not needed. Do you recall that?

3 A: Yes.

4 Q: Now, part of the reason they asserted that was
5 they were so underutilized. Do you recall that?

6 A: They being Trident?

7 Q: They being Trident.

8 A: Yes.

9 Q: Did you consider that argument? And if yes,
10 what did you -- how did you analyze it and what
11 did you conclude?

12 A: It was a -- yes, I did consider the argument.
13 I consider every -- as a rule, I would consider
14 argument raised by an affected party or an
15 opposition party. Trident's -- however, Trident
16 didn't really back up that argument with any
17 specific data. There were no specifics as to
18 how the project or projects would affect
19 Trident's utilization. There was simply the
20 conclusion that Trident's underutilized,
21 therefore MUSC should just send all of its
22 patients in the area of the proposed projects to
23 Trident, so that they don't have to travel down
24 to MUSC.

25 Q: Does Standard 7 of the State Health Plan include



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ROA_0661

1 an adverse impact element that would have
2 applied to Trident and their utilization?

3 A: Standard 7?

4 Q: Standard 7.

5 A: Not specifically, no.

6 Q: Standard 6 in the 2015 State Health Plan for
7 linear accelerators, does it contain an adverse
8 impact element?

9 A: It does -- just by virtue of the standard itself
10 it does, because if there is a -- if there are
11 other providers in the service area that are
12 underutilized enough, then there will not be
13 sufficient utilization service area-wise to
14 approve a new linac.

15 Q: Do you recall Trident claiming that both Roper
16 and MUSC linac projects would cause it adverse
17 impact?

18 A: Yes.

19 Q: Did Trident quantify the alleged loss of volume
20 they would suffer?

21 A: No.

22 Q: Did Trident quantify the loss of revenue that
23 they would suffer as a result of lost volume?

24 A: No.

25 Q: Did Trident's decision not to quantify these



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ROA_0662

1 elements make its adverse impact claim more or
2 less persuasive in the DHEC staff ...

3 A: Less persuasive.

4 Q: There's been some discussion in this case,
5 mostly between Mr. Thomas and I, about a claim
6 that Trident may be trying to assert in this
7 case. This claim -- I'm going to describe it to
8 you -- is based on the notion that MUSC has a
9 long list of current and proposed CON projects
10 and other proposed and potential financial
11 transactions and obligations that makes it such
12 that MUSC is not financially able to establish
13 the Nexton linac and/or somehow makes the Nexton
14 linac not financially feasible. My question is,
15 was that claim made to you during the DHEC staff
16 review process?

17 A: I don't believe so.

18 Q: Let's look at MUSC Exhibit 10, Bates page 422.
19 There's the beginning document. Do you
20 recognize that as a slide that you may have seen
21 as part of this review process?

22 A: Yes.

23 Q: All right. I'm going to take you to a
24 particular slide, 422, I think. All right.
25 This is a Trident slide, I'll represent to you.



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ROA_0663

1 Due to the lack of patient volumes we only
2 operate two of our three linacs. Do you recall
3 Trident offering that information to you during
4 the DHEC review process?

5 A: Yeah. I recall this slide from that ---

6 Q: All right. We heard testimony in this case
7 that, when Trident installed its third linac in
8 2015, they ceased operating their second linac
9 and have not operated it since then. We've also
10 heard that they hold it in reserve to use it in
11 case other linacs go down for an extended period
12 of time. Finally, we heard that their linacs
13 between 2015 and now, the two that they operate,
14 have never gone down for an extended period of
15 time, such that they had to use their redundant
16 third linac. So, my question is this; if they
17 permanently shut down and remove the linac, they
18 don't operate because of low utilization, what
19 effect on Trident's State Health Plan linac
20 capacity?

21 MR. THOMAS: Object to the -- objection. I'm going
22 to say false premise and assuming facts not in
23 evidence, Your Honor. He's basically asking
24 her, as a non expert, to make a hypothetical or
25 giving her a hypothetical. Trident has not



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ROA_0664

1 permanently disabled its third linac. No
2 testimony thus far has indicated that it has.
3 It was always ready in reserve, the other two at
4 100 percent capacity now, and they're installing
5 a third TrueBeam. So, there's no basis or
6 premise for this question to even be asked, Your
7 Honor.

8 **MR. DAYHUFF:** I think this question is okay, Your
9 Honor. This is not a jury trial in which The
10 Court would be misled by answers ---

11 **THE COURT:** I appreciate your confidence. She's
12 already said that she considered ---

13 **MR. THOMAS:** Utilization.

14 **THE COURT:** Yeah. So, I'm going to allow the
15 question.

16 **Q:** Do you recall what the question is?

17 **THE COURT:** You might try again.

18 **A:** One more time.

19 **Q:** If they were to permanently shut down and remove
20 one of the three linacs they don't operate, it
21 would have the effect of reducing or increasing
22 their State Health Plan assigned linac capacity.

23 **A:** Practically speaking, it would reduce their
24 capacity. But I think it would require a trip
25 through the State Health Plan process in order



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ROA_0665

1 to permanently reduce the capacity of that
2 linear accelerator ---

3 Q: Sure. Understood.

4 A: --- for the purposes of applying State Health
5 Plan standards.

6 Q: Understood. And I'm not seeking to do that
7 right now with you. Absolutely.

8 A: And that's something that we certainly would
9 look at during the process. I will have
10 questions about that in the future.

11 Q: Right. So, if they were to shut down a linac,
12 it would reduce their capacity and increase
13 their utilization? That'd just be the math.

14 A: Yes.

15 Q: All right. What effect does Trident's practice
16 of having three linacs at their hospital, but
17 only operating two, have on the utilization
18 percentage of linac in the four-county service
19 area?

20 A: It will decrease utilization of the service area
21 wide.

22 Q: All right. What effect does that practice have
23 on the ability of new providers to enter that
24 service area?

25 A: It provides a greater barrier.



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ROA_0666

1 Q: As the DHEC CON director, does that situation
2 cause you any concern?

3 A: Yes. Depending on why.

4 Q: Sure.

5 A: Unless there was a good reason, some -- and I
6 don't want to speculate as to what those would
7 be, but without a valid reason ---

8 Q: You'd have to analyze the situation to
9 determine.

10 A: Right.

11 Q: Right.

12 MR. DAYHUFF: That's all I have, Your Honor.

13 THE COURT: Thank you, sir. Mr. Thomas.

14 MR. THOMAS: Yes, sir. One second, please.

15 THE COURT: All right.

16 **MS. MURDOCK - CROSS-EXAMINATION BY MR. THOMAS:**

17 Q: Ms. Murdock, how are you?

18 A: I'm fine. How are you?

19 Q: I'm doing well. You are the CON director; are
20 you not?

21 A: I am.

22 Q: Who is, I guess, kind of the chain of command to
23 you in the bureau of Health Facility
24 Regulations? Who would be above you?

25 A: Louis Eubank.



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ROA_0667

1 Q: What is his title?

2 A: He's the bureau chief for the bureau of Health
3 Care Planning and Construction.

4 Q: Construction, okay.

5 A: It's a somewhat new bureau, so I get stuck on
6 the name.

7 Q: Okay. Now, in your direct testimony, I believe,
8 you testified that you discussed the issue of
9 rounding, you considered it, and you discussed
10 it with the bureau chief, Mr. Eubank, and y'all
11 came to the conclusion on behalf of the
12 Department that you would not permit rounding
13 and that a minimum is a minimum. Do I have that
14 right?

15 A: Almost. We didn't go as far as to make a
16 finding on behalf of the Department. We
17 discussed what we thought we should do if that
18 situation arose. And the rest of that statement
19 is true. We thought what we should do is not
20 round.

21 Q: Okay. So, if I'm hearing you right that, if
22 this came up today, somebody came up and you had
23 no guidance from the Administrative Law Court,
24 but somebody came in at 79.95 or 96, 97, and
25 said, Ms. Murdock, we strongly urge you to allow



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ROA_0668

1 us to round this to 80, 80 will appear in our
2 CON application due to rounding, would they be
3 in compliance with Standard 7 of the Health
4 Plan?

5 A: I would not agree that that was compliant if I
6 had to make that decision today, right now.

7 Q: Okay.

8 **MOTION BY MR. THOMAS:**

9 **MR. THOMAS:** Your Honor, kind of point of order, if
10 I could. I'd like to go ahead at this time and
11 make a judgement as a matter of law on this
12 issue and make a motion for a judgement as a
13 matter of law. We now have DHEC, the CON
14 director sitting in the chair under oath, and
15 she has now admitted she would not allow
16 rounding. It is not this Court's principal duty
17 to provide guidance. There is no such thing, as
18 I know of, as an advisory opinion process from
19 the Administrative Law Judge. And if I can make
20 my motion, this may save us a lot of time. You
21 could reject it. It's not going to be a long
22 motion. I promise you that. But I think it's
23 a very compelling motion. And if you'd allow
24 me, I'd like to make it.

25 **THE COURT:** Make your motion.



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ROA_0669

1 **MR. THOMAS:** Thank you. So, as I said, DHEC has now
2 admitted under oath that it would not have
3 rounded to 80 percent, Standard 7, for an
4 application that came in today, if I heard Ms.
5 Murdock correctly. Nor could she -- nor would
6 she have back then had she sat down and thought
7 about it. That being said, the Department could
8 not have approved MUSC's CON application back in
9 2017. Consequently, we now know without a
10 shadow of a doubt that the approval of MUSC's
11 CON application was done so on the premise of a
12 data error by MUSC. We all know that. DHEC has
13 admitted the standard has been violated. We
14 know that a CON application cannot be approved,
15 unless it complies with the State Health Plan
16 per the CON Act and its regulations. And I put
17 that law right up in my opening statement.

18 Now, I know that DHEC and MUSC is going to
19 argue this is a de novo case and that data
20 postdating the decision should be used to uphold
21 DHEC's decision, based on erroneous data. Let
22 me tell you why I believe this argument under
23 the law is fundamentally unfair. It per se
24 violates Trident's due process rights, because
25 Trident, and not MUSC, has the burden of proof.



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ROA_0670

1 Now, how do we know that? I'm going to hand up
2 an Order to The Court. And the thing about this
3 order is that Mr. Dayhuff and Mr. Westbrook's
4 name is on it. And what it states, Your Honor,
5 on page two at the top under standard review and
6 burden of proof, it does say that The Court
7 reviews contested cases de novo. And Malboro
8 Park is cited there and my law partner, Mr.
9 Summer, was involved in that decision back in
10 '04. It goes on to say that Petitioner bears
11 the burden of proof by a preponderance of the
12 evidence. CRCC, that is Trident in this case,
13 bears the burden to prove that DHEC was in error
14 for granting a CON to Ford. Likewise, Ford
15 bears the burden to prove that DHEC was in error
16 for granting a CON to CRCC. That was a
17 competing application case. We don't have that
18 here. This is just only one party has the
19 burden here and it's Trident. And then on page
20 11 at the top it goes -- in the kind of
21 conclusions of law section it says, to succeed,
22 comma, therefore, comma, each must prove by a
23 preponderance of evidence that its opponent's
24 application should be denied. Again, it's
25 competing application. We don't have the same

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ROA_0671

1 thing here. But that's where we are, Your
2 Honor. They want to say de novo, de novo, de
3 novo; you can consider this, that, and the
4 other. But at the end of the day, de novo
5 doesn't overcome my client's due process rights,
6 because we have the burden of proof. When MUSC,
7 if they decided to challenge the decision of the
8 Department to say we will not accept rounding,
9 you're not at 80 percent, come back later, they
10 would have had the burden of proof.

11 So, at the end of the day, Your Honor, you
12 know, the fact that the contested case hearing
13 is de novo simply shouldn't operate to deny my
14 client its rights. I believe the proper remedy
15 here is that the decision should be overturned
16 given the mistake in approval and the fact that
17 Trident's due process rights are inherently
18 violated under the present posture of the case.

19 Now, at the very least if The Court is not
20 inclined to grant my oral motion, I believe the
21 parties should be able to come brief this issue.
22 And I don't think we need to go forward with
23 anymore of MUSC's witnesses and let them put up
24 their case in chief in the interest of judicial
25 economy, because that's a long and expensive



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ROA_0672

1 proposition, especially if you're in any way
2 inclined to actually grant a judgement, a matter
3 of law, given this revelation by the CON
4 director here today.

5 You know, moreover we also know that Dr.
6 Jenrette's not even going to be able to testify
7 tomorrow, so we're going to be coming back to
8 The Court at a later date sometime anyway. So,
9 in the interim I believe that we ought to either
10 be allowed to brief this issue or, as Ms.
11 Biggers suggested on the remand front, that
12 perhaps The Court at this point remands this
13 case back to Ms. Murdock under the process that
14 The Court has and ask her to render -- the
15 Department to render a new decision. Although
16 I think the better thing is, given the due
17 process issues here, is to dismiss the case and
18 have them re-file. That's all I have to say.
19 I'm sure Mr. Dayhuff might have something to say
20 about this.

21 **MR. DAYHUFF:** That was kind of a surprise, Your
22 Honor. So, I don't think this case is
23 appropriate for a judgement as a matter of law.
24 I think we have issues of fact. We have
25 applying facts to law. We have expert opinions



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ROA_0673

1 on what all of these things mean. This is a de
2 novo matter. Mr. Thomas keeps talking about
3 it's your job to decide whether DHEC made a
4 mistake or not. It's not your -- that's not why
5 we're here. This Court decides whether the CON
6 application is granted or not. So, that kind of
7 fundamental misunderstanding of the posture that
8 we're in I think is the reason that judgement as
9 a matter of law doesn't make sense.

10 Judgement as a matter of law also doesn't
11 make any sense now. We got a dispositive
12 motions deadline in this case. If Mr. Thomas
13 wanted to file a motion as despotic, the time to
14 do is not halfway through trial. This Court can
15 certainly take up his claim that this is somehow
16 a violation of due process through the proposed
17 order process. He's certainly made his legal
18 argument here. It makes very little sense to go
19 all the way through a case -- and Mr. Thomas is
20 acting like this is a revelation. This
21 revelation, I think, is probably in the
22 deposition. So, I think as a matter of
23 efficiency and comity at this point, this type
24 of motion would not be well received.

25 I do think this Court has several ways



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ROA_0674

1 within this de novo process to decide that you
2 could grant that application. One of those is
3 79.97 is okay. And this Court could make that
4 decision. This Court could decide that it is
5 appropriate to use calendar year 2017 and 2018.
6 Both are over 80 percent. The Court hasn't even
7 heard from Mr. Levitt that there are multiple --
8 19 periods within the time we filed and now
9 where we meet this. All of those ways this
10 Court could decide to resolve this case.

11 If The Court is concerned about the burden
12 of proof, there are ways to even resolve that if
13 that's an issue. And I'm not sure that it is.
14 We would have to brief that I think.

15 So, I would ask you to deny this motion --
16 I guess one other thing. The solution is to go
17 back to Ms. Murdock now, further delay our
18 project. She looks at calendar years '17 and
19 '18. We're over 80 percent. We're back here.
20 That circle has never made sense to me from the
21 perspective of health planning, the de novo
22 nature of this, or judicial economy.

23 **THE COURT:** Ms. Biggers.

24 **MS. BIGGERS:** Your Honor, I believe that Ms.
25 Murdock's testimony so far, not only in my



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ROA_0675

1 Direct, but perhaps more clearly when Mr.
2 Dayhuff was questioning her, included that, if
3 she were looking at this at this point in time,
4 she would be looking at the calendar years 2017
5 and 2018 data. And per Mr. Thomas' objections
6 regarding as to whether or not it would be
7 appropriate for Your Honor to look at that and
8 that being a legal conclusion, I think that
9 that, you know -- certainly that's something for
10 Your Honor to consider. But her testimony as
11 to, if she were in the position, if it were in
12 her realm right now and she were the decision
13 maker right now, she would be looking at 2017
14 and 2018 data. And that's why I think at this
15 moment in time it is inappropriate to grant a
16 motion for a directed verdict on that basis.

17 **THE COURT:** Any response, Mr. Thomas?

18 **MR. THOMAS:** Yes. Your Honor, so Mr. Dayhuff said I
19 knew about this somehow and the dispositive
20 motion deadline had come and gone, I'm kind of
21 incredulous. I'm looking at Ms. Murdock's
22 deposition testimony now and I asked her in her
23 deposition, you know, where did you leave the
24 conversation or where was the conversation left?
25 Well, I know we discussed a lot of what a number



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ROA_0676

1 -- whether or not we should ever round a number
2 like 79.97 percent up to 80. Right. And what
3 that meant and the fact that it said 80 instead
4 of 80 percent in the State Health Plan. I
5 didn't -- I didn't -- I did not have a specific
6 answer. And that's about the meeting with MUSC.
7 I did not have a specific answer as to whether
8 we would or wouldn't do that, because I had made
9 the decision in light of the information I had
10 with me at the time. And that was what was in
11 the application. And so, I didn't want to
12 reevaluate that decision on the fly without
13 looking deeper into it. I did not know which
14 way the Department was going at that time and I
15 figured she might say, well, we'd allow it. And
16 she said something different. And had I known
17 it back then, and this was only on 12/14, Your
18 Honor, I absolutely would have made the
19 dispositive motion to keep us from going through
20 any trial. I mean, that's -- you know, nobody
21 really likes to try a case at the end of the
22 day. You like it when it's done, but getting
23 ready for it, certainly. And so, I hear what
24 Mr. Dayhuff's saying, but it seems to me -- and
25 Ms. Biggers too, but she's the CON director.

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ROA_0677

1 And this Court should not be used as an advisory
2 opinion process. This is when there is some
3 error made below. And now we have the
4 Department's position, because the CON director
5 said it under oath and that she conferred with
6 the bureau chief on this. So, at the end of the
7 day, Your Honor, it just seems to me like it's
8 improper to go forward given the due process
9 considerations. And, you know, I hear what Mr.
10 Dayhuff is saying about the burden, if there's
11 someway to correct the burden, but I don't know.
12 I mean, I had to prepare my entire case, and get
13 ready, do all my depositions and everything as
14 if I am the one -- the party with the burden of
15 proof, because at that point in time I thought
16 I was. So, I just think it's inherently and
17 fundamentally a violation of due process. That
18 would be my response.

19 **MR. DAYHUFF:** Just a couple of things. Yeah, I don't
20 recall exactly what happened in that deposition.
21 Mr. Thomas knew at that deposition we were at
22 79.97. We're not here -- we can't take the case
23 away from The Court because of the opinion of
24 Ms. Murdock at this point. That's not the way
25 it works. This case is here before you now to



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ROA_0678

1 decide whether what happened is right or wrong
2 and to decide whether the CON application should
3 be granted.

4 **THE COURT:** Mr. Thomas, I certainly understand why
5 you are making this motion and I don't blame you
6 for doing it. Certainly we've got -- I was
7 surprised and I thought everybody in the court
8 was surprised when she said what she did. So --
9 but I don't think that's necessarily the end of
10 what we're here for. And so I would -- I would,
11 to the extent that I'm denying your motion -- I
12 hate when people say I deny your motion at this
13 time, but I would certainly allow if -- I would
14 probably ask for proposed orders and you could
15 certainly raise that issue or respond to that
16 issue and the burden of proof issue in your
17 proposed orders. So, I would not deny it to the
18 extent that I don't want to hear of this ever
19 again. I would allow you to keep that issue
20 alive for that purpose.

21 **MR. THOMAS:** Thank you, Your Honor.

22 **Q:** All right. Sorry about that brief interlude.
23 It had to happen.

24 **A:** I feel kind of like a jerk now, though.

25 **Q:** You didn't know until a month ago; isn't that



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ROA_0679

1 correct?

2 A: Yes.

3 Q: All right. Now, just for the record, Ms.
4 Murdock, you have not been designated as an
5 expert in healthcare planning or finance by the
6 Department in this case, correct?

7 A: Correct.

8 Q: You would admit that your education and
9 experience in health planning is somewhat
10 limited?

11 A: Compared to the other experts in the court
12 today, mostly can be, yes.

13 Q: Okay. And you got a lot of your health planning
14 knowledge kind of on the job; is that fair?

15 A: Yes, that's fair.

16 Q: Would it be fair to say that your health
17 planning knowledge back when you made the
18 decision in 2017 is probably a little bit less
19 than what it is today in 2019?

20 A: Yes. That's fair to say.

21 Q: You never had any course work in healthcare
22 planning, did you?

23 A: No.

24 Q: Okay. And you never did any continuing
25 education work in healthcare planning or



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ROA_0680

1 finance, did you?

2 A: Not prior to coming to DHEC.

3 Q: Okay. And have you ever taken any accounting or
4 finance classes that were healthcare related or
5 focused?

6 A: No.

7 Q: Okay. Now, would you agree that one of the
8 purposes of the CON Act is to prevent the
9 unnecessary duplication of services?

10 A: Yes.

11 Q: Okay. And you would agree with me that the
12 reasoning behind that concept is to prevent the
13 unchecked development of facilities that may
14 result in facilities standing idle or that are
15 severely underutilized or just running
16 inefficiently?

17 A: Those are some of the scenarios I think that
18 that purpose seems to avoid, yes.

19 Q: And another purpose of the CON Act is cost
20 containment?

21 A: Yes.

22 Q: And the concept behind that is that the
23 Department seeks to avoid unnecessary cost in
24 construction and the purchase of healthcare
25 equipment that would perhaps inflate the cost of



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ROA_0681

1 healthcare unnecessarily, correct?

2 A: That is one of the scenarios I believe that the
3 cost containment purpose seeks to avoid, yes.

4 Q: And if the healthcare system is losing money,
5 one way it may try to remedy that is to get
6 higher rates from commercial payers on certain
7 healthcare services. Is that a fair statement?

8 A: I'm sure that's one of the many ways that a
9 healthcare system could attempt to increase its
10 revenue.

11 Q: Now, you would agree with me, Ms. Murdock, that
12 the Department absolutely considered the issue
13 of financial feasibility of the MUSC linear
14 accelerator project when reviewing the CON
15 application, correct?

16 A: Correct.

17 Q: No doubt in your mind that the issue of
18 financial feasibility was vetted and considered
19 by the Department below?

20 A: Yes.

21 Q: Did DHEC consider cost containment as part of
22 the overall purpose of the application?

23 A: Yes.

24 Q: Okay. Did DHEC weigh MUSC's project's potential
25 adverse effects on other providers against the



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ROA_0682

1 overall improvement in access to MUSC's proposed
2 linac?

3 A: Yes.

4 Q: Now, at the time I deposed you, you didn't
5 recall any specific changes in MUSC's cancer
6 program from 2015 to 2017. Do you recall that
7 testimony?

8 A: I didn't recall -- I didn't have any
9 recollection of it. It doesn't mean that it
10 wasn't included in some part of the application.
11 And I still don't. I didn't go back and check
12 to see.

13 Q: Fair enough. So, my question still stands, you
14 didn't recall any changes?

15 A: Right.

16 Q: Okay.

17 A: That's right.

18 Q: And in 2015 MUSC applied for a linear
19 accelerator to be located less than a mile from
20 Trident, correct?

21 A: I believe it was less than a mile, yes.

22 Q: Okay. And I think at that time you were the
23 DHEC staff reviewer who denied MUSC's
24 application, correct?

25 A: Yes.



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ROA_0683

1 Q: Okay. And that was certainly one of the
2 reasons, not the only reason, but one of the
3 reasons it was denied, was its proximity to
4 Trident Medical Center, MUSC's linac.

5 A: That was a -- that was a factor, but I don't --
6 I'm not -- that wasn't really one of the main
7 reasons why it was denied.

8 Q: Okay. We'll ---

9 A: But it didn't help.

10 Q: Do you recall what the main reason was why it
11 was denied?

12 A: I think the main reason is that the project did
13 not comply with the State Health Plan in effect
14 at the time it was filed.

15 Q: What standard would that have been?

16 A: I don't recall the number, but I think that the
17 utilization was too low.

18 Q: Below 80 percent, right?

19 A: Yes.

20 Q: And that was Standard 7, wasn't it?

21 A: Again, I don't remember the numbering. I
22 believe that was the 2012, 2013 Plan.

23 Q: Okay.

24 A: But it was the same standard that we've been
25 discussing today, that is Standard 7.



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ROA_0684

- 1 Q: Fair enough. If we can we go to Exhibit P 6,
2 page 76. I want to show you, Ms. Murdock,
3 MUSC's utilization that was reported in that CON
4 application that you reviewed. All right. So,
5 the treatments -- reported treatments at the
6 time for MUSC in 2015 in the CON application,
7 2010 was 18,707, correct?
- 8 A: Yes.
- 9 Q: And same thing, five linear accelerators,
10 capacity of 24,000, right?
- 11 A: Right.
- 12 Q: Okay. The treatments in 2011 were 20,290,
13 right?
- 14 A: Right.
- 15 Q: So, they were above the 80 percent threshold at
16 that time. In 2012 the treatments were 20,288,
17 correct?
- 18 A: Correct.
- 19 Q: And then from 2012 to 2013 there was somewhat of
20 a decrement, not much but somewhat, down to
21 19,824, but still in 2013 above the 80 percent
22 threshold, right?
- 23 A: Right.
- 24 Q: Okay. And so a slight kind of downward trend
25 from 2011 to 2013. Is that a fair statement?

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ROA_0685

1 A: Yes.

2 Q: Okay. Now, let's go to -- you'll have the
3 notebook up there and we'll try to get it up on
4 the board for you too -- Exhibit DHEC 1 at CON
5 18. Okay. And, Ms. Murdock, the JAR for 2015
6 that was reported by MUSC was 19,823. Do you
7 see that?

8 A: Yes.

9 Q: Do you remember what it was in 2013? We just
10 looked at it. It was 19,824, wasn't it?

11 A: That sounds right.

12 Q: Okay. So, one treatment less from 2013 to 2015,
13 right, at least reported?

14 A: Right.

15 Q: Okay. And then for fiscal year 2016 MUSC didn't
16 use the JAR, right? They used internal data for
17 fiscal year 2016, right?

18 A: That's the way it's labeled here, yes.

19 Q: Okay. And they reported to you 19,221, correct?

20 A: Correct.

21 Q: Okay. And in the CON application, I've looked,
22 they didn't provide -- MUSC never provided the
23 historical treatment volumes for all of the
24 different providers in the service area, did
25 they?



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ROA_0686

1 A: I don't recall specifically. I know I looked at
2 that, but I don't know if they provided it in
3 their application.

4 Q: Yeah. And we'll get to your handwritten notes.

5 **MR. THOMAS:** Let's put up Exhibit P 9, page four, -
6 004 if we could.

7 Q: Okay. I'm showing you what's already in
8 evidence. It's based on the joint annual
9 reports of hospitals and MUSC's document, which,
10 I think, changed something and for 2016. From
11 2010, Ms. Murdock, to 2017 the number of
12 treatments in the service area for all the
13 providers hasn't really changed at all, has it?

14 A: It -- I mean, it depends on what you mean by
15 hasn't really changed at all. I mean, it's not
16 -- there's not a huge trend one way or the
17 other.

18 Q: Hasn't changed, as another way of saying --
19 that's kind of a fancy way of saying hasn't
20 changed, right?

21 A: It just fluctuated kind of up and down around
22 the same.

23 Q: Around the same numbers, 45, 46, right in there,
24 right?

25 A: Yeah. Yep.



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ROA_0687

1 Q: Okay. And at MUSC from, you know, 2010 to 2017,
2 about the same really. It's fluctuated. It's
3 gone up. It's gone down. But it's kind of been
4 right there in the ballpark, hasn't it?

5 A: Sure. Between, you know, a little over 18 and
6 under 20,000

7 Q: Okay. So, obviously we talked a lot about the
8 State Health Plan and Standard 7. But you would
9 agree with me that if a provider's stated
10 capacity is 20,000, it would need to be
11 operating at 16,000 treatments or above to meet
12 the 80 percent requirement of State -- of
13 Standard 7, correct?

14 A: I would have to do -- I need a pen and paper to
15 do that math. But if that division problem
16 works out to 80 percent, then yes.

17 Q: Okay. And so the meeting you had with MUSC, I
18 guess, representatives of MUSC, including the
19 legal counsel and Mr. Levitt, who is in the room
20 with us, where they told you about the change to
21 the 2016 fiscal year treatment number, was on
22 December 7th, 2018; is that correct?

23 A: That sounds right. I'd have to check, but that
24 sounds about right.

25 Q: And I believe you said they didn't leave behind



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ROA_0688

1 anything, any documents with you, did they?

2 A: No.

3 Q: Okay. And at that time you weren't ready to
4 make a decision regarding this issue of the
5 rounding, correct?

6 A: No. I mean, yes, that's correct. No, I was not
7 ready to make a decision.

8 Q: Got you. I'll try to rephrase -- phrase the
9 questions better for you. And I think at that
10 time MUSC was suggesting that it would be okay
11 for you or someone to consider later time
12 periods as well, is that right, in terms of the
13 past two years in the Standard 7?

14 A: Yes.

15 Q: Okay. Now, did anyone from MUSC at that meeting
16 inform you that its 2017 JAR report was also
17 erroneous?

18 A: I believe they informed me that both of the
19 years in question needed adjustment.

20 Q: Do you mean the 2016, but not 2015, correct?
21 That wasn't ever adjusted, was it?

22 A: Whatever the -- I believe. And, again, I don't
23 recall exactly, but the two years, the two JAR
24 years that I looked at in reviewing the
25 application, I think it was those years that



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ROA_0689

1 needed adjustment, but I'd have to check.
2 Again, I just knew as a result of that
3 conversation that one of the years, at least
4 that were part of the decision, had to be
5 adjusted downward below 80 percent.

6 Q: Okay. And the standard, Standard 7 -- if you
7 need to look at it, just let me know -- but it
8 requires the Department to look at the past two
9 years to determine whether or not the applicant
10 is in compliance with the 80 percent standard,
11 correct?

12 A: Yes. Each of the past two years.

13 Q: Each of the past two year. But it doesn't say
14 that, you know, each of the past two years
15 premised on the JARs, does it?

16 A: No.

17 Q: Okay. So, it could be calendar years, it could
18 be rolling 12, it could be the JAR years,
19 correct?

20 A: Yes.

21 Q: Okay. And I believe I heard you earlier in your
22 testimony with either Ms. Biggers or maybe it
23 was Mr. Dayhuff, but that you wanted to look at
24 the most recent reliable data available.

25 A: Yes.



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ROA_0690

1 Q: Okay. Now, MUSC, what they decided to show you
2 in an application that was filed on May 22nd,
3 2017, was a fiscal year 2016 that started -- or
4 that ended, 11 months earlier, correct, on June
5 30, 2016, right?

6 A: I believe that's correct.

7 Q: Okay. And then another year previous to that
8 for fiscal year 2015, correct?

9 A: Yes.

10 Q: So, another way of looking at it is a start on
11 July 1, 2015, go to June 30, 2016. That's
12 fiscal year -- excuse me, July 30, 2014 go to --
13 I screwed it up again. All right. Let me get
14 this right. July 1, 2014 to June 30, 2015,
15 that's going to be fiscal year '15, correct?

16 A: Yes.

17 Q: And they had a JAR there for you. And then
18 they've used internal data for July 1, 2015, to
19 June 30, 2016, to get you year two, correct?

20 A: Yes.

21 Q: And then they went 11 months and 22 days to May
22 22nd, 2017, and they submitted an application,
23 correct?

24 A: Yes, that sounds right. Calendar math is not my
25 strong suit, so without it in front of me ---



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ROA_0691

1 Q: As you can tell, it's not mine either.

2 A: Yeah, that sounds right.

3 Q: All right. At the time that you reviewed the
4 application, did you appreciate that MUSC's
5 fiscal year, for purposes of each of the past
6 two years, that the second of the past two years
7 started 11 months earlier from when the CON
8 application was submitted?

9 A: And you're asking me ...

10 Q: Did you realize that at the time?

11 A: Not specifically, no. I did not go and do the
12 -- and count the JAR reporting year and do the
13 math.

14 Q: Because do you realize, if MUSC had actually
15 used --

16 **MR. THOMAS:** Let's pull up P 11 if we can --

17 Q: -- the previous 12-month period of calendar year
18 2017 or the rolling 12-month period from May
19 2016 through April 2017, did you realize that
20 calendar year 2016 was 79.33 percent and the
21 rolling 12, which is right up to the month
22 before MUSC applied, was 76.89 percent; did you
23 realize that?

24 A: I didn't know that.

25 Q: Because nobody at MUSC ever told you that,



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ROA_0692

1 right?

2 A: Right.

3 Q: Okay. And you couldn't have approved the
4 application pursuant to Standard 7 if it had
5 been 79.33 percent for calendar year 2016,
6 correct?

7 A: If that were one of the years that I was relying
8 on, no, I could not have approved it.

9 Q: You couldn't have done it with rolling 12
10 either, right?

11 A: Again, if that was the time period I had used as
12 one of the applicable years, then no.

13 Q: Okay. And MUSC could have presented that as the
14 most recent reliable data, either one of those
15 two time periods, correct?

16 A: Assuming it had collected it all and had access
17 to it, yes, it could have.

18 Q: Are you aware of any reason that MUSC wouldn't
19 have had access to data for year ending calendar
20 year 2016 and May of 2017?

21 A: I'm not aware of any reason why they wouldn't
22 have access to it, no.

23 Q: Okay. Now, because The Court hasn't made a
24 decision yet on rounding, I'm going to ask you
25 some questions. The Department's position is 70



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ROA_0693

1 -- 80 percent is the minimum, correct?

2 A: Correct.

3 Q: Okay. Actually, I am going to skip those
4 questions. How about that? And let me ask you
5 this. Is one reason you'd want to hold it at 80
6 percent is so that you have a hard number and
7 you can't treat certain applications --
8 applicants one way as opposed to another?

9 A: Uniform application as a standard is one of the
10 reasons, yes.

11 Q: Now, would you agree with me that the linac --
12 I say linac, you say linac, right? I say aunt,
13 you may say aunt.

14 A: I may just be more southern than you.

15 Q: You might be. That's true, although I've never
16 been accused of that. Would you agree with me
17 that the linac dynamic in the north area -- for
18 purposes of the north area we kind of described
19 as Berkeley, Dorchester, and the North
20 Charleston area, is kind of collectively what
21 we've been referring to as the north area. But
22 would you agree with me that the dynamic in that
23 north area has changed since before your meeting
24 with MUSC on December 7th, 2018?

25 A: I'm not sure I understand.



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ROA_0694

1 Q: Well, up until a certain time in 2018, Roper was
2 involved in the CON litigation with respect to
3 these linear accelerators, correct?

4 A: Yes.

5 Q: Yeah.

6 A: I believe that's the application Trident said
7 was even more fatally flawed than MUSC's was.

8 Q: Correct. But we believe they were both flawed,
9 correct?

10 A: Trident alleged that they were both flawed, yes.
11 Just Roper more so.

12 Q: Right. Now, we now know that they have a CON.
13 There's a CON that Roper has in the Carnes
14 Crossroads area for a linear accelerator,
15 correct?

16 A: Yes.

17 Q: Okay. I want to talk a little bit about the
18 capacity standards. So, the capacity standard
19 for the conventional 7,000, correct?

20 A: Yes.

21 Q: Conventional treatments? For IMRT, if you can
22 show a sufficient volume of IMRT, it's 5,000,
23 right?

24 A: Right.

25 Q: For SBRT it's 4500, correct?



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ROA_0695

1 A: Correct.

2 Q: And for SRS it's 1500?

3 A: Right.

4 Q: Right. Okay. Now, when I deposed you back in
5 December, you'd really didn't know what the
6 basis for those kind of capacity numbers were;
7 is that correct?

8 A: Do you mean the numbers in the State Health Plan
9 or the numbers in -- for each linac?

10 Q: Yeah. The numbers in the State Health Plan, the
11 actual standard.

12 A: The genesis of those capacity numbers, no, I
13 wasn't aware of the exact reasoning behind that.

14 Q: Okay. Now, would you agree with me that, if the
15 capacity is lower for a linear accelerator that
16 performs a certain type of procedure, it's
17 related to the amount of time that procedure
18 takes? And let me give you an example. So, the
19 lowest standard, which is for stereotactic
20 radiosurgery, or SRS, is 1500. And that's
21 premised on at least some fact or the fact that
22 those linear accelerator treatments take a
23 little bit longer than an SBRT, IMRT, or a
24 conventional treatment, correct?

25 A: I don't know specifically that that's the main



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ROA_0696

1 or one of the main reasons it makes sense, but
2 there could be other reasons why the capacity
3 would be lower.

4 Q: But you just don't know what those are?

5 A: Exactly.

6 Q: Okay. Now, would you -- do you know the last
7 time the standards, the capacity standards, have
8 been revised for SBRT, IMRT, and conventional?

9 A: I don't know when they were last revised, no.

10 Q: If I told you the 2010-2011 Health Plan, when
11 that was approved, would that surprise you that
12 it's been now nine years since those standards
13 have been in place?

14 A: I'm not sure if surprised is the right word.

15 Q: You didn't know one way or the other, right?

16 A: I just don't know one way or the other.

17 Q: Okay. Now, in terms of this phrase sufficient
18 volume, would you agree with me that's kind of
19 a key phrase in the State Health Plan Standard
20 2, 3, and 4 related to these capacities?

21 A: Yes.

22 Q: Okay. And sufficient volume has to mean
23 something, right?

24 A: Right.

25 Q: And just kind of from a plain-language



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ROA_0697

1 perspective -- and I meant to ask you earlier,
2 are you a licensed attorney still in South
3 Carolina?

4 A: Yes.

5 Q: Okay. So, you're very familiar with the plain-
6 language standard in interpreting statutes and
7 regulations and that type of thing, correct?

8 A: Correct.

9 Q: Okay. In terms of sufficient volume, shouldn't
10 that mean something, mean a sufficient number of
11 that certain treatment to justify the lower
12 capacity that has been assigned?

13 A: Yes.

14 Q: Okay. And an example I'd give is that, if one
15 SRS procedure takes an hour, when four
16 conventional treatments take 15 minutes,
17 sufficient volume would have to mean enough to
18 affect the capacity of that particular linear
19 accelerator unit as compared to the units that
20 may do a significant volume of 15 minute
21 treatments, is that -- only 15 minute
22 treatments. Is that a fair statement?

23 A: Can you say it one more time?

24 Q: Yeah. So, if one SRS, stereotactic
25 radiosurgery, takes an hour -- and I'm not



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ROA_0698

1 saying that it does, I'm using that to make a
2 point -- and four conventional or IMRT
3 treatments take 15 minutes, sufficient volume
4 for that particular unit would have to mean
5 enough to effect the capacity of a linear
6 accelerator as compared to a unit that doesn't
7 do any SRS procedures, correct?

8 **MR. DAYHUFF:** Objection. Compound; really confusing.

9 **MR. THOMAS:** I think it's a perfectly good
10 hypothetical.

11 **Q:** Do you understand the question? I think that's

12 ---

13 **A:** I don't and I apologize. Maybe if we can do it
14 in steps.

15 **Q:** All right. You have -- I'm getting through
16 this, because I think it's important. You have
17 a linear accelerator. It's been assigned 1500
18 as a capacity.

19 **A:** Yes.

20 **Q:** In order to do that, it's got to do enough
21 volume of SRS for that unit if it also does
22 other treatments like IMRT. If it does 5,000
23 IMRTs a year and one SRS, one SRS that takes an
24 hour as opposed to the 5,000 that take 15
25 minutes, it's not going to affect the



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ROA_0699

1 utilization of that unit, is it?

2 **MR. DAYHUFF:** Same objection.

3 Q: I think you understand.

4 A: I am struggling. I know we can get there, but
5 I'm ---

6 Q: All right. You've got a linear accelerator.

7 A: Right.

8 Q: It does -- it is assigned a capacity of 1500
9 because the applicant has told you that they're
10 going to do a sufficient volume of SRS.

11 A: Yes. Right.

12 Q: Now, if they're doing 5,000 IMRTs a year on that
13 and only one SRS, that couldn't be sufficient
14 volume to affect the utilization such that the
15 capacity should be lower for that particular
16 unit.

17 **MR. DAYHUFF:** Is Mr. ---

18 **THE COURT:** You go ahead.

19 **MR. DAYHUFF:** --- Thomas asking Ms. Murdock to
20 interpret the State Health Plan, which is your
21 job and I thought I got an objection on that a
22 moment ago.

23 **THE COURT:** No, no. I think what he's asking is what
24 she considers a sufficient volume to lower a
25 capacity.



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ROA_0700

1 **MR. THOMAS:** Through an example. Maybe it's a
2 terrible one. It makes perfect sense in my
3 crazy brain, but.

4 **A:** I think -- so, if the 5,000 IMRT treatments each
5 took 15 minutes and the one longer treatment
6 took an hour, if you just added the one hour per
7 year?

8 **Q:** Right.

9 **A:** I don't think that would be sufficient volume to
10 adjust the capacity.

11 **Q:** All right. Now, is it fair to say, as the
12 Department's policy now stands, what is
13 sufficient volume is somewhat left up to the
14 applicant to determine after the capacity
15 standard has been assigned?

16 **A:** After the capacity standard has been assigned --
17 -

18 **Q:** Yeah.

19 **A:** --- by who?

20 **Q:** By DHEC.

21 **A:** Okay.

22 **Q:** Doesn't it have to be ---

23 **A:** Do you mean after the ---

24 **Q:** The applicant.

25 **A:** --- after the review process is completed?



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ROA_0701

1 Q: Right.

2 A: And the certificate is issued?

3 Q: Right.

4 A: And so you're asking me what the applicant has
5 to determine is sufficient volume after that?

6 Q: Yeah. I mean, what I'm asking you is, the
7 Department doesn't have any standards as to what
8 sufficient volume is, correct, for SBRT
9 machines, for IMRT machines, or for units that
10 are claiming to do a sufficient volume of SRS
11 machines? That's a correct statement. There
12 are no standards at the Department with respect
13 to capacity volumes.

14 A: We don't have a specific percentage or a number.

15 Q: Right.

16 A: We haven't identified a specific number, floor
17 or ceiling, of what constitutes sufficient
18 volume.

19 Q: Okay. So, there's no policy on that?

20 A: There's not a hard-and-fast number. The policy
21 is to review it under a standard of
22 reasonableness and plain language. We do look
23 at the data and we look to see what volumes are
24 being done either in the applicant's projections
25 or the data the applicant gives us. And then we



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ROA_0702

1 also look at that information -- now we're
2 getting that information on the joint annual
3 reports.

4 Q: Okay. Back when you reviewed this application,
5 and as far as I know the joint annual reports
6 for 2017, there is no way to determine -- for
7 the Department to determine by linac unit what
8 is being done on those individual units that
9 have individual capacity assignments, correct?

10 A: By individual unit ---

11 Q: Yes.

12 A: --- no.

13 Q: Okay.

14 A: We don't seek out that information.

15 Q: So, that would be a very important consideration
16 for a provider like MUSC, use your words, who
17 has a fleet of linear accelerators, correct?

18 A: I think there's more to the analysis than just
19 a per-unit calculation. I think you look at the
20 system as a whole. I think you look at the
21 entire fleet. Because, as Trident knows, you
22 could have three, but only use two and keep one
23 in reserve, but that doesn't necessarily mean
24 that we don't look at all three when we
25 determine utilization. Same thing is true when



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ROA_0703

1 we're looking at capacity.

2 Q: Okay. I guess I can get it now. In terms of
3 these capacity assignments, are you now telling
4 me that I can use, if I'm doing -- if I've got
5 a tomotherapy machine that's doing 7,000 IMRTs,
6 I can assign those IMRTs to other units in order
7 to increase my capacity threshold on those
8 particular units? You're not suggesting that,
9 are you?

10 A: I'm not sure what you're even asking me if I'm
11 suggesting. We don't assign a specific
12 treatment to a specific unit. We look system
13 wide. When we're looking at a new application
14 for a new linac, then we evaluate what the
15 applicant proposes to do with that particular
16 unit.

17 Q: MUSC, in their application, didn't -- bear with
18 me. They indicated that they had three units --
19 if you go to CON 18 in DHEC 1.

20 A: Yes.

21 Q: Three units at 5,000 capacity and two at 4500,
22 correct?

23 A: Correct.

24 Q: And they multiplied that, showed you that their
25 total is 24,000.



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ROA_0704

1 A: Right.

2 Q: Okay. Now, if a unit is assigned 5,000, okay,
3 then that means it's doing IMRTs in sufficient
4 volume in order to justify the capacity for that
5 unit, correct?

6 A: Yes.

7 Q: Okay. And if it's doing no IMRTs, but only
8 conventional, that would be an incorrect
9 assignment of capacity to that particular unit,
10 correct?

11 A: It depends. If you have three units with a
12 capacity of 5,000 each and one of the units
13 needs repairs or maintenance or is out of
14 service because it needs to be replaced, then at
15 the end of the year that particular unit might
16 have a depressed number of IMRT treatments. And
17 as a result of that situation, that facility may
18 have had to increase the treatments done on the
19 other two units to make up for the unit that's
20 out of commission. But we would look at the
21 three units as a whole in determining whether or
22 not there was sufficient volume.

23 Q: So, if you had one unit that did 400 SRSS and
24 there were five total, would you spread those
25 SRSSs over the five?



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ROA_0705

1 A: It depends ---

2 Q: Other linacs?

3 A: It depends on what the capacities were of the
4 linacs, it depends on -- so, it really depends.

5 Q: Okay. So, just for the record, there is
6 absolutely no numerical value or percentage in
7 the Health Plan in a Department policy or
8 otherwise that indicates what a sufficient
9 volume is for an individual linac unit that's
10 been assigned a specific capacity. Is that a
11 fair statement?

12 A: The Department doesn't have a specific number --
13 -

14 Q: Right.

15 A: --- or percentage that its ---

16 Q: Or policy or otherwise?

17 A: Doesn't have a specific number as part of its
18 policy?

19 Q: right.

20 A: It has a policy, but not a number or a
21 percentage.

22 Q: Okay. So, the sufficient volume for one
23 provider could be different than the sufficient
24 volume in another provider's mind. Is that a
25 fair statement?



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ROA_0706

1 A: No.

2 Q: It's not?

3 A: A sufficient -- we would try to be uniform in
4 our analysis, but we haven't settled on a
5 specific number.

6 Q: Would you ---

7 A: If, for example, we decided that 70 percent was
8 sufficient for Trident, we would not then turn
9 around and decide that 40 percent was
10 sufficient for MUSC if we had told Trident that
11 40 percent was not sufficient for Trident. If
12 we looked at a number that we considered to be
13 appropriate, it would be appropriate for all
14 providers, not just the one.

15 Q: But you haven't done that. The Department
16 hasn't done that.

17 A: Come up with a specific number?

18 Q: Right.

19 A: No.

20 Q: Or a percentage, right?

21 A: Right. That's right.

22 Q: And it would not surprise you to know that
23 there is a difference in opinion from one
24 healthcare facility to the other regarding what
25 is sufficient volume to justify a specific



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ROA_0707

1 capacity, correct?

2 A: That does not surprise me.

3 Q: Okay. And that the capacity numbers might
4 differ from one provider to the next, correct?

5 A: The capacity numbers as in what that provider
6 thought was an appropriate capacity to consider
7 sufficient volume?

8 Q: Right. Sufficient volume, yes.

9 A: Sure.

10 Q: Okay. And the Department hasn't been tracking
11 whether or not radiation therapy providers are
12 performing sufficient volume to justify their
13 self-assigned capacity per linac unit, correct?

14 A: The capacities are Department assigned.
15 They're requested via the application, but the
16 Department makes the determination. And then
17 they remain constant, unless they're changed in
18 the health planning process. And the
19 Department actually does request information
20 regarding specialized treatments on the JAR.
21 So, we do look at that.

22 Q: I'm going to ask the question again -- and
23 maybe there was a part that I didn't enunciate
24 well. But the Department hasn't been tracking
25 whether or not radiation therapy providers are



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ROA_0708

1 performing sufficient volumes to justify their
2 self assigned capacity per linac unit, correct?

3 MR. DAYHUFF: Asked and answered.

4 MR. THOMAS: It wasn't answered.

5 MR. DAYHUFF: Well, I believe it was.

6 A: I'm not sure I can answer that, because I don't
7 think that the capacities are self assigned.
8 They're requested and then assigned via the --
9 just like a facility doesn't assign itself a
10 Certificate of Need. It requests a capacity
11 and then the Department decides whether or not
12 that capacity is appropriate.

13 Q: I'm asking ---

14 A: It may be semantics that aren't really
15 important. If you took the word self assigned
16 out of that and asked it again, maybe we can
17 move on.

18 Q: One second, bear with me. All right. I'm
19 going to hand you your deposition testimony.
20 Let me find mine. Let's see. Bear with me.
21 Are you saying that the applicant doesn't self
22 assign their capacity threshold, that they
23 don't come to you and say I want 5,000 for my
24 linac that does a -- that will do a sufficient
25 volume of IMRTs?



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ROA_0709

1 A: That describes requesting a capacity that we
2 either agree or don't agree that's appropriate
3 and then it is assigned via the certificate ---

4 Q: Okay.

5 A: --- by the Department.

6 Q: Okay. All right. So, we'll take that out.

7 A: Okay.

8 Q: Do you -- does the Department track the volumes
9 of providers to determine whether or not they
10 are providing SBRS -- SBRT, SRS, IMRT for the
11 specific units to make sure that they're
12 complying with the capacities that have been
13 assigned?

14 A: The Department does track that and is currently
15 tracking it and will be making that part of the
16 next State Health Planning process.

17 Q: When did the Department start tracking that?

18 A: We started tracking it on the JARs. And the
19 last two JARs, I believe, we have collected --
20 we have begun collecting that data. I'd have
21 to check, but I think it's the last two JARs.

22 Q: Okay. But not per unit, correct?

23 A: We don't ask for a specific unit, no. We only
24 ask for a system-wide number.

25 Q: Okay. You would agree with me that providers



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ROA_0710

1 should be able to rely on the data in the State
2 Health Plan to include the inventories, figures
3 and calculations therein, correct?

4 A: Yes.

5 Q: Okay. You would agree with me that I -- that
6 as a provider, I would not get the benefit of
7 a 5,000 treatment capacity on a linac if I'm
8 only doing 12 IMRTs on the linac and on a year-
9 after-year basis, correct?

10 A: I'm not sure I understand the question. Can
11 you ask it again?

12 Q: Yeah. As a provider, would I get the benefit
13 of a 5,000-treatment capacity on a linac, which
14 means I would be doing IMRTs in a sufficient
15 volume, if I am only doing 12 IMRTs on the
16 linac year after year?

17 A: As a provider, you will -- you'll have the
18 assigned capacity of your linac or fleet of
19 linacs unless and until those capacities are
20 changed via the State Health Planning Process.
21 If the Department knows that year after year
22 there is a dearth, a sufficient dearth of
23 treatments, of a certain type, then the
24 Department intends to work towards adjusting
25 capacities to match reality.



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ROA_0711

1 Q: Go to page 62 in your transcript there for me.

2 A: Okay.

3 Q: All right. I'm going to read the question
4 there at page 62 and you read the answer.
5 Would I get the benefit, as a provider, of the
6 5,000 standard, treatment standard -- the 5,000
7 standard if I'm only doing 12 IMRT procedures,
8 which is roughly three hours of procedures?
9 What's your answer?

10 A: If this was a hypothetical CON application ---

11 Q: I asked you -- that's not what your answer is.
12 Line 14.

13 MR. DAYHUFF: The witness needs to be able to offer
14 her answer to the question and explanation if
15 she has it.

16 MR. THOMAS: Well, that's fine if she ---

17 THE COURT: She's got to start with the answer,
18 though.

19 A: The answer says, I would say, without having
20 any other information available, it's unlikely.

21 Q: Okay. Thank you. That's my question. Now,
22 Ms. Murdock, other than for IMRT, SBRT, and SRS
23 treatments, you're not aware of any standards
24 that provide a capacity exception to the 7,000-
25 treatment capacity standard, are you?



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ROA_0712

1 A: Other than the ones listed in the State Health
2 Plan, no, I'm not aware of any other ones.

3 Q: Okay. And, Ms. Murdock, when you review a CON
4 application, do you determine whether there are
5 other projects pending in the area that might
6 be related to determine if there are any
7 competing CON applications?

8 A: Yes.

9 Q: Okay. And that's important because, if a CON
10 application is in a competing posture and the
11 Department deems it so, the Department can only
12 approve one of those CON applications, right?

13 A: They're competing -- by its very definition, if
14 they're competing, it means that the Department
15 cannot approve both.

16 Q: Okay. And even though MUSC and Roper, their
17 projects were going to be located about three
18 miles away from each other, Carnes Cross Roads
19 and Nexton, the Department in this case did not
20 consider those applications to be competing,
21 correct?

22 A: Correct.

23 Q: Okay. Now, you will also determine whether
24 there are some follow-up questions for the
25 applicant if they leave something out and that



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ROA_0713

1 sort of thing, of their application, correct?

2 A: Yes.

3 Q: Okay. You would agree with me in this CON
4 review you didn't have any follow-up questions
5 for the applicant, correct?

6 A: I don't recall specifically.

7 Q: None are coming to mind right now?

8 A: No.

9 Q: And you certainly -- in the application I
10 didn't see any kind of written, you know,
11 letter to MUSC asking for additional
12 information, correct?

13 A: No. If it's not in the file, then no.

14 Q: Okay. Now, you did -- you admit that in this
15 situation you denied a similar project
16 submitted by MUSC just 17 months earlier. Is
17 that a fair statement?

18 A: Again, I don't recall the time period, but it
19 was -- but I did deny an application for a new
20 linear accelerator in North Charleston for
21 MUSC.

22 Q: Right. Now, MUSC, you've heard them, you've
23 reviewed many CON applications of MUSC's that
24 are for projects that are going to be located
25 kind of in Berkeley, in the Berkeley area, in



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ROA_0714

1 North Charleston. And one of kind of the
2 common claims in their application is that
3 getting down to the peninsula, it's difficult
4 because of parking and way-finding and
5 sometimes the weather, flooding, correct?

6 A: Yes.

7 Q: Okay. Did that factor into DHEC's decision to
8 approve the CON application for MUSC at the
9 Nexton area? Did any one of those factors,
10 parking, way-finding, or weather?

11 A: Parking, way-finding, and weather, minimally.

12 MR. THOMAS: Now, let's bring up Exhibit P 54 if we
13 could.

14 (Petitioner's Exhibit Number 54 was introduced into
15 the record at this time.)

16 Q: These are -- you can see on the screen, you
17 recognize that.

18 A: Yes.

19 Q: Let me know if you -- if you can't read it,
20 then I can certainly show you where it is in
21 the notebook.

22 A: No. That might not necessarily help, but,
23 yeah, I recognize that.

24 Q: You recognize the chicken -- your chicken
25 scratch?



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ROA_0715

1 A: I'm aware of my own writing and the
2 difficulties therein.

3 Q: Okay. So, what you're doing here is you were
4 going through and just tallying. You wanted to
5 work out the math in terms of the utilization
6 percentage of the radiation therapy provider's
7 stated capacity. That was one purpose of this
8 exercise, correct?

9 A: That was one of them, yeah.

10 Q: Okay. And here you got MUSC right at 80.1
11 percent. You see Trident went from 75.7
12 percent down to 63.2 percent, correct?

13 A: Yes.

14 Q: Okay. And Trident, during the CON application
15 process, certainly provided that information to
16 the Department to say, hey, before you approve
17 this application, please note that we've taken
18 a 2,000 treatment hit in the last year in our
19 service, correct, and you were aware of that?

20 A: Trident did make the Department aware of its
21 low utilization, yes.

22 Q: Okay.

23 A: I think it was more of a percentage than a
24 specific hit in number of treatments, but I was
25 aware of it either way.



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ROA_0716

1 Q: Right. So, I mean, it went from 75 percent of
2 capacity to 63.2 percent of capacity, correct?

3 A: Yes.

4 Q: And it took almost a 20 percent decrease year
5 over year from 2015 to 2016 in the number of
6 treatments, right?

7 A: It went from 75.7 to 63.2 percent.

8 Q: Well, that was the capacity of its total,
9 correct? I'm talking about the loss of actual
10 -- you know, from 12,493 to 10,422. That's a
11 pretty significant percentage.

12 A: Oh, yeah. Okay. I'm sorry.

13 Q: Yeah.

14 A: I thought you were talking about capacity.

15 Q: No. Is it your understanding -- I want to kind
16 of go back to this idea of capacity. But is it
17 your understanding that an SBRT treatment takes
18 any more or less time than, say, an IMRT
19 treatment?

20 A: It is my assumption that it takes more time.

21 Q: Okay. And is that anything that the Department
22 has actually looked at and studied in the last
23 two or three years to determine if that's the
24 case?

25 A: To determine how much time each of those



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ROA_0717

1 treatments -- no, we have not. The CON Program
2 has not undertaken that study. I don't know of
3 any other DHEC program that's done that.

4 Q: Fair enough. Now, can you turn --

5 **MR. THOMAS:** Can we go to P 6, Ms. Mitchell?

6 Q: All right. You've seen this. This is the 2015
7 CON application that was submitted by MUSC?

8 A: Yes.

9 Q: All right. And I think you've already
10 testified you were the reviewer on this
11 application, correct?

12 A: Ultimately, yes. It didn't start with me, but
13 I'm the one who made the decision.

14 Q: And that application, if you want to --

15 **MR. THOMAS:** Why don't you -- can you pop over to
16 page ten of P 6?

17 Q: All right. That may be difficult to read, but
18 can you tell how much the total project cost
19 for this particular linear accelerator project
20 was for MUSC? Actually, I think you want to go
21 down ---

22 A: Total project cost is 8,131,422.

23 Q: Okay. Very good.

24 A: Of something. I'm assuming it's dollars.

25 Q: Right.



1 A: But yeah.

2 Q: And we've already talked about the fact that
3 MUSC kind of included a need section in here.
4 We went to that earlier. And it showed that
5 the utilization for, I think, 2011, 2012, and
6 2013 was, you know, 20, then 19, then 19, or
7 something like that.

8 **MR. THOMAS:** Why don't you go to P 7 -- P 6, page 73
9 for me. I say 73, doesn't -- hold on. Give
10 me a second. I bet it's the actual -- go to
11 76. I'm sorry.

12 Q: Okay. When we looked at this earlier, at the
13 top there it shows what the treatment volumes
14 were for MUSC and that they were going down
15 slightly from 20,290 in 2011 to 19,824 in 2013,
16 correct?

17 A: Correct.

18 Q: All right. And we actually talked about the
19 fact that MUSC's utilization was higher back
20 then than it was reported in the 2017
21 application for the years 20 -- fiscal years
22 2015 and 2016, correct?

23 A: That sounds about right.

24 Q: Okay. And I think you drafted the decision
25 letter in that case, right?



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ROA_0719

1 A: Right.

2 Q: Okay. And, I tell you what, we can go to that.
3 It will probably be easier for you, Maggie, to
4 look at that -- Ms. Murdock. Sorry. Let's go
5 to Exhibit P 55. Let me know when you get
6 there.

7 A: I am there.

8 Q: Okay. All right. So, P 55. So, one of the
9 reasons that you denied this application was
10 because, one, it didn't comply with the South
11 Carolina Health Plan, correct?

12 A: Correct.

13 Q: When you found out -- they showed you 2011,
14 2012, and 2013, MUSC showed you those years'
15 data, but when you got the MUSC 2014 JAR data,
16 it actually showed that MUSC's utilization was
17 below the 80 percent threshold, correct?

18 A: Yes.

19 Q: Okay. And what -- do you remember what the
20 date was on that, on that 2015 CON application,
21 Ms. Murdock?

22 A: On the application?

23 Q: Yeah.

24 A: No.

25 Q: Wasn't it February of 2015?



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ROA_0720

1 A: I really don't know.

2 Q: Okay. If it was February of 2015, do you think
3 that MUSC would have had the fiscal year 2014
4 data available to provide to the Department for
5 its linear accelerator treatments?

6 A: I would assume they had access to that data.

7 Q: Now, let's go back to the letter. The other
8 standard that you were concerned about in this
9 case was MUSC tried to get its capacity set at
10 5,000 rather than 7,000, and MUSC provided no
11 further documentation that it would provide
12 these specialized treatments in sufficient
13 volume to justify why it would get that
14 assignment, correct?

15 A: Correct.

16 Q: Okay. And you would agree with me that, when
17 fell below the 80 percent threshold, when you
18 noted that in your letter, that that alone,
19 that was a determining factor for denying the
20 application, although you still needed to go
21 and address the other project review criteria,
22 correct?

23 A: Correct.

24 Q: Okay. So, you -- that violation of Standard 7
25 alone, maybe a better way of putting it, that



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ROA_0721

1 was enough to make the CON application
2 unapprovable, correct?

3 A: Correct.

4 Q: All right. Now, just for the record, this idea
5 of each of the past two years, that's not an
6 average of two-year periods?

7 A: No.

8 Q: You've got to be above 80 percent in year one
9 and year two, correct?

10 A: Yes.

11 Q: Now, if you look on page two of your denial
12 letter, Exhibit 55, for Petitioner 55, under
13 Community Need Documentation you referenced the
14 fact that the data from 2011 to 2014 show a
15 yearly decline in the combined utilization of
16 all the linacs -- linac units in the service
17 area from 47,639 in 2011 to 44,937 in 2014; is
18 that right?

19 A: That's right.

20 Q: Okay. And then you also found that the
21 location of MUSC's project was not far from
22 Trident's linac and that was a problem for
23 MUSC, right?

24 A: I believe I said -- I mentioned the distance.

25 Q: If you want to look in -- I believe it's number



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ROA_0722

1 three, Distribution, Accessibility.

2 A: Right.

3 Q: MUSC affirms in its application that the
4 project will not unnecessarily duplicate
5 existing services or facilities in the service
6 area.

7 A: Right.

8 Q: Nevertheless, all of the existing linacs in the
9 service area are located in Charleston County,
10 and MUSC seeks to implement the project less
11 than one mile from Trident's three existing
12 units.

13 A: Right.

14 Q: Which operated at a combined use rate of 68
15 percent in 2014.

16 A: Right.

17 Q: And you've kind of round that out and say MUSC
18 has failed to provide justification for this
19 duplication of services.

20 A: That's right.

21 Q: Okay.

22 A: The combination of all those factors and there
23 was nothing that mitigated the proximity to
24 Trident.

25 Q: Okay. Now, and we know that in 2017 the



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ROA_0723

1 utilization and the service area wasn't growing
2 and at MUSC it was declining as well, correct?

3 A: Declining from -- over the course of what time
4 -- I mean ---

5 Q: Yeah. From 2014, 2015, 2016, MUSC was on a
6 downward slope, correct?

7 A: I'd have to go back and look specifically, but
8 I believe you.

9 Q: Okay. And what's different in kind of 2017,
10 what's certainly a big difference, is that
11 Roper was also applying for a linac in the same
12 kind of region of the service area, correct?

13 A: Right.

14 Q: Now, the approval of MUSC's CON application in
15 this case, I believe you testified at your
16 deposition, was that you didn't find the same
17 concerns you did in the 2015 CON application.
18 Is that a fair statement?

19 A: I didn't -- right. Either I didn't find the
20 same concerns or I didn't find the same
21 concerns to the same degree as I found in ---

22 Q: Fair enough. But a big key for you was the
23 fact that MUSC was actually compliant with the
24 State Health Plan this time around, right?

25 A: Yes.



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ROA_0724

1 Q: Okay. But we know that's not the case now,
2 correct, for 2017?

3 A: That what's not the case now?

4 Q: That they're not compliant.

5 A: I know that their JAR data doesn't -- I would
6 not be able to rely on that JAR data if it says
7 that it was below 80 percent. I wouldn't have
8 relied on that year's JAR data.

9 Q: Okay. All right. Let's go to -- can you just
10 flip over quickly, Ms. Murdock, to the pro
11 forma for me on CON 165? That's DHEC Exhibit
12 1. All right. It's up on the screen too, it
13 looks like. This is just the project pro
14 forma.

15 A: Right.

16 Q: And you stated financial feasibility's
17 obviously one of the issues you considered.

18 A: Yes.

19 Q: Now, when you reviewed the pro forma, you
20 didn't ask MUSC to provide any follow-up data
21 on the pro forma, did you?

22 A: I don't believe so.

23 **MR. DAYHUFF:** Your Honor, let me make an objection
24 here. Mr. Thomas is going to start talking
25 about financial feasibility. They didn't raise



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ROA_0725

1 any claim about financial feasibility before
2 DHEC. There are no pro formas. Our pro formas
3 were in the CON application. There were no
4 power point slides from Mr. Sullivan or anyone
5 else about financial feasibility. Now, Mr.
6 Thomas' theory, and he's persistent, is that,
7 if DHEC uses -- applies the criteria of
8 financial feasibility, he now can make a claim
9 in this Court, when he didn't make it at DHEC,
10 that there's some issue with financial
11 feasibility or this pro forma. That is not the
12 way I understand the CON Act to work. It
13 doesn't make any sense. If that were the case,
14 no claims would have to be raised to Mr.
15 Murdock at the DHEC level if she applies a
16 criterion, and then you come to court and we
17 have claims made that DHEC never heard. It's
18 the same issue we had ---

19 **THE COURT:** Well, you know, you're saying they never
20 heard a complaint about it, but she's testified
21 that they considered it, they considered
22 financial feasibility.

23 **MR. DAYHUFF:** Correct.

24 **THE COURT:** I don't know why he can't ask her
25 questions about it.



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ROA_0726

1 **MR. DAYHUFF:** I'm suggesting that the CON Act
2 requires you to raise claims. Otherwise, the
3 idea of the CON Act Reform was, if you've got
4 a claim -- if you've got a beef with an
5 application -- and they could have had this
6 beef below. Our pro formas were in the CON
7 application. If you've got a beef, raise it.
8 That's the issue. Now, if they weren't able to
9 inquire into it, I think that's another thing
10 entirely. They only learned about it through
11 discovery, another thing entirely. These pro
12 formas were available. And it's an eleventh-
13 hour claim.

14 **THE COURT:** I understand Mr. Dayhuff. I'm going to
15 allow him some leeway ---

16 **MR. DAYHUFF:** Thank you.

17 **THE COURT:** --- to ask the questions. I agree that
18 there's got to be some -- what I can do about
19 it is going to be limited.

20 **MR. THOMAS:** And just to preserve the record on the
21 objection, because I don't want him to try to
22 utilize this as a basis for appeal, the fact of
23 the matter is, I think Mr. Dayhuff was hoisted
24 by his own petard back on Monday when he read
25 the law to The Court. And the law clearly says



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ROA_0727

1 an issue either considered -- either raised
2 below or considered by DHEC. It doesn't say
3 and it says or. So ...

4 **MR. DAYHUFF:** I'm suggesting to you that that is an
5 improper way to interpret that statute. That's
6 The Court's decision. I think you have to say,
7 we've got a problem with financial feasibility.
8 Never said below and now they say it here. So,
9 I don't think that's the way the CON Reform Act
10 was designed. It was designed to allow DHEC
11 the opportunity to hear claims on the criterion
12 before they approve. That's the logic.

13 **MR. THOMAS:** And let me tell you why that makes zero
14 sense, Your Honor. The reason is, once again
15 Mr. Dayhuff actually provided you with the
16 basis in his argument, is that there are times
17 when you cannot know what -- if there's a
18 problem with an issue that DHEC considered
19 below because you haven't had discovery. For
20 instance, I'm surprised he's not raising the
21 fact that we can't raise the issue below that
22 DHEC considered wrong data. We didn't know
23 about it until December. I mean, you know,
24 obviously there's a reason for that. He has no
25 case law in this. Judge Lenski decided more



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ROA_0728

1 than -- less than a year ago when I was trying
2 a case in February in his courtroom, very
3 similar issue. If DHEC considered it, it's in.
4 But if there's something else outside of those
5 project review criteria that I didn't bring up
6 -- and Mr. Dayhuff is right, if there is an
7 issue -- for instance, if I don't know, record
8 of the applicant, if I am now saying MUSC's got
9 so many fines and violations, they shouldn't be
10 allowed to do this. He's absolutely right. If
11 I knew about those at the time, I couldn't
12 bring them up. But he's wrong on the other
13 part. He just is.

14 **MR. DAYHUFF:** I never said they couldn't raise the
15 incorrect data because they didn't know.
16 They're basing this on a pro forma that was in
17 the CON application that Mr. Sullivan never put
18 up on his power point slide and said, you know,
19 we've got some issues with some of these line
20 items. That's what we're about to do here.
21 There's a big difference.

22 **THE COURT:** Well ---

23 **MR. THOMAS:** Judge ---

24 **THE COURT:** --- let's see.

25 **MR. THOMAS:** Yeah. I'm actually going to ask her



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ROA_0729

1 just about the review process that she did with
2 the pro forma, which is -- clearly I'm allowed
3 to do.

4 **THE COURT:** I'm going to allow it.

5 **MR. DAYHUFF:** Thank you, Your Honor.

6 **THE COURT:** But if I think it's gone too far, I'll
7 stop it.

8 **Q:** Ms. Murdock, when you reviewed the pro forma,
9 would you agree with me that you didn't ask
10 MUSC any follow-up questions about the pro
11 forma?

12 **A:** I don't believe I did.

13 **Q:** Okay. You never asked MUSC what its yearly
14 rent was, correct?

15 **A:** I did not ask that.

16 **Q:** Okay. And there certainly is not a line item
17 for rent; isn't that correct?

18 **A:** I don't believe so.

19 **Q:** Okay. Didn't inquire with MUSC as to what its
20 service contract expense was on the linacs?

21 **A:** I did not ask any follow-up questions about the
22 pro forma.

23 **Q:** Okay. And would you agree with me that on this
24 particular pro forma there's not a management
25 fee line item, is there?



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ROA_0730

1 A: I don't see one.

2 Q: Okay. And even though there's a line item for
3 depreciation and interest, you do realize that
4 MUSC is renting -- or at least an entity of
5 MUSC is renting space in order to operate this
6 linear accelerator, correct?

7 A: I'd have to go back and look at that part of
8 the application to see how they answered that
9 question.

10 Q: But what you do is rely on MUSC's good faith to
11 let them know what their revenues and expenses
12 are going to be, correct?

13 A: I rely on DHEC's good faith to let them -- to
14 let us know?

15 Q: MUSC's good faith to let you know what their
16 revenues and expenses are going to be, correct?

17 A: I rely on the information that they provide to
18 us, which includes the pro forma and the
19 specific attestations by their financial
20 representative. I think in this case it was
21 John Cooper?

22 Q: Okay. And as far as you know, it's John Cooper
23 who developed the pro forma for this
24 application?

25 A: John Cooper attested to the accuracy of it. I



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ROA_0731

1 don't recall whether or not he was the one who
2 actually developed the pro forma from their
3 inception.

4 Q: And do you realize that MUSC didn't provide a
5 current annual budget for their overall
6 facility? Did you realize that they never did
7 that when they applied for this in May of 2017?
8 They didn't provide an annual budget for fiscal
9 year '18?

10 A: For '18? No. I don't see one here.

11 Q: And you agree that a current budget is
12 required for an expansion project under Section
13 B(16) of the CON application?

14 A: Question B(16) requests that, yes.

15 Q: Okay. And just for the record, the application
16 itself is a part of Regulation 61-15. It's
17 actually the law, isn't it?

18 A: Yes. The questions answered come from our
19 regulation, yes.

20 Q: Okay. And just for the record, you never asked
21 MUSC in follow-up to provide a current budget
22 for the purposes of the CON application with
23 you, right?

24 A: I did not ask MUSC to provide a 2018 budget,
25 no.



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ROA_0732

1 Q: Okay. Do you have any idea what MUSC's
2 operating income was for fiscal year 2018?

3 A: Off the top of my head, no.

4 Q: If I told you negative 2.8 million on revenues
5 of 1.4 billion, is that something that you've
6 heard of?

7 A: I have no way to know.

8 **MR. DAYHUFF:** So, this is a little bit of what I was
9 concerned about. We're now back to the claim
10 that somehow all these projects and all these
11 expenses are related to the financial
12 feasibility of the project that we're for now.
13 None of this stuff was raised to DHEC. And I
14 know it's his theory that, because the word
15 financial feasibility was a criterion and it
16 was applied, that we get to do all this. This
17 is beyond the scope of what they did below and
18 I think it's not proper.

19 **MR. THOMAS:** I'd like to request a recess to brief
20 this issue. He's now improperly objected at
21 least five times, based on this theory that I
22 cannot raise something or discuss something in
23 your courtroom that was considered by the
24 Department. And he's flat wrong. The
25 statutory language -- it'd be a plain language



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ROA_0733

1 argument, Your Honor. The plain language of
2 the statute says that a contested case can deal
3 with issues that are considered below or raised
4 below. Ms. Murdock has already stated under
5 oath she considered all of this.

6 Now, what's interesting, this is what Mr.
7 Dayhuff says, he's going to get into all these
8 projects. You're right. I am going to get
9 into them. MUSC didn't file for a 320 million
10 dollar hospital until after the CON application
11 was submitted to the Department. They didn't
12 file for a micro-hospital on Beaufort County,
13 50, 60, 80 million dollar hospital. They
14 didn't file in a joint venture project for
15 linac down in Beaufort County, another 20
16 million dollar project. They're spending money
17 like drunken sailors all over the State of
18 South Carolina, Your Honor. 150 million
19 dollars on four hospitals. None of that was
20 known prior to this CON application. Now, he's
21 saying I can't raise it, and he's flat wrong on
22 the law.

23 **MR. DAYHUFF:** Let me respond, I suppose. We heard
24 from Mr. Sullivan yesterday, his health
25 planning expert, who said in both his



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ROA_0734

1 deposition and in response to my Cross, are you
2 making this claim? No. The reason he's not
3 making this claim is we are here about a nine
4 million dollar project. The claim that Mr.
5 Thomas is making he didn't make below. MUSC
6 has had lots of projects for a long time
7 because he's raised this claim in several
8 cases. Hasn't gotten any traction. So, the
9 idea that somehow there's new information, he's
10 raised this again and again. Not raised below
11 -- and I would suggest to you, it doesn't even
12 find a home in financial feasibility. We don't
13 have to get there because he never argued it
14 below.

15 **MR. THOMAS:** I can respond if you want, Your Honor.
16 There's another expert, who still has to
17 testify in this case.

18 **THE COURT:** Well, I have heard the negative two
19 million dollar number prior to today. Insofar
20 as some of these projects were unknown at the
21 time that this process started, I don't know
22 how he could have raised them in this -- before
23 DHEC, before we started discovery in this case.
24 Although I know -- well, I don't know -- I
25 suspect that these were not discovered during



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ROA_0735

1 discovery. They are just -- they may even be
2 public information for all I know. But if he
3 wants to talk about it, he wants to spend some
4 time asking her questions that she can answer,
5 I'm going to allow it. I don't know that it's
6 going to find a place in an order in this case.
7 But if he can make it -- if he can make it into
8 an elephant instead of an ant I'm going to give
9 him the opportunity.

10 **MR. THOMAS:** Thank you, Your Honor. Despite that
11 caveat, I'm going to ask a few more questions
12 on this.

13 **Q:** Mr. Murdock, at the time you made your decision
14 in this case, were you aware that MUSC was
15 going to propose a 320 million dollar hospital
16 in Berkeley County?

17 **A:** I don't specifically recall. It wouldn't
18 surprise me if I was, but I don't remember the
19 sequence.

20 **Q:** Okay. And you certainly didn't know that MUSC
21 was engaged somewhere in the 150 million dollar
22 range of a purchase of four hospitals in other
23 areas of the state, were you?

24 **A:** I was -- that was not an issue I considered at
25 the time I made this decision.



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ROA_0736

1 Q: Were you aware of the hospital in -- micro-
2 hospital in Beaufort County at the time you
3 made your decision in this case?

4 A: I'd have to look at the timing. I'm not
5 entirely sure.

6 Q: You would agree with me that none of this, none
7 of the expenses that would be somehow kind of
8 associated with these type of projects, as
9 definitely -- they're not in the pro forma that
10 was submitted in the CON application back in
11 May of 2017, correct? If you know.

12 A: Can you ask me that again?

13 Q: Yeah. Do you know if any of the expenses
14 associated with the projects that I've
15 mentioned, specifically the purchase of four
16 hospitals throughout the State of South
17 Carolina, which we understand is going to
18 occur, are they baked in -- or the revenues,
19 for that matter, baked into the pro forma that
20 was submitted in the CON application?

21 A: I don't know.

22 Q: You don't know, correct?

23 A: They're not fleshed out either way, so I don't
24 know.

25 Q: Do you have any concern of all -- concern that



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ROA_0737

1 MUSC is not the manager of this project, that
2 a company called Alliance is?

3 **MR. DAYHUFF:** Object to the characterization of the
4 agreements between Alliance and MUSC. That is
5 a gross oversimplification. Alliance is a
6 joint venture partner, 51 percent. MUSC is 49
7 percent. Alliance handles business decisions
8 based on a board that has three Alliance folks
9 and two MUSC folks. Clinical decisions are run
10 through a clinical board with three MUSC folks
11 and two Alliance folks. There's no facts in
12 evidence. There's no foundation. It's not
13 even accurate.

14 **MR. THOMAS:** Let's go to CON -- DHEC 1 CON 15 if we
15 could **MR. DAYHUFF:** By the way, this also wasn't
16 raised below, Your Honor.

17 **MR. THOMAS:** Thankfully it was in the CON
18 application, so we know that it was considered.

19 Q: Just real quickly, Ms. Murdock -- well, I guess
20 the management entity is MUSC Healthcare --
21 Health Cancer Care Network, LLC, is that right,
22 if you look on CON 15?

23 A: Yes.

24 Q: All right. And the officers of the management
25 entity at the end of the page, you've got Greg



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ROA_0738

- 1 Spurlock with Alliance, Elizabeth Pace with
2 Alliance, Marianne Krease with Alliance. Do
3 you see that? You might have to turn the page.
4 A: Okay, yes.
5 Q: Okay. And so, there's three Alliance members
6 and two MUSC Health members, right?
7 A: Right.
8 Q: Okay. So, in that joint venture Alliance would
9 have the majority on the board, correct?
10 A: It would appear as such. Yes.
11 Q: What do you know about the entity Alliance, if
12 anything?
13 A: I don't recall specifically sitting here today.
14 Q: Okay. Let's talk about access. Would you
15 agree with me, Ms. Murdock, that MUSC's
16 proposed linac location is very close to the
17 Berkeley County line in southern Berkeley
18 County?
19 A: I don't know exactly how close to the county
20 line it is.
21 Q: Let's go to P ---
22 A: I think it's closer to the county line than it
23 is to the center of the county.
24 Q: Let's go to P 19. I'm sorry. I've just got to
25 get it clear for the record.

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ROA_0739

1 A: Sure.

2 Q: Actually, I'm sorry. I want to go to Exhibit
3 DHEC 1, CON 20.

4 A: That was easy. I'm right there.

5 Q: Yeah. Okay. Now, you can see from this map --

6 -

7 A: Yes.

8 Q: --- Charleston's the yellow, Berkeley's the
9 blue, and Dorchester I guess is the lighter
10 blue. And the proposed site is pretty close --
11 I said very, I still think that's the right
12 characterization -- to the Berkeley County
13 line, correct?

14 A: Correct.

15 Q: Okay. And --

16 **MR. THOMAS:** Keep it up.

17 Q: If Trident is located right here, it too is
18 very close to the Berkeley County line,
19 correct? Did you see where I indicated?

20 A: Yes. I think it is close to the county line.

21 Q: Almost equidistance to the Berkeley County
22 line, correct?

23 A: On this scale I would hesitate to say
24 equidistant. But sure, I mean, they are both
25 pretty close to the county line.



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ROA_0740

1 Q: I like that. That's a good characterization.
2 All right. And you would agree with me that
3 Roper's location is going to be Carnes
4 Crossroads. That's a little bit further into
5 Berkeley County, correct?

6 A: Yes.

7 Q: All right. And you would agree with me that
8 DHEC could not make an applicant pick a certain
9 site for proposed services, correct?

10 A: Correct.

11 Q: But DHEC can certainly deny an application for
12 a location that doesn't make a lot of sense
13 from an access or community health or a need
14 perspective, correct? I'm not asking you about
15 this case, but you could do that?

16 A: If it was not compliant enough with enough of
17 the project review criterion -- of course if it
18 was not compliant with the State Health Plan,
19 we couldn't approve it. But if it failed to
20 comply enough with other project review
21 criteria, we could deny it.

22 Q: Okay. And you would agree with me that linac
23 services are not inaccessible to residents in
24 the Nexton area, correct? They're just a
25 little bit further away from where MUSC would



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ROA_0741

1 be. Is that a fair characterization?

2 A: Just ask me one more time. I think I
3 understand, but just say it one more time.

4 Q: Yeah. Would you agree with me that linac
5 services, linear accelerator services, are not
6 inaccessible to residents in the Nexton area.
7 They're just going to be a little bit further
8 away from where MUSC intends to locate in the
9 Nexton area. Maybe I can do it visually. If
10 this is a tier, the yellow star, and Trident is
11 right here, there's no inaccessibility to
12 radiation therapy services. They're just a
13 little bit further away from the Nexton area.

14 A: That would require me to define accessibility
15 solely based on the mileage distance from a
16 patient to a specific linear accelerator.
17 Based on that characterization, then I wouldn't
18 necessarily say that they're inaccessible for
19 -- on the whole.

20 Q: You would just say that they were a little bit
21 further away, right?

22 A: Yes.

23 Q: Okay.

24 A: If solely -- distance was the sole criteria you
25 were using to evaluate that.



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ROA_0742

1 Q: Why don't you just flip over to page 98 of your
2 deposition real quick and go to line six for
3 me.

4 A: Did you say 98?

5 Q: 98, yes, line six. And tell me when you get
6 there.

7 A: Yes.

8 Q: All right. Okay. So were linac services
9 somehow inaccessible for residents in the
10 Nexton area? Answer?

11 A: Inaccessible? I wouldn't say that. I just --
12 they were farther away.

13 Q: Okay. That's what you testified at your
14 deposition, right?

15 A: Those are the words I said. I'd need to look
16 at the context of the, you know, assumptions
17 leading up to the question. But, yes, that is
18 what I said.

19 Q: Okay. Now, community support letters in the
20 CON application.

21 **MR. THOMAS:** You want to object?

22 **MR. DAYHUFF:** Yes. His own healthcare planner
23 conceded that we satisfied that criterion, so
24 I wouldn't think we would need to go into it,
25 but that would just be my ...



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ROA_0743

1 MR. THOMAS: I still want to go into it.

2 THE COURT: Again, I will allow it. But, again, you
3 know, what Mr. Sullivan says as an expert may
4 differ from what Ms. Murdock says as the person
5 who, I assume, received the letters or not.

6 MR. DAYHUFF: Fair enough.

7 Q: Let's go to Exhibit DHEC 1, page 205. Ms.
8 Murdock, you consider community letters of
9 support when you review an application,
10 correct?

11 A: Correct.

12 Q: And in the DHEC regulations, one of the
13 requirements -- I'm looking for my reg. One of
14 the requirements at 61-15-202c(8) is that the
15 applicant show some type of community support,
16 correct?

17 A: I need to look at the ---

18 Q: All right.

19 A: --- language.

20 Q: So, sitting here today, you're not aware of
21 that regulation as the CON director?

22 A: I'm not sure what you're referring to. I know
23 we -- there's part of an application,
24 submission of letters of community support.
25 But I want to make sure that you and I are on



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ROA_0744

1 this -- literally on the same page.

2 Q: Fair enough. Section c(8) of 202 of reg 61-15.
3 Endorsement from the community that the project
4 is desirable. This may include but is not
5 limited to members of the medical community,
6 citizen groups, government elected officials
7 and other health and social service disciplines
8 of the community, correct?

9 A: Correct.

10 Q: Now, it's fair to say that, in MUSC's CON
11 application, they submitted 12 letters of
12 support and not one was from just a normal
13 citizen of the community, who wasn't somehow
14 affiliated with MUSC or a state representative,
15 correct?

16 A: I'd have to go back and look at the letters of
17 support to identify the drafters of the
18 letters.

19 Q: Go to CON 205 for me.

20 A: I'm there.

21 Q: All right. The first letter is from a
22 Representative Davis, correct?

23 A: Correct.

24 Q: The second letter is from a MUSC physician
25 Lindhorse.



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ROA_0745

- 1 A: Correct.
- 2 Q: Third, MUSC physician Stuart.
- 3 A: Yes.
- 4 Q: Fourth, MUSC physician Marshall, correct?
- 5 A: Yes.
- 6 Q: Fifth, Bruce Bailey, President and CEO of
- 7 Tideland Health, correct?
- 8 A: Correct.
- 9 Q: And Tideland Health has an affiliation with
- 10 MUSC, correct?
- 11 A: (No response).
- 12 Q: Do you know that to be the case?
- 13 A: I believe they have partnered on some projects.
- 14 Q: Such as their PCI program?
- 15 A: Yeah. I know they've worked together, yes.
- 16 Q: Kershaw Health by Mr. Terry Gunn, another MUSC
- 17 affiliate, correct? If you don't know, just
- 18 say you don't know.
- 19 A: I mean, it depends on how you define affiliate.
- 20 Have they worked with MUSC, sure, yes.
- 21 Q: All right. Next page, MUSC physician Britten?
- 22 A: Yes.
- 23 Q: The next page, MUSC physician Adams?
- 24 A: Yes.
- 25 Q: The next page, MUSC physician Abbott?



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ROA_0746

- 1 A: Yes.
- 2 Q: And then the next three letters are from MUSC
- 3 physicians, correct?
- 4 A: Yes.
- 5 Q: Okay. So, no just normal regular community
- 6 letters of support indicating, you know, hey,
- 7 we need this in the area, this would be great,
- 8 that type of thing, correct?
- 9 A: I promise I'm not trying to be difficult, but
- 10 it depends on how you define normal, regular.
- 11 Q: Okay.
- 12 A: I mean, you know ---
- 13 Q: How about this? No non-representative, non-
- 14 physician, non-CEOs who have had some type of
- 15 interaction with MUSC administration in the
- 16 past. Can I get there with that?
- 17 A: Right. Sure. Yes..
- 18 Q: Okay.
- 19 A: I'm okay with that.
- 20 Q: Okay. In terms of -- do you get a lot of
- 21 applications sometimes that have hundreds of
- 22 letters of community support in them?
- 23 A: There's a wide range of numbers of letters of
- 24 support that we get.
- 25 Q: Okay. And sometimes you get applications with



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ROA_0747

1 hundreds of them in there. I know because I've
2 submitted some of those applications.

3 A: Sometimes we have quite a lot. I don't -- it
4 wouldn't surprise me if it was hundreds.

5 Q: Okay.. It wouldn't surprise you or it would?

6 A: Well, it's not extremely common, at least
7 recently, for us to get hundreds of letters for
8 applications, but it's not shocking either.
9 But I honestly don't recall off the top of my
10 head how many have had hundreds, how many have
11 had tens. I just don't know.

12 Q: And were you presented in the CON application
13 with any data indicating that patients were
14 unsatisfied with their radiation oncology
15 experience at MUSC?

16 A: I don't recall getting any information about
17 that specifically.

18 Q: Okay. And, Ms. Murdock, would you agree with
19 me that you're not aware of any prohibitions on
20 MUSC's physicians who treat cancer from a
21 medical or surgical perspective that would
22 prevent them from referring patients to MUSC-
23 trained radiation oncologists who work at
24 Trident? Would you agree with me that there's
25 nothing that prevents that?



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ROA_0748

- 1 A: I'm not aware of any prohibitions of that kind.
- 2 Q: Okay. And recently the Department approved two
- 3 freestanding EDs less than a half a mile apart
- 4 from them, correct, in Berkeley County, one of
- 5 which was Trident and the other was MUSC's?
- 6 A: Less than two miles apart?
- 7 Q: Less than half a mile apart.
- 8 A: From each other?
- 9 Q: One another, yeah.
- 10 A: I don't specifically know the mileage, but,
- 11 yes, we did recently approve two in Berkeley
- 12 County, one Summerville and one for MUSC.
- 13 Q: Do you recall that they were very close to each
- 14 other?
- 15 A: I believe so.
- 16 Q: Okay. Ms. Murdock, if there -- let me scratch
- 17 that. Let me get through my notes and finish
- 18 up here. You mentioned in your discussions
- 19 with Mr. Dayhuff a DHEC reviewer cannot change
- 20 the capacity by themselves, correct?
- 21 A: Of a ---
- 22 Q: Of a linac.
- 23 A: Of a linac that's already been through the CON
- 24 approval process and has received a CON and
- 25 been assigned a capacity.



1 Q: So, if a -- is it your testimony on behalf of
2 the Department, if a linear accelerator
3 operator has had a linac for five, six, or
4 seven years, has never done an SBRT, but has
5 had a 4500 capacity treatment volume for that
6 linac, that the Department can't take note of
7 that in its decision-making process? Is that
8 your testimony today?

9 A: No. I did not ever say that the Department
10 can't take note of it.

11 Q: Thank you. Now, what effect -- pardon me. If
12 a provider decides, such as Trident that has
13 three linear accelerators and two are operating
14 at full capacity, but decides to keep one idle
15 because it doesn't want to staff three instead
16 of two, is that -- is that a good reason, in
17 your mind, to keep one of the machines idle?
18 Or let me present it this way. Or should
19 Trident fire up all three machines and spread
20 the patients out among all three, which could
21 certainly be done, but at higher expense and
22 less cost containment.

23 A: Sitting here today, I'd need more information
24 to evaluate that question.

25 Q: Okay. Fair enough.



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ROA_0750

1 MR. THOMAS: That's all the questions I have, Your
2 Honor.

3 THE COURT: Okay. Ms. Biggers, Re-Direct?

4 MS. BIGGERS: Yes, Your Honor. Just a few
5 questions.

6 MS. MURDOCK - REDIRECT EXAMINATION BY MS. BIGGERS:

7 Q: Ms. Murdock, I'm just going to follow up on a
8 few areas that Mr. Thomas questioned you about
9 on Cross. So, one that I'll start with is the
10 2015 MUSC denial decision he asked you about.

11 A: Yes.

12 Q: Could you just clarify for us, what were the
13 differences between that decision and the
14 decision we're here about today that
15 differentiated your decisions on the two?

16 A: The one that is foremost in my mind, of course,
17 that we've already discussed is the compliance
18 with the standard in the Plan. In the 2015
19 decision I relied on data that was more recent
20 that had not been submitted by MUSC with the
21 applications, but that was available to me,
22 that showed a use rate too low to comply with
23 the standard.

24 Q: Do you recall whether that use rate was 79.5
25 percent or above or perhaps below 79.5 percent?



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ROA_0751

1 A: I believe it was below 79 -- I believe it was
2 below 79 at least. I can't remember
3 specifically. And the -- there were some
4 issues, particularly with the projected
5 volumes, in the 2015 decision. I think the
6 decision was submitted in 2014. But in looking
7 at the calculations submitted by MUSC, I
8 thought that the projections were not
9 reasonable. And one of the issues that sticks
10 out in my mind is that MUSC had included a per-
11 patient number of treatments, an average number
12 of treatments per patient, that I thought was
13 unreasonably high given all the data available
14 to me about what had been going on in the
15 service area at the time of the decision and
16 during the years leading up to that decision.
17 And so that high per-patient number of
18 treatments projected at what I thought was an
19 unreasonably high number of treatments, an
20 unreasonably high projection of the number of
21 treatments in the future. So, I didn't feel
22 comfortable relying on MUSC's projections
23 regarding whether or not it could operate at a
24 minimum use rate of 50 percent or above for the
25 years after the project was implemented. I

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ROA_0752

1 also thought that that would affect the
2 projected revenues for the project. And that
3 was one of the project review criteria. And
4 it's worth noting that I was not -- I was not
5 the person who chose the relative importance
6 criteria for this case. Those were chosen and
7 identified before -- I think before I even
8 joined DHEC.

9 Q: By this case, are you referring ---

10 A: I'm sorry, the 2015. Yeah, the older one. The
11 2015 decision. So, that was a specific problem
12 that I thought was -- there was nothing else in
13 the application or information that I had that
14 would mitigate my concerns about those
15 projections and the -- so, that was an issue.
16 And then the distribution question, because I
17 did not see any other -- I did not think that
18 there was enough evidence in the application to
19 overcome the fact that this 2015 proposed
20 project was less than a mile from Trident and
21 its chronically underutilized linear
22 accelerators. So, without enough evidence to
23 weigh this duplication against any improved
24 accessibility in that application, I couldn't
25 find that it was compliant with distribution.



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ROA_0753

1 Let's see, projected revenues, I think
2 I've already touched on the reasons why the --
3 I didn't believe the application complied with
4 that criteria, because I couldn't rely on the
5 projected revenues, based on the projected
6 patient volumes that I thought were not
7 reliable. That was a related concern that
8 affected both criteria.

9 That's -- those are the -- kind of the
10 highlights of the difference that I recall,
11 differences between that and the application
12 we're discussing here today, where there is
13 better evidence in the application of improved
14 access, specifically to MUSC's target
15 population, which is the target population that
16 their current patient base that lives near the
17 -- in or near the area of the proposed project.
18 Those patients are already and have been
19 traveling to MUSC for treatment. I don't know
20 why they're not currently going to Trident, but
21 they're not. They're still driving all the way
22 to MUSC. And that -- and so I believe that the
23 application showed that that population will
24 have improved access. And it's a significant
25 chunk of MUSC's patient base for radiation



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ROA_0754

1 therapy. That patient base will have
2 significantly improved access by an MUSC
3 facility right there close to them.

4 Regarding the projections in the
5 application, I looked at the per patient --
6 specifically the per patient treatments in the
7 current application that we're discussing now
8 to see if that was a more reasonable
9 calculation. And I believe that it was. And
10 it more closely matched MUSC's actual
11 experience as opposed to the higher number that
12 MUSC submitted with the 2015 application. So,
13 I thought that the projected volumes were much
14 more reasonable in the current application as
15 compared to the 2015 application.

16 And then of course there's this compliance
17 with the State Health Plan. The data I had at
18 the time indicated compliance with the State
19 Health Plan. I didn't -- I wasn't aware that
20 there was an issue with the JAR volumes, so I
21 did not have cause to request clarification or
22 additional information or more recent data from
23 MUSC, which I would have done in the face of a
24 problem with the JAR. I would have addressed
25 that and given MUSC an opportunity to address



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ROA_0755

1 that problem then. I can't say one way or the
2 other whether or not they would have
3 successful, but I certainly would have given
4 them an opportunity to address that issue at
5 the time had I known that the JAR data said
6 that their utilization for one of the
7 applicable years was 79.97 percent. So, those
8 are the differences that I recall.

9 Q: Well, out of the numerous differences that
10 affected your decision then versus your
11 decision now that you just went through, I want
12 to ask you in particular about the idea of
13 accessibility. And so Mr. Thomas asked you a
14 question whether -- on his Cross Examination
15 whether linac services were inaccessible, or I
16 believe his phrasing, I believe, the record
17 will show my -- if I'm wrong, that linac
18 services are not inaccessible to residents in
19 the Nexton area. Is inaccessibility a standard
20 in the CON project review criteria or State
21 Health Plan, I mean, that services are
22 inaccessible?

23 A: Inaccessibility is not the -- it's improved
24 access. It's not necessarily a requirement
25 that services be inaccessible in order to



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ROA_0756

1 justify addition or expansion of a service.
2 And I'll have to go back and look at the
3 specific language, but it's improvement of
4 access. It's better access. It's not just
5 either access or no access.

6 Q: Regarding the decision we're here about today,
7 do you feel it improves access --
8 accessibility?

9 A: Yes, I do.

10 Q: Why?

11 A: Because the location -- certainly compared to
12 the 2015 application, the location, I think, is
13 a better location. As Mr. Thomas pointed out,
14 I can't require an applicant to choose a
15 particular location, but this is better. This
16 is more -- this is farther into Berkeley
17 County, and so it's further away from existing
18 linacs and closer to a quickly-growing
19 population that -- in a county that has
20 currently no radiation therapy services at all.
21 So -- and in particular, I think this MUSC's
22 existing patient population is clearly -- is
23 going -- that population is driving down to the
24 peninsula to receive radiation therapy
25 treatments. This particular kind of -- type of



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ROA_0757

1 service often requires a patient to travel on
2 a daily -- daily to go receive the treatments.
3 So, more than many other types of services, I
4 think it's -- I think with linear accelerators
5 it's arguably one of the most important issues,
6 is whether or not the patient is able to -- is
7 improved access to the actual linac by virtue
8 of being able to get there faster, easier and
9 with less hardship.

10 Q: And looking at that issue of improved
11 accessibility, do you take into consideration
12 at all what patients, what -- the data that's
13 currently available to show where patients are
14 choosing to go?

15 A: Yes. We can't ---

16 MR. THOMAS: I'm objecting to the premise of the
17 question, Your Honor. We've now had expert
18 testimony that patients -- all of these
19 patients aren't choosing to go anywhere.
20 There's no data that says these patients made
21 a choice to go here. They are referred
22 primarily. Mr. Sullivan testified 70 to 80
23 percent of those patients, and this is facts in
24 evidence, are referred by their physician and
25 they will follow where their physician goes.



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ROA_0758

1 So, it's not a choice issue and that is an
2 incorrect statement in the record.

3 **MS. BIGGERS:** I can rephrase ---

4 **THE COURT:** Rephrase.

5 **MS. BIGGERS:** --- and remove the word choose.

6 **MR. THOMAS:** Thank you.

7 **MR. DAYHUFF:** And that's an opinion ---

8 **MR. THOMAS:** Wait, I don't think he gets a shot
9 here. I don't think he does, Your Honor.
10 That's her witness.

11 **THE COURT:** I understand. Ms. Biggers has offered
12 to rephrase the question, so we'll allow her to
13 rephrase it.

14 **Q:** Ms. Murdock, when you, as a reviewer of an
15 application, are looking at the issue of
16 improved accessibility, do you consider any
17 data available to you as to patient origin, as
18 in residence, versus where patients are
19 receiving their treatment, as in location of
20 the provider they're receiving treatments from?

21 **A:** Yes.

22 **Q:** Why do you do that?

23 **A:** Because it -- again, with linear accelerators
24 specifically, especially with linear
25 accelerators, the proximity of the patient to



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ROA_0759

1 the unit where -- to the linac where they are
2 receiving treatment makes a difference in the
3 accessibility of that service.. And in this
4 case, MUSC presented significant evidence that
5 there is a large number of patients that are,
6 for whatever reason, traveling all the way from
7 the area of the proposed project to the
8 Charleston peninsula to receive radiation
9 therapy treatments many times, on a daily
10 basis, or at least multiple times. So, that's
11 why I consider the information about patient
12 origin, specifically in this case, as
13 important.

14 Q: And then just one more topic area that I'll ask
15 you about. And this goes to letters of
16 support. Was acceptability a project review
17 criterion that you applied to this project?

18 A: No.

19 Q: Okay. But does the application form itself, as
20 set out in the regulation, address endorsement
21 from the community?

22 A: I think it requests, and I'm summarizing here,
23 letters of support.

24 Q: Let me just ask you to look at, and I think we
25 can pull this up the screen for you to look at,



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ROA_0760

1 Regulation 61-15, CON regulation, the section
2 in Chapter 2 on the application -- Section 202
3 of the application itself, Part c, number (8).
4 Can you just read aloud what that says for part
5 c, number (8) of the application form?

6 A: Yes. Endorsement from the community that the
7 project is desirable. This may include but is
8 not limited to members of the medical
9 community, citizen's groups, governmental
10 elected officials and other health and social
11 service disciplines in the community.

12 Q: Were there any -- are you aware of any letters
13 in this particular application from, for
14 instance, a government elected official as part
15 of this application?

16 A: Yes.

17 Q: Who was that?

18 A: It was the representative. And I'm going to
19 have to go back and look. I think I'm looking
20 in the wrong notebook, which would explain why
21 I can't find it.

22 Q: It would be the DHEC Exhibit 1 notebook.

23 A: Yeah. Thanks.

24 Q: And it's up on -- you can see it on the screen.

25 A: There is it. Yes.



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ROA_0761

1 Q: There you go.

2 A: Technology. Yes. Representative Davis. And
3 there were also multiple letters from the
4 medical community.

5 **MS. BIGGERS:** And that's all the Re-Direct that I
6 have, Your Honor. And I would ask that this
7 witness be excused.

8 **THE COURT:** Okay. Ms. Murdock, thank you for your
9 patience ---

10 **MS. MURDOCK:** Thank you.

11 **THE COURT:** --- and resilience. And you may step
12 down.

13 **MS. MURDOCK:** Thank you.

14 **THE COURT:** I don't know that we have anything else
15 to do today, but we do have a matter to
16 resolve. Am I correct?

17 **MR. WESTBROOK:** Well, we have one more witness today
18 as well.

19 **THE COURT:** Oh, we do?

20 **MR. WESTBROOK:** We do.

21 **MS. BIGGERS:** Well, DHEC rests officially for the
22 record.

23 **THE COURT:** Okay. Sorry.

24 **MR. WESTBROOK:** Okay. Sorry about that. Yes. And
25 I think we do have something to resolve as



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ROA_0762

1 well. Yes, Dr. Cawley from MUSC is here today.
2 He would be starting a little later than we had
3 anticipated, but he's been here since 9:00 this
4 morning, so hopefully we'll be able to get it
5 in today. But, you know, we -- if we can't, we
6 can't. Why don't we -- what might be helpful,
7 Your Honor, I would just suggest, is let's see
8 if we can resolve the issue that needs to be
9 resolved and then we'll -- and that may have
10 some effect on Dr. Cawley.

11 **THE COURT:** Okay. All right. Mr. Thomas, I
12 believe you are aware of Dr. Jenrette's
13 situation?

14 **MR. THOMAS:** Yes, sir.

15 **THE COURT:** What's the update?

16 **MR. WESTBROOK:** The update is this. Dr. Jenrette --
17 let me give you a little more detail. I'm not
18 sure how much detail you've gotten. And I
19 won't go into much detail, but just give you a
20 little ---

21 **THE COURT:** All I know is that he was -- he went to
22 the emergency room last night.

23 **MR. WESTBROOK:** Yeah. He started hemorrhaging from
24 his leg.

25 **MR. THOMAS:** Do we want to go off the record for



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ROA_0763

1 this?

2 **MR. WESTBROOK:** That's a great idea.

3 **THE COURT:** Yeah. Okay. We can do that. We'll be
4 off the record.

5 (Off the Record)

6 **THE COURT:** All right. We're back on the record in
7 case number 18-07-0100. Mr. Westbrook, what do
8 you have for us?

9 **MR. WESTBROOK:** Your Honor, with gratitude to you
10 and opposing counsel, I want to call as our
11 next witness Dr. -- or as our first witness,
12 excuse me, Dr. Pat Cawley.

13 **THE COURT:** All right. Dr. Cawley.

14 **COURT REPORTER:** Dr. Cawley, please state and spell
15 your first and last name.

16 **DR. CAWLEY:** Patrick Cawley, C-A-W-L-E-Y.

17 **PATRICK D. CAWLEY, M.D.,** having been duly sworn,
18 testifies as follows:

19 **DR. CAWLEY - DIRECT EXAMINATION BY MR. WESTBROOK:**

20 **Q:** Dr. Cawley, would you, please, once again state
21 your name for the record, please?

22 **A:** Patrick Cawley, C-A-W-L-E-Y.

23 **Q:** All right. And, Dr. Cawley, you -- what is
24 your job position within MUSC?

25 **A:** I'm the CEO of MUSC Health and Vice President.



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ROA_0764

1 of Health Affairs for the Medical University of
2 South Carolina.

3 Q: All right.

4 **MR. WESTBROOK:** Let's start by putting Exhibit --
5 MUSC Exhibit 62 up on the screen, Dan.

6 **(Respondent MUSC's Exhibit Number 62 was introduced**
7 **into the record at this time.)**

8 Q: Dr. Cawley, there's a book of exhibits if you
9 want to see a hard copy, but it's going to be
10 right up on the screen right there to your
11 right and you can look on it to the extent that
12 you need it. Let me start off with we have
13 these boxes with various entities. And I would
14 like you -- I'm going to ask you some questions
15 about each one of these, so we can kind of
16 clarify the way MUSC is organized. So let's
17 start with the one on the top, the Medical
18 University of South Carolina, MUSC. Tell me,
19 Dr. Cawley, what is MUSC and what position --
20 again, if you would tell us what your position
21 is with that organization?

22 A: Well, Medical University of South Carolina is
23 the main organization. I often call it the
24 umbrella organization and everything else falls
25 underneath that. It's a state institution



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ROA_0765

1 dedicated toward a three-part mission;
2 education, research, and clinical care.

3 Q: All right. And, once again, what position do
4 you hold within MUSC?

5 A: I am Vice President of Health Affairs.

6 Q: All right. And as Vice President of Health
7 Affairs, how would you describe your job
8 duties?

9 A: So, that relates to anything clinical
10 underneath -- directly underneath Medical
11 University of South Carolina that I would be in
12 charge of.

13 Q: All right.

14 A: Or have some ability to coordinate.

15 Q: All right. Let's take these other boxes one at
16 a time starting with the one to my left, MUHA,
17 Medical University Hospital Authority, who is
18 technically, I think, the party in this case.
19 What is MUHA?

20 A: MUHA, or MUHA as we call it, is a ---

21 Q: You had to do that, Dr. Cawley. Go ahead. I'm
22 sorry.

23 A: --- is a -- that joke's lost on me -- is a
24 state entity in which the hospital -- it's a
25 separate stated entity from the Medical



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ROA_0766

1 University of South Carolina, but in its
2 organizing principals does state that it serves
3 to further the mission of Medical University of
4 South Carolina. And of that entity I am the
5 Executive Director.

6 Q: All right. And what do you do as Executive
7 Director of MUHA?

8 A: I'm the lead executive that oversees that
9 entity, which is basically a hospital that --
10 in all its different pieces and parts.

11 Q: All right. And does MUHA have a separate Board
12 or a -- from MUSC or do they share the same
13 Board?

14 A: It's technically a separate Board, although the
15 members of both the Medical University Hospital
16 Authority Board and the Medical University of
17 South Carolina Board are the same people, but
18 technically two separate Boards.

19 Q: All right. Okay. The next organization is --
20 the next box there says MUSC Physicians. What
21 is the MUSC Physicians, please?

22 A: That is a separate entity, which seeks to
23 employ the physicians at MUSC. It's an entity
24 set up almost 30 years ago. And my role in
25 that is I sit on the Executive Committee of



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ROA_0767

1 their Board.

2 Q: All right. And is MUSC Physicians-- there's
3 another term that I've heard, UMA, or
4 University Medical Associates. What's the
5 relationship between University Medical
6 Associates and the ---

7 A: The legal name of that entity is University
8 Medical Associates, UMA.

9 Q: Okay.

10 A: And MUSC Physicians is a d/b/a.

11 Q: And you said you sat on the -- I believe you
12 said the Executive Committee; is that what you
13 said?

14 A: Yeah, in my role as CEO of MUSC Health, I'm a
15 permanent member of the Executive Committee of
16 the Board of MUSC Physicians.

17 Q: Now, you yourself are a physician, right?
18 We're calling Dr. Cawley.

19 A: Yes.

20 Q: So -- and do you have another role then with
21 MUSC Physicians?

22 A: Yeah. So, I'm also a physician, a member of --
23 we call that the Practice Plan. I'm a member
24 of the Physician Practice Plan.

25 Q: All right. And speaking of practice, are you



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ROA_0768

1 a practicing physician?

2 A: Yes. I'm an internal medicine hospitalist and
3 I continue to do that every now and then.

4 Q: All right. And the next box says MUSC
5 Strategic Ventures. What is that?

6 A: Strategic Ventures is a separate 501(c)(3) set
7 up about three years ago. Once again, and it's
8 organizing principal is to serve -- is to
9 further the mission of MUSC. And it's main
10 function is to joint venture with other
11 companies or other entities to help fulfill
12 that mission.

13 Q: All right. MUSC Strategic Ventures, you may
14 have said this already, but I missed it if you
15 did, what was the original name of the MUSC
16 Strategic Ventures?

17 A: Well, in the first six to 12 months of its --
18 after its birth, it was called MUSC Health for
19 a period of time. And that was -- that became
20 too confusing and different -- internally and
21 we ended up just separating that out about six
22 to 12 months later.

23 Q: And in a minute we're going to get to the last
24 box, which says MUSC Health, but, again, as I
25 understand it, MUSC Strategic Ventures was not



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ROA_0769

1 it's original name?

2 A: Correct.

3 Q: Is that what you said?

4 A: Correct.

5 Q: Okay. And what's your position or do you have
6 a position with ---

7 A: And I'm the CEO of MUSC Strategic Ventures.

8 Q: All right. And -- okay. So, that leaves us
9 MUSC Health, the last box. What is MUSC
10 Health?

11 A: MUSC Health is not a legal entity. It's a --
12 it's really a brand construct in which we
13 encompass all things clinical across all of
14 MUSC and all of its related entities, which all
15 those things underneath, Medical University of
16 South Carolina and what we call related
17 entities. So, being a CEO of MUSC Health, it's
18 a way to -- it's a way to portray and talk
19 about how I have the authority to go across any
20 of those related entities when it becomes a
21 clinical issue.

22 Q: All right. And did you say you were CEO of
23 MUSC Health?

24 A: Yes.

25 Q: And when you're talking about clinical entities



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ROA_0770

1 or related entities, you're talking about --
2 how does the Radiation Oncology program of MUSC
3 fit into this organization that your talking
4 about?

5 A: Yeah, that directly -- well, there's two pieces
6 of that. There's -- the radiation program is
7 underneath the Medical University Hospital
8 Authority. There's also a joint venture with
9 Alliance underneath Strategic Ventures.

10 Q: All right. And so, what is your role then,
11 given your positions with MUHA and MUSC Health
12 and MUSC Strategic Ventures, what is your role
13 in terms of the Radiation Oncology program?

14 A: Well, given my different roles there, whether
15 -- I mean, to simply move forward on this
16 strategic direction is ultimately my
17 responsibility.

18 Q: All right. Now, let's look at MUSC Exhibit 1.

19 **(Respondent MUSC's Exhibit Number 1 was introduced**
20 **into the record at this time.)**

21 Q: And, Dr. Cawley, can you identify this as your
22 CV?

23 A: Yes.

24 Q: Is this current or relatively current?

25 A: I believe it's relatively current.



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ROA_0771

1 Q: All right. Good. So, we're not going to go
2 through all of this, but I do want to just ask
3 you about a few things on the first couple of
4 pages. So, why don't we start with page one,
5 some -- just some background stuff. Where did
6 you go to med school, please?

7 A: I went to medical school at Georgetown
8 University in Washington, D.C.

9 Q: All right. Where did you do your internship
10 and residency?

11 A: I did those at Duke University Medical Center
12 in Durham, North Carolina.

13 Q: And you also have an MBA, I believe?

14 A: Yes.

15 Q: Where was that from and when did you get it?

16 A: From the University of Massachusetts and
17 graduated in 2007.

18 Q: And I believe this -- if we go on down the
19 page, I think we -- it lists your Board
20 certifications. Why don't you tell us about
21 those, just summarize those for us.

22 A: I mean, the main one there is the third and
23 fourth lines, which is Board certified in
24 internal medicine.

25 Q: All right. And if you'll turn over to the next



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ROA_0772

1 page, page two, at the top of the page it says
2 you're an associate professor; is that correct?

3 A: Yes.

4 Q: Is that current?

5 A: Yes.

6 Q: And so, what are your duties as associate
7 professor?

8 A: When I practice as a physician at MUSC, that's
9 my role there. I'll see patients ---

10 Q: All right.

11 A: --- in the hospital.

12 Q: And you also mentioned earlier that you have
13 some -- or maybe you didn't, I don't know. Do
14 you have teaching responsibilities?

15 A: Yes. So, when I see patients at MUSC, it's
16 almost exclusively with residents and/or
17 medical students.

18 Q: All right. Dr. Cawley, how long have you been
19 at MUSC?

20 A: I've been there since 2003.

21 Q: All right. And in 2003 it looks like, again
22 from your resume, at the bottom of the page I'm
23 looking, it says 2003 to 2006 it says at the
24 very bottom of the page you were the Director
25 of Hospitalist Services in the Department of



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ROA_0773

1 Medicine. What -- tell us what your -- what
2 that entailed, that job?

3 A: Sure. So, what the highlighted section says,
4 when I first came to MUSC in 2003 I was
5 predominantly there for two reasons. The very,
6 very bottom one was to start a hospitalist
7 service and then to run that service. And
8 that's simply overseeing the physicians that
9 take part in that service. And then the other
10 one, it says Associate Chief Medical Officer of
11 the Hospital Authority, and I worked as the
12 Associate Chief Medical Officer

13 Q: All right. Let me go back to hospitalist for
14 a minute. What is a hospitalist?

15 A: A hospitalist is a physician that simply limits
16 their practice to seeing patients in the
17 hospital.

18 Q: All right.

19 A: Heart attacks, skin infections, pneumonias,
20 those kind of things.

21 Q: All right. And you were the director of that
22 area, correct?

23 A: Yes.

24 Q: That department or whatever it was. Area or
25 division.



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ROA_0774

1 A: Yes.

2 Q: And then in also looking at your resume -- or
3 your CV, and I think this will be the last
4 question I ask you about your CV, but about the
5 middle of the way on that page it says from
6 2006 to 2013 that you were Executive Medical
7 Director, parenthesis, Chief Medical Officer,
8 close paren, Medical University Hospital
9 Authority, Medical University of South
10 Carolina. So, as Chief Medical Officer, what
11 were your duties?

12 A: You know, a typical chief medical officer, it
13 may different at different hospitals. But my
14 duties at Medical University Hospital Authority
15 fell under one of three categories. First was,
16 I'll call it general medical staff affairs;
17 anything that has to do with the physicians,
18 the residents, or any students working in the
19 Hospital Authority. The second area was to
20 oversee all things quality and quality affairs.
21 And then the third area was to oversee our
22 clinical service lines.

23 Q: And, I'm sure this is a dumb question, but
24 clinical service lines, what would be some
25 examples of that?



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ROA_0775

1 A: A heart and vascular institute, The Hollings
2 Cancer Center, Children's Hospital.

3 Q: All right.

4 A: Things like that.

5 Q: And the Hollings Cancer Center is -- what's the
6 relationship between the Hollings Cancer Center
7 and Radiation Oncology?

8 A: Radiation Oncology is a sub-entity of the
9 Hollings Cancer Institute.

10 Q: All right. Good. All right. Dr. Cawley,
11 thank you. Let's go to --

12 **MR. WESTBROOK:** Dan, why don't you put up
13 demonstrative 4, and as you -- before you take
14 too hard a look at that, let me just ask you,
15 are you familiar with the MUSC Mission
16 Statement?

17 A: Yes.

18 Q: All right. I'm guessing, but you tell me, do
19 you have it -- you don't have it memorized word
20 for word?

21 A: I don't have it memorized. I mean, I would say
22 this is the official statement, but generally,
23 you know, what I usually say is -- just the
24 shortened version of the mission statement is
25 that MUSC exists to improve the health of South



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ROA_0776

1 Carolinians through education, research, and
2 clinical care.

3 Q: All right. Good. Now, has MUSC received any
4 particular honors or awards that you could tell
5 us about in recent years?

6 A: Yes. I mean, MUSC has done very well in
7 receiving all kinds of awards.

8 Q: And I'll tell you what, before you get into
9 that, let me just ask you this. Have you
10 helped oversee the preparation of the
11 demonstrative that would summarize some these
12 honors and awards?

13 A: Yes.

14 MR. WESTBROOK: Let's put that up on the screen,
15 Dan.

16 Q: And, Dr. Cawley, tell me if this is the
17 demonstrative you were talking about?

18 A: Yes.

19 Q: All right. So why don't we take those just one
20 at a time. We'll start with the --

21 MR. WESTBROOK: Dan, can you call out the NCI-
22 Designation Center Center?

23 Q: What does that refer to, Doctor?

24 A: Sure. That refers to -- and you can see all
25 the different cancer institutes -- national



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ROA_0777

1 cancer institutes across the nation. Right
2 there is about 50 or 60 of them. That is a
3 designation given to medical centers that do
4 all three of those things I just mentioned. So
5 it's not only clinical care, but there's a
6 research component and there's an education
7 component.

8 Q: All right. And what is the significant, if
9 any, of that designation to ---

10 A: Well, I think that calls out that these are the
11 -- these are the top cancer institutes across
12 the nation where cancer care is delivered.

13 Q: All right. Let's go to the next award there,
14 it says Becker's Hospital Review, 100 Great
15 Hospitals in America. What is Becker's
16 Hospital Review?

17 A: Becker's is a media publication and it puts
18 together different lists. And for several
19 years now MUSC has been consistently listed in
20 the top 100 of Becker's.

21 Q: All right. Let's go to the next one. It says
22 Leapfrog Hospital Safety Grade, A. Tell us
23 what does Leapfrog ---

24 A: Leapfrog is a group, a business coalition
25 actually, that focuses on proving, not only the



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ROA_0778

1 cost of healthcare, but the safety in
2 healthcare. And this one is a recognition --
3 they grade hospitals on -- at an A through F
4 level. And MUSC in the latest survey has been
5 graded an A. I think that's indicative of a
6 lot of focus we put on improving patient
7 safety.

8 Q: Good. All right.

9 **MR. WESTBROOK:** Next, Dan, I want you to call out
10 the NAPBC, it says National Accreditation
11 Program for Breast Centers.

12 Q: Dr. Cawley, what's the significance of any of
13 this particular ---

14 A: Our physicians and our team love to get
15 different certifications for a variety of
16 reasons. This is one that comes from the
17 American College of Surgeons that just simply
18 looks at our breast program. And it looks at,
19 are you taking care of -- are you doing the
20 latest, the best when it comes to taking care
21 of people with breast cancer?

22 Q: All right. Good. And we have two more areas
23 -- well, I won't say that. Let me just go with
24 the next one. It says Forbes Best Employers.
25 Now, why do we have this on the list?



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ROA_0779

1 A: Well, I think this one's indicative of our team
2 focus. This one we started actually earning
3 about two years ago and have been named again
4 just actually just a couple days ago. And to
5 me what that's indicative of is our team focus,
6 because I think that's what Best Employers
7 measures. It measures right down to your
8 surveys and how your people feel about working
9 together and working for the organization.

10 Q: And what kind of teams are we talking about?

11 A: Well, I mean, we're a hospital health system.
12 Predominantly these are clinical teams. You
13 know, teams that are seeing the patients;
14 nurses, doctors, technicians, et cetera.

15 Q: All right. Okay. Now, then let's go back to
16 the big survey. We've got several things with
17 best hospitals, but -- excuse me, I'm sorry,
18 with U.S. News and World Report. Rather than go
19 there for right now what I'd like to do though
20 is go to another demonstrative that can be read
21 a little bit easier, demonstrative 6. Once
22 again, have you overseen the preparation of
23 this, do you know -- are you ---

24 A: Yes.

25 Q: --- familiar with what this about?



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ROA_0780

1 A: Yes.

2 Q: So, why don't we walk through it starting in
3 the upper left hand. It says, Best Hospitals -
4 U.S. News Report, Ranked Top 25. Tell us about
5 what that has to do with the case that we're
6 here ---

7 A: Well, U.S. News and World Report is another
8 media publication and puts together a list of
9 best hospitals. They have different criteria.
10 Widely considered one of the better ranking
11 systems in healthcare. The top left there, the
12 top 25. So, knowing there's a little over
13 6,000 hospitals in the U.S. And those six
14 categories there are pediatric -- or five
15 categories really, pediatric cancer, pediatric
16 cardiology and heart surgery, which is
17 technically one, adult cancer, adult ear, nose,
18 and throat, and adult gynecology. In those
19 five programs, we are ranked in the top 25
20 across those 6,000 -- over 6,000 hospitals.

21 Q: And which of those relate to the case that
22 we're here about today?

23 A: Yeah. Obviously pediatric cancer and adult
24 cancer. But then actually adult ENT and
25 gynecology also have large cancer components.



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ROA_0781

1 So, we're a large head and neck cancer center.
2 We're also a large center for gynecologic
3 cancers.

4 Q: Okay. Thank you. The other little rectangle
5 at the top of the page, it says Number One
6 Hospital in SC. Tell us what that award is
7 for.

8 A: Yeah, I mean, very similar. They have certain
9 criteria to rank hospitals based upon outcomes,
10 process measures such as are you following
11 certain safety and best practices. And for the
12 last four or five years we've been ranked
13 number one.

14 Q: And this is overall?

15 A: Overall.

16 Q: Okay.

17 A: All hospitals in South Carolina.

18 Q: All right.

19 A: That's about 60, 70 hospitals.

20 Q: All right. And -- give us -- the two bottom
21 rectangles, why don't you quickly summarize
22 what those are?

23 A: The one on the left, you know, the top -- I
24 talked about the top 25. But nationally ranked
25 means you're ranked in the top 50. And we have



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ROA_0782

1 11 specialties; five adults, six children.
2 Ranked in the top 50. And if you're somewhere
3 between 50 and 100, you're called high
4 performing. We're the only facility in South
5 Carolina that has any nationally ranked
6 specialties.

7 Q: All right. Good. All right. Dr. Cawley --

8 **MR. WESTBROOK:** Dan, I think you can take that off
9 the screen please.

10 Q: Dr. Cawley, now historically MUSC is
11 headquartered -- has always been headquartered
12 down on the Charleston peninsula downtown; is
13 that right?

14 A: Yes.

15 Q: Okay. All right. There's been some discussion
16 in the trial so far this week about places off
17 the peninsula. Can you tell us about a few of
18 those projects and what's the reason for the
19 expansion in recent years off the peninsula?

20 A: Well, it's really not recent years, it's really
21 been -- I've been at MUSC almost 15 years. And
22 for 15 years there's been this push to get off
23 the peninsula. The number one thing driving
24 that is, when we survey our patients, we do
25 very, very well in all survey indicators. But



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ROA_0783

1 the one we don't do well on is -- comes out of
2 the general category of access. And the main
3 issue, when you look at the questions
4 underneath that category of access, is MUSC is
5 close to me, close to my home. And so, we've
6 noted that to be an issue. We've gotten it
7 better in the past 15 years, but still it's the
8 lowest ranked question under all things. And
9 so, we've been pushing to be off the peninsula,
10 you know, mainly to take care of the patients
11 that want to come to us.

12 Q: And your patients, what parts of South Carolina
13 do your patients come from?

14 A: Our patients come from all parts of South
15 Carolina. In fact, every single county is
16 represented. About half come from the tri-
17 county area of Dorchester, Berkeley,
18 Charleston. And then the other half come from
19 outside the tri-county.

20 Q: Do you have patients from out of state too?

21 A: Yes.

22 Q: All right. Okay. And Berkeley County, we've
23 talking about a good bit this week and we will
24 talk about some more. You've got some projects
25 in Berkeley County near the Nexton Community.



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ROA_0784

1 Can you tell us about those?

2 A: Yes. We have several projects up there. It's
3 really part of our -- our Board of Trustees,
4 approximately five years ago, looked closely
5 and voted to -- on a strategic plan that really
6 pushed us, not only into Berkeley County, but
7 also into West Ashley and Mount Pleasant ---

8 Q: All right.

9 A: --- as well. So ---

10 Q: We'll get to that in a moment. Let me focus on
11 Berkeley first.

12 **MR. WESTBROOK:** Dan, would you put demonstrative 8
13 up on the board -- on the screen, please?

14 Q: And so, what are these two blue dots and the
15 language by them? Do you see what it says?
16 What are they? What do they represent?

17 A: Right. So, the MUSC Radiation Center, or
18 radiation therapy is what we've been talking
19 about here at this trial, that's right off of
20 -- on the line there, I think that's the county
21 line. Yeah, because Route 26 as well. And
22 then two and a half miles away, maybe almost
23 three, is where we're planning to build a
24 community hospital.

25 Q: All right. Now, what is the CON status of



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ROA_0785

1 these two projects?

2 A: We have preliminary CON approval, but they're
3 both going through an opposition process.

4 Q: All right. And is there also, in addition to
5 that -- we don't need to -- I don't think it's
6 on the map, but you have a freestanding ED
7 somewhere in that area or where would it be ---

8 A: Yes. Which is not far from the radiation
9 therapy center.

10 Q: All right. And is ---

11 A: Which would not be far, yeah.

12 Q: And what's the status of that freestanding ---

13 A: The same thing. Have the CON, but it's going
14 through an opposition ---

15 Q: All right.

16 A: --- process.

17 Q: Now, we've already been over this and I don't
18 want to spend a whole lot of time, because I
19 think there's already been some testimony about
20 this. But just so you can comment about it,
21 other providers have been coming in that area.

22 **MR. WESTBROOK:** Dan, can you add that.

23 Q: What do these two purple circles indicate?

24 A: The one at the very, very top is a -- is Roper
25 St. Francis Health System. That's a



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ROA_0786

1 freestanding ER. That's up in Moncks Corner.
2 That's been up there many years. I don't know
3 how many. And then the other dot just to the
4 right of the community hospital is where the
5 Saint -- Roper St. Francis hospital's going to
6 open I believe this summer.

7 Q: This summer, did you say?

8 A: Yes, this summer or maybe early fall.

9 Q: All right. And at one point in time are you
10 aware that this case, there was a -- Roper had
11 a linear accelerator that was also the subject
12 of this case? Do you recall that?

13 A: Yes. Yes.

14 Q: And where is that linear accelerator going to
15 be located?

16 A: I believe it's going to be on their campus.

17 Q: At that hospital?

18 A: At the Berkeley Hospital campus.

19 Q: All right. Good. And -- all right. Let's --
20 what about Trident?

21 **MR. WESTBROOK:** Dan, can you --

22 Q: And we have some blue circles there for Trident
23 facilities. What do you know about those, Dr.
24 Cawley?

25 A: Yeah, I think on the bottom there is a



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ROA_0787

1 representation of where the Trident
2 freestanding ER. They also have approval.
3 It's not far from -- it's right there off the
4 exit of 26. And then up the top there you see
5 two circles. One is Trident themselves and a
6 freestanding ER that's up in Moncks Corner.
7 And they've had that a number of years. I
8 don't know how many. And then I believe the
9 other dot is where Trident proposes to build a
10 new hospital.

11 Q: All right. And what's the attraction to
12 Berkeley County for these various healthcare
13 facilities going up there?

14 A: Well, it's where everybody's moving. In
15 Charleston it's, for a lot of different
16 reasons, I think mainly cost of living, just a
17 lot of people are moving into that area.

18 Q: All right.

19 A: Even from outside Charleston, but also even
20 within Charleston, the tri-county area, people
21 are moving into that area.

22 MR. WESTBROOK: And, Dan, could you show us the next
23 -- the demonstrative 1 I guess is what would be
24 next.

25 Q: Tell us what Nexton is. We've been talking



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ROA_0788

1 about Nexton a good bit.

2 A: Nexton's a community to be developed in that --
3 in Berkeley County. It's one of probably a
4 half a dozen to a dozen large communities that
5 are being developed over a 20, 30, 40-year.
6 And Nexton just happens to be fairly in the
7 middle. I mean, just some of those other dots
8 you have there are just to show how things are
9 -- the newer things are being -- newer
10 employers that are coming to Charleston are
11 also moving out, like Mercedes and Volvo.

12 Q: Okay. And -- all right. Good.

13 MR. WESTBROOK: Thank you, Dan. You can, I think,
14 take that off.

15 Q: You mentioned earlier Hollings Cancer Center.
16 What is Hollings Cancer Center?

17 A: Hollings Cancer Center is the brand name for
18 the MUSC, you know, cancer system.

19 Q: All right.

20 MR. WESTBROOK: And, Dan, how about putting up on
21 the screen MUSC Exhibit 45.

22 (Respondent MUSC's Exhibit Number 45 was introduced
23 into the record at this time.)

24 Q: So, how does Hollings Cancer Center relate to
25 these pretty blue dots and that one red dot



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ROA_0789

1 that's on that map, Dr. Cawley?

2 A: Well, this shows where MUSC has some related
3 radiation therapy involvement. Once again,
4 remember radiation therapy is one component of
5 cancer care.

6 Q: Okay.

7 A: The other components being medical oncology and
8 surgical oncology.

9 Q: Okay.

10 A: The one -- the two dots in the middle represent
11 ---

12 Q: Right here?

13 A: Correct.

14 Q: Yeah.

15 A: The larger dot is on the peninsula right in
16 Charleston. The smaller dot is a radiation
17 treatment center we've had for -- I'm going to
18 guess -- 10, 12 years in Mount Pleasant that we
19 run. And then down in the south there is a --
20 that's a radiation treatment center with
21 Beaufort Memorial Hospital that we're in a
22 joint venture on.

23 Q: All right. And this up here?

24 A: And then that's a joint venture between MUSC
25 and Tideland Health.



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ROA_0790

1 Q: All right. What town is that located?

2 A: Murrells Inlet.

3 Q: Murrells Inlet?

4 A: Uh-huh.

5 Q: All right. And then what -- the red dot, of
6 course, is what?

7 A: That's the facility we're talking about in this
8 trial.

9 Q: Okay. Now, can you describe for us the level
10 -- the degree to which these various off-
11 peninsula radiation therapy centers are
12 integrated with the Hollings Cancer Center
13 downtown Charleston?

14 A: They're completed integrated. So, it's -- you
15 know, we oversee the quality on all these
16 institutions. We're heavily involved in the
17 operations, some places more than others. In
18 Murrells Inlet, we actually run that facility.
19 Over in Beaufort we're heavily tied to it. The
20 two in the middle we obviously run. So, it's
21 intimately connected.

22 Q: All right. What is the MUSC Cancer Care
23 Network?

24 A: That is a joint venture between MUSC and
25 Alliance Oncology.



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ROA_0791

1 Q: All right. Let's look at MUSC Exhibit 63.

2 (Respondent MUSC's Exhibit Number 63 was introduced
3 into the record at this time.)

4 Q: And this organizational chart here or look at
5 the blue boxes, another set of blue boxes up on
6 the screen. What does this represent, Dr.
7 Cawley?

8 A: Well, the left is who receives the license and
9 that's the Medical University Hospital
10 authority. And then we have -- and we started
11 this about five years ago, started working
12 closely with Alliance Oncology, maybe six years
13 ago at this point. And we elected for a
14 variety of reasons to work with Alliance. And
15 then part of that evolution of that
16 relationship is when we had put Strategic
17 Ventures together, we developed a joint venture
18 with Alliance Oncology to operate other
19 radiation treatment centers.

20 Q: All right. And it says at the top of this
21 Exhibit, the heading says MUSC Radiation
22 Therapy Center - Berkeley County, which is the
23 one that we're talking about in Nexton,
24 correct?

25 A: Correct.



1 Q: But is that -- is that the same or different
2 models that are used for the other radiation
3 therapy centers that cancer -- MUSC Cancer Care
4 Network is involved in?

5 A: It's the exact same one for Beaufort. It's a
6 little different for MUSC -- or Medical
7 University Hospital Authority. We don't have
8 a joint venture there, on the peninsula I'm
9 talking about.

10 Q: Yeah.

11 A: And then Alliance is not involved in the
12 Tidelands Health joint venture.

13 Q: The one up at Murrells Inlet?

14 A: Correct.

15 Q: Okay. So, this one right here, you've got --
16 it says the licensee is MUHA. And then the two
17 -- the MUSC Cancer Care Network itself, it
18 looks like it has -- it's underneath two
19 different boxes, Alliance Oncology and MUSC
20 Strategic Ventures. And once again, remind us
21 what you testified when you were going through
22 the first set of blue boxes. MUSC Strategic
23 Ventures' original name was what?

24 A: In the first six or 12 months, I don't remember
25 exactly, it was called MUSC Health.



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ROA_0793

1 Q: All right. Now, so you said -- I think you
2 just said you've been working with Alliance for
3 five or six years. Why did you choose to
4 partner with Alliance in these projects? What
5 do they bring to the table?

6 A: The main thing they bring, at the time we got
7 together with them, was they bring financial
8 resources in order to keep our equipment very
9 cutting edge. So, we have a lot of radiation
10 therapy equipment and have had for a long time.
11 Keeping that very cutting edge, keeping it on
12 -- keeping the best equipment or getting the
13 best equipment ends up being very expensive.
14 And so, we work with Alliance. Alliance is a
15 large provider across the entire world,
16 actually. And they buy -- they buy these --
17 they don't buy one at a time, they buy dozens.
18 And they're able to get very, very good rates
19 on the equipment. And that was the major
20 reason. Since then we've developed and worked
21 with them and they bring tremendous operational
22 expertise to the radiation oncology business as
23 well. And we've enjoyed that relationship.

24 Q: Good. All right. Let's look at MUSC Exhibit
25 5. And pull it up.



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ROA_0794

1 (Respondent MUSC's Exhibit Number 5 was introduced
2 into the record at this time.)

3 Q: That says Operating Agreement of MUSC Health
4 Cancer Care Network, LLC. And, Dr. Cawley,
5 what's the date on that agreement?

6 A: January 22, 2016.

7 Q: Okay. And are you familiar generally with this
8 agreement?

9 A: Yes.

10 Q: Who signed this agreement on behalf of MUSC?

11 A: I did.

12 Q: Okay. Let's go to, I believe the first page,
13 yeah. Yeah. Dan has pulled out for us one of
14 the whereas clauses on the first page. Can you
15 read that into the record, Dr. Cawley?

16 A: Whereas, as part of the Network, the Members
17 agree that the Company and its affiliated
18 service lines shall abide by the clinical
19 standards of the Hollings Cancer Center and
20 shall extend its reputation for academic
21 excellence, as well as the operational and
22 marketing expertise with respect to oncology
23 services of Alliance Oncology, LLC, Alliance,
24 to various South Carolina communities.

25 Q: Is that -- what's the significance of that



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ROA_0795

1 clause to you, to MUSC?

2 A: That culls out -- it was important to us to
3 cull out that it -- that the standards, the
4 clinical and quality standards will be set by
5 MUSC in the Hollings Cancer Center.

6 Q: All right. I want to turn over to -- in the
7 same agreement, to section 4.2, which is at
8 Bates page MUSC00025. And 4.2, this section,
9 is long -- too long for you to read or me to
10 read into the record, so we won't do that. I
11 just want to ask you to look at a couple of
12 different sections. You're familiar generally
13 with this section, Dr. Cawley?

14 A: Yes.

15 Q: All right. Let's --

16 MR. WESTBROOK: Dan, highlight one of those
17 sentences up there, I believe the second
18 sentence in the whole paragraph. If you can
19 highlight and pull that out.

20 Q: Dr. Cawley, to save your voice, I'm going to
21 read this one into the record. You tell me if
22 I miss anything. For so long as MUSC Health or
23 one or more of its Affiliates is a Member, the
24 Company and each Center shall be operated and
25 managed in a manner that furthers MUSC Health's



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ROA_0796

1 charitable purposes by promoting health for a
2 broad cross-section of the community,
3 especially those persons who are poor. And
4 before I ask you to comment about that, I want
5 to go over to the last paragraph in this
6 section.

7 **MR. WESTBROOK:** And, again, can you highlight the
8 section that we've talked about before Cross,
9 Dan?

10 **Q:** And as you see, just for the sake of brevity,
11 I'm just going to -- we've just highlighted a
12 portion of this paragraph that says, each
13 Member agrees that any decision of the Company
14 to take an action which furthers the charitable
15 purposes over any profit-making motives of the
16 Company, shall not be a breach of the duty of
17 loyalty or a breach of any fiduciary duty to
18 the Company, notwithstanding that any such
19 decision is not in the best interests of the
20 Company. Now, my question to Dr. Cawley is,
21 why are those -- why is that language in there
22 and why is that significant to you and MUSC?

23 **A:** Well, once again, just like I responded
24 earlier, we felt this was important to us as
25 part of our mission. We needed to be very



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ROA_0797

1 clear, you know, working with Alliance, that we
2 were going to continue our mission. And taking
3 care of South Carolinians, even those that
4 can't pay, is important. And we just wanted to
5 lay it out. In the end we didn't want to be
6 called out for, you know, this is a company,
7 Alliance -- you know, once again, Alliance is
8 a for-profit entity. Making sure profit isn't
9 a -- reaching an appropriate profit, that's a
10 fiduciary responsibility they have and we
11 wanted to make sure that that didn't run into
12 conflict with our responsibilities.

13 Q: All right. Okay. Let's go to another
14 agreement involving Cancer Care Network. This
15 is Exhibit 4.

16 MR. WESTBROOK: Dan, can you put that up for us.

17 (Respondent MUSC's Exhibit Number 4 was introduced
18 into the record at this time.)

19 Q: And this is entitled Network Management
20 Agreement. Are you familiar with this
21 agreement?

22 A: Yes.

23 Q: And, again, is this one that you signed
24 yourself?

25 A: Yes.



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ROA_0798

1 Q: All right. Let's go to section 4(a), which is
2 on -- I believe it's on page three. But
3 wherever it is, 4(a). Again, this is a long
4 section, so I don't want you to read this into
5 the record, it'll take too long, but it's --
6 the title of it is Quality Assurance. Take a
7 moment to refresh your memory if you need to of
8 what this section says and then tell us the
9 importance of this section to MUSC Health.

10 A: It's similar to the previous section on
11 quality. And it calls out the importance that
12 MUSC is going to be involved and is going to
13 oversee the quality assurance program of any
14 site in which this joint venture is active.

15 Q: All right. Does this paragraph reference the
16 Clinical Standards Committee?

17 A: Yes.

18 Q: The clinical standards of MUSC? Tell us about
19 that.

20 A: The Clinical Standards Committee is a committee
21 that's underneath the overall Board that we
22 delegate all clinical decision making to, that
23 the Board delegates clinical decision making
24 to.

25 Q: All right. Now, let's go over to 4(b), which



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ROA_0799

1 is a refreshingly short section. How about
2 reading that into the record for us. It says,
3 Telemedicine.

4 A: MUSC-H shall develop and provide telemedicine
5 service to the Sites, in consultation with each
6 Hospital, pursuant to terms to be set forth in
7 service agreements with each Hospital.

8 Q: Telemedicine is -- is that different or the
9 same thing as telehealth?

10 A: It's the same thing.

11 Q: And what does it mean?

12 A: It means delivering clinical services over --
13 not directly to the patient, face-to-face. It
14 could be over a computer; it could be over the
15 telephone; it could be over e-mail. There's a
16 variety of ways to deliver telemedicine
17 services.

18 Q: All right. What kind of telemedicine services
19 or telemedicine program do you have at MUSC
20 now?

21 A: MUSC has gotten heavily into telemedicine in
22 the last five to six years. I think we have
23 over 80 different types of programs right now.
24 When it comes to cancer care, we do tele-cancer
25 consultations remotely. We also do what we



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ROA_0800

1 call virtual tumor boards. And there's dietary
2 follow up, things like that.

3 Q: Will tel-medicine be a feature or be involved
4 at all in the Nexton site if it's ultimately
5 approved?

6 A: Yes. Just about everything we're doing anymore
7 heavily involves telemedicine.

8 Q: All right.

9 A: And that includes this project.

10 Q: Okay. The next paragraph I want you to look at
11 is 5(b), which is on the same page if you'll go
12 down a little bit.

13 **MR. WESTBROOK:** Dan, are you putting that up?

14 Q: It says Research. And, Dr. Cawley, once again,
15 would you just read the highlighted section
16 into the record, please, and comment on that
17 for us?

18 A: The parties shall jointly work to create a
19 research data bank, in compliance with all
20 applicable laws and regulations, including
21 without limitation support for oncology
22 clinical trials.

23 Q: All right. What is the significance of a
24 research data bank including without limitation
25 support for oncology clinical trials? What is



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ROA_0801

1 the significance of that to this project in
2 Nexton?

3 A: Well, once again, I'll go back to the mission
4 of MUSC. The mission of MUSC is not just to
5 provide clinical care, but also to do research
6 and to do education. So, it's important to us
7 that we wanted to be able to deliver research
8 capability at this site, not just clinical
9 care, and we wanted to put it in the agreement,
10 make it clear. And this is what this says.
11 The reason research is important to us, because
12 it's just -- it's part of our mission. And we
13 know that there can't be clinical care without
14 research into developing that -- those clinical
15 care pathways.

16 Q: All right. And let me ask you just a really
17 fundamental question. The reference there is
18 to oncology clinical trials. What are clinical
19 trials?

20 A: Clinical trials are the very end of research.
21 So, research starts with just people in a lab
22 maybe develop a drug or a therapy. And at the
23 very, very end before you can actually release
24 that out widely before the FDA approves it, you
25 must actually measure it in clinical trials.



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ROA_0802

1 That's what a clinical trial is. It actually
2 takes the final, final -- the final, final step
3 before something can be approved for use.

4 Q: All right. And I note that at the last line of
5 this paragraph there's a reference to the
6 development of a virtual tumor board. You
7 mentioned that term a moment ago. Remind us,
8 what is a virtual tumor board?

9 A: A tumor board is one component of what I would
10 call multi-disciplinary care. We know that
11 cancer care is done best when it's delivered by
12 a multi-disciplinary team. By that I mean that
13 the surgeon, the medical oncologist, the
14 radiation oncologist, the dietician, and the
15 social worker, all kinds of other people come
16 together to discuss the patient and what's the
17 best treatment. And that's done best in -- and
18 when these people all come together, they sit
19 in a room and they talk about the patient,
20 that's called euphemistically a tumor board.
21 And historically sometimes it's hard to get
22 everybody together. And by doing it virtually,
23 you can make sure everybody that needs to be
24 there is there.

25 Q: Okay.



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ROA_0803

1 A: Some may be in the room, some may be there via
2 video, et cetera.

3 Q: Okay. And so, you've been working with
4 Alliance now, you said for five or six years.
5 I asked you and you told us why you chose to
6 partner with Alliance. How is that partnership
7 been going for you?

8 A: I think the partnership has gone very well.
9 It's helped us on the financial side, it's also
10 helped us on the operational expertise side.
11 So, we're halfway through a ten-year contract
12 and I'm very satisfied with it.

13 Q: All right. Now, Dr. Cawley, let's focus on
14 this specific project a little bit in Nexton,
15 the radiation therapy project. What --
16 generally speaking as a -- from your role as a
17 CEO at MUSC Health, what impact did you expect
18 this to have on the community?

19 A: Well, the reason for doing this was, as I
20 stated earlier, was to improve access to the
21 patients that want to come to MUSC. So, the
22 main impact to me is that it improves access to
23 those patients that want to come and receive
24 our services.

25 Q: What impact on the providers?



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ROA_0804

- 1 A: At the MUSC level or other providers?
- 2 Q: Other providers.
- 3 A: I don't think it'll have any impact.
- 4 Q: Why do you say that?
- 5 A: I'm sorry?
- 6 Q: I'm sorry. Why do you say that? What's ...
- 7 A: Because we're building this to -- for access to
- 8 our patients. We don't plan on having any
- 9 additional doctors. So, any physicians related
- 10 to this that take care of these patients today
- 11 on the peninsula, they'll now take care of
- 12 patients in that area. So, I think the total
- 13 number will stay the same. And those patients
- 14 that want that better access will get that
- 15 better access, those patients that live closer
- 16 to that radiation treatment center.
- 17 Q: All right. Now, does MUSC have a policy or a
- 18 practice to discourage it's physicians from
- 19 making referrals outside of MUSC?
- 20 A: We do not.
- 21 Q: Has that ever been, to your knowledge a policy
- 22 -- since you've been at MUSC, a policy or
- 23 practice at MUSC?
- 24 A: It has never been a policy. I've worked in
- 25 many organizations and I would say it's best



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ROA_0805

1 not to require doctors to make certain
2 referrals to certain places. It's --
3 physicians feel impinged upon and will often
4 not obey that anyway, so it's -- to us it's
5 always about wherever they feel the best care
6 is provided. As physicians that's within
7 they're decision-making authority.

8 Q: All right. Well, if you don't discourage
9 referrals, let me ask you a question. Rather
10 than build your own radiation therapy center in
11 Nexton, have you considered encouraging your
12 physicians or incentivizing your physicians or
13 in some way to make referrals of radiation
14 therapy patients to Trident?

15 A: Well, we don't encourage or discourage to
16 others. We know that -- we know what
17 physicians want. And as a physician, I
18 understand many of those aspects. And what
19 physicians often want, just a few things, are
20 they want care continuity, they want to be able
21 to see the patient's full record. And I would
22 say the main way we encourage physicians to
23 make any referrals or for the most part use the
24 MUSC system, which overwhelmingly they do, is
25 to provide those things that we know are



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ROA_0806

1 important to them. And those are just some
2 examples. But there's other things they would
3 want as well and we provide those things. We
4 do not force them, require them, but we lay out
5 what we think is the best thing and what
6 physicians would want. And then usually almost
7 always I would say they stay, you know, in the
8 system.

9 Q: Have you worked at other systems or are you
10 familiar with other systems that's outside of
11 MUSC?

12 A: I have, yes.

13 Q: And what you described, I mean, how is -- how
14 would that -- how would you relate that to the
15 way your experience with other systems and how
16 other systems ...

17 A: I would say the majority of health systems
18 follow that same construct. It goes back to my
19 previous statement. When you begin to mandate
20 physicians, have to use certain specialists or
21 have to use certain places for their patients
22 to go, it just almost always ends up in some
23 kind of failure.

24 Q: All right.. The MUSC system of care, for lack
25 of a better -- I'm not sure if that's a good



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ROA_0807

1 phrase or not, but that's the phrase I'm going
2 to use for lack of a better one. Can you --
3 you've talked throughout your testimony so far
4 I think from time to time about various aspects
5 of the MUSC system of care. And I want to kind
6 of focus down on that a little bit more
7 specifically right now. So, you said that
8 there was an education component to that
9 system; is that right?

10 A: Yes.

11 Q: And can you be a little more specific? When
12 you say education component, what are you
13 talking about?

14 A: Well, when we build any place, any clinical
15 place, we always consider several things. So,
16 number one, we consider education. So, by that
17 we mean medical students, nursing students, you
18 know, if there's therapy there, maybe therapy
19 students, residents, fellows. That's a core of
20 who we are. We're -- part of our mission is to
21 teach the next generation. And if we weren't
22 providing that, we wouldn't be in line with our
23 mission. So, unlike many other health systems
24 that are just focusing on the health -- or the
25 clinical care, they're not worrying about any



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ROA_0808

1 education, they're not worrying about any
2 research. We worry about those things
3 extensively.

4 Q: All right. How does education related to
5 clinical care or does it?

6 A: Sure. It's intimately related. You can't do
7 -- you can't educate the next generation of
8 clinicians, whether that's doctors or nurses or
9 technicians, without them being -- without them
10 directly taking care of patients under the
11 supervision of a licensed mentor.

12 Q: All right. And this education component that
13 you're talking about, how does that relate to
14 the Nexton project, if that project is
15 approved?

16 A: Well, whenever you have to consider education,
17 you have to consider there needs to be a little
18 bit more space, there needs to be education
19 rooms. So, as we put together this radiation
20 treatment center, we've got all those things
21 we've considered, that we've added that -- that
22 if you're not a health system that's worried
23 about that, you wouldn't typically have those
24 kind of things.

25 Q: Now, will residents, med students that you



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ROA_0809

1 mentioned a moment -- a minute ago, what, if
2 any, involvement would they have at Nexton?

3 A: Yeah, they would have full involvement.

4 Q: Any different from their involvement at Nexton
5 than it would be, say, at, you know, the
6 Hollings Cancer Center downtown?

7 A: No.

8 Q: Okay. All right. What about -- you talked
9 some about the research component, tell us a
10 little more time -- or expand a little bit on
11 what you've said. What's the research
12 component of the MUSC system?

13 A: So, the research component, once again, is part
14 of our mission. And any time we're putting any
15 clinical service together, we're always worried
16 about the research component as well. So,
17 where that's important in cancer is mainly
18 around clinical trials. So, when we deliver
19 this clinical care, we need to make sure we
20 have the space for there to be clinical trial
21 coordinators, you know, somebody to come in and
22 talk to the patient, somebody to follow up with
23 the patient, always requires an extra space.
24 And in order to maintain our National Cancer
25 Center designation, which I talked about



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ROA_0810

1 earlier, we have to have a certain level of our
2 patients need to be enrolled in clinical
3 trials.

4 Q: All right. And the tumor boards that you
5 mentioned earlier, I don't know the answer to
6 this, you tell me, are tumor boards relate to
7 the research component or the clinical
8 component or ---

9 A: Well, the tumor boards are a nice -- are a nice
10 intersection of all three things. So, first
11 and foremost, I think anybody delivering
12 clinical care these days delivers cancer care
13 with the tumor board fashion. But for us, it's
14 a great education venue and it's also a great
15 research venue. So, there may be a discussion
16 there and somebody may say, you know what, that
17 patient would be a good participant in some
18 trial.

19 Q: Now, do you know offhand how many oncology
20 tumor boards MUSC has?

21 A: I think we're somewhere around 10 or 11.

22 Q: All right. Ten or 11? And would those tumor
23 boards -- what -- you know, there's specialists
24 and there's sub-specialists. And would the
25 tumor boards be organized around a speciality



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ROA_0811

1 or a sub-specialty or how would that be
2 organized?

3 A: Our tumor boards are organized around cancer --
4 particular cancers. So, we have a breast
5 cancer, we have a colon cancer, a lung cancer
6 tumor board. These are all separate tumor
7 boards. And the members of the tumor boards
8 tend to be physicians, nurses who specialize in
9 that. It could be radiation treatment doctors
10 or medical oncologists or surgeons. We're very
11 specialty driven. We firmly believe in that,
12 because we think it helps deliver the best
13 care.

14 Q: Do you have a general tumor board?

15 A: We do not have a general tumor board, not in
16 cancer.

17 Q: Okay. And I think you've mentioned the word --
18 or the term in your testimony multi-
19 disciplinary cancer treatment or cancer care or
20 cancer program, something like that. Multi-
21 disciplinary though. What do you mean by that?

22 A: Multi-disciplinary just means what it says.
23 You take the different disciplines, the
24 multiple disciplines that have specialized in
25 cancer care, doctors, nurses, social workers,



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ROA_0812

1 quality people, researchers, educators, and you
2 bring them all together, those multiple
3 disciplines, into a meeting. And that's what
4 the virtual tumor board is.

5 Q: Well, aside from the virtual tumor board, just
6 any tumor board you have in oncology at MUSC.
7 Do you know how many -- again, do you know
8 offhand how many oncology multi-disciplinary
9 cancer programs you have?

10 A: Well, they follow the tumor board. There's
11 probably -- I think there's ten or 11.

12 Q: All right. How are they distinct from the
13 tumor board or are they distinct?

14 A: It's -- the tumor board is just a small piece
15 of the larger care continuum.

16 Q: All right. Now, this project, this Nexton
17 project, how did it -- give us a little
18 history. How did it develop from a strategic
19 planning perspective?

20 A: Well, as I mentioned earlier, this follows --
21 this is just one aspect of looking at being
22 able to give to our patients better access. It
23 follows a 15-year plan where we've consistently
24 gotten off the peninsula and try to get closer
25 to where our patients are. This most current



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ROA_0813

1 iteration came out of our Board of Trustees
2 asking for a strategic plan, a five year plan.
3 So, this came out in 2011, 2012. And this
4 called for a cancer center on the north end.
5 Mainly driven by what we were hearing from
6 patients and what we were starting to see, that
7 more and more of our patients were coming from
8 this area.

9 Q: All right. And you were here for part of Ms.
10 Murdock's testimony earlier today weren't you?

11 A: Yes.

12 Q: All right. Do you recall Ms. Murdock
13 testifying about improved access -- the
14 significance of improved access for radiation
15 therapy patients?

16 A: Yes.

17 Q: And what is typically -- how often during a
18 week does a radiation patient -- therapy
19 patient have to go get radiation therapy?

20 A: Typically five days a week.

21 Q: All right. For how long typically?

22 A: You know, on the low end. Just a few days up
23 to until several weeks.

24 Q: Okay. And are these generally outpatient
25 procedures?



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ROA_0814

1 A: Yes.

2 Q: All right. So, as a physician, have you
3 treated cancer patients in your life?

4 A: Yes.

5 Q: And how do these -- what's your experience of
6 how patients' condition, physical condition, is
7 typically during the regimen of -- regimen not
8 regime -- of radiation therapy that they
9 receive?

10 A: They typically feel very poorly.

11 Q: Why is that?

12 A: It's an impact on the body. And typically
13 within a few days of starting to receive
14 radiation therapy they have very little energy.
15 They feel fatigued. And getting to the
16 radiation treatment center, you know, becomes
17 an issue.

18 Q: All right. What about -- how does the
19 chemotherapy relate, or just in terms of
20 timing, with the radiation therapy treatments?
21 Is you do one first, one later or are they at
22 the same time? How does that work?

23 A: It could be sequential. It could be one after
24 the other or one before the other. It could be
25 at the same time. I think many people are



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ROA_0815

1 familiar with chemo and what people feel like
2 with chemo.

3 Q: Remind us.---

4 A: Just, once again, very poor, no energy, no
5 appetite, not able to eat. People get the same
6 way with radiation therapy. And sometimes it's
7 harder with radiation therapy, because you're
8 going -- you got to be there every day.
9 Whereas chemo tends to be a two-to-three week
10 regimen. You go in one day and then you go
11 home for several weeks. So, in some ways it's
12 harder.

13 Q: All right.

14 MR. WESTBROOK: Dan, would you put up Exhibit --
15 MUSC Exhibit 46 on the screen, please?

16 (Respondent MUSC's Exhibit Number 46 was introduced
17 into the record at this time.)

18 Q: All right. This is -- got a lot of colors in
19 it. Dr. Cawley, do you recognize this little
20 map?

21 A: Yes.

22 Q: What is it?

23 A: It's a picture of the larger -- or a portion of
24 the larger Nexton development.

25 Q: All right. And let's see here, what do -- is



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ROA_0816

1 the --

2 **MR. WESTBROOK:** I think maybe, Dan, let's go to --
3 bear with me a minute.

4 Q: Okay. Let's -- okay, so look there.

5 **MR. WESTBROOK:** Dan, is --

6 Q: I was about to ask you where the proposed
7 community hospital is that you talked about for
8 MUSC. Is that an accurate ---

9 A: Yes, that is accurate.

10 Q: All right. And that's the one that is being
11 challenged right now at the ALC; is that
12 correct?

13 A: Yes.

14 Q: And what -- and let's --

15 **MR. WESTBROOK:** Dan, put up the --

16 Q: This little funny picture of a -- it looks like
17 a profile of linear accelerator? Is that what
18 that's supposed to be?

19 A: Yes, I assume so.

20 **MR. THOMAS:** We'll stipulate to that.

21 Q: Thank you. Thank you. Does that -- is that an
22 accurate ---

23 A: Yes.

24 Q: --- sort of depiction of their -- what am I
25 trying to say -- their relationship?



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ROA_0817

1 A: They're about two and a half miles apart.

2 Q: Okay. Now, they're two and a half miles apart.
3 Let me ask you this, why didn't you put the --
4 why didn't you co-locate? Why didn't you put
5 the radiation therapy center on the hospital
6 campus or inside the hospital?

7 A: Well, a couple of reasons. The first reason is
8 that at the time we were developing the plan
9 for this cancer center, the hospital was not
10 even on the radar at that time. The second
11 thing is, predominantly cancer care anymore is
12 ambulatory meaning outpatient. It does not
13 need to be on a hospital campus. And even
14 after we decided to build the hospital, we felt
15 there's no need to put that cancer center on
16 that campus.

17 Q: All right.

18 A: No sense moving it. It's closer to 26. We
19 think it's better access for patients and it's
20 not a problem.

21 Q: All right. Now let's look at -- let's go to
22 DHEC Exhibit 1, which is I believe the DHEC
23 record, and go to Bates page 96, which is a
24 part of the application, MUSC application.

25 **(Respondent DHEC's Exhibit Number 1 was introduced**



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ROA_0818

1 into the record at this time.)

2 Q: And, Dr. Cawley, I want you to look at sort of
3 the center there. There's a circle and then
4 there's a rectangle adjacent to each other.

5 MR. WESTBROOK: Thank you, Dan. You have culled
6 that out.

7 Q: So, you see there, the circle it says in the
8 box proposed cancer center. Does that look
9 familiar to you? Is that an accurate depiction
10 of ---

11 A: Yes.

12 Q: --- where that is? And so, let's talk about
13 that proposed cancer center for just a minute.
14 Do you know approximately, for the entire
15 building, how many square feet we're talking
16 about?

17 A: That's about 30,000 square feet.

18 Q: And how much of that square footage of that
19 entire building are you leasing for the
20 radiation therapy center?

21 A: Approximately 8,500 square feet.

22 Q: All right. And what about the rest of the
23 building? How much of the rest of the building
24 are you leasing?

25 A: For the cancer center?



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ROA_0819

1 Q: Yeah.

2 A: The overwhelming majority of it. But it won't
3 be radiation treatment. It would be for
4 medical oncology, physician offices related to
5 cancer, education space as I mentioned before,
6 research space as I mentioned before, infusion.

7 Q: All right. So, .85 ---

8 A: Any -- all cancer-related services.

9 Q: All right. Good. Thank you. All right. And
10 then adjacent to that building is a rectangle,
11 it says MOB 1. What is that?

12 A: That's a medical office building that is being
13 built by Palmetto Primary Care.

14 Q: And what is Palmetto Primary Care?

15 A: That is a large primary care special -- or
16 primary care group in Charleston.

17 Q: All right. And will you -- will MUSC -- does
18 MUSC intend to lease any space in that medical
19 office building?

20 A: Yes.

21 Q: Will that be oncology related or other kinds of
22 space or what? What will it be?

23 A: You know, that's not fully decided yet. It
24 could be oncology space. We're leasing
25 approximately 25,000 square feet. I think that



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ROA_0820

1 whole building's about 75 to 80,000 square
2 feet. We're taking about a third of it. And
3 we're looking now to decide what specialties we
4 will put in there.

5 Q: All right. And do you have any -- does MUSC
6 have any exclusivity rights in that MOB?

7 A: We do. I mean, it's very typical in medical
8 office buildings, particularly when you are
9 going to occupy a large space like we are, to
10 have exclusivity rights. And there are
11 multiple specialties that we have those rights
12 to -- meaning to put the specialty in first.
13 If we don't put the speciality in, there is a
14 time line on that. And I think it -- I'm not
15 sure exactly, but I think it's 18 to 24 months.
16 If we don't put that specialty in, we lose the
17 exclusivity.

18 Q: All right. Do you recall, Dr. Cawley,
19 testifying about the cancer building -- cancer
20 -- we were just talking about and the space
21 that you were leasing, do you recall testifying
22 about that in your deposition?

23 A: I don't recall exactly.

24 Q: All right. Let me just ask you this, the
25 testimony that you've given today, that you've



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ROA_0821

1 just given about the amount of square footage
2 that you're leasing and the uses for those --
3 for that square footage in that proposed cancer
4 center and the amount of square footage that
5 you're leasing in the MOB, you're -- are you
6 confident that those are correct?

7 A: Yes.

8 Q: All right. Thank you. Now, let's see here --
9 are you going to -- do you plan to be
10 recruiting any oncologists? You may have
11 already addressed this, but I'm not sure
12 whether you did or not. Are you planning on
13 recruiting any oncologists to this Berkeley-
14 Dorchester area?

15 A: We're -- I mean, we're not planning on
16 recruiting radiation oncologists or surgical
17 oncologists. We're always in the market -- or
18 have -- seems to be in the last 10 years, for
19 medical oncologists.

20 Q: Why is that?

21 A: There's a tremendous need for medical
22 oncologists, there's just simply not enough
23 being trained, and you're competing with every
24 community across the United States. And so,
25 we're constantly trying to bring more to



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ROA_0822

1 Charleston, as I believe just about every
2 health system in Charleston is doing as well.

3 Q: All right. Let's go to the same exhibit, DHEC
4 Exhibit 1, Bates page 98. And, Dr. Cawley, do
5 you recognize this from the CON application?

6 A: Yes.

7 Q: And it just says Radiation Oncology Suite Space
8 Program as of February 2017. I'm not going to
9 get you to read through all of that, but just
10 a few things in this. And you see the total at
11 the bottom there. How many square feet does it
12 total?

13 A: Eighty five hundred.

14 Q: And so, this is the radiation therapy center
15 space that you would be leasing in that
16 building?

17 A: Yes.

18 Q: All right. How many -- just read into the
19 record just a couple of things. How many --
20 just in the radiation therapy space, how many
21 offices do you have there? Second line?

22 A: Four.

23 Q: And a couple lines down, how many exam rooms?

24 A: Four.

25 Q: You've got an area -- well, you tell me. It



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ROA_0823

1 says does dosimetry/physics. What does that
2 refer to?

3 A: In radiation therapy it's very important that
4 you correctly dose the radiation that's being
5 given to the patient. And that is done by --
6 they'll dosimetrist as well as check by a
7 physicist. So, it's very -- that's the way
8 radiation treatment is, is deliver those
9 important components of radiation treatment.

10 Q: All right. And then a couple lines down from
11 there it says CT/Simulator plus Control. Why
12 do you have a CT machine there?

13 A: You have a CT machine mainly -- and you want
14 the same CT machine that you're measuring the
15 tumor and looking at and it's deeply connected
16 to how the radiation treatment is ultimately
17 delivered, which is what the accelerator is.
18 So, the CT simulator and the accelerator work
19 together.

20 Q: And the largest allocation of square footage is
21 the next line. It appears 2,000 square feet
22 Accelerator plus Control. Does that refer to
23 the linear accelerator?

24 A: Yeah, that's the machine that delivers the
25 radiation therapy.



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ROA_0824

- 1 Q: And what kind of room does it sit in?
- 2 A: It sits in a lead-lined room.
- 3 Q: Is that -- what do you normally refer to that
- 4 as, that room? Do you refer to it -- you know
- 5 the term vault?
- 6 A: Vault. Yes. Thank you. Yes.
- 7 Q: Good. You've probably got one of those in your
- 8 home, right?
- 9 A: I wish.
- 10 Q: Let's see. Now, let me ask you about the
- 11 linear accelerator. Do you -- I know you're
- 12 not a radiation oncologist, but you're --
- 13 ultimately Dr. Jenrette, who we've talked about
- 14 some today and we hope to see next week, he
- 15 ultimately reports to you, doesn't he, on this?
- 16 A: Yes.
- 17 Q: And what kind of linear accelerator -- do you
- 18 know what kind you're going to be getting?
- 19 A: Yes. We plan at this moment a Varian TrueBeam.
- 20 Q: All right. And, now, Dr. Cawley, ultimately
- 21 who is going to make the decision as to whether
- 22 that linear accelerator has stereotactic
- 23 capabilities or not?
- 24 A: That would be done between the clinicians who
- 25 take care of the patients ---



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ROA_0825

1 **MR. SUMMER:** I'm going to object just because in the
2 CON application they didn't say they were going
3 to do stereotactic. So, if this is -- I mean,
4 this is a change from what they were doing or
5 what they've applied for.

6 **THE COURT:** I think he's just asking about the
7 process.

8 **MR. WESTBROOK:** Well, I'm going to start with
9 process, but I'm going to go and I'm going to
10 ask him about the CON application, as a matter
11 of fact.

12 **MR. SUMMER:** So, is it -- are we now to understand
13 that they're going to provide stereotactic
14 therapy?

15 **MR. WESTBROOK:** I guess we'll find out depending on
16 what Dr. Cawley says.

17 **MR. SUMMER:** But that wasn't considered by the
18 Department.

19 **MR. WESTBROOK:** Your Honor, we can have this
20 discussion now, but there are changes that are
21 always made to CON applications. Some large
22 and some small. The -- if the change is over
23 a certain dollar amount, \$600,000, you have to
24 get a new CON. If the change is any other way,
25 it is what the Department deems to be a



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ROA_0826

1 substantial change, you would have to get a
2 CON. If it's not a substantial change, you
3 don't have to get another CON. Now, what I
4 will ask him about are the plans that he has
5 and MUSC has for stereotactic capabilities at
6 this Nexton project. What it says in the
7 application, and I can just tell you, I'm
8 paraphrasing here, it says this project will
9 not start off with any stereotactic
10 capabilities or something words to that effect,
11 but reserve the right to include them in the
12 future. That's what it says. So, I want to
13 ask him about that sentence, that language, and
14 what his intentions are.

15 **MR. SUMMER:** I guess my position would be, one, it
16 wasn't considered by the Department and, two,
17 he said if it's a material change, that means
18 that they need a new CON. Does that mean we
19 need to remand this case if that's what they
20 intend to do?

21 **THE COURT:** Well, we have to listen to the questions
22 and the answers to find out. And I'm going to
23 allow the questions.

24 **Q:** So, Dr. Cawley, are you familiar with what our
25 application says about stereotactic



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ROA_0827

1 capabilities with this linear accelerator?

2 A: Yes.

3 Q: All right. And did I accurately paraphrase ---

4 A: Yes.

5 Q: --- the language?

6 A: Yes. It says that -- it doesn't say we're
7 going to put it in, but we reserve the right.

8 Q: All right. And have you ---

9 A: Something to that effect, it may not be exactly
10 the right words.

11 Q: Yeah. Now, what are your current plans with
12 respect to stereotactic capabilities?

13 A: The current plans are to not do it. And
14 although I would say that this is something --
15 I think the likelihood of delivering
16 stereotactic on this machine in the future is
17 very high. All right. Why is that? Because
18 I think increasingly that's the way, for many
19 cases that's how it's delivered. We've talked
20 about this with Dr. Jenrette. And the
21 likelihood we would add stereotactic capability
22 to this machine in the future is -- you know,
23 I'm not going to say today it's definitely
24 going to happen, but I think the likelihood is
25 very high that it's going to be added at some



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ROA_0828

1 point. Unless the cost of stereotactic all of
2 a sudden goes the roof, it would not trigger
3 another CON.

4 Q: Right.

5 A: It would be below the threshold.

6 Q: All right. And do you -- would you consider
7 this -- do you know how the Department measures
8 substantial change?

9 A: I do not, other than the monetary thresholds.

10 Q: All right. And so, the -- if there's a --
11 regardless of the monetary thresholds of that
12 dollar amount, whether this is a substantial
13 change would be a issue for DHEC to decide; is
14 that correct?

15 A: I would assume so.

16 Q: All right. Or this Court, correct?

17 A: Absolutely.

18 Q: Okay. All right. Now, what about -- do you
19 know what RapidArc technology refers to?

20 A: In general. It helps the machine turn in a
21 certain way, so the patient doesn't have to be
22 turned.

23 Q: All right. Have you -- what is -- in
24 determining the type of technology, the type of
25 equipment that would go into the Nexton center,



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ROA_0829

1 what would the role of Dr. Jenrette be in that
2 decision-making process?

3 A: He would advocate for changes to the equipment,
4 modifications, anything -- this happens all the
5 time in all kinds of equipment. And
6 particularly when it takes a while to get the
7 equipment. And a while means anything over --
8 to me means anything over six months. Because
9 technology is changing so fast that equipment
10 that we may order today, six months from now
11 may be different. So ---

12 Q: When did you file this application, how long
13 ago?

14 A: Over two years ago.

15 Q: All right. And is it -- if Dr. Jenrette has a
16 suggestion related to technology or equipment
17 or upgrades or anything of that nature, you, as
18 the ultimate decision maker, how do you factor
19 his recommendation ---

20 A: As with all our physicians, that weighs in
21 extremely heavily.

22 Q: All right.

23 A: So -- and then, you know, we'd look at the
24 dollars and we combine those two things.

25 Q: So, at this point in time what are your plans



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ROA_0830

1 with respect to RapidArc technology?

2 A: I think the likely -- once again, I think the
3 likelihood of adding that technology, in
4 talking to Dr. Jenrette, and he'll be asked
5 about it next week, is pretty high.

6 Q: Okay. All right. What is an HDR machine?

7 A: It's a technology that can be put on to the --
8 this Varian TrueBeam, that allows you to do
9 brachytherapy.

10 Q: All right. Now, are you familiar -- I mean,
11 you're not a radiation oncologist -- do you --
12 you don't do
13 brachytherapy, do you?

14 A: No, I don't do it. You wouldn't want me doing
15 it, no.

16 Q: I understand. I understand that. And so,
17 you've never operated an HDR machine, have you?

18 A: I personally have not. I've seen them. I
19 understand what they are, but not have operated
20 one myself.

21 Q: Do you know if your CON application says
22 anything about an HDR?

23 A: I don't -- I believe it does not.

24 Q: All right. Once again, with respect to an HDR
25 machine, what are your current plans with



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ROA_0831

1 respect to an HDR machine. How would you
2 characterize the likelihood that you will
3 purchase one?

4 A: I would characterize it the same as what we've
5 already said -- what I've already said in
6 regards to the other technology. I talked to
7 Dr. Jenrette. He thinks it's something that
8 over time would be added. And to him time is
9 within not too long after we get this up and
10 running. And, once again, it would be the same
11 process. We would, you know, as long as it
12 doesn't trigger a CON issue or a major change
13 issue, you know, we would evaluate that. Weigh
14 what he's -- weigh his recommendation, look at
15 our finances, and make a decision from there.

16 Q: All right. Okay. I've asked you several
17 questions about the MUSC system and you've
18 talked about the various components of that
19 system. I think you probably addressed this in
20 part, but I think this is the first time I've
21 asked you the direct question here. Can you
22 describe for us what you believe is the overall
23 significance of MUSC Nexton being part of the
24 MUSC system of cancer care?

25 A: I think it's -- it brings the MUSC approach,



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ROA_0832

1 which, as I stated earlier, is really what we
2 call that tripartite approach. It's clinical
3 care in combination with education, meaning
4 we're going to teach people there how to use
5 the machine, how to give appropriate cancer
6 care, and we're going to bring research there
7 as well. We think that provides an optimal way
8 of taking care of patients.

9 **MR. WESTBROOK:** All right. If you can bear with me
10 just a second, Your Honor. No further
11 questions. Thank you. Answer any questions
12 that Mr. Summer may have for you.

13 **THE COURT:** Mr. Summer?

14 **MR. SUMMER:** Thank you, Your Honor.

15 **THE COURT:** Does anyone want to take a short break
16 before we start the Cross-Examination?

17 **MR. WESTBROOK:** It's probably a good idea.

18 **MR. SUMMER:** It's fine with me, I just ---

19 **MR. WESTBROOK:** No objection, Your Honor.

20 **DR. CAWLEY:** That'd be great. Two minutes would be
21 fine.

22 **THE COURT:** All right. We'll take a short break.
23 Five or six.

24 **(Off the Record)**

25 **THE COURT:** All right. Dr. Cawley, I think someone



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ROA_0833

1 wants to talk to you.

2 **MR. SUMMER:** Thank you, Your Honor.

3 **DR. CAWLEY - CROSS-EXAMINATION BY MR. SUMMER:**

4 Q: Dr. Cawley, my name's David Summer. I
5 represent Trident Health System. And I've just
6 got a few questions. The good news is that all
7 those red tags from your deposition have --
8 most of them have already been covered by your
9 counsel. So, I'm going to try to make short
10 shrift of this if I can. I do want to talk a
11 little bit -- you spent a good bit of time
12 talking about getting off the peninsula, some
13 of the projects that y'all have got underway.
14 And I'd like to walk through some of those and
15 talk about which ones are joint ventures and
16 which ones are not. And so, the first one I
17 want to talk about is, in North Charleston
18 you're doing basically which is an outpatient
19 peds campus; is that correct?

20 A: Correct.

21 Q: Can you tell me just a little bit about that
22 project just briefly?

23 A: That's a -- an ambulatory campus in general
24 that's going to open up in just a couple more
25 months. And it's a medical office building as



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ROA_0834

1 well as an ambulatory surgery center.

2 Q: Okay. And that's about a 50 million dollar
3 project?

4 A: Correct.

5 Q: Okay.

6 MR. WESTBROOK: I'm sorry to interrupt, but I need
7 to just say one thing and get it off my chest
8 and then I'm going to sit down, I promise.

9 THE COURT: Fine.

10 MR. WESTBROOK: I wold just like to -- because I
11 think I know where Mr. Summer is going to be
12 going with some of this. I want to just simply
13 not remake the argument, but renew the argument
14 that Mr. Dayhuff made a couple of times earlier
15 objecting to the information about the
16 financial stability of that. I know you've
17 already ruled on that, so that's why I'm not
18 going to argue it now unless you want me to.

19 THE COURT: I understand your position. I will --
20 your objection is noted for the record. I'm
21 going to allow the questions.

22 MR. WESTBROOK: I understand. Thank you.

23 Q: All right. And then you've got the Citadel
24 Mall project as well. That's West Ashley,
25 correct?



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ROA_0835

1 A: Correct.

2 Q: All right. And what is that project?

3 A: That's a medical office building and a
4 ambulatory surgery center.

5 Q: Okay. And that's about a 40 million dollar
6 project; is that correct?

7 A: Correct.

8 Q: Okay. You're also doing some projects down in
9 Beaufort County. You talked a good bit about
10 that in your Direct. One, I believe, is a
11 Beaufort County -- is it -- are you doing a
12 radiation therapy center down there?

13 A: We're doing a joint venture with Beaufort
14 Memorial, their radiation center -- operating
15 their radiation center.

16 Q: Okay. So, that's the community hospital down
17 there, right?

18 A: Correct.

19 Q: Okay. Do you know how much that project is?

20 A: I don't know the answer to that.

21 Q: Let's see. I might be able to help you out.
22 I might be able to give you something to
23 refresh your recollection. I'll move on to the
24 next one. Then you're also doing something
25 called a micro-hospital down in Beaufort



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ROA_0836

1 County?

2 A: Yes.

3 Q: What exactly is that?

4 A: That's a joint venture with Beaufort Memorial
5 Hospital on development of a new hospital in
6 Bluffton.

7 Q: And that's about a 45 million dollar project?

8 A: Total project, 50/50 joint venture.

9 Q: Okay. But about 45 million?

10 A: Correct.

11 Q: Okay. And again, you're joint venturing with
12 the community hospital there, right?

13 A: Right. So, we would be on the hook for half of
14 that.

15 Q: Okay. They were looking at this project, which
16 is about -- Berkeley County, which is about a
17 10 million dollar project, right?

18 A: Correct. And this was a joint venture, so we'd
19 be on the hook for about half of that.

20 Q: That's a joint venture with a for-profit
21 company, Alliance, correct?

22 A: Correct.

23 Q: That's not a joint venture with the local
24 community hospital is it?

25 A: Correct.



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ROA_0837

1 Q: Okay. You could have, though, couldn't you
2 have joint ventured with Trident on this? Did
3 you ever even ask them if they wanted to joint
4 venture alone?

5 A: We did not.

6 Q: Okay. Alliance is a for-profit company owned
7 by individuals; is that correct?

8 A: They're a for-profit company with stock on Wall
9 Street, so, you know, who owns it, I do not
10 know.

11 Q: Okay. So, your understanding it's publicly
12 traded?

13 A: Yes.

14 Q: Okay. Do you own any stock in Alliance?

15 A: I do not.

16 Q: Okay. The Berkeley County free-standing ED is
17 a project that you've got on the boards and
18 that's about a 13 million dollar project?

19 A: That is correct.

20 Q: Okay. Then you've got -- and you've announced
21 this, it's been in the news. Community Health
22 Systems out of Franklin, Tennessee is selling
23 a number of hospitals in South Carolina. And
24 when you complete your transaction, they will
25 have sold all of them. But you have, at least



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ROA_0838

1 under a letter of intent, Marion, Carolinas in
2 Florence; Chester in Chester, South Carolina;
3 Springs Memorial in Lancaster under contract;
4 is that correct?

5 A: That is correct.

6 Q: Okay. And when do you expect that deal to
7 close? And I know those things are moving
8 targets, but about?

9 A: Probably within the next 60 days.

10 Q: Okay. And what was the purchase price for
11 that?

12 A: That has not been announced yet, but likely in
13 the next 60 days that will be -- it'll be
14 announced. It's still under negotiation.

15 Q: Ballpark about 150 million dollars?

16 A: Give or take.

17 Q: Okay. Then the other project that is nearing
18 completion is the 385 million dollar new
19 children's hospital, correct?

20 A: Yes.

21 Q: Now, that's on the peninsula, right?

22 A: Yes.

23 Q: And that includes, in addition to the
24 children's hospital, I assume a pediatric
25 emergency room as well, right?



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ROA_0839

1 A: Yes.

2 Q: Okay.

3 A: Yes.

4 Q: The nature of radiation therapy is, is that --
5 and you've gone through this, so I'm going to
6 try to short pan this. But when you present as
7 a patient for that therapy, you're going to go
8 in, you'll have what they call that CT mapping
9 where they'll come in and decide what your
10 treatment plan's going to look like first
11 thing, right?

12 A: Yes.

13 Q: Then, based upon protocols, they'll either tell
14 you you're coming back five or 15 times or
15 whatever it is for the particular type of
16 cancer that you have and what they're trying to
17 do with that tumor and radiation therapy, fair
18 statement?

19 A: Correct.

20 Q: Okay. That's scheduled care; would you agree
21 with that?

22 A: Yes.

23 Q: Okay. A child going to an emergency room is
24 emergent care, correct?

25 A: Most of the time. Not always. Correct.



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ROA_0840

1 Q: Your children's hospital is going to be filled
2 with children that are in-patients, correct?

3 A: Correct.

4 Q: And their families are going to have to travel
5 from all over the State of South Carolina and
6 come into the peninsula for that care, correct?

7 A: Correct.

8 Q: Okay. You easily could have put that pediatric
9 hospital closer to 95 and up on 26 with much
10 greater accessibility to the people that you
11 serve; but you didn't do that, did you?

12 A: Correct. For very specific reasons.

13 Q: Would you agree with me it would have been much
14 more convenient for the majority of the
15 patients that you serve for that hospital not
16 to have been on the peninsula?

17 A: It would solve one problem; it would create
18 other problems. It would solve the access
19 problem. It would not solve -- it would be
20 significantly more expensive because our
21 children's hospital is actually a hospital
22 within a hospital and there are many things
23 that the children's hospital shares with the
24 adult hospital. And so, we'd have to replicate
25 all of those services. So, that probably would



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ROA_0841

1 have been closer to a 500 million dollar
2 hospital if we had to do that.

3 Q: But that care's not scheduled is it?

4 A: In the children's hospital?

5 Q: Correct. The vast majority of in-patient care
6 for children.

7 A: Well, I think children's a little bit different
8 than adult. What -- how much of that's
9 emergent; how much of that is scheduled. In
10 children there's more scheduled care than there
11 is emergent care. It's just the nature of they
12 need certain procedures, you got to set them up
13 to come in. So, it's not all emergent I would
14 say.

15 Q: But you agree it would have been more
16 convenient for terms of access for your
17 patients if that hospital would have been up on
18 I-26.

19 A: Once again, I would re-emphasize, yes, it would
20 have been better in terms of access; it would
21 not have been better in terms of many other
22 elements in our choices to make.

23 Q: Okay. Are there other projects that I've
24 failed to mention in terms of major capital
25 projects that you've got underway? How about



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ROA_0842

1 Berkeley Hospital?

2 A: Berkeley -- didn't you say the Berkeley
3 Hospital?

4 Q: That's a JV, right?

5 A: No, the Berkeley Hospital is not a joint
6 venture.

7 Q: So Beaufort is JV, Berkeley is not, and that's
8 a 325 million dollar project?

9 A: Right.

10 Q: Okay. And I think you testified in your
11 deposition that you anticipate using HUD
12 financing for that?

13 A: Yes.

14 Q: All right. I'm going to ask you to turn to
15 just a few documents that I want to make sure
16 that, one, that we refer to in the record, but
17 even more importantly that you acknowledge for
18 the record what they are. If you would -- and
19 I am in what is going to be a yellow book to
20 review. Do you see any yellow books up there?

21 A: Yeah. Volume one or two?

22 Q: We're going to be in number one and we're going
23 to be turning first to Trident Exhibit 16. And
24 I just want you to identify that document for
25 me.



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ROA_0843

1 (Petitioner's Exhibit Number 16 was introduced into
2 the record at this time.)

3 A: This looks like the front page of the financial
4 statements for the year ending June 30, 2017.

5 Q: Okay. And that's for what entity?

6 A: That's for the Medical University Hospital
7 Authority.

8 Q: Okay. So, that's just for the entity that runs
9 the clinical care, fair statement?

10 A: That runs a component of the clinical care.

11 Q: Okay. And I know it sounds like we're in the
12 Marine Corp, but you refer to this as MUHA,
13 right?

14 A: Yes, MUHA or I'll call it Hospital Authority.

15 Q: We'll just call it the Authority.

16 A: To be clear.

17 Q: The Authority is the Applicant in this case,
18 right?

19 A: Yes. That is correct.

20 Q: They're the ones that has submitted the
21 application for the linear accelerator. All
22 right. And so, to the best of your knowledge,
23 is that an accurate copy of the financials for
24 ending June 30th, 2017?

25 A: It appears to be.



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ROA_0844

1 Q: Okay. Let's do the same thing, turn over to
2 number 17. And what document is this?

3 **(Petitioner's Exhibit Number 17 was introduced into**
4 **the record at this time.)**

5 A: This appears to be the Authority financial
6 statements for the year ending June 30 of 2016.

7 Q: Okay. With the auditor's report, correct?

8 A: Correct.

9 Q: All right. Again, that's just for the
10 Authority, correct?

11 A: Correct.

12 Q: And then we turn over to Number 18, please,
13 sir.

14 **(Petitioner's Exhibit Number 18 was introduced into**
15 **the record at this time.)**

16 Q: Are you with me?

17 A: Yes.

18 Q: And 18 is what?

19 A: 18 appears to be the financial statements for
20 the Authority ending June 30 of 2015.

21 Q: Okay. And if you don't mind jumping over to
22 the other binder, number II, 37. This appears
23 to be an Interim Financial Statement, again
24 just for the Authority; is that correct?

25 A: Correct.



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ROA_0845

1 Q: Okay. Is KPMG still your auditor?

2 A: Yes.

3 Q: Have they completed their audit for '18?

4 A: Yes.

5 Q: Okay. As far as you know, are the numbers
6 substantially similar between the final audit
7 and these -- this document?

8 A: I don't recall the details, but I believe they
9 were roughly the same.

10 Q: Okay. Now, if you don't mind, what I'd like to
11 do is -- and I've showed this to your attorney
12 and I think he talked to you a little bit about
13 it before we started. But I went on the
14 internet and looked because I was having
15 trouble -- I'm a late-comer to the party. I
16 didn't take your deposition. And I was having
17 trouble understanding and we got a lot of
18 things cleaned up on Direct about various
19 entities.

20 **MR. SUMMER:** But can we put that up, please, ma'am.

21 Q: I'm going to put your org chart that is from
22 your website. When I say yours, it's from the
23 Medical University website. Let's see if we
24 can get that up. Apparently we can't put it
25 up. I'm going to ask you and then just --



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ROA_0846

1 there we go. If you don't mind, this is from
2 your website; is it not?

3 A: Yes.

4 Q: Okay. Let's go to that next page, please.

5 A: Okay.

6 Q: There we go. At the top we've got the Medical
7 University of South Carolina. And this
8 purports to show all of the organizations
9 that's under what you referred to as that
10 umbrella earlier; is that correct?

11 A: Correct. Correct.

12 Q: Okay. And so, underneath the University
13 itself, you've previously talked about the
14 Authority, that's over here, number one. And
15 this is helpful, I know that a number of these
16 entities are just not involved in what we're
17 doing so I'm not going to ask you about all of
18 them. But if you look at number one, it says
19 the Medical University Hospital Authority was
20 formed in June of 2000 to manage and operate
21 the hospitals and clinics of the University; is
22 that an accurate statement?

23 A: Correct.

24 Q: And that was by legislation passed by the
25 legislature, correct?



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ROA_0847

1 A: Correct.

2 Q: Okay. Next door to that, you see number two,
3 which is UMA, which I thing previously in your
4 slides you referred to MUSC Physicians as kind
5 of the trade name or brand name for UMA, fair
6 statement?

7 A: Correct.

8 Q: Okay. So, number two UMA is Universal Medical
9 -- University Medical Associates is a non-
10 profit corporation established to promote and
11 support the educational, medical, scientific,
12 and research purposes of the University; is
13 that accurate?

14 A: Yes.

15 Q: Okay. Great. And there are other companies on
16 here that I'm just not going to refer to,
17 because they're not at issue in the CON
18 application. And since they weren't considered
19 below, I'm not going to ask you any questions
20 about them. But one that was is MUSC Strategic
21 Ventures. And do you see the note number
22 seven?

23 A: Yes.

24 Q: It says MUSC Strategic Ventures was formed in
25 September of 2015 to allow affiliation with tax



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ROA_0848

1 exempt entities to support the missions and
2 programs of the Medical University of South
3 Carolina, UMA, and the Authority; is that
4 accurate?

5 A: Yes.

6 Q: Okay. Now, if you would, turn with me to the
7 CON application, which is Number 1 and it
8 should have it's own. --

9 **MR. SUMMER:** do you have any objection to me putting
10 that into evidence?

11 **MR. WESTBROOK:** I'm sorry, what?

12 **MR. SUMMER:** What we were just looking at?

13 **MR. WESTBROOK:** The org chart?

14 **MR. SUMMER:** Yeah.

15 **MR. WESTBROOK:** No...

16 **MR. SUMMER:** Okay. Could we please mark that as
17 Petitioner's Number 56?

18 **THE COURT:** Any objection to that?

19 **MR. WESTBROOK:** No, Your Honor.

20 **THE COURT:** That's admitted without objection.

21 **(Petitioner's Exhibit Number 56 was marked and**
22 **admitted into the record.)**

23 Q: So, now we're going to turn to the CON
24 application itself. And if we look at the very
25 -- have you got that?



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ROA_0849

1 A: What number?

2 Q: Hang on, I'm going to help you. It should be
3 in the DHEC's Trial Exhibit Number 1. So,
4 we're now looking at DHEC's Trial Exhibit
5 Number 1. And if we look at -- if we look at
6 the bottom page, and I think you may have to
7 turn a page, but it says, CON 1 on the bottom,
8 bottom right hand corner?

9 A: Yes.

10 Q: Okay. This is the application certificate.
11 And it states, the Applicant hereby certifies
12 that the information contained in this
13 Application, including all assurances and
14 attachments, are correct to the best of his
15 knowledge and belief. Do you see that
16 sentence?

17 A: Yes.

18 Q: Okay. And is that your signature?

19 A: Yes.

20 Q: And when you signed this, you were signing on
21 behalf of the Medical University Hospital
22 Authority; is that correct?

23 A: Correct.

24 Q: Okay. Next I want to take you back to the
25 yellow book, so we're going to go to



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ROA_0850

1 Petitioner's Number 14.

2 **(Petitioner's Exhibit Number 14 was introduced into**
3 **the record at this time.)**

4 Q: And that's going to be in yellow book number
5 one. All right. We're going to go to tab 14,
6 please. I think you would have referred to
7 this as a different exhibit, it's the same
8 document I believe. I just want to get you to
9 verify that. Is this the operating agreement
10 for MUSC Health Cancer Care Network, LLC?

11 A: Yes, it appears to be.

12 Q: Okay. And I think you've cleared up something
13 for me that I found incredibly confusing. When
14 you get to the last page, you sign this -- and
15 I'm going to look at page 39 of that document.
16 So, again, we are in Petitioners 14, Trident's
17 14, we're on the 39th page of that document,
18 which has a Bates label of MUSC57. Is that
19 your name and that your signature?

20 A: Yes.

21 Q: Okay. And you're signing it says as CEO of
22 MUSC Health, but your testimony is, is that was
23 the prior name for Ventures; is that correct?

24 A: Correct.

25 Q: So, when I look in this document and I go back



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ROA_0851

1 and it defines MUSC Health as a 501(c)(3)
2 company, that really now is known as Ventures;
3 is that accurate?

4 A: Correct.

5 Q: Okay. While you're looking there where you
6 signed this document, look over to the other
7 side and you can see Schedule -- it's either
8 going to be Schedule 1 or Schedule I. I assume
9 it's Schedule I, Roman Number I, which is
10 MUSC58. Do you see that Schedule?

11 A: Yes.

12 Q: Okay. And that is -- that denotes the members
13 in this LLC, correct?

14 A: Correct.

15 Q: And the members when it was organized on
16 January the 22nd of 2016 was Alliance Oncology,
17 LLC, 51 percent, correct?

18 A: Yes.

19 Q: And that's the for-profit entity, Alliance,
20 correct?

21 A: Correct. I assume so, yes.

22 Q: Okay. And MUSC Health is actually MUSC
23 Strategic Ventures?

24 A: Correct.

25 Q: Okay. So, the University's entity, MUSC Health



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ROA_0852

1 or Strategic Ventures, is a minority owner of
2 Network, correct?

3 A: Correct.

4 Q: Okay. Consequently, when we look at how the
5 Board is comprised, Alliance gets three Board
6 members in the Network and MUSC gets two; is
7 that correct?

8 A: Correct.

9 Q: Okay. Now, I believe you testified previously
10 that some of the great stuff you get out of
11 this alliance, for lack of a -- I don't mean to
12 make a pun, but -- one of the things you get is
13 access to capital, correct?

14 A: Yes.

15 Q: Okay. Because they're the ones who are buying
16 the equipment and everything that's going into
17 this facility, correct?

18 A: Correct.

19 Q: Okay.. The other advantage you have from a
20 financial standpoint in having that type of a
21 partner is you're taking that off of your
22 balance sheet; are you not?

23 A: Taking the 51 percent off?

24 Q: Well, the assets that are owned by Network are
25 not going to appear on your balance sheet, are



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ROA_0853

1 they?

2 A: Correct.

3 Q: Neither will their liabilities appear on your
4 balance sheet?

5 A: Correct. They'll be referred to though in
6 other -- not directly on the balance sheet, but
7 they'll be other notes attaching them.

8 Q: But, again, by giving you access to capital,
9 you've basically taken that off of your balance
10 sheet through this joint venture?

11 A: Yes.

12 Q: Okay. I'd like to go back to discussing --
13 there was a little bit of a discrepancy. And
14 I understand where you said 30,000 feet.
15 There's a lot of stuff you've got to remember.
16 And today your testimony is that the MOB at
17 Nexton that you're actually -- when I say you,
18 I'm referring to the Authority -- is actually
19 taking down about 25,000 square feet in that
20 building; is that accurate?

21 A: Correct.

22 Q: Okay. And 25,000 square feet's going to allow
23 you to put at least 25 doctors in that space;
24 would you agree with that?

25 A: Yeah, at least. Yeah.



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ROA_0854

1 Q: Okay. You do have exclusivity, based upon if
2 you put oncologists in there and nobody else
3 can, fair statement?

4 A: Correct.

5 Q: Okay. You're also leasing this from Palmetto
6 Primary Care; is that correct?

7 A: Correct.

8 Q: All right. And Palmetto Primary Care is an
9 extremely large physician practice; is it not?

10 A: Actually, I would -- let me correct that,
11 because I believe Palmetto Primary Care has
12 actually, that's changed hands, so the new
13 lease is not going to be with Palmetto Primary
14 Care, so ---

15 Q: But they have an interest in the building.

16 A: They have an interest in the building, but I
17 don't believe actually -- I think they're
18 selling that. So, I say that only because in
19 the last month a new -- or lease is being
20 negotiated with somebody else.

21 Q: Okay. Nevertheless, that's a project -- you
22 would agree with me that they're developing
23 that site, Palmetto Primary Care?

24 A: They're a -- they're a primary or a primary
25 partner in developing it, correct.



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ROA_0855

1 Q: They have over a hundred physicians in that
2 practice; do they not?

3 A: I don't know if it's physicians, but between --
4 I think between doctors and advance practice
5 providers, I think they -- I would say
6 clinicians is probably the better term.

7 Q: Okay. You would agree with me that most cancer
8 patients are going to emerge and be referred
9 into a system for care from a primary care
10 physician; are they not?

11 A: No, I wouldn't necessarily agree with that. I
12 don't think all patients go to primary care
13 doctors. You know, they show up at an ER and
14 be found to have a tumor and then they get
15 referred straight into oncology.

16 Q: This is a ritual we have to do. I apologize.
17 I'm going to hand you a copy of your
18 deposition. Do you remember giving a
19 deposition, ---

20 A: Yes.

21 Q: --- in this case? And that was about a month
22 ago; was it not?

23 A: Yes.

24 Q: Okay. Let me find my copy. Bear with me. Let
25 me turn your attention to -- the good news is



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ROA_0856

1 most of it's exhibits and not your testimony.
2 Turn, if you would, to page 89 of that
3 document. I'd like to start reading at number
4 -- at line 13. And I'll just ask the question.
5 And, again, I didn't take the deposition, it
6 was my partner. But I'm going to ask the
7 question. If you would just read your answer
8 at the time.

9 A: Okay. Go ahead.

10 Q: All right. Line 13, how do patients typically
11 get to an oncologist? What's the general path,
12 from an internal medicine perspective? And
13 your answer?

14 A: My answer is, generally, they're diagnosed by
15 somebody else, they're found to have a tumor or
16 something like that, and then they usually get
17 a biopsy, almost always it's an outpatient, and
18 then if cancer is determined, then they're
19 referred at that time.

20 Q: Question, so, typically, it might be a family
21 practice doctor or an internal medicine
22 physician who will identify that something is
23 off that needs to be investigated. Is that
24 fair?

25 A: My answer is, correct.



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ROA_0857

1 Q: If you turn to the next page, page 90.
2 Question, after some investigation, there will
3 be, if necessary, a referral to an oncologist.
4 Is that correct?

5 A: Correct.

6 Q: Okay. Next line 5. And typically, once a
7 primary care physician has made a referral,
8 does the patient typically go where the primary
9 care physician refers him or her to? Your
10 answer?

11 A: Generally.

12 Q: Okay. So, let's go back to Palmetto Primary
13 Care. They have a lot of family practice and
14 internists in that practice; do they not?

15 A: Yes, they do.

16 Q: Okay. And you're going to be in a business
17 relationship that they benefit from, correct?

18 A: I can't answer to how they benefit from us
19 taking a lease in their space.

20 Q: Okay. Are you going to refuse to take
21 referrals from Palmetto Primary Care?

22 A: No.

23 Q: Okay. Let's go back to that page with the
24 Nexton map where it has the primary care and
25 where the site is. I think it's in the CON



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ROA_0858

1 application. Ninety six in the CON
2 application. So, let's make sure I got you in
3 the right book again. If you want to, we can
4 just refer here. Do you remember going over
5 this with Mr. Westbrook in your Direct?

6 A: Yes.

7 Q: And looking at this. And the MOB that's going
8 to have -- that you'll have 25,000 square feet
9 -- when I say you, I mean MUSC -- is MOB 1
10 right there, correct?

11 A: Correct.

12 Q: Your proposed cancer center is going to be
13 right next door, correct?

14 A: Correct.

15 Q: All right. You're not going to move the linear
16 accelerator to the location of your new
17 hospital two and a half miles away; your
18 testimony is, you're going to keep it there,
19 correct?

20 A: Correct. That's the current plan, yes.

21 Q: Okay. In the Palmetto Primary Care
22 development, correct?

23 A: Once again, I just want to clarify that. I'm
24 not sure what prompted -- only because this was
25 all changed. I'm not sure what development



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ROA_0859

1 they have and what they don't have. But, yes,
2 Palmetto Primary Care has been a large impetus
3 of getting that going.

4 Q: Okay. And I believe your testimony was they're
5 still a partner in this development, correct?

6 A: Well, as far as I know. I'm not sure, because
7 we're in the midst of change.

8 Q: As far as you know, there's still a partner?

9 A: As far as I know.

10 Q: Talk to me a little bit about palliative care
11 and radiation therapy. You're a hospitalist,
12 you understand that, I assume. Correct?

13 A: Yes.

14 Q: All right. When do we use -- when would you
15 expect palliative care to be used in an
16 inpatient capacity?

17 A: When the patient has elected to proceed with
18 comfort measures are more important than what
19 we call curative measures.

20 Q: So, it's not infrequent that end-of-life
21 inpatient cancer patients receive radiation for
22 comfort care, correct?

23 A: I'd say that's unusual. It does happen, but
24 for the most part that's -- usually it's only
25 certain kinds of cancers, particularly like



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ROA_0860

1 spinal cord cancers. But for the most part
2 that is not, I would say, a palliative measure.

3 Q: Okay. But inpatients do receive radiation
4 therapy, correct?

5 A: Once again, unusual. Even down at MUSC where
6 we have complicated patients, not a lot of
7 patients get inpatient therapy.

8 Q: Okay. Dr. ---

9 A: Not a lot of inpatients get radiation therapy.

10 Q: Okay. But they do get palliative care?

11 A: Yes. There are some patients on the inpatients
12 side that get palliative care. More on the
13 outpatient side get palliative care than
14 inpatient care.

15 Q: You're going to build a 325 million dollar
16 hospital two and a half miles away and any
17 patient in that facility that needs radiation
18 therapy's going to have to be put in an
19 ambulance, taken over to this site, treated,
20 and then taken back to the hospital bed,
21 correct?

22 A: Potentially. I would say, once again, it's
23 very unusual for some -- for an inpatient to
24 require radiation treatment.

25 Q: Downtown your patients have access to radiation



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ROA_0861

1 therapy, your inpatients have access to
2 radiation therapy on site; do they not?

3 A: They do. It's technically in an outpatient
4 building, though.

5 Q: But as adjacent to the hospital; is it not?

6 A: It's adjacent to the hospital.

7 Q: You're not putting them in an ambulance to take
8 them to radiation therapy, are you?

9 A: Downtown? Depends on what building they're in.
10 If they're in the Ashley Tower, yes, they're
11 being put in an ambulance. If they're in the
12 University hospital, they are being wheeled
13 over.

14 Q: Okay.

15 **MR. SUMMER:** Bear with me, Your Honor. I'm trying
16 not to go over the things Mr. Westbrook did,
17 just to keep us moving.

18 Q: This thing about telemedicine, you know, my
19 experience in working with my oncology clients,
20 my radiation oncology clients is, is that the
21 physician is present during treatment. Is that
22 your understanding?

23 A: During radiation therapy?

24 Q: Uh-huh (affirmative response).

25 A: Yes.



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ROA_0862

1 Q: Okay. You're not suggesting that you're going
2 to use telemedicine for the treatment of
3 oncology patients in that center, are you?

4 A: No.

5 Q: Okay. That's just an added benefit, especially
6 for the MOB, correct?

7 A: Well, there's many other aspects of care
8 leading up to and after radiation treatment.
9 Just staying in radiation treatment there's
10 seeing the patient, there's consultation,
11 there's follow-up afterwards, so there's many
12 things that could be provided on a telemedicine
13 service.

14 Q: So, your doctors don't have to drive out there?

15 A: No. Predominantly it's so that patients don't
16 have to come to the center. I mean, they would
17 come to the center for the treatment itself,
18 but they could be followed up before or after
19 a treatment as well. So, they may not have to
20 come to the center for a follow-up that's not
21 radiation-based.

22 Q: They're still going to be in front of a screen
23 somewhere?

24 A: Yeah. Could be at their home.

25 Q: Okay. Once again, you don't have to drive the



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ROA_0863

1 physician out into the north area, you can
2 utilize telemedicine and let them stay
3 downtown?

4 A: Or increasingly what we're using, we're
5 combining telemedicine where the doctor's
6 seeing the patients. So, if there's a
7 physician seeing a patient, say, in MOB 1 right
8 there, they may see some patients live and they
9 may see some patients via telemedicine. So,
10 the benefit of telemedicine is more heavily
11 related to the patient not having to travel.

12 Q: Okay. You would agree with me that, to the
13 extent that a Certificate of Need is required
14 for any of the things you discussed on Direct
15 Examination that you would be required to go
16 and file a CON for, if it's required you're
17 going to have to do that, you would comply with
18 the law, correct?

19 A: I'm sorry. Which component?

20 Q: Let's talk about HDR, let's talk about
21 RapidArc, stereotactic.

22 A: If there's a requirement, either the treatment
23 itself or a monetary threshold, yes.

24 Q: Okay. And then from your perspective, you're
25 doing this project primarily for the



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ROA_0864

1 convenience of your patients. Would you agree
2 on that?

3 A: Yes.

4 Q: Okay. And you view access and convenience to
5 be synonymous; do you not?

6 A: They're very close, yes.

7 Q: Okay. You would agree with me that
8 stereotactic treatment has been available for
9 a number of years, correct?

10 A: Yes.

11 Q: So, when you applied in 2017, you could have
12 included that in your application.

13 A: Yes.

14 Q: Okay. Same for RapidArc, correct?

15 A: You know, I don't know the exact timeline when
16 RapidArc was available. But if it was
17 available then, we could, yes.

18 Q: HDR as well?

19 A: Same answer that I gave to RapidArc.

20 **MR. SUMMER:** Beg The Court's indulgence. I want to
21 thank you very much. Appreciate it. Answer
22 any questions your counsel may have.

23 **THE COURT:** Mr. Westbrook.

24 **MR. WESTBROOK:** Yes, sir.

25 **THE COURT:** Re-Direct, sir.



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ROA_0865

DR. CAWLEY - REDIRECT EXAMINATION BY MR. WESTBROOK:

Q: All right. Dr. Cawley, just a few really brief. All right. Now, Mr. Summer asked you some questions about Shawn Jenkins Children's Hospital, the new hospital that you're building down on the peninsula. Do you recall those?

A: Yes.

Q: Yeah. And there was a discussion about convenience and the choice to locate down on the peninsula as opposed to somewhere, I guess, closer to North Charleston. Do you recall those questions?

A: Yes.

Q: He also asked you some questions about pediatric centers that were in the works for MUSC. Do you recall those?

A: Yes.

Q: Are those inpatient or outpatient centers?

A: That's an outpatient center.

Q: All right. And it involves -- where is that located?

A: That's up in North Charleston.

Q: All right. And is -- what kinds of services do those -- involved in those peds?

A: That is outpatient services, you know, medical

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ROA_0866

1 office building and an ambulatory surgery
2 center.

3 Q: I'm sorry. What was the last thing you said?

4 A: Medical office building and an ambulatory
5 surgery center.

6 Q: Ambulatory surgery center?

7 A: Yeah.

8 Q: Okay. All right.

9 A: Those -- today in Charleston all of that, 100
10 percent, both ambulatory and inpatient, is on
11 the peninsula. And back when we were looking
12 at developing a new children's hospital, one of
13 the things that we made the decision on,
14 there's -- and convenience and access was a big
15 component of that. At the same time delivering
16 quality care in a cross-effective manner was
17 also a component. And we elected to actually
18 split the ambulatory and the inpatient
19 component, leaving the inpatient component
20 downtown for quality and monetary, fiscal
21 reasons, and moving the ambulatory component to
22 North Charleston, because it didn't affect the
23 quality, but we felt that it was better for
24 patients' access.

25 Q: All right. And ambulatory, does that



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ROA_0867

1 ambulatory peds center, does it have imaging
2 services as well?

3 A: Well, it's not open yet. It's going to open in
4 a couple month. Yes, it well.

5 Q: And it -- Mr. Summer also asked you about
6 palliative care with inpatients and there were
7 some -- a few questions along that line. I
8 just want to -- one of his questions had to do
9 with end-of-life cancer patients and palliative
10 care. Maybe multiple, but I remember that
11 phrase being particularly used in one of his
12 questions. My question to you is, would end-
13 of-life cancer patients more or less likely be
14 in a hospital or a hospice?

15 A: I think the overwhelming majority would be
16 either at home or at a hospice.

17 Q: Okay. Telemedicine. The telemedicine, what
18 equipment is used for a telemedicine procedure?
19 Is it a -- what kind of equipment do you need?
20 You mentioned a screen. Anything else?

21 A: I mean, a regular computer screen and
22 increasingly a phone with video capability is
23 what's used.

24 Q: Now, right now, the office space that you're
25 planning on leasing in the Palmetto -- or what



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ROA_0868

1 used to be at least the Palmetto, may still be
2 the Palmetto medical office building -- at this
3 point do you have definite plans to put
4 oncologists in there or what kind of services
5 are you going to -- doctors are you going to --
6 --

7 A: Well, we have not come to the final conclusion
8 of what we're going to put in there, so we're
9 actually working on that. We're not due to be
10 in there until the fall of twenty -- of this
11 year, 2019. And we haven't decided what
12 services to put up there yet.

13 Q: And you -- but you testified, as I recall
14 earlier, that for the -- that cancer center
15 building, the one -- that 8500 square feet of
16 which will be the radiation therapy, that
17 you're leasing the rest or most of the rest of
18 that building; is that correct?

19 A: Yes.

20 Q: And what kind of services did you say are going
21 to be in there?

22 A: All cancer-related services.

23 Q: So, the telemedicine, telephone and computer,
24 which building would that be in, the MOB or in
25 the cancer building?



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ROA_0869

1 A: Well, for cancer services, it'll be over there,
2 but it'll also be -- I mean, we're putting
3 telemedicine wherever we are, so it'll be in
4 both.

5 Q: All right. Okay. Good. All right. Now, at
6 the start of this Cross, Mr. Summer asked you
7 some questions about some other projects.

8 MR. WESTBROOK: And, again, I promise for the last
9 time, I just want to restate my objection. But
10 since he went there, I'm going to go there too
11 without waiving my previous objection, if
12 that's ---

13 THE COURT: Go ahead.

14 MR. WESTBROOK: --- all right with Your Honor.

15 Q: The North Charleston peds outpatient campus
16 that he asked you about that you and I were
17 just talking about, do you recall when that CON
18 was filed approximately? I certainly don't
19 want a date.

20 A: It's probably going back about five years.

21 Q: All right. So, that's been public knowledge
22 for about five years or so then?

23 A: It was filed in -- yes. Yeah, from when it was
24 filed, yes.

25 Q: All right. Mr. Summer asked you about the



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ROA_0870

1 Citadel Mall project as well, has a MOB and an
2 ASC in it, ambulatory surgery center. How long
3 has that been public knowledge?

4 A: A little less, probably about four years.

5 Q: All right. The free-standing ED, a free-
6 standing emergency department or ER that's up
7 in the next scenario that we're having a trial
8 about with Judge Robinson in -- before long,
9 when was that application filed, approximately?

10 A: A year and a half ago.

11 Q: All right. Now -- and, of course, the record
12 would speak for itself on that, whenever that
13 was filed. But that's your ---

14 A: Those are guesstimates, yes.

15 Q: Yeah.

16 A: Yes.

17 Q: Okay. And the Shawn Jenkins Hospital, the big
18 children's hospital downtown, the 385 million
19 dollar project, how long has that been
20 newsworthy or in the news?

21 A: At least five years.

22 **MR. WESTBROOK:** All right. If you could -- beg The
23 Court's indulgence for just a minute. No
24 further questions. Thank you, Dr. Cawley.

25 **DR. CAWLEY:** Thank you.



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ROA_0871

1 THE COURT: Dr. Cawley, you can try to escape if you
2 can.

3 DR. CAWLEY: Thank you, Judge.

4 THE COURT: We are now adjourned until probably 1:00
5 o'clock on Wednesday next. I say probably 1:00
6 o'clock. You might want to check with us. I
7 suspect we'll be done by 12:00. Starting at
8 10:00, we should be done by 12:00.

9 (Wednesday, January 16, 2019 ended at 7:00 p.m. and
10 reconvened on Wednesday, January 23, 2019 at 1:13
11 p.m.)

12 THE COURT: All right. We are reconvening in case
13 number 18-ALJ-07-0100. And we are -- maybe you
14 should tell me where we are. Is Dr. Jenrette
15 been taken care of?

16 MR. DAYHUFF: Dr. Jenrette is coming tomorrow.

17 THE COURT: He's coming tomorrow.

18 MR. DAYHUFF: Yeah. Unfortunately we couldn't have
19 him come today.

20 THE COURT: Right. I knew he had some patients
21 today, so.

22 MR. DAYHUFF: We're going to proceed with Mr. Levitt
23 today.

24 THE COURT: Okay. All right. Then Mr. Levitt.

25 MR. DAYHUFF: Mr. Levitt has already assumed the



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ROA_0872

1 position.

2 **THE COURT:** All right. We'll swear you in.

3 **COURT REPORTER:** Please state and spell your first
4 and last name.

5 **MR. LEVITT:** David Levitt, L-E-V-I-T-T.

6 **COURT REPORTER:** Is it Doctor?

7 **MR. LEVITT:** No.

8 **DAVID LEVITT,** having been duly sworn, testifies as
9 follows:

10 **MR. LEVITT - DIRECT EXAMINATION BY MR. DAYHUFF:**

11 Q: Good afternoon, Mr. Levitt.

12 A: Hello.

13 Q: Could you state your full name for the record,
14 please?

15 A: David Samuel Levitt.

16 Q: Mr. Levitt, where do you reside?

17 A: I live in Beaufort, South Carolina.

18 Q: And how long have you lived in Beaufort?

19 A: I split my time between Atlanta and Beaufort
20 for a number of years, but I'm now full time in
21 Beaufort for the last six or eight years.

22 Q: I understand that you're the health planner who
23 worked on MUSC's CON application for the linear
24 accelerator facility in the Nexton area.

25 A: I am.



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ROA_0873

1 Q: And I understand you have some health planning
2 opinions that you propose to offer in this
3 case.

4 A: I do.

5 Q: All right. Before we get to those opinions,
6 let's discuss your education and experience in
7 health planning. I understand you went to
8 Virginia Tech.

9 A: I have a bachelor's in science from Virginia
10 Tech, correct.

11 Q: And when did you graduate from Virginia Tech?

12 A: 1989.

13 Q: Did you attend graduate school?

14 A: I did. I went to George Washington University.
15 I got a master's in health administration with
16 a focus in planning and hospital
17 administration.

18 Q: All right. And what year did you complete that
19 graduate program?

20 A: I went through quickly, the didactic portion.
21 So, I finished that in a little over a year and
22 then I went on -- before they'll give you a
23 degree, you have to do a residency. And so I
24 did a one-year residency at a hospital and
25 ended up turning into just a three-month



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ROA_0874

1 residency that they then turned into an
2 administrative position and gave me the
3 departments that no one else wanted, so I was
4 in charge of all of the less-desirable
5 departments. I stayed there for about a year
6 and a half in total and left to start doing
7 consulting.

8 Q: All right. And the departments that you worked
9 in for the hospital system, was that doing
10 health planning or something else?

11 A: I did health planning. I did -- in Virginia
12 they call it COPNs, Certificate of Public Need.
13 So, I helped with the Certificate of Need
14 applications for the hospital and then also had
15 line manager responsibilities over in dietary,
16 housekeeping, maintenance, things that were
17 problematic.

18 Q: Good. Then I understood you to say you
19 transitioned into health planning and
20 consulting.

21 A: I did. I worked with consultants. And their
22 job looked a lot better than my job, so I
23 decided that that's what I wanted to do for the
24 next 30 years, so I left hospital
25 administration and went into healthcare



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ROA_0875

1 consulting.

2 Q: All right. And let's talk about the different
3 places that you've done your healthcare
4 consulting work.

5 A: So, I left Potomac Hospital in 1992 to go to
6 Atlanta to work at a firm called Fowler
7 Healthcare Affiliates. And Fowler Healthcare
8 Affiliates -- so, all the firms I've ever
9 worked for, except for a period of time, were
10 exclusively healthcare consulting. So, Fowler
11 Healthcare Affiliates was predominantly a post-
12 acute firm, so we did a lot of rehabilitation,
13 you know, medical rehabilitation, outpatient
14 services, skilled nursing care. Back then we
15 called it sub-acute care. A lot of those, sort
16 of, strategic planning studies. We also did
17 implementation. So, if a hospital was approved
18 to implement a rehab unit or a skilled nursing
19 unit, we went in and got those up and running,
20 worked policies and procedures and operational
21 aspects of it. I also did financial
22 feasibility studies related to those projects,
23 as well as others.

24 Q: And that was at Fowler?

25 A: That was at Fowler Healthcare. I stayed there



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ROA_0876

1 for about two years and we left -- a group of
2 us left. Basically at the time there was
3 probably 20 employees and 18 of us left and
4 started our own firm, Gill/Basano Consulting,
5 doing the same thing for the same clients and
6 additional clients. I did that for a very long
7 period of time. We sold a portion of the
8 company and bought it back, and sold the
9 company and bought it back. And then finally
10 sold the company for one last time to a couple
11 of different organizations. The last
12 organization I stayed with for about a year and
13 a half. I couldn't quite stick out the two
14 years and left and started Levitt Healthcare
15 Affiliates.

16 Q: All right. And Levitt Healthcare Affiliates,
17 you have offices in Beaufort and Atlanta; is
18 that right?

19 A: We have offices in Beaufort, Atlanta, and
20 Raleigh.

21 Q: All right. And what types of health planning
22 work do you do through your firm?

23 A: We do a lot of the same work I've been doing
24 since I started; strategic planning, financial
25 planning, financial feasibility studies,



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ROA_0877

1 Certificate of Need work is a large portion of
2 what we do, litigation support in both CON and
3 non CON matters, regulatory compliance, sort of
4 a full array of healthcare consulting.

5 Q: What type of clients do you serve?

6 A: Over the years we've served all sorts of
7 providers along the healthcare continuum; from
8 physician practices, ambulatory surgery
9 centers, skilled nursing facilities, long term
10 care companies, assisted living companies,
11 small rural hospitals, large academic medical
12 centers, multi-hospital systems. So, it's sort
13 of a full gamut.

14 Q: Can you give The Court a sense of the
15 geographic breadth of your consulting practice?

16 A: I personally have worked in 48 states. I've
17 done consulting in -- nationwide. I did a
18 couple of international projects. I did one in
19 Argentina and one in Japan. I have not done a
20 project in Alaska or one of the Dakotas, the
21 one that doesn't have Mount Rushmore. I think
22 North Dakota.

23 Q: North?

24 A: Yes.

25 Q: But those are on your bucket list?



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ROA_0878

1 A: They are.

2 Q: All right. So, let me just ask these, I guess,
3 in a bullet-point fashion. Your CON work,
4 let's focus on that, includes advising on
5 healthcare projects that require a CON?

6 A: Correct. I mean, the best engagement in my
7 mind is working with a client doing a
8 feasibility study for a service, identifying
9 it's a needed service, it's something they can
10 offer. The next step would be, in most states,
11 file a CON application to help them get that
12 service, get the approval to develop that
13 service.

14 Q: So, you're drafting and revising CON
15 applications?

16 A: Drafting and revising CON applications,
17 submitting it to the state, dealing with the
18 state, interacting with the state on behalf of
19 the client, obtaining an approval, moving
20 forward -- again, sort of the ultimate project
21 is soup to nuts. You do the strategy, the CON.
22 Once it's approved, you help them implement it.
23 And the satisfaction of knowing that there's a
24 new service out there that's met a need that
25 you helped identify.



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ROA_0879

1 Q: Now, this might be difficult to do, but
2 thinking back over your career in the private
3 consulting side, can you estimate for The Court
4 how many CON applications you've worked on,
5 drafted, revised, or otherwise analyzed?

6 A: I think the number is over a thousand now.

7 Q: All right. And let's focus on linear
8 accelerators. Can you estimate how many CON
9 applications you've worked on, drafted,
10 revised, otherwise analyzed related to linear
11 accelerator projects?

12 A: I've probably done 20 or 30, maybe more.

13 Q: And where your work is a matter of public
14 record, can you give us a sampling of the
15 clients in South Carolina you've assisted on
16 linac projects?

17 A: In South Carolina I would say at least a dozen
18 linac CON applications, including a number for
19 MUSC, a number for Tidelands -- what is now
20 Tidelands Health, which was Georgetown Hospital
21 System, McLeod in Florence, St. Francis in
22 Greenville, Spartanburg Regional. There's
23 probably others, but those are the ones that
24 come to mind.

25 Q: That's a fair sample. Have you been qualified



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ROA_0880

1 by courts to give expert health planning
2 testimony?

3 A: I have. I've been qualified as an expert in
4 South Carolina and other courts for -- as an
5 expert in healthcare planning and healthcare
6 finance.

7 Q: How about in the Administrative Law Court, have
8 you been qualified as an expert?

9 A: I have. In South Carolina I've testified in a
10 number of CON matters, over a dozen.

11 Q: When you're qualified in the South Carolina
12 Administrative Law Court, in what areas have
13 you been qualified?

14 A: Healthcare planning and healthcare finance.

15 Q: All total, how many years have you been working
16 in health planning?

17 A: I would say close to 30; 27, 28 years.

18 Q: So, you are rounding up?

19 A: I am rounding 27 or 28 up to 30.

20 Q: All right. Take a look at MUSC Exhibit 3 for
21 us, please. Can you identify that for the
22 record?

23 **(Respondent MUSC's Exhibit Number 3 was introduced**
24 **into the record at this time.)**

25 A: Yeah. That's actually an old resume, but it's



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ROA_0881

1 a resume. The only reason I know it's old, it
2 has the Atlanta address on there still.

3 Q: All right. Taking in consideration that it's
4 a little older, does it fairly and accurately
5 represent much of your education and health
6 planning expertise?

7 A: It did. It does. The only update would be to
8 take that address off and probably change some
9 of the numbers in there as far as years of
10 experience, number of clients, and things like
11 that.

12 **MOTION BY MR. DAYHUFF:**

13 **MR. DAYHUFF:** All right. At this time, Your Honor,
14 I'd ask The Court to qualify Mr. Levitt as an
15 expert in health planning and healthcare
16 finance.

17 **MR. THOMAS:** Without objection, Your Honor.

18 **THE COURT:** Without objection -- Ms. Biggers, you
19 don't object, do you?

20 **MS. BIGGERS:** No objection.

21 **THE COURT:** I'm going to try to work you in here.

22 Okay. Without objection, Mr. Levitt, you are
23 qualified as an expert.

24 **MR. DAYHUFF:** Thank you.

25 Q: Mr. Levitt, have you selected exhibits and



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ROA_0882

1 demonstrative exhibits that you have either
2 prepared or that were made at your direction
3 and have you ordered those exhibits and
4 demonstrative exhibits for purposes of your
5 testimony today?

6 A: I have.

7 Q: Will these exhibits and demonstrative exhibits
8 help you present and explain your health
9 planning opinions in this case?

10 A: That's my goal, yes.

11 Q: Excellent. All right.. Well, let's start with
12 DHEC Exhibit 1. That's the DHEC record. This
13 has already been entered into evidence. I'd
14 like you to identify this for the record.

15 A: This is the CON application for the project
16 that this case is about, the linear accelerator
17 to be placed at the Nexton location submitted
18 by MUSC on September -- on May 22nd, 2017.

19 Q: Let's look down at page three. And I want you
20 to identify the licensee.

21 A: So, the legal entity that operates the medical
22 center for MUSC is the Medical University
23 Hospital Authority, and that would be the
24 licensee for this location as well.

25 Q: MUHA.



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ROA_0883

1 A: MUHA.

2 Q: Okay. Let's look at six, please. Now, we
3 heard from Dr. Cawley last week that this
4 project is a cooperative collaborative project
5 involving MUSC and Alliance Oncology, LLC.
6 What is Alliance?

7 A: Alliance Oncology is a multinational
8 organization, national -- international, I
9 guess, organization that provides oncology
10 services and resources to partner organizations
11 through some of their subsidiaries. And they
12 assist in sort of business office, back office,
13 activities, like billing and collections and
14 information systems and things like that.

15 Q: From the health planning perspective, what
16 benefits, if any, will result from this
17 MUSC/Alliance partnership on this project?

18 A: Well, it provides access to a organization that
19 has the expertise in a specific product line
20 from a back office perspective versus the MUSC
21 experience from a clinical perspective. So,
22 Alliance Oncology helps with the business
23 operations and MUSC does the clinical
24 operations.

25 Q: All right. Before we leave this page, let's



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ROA_0884

1 look down at Building Owner Equity, LLC. What
2 role does Equity, LLC have in this project?

3 A: Equity, LLC is the organization that's actually
4 building the medical office building that this
5 is going to be housed in. So, this is not a
6 MUHA or MUHA project or Alliance Oncology or an
7 MUSC Cancer Center building. So, an unrelated
8 third party is building the building that we
9 are leasing ---

10 Q: What health planning significance, if any, is
11 there to having Equity, LLC involved?

12 A: Well, for CON purposes, we included all costs
13 in the cost section, so we -- a little less
14 than 10 million dollars total project cost from
15 a CON perspective. But Equity, LLC is going to
16 be incurring the cost of the land. Equity, LLC
17 is going to be incurring the cost of building
18 the building. Equity, LLC is incurring those
19 costs. So, they're in the project cost, but
20 the applicant isn't incurring those costs.

21 Q: I see. All right. Do you recall last week,
22 there was a line of questioning, a line of
23 Trident questioning, related to Alliance and
24 Alliance's 51 percent ownership interest. And
25 essentially I think the line of questioning



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ROA_0885

1 asserted that the MUSC Nexton linac facility
2 would really be an Alliance facility or
3 controlled by Alliance. Do you recall that?

4 A: I recall that question, yes.

5 Q: All right. And I think you have some exhibits
6 that you wanted us to put up on that topic.
7 And the first is Exhibit 5, MUSC Exhibit 5. If
8 you can you see that, can you identify that?

9 **(Respondent MUSC's Exhibit Number 5 was introduced**
10 **into the record at this time.)**

11 A: Yeah. So, this is the operating agreement.
12 It's an attachment to the CON application that
13 identifies the operating agreement for the LLC
14 MUSC Health Cancer Care Network that's going to
15 be the management entity that will manage the
16 Nexton location.

17 Q: And I think you have a few provisions you
18 wanted to draw to our attention.

19 **MR. DAYHUFF:** Let's go to the first one, Mr. Bupp.

20 Q: Talk to us about what's important.

21 A: So, this is the section that identifies the
22 complement for the Board of Managers of Board
23 of Directors, depending on how you -- the
24 nature of the organization, since it's an LLC,
25 this is the Board of Managers, but it's



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ROA_0886

1 basically the Board. And while it's blank,
2 because it hasn't been finalized I think, you
3 know, underneath those Alliance Board
4 Appointees and MUSC Board Appointees would be
5 normally some individuals' names. But the
6 paragraph above, 10.2(a), identifies the
7 complement. And it's a five-member board with
8 three from Alliance and two from MUSC.

9 Q: All right. So, Alliance is going to control
10 this entity?

11 A: Well, no, they just have a majority membership
12 in the board, not necessarily in the operations
13 of the organization.

14 Q: Let's look at the next provision you have for
15 us, 10.3. What's important here?

16 A: So, this is where it identifies that the
17 management agreement that they're -- they're
18 the non-clinical side. So, as I said, the
19 benefit of the Alliance Oncology alliance is
20 that the non-clinical expertise and resources
21 that Alliance brings is for the non-clinical
22 side. And that's what the management provision
23 there, 10.3(a), identifies.

24 Q: And is that what you described earlier as kind
25 of the back-office element of the project?



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ROA_0887

1 A: Yes.

2 Q: All right. Let's look at 10.4. All right.
3 Actions Requiring the Consent of a
4 Supermajority. What's important about this?

5 A: Yeah. So, this says that four members of the
6 Board have to agree to this, so -- of these
7 different elements of operating the facility or
8 the organization. So, this would prevent
9 Alliance's three board members from outvoting
10 MUSC on matters specifically identified under
11 10.4. You know, we've highlighted 10.4(e)
12 relocating the center, there would have to be
13 a supermajority vote. So, at least one of the
14 MUSC board members would have to agree that
15 moving it makes sense. And then on the next
16 page, what's pull that here, item (k), any
17 material change to the business, purpose or
18 mission of the corporation that would adversely
19 impact their tax-exempt status. So, the
20 mission of MUSC or MUHA would have to -- you
21 know, if we're changing something that would
22 impact the mission, it has to be done under a
23 supermajority vote.

24 Q: So, the Board that we saw in the earlier
25 provision, the five-member board that is in



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ROA_0888

1 control of non-clinical matters, that board's
2 authority is cabined by 10.4?

3 A: Correct.

4 Q: All right. You have one more provision to show
5 us, 10.5.

6 A: 10.5 shows the Clinical Standards Committee.
7 And this is how the clinical standards would be
8 developed. And you can see it says it's
9 consistent with the clinical standards of the
10 Hollings Cancer Center. So, this, I think,
11 really memorializes the concept that the
12 alliance between Alliance and MUHA is just as
13 I described, that Alliance brings the back
14 office business expertise and MUHA brings the
15 clinical expertise. And you can see the
16 committee that develops the standards for
17 clinical operations of it, it's consistent with
18 the Hollings Cancer Center organization and the
19 membership is three MUSC and two Alliance. So,
20 they recognize from a business perspective they
21 have a majority on the Board, but from a
22 clinical perspective, MUSC has majority on the
23 clinical standard.

24 Q: Understood.

25 MR. DAYHUFF: And you can take that down.



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ROA_0889

1 Q: Just a couple of concluding questions on this
2 topic. Did you hear Mr. Sullivan claim during
3 his testimony last week that MUSC and Alliance
4 partnering on this project was a bad thing from
5 the perspective of health planning?

6 A: No.

7 Q: Did he claim that this partnership made it such
8 that the CON application did not satisfy a
9 criterion?

10 A: He did not.

11 Q: All right. Let's move on to DHEC Exhibit 1.
12 That's CON 369. And you mentioned earlier we
13 submitted our CON application on May 2017.
14 Here we have a letter dated July 10, 2017.
15 Could you identify that?

16 A: This is the letter from DHEC that deems the
17 application complete.

18 Q: The deemed complete letter, correct?

19 A: Yes.

20 Q: Good. All right. And if you look further down
21 in the letter, it has a list. What is this
22 list?

23 A: This is a list of the criteria that would be
24 given -- the relative importance review
25 criteria by which the application would be



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ROA_0890

1 reviewed under.

2 Q: All right. Do you recall Ms. Murdock
3 testifying that she developed this list?

4 A: Yes.

5 Q: All right. And you heard her testimony that
6 DHEC staff, in her opinion, has the discretion
7 to vary from the list of most important project
8 review criteria set forth in the State Health
9 Plan for linac?

10 A: Yes. I heard her -- I heard her testimony and
11 that's been my experience as well.

12 Q: All right. Now, Mr. Sullivan offered some
13 testimony, I think, that he didn't understand
14 that a CON applicant or affected person had the
15 ability to request changes in the list that
16 appears in the deemed complete letter. Do you
17 recall that?

18 MR. THOMAS: Objection, Your Honor.
19 Mischaracterizes the testimony of Mr. Sullivan.
20 He did not say that. He didn't testify to
21 that. As I recall, he testified that he could
22 not remember a time when an applicant requested
23 that a project review criteria be added or
24 subtracted from the deemed complete letter and
25 the Department actually complied with the



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ROA_0891

1 request of the applicant or an opposing party.

2 That was the testimony.

3 Q: That was a fine question. Did you hear that?

4 A: I did.

5 Q: Did you recall Mr. Sullivan offering that
6 testimony?

7 A: Generally, yes.

8 Q: All right. What's been your experience with
9 respect to whether a list of criteria in a
10 deemed complete letter can be changed at the
11 request of an applicant or an affected party?

12 A: My experience has been that it can -- you can
13 request a change and DHEC has, in the past,
14 made changes to the list.

15 Q: All right. Now, let's look at the final
16 paragraph of this letter. What's the
17 significance of this paragraph?

18 A: So, this identifies the criteria and then says
19 that, if you want to submit any additional
20 information, you have 30 days to do that. So,
21 that would say that, if an applicant feels as
22 though the criteria should be different,
23 something should be added, something should be
24 deleted, they have 30 days to submit a letter
25 to DHEC to say that's the case, as do opposing



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ROA_0892

1 parties.

2 Q: All right. And we have Mr. Thomas' CC there
3 highlighted. What's the point?

4 A: That this letter was sent to he and whoever
5 Matt Hasbrouck is at HCA. So, they were aware
6 of the criteria in July.

7 Q: Did Trident make a request to add adverse
8 impact to this list of most important criteria
9 in the deemed complete letter?

10 A: They did not.

11 Q: Did they make any request to modify the list in
12 any way?

13 A: No.

14 Q: All right. Let's go to the State Health Plan.

15 **MR. DAYHUFF:** Joint Exhibit 5, Mr. Bupp, at page IX-
16 6.

17 Q: Now, what is this, Mr. Levitt?

18 A: This is the review criteria identified in the
19 Health Plan for the linear accelerator
20 projects.

21 Q: And I believe Ms. Murdock used some of these
22 criteria in her deemed complete letter.

23 A: She did. She didn't include them all, but she
24 included some.

25 Q: All right. And I hope I'm paraphrasing Mr.



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ROA_0893

1 Sullivan's testimony correctly here, but I'm
2 sure I will hear if I'm not. I believe he
3 offered some testimony about the sentence below
4 the project review criteria. I believe the
5 import was this sentence makes adverse impact
6 important in this case; do you recall something
7 along that line?

8 A: Yes.

9 Q: All right. Do you have any opinions about
10 that?

11 A: Yeah. It's not a review criteria. That's why
12 it doesn't have a number eight next to it.
13 It's a finding at the end of extra section in
14 the Health Plan. It's mandated by the statute.
15 The statute says you've got to have project
16 review criteria identified in the Health Plan
17 and you have to have a finding at the end of
18 each section of how accessibility will be
19 weighed against adverse effects.

20 Q: Is the adverse effects concept in that sentence
21 the same thing as the adverse impact project
22 review criteria?

23 A: No, it is not.

24 Q: How are they different?

25 A: Well, so adverse effects, you know, in planning



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ROA_0894

1 you have impact and then you have adverse
2 impact. And, you know, many projects would
3 impact other providers just by a new entrant
4 into the market or a new provider -- a provider
5 having new services. That's going to impact --
6 it could potentially impact other providers.
7 The question is, does it rise to the level of
8 being adverse. And that's different than the
9 adverse effects. And this one, in fact, says
10 adverse effects of duplication. So, what this
11 is saying is, if -- you should weigh improved
12 accessibility equally with duplication. It
13 doesn't say it should be weighed less, it
14 doesn't say it should be weighed more. And if
15 you go through the Health Plan, every section
16 has the same finding, that they should be
17 weighed equally. There's one section, home
18 health, that says it should -- improved
19 accessibility outweighs effects. The rest all
20 say they are weighed equally.

21 Q: In your experience has the DHEC staff ever
22 considered this sentence to make adverse impact
23 a most important criterion for a project?

24 A: No.

25 Q: All right. Let's look back at the complete



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ROA_0895

1 letter again. And what I'd like to do, Mr.
2 Levitt, is to work through your health planning
3 analysis kind of using the order of the
4 standards and the project review criteria in
5 the complete letter.

6 A: Okay.

7 Q: So, first up is Compliance with a Need Outlined
8 in the Plan. Let's go to Joint Exhibit 5, the
9 State Health Plan, page IX-4. Now, do you
10 recognize this? We're going to Standard 6,
11 jump to Standard 6.

12 A: I see that, yes.

13 Q: All right. Does Standard 6, radiotherapy
14 services, apply to the MUSC CON application?

15 A: No.

16 Q: Why not?

17 A: Because it's not a new radiotherapy service.
18 It's an expansion of an existing. So, Standard
19 6 is for a new provider. Standard 7 would be
20 for an expansion of existing provider.

21 Q: All right. And Roper -- our friends at Roper,
22 who used to be in this matter, did they apply
23 under 6?

24 A: They did.

25 Q: And does Standard 6 contain an adverse impact



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ROA_0896

1 element?

2 A: It does, so if you go to 6b -- so, 6a says
3 everybody has to be at over 80 percent for you
4 to be approved. And then it says and then you
5 must project that you'll perform a minimum of
6 50 percent of capacity on your new machine
7 without bringing the existing machines in the
8 service area below 80 percent. So, that's the
9 adverse impact. It says you've got to project
10 there's enough need for you to be half full
11 without harming the existing providers. And
12 harm is identified at taking them below 80
13 percent.

14 Q: All right. Let's look at Standard 7. You've
15 already told us, I think, that this is the one
16 that applies to MUSC's CON application?

17 A: It is because, as you can see, the first few
18 words, expansion of an existing service. We're
19 an existing service with five accelerators.
20 We're expanding it to six.

21 Q: All right. Does Standard 7 have an adverse
22 impact element in it?

23 A: It does not. It identifies that, if you're
24 over 80 percent for two years, then you've met
25 the capacity constraint threshold and you



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ROA_0897

1 should be afforded the opportunity to add
2 resources and you have to project that the
3 volume on the new machine would be at 50
4 percent. It doesn't give consideration or
5 effect to the volume or utilization of existing
6 providers.

7 Q: Well, what health planning rationale, if any,
8 exists for having an adverse impact element in
9 6, but not in 7?

10 A: Well, because 6 is for a new provider. So, the
11 question is, does a new provider need to come
12 into the market to serve patients? And if it
13 does, then it can only do that if it's not
14 going to negatively impact the existing
15 providers. Standard 7 says, are you full and
16 do you need additional resources? So, it
17 doesn't matter if you're going to -- it doesn't
18 matter what the capacity is in the market on
19 other providers or what their utilization is,
20 because you're full and you need more
21 resources.

22 Q: So, as part of your health planning analysis,
23 and I suppose in the CON application, did you
24 apply the 80 percent capacity and the 50
25 percent capacity referenced in Standard 7 to



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ROA_0898

1 the Nexton linac?

2 A: Yes.

3 Q: All right. Let's go to MUSC Exhibit 68.

4 **(Respondent MUSC's Exhibit Number 68 was introduced**
5 **into the record at this time.)**

6 Q: Now, this is the first figure that you asked us
7 to put up with respect to our project's
8 compliance with the 80 percent element in
9 Standard 7?

10 A: Correct.

11 Q: What does this slide demonstrate?

12 A: This is the slide from the CON application that
13 demonstrates that we were over 80 percent for
14 fiscal year 2015 and 2016 at the time of the
15 application.

16 Q: So, the 24,000 total capacity that's listed for
17 MUSC, where does that come from?

18 A: That comes from the State Health Plan. So, it
19 identifies that MUSC has three machines with
20 the capacity of 5,000 and two machines with a
21 capacity of 4,500 for a total of 24,000.

22 Q: And not to belabor this too much, I suppose,
23 but if the idea is to get to 80 percent, what
24 treatment volume would get MUSC the 80 percent?

25 A: Well, 19,200 would be exactly 80 percent.



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ROA_0899

1 Q: All right. And at least on this slide we are
2 showing at above 80 percent. All right.
3 Let's go to MUSC 9. At MUSC 9 can you tell
4 where that came from? It is at 553.

5 A: Yes. So, this is from the project review
6 presentation that I think was in September.
7 So, by that point in time -- you know, we
8 submitted the application in May. The JARs
9 hadn't been submitted yet. We had pulled the
10 data -- we had received the JAR form, but we
11 hadn't submitted it yet. We pulled the data,
12 so we knew the number. Then when the JAR was
13 submitted in, I think, July, the same numbers
14 are there, 19,221, so this -- really the only
15 difference is it goes from JAR data for 2015
16 and internal data for 2016 to JAR data for both
17 years.

18 Q: And the point here, again, is we're satisfying
19 the 80 percent threshold in Standard 7?

20 A: Correct.

21 Q: All right. But, alas, there's an error with
22 the JAR data; is that right?

23 A: There was an error in that 19221.

24 Q: All right. And who did we learn that there was
25 an error in the 19221?



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ROA_0900

1 A: During the discovery process when we pulled
2 volume by machine, we identified that there
3 were -- there was a discrepancy. And that
4 discrepancy -- there were two discrepancies.
5 The first discrepancy we identified was some
6 port films were included in that 19221.

7 Q: And what are port films, if you know?

8 A: Port films are the calibration. They turn the
9 machine on to calibrate it. And that was
10 included in there.

11 Q: Understood.

12 A: Versus an actual treatment. I mean, there's an
13 argument that that should be included, because
14 it affects the capacity of the machine. But
15 generally those are instructed to be excluded,
16 so those were taken out. We also identified a
17 number of treatments, I think the number was
18 six or eight treatments, that weren't in there
19 because we didn't have a machine identified.
20 So, since the machine, the treatment machine
21 was left blank, it didn't get into the number.
22 So, the bottom line was that that number
23 changed.

24 Q: All right. Let's go to the next slide you have
25 for us, which is the demonstrative,



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ROA_0901

1 demonstrative 28. And tell us what this slide
2 reflects.

3 A: So, these are the corrected numbers, based off
4 of -- you can see on the source; those are the
5 discovery documents where we pulled the
6 utilization by a machine. And for 2015 the
7 utilization was 19819 for a utilization rate of
8 82.58, if you take it out two decimal places.
9 And for 2016, 19,192 for a utilization of
10 79.97.

11 Q: Now, is it your health planning opinion that
12 the utilization reflected on this slide
13 satisfies the 80 percent threshold?

14 A: Yes.

15 Q: All right. And I think we have a DX, a
16 demonstrative exhibit, that outlines some of
17 the basis for that opinion. So, what I'd like
18 to do is just have you walk us through the
19 elements here of your demonstrative and explain
20 why you believe that we satisfy the 80 percent.

21 A: So, the first one -- I mean, obviously there's
22 no prohibition against rounding in Health Plan.
23 And you'll see later that, in fact, there is
24 rounding in the Health Plan. The 80 percent is
25 what's identified in the standard, Standard 7.



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ROA_0902

1 It says eight zero percent.

2 Q: I think we have a demonstrative on this
3 particular bullet point too.

4 **MR. DAYHUFF:** Dan, do we have DX 12?

5 A: Right. So, the standard says 80 percent of
6 capacity. It doesn't say 80.0 or 80.00 it says
7 80 percent. And in fiscal year 2016 we were at
8 79.97. Mr. Sullivan's Exhibit 11 said that
9 79.97 doesn't equal 80. If you round 79.97 to
10 one decimal place, it's 80.0. If you round it
11 to zero decimal places, it's 80. I think it
12 does comply with the standard and the practice
13 that DHEC of calculating numbers.

14 Q: All right...

15 **MR. DAYHUFF:** Dan, let's go back to demonstrative
16 32.

17 Q: All right. I think that's your second bullet
18 point, rounding necessary to reach 80 percent
19 and a third is de minimus.

20 A: Right. So, as you saw in that last one, it was
21 79.97. It's .03 percent or, you know, before
22 you turn it into a percent, it's .0003 from a
23 calculation away from the number. It's eight
24 treatments, which is less than half a patient.
25 Even if you accept -- and I think we'll talk



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ROA_0903

1 about it later, Mr. Sullivan said the average
2 number of treatments we do is 15, so it's less
3 than -- it's about half a patient. So, we're
4 not rounding saying, well, you know, we were 10
5 patients shorts, so we should round up. We're
6 eight treatments short over a course of a year.
7 That's less than one treatment a month.

8 Q: The fact that it's a half patient or a partial
9 patient, if we go with, I guess, Mr. Sullivan's
10 calculation of treatments per patient, why is
11 that important from a health planning
12 perspective?

13 A: Well, because when you're doing health planning
14 -- and I think we'll hit it on the next bullet
15 -- you have to round. Whenever you do math,
16 you have to round. Otherwise, you would have
17 multiple decimal places in every calculation.
18 Numbers wouldn't add up. Often you see that in
19 CON applications. Numbers don't add due to
20 rounding. And that's accepted. But if you
21 rounded, the numbers would add. And it depends
22 on when you round. So, the half a patient, you
23 know, you can't treat half a patient, so
24 generally in health planning you would -- not
25 only in health planning would you round, you



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ROA_0904

1 would truncate half a patient, so you would
2 round that up. So, because you can't treat
3 half of a patient or part of a patient, you
4 would generally round that up to the next full
5 patient. And you can see the third sub bullet
6 point under rounding. You know, the question
7 in Standard 7 is, are you at a level at which
8 you need additional resources? Are you over 80
9 percent? Have you treated 80 percent of your
10 capacity? And I think eight treatments short
11 of that is not meaningfully less busy. So,
12 it's not as thought, you know, Dr. Jenrette or
13 others at the center say, oh, you know, we
14 could treat about eight more patients and then
15 that's it, we're full. It's those eight
16 patients, less than one a month, for a year.
17 And so I don't think it's meaningfully less
18 than 80.000 or 79.97. And that actually goes
19 out further than the 7.

20 Q: Understood. Health planners utilize rounding.
21 I think I talked to Mr. Sullivan about that.
22 I don't know that that's a dispute. But what
23 is the health planning point here?

24 A: Yeah. So, like I said, whenever you do math,
25 you have to round because you just do. I



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ROA_0905

1 mean, even a simple calculation, two divided by
2 three; we have to round that, because it's a --
3 an infinite decimal that repeats. So, at some
4 point you got to round, otherwise you can't
5 keep doing the math. And that's what health
6 planners do, is they do a substantial amount of
7 math. So, generally you would do a, you know,
8 population analysis, you'd look at the
9 population growth rate. And if there were two
10 people in the service area and it changed to
11 three, what's that change? You'd have to round
12 that, otherwise you would have a figure that
13 has a lot of decimal places. And then the next
14 step is generally when you do a calculation,
15 you say -- for instance, if you were to apply
16 a use rate to a population, you take the use
17 rate, multiply it by population, and you get a
18 result. Sometimes it might be a whole number,
19 but more than often than not it's a fractional
20 number.

21 Q: Those are magic moments on your ---

22 A: They are.

23 Q: --- get the whole number?

24 A: Yeah. It's kind of like when you go to a
25 grocery store and it comes out to like \$20.



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ROA_0906

1 Q: You tell your family about it ---

2 A: Yeah. And so the calculations sometimes come
3 out to a whole number, but not very often.

4 Q: Right.

5 A: And so you have to round to show the numbers,
6 to do the math, to get a result. So, health
7 planners utilize all the time. And then the
8 last bullet talks about DHEC utilizing. So,
9 DHEC does, in fact, round because they are sort
10 of what I would call quasi health planners.

11 They analyze the work of health planners. They
12 too have to do calculations and math. And when
13 you do calculations at math, you have to round.

14 Q: All right. And apparently they round in both
15 Plan and in their decisions.

16 A: They do.

17 Q: And do you have an example or two of those you
18 could show us?

19 A: I do.

20 **MR. DAYHUFF:** Dan, can you go to demonstrative 19?

21 Q: So, where are we?

22 A: So, this is the 2015 Health Plan, the Plan
23 under which we are reviewed for the linear
24 accelerator. And this is the front part of the
25 Plan that does bed need calculations. So, the



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ROA_0907

1 example here is for Coastal Carolina Medical
2 Center in Jasper County. And I think what I
3 heard Mr. Sullivan say is, yeah, you know,
4 planners round, but not when it's important.
5 And I'm not sure what he thinks is important or
6 not important, but I think this is an important
7 example of rounding where DHEC did some
8 rounding and it has important consequences.

9 Q: An important example of where the rounding is
10 important?

11 A: Correct.

12 Q: All right. So, what is shown is there's a bed
13 need of one bed in Jasper County. The
14 provision says for a hospital or hospital beds
15 that, if there's a need of one or more, an
16 applicant can apply to add beds to the hospital
17 and they can add up to 50 beds if there's a bed
18 need of one. So, in this scenario Coastal
19 Carolina could submit an application, because
20 the bed need in the Plan demonstrates one bed
21 needed. So, more importantly, because Coastal
22 Carolina is the only hospital in Jasper County
23 -- Jasper County borders Georgia, often it
24 borders Beaufort County, which is a high-growth
25 area -- Jasper is also a high growth area,



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ROA_0908

1 those are the areas that are exposure for out-
2 of-state providers to come in. I was involved
3 in a Fort Mill application. I still am
4 involved. And so what could happen under this
5 calculation is St. Joe's/Candler, Memorial,
6 Tenet -- well, I guess Tenet owns the hospital
7 there, but anybody could come into the market
8 and apply for a 50-bed hospital, because
9 there's a bed need of one in the Plan. Well,
10 that one is rounded, and it's rounded not using
11 conventional rounding. So, you know, it's sort
12 of third-grade math, says if it's .5 or higher,
13 you round up. If it's .49 or lower, you round
14 down. So, if DHEC had not rounded their
15 calculations in the Plan, where they have the
16 projected ADC, projected average daily census,
17 of zero, eight, and 19 to total 27, then there
18 wouldn't be a bed need of one in the Plan.
19 There'd be a bed need of .22. And if you can't
20 round, even if you can't -- I guess if you
21 can't round, that's zero. So, that would
22 result in no bed need in Jasper County.
23 Coastal Carolina couldn't file for a CON.
24 Someone else couldn't file for a CON. And
25 that's a pretty important implication where

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ROA_0909

1 DHEC rounded.

2 Q: Okay. And you mentioned that this wasn't
3 conventional rounding. Is there a health
4 planning reason not to do conventional
5 rounding, i.e. if you've got a partial bed need
6 to take it to one?

7 A: Well, I think that falls under the category I
8 talked about earlier. If you have a partial
9 patient, you can't treat a partial patient, so
10 you round up. You can't have a partial bed, so
11 they rounded up.

12 Q: Got you. So, rounding in this case is the
13 difference between potentially a 50-bed
14 hospital and nothing.

15 A: Correct.

16 Q: All right. Do you have an example of rounding
17 that pertains to linac ---

18 A: I do.

19 Q: --- that we could look at?

20 A: Yes.

21 Q: Good.

22 **MR. DAYHUFF:** All right. Mr. Bupp.

23 A: So, same health plan, same section actually,
24 linear accelerators that we're applying under.
25 You know, I'm sure there are literally hundreds



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ROA_0910

1 of examples in the Health Plan of rounding.
2 So, this was the first one I came to in going
3 down the list, second planning area in
4 radiation oncology, Abbeville, Edgefield,
5 Greenwood, Laurens, McCormick, and Saluda,
6 those are the counties they group for that
7 service area. There's two linear accelerators
8 in that area. And they show the capacity to be
9 52.7. So, remember the Standard 6 says that a
10 new provider can only be approved if the
11 capacity is over 80 percent. So, they rounded.
12 The 52.7 is in fact 52.67. So, they rounded up
13 by .03 percent to get to the 52.7.

14 Q: Is that important rounding or not?

15 A: Well, it can be. So, this is their practice.
16 This is what they do. And if the scenario were
17 that MUSC was the only provider in the four-
18 county service area in 2016, their 79.97 would
19 be rounded up to 80 percent and then someone
20 could then apply for a new -- they could meet
21 Standard 6 because Standard 6 says for all the
22 existing providers over 80 percent. Well, if
23 MUSC were the only provider at 19,192
24 treatments, the Plan would show them at 80
25 percent capacity and others could apply.



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ROA_0911

1 Q: That rounding that you just described in a
2 hypothetical would be the difference between
3 need or not need in a service area?

4 A: Correct.

5 Q: Under, I suppose, 6; is that right?

6 A: Under Standard 6, correct.

7 Q: All right. Do you have an example from a
8 letter you'd like to show us?

9 A: I do.

10 Q: All right. Let's go there. All right. And we
11 pulled out some information from the letter.

12 A: Yeah.

13 Q: What letter is this? What project is it?

14 A: This is for Tidelands Health second linear
15 accelerator. It was the CON application letter
16 that I did, I was involved in. And you can see
17 that DHEC's analysis to Standard 7 -- again, so
18 it was an expansion of an existing provider.
19 They say they acknowledge that the JAR data
20 shows the use rate of 79 percent and 112
21 percent for '15 and '16 respectively. So,
22 they rounded to no decimal places in that. So,
23 the red numbers show the actual calculation
24 from the JAR utilization. And so in 2015
25 Tidelands was at 78.58714 et cetera.



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ROA_0912

1 Q: I'm sorry. How did you determine that that was
2 the actual use rate?

3 A: Well, it was easy. You divide the number of
4 treatments by their capacity and that's the
5 mathematical result.

6 Q: I see. Go ahead.

7 A: And so rather than say Tideland's was at 78.58,
8 or I guess it would be 78.59 using conventional
9 rounding or even 78.6, DHEC said it's at 79
10 percent, pretty close. And they said it was
11 112 percent, not 111.9 or even 111.99. So, in
12 their own calculation, if they were to take the
13 -- use the same mathematical calculations on
14 the 2016 JAR from MUSC, they would show it at
15 80 percent.

16 Q: Understood. So, the State Health Plan applies
17 rounding, need calculations, utilization
18 calculations, and probably other areas. And we
19 have an example of DHEC rounding in an approval
20 letter. Why does that mean we should apply
21 rounding to the -- or why should we not apply
22 the 80 percent in a mathematically precise
23 manner to the hundredth or thousandth decimal
24 point?

25 A: I think, you know, the CON review process has



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ROA_0913

1 an area of subjectivity. And I think, looking
2 at the materiality of the rounding, the reason
3 for the rounding, the context for the rounding,
4 I think all of those are important and I think
5 that's what we're asking to be done is, let's
6 view this in context and is it de minimus or is
7 it material.

8 Q: So, are you proposing a particular degree of
9 rounding that the Administrative Law Court
10 should bless and that DHEC staff should use
11 ever after for linac CON applications?

12 A: No. Just like every CON analysis, it's a
13 situation-by-situation case. And to the extent
14 that a good argument can be made for or against
15 rounding a number or using a number or looking
16 at an analysis in a certain way, I think that
17 should be considered.

18 Q: Wouldn't that create an un-level playing field
19 where certain applicants get to round and
20 others don't?

21 A: No. No, not at all. Because, again, it's up
22 to the applicant or the opposing party to
23 demonstrate why rounding may or may not make
24 sense or why looking at a certain aspect of a
25 project may or may not make sense. And all of



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ROA_0914

1 those are situational specific and have a set
2 of facts of their own. And I think it would
3 make it a level playing field because it is a
4 case-by-case basis.

5 Q: All right. Let's look at MUSC Exhibit 39 next.

6 All right. What does this reflect Mr. Levitt?

7 A: This shows the most recent four year fiscal
8 year utilization at MUSC. And it shows that
9 '15 and '16 are over 80 percent at 82.6 and
10 80.0.

11 Q: And that 80.0 was achieved through the rounding
12 we've been discussing?

13 A: It is. And I think it's important to make sure
14 that the Judge understands. I didn't type in
15 80.0. This is a calculation. So, using -- in
16 this case I used Excel, the number spreadsheet
17 program. That's what comes up. I didn't type
18 it in. And same thing if you used a calculator
19 and you set it to one decimal place, that's
20 what would come up, 80.0.

21 Q: All right. Now, I believe you looked at other
22 time periods of utilization data for MUSC's
23 linacs.

24 A: I did.

25 Q: All right.



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ROA_0915

1 MR. DAYHUFF: Let's go to MUSC Exhibit 40, Mr. Bupp.
2 (Respondent MUSC's Exhibit Number 40 was introduced
3 into the record at this time.)

4 Q: Tell us -- we pulled it out. It looks like we
5 had treatments and capacity, but tell us what's
6 important and what this slide demonstrates.

7 A: So, this is looking at utilization by calendar
8 year. This is the most recent data available,
9 hot off the presses. Calendar year '18 ended
10 23 days ago, so calendar year '18 showed 19,318
11 treatments for an occupancy of 80.5 percent.
12 Calendar year '17 showed 19,679 treatments for
13 an occupancy of 82 percent.

14 Q: Let me ask you a question. Did you round here?

15 A: Yes. So, the 82.0 is actually 81.9958 and the
16 80.5 is actually 80.4917. And I guess I could
17 keep going, but I stopped at four decimal
18 places.

19 Q: Fair enough. Now, we heard from Ms. Murdock
20 that she believes it's appropriate for the ALC
21 to use calendar year here and now to measure
22 compliance with Standard 7, the 80 percent
23 threshold. Do you agree or disagree and then
24 why?

25 A: I agree, because this is the most recent



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ROA_0916

1 information available. It would seem
2 nonsensical not to consider it when the
3 standard says, are you full and do you need
4 another machine, and we demonstrated that we
5 were full, we needed another machine. And we
6 continue to demonstrate that we're full and we
7 need another machine.

8 Q: All right. I recall Mr. Sullivan disagreeing
9 and suggesting that the resolution here, or a
10 possible solution, is withdraw and re-file. Do
11 you have any thoughts on that?

12 A: Yeah. Well, I guess I have two thoughts.
13 First he did say that in his trial testimony.
14 In his deposition testimony he said you could
15 look at calendar year.

16 Q: We had a disagreement about what he meant
17 there, I think.

18 A: I'm under oath, so I don't recall, but I'll
19 accept your ---

20 Q: All right.

21 A: It was a week ago and it's hard to remember.

22 Q: I really thought I had.

23 A: The reason you should consider it, again, is
24 because ---

25 MR. THOMAS: I need to lodge a quick objection. I'm



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ROA_0917

1 sorry, Your Honor. I was writing something
2 down. I think both the counsel and the witness
3 are mischaracterizing Mr. Sullivan's testimony.
4 I think what he was talking about was the use
5 of calendar year in later time periods, not
6 necessarily the general use of calendar year,
7 if the application is submitted on May 22nd,
8 could you use a time period -- 12-month time
9 period from calendar year -- for calendar year
10 2016. So, I think that was the context, if I
11 recall it correctly. It's a little bit
12 different. I just want to clear that up for
13 the record.

14 **MR. DAYHUFF:** Yeah. I'm not here to re-litigate the
15 context of that deposition. We had the back-
16 and-forth with Mr. Sullivan and I thought he
17 said what he said. But I get it I get it, I
18 don't think Mr. Thomas' clarification is
19 necessary for this line of questioning.

20 **THE COURT:** Well, I guess I can go back and listen
21 to it. The Court has heard the objection. I
22 don't think it changes what Mr. Levitt is
23 saying.

24 **MR. THOMAS:** Thank you, Your Honor.

25 **Q:** Mr. Levitt, can you continue, so that ---



1 A: So, I think we moved on, hopefully, to why it
2 doesn't make sense to resubmit the application.

3 Q: Yes.

4 A: And why it doesn't make sense to resubmit the
5 application is because it's just a prolonged
6 delay with the same outcome. So ---

7 Q: Well, hold on. On the same outcome, I believe
8 Mr. Sullivan said to me that, if we had to pull
9 our CON application and re-file, there could be
10 a competing applicant, which would change the
11 results. Any thoughts about that?

12 A: Yeah. There can't be. He was mistaken. It's
13 impossible for there to be a competing
14 applicant because, again, we're applying under
15 Standard 7. Standard 7 is for an expansion of
16 an existing provider. It doesn't give effect
17 to any other providers in the market. It
18 doesn't give effect to any other applicants at
19 the same time, as evidenced by DHEC approving
20 Roper and MUSC at the same time. So, if
21 there's a need in the market, someone could
22 file for that. If we have an internal need
23 under Standard 7 for any additional resources,
24 we can file for that. But those two
25 applications aren't competing. And even if,



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ROA_0919

1 sort of the wild scenario, something happens at
2 Trident and they go gangbusters and they need
3 a fourth accelerator, they could file at the
4 exact same time we file for our sixth
5 accelerator and they still wouldn't be
6 competing.

7 Q: And in the alternative, if they were to not go
8 gangbusters, but the floor were to fall out,
9 what effect on our application?

10 A: Again, no effect, because we're applying based
11 on our utilization as an expansion to an
12 existing provider. We're not applying under
13 Standard 6, which has the adverse impact level.

14 Q: Now, I think I interrupted you. You were
15 describing, I think the delay that would ensue
16 as a result of the re-file. What, in your
17 experience, would we be looking at if we had to
18 re-file this application now?

19 A: Well, it would be a long delay. So, if we were
20 to file the application today and looking at
21 the two most recent calendar years we would
22 meet the 80 percent threshold, DHEC would
23 generally take about six months to issue a
24 decision. That decision would then be appealed
25 to the board, the DHEC board. That adds a



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ROA_0920

1 couple of months, several months. And then it
2 would be appealed to the ALJ. And then we'd
3 have to go to schedule a trial, do depositions,
4 do discovery. And so that could be a very long
5 period. So, you remember we submitted this
6 application in May of 2017 and it's January of
7 2019. That's an example of the delay.

8 Q: All right. I believe you also considered other
9 time periods for MUSC's utilization of linac.

10 A: I did.

11 Q: All right. Let's start with MUSC Exhibit 11.

12 **(Respondent MUSC's Exhibit Number 11 was introduced**
13 **into the record at this time.)**

14 Q: This is a little difficult to see on the
15 screen, but we'll just start here to try to
16 understand your methodology. So, tell us what
17 this is.

18 A: So, I went back to January of 2013, so starting
19 in that calendar year, and looked at monthly
20 utilization at MUSC and looked at occupancy.
21 So, this just assumes 24,000 divided by 12.

22 Q: You said occupancy -- utilization?

23 A: Utilization or occupancy, yes. So, this says
24 our capacity is 24,000. So, 24,000 divided by
25 12 gives you the monthly capacity. So, then



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ROA_0921

1 divide that by 1742 for January, says we were
2 87.1 percent of capacity for that month.

3 Q: Okay.

4 A: So, I did that from January of '13. I made
5 some estimates through December of 2018,
6 because at the time, November and December,
7 that's why it's highlighted in blue, weren't
8 available when I did this. They're not
9 available after the analysis. I just used --
10 I did placeholders in there for November and
11 December of 2018. I used the same volume in
12 November and December of 2017 as placeholders.
13 The actual numbers came in a little different.
14 I think November was a little higher and
15 December was a little lower. But we have those
16 in another exhibit. So, what I did was I went
17 through all of these months and I looked at, at
18 what point in time -- if you scroll down on
19 column D, column D is the first period,
20 December of 2013, where I had 12 months of
21 data. So, I said for the last 12 months,
22 January of '13 through December of '13, what
23 were we at capacity? We were at 78.6 percent
24 of capacity.

25 Q: So, you're at 78.6 percent of capacity looking



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ROA_0922

1 back.

2 A: Correct. So, for -- said another way, calendar
3 year '13 we were at 78.6 percent utilization.
4 So, then I did sort of a running average. So,
5 I kept moving that forward. Those 12 month --
6 those two 12-month period forward a month. So,
7 January of '14 we were at 77.7 percent
8 utilization for the 12 months ending in January
9 of '14, the 12 months ending in January of '15,
10 77.1, and I continued to do that to look and
11 see what -- how many times or what periods
12 would we have been over 80 percent utilized for
13 two consecutive 12-month periods.

14 Q: Okay. And what did your analysis reveal?

15 A: So, the analysis showed that there were 19
16 occasions over that time period where MUSC's
17 utilization was over 80 percent for two 12-
18 month periods, two consecutive 12-month
19 periods.

20 Q: And we're showing some of those now, but I
21 believe you also have a graphic representation
22 of this on work paper?

23 A: I do.

24 **MR. DAYHUFF:** All right. Mr. Bupp, if you could ...

25 Q: All right. So, what does this demonstrate?



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ROA_0923

1 A: So, this is sort of a first step in that
2 graphic. This shows by month the utilization.
3 The red line is the 80 percent threshold and
4 the blue line is each month their monthly
5 utilization. And what it shows is, you know,
6 all of the blue lines above the line when we're
7 over 80 percent. All of the blue lines below
8 the line are the months that we're under 80
9 percent. You can see we're pretty much
10 balancing around 80 percent because that's the
11 capacity constraint. It's hard to really
12 operate above it, but we've done it. And the
13 dips, the two dips -- I think it was October
14 '13, which show a couple of low dips, and then
15 I know the one in January of '17 is when
16 equipment was replaced. So, there were two
17 machines down on capacity in '17 -- '16 and
18 '17, so that's why the utilization is lower
19 there. But this sort of illustrates that, you
20 know, since 2013 the utilization at MUSC is
21 very well utilized. Remember we applied in
22 2015 to get another machine because we were
23 well utilized. We applied again in 2017 to try
24 to get another machine because we're well
25 utilized. And I think this illustrates that.

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ROA_0924

1 Q: Let's look at MUSC Exhibit 92.

2 (Respondent MUSC's Exhibit Number 92 was introduced
3 into the record at this time.)

4 A: 92 shows all those time periods that we could
5 have applied. So, if you -- my position, and
6 I believe DHEC's position, is it doesn't have
7 to be a JAR year for an expansion. It makes
8 sense for a new provider because that would
9 then create the level playing field. Everybody
10 knows what everyone's utilization is.
11 Everybody knows if you're over 80 percent and
12 is it time to apply for a new provider. You
13 don't have ---

14 Q: Take a moment and explain why JAR year is more
15 important for a new provider than a provider
16 seeking to expand.

17 A: Right. So, the JAR year is the only source of
18 data that you can have for all providers in a
19 market. So, that's why DHEC memorialized that
20 concept in the current Health Plan. They
21 changed it to say, under Standard 6, it has to
22 be the two most recent JAR data that shows over
23 80 percent utilization for a new provider to be
24 approved, because that's the only source of
25 data for everyone. For an expansion, no one's



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ROA_0925

1 data matters except for the provider that's
2 expanding. If they're full, they need
3 additional resources. They don't need to wait
4 until their fiscal year, which is what's
5 generally reported on the JAR. And I guess
6 sort of not to go too far on a tangent, but
7 that's not even a requirement. You can report
8 whatever 12 months you want on the JAR as long
9 as you identify on the JAR what 12 months it's
10 for. Most people do fiscal year, because it's
11 easier. But everyone has -- many providers
12 have different fiscal years. Some have fiscal
13 years ending in December. Some have fiscal
14 years ending in June. Some have fiscal years
15 ending in September. So, everyone has a
16 different fiscal year. So, even if you looked
17 at JAR data, it's really looking at different
18 time periods, but that's what you have to do,
19 based on the current regs -- or the State
20 Health Plan. But for an expansion, you don't
21 have to do that. And it doesn't make sense
22 that you would have to do that, because, you
23 know, the scenario would be a hospital has a
24 fiscal year that, say, ends in June like MUSC.
25 They -- if they're full in September or August,

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ROA_0926

1 they don't have to wait until, you know, 11
2 months, 10 months, nine months, to submit an
3 application to say, hey, we were full, but we
4 had to wait because we had to submit a JAR to
5 show the data. That just doesn't make any
6 sense.

7 Q: The State Health Plan language reflects that
8 difference, right?

9 A: The State Health Plan, they say specifically in
10 Standard 6 it has to be JAR data. In Standard
11 7 it does not say it has to be JAR data,
12 because they recognize it. So, they didn't
13 change Standard 6 to include the JAR data. And
14 my experience, specifically in linear
15 accelerator projects, is we've submitted
16 projects for a time period other than fiscal
17 year or calendar year for an expansion, because
18 they're full and they need the resources. It's
19 time to apply.

20 Q: All right.

21 A: So, what this shows is the 19 occasions under
22 which the MUSC could have applied, because they
23 meet the 80-percent threshold.

24 Q: Some of those 19 occasions are a long time ago,
25 right?



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ROA_0927

1 A: They are. So, there were a lot in '15 and '16.
2 And remember we had applied in '15 trying to
3 get another machine, telling the agency that we
4 were full and we needed another machine. This
5 demonstrates that. It was denied. So, we
6 submitted again in '17. And then you can see
7 there were two occasions in '17 during the CON
8 review cycle of this application where we were
9 over 80 percent for two consecutive 12-month
10 periods.

11 Q: So, we applied in May of 2017?

12 A: We applied in May of 2017. The project review
13 was in September. So, at that point, you know,
14 I guess in an appropriate world or in a
15 different world or an alternative universe, if
16 we had identified the JAR information had an
17 error in it and we were at 79.97, we still
18 would have said we think that meets the burden.
19 But if it doesn't, let's look at the most
20 recent data. And the most recent data would
21 have been September of 2017. We met it the
22 month before. Let's look at that. August of
23 '17 we met it. So, had DHEC asked for more
24 recent utilization, we would have met it. And
25 then the last sort of grouping, July through



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ROA_0928

1 December, is the last six months of 2018, which
2 is now. So, under the last six months we have
3 been over 80 percent for each of the last two
4 years.

5 Q: Let me understand this. How are you proposing
6 that this data, these 24-month periods, be used
7 in the health planning that we're doing now in
8 this case?

9 A: Yeah. So, I think what this shows is sort of
10 the totality of the utilization at MUSC, the
11 number of times we've exceeded the required
12 threshold identified in the Health Plan, the
13 number of times at which we should have been
14 approved for an additional application -- for
15 an additional accelerator. And so it's not as
16 though there was the two years where one of
17 them was 97.97 and you've got to round up,
18 because those are the only times that we can
19 demonstrate we were over 80 percent.

20 Q: Okay. I think we have a demonstrative that
21 recaps your opinion on the 80-percent
22 threshold. Why don't you walk us through this
23 in a similar fashion.

24 A: Sure. So, Standard 7, again, that's the one
25 that says existing providers over 80 percent



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ROA_0929

1 they can add another accelerator. You know,
2 fiscal year 2015 the JAR for 2015, the JAR for
3 2016, we were over 80 percent, the 79.97 rounds
4 to 80 percent. For calendar year '17 and '18,
5 the most recent two periods, were at 82 percent
6 and 80.5 percent. And then, as I talked about,
7 there were 19 occasions where we were over 80
8 percent from 2014 to 2018.

9 Q: Understood. Mr. Levitt, your opinions that we
10 exceed the threshold, for the reasons you just
11 told us, are based on our State Health Plan
12 assigned capacity of 24,000 treatments?

13 A: They are.

14 Q: All right. Well, I'm sure you've heard, Mr.
15 Sullivan has been busy increasing our total
16 capacity for linac. Let me just start with a
17 few important questions, I hope. Have you ever
18 seen DHEC staff modify a linear accelerator
19 provider's total State Health Plan linac
20 capacity during review of the CON application?

21 A: No, never.

22 Q: Have you ever seen the Administrative Law Court
23 modify a linac provider's State Health Plan
24 assigned capacity as part of a contested case
25 on a CON application?



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ROA_0930

1 A: No. As Ms. Murdock said, the only way to
2 change the capacity is through the health
3 planning process. The provider submits a
4 letter asking DHEC to change their capacity
5 based on a rationale and then it gets
6 incorporated into the Health Plan so that
7 everybody knows about it.

8 Q: Well, let's set aside your opinion and DHEC's
9 opinion that you can't change except through
10 the State Health Planning process. So, let's
11 say you could change. What effect -- or what
12 opinion do you have about how changing
13 capacities through the DHEC review process
14 through a contested case, how would that affect
15 health planning?

16 A: Yeah. So that would be the slippery slope,
17 uneven playing field that Mr. Sullivan talked
18 about. So, it would create chaos and you
19 couldn't do health planning. So, if you were
20 to change the capacity -- you know, if the
21 capacity at MUSC was raised, they say, well,
22 you didn't do SBRT, so you shouldn't have that
23 capacity, so it's much higher. Well, if that's
24 the case, well, then the Roper application
25 would never have been submitted. And if it



1 was, it wouldn't have been able to be approved,
2 because then the aggregate utilization in the
3 market wouldn't have been over 80 percent and
4 it couldn't have been approved. If you change
5 ---

6 Q: And aggregate utilization is from the Standard
7 6, that's the adverse impact element?

8 A: No. It's the first section where it says all
9 existing providers are over 80 percent.

10 Q: Okay. All right.

11 A: And if the capacity is higher, the utilization
12 is lower, so they would be under the 80
13 percent. And so that's just -- I mean, you
14 can't plan under that. So, then an applicant
15 says, well, based on the Health Plan, here's
16 the standard, here's the capacity. I'd have
17 that calculation we showed for Abbeville, 52
18 percent. If that's at over 80 percent, then
19 some would say, oh, great, there's need, we're
20 going to apply. And then DHEC says, well,
21 actually there's not need, because somebody
22 changed their capacity or we think they should
23 change their capacity or someone else thinks
24 they should change their capacity. You just
25 can't do that. And you can ask. You can write



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ROA_0932

1 a letter during the planning review process.
2 The Plan's developed at a minimum every two
3 years by law, often every year they update it.
4 And that process is DHEC issues a draft, CON
5 State Health Plan that has those numbers in
6 there. Someone can write a letter to say, I
7 don't think this number is right, I don't think
8 they were providing enough SBRT, I don't think
9 they should have a lower capacity, whatever the
10 argument is. DHEC considers it, presents it to
11 the Planning Committee. The Planning Committee
12 agrees or disagrees, and then the Plan becomes
13 final. And that's the document by which
14 everybody uses to do planning in the future,
15 until the next Plan comes out.

16 Q: All right. And let's look at Joint Exhibit 5,
17 the State Health Plan, 2015, Standard 7. You
18 asked us to pull this up and highlight this
19 language. What's the import here?

20 A: Yeah. So, the important part is the last line.
21 And I think in English it's called the aside
22 between the commas. As well as future capacity
23 calculations. So, what this says is, you apply
24 for a CON and you identify your capacity. And
25 right now you got three choices; you got 7,000,



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ROA_0933

1 5000, or 4500. And if you're approved under a
2 CON, then that's your capacity in the future.
3 So, that gets baked into the number in the
4 Health Plan. It gets used by everyone to
5 determine whether or not the existing providers
6 are over 80 percent. And it gets used for
7 other purposes. And it's -- as well as future
8 calculations. So, it's saying that's your
9 capacity until, through the health planning
10 process, it changes.

11 Q: All right. Let's go to Trident Exhibit 8. Do
12 you recognize this document?

13 A: Yes.

14 Q: So, this is a Sullivan analysis on capacity,
15 right?

16 A: It is.

17 Q: All right. And I asked Mr. Sullivan about
18 certain of our units and questioned him about
19 the capacity. I recall asking him about our
20 Varian 600CD and asking him whether he knew how
21 we got our capacity for that unit. Do you know
22 how we got the capacity for that Varian unit?

23 A: I do.

24 Q: All right. And I think you have some exhibits
25 for us. Joint Exhibit 2, page Roman Numeral



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ROA_0934

1 II-62.

2 (Joint Exhibit Number 2 was introduced into the
3 record at this time.)

4 Q: Now, what is this document?

5 A: So, this is the 2008 and 2009 Health Plan,
6 effective September of 2008.

7 Q: You have some elements of it highlighted?

8 A: Yeah. If you go to the Linear Accelerators
9 section. So, this was before they had changed
10 the standards to say, you know, if you do IMRT
11 and IGRT, you're at a capacity of 5,000. If
12 you do stereotactic, you have a capacity of
13 4500. And so what it says is, in addition, the
14 average treatment time for highly specialized
15 techniques such as total body irradiation or
16 for treating children is longer. Therefore,
17 these systems cannot treat as many patients per
18 day and a lower capacity of 4,000 treatments
19 per year, 16 patients per day, five days a
20 week, 50 weeks a year, is established for such
21 equipment. So, it's saying that total body
22 irradiation is a category for which you have
23 lower capacity.

24 Q: At that time it was 4,000.

25 A: At that time it was 4,000. And it goes on to



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ROA_0935

1 say, at this time, two of the linear
2 accelerators at MUSC, tomotherapy at
3 Spartanburg and Carolina Regional Cancer
4 Center, which is the 21st Century in Horry
5 County, are determined to meet this definition
6 and they're adjusted accordingly.

7 Q: What does that mean?

8 A: So, this was sort of the first and only
9 adjustment to the calculation. So, every other
10 accelerator in the state had a capacity of
11 7,000, except for these five, or four; two at
12 MUSC, Spartanburg and Carolina Regional,
13 because they were doing specialized treatment
14 that no one else was doing in the state.

15 Q: And these entities got that capacity through
16 what process?

17 A: Well, so it's a little hybrid. So, Carolina
18 and Spartanburg got it through this, through
19 the Health Plan. And one of the MUSC
20 accelerators got it through the Health Plan.
21 But that 600CD, we got that through a CON
22 application. So, we ---

23 Q: Is there a footnote to that?

24 A: There is. If you go to the inventory, you can
25 see MUSC has four accelerators and the footnote



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ROA_0936

1 seven says that we got a CON to move and
2 replace a linear accelerator to Mt. Pleasant in
3 2003. And then we also applied in 2005 to keep
4 the old 600CD for pediatric and time intensive
5 procedures. And it even identifies the old
6 unit. And that was in 2008. And here we are
7 ten years later, so I guess it's the really old
8 unit.

9 Q: Okay. All right. Well, what's the health
10 planning point here? Well, let's go to the
11 Joint Exhibit 3. I think there's one other
12 element of the kind of history you want to show
13 us.

14 **(Joint Exhibit Number 3 was introduced into the**
15 **record at this time.)**

16 Q: What is this document?

17 A: So, then in the 2010 Plan -- so, if a health
18 planner isn't involved in the process -- you
19 know, I am involved, I helped write that
20 language, I helped the Planning Committee
21 determine how to do that. If you're not
22 involved, then you come in and you see, I guess
23 -- I know Mr. Sullivan is involved in a lot of
24 this, but apparently he wasn't involved in this
25 -- you see the capacity in the Plan by region



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ROA_0937

1 and you can't figure out how to get there. If
2 you're not involved, you say, well, why did
3 they have a capacity of 59,000 in the
4 Charleston, Berkeley, Dorchester, Colleton
5 area? Because if they have nine machines at
6 7,000, that should be 63,000. That's not what
7 it says. Well, if you go to the 2011 Plan, if
8 you go to the language, it tells you, well,
9 here's why, because MUSC has three linear
10 accelerators at 5,000 and two at 4500. And it
11 goes on to explain the other ones too. So, if
12 you were to look at the Spartanburg planning
13 area, you'd say, well, this doesn't add up.
14 This isn't a multiple of 7,000. Well, why not?
15 Well, because Spartanburg has a capacity of
16 4500 on their tomo. And if you were to look at
17 Horry County, you'd say, well, this doesn't add
18 up to a multiple of 7,000. Well, that's
19 because the next sentence says, Carolina
20 Regional has a capacity of 5,000. And so this
21 is where it started to migrate. So, before it
22 was 4,000. Now it's 5,000 and 4500. And then
23 even the two tomotherapy units, there's not a
24 lot of consensus on, well, is it 4500 or is it
25 5,000? And I do work for Spartanburg Regional

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ROA_0938

1 and we submitted information to the Planning
2 Committee to say, it's not 5,000, it's 4500,
3 and they said okay. And Carolina Regional
4 Cancer Center said, no, we think it's 5,000.
5 So, they said, okay, that's what we'll give
6 you. So, these are the capacities that are in
7 the Plan that the Planning Committee accepted,
8 that DHEC accepted for future calculations.

9 Q: And I believe the Varian CD that we're
10 discussing now was moved by -- or proposed to
11 be moved from 5,000 to 7,000 by Mr. Sullivan?

12 A: That was what he supposed, assumed.

13 Q: So, what's the health planning point here?

14 A: Well, you can't change it, because we have a
15 specific CON application submitted in 2005 that
16 specifically said we want to keep this machine
17 to do total body irradiation and treat
18 children. It's a great machine for that. It's
19 an old machine. It's not good for much else.
20 So, we want a dedicated machine for that. We
21 received a CON application for that. And we
22 still operate that machine under that CON
23 application.

24 Q: All right. So, we get to keep that capacity.
25 If there's an affected party that doesn't think



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ROA_0939

1 we should have that capacity, what's the
2 remedy?

3 A: They write a letter to DHEC into the Planning
4 Committee and ask that it be changed.

5 Q: And has Trident done that?

6 A: They have done that. They wrote a letter ---

7 Q: On the Clinac?

8 A: I don't know if they specifically identified
9 the Clinac, but they wrote a letter -- Mr.
10 Gallati wrote a letter to DHEC saying -- when
11 it was time to update the Health Plan to say,
12 how come MUSC has different capacities than
13 everybody else? You should change it. And DHEC
14 said, no, there's a reason for it and we're
15 leaving it.

16 Q: I like when you surprise me. That's great.
17 All right. Let's look at Trident Exhibit 8.
18 And I believe the work papers. And let me have
19 you identify this, Mr. Levitt.

20 A: This is Mr. Sullivan's work paper where he
21 looked at our utilization by machine.

22 Q: All right. And I wanted to get your
23 observations here about this. So, the TB140,
24 is that our -- the MP, that's our Mr. Pleasant
25 linac?



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ROA_0940

- 1 A: Yeah. That's what the MP means.
- 2 Q: Good. Thank you. So, is this one of the units
3 that got its capacity increased, proposed to
4 have its capacity increased?
- 5 A: By Mr. Sullivan, yes.
- 6 Q: All right. And what is he doing there in that
7 column?
- 8 A: He's looking at the IMRT volumes and the SBRT
9 volumes and identified that, on that machine,
10 because they only did 20 SBRT treatments, he
11 rounded the percentage to zero and said that,
12 because they don't do a sufficient volume of
13 SBRT, the capacity should be changed.
- 14 Q: All right. I should have asked this question
15 earlier. Does the State Health Plan define
16 sufficient volume for purposes of SBRT scan?
- 17 A: No, they don't.
- 18 Q: All right. Let's look at TB41. Now, at least
19 my recollection is this one wasn't modified at
20 the time of his deposition, but alas it was
21 modified during trial.
- 22 A: Correct.
- 23 Q: Do you have any thoughts about that one?
- 24 A: Right. So, he came back at the trial and said
25 that they only did -- we only did 389 SBRT

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ROA_0941

1 treatments, about eight percent, which he also
2 rounded to no decimal places, and didn't think
3 that was sufficient volume to have a lower
4 capacity.

5 Q: All right. Let's look at Joint Exhibit 1, the
6 JAR 2015. I think I showed this to Mr.
7 Sullivan. But if I didn't, what did you have
8 us include this in the outline for?

9 A: Well, because what I wanted to do was look and
10 see what was Trident's volume, what was
11 Trident's SBRT volume, on their machines, to
12 determine what they thought was sufficient,
13 because they have a lower capacity on their
14 machine.

15 Q: What does 2015's JAR reflect?

16 A: Well, I guess before we get there, what I
17 wanted to do was I wanted to do that analysis
18 as part of my preparation for the hearing ---

19 Q: Right.

20 A: --- for the trial. But that data wasn't
21 provided by Trident. Trident said they
22 couldn't give us utilization by machine. So,
23 we gave them utilization by machine and that's
24 the analysis -- the data that Mr. Sullivan used
25 for analysis, but they told us they couldn't



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ROA_0942

1 give us that information. So, the proxy was
2 the JAR. So, let's see how many IMRT
3 treatments and stereotactic treatments they did
4 in total. Now, I won't know which machines
5 they did those on. I did learn through
6 depositions there are only like two machines.
7 So, it has to be one of the two machines, not
8 three machines, but they didn't report any in
9 2015.

10 Q: All right.

11 A: I'm sure they did some. They didn't report
12 any.

13 Q: So, that wasn't very informative.

14 A: It was not very informative.

15 Q: Let's go to the next JAR here.

16 A: So, this is the Trident JAR for 2016. If you
17 go to that same section that they did report
18 data for 2016, they reported 6641 IMRT
19 treatments. Again, we don't know if it's on
20 both machines. We know it's not on one machine
21 because one machine they're not using. We
22 don't know if that's on both machines that they
23 use or on one machine. And then the
24 stereotactic they reported 126. So, they
25 thought that our 300 was too small, but they're



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ROA_0943

1 only at 126.

2 Q: So, on our Varian TB41 we did 389 stereotactic
3 and that number was enough for Mr. Sullivan to
4 raise the capacity. And they did 126 between
5 two machines at Trident, SBRT.

6 A: Either on one or between two, yes.

7 Q: All right. Well, and I thought that was
8 important. But when I asked Mr. Sullivan about
9 it, he said, you know what, raise our capacity.
10 It should be raised.

11 A: Yeah.

12 Q: Do you have any expert opinions on that issue?

13 A: I do, because -- so, the machine that they have
14 the SBRT 4500 capacity on is the one they're
15 not using. So, that -- you know, if you want
16 to -- there's no bright-line definition for
17 sufficient volume. They wrote a letter to DHEC
18 saying, we have sufficient volume to have a
19 lower capacity on that machine. So, you know,
20 there's no bright-line definition to what
21 sufficient volume is for IMRT or stereotactic,
22 but I can tell you without a doubt zero is not
23 sufficient volume. So, they have a machine
24 that has a capacity of 4500. They have zero
25 treatments on it, any kind. So, that's not



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ROA_0944

1 sufficient volume to have a specialized -- a
2 capacity lower than 7,000.

3 Q: Let me take it one step back for a moment. If
4 we were to take Mr. Sullivan up on his offer to
5 raise the capacity of Trident's linac, or
6 linacs even, is that helpful from the
7 perspective of health planning?

8 A: No. Again, so that goes back to the whole
9 chaos. So, in the Health Plan it identifies
10 their capacity as 16,500; one machine at 7000,
11 one machine at 5000, one machine at 4500. So,
12 that's the basis by which everyone does
13 planning. That's the basis by which Roper
14 identified the capacity in the market was over
15 80 percent. That's by which someone else
16 coming into the market wants to apply. That's
17 the barometer or the yardstick that they have
18 to use. They can't go back and say, hey, they
19 didn't do it right. Let's change the capacity
20 and now the planning analysis is completely
21 different.

22 Q: So, if Trident or an affected person or DHEC
23 wants to change Trident's State Health Plan
24 assigned capacity, how should that be done?

25 A: Through the health planning process. So, you



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ROA_0945

1 would submit a letter saying that, you know, we
2 were in a trial and we found out that they
3 don't even use one of their machines, so that
4 capacity should be raised, you know, or
5 whatever other argument you'd like to make.
6 And DHEC would consider that and change the
7 Plan in the next Health Plan.

8 Q: All right. Let's go to MUSC Exhibit 9 on page
9 25. Now, I think there was some questioning
10 about whether perhaps Mr. Levitt, you were
11 living in a glass house with respect to these
12 capacities and if they should be changed or
13 not. And I think that line of questioning
14 arose from your position you took at project
15 review. Would you like to explain?

16 A: Yes. So, I think a couple of things to explain
17 here. So, first of all this is in the context
18 of everything we've been talking about. You
19 can't just change your capacity in the middle
20 of a review cycle or in the middle of any sort
21 of analysis. You have to do it through the
22 planning process. So, my criticism of Roper in
23 the project review meeting was that they
24 submitted a letter in December that said our --
25 we do 20 percent of our volume is IMRT and



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ROA_0946

1 IGRT. And therefore we should have a lower
2 capacity on our machines. So, they submitted
3 that in December. Then in -- you know, around
4 the same time we did, sometime in early 2017,
5 you know, four or five months later, they
6 submitted an application saying, we need
7 another machine because we have low capacity
8 and we're over-utilized. So, they did exactly
9 what I think is creating an uneven playing
10 field and chaos by saying our capacity is
11 lower. Now that we have a lower capacity,
12 we're full. Because we're full, we need another
13 machine. But that's the context of all of
14 this. And specifically what I said was, saying
15 that you have 20 percent capacity -- or 20
16 percent IMRT in a letter doesn't justify why
17 you should have lower capacity on a machine.
18 And you can see the sub-bullet there, it's
19 lower than the national average. So, if you're
20 doing lower than average, I don't know that
21 that's sufficient volume.

22 Q: All right.

23 A: So, I sort of had two issues with that.

24 Q: Well, let me make sure I understand. So, this
25 was a letter submitted before Roper sent in



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ROA_0947

1 their CON application.

2 A: Correct. They submitted it in December,
3 submitted in early '17.

4 Q: And did they get the benefit of the lower
5 capacity before the issuance of the next State
6 Health Plan?

7 A: Yeah. That was what they put in their CON
8 application for DHEC to consider, that this is
9 our new capacity and because of that we need
10 another machine and the market needs another
11 machine.

12 Q: That's the kind of changing of capacities
13 within a CON review process that you were
14 criticizing earlier?

15 A: Yes.

16 Q: And did Mr. Sullivan also criticize that?

17 A: He did.

18 Q: All right. And one other question, I think,
19 just for me. When you're talking about IMRT,
20 IGRT, is that the same thing as the
21 stereotactic basis that Mr. Sullivan was using

22 ---

23 A: No.

24 Q: --- to modify our capacity?

25 A: No.



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ROA_0948

1 Q: All right. So, different types of scans?

2 A: Correct.

3 Q: Okay. All right. You've got one more
4 demonstrative you asked us to put up on this
5 topic. It's DX 30. It's a letter from Trident
6 Health, July 25, 2012.

7 A: Right. So, this is where they -- this is
8 exactly what we said. So, you can see in the
9 subject line Comments Regarding Draft Health
10 Plan (sic). So, Mr. Gallati -- I believe this
11 letter is from Mr. Gallati -- wrote a letter to
12 Les Shelton, who at the time was in charge of
13 the Health Plan, saying that the draft Health
14 Plan shows us at 7,000. We think we should
15 have a capacity of 4500, because we're going to
16 do or we do do SBRT and SRS on our Synergy.

17 Q: Okay. And when did he ask for that to be
18 applied? Let's go to the end of the letter.

19 A: In the final Health Plan, the final -- so,
20 there was a draft out. He submitted a letter
21 saying I'd like you to change it to 4500 in the
22 next Health Plan. And then that's what would
23 be incorporated in the capacity for the market
24 and for all -- everyone to use.

25 Q: Okay. And what's the health planning



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ROA_0949

1 significance of the way in which this was done?

2 A: Well, so I think number one is that he
3 understands and complied with the concept of,
4 you've got to do it during the CON health
5 planning cycle. He submitted a letter during
6 that time to adjust his capacity. And DHEC
7 accepted that and changed their capacity. And
8 it's reflected in the Plan and it continues to
9 be reflected in the Plan today.

10 Q: Okay. Good. All right. Let's move on to
11 Joint Exhibit Number 5 at ---

12 A: Before we move off of that ---

13 Q: Sure.

14 A: --- I think it's important to point out in that
15 letter there is no volume identified. So, Mr.
16 Gallati doesn't say 20 percent of our
17 treatments are SRS, SBRT. It doesn't say 50
18 percent of our treatments. It doesn't even say
19 how many of his treatments are SRS or SBRT.
20 So, the whole question of what's the sufficient
21 volume, he apparently didn't know what it was,
22 but he wanted the lower capacity.

23 Q: Did the Health Plan at that time ---

24 MR. THOMAS: Your Honor, move to strike the
25 narrative that Mr. Levitt just gave to a



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ROA_0950

1 question that was not asked. You know, I think
2 it's Rule 611, I'd have to look at it again,
3 which would give you the ability to strike that
4 testimony, South Carolina Rules of Evidence.
5 You know, I'm fine with Mr. Dayhuff, of course,
6 asking questions and eliciting opinions from
7 his expert, but I'm not fine with dispositive
8 narrative, which is not appropriate in a Court
9 of Law. And that's exactly what he just did.
10 He wanted to say something and clearly they've
11 rehearsed this and what didn't get out and then
12 he remembered, oh, I'm supposed to say this,
13 but Mr. Dayhuff forgot to ask the question.
14 And that's not appropriate.

15 Q: What else is important about this letter that
16 you'd like to offer to us?

17 MR. THOMAS: Your Honor, again ---

18 THE COURT: He's moved to strike that testimony.

19 MR. DAYHUFF: I guess my reaction to that would be
20 this is unnecessary. This would just elicit a
21 question that I just offered, what else is
22 important about this? I think we can allow
23 this expert to offer his opinions about this
24 document without the formality of me going back
25 and doing that, but I'd be happy to, if that's



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ROA_0951

1 what The Court wants.

2 **MR. THOMAS:** What I'd like to address is the fact
3 that, you know, of course I've made the motion
4 to strike now and he now can say that, but he
5 would have never asked that question or
6 elicited that testimony. And he's not allowed
7 to talk to his witness when he gets off the
8 witness stand, so it's not like he could have
9 prompted him to do that. So that's fine. I'll
10 tell you what, Your Honor, this is the
11 compromise I'll make. I'm fine with this
12 happening now, but in the future I don't think
13 it's appropriate for Mr. Levitt to be doing
14 off-the-cuff narrative disposition in this
15 courtroom because he remembers something that
16 his lawyer doesn't.

17 **MR. DAYHUFF:** Yeah. I don't think we're that
18 restricted, Your Honor, with an expert witness
19 in CON health planning. The object of him
20 being on the stand is to offer all the opinions
21 he has. And if he wants to offer an additional
22 opinion and suggests that he should, I don't
23 see anything wrong with that. I just don't.
24 I think it's overly formalistic for this ---

25 **MR. THOMAS:** I guess maybe if I get the same leeway.



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ROA_0952

1 with my expert, Your Honor, on rebuttal, I can
2 ---

3 **THE COURT:** Well, I think we can allow that. I mean,
4 we're stretching a little bit here. And I
5 could inform Mr. Levitt that -- I heard you
6 refer to what was on somebody else's mind. So,
7 I just -- I think -- I hope you guys can play
8 nice with each other. And to the extent that
9 you need to remind me of what I can do and what
10 I can't do, I -- we can all get this done and
11 certainly you will have the opportunity in
12 preparing proposed orders to correct
13 overstatements. I would allow that to go both
14 ways..

15 **MR. THOMAS:** That's fine.

16 **MR. DAYHUFF:** Thank you.

17 **Q:** All right. Mr. Levitt, going back to where we
18 were, I suppose, with respect to the letter
19 that Trident's CEO sent to the State Health
20 Planning Committee or DHEC, any further health
21 planning comments regarding this letter?
22 That's a tough one, isn't it?

23 **A:** Yes.

24 **Q:** Okay. Go ahead..

25 **A:** So, this letter asks for an adjustment in the



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ROA_0953

1 capacity. It doesn't identify what the
2 sufficient volume is to justify that
3 adjustment.

4 Q: All right. And I think we learned earlier, but
5 I'll ask you, did the State Health Plan at this
6 time define what sufficient volume was for
7 purposes of SBRT?

8 A: No.

9 Q: So, what's the health planning point that
10 you're making about the lack of numbers in the
11 SBRT?

12 A: That there's not -- again, that there's not a
13 bright line definition of what's sufficient.
14 And if a provider feels as though they meet
15 that requirement, they submit a letter to DHEC
16 and DHEC either accepts or doesn't accept that.

17 Q: Understood. All right. Let's go to Joint
18 Exhibit 5, State Health Plan, IX-5. Now, we
19 are -- just to reset a little bit, we're
20 talking about the State Health Plan standards.
21 I believe we've talked about the 80 percent.
22 You've applied it for us, which takes us to the
23 next standard, 50 percent. So, what does the
24 50 percent threshold require?

25 A: That the applicant project 50 percent



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ROA_0954

1 utilization on the new machine within three
2 years of operation.

3 Q: All right. So, that's our Nexton linac. And
4 what capacity are we attempting to achieve 50
5 percent or more of?

6 A: Fifty percent of 5,000 because we're going to
7 be providing IMRT at this site.

8 Q: All right. Let's look at MUSC Exhibit 74. And
9 does this relate or address the utilization
10 projection, the 50 percent of Standard 7? And
11 if so, how?

12 A: It does. So, you can see the first line, the
13 Berkeley linac would be the Nexton linac.

14 Q: Okay.

15 A: You can see the projected utilization for '16,
16 '17, and '18 is zero, because it wasn't
17 expected to be operational. At that time we
18 thought we'd be open by 2019, you know, two
19 years, 2017 to 2019. But the first year shows
20 it about 3786. And on a 5,000 capacity, that's
21 76 percent. Going up to 3975 by the third full
22 year. And that's 80 percent utilization. So

23 ---

24 Q: Where do we get the 3786 from?

25 A: 3786 is -- so, that represents about 18 percent



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ROA_0955

1 of MUSC's total utilization. I think somewhere
2 along the lines. -- maybe Dr. Cawley or Mr.
3 Sullivan or somewhere, it's certainly in the
4 CON application. About 30 percent of the
5 patients come from that area. So, this
6 represents about two-thirds of those patients
7 would be treated locally at the Berkeley linac,
8 at the Nexton, and some would still go down to
9 the main campus.

10 Q: All right. And I interrupted you. You can
11 continue with the discussion.

12 A: So, this demonstrates that the Berkeley linac
13 is going to be above 50 percent -- projected
14 utilization is above 50 percent by the third
15 year because we are above by the first year.

16 Q: Why is the volume going up?

17 A: The volume's going up at the rate of population
18 growth. So, you know, the MUSC total linac
19 volume we project it to grow by 1.6 percent,
20 which is the population growth. And the linac
21 ---Berkeley linac volume goes up by that same
22 percent.

23 Q: All right. Let's look at MUSC Exhibit 75. It
24 looks like you add a few layers onto the bottom
25 of your previous exhibit.



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ROA_0956

1 A: Yeah. So, this is sort of a whole figure in
2 the CON application. The top right you can see
3 is the same. It shows the Berkeley linac
4 volume, the occupancy, or capacity, utilization
5 rate of 76 to 80 percent. The other MUSC
6 linacs, those five remaining on the peninsula,
7 shows their projected utilization. There is
8 some -- you know, 2019 the volume goes down,
9 because there's a redirection to Nexton. And
10 the total linac volume at MUSC in 2019 is
11 projected to be about 20,000 treatments, which
12 is pretty close to where it is now. You can
13 see the capacity of the remaining accelerators,
14 the 24,000 capacity. Remember the three at
15 5,000, the two at 4500, would be in the 70-
16 percent range in the projected period for
17 Nexton. The other important thing here is the
18 other service area linacs. So, that's Trident
19 and Roper and what's left over for them. You
20 can see 2016 we've got 27,163. That's
21 projected to also grow by 1.6 percent. So,
22 29,942 by year 2022. So, that's almost 3,000
23 more treatments for those providers. So, it's
24 not our assumption that we're going to take
25 volume from the existing providers. It's not

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ROA_0957

1 our assumption that the only way we can get
2 through our volumes is to take volume from
3 other providers. That the market's going to
4 grow modestly by population -- by population
5 growth. And as a result, the market will be
6 larger, we're going to redirect patients that
7 would have otherwise gone to the peninsula, and
8 everybody is at a volume at or above where they
9 were in 2016.

10 Q: Did Mr. Sullivan either at the DHEC level or at
11 trial contest your projected volumes increasing
12 by the amount of population?

13 A: No. I think he said that it was more
14 reasonable than Roper's.

15 Q: Did Mr. Sullivan, or anyone else from Trident,
16 during DHEC review, or during this trial,
17 contend that MUSC did not satisfy the 50-
18 percent threshold in Standard 7?

19 A: No.

20 Q: All right. Let's look at the remaining State
21 Health Plan standards, Joint Exhibit 5, IX-5.
22 We're back at the 2015 State Health Plan. What
23 do we have here, Mr. Levitt?

24 A: Yeah. So, like 1 through 5 are just capacity
25 numbers. 6 is the standard for a new provider.



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ROA_0958

- 1 7 is the standard for the expansion. And 8 and
2 9 is all that's left and that's what's up on
3 the screen. 8 talks about the referral
4 sources, letters of support from physicians.
5 We comply with that standard. And Standard 9
6 is an affirmation that we will provide these
7 services and have these resources. And
8 obviously as an existing provider, we have all
9 of that.
- 10 Q: All right. Has anyone contended that our CON
11 application does not satisfy Standards 8 or 9?
- 12 A: No.
- 13 Q: All right. Let's move back to the deemed
14 complete letter. So, I think now we're moving
15 into the most important project review
16 criteria.
- 17 A: Yes.
- 18 Q: Let's start with community need. Did you apply
19 this criteria to MUSC's CON application?
- 20 A: Yes. We demonstrated compliance with that
21 criteria.
- 22 Q: All right. We talked earlier about Standard 7
23 and the 80 percent, 50 percent. How, if at
24 all, do those standards relate to community
25 need?

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ROA_0959

1 A: Well, they are the calculated need for the
2 community -- for the services. So, 6 is for a
3 new provider; 7 is for an expansion.

4 Q: All right. Let's look at your exhibits on
5 community need. Let's go to Exhibit 70.

6 **(Respondent MUSC's Exhibit Number 70 was introduced**
7 **into the record at this time.)**

8 Q: Describe what we have here.

9 A: So, this is the four-county service area. I
10 think it was, you know, maybe 2008 or '7 they
11 added Colleton. I'm not sure why. It's a
12 small population and it's far and not generally
13 in the sort of economic Tri-County area. But
14 it's included. It's identified in the Health
15 Plan as a service area. So, this is the health
16 radiation therapy service area that MUSC's
17 located.

18 Q: All right. Let's look at 69 please, MUSC 69.

19 **(Respondent MUSC's Exhibit Number 69 was introduced**
20 **into the record at this time.)**

21 A: So, this is the patient origin for linear
22 accelerator patients for 2015 and 2016. And
23 MUSC utilizes these planning regions or areas
24 or submarkets, I think they refer to them. And
25 these are the names. You know, East Cooper is



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ROA_0960

1 pretty self explanatory. That's the Mt.
2 Pleasant, East Cooper area, Moncks Corner,
3 North Charleston, the peninsula. And it's a
4 compilation of a number of ZIP codes that MUSC
5 uses for planning purposes for all of their
6 projects. And you can see that in 2016, the
7 most recent year, 58 percent of the patients
8 came from the Tri-County area. So, I think
9 what's important in that is that a large number
10 of patients came from outside the Tri-County
11 area. So, it sort of indicates that MUSC is a
12 referral facility, people seek out care at
13 MUSC, and they travel great distances across
14 the state. I think you heard Dr. Cawley say
15 they treat residents of every county in the
16 state. And this is true for linear accelerator
17 treatments as well. Specifically the service
18 area we're talking about, North Charleston, in
19 2016 about 15 percent; Summerville another 11
20 percent; and then Moncks Corner another five
21 percent. So, combined it's about 31 percent of
22 the patients come from those three areas, which
23 are closer to Nexton than the peninsula. And
24 ironically, I guess this is perhaps where we
25 hit it, Mr. Sullivan's solution was put another



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ROA_0961

1 one at East Cooper. Well, you can see that
2 it's only 12 percent of the population comes
3 from the East Cooper area. And we already got
4 -- we already have one there. And then the
5 other alternative is to build another one at
6 the hospital, at MUSC. Well, the peninsula, we
7 only have three percent of our patients from
8 the peninsula... So, from a distribution
9 perspective, neither one of those is a good
10 idea. It doesn't put the resources closer to
11 where the patients are coming from.

12 Q: All right. Let's look at MUSC Exhibit 71..

13 **(Respondent MUSC's Exhibit Number 71 was introduced**
14 **into the record at this time.)**

15 Q: What does this demonstrate?

16 A: This is the population projections for the four
17 counties in the service area total and in the
18 state. You can see the service area total is
19 projected to grow from -- was projected to grow
20 from 2016 to '21; '20, '21 by about 8.1 percent
21 compared to a statewide average of about 5.4
22 percent. So, it's growing almost twice the
23 rate. And the elderly population, those that
24 which consume services at a greater rate -- and
25 I guess as I get closer to it, I think I'm



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ROA_0962

1 going to change calling 65 and older elderly to
2 just 65 and over, because I'm getting close.
3 It's 21 percent population growth and 19.7
4 percent for the state. So, the 65 and plus,
5 the older population, is also growing at a rate
6 greater than the state. So ---

7 Q: Did you and Mr. Sullivan have any disagreement
8 about the projections -- population projections
9 for the service area?

10 A: No.

11 Q: Fair enough. Go ahead.

12 A: So, you can see this is a growing area. You
13 know, we talked about Colleton. Colleton is a
14 small population, 35,000, and overall it's
15 projected to go down. So, it's not a large
16 area and it's not a growing area.

17 Q: Okay. So, we've looked at the service area, I
18 think. We've looked at MUSC patient origin
19 data. We've looked at population growth and
20 projected growth. What health planning
21 conclusion do you reach from the consideration
22 of these elements?

23 A: Yes. That, based on the analysis of the
24 market, the defined service area in the Health
25 Plan, the population growth and our patient



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ROA_0963

1 origin, deploying resources to the area closer
2 to those, the 30 percent of our patients, is
3 sound health planning and it helps decant the
4 downtown utilization.

5 Q: And when you say decant, what does that mean?

6 A: That the utilization is capacity-constrained.
7 We're about 80 percent downtown. And moving
8 some of those patients off of the peninsula and
9 getting closer to where they live is going to
10 reduce the utilization downtown as well.

11 Q: Got it. Now, I believe Mr. Sullivan did some
12 health planning analysis related to community
13 need, I think, looking at things like trends
14 and radiation in patients and trends in
15 treatments, and I think we have some exhibits
16 on that. Let's look at Trident's Exhibit 9,
17 Sullivan 39. Now, you recall Mr. Sullivan
18 offering these, I suppose. It's revised. A
19 version of this was offered at his deposition
20 and then as a trial exhibit.

21 A: Yes.

22 Q: And I think you made some corrections in an
23 exhibit that we have.

24 A: I did. I changed it a little bit.

25 Q: Okay. Let's look at MUSC Exhibit 79.



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ROA_0964

1 (Respondent MUSC's Exhibit Number 79 was introduced
2 into the record at this time.)

3 A: So, using his information, you know, he had
4 Roper and Bon Secours separate. So, I think if
5 you look at it in total -- so, the reason it
6 was separate was, because at one point they
7 were all done -- all the accelerators were at
8 Roper and then they moved some to Bon Secours
9 St. Francis in West Ashley. But I think from
10 a trend analysis, it's important to look at it
11 combined, because that's the experience of that
12 provider. So, just as MUSC is the Mt. Pleasant
13 and the peninsula location, Roper/Bon Secours
14 is the Mt. Pleasant -- or the peninsula West
15 Ashley location.

16 Q: It's appropriate to consider those two
17 together, which is what you ---

18 A: I think it is. And I think it shows as more
19 reflective of the actual trend in the area.

20 Q: All right. Well, what trends do you see here
21 looking at 2010 to '17?

22 A: So, what it shows is that the facility or
23 provider that has the largest growth by far is
24 MUSC. So, assuming these numbers are correct,
25 the number of patients are correct, they have



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ROA_0965

1 almost a 37-percent, rounding, growth in the
2 market, in the number of patients treated. So,
3 that's a tremendous growth over the time
4 period, much higher than any other provider.

5 Q: And why is that important for purposes of this
6 matter?

7 A: Well, to the extent that we keep getting more
8 patients, we need more resources to treat those
9 patients.

10 Q: Okay. Any other health planning thoughts on
11 this exhibit?

12 A: I think that covers it.

13 Q: All right. Let's do MUSC Exhibit 83.

14 **(Respondent MUSC's Exhibit Number 83 was introduced**
15 **into the record at this time.)**

16 Q: So, we just looked at patients. I think now
17 we're going to look at treatments. Now, we're
18 not going to bounce back to it. Do you recall
19 Mr. Sullivan offering, both at deposition and
20 as a trial exhibit, his analysis of trend and
21 radiation therapy treatments?

22 A: I do.

23 Q: All right. And you provided this exhibit
24 making corrections; is that correct?

25 A: Yes.



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ROA_0966

1 Q: All right. Well, what did you change or modify
2 here?

3 A: Well, so few things. So, one thing is I added
4 2018, because we have our MUSC 2018 utilization
5 of almost 21,000 treatments. We have Trident's
6 annualized information. So, through discovery,
7 we've got January through June, so I annualized
8 it. That came out to be about 11,600. I heard
9 one of the Trident witnesses last week say that
10 their 2018 volume was a little over 12,000.
11 So, annualized was a little short, so I guess
12 they had a little bit of an uptick, so they're
13 about 12,000. So, that's not reflected on
14 here, but it would be about 400 more treatments
15 in the market. And then I held Roper constant,
16 because I don't have their information. So, I
17 said if their volume stayed the same in '18 as
18 it was in '17, the market volumes would be
19 47,700 and that represents about a three
20 percent growth in the market. And Mr.
21 Sullivan's analysis that said the market's flat
22 to growing modestly, I think what's illustrated
23 here is it wasn't shown, it wasn't as evident
24 as guess, when he had Roper and Bon Secours
25 separate, because he showed Roper going down by



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ROA_0967

1 like 80 percent, because they moved machines
2 off. So, when you look at it together, if the
3 market's going down, it looks like it's because
4 of Trident. So, everyone else's volumes are
5 going up, even assuming Roper is flat,
6 Trident's going down.

7 Q: Okay. Let's look at -- do you recall whose
8 testimony you heard? Was that Mr. Clements
9 offering the testimony related to their
10 calendar year 2018?

11 A: I believe the calendar year and fiscal year for
12 them is the same.

13 Q: Got you. All right. MUSC Exhibit 86.

14 **(Respondent MUSC's Exhibit Number 86 was introduced**
15 **into the market at this time.)**

16 Q: All right. I think this is just a
17 representation graphically of what we just
18 discussed, but please tell us what this
19 demonstrates.

20 A: So, this shows the trend from 2007 to 2018 of
21 treatments. And it shows -- this is MUSC's
22 treatments. And it shows we went from 16,000
23 in 2007 to 20,000 in 2018. So, you know, we
24 had some peaks in 2011 and '12. Volumes were
25 bouncing around 19,000 pretty consistently from



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ROA_0968

1 2013 to 2018.

2 Q: I see. Let's look at 88, please.

3 **(Respondent MUSC's Exhibit Number 88 was introduced**
4 **into the record at this time.)**

5 A: 88 shows Trident's treatments. Again, the 2018
6 11602 is annualized number. Mr. Clements
7 identified it was over 12,000. So, their
8 volume's gone up. So, Mr. Sullivan's saying
9 that the market's flat to declining. We're
10 growing. They're growing. Roper's growing.
11 I'm not sure that his assumption is accurate.

12 Q: All right. Do you recall Mr. Sullivan
13 testifying that MUSC's CON application didn't
14 demonstrate that we were capacity constrained?

15 A: Yes.

16 Q: All right. Do you have any opinions about
17 that?

18 A: Yes.

19 Q: All right. Does the State Health Plan or the
20 regulation require a particular indicia of
21 capacity constraints?

22 A: No. So, Standard 7 says, if you're at 80
23 percent, then you're at a capacity by which you
24 need additional resources. It doesn't require
25 that you identify any of the things that Mr.



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ROA_0969

1 Sullivan identified as, you know, late hours of
2 operation, wait time for scheduling, things
3 like that. I think those would be in addition
4 to, but not a necessary requirement.

5 Q: Well, does the 80 percent threshold, the
6 planning threshold, the capacity threshold in
7 Standard 7, is it designed to prevent the type
8 of indicia, the capacity constraint indicia
9 that Mr. Sullivan wanted to require of our
10 application?

11 A: It doesn't prohibit it, but it doesn't require
12 it. Basically it says, if you're full, you
13 should have additional machine. And if you're
14 full, that measure is if you're at 80 percent
15 of capacity.

16 MR. DAYHUFF: All right. Let's look at MUSC 42, Mr.
17 Bupp.

18 (Respondent MUSC's Exhibit Number 42 was introduced
19 into the record at this time.)

20 Q: Now, here you have -- the V600 is our Varian
21 that we spoke of earlier, right, the old unit?

22 A: That's the Clinac linac.

23 Q: The Clinac linac, now a very old unit. So,
24 you've asked us to put this up related to
25 capacity constraint. Why don't you talk to us



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ROA_0970

1 about why you have broken out the Varian 600.
2 A: So, remember I did an application in 2005 that
3 allowed us to keep that V600 because it was a
4 specialized machine doing children and total
5 body irradiation. So, we don't do a lot of
6 treatment on it. We told DHEC we weren't going
7 to do a lot of treatment on it. But we needed
8 to keep it because it was very, very efficient
9 and good at doing that kind of care. It
10 wouldn't disrupt the other machines. We could
11 still use those other machines to treat
12 traditional linear accelerator patients without
13 interrupting them with the two to three-hour
14 treatment in the middle of them. So, if you
15 take those out of the mix, the remaining volume
16 is shown below on the other machines. We've
17 got some extra machines in there. So, we have
18 four machines, but we have one, two, three,
19 four, five, six listed because two of them were
20 replaced. And so you can see 2015, I told you
21 one of the machines was down, our volume dipped
22 that time period. In 2015 one of the machines
23 was down, because we replaced it. So, that's
24 why they're on there twice, because at one time
25 period it was operational and it was replaced

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ROA_0971

1 with another one. And you can see, if you look
2 at the subtotal of those, so for 2018 the
3 20,010 treatments is the difference between our
4 total treatments and the 73 total body
5 irradiation treatments done on the special
6 machine that we have a special CON for. The
7 remaining 20,100 (sic) on the capacity of
8 19,000, two machines at 4,000, two machines at
9 5,000, shows us at 105 percent utilization.

10 Q: What does that tell us about capacity
11 constraints at MUSC?

12 A: I think what it says is we're full. We need
13 another machine.

14 Q: Well, hold on. I think Mr. Sullivan testified
15 that we could be doing more treatments than
16 we're doing. He raised our capacity 700 -- or
17 7,000 on the V600. And I think there was some
18 math done about, well, you know, we could do
19 lots more treatments there. What do you think
20 about that testimony? What health planning
21 opinions do you have?

22 A: Yeah, no. So, we did that application in 2005
23 and we specifically identified that it was an
24 old machine and it wasn't good for other
25 advanced treatments. It didn't have a multi-



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ROA_0972

1 leaf collimator. So, we can't do the things on
2 that old machine that you can do on a new
3 machine. And what you can do on it really well
4 is, because it doesn't have a multi-leaf
5 collimator, so that helps form the beam to hit
6 just the tumor. Well, since it doesn't have
7 that, it just shoots the beam. And that's
8 perfect if you want to hit somebody's whole
9 body.

10 Q: Total body irradiation.

11 A: That's right.

12 Q: Right. Right. Does anyone else in our service
13 area to TBI?

14 A: No.

15 Q: Now, I want to talk about -- we're in the
16 community need criterion right now. We're
17 talking about capacity constraints. I want to
18 talk about unnecessary duplication. How is
19 community need and unnecessary duplication
20 related?

21 A: Well, I think, you know, in some states they
22 refer to it as a toggle, that if you've
23 demonstrated need, then by definition it's not
24 a necessary duplication. It may be sort of --
25 using the common definition of duplication, it



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ROA_0973

1 may be something that already exists, so
2 there's two of them, so it's a duplicate, but
3 it's not unnecessary because you've
4 demonstrated need.

5 Q: I believe Trident alleges that MUSC Nexton
6 would be unnecessarily duplicating Trident's
7 linacs. Do you have a health planning opinion
8 about that?

9 A: Yeah. So, it wouldn't, because the application
10 is to expand the resources at MUSC. So, it's
11 not duplicating the resources at Trident. It
12 is independent of the resources at Trident. We
13 are capacity constrained and we need additional
14 resources. So, it's not duplicating what they
15 have. It's adding to the capacity of what we
16 have.

17 Q: All right. Let's move to the next important
18 project review criteria.

19 **MR. DAYHUFF:** Mr. Bupp, if you'd go back to the
20 deemed complete letter.

21 Q: And we're on Distribution, Accessibility. Have
22 you applied this criterion to this CON
23 application?

24 A: I have.

25 Q: All right. Let's look at MUSC Exhibit 98.



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ROA_0974

1 (Respondent MUSC's Exhibit Number 98 was introduced
2 into the record at this time.)

3 Q: Tell us how this exhibit relates to
4 distribution accessibility.

5 A: So, I think Mr. Sullivan presented what I would
6 call a false argument that that's not -- he's
7 saying that what we should look at is the drive
8 time improvement between residents of the area
9 and if they wanted to go to Trident. Well,
10 they're not going to Trident.

11 Q: Well, the difference between going to Trident
12 and MUSC Nexton, right?

13 A: Correct.

14 Q: A versus comparison.

15 A: Correct. And that's not the case. The case is
16 the difference between them going to the
17 peninsula or Mt. Pleasant for care or going to
18 Nexton for care.

19 Q: Why is your comparison appropriate?

20 A: Again, because we're not proposing a new
21 center. We're proposing expansion of the
22 existing center. We showed in our need volume
23 projections that it's redirection of patients.
24 It's our volume of patients. The peninsula
25 volume's going to go down, because it's



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ROA_0975

1 patients that would have otherwise gone to the
2 peninsula. We showed the other providers in
3 the market growing, because we're not taking
4 Roper's patients or Trident's patients. We're
5 serving MUSC's patients. So, that's the
6 analysis to look at is, what does this do to
7 improve accessibility for residents of the area
8 to MUSC resources. And what it shows is that
9 it improves it substantially. You know, 28
10 minutes from Summerville to East Cooper, 28
11 minutes from Summerville to downtown on the
12 peninsula, and three minutes to Nexton. So,
13 that's the time saving, is the improved
14 accessibility and the improved distribution of
15 services to residents of the area. . North
16 Charleston, again -- so Summerville, North
17 Charleston, and Moncks Corner represented about
18 30 percent of our volume, so those are the
19 patients we intend to treat at the Nexton
20 location. So, what's the savings for them?
21 Moving on to the next one, the North Charleston
22 area, 29 minutes to East Cooper or Mt.
23 Pleasant, 34 minutes to the peninsula, and 16
24 minutes to Nexton. So, it saves them time as
25 well. And then Moncks Corner, 36 minutes, 39

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ROA_0976

1 minutes versus 17 minutes. So, you can see
2 it's a substantial savings of 15 to 25 minutes
3 each way for residents to go to Nexton versus
4 going to either the peninsula downtown or Mr.
5 Sullivan's solution of East Cooper.

6 Q: All right. Do you recall my discussion with
7 Mr. Sullivan about hub and spoke? Do you
8 recall it fondly?

9 A: Yes, very fondly.

10 Q: Do you have any opinions about whether MUSC's
11 project comports with the kind of traditional
12 hub and spoke model?

13 A: It does. It's an excellent example. So this
14 would be, just as what we're calling East
15 Cooper or Mt. Pleasant is a spoke of the
16 Hollings Cancer Center downtown, this would be
17 a spoke of the Hollings Cancer Center downtown
18 at the Nexton Site. So, it's consistent with
19 the hub and spoke approach.

20 Q: All right. I recall Pat Cawley getting
21 questioned about access. And the suggestion
22 was made during the questioning that, if MUSC
23 was really concerned about geographic access,
24 we would have built the children's hospital in
25 a different location than we did. Do you



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ROA_0977

1 recall that?

2 A: I did. It didn't make any sense, because the
3 peninsula is the hub. The main hospital is the
4 hub. We are building a new building on the
5 peninsula for the Children's Hospital, because
6 it's in an old building on the peninsula and
7 it's connected to the other buildings. It
8 shares many of -- the first and second floor,
9 I think, are shared with the Ashley River Tower
10 and shares the parking of the Ashley River
11 Tower. So, it's not like we have -- as Dr.
12 Cawley said, it's a hospital within a hospital.
13 It's not a separate hospital that happens to be
14 near MUSC. It's part of MUSC on the peninsula.
15 And I think the suggestion was putting it at
16 the intersection of I-26 and 95. Well, that
17 doesn't make any sense for obvious reasons and
18 that's not the hub and spoke. The hub is the
19 peninsula. The spokes are all the other
20 places.

21 Q: Now, that's kind of the geographic thing. But
22 what tends to be at the hub?

23 A: Yeah. So the inpatient tertiary, high-level
24 services are at the hub, which would be the
25 inpatient pediatric services. And then we have



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ROA_0978

1 developed a spoke for pediatric services. In
2 spite of the opposition we received, we applied
3 to add pediatric services in the North
4 Charleston area, outpatient services to include
5 AmSurg and outpatient imaging and a medical
6 office building. So, we're employing the hub
7 and spoke approach for pediatric services
8 consistent with the logical interpretation of
9 hub and spoke.

10 Q: And is the radiation oncology service that we
11 propose to be provided at MUSC Nexton, is that
12 inpatient or outpatient?

13 A: It is outpatient.

14 Q: All right. Let's look at MUSC 51 on this topic
15 of hub and spoke.

16 **(Respondent MUSC's Exhibit Number 51 was introduced**
17 **into the record at this time.)**

18 Q: All right. So, this is obviously reflecting --
19 I think we've seen this at least once before.
20 This is reflecting a variety of healthcare
21 facilities in the three-county area. What, if
22 anything, does this demonstrate with respect to
23 hub and spoke?

24 A: Well, I think it shows that it is a fairly
25 common concept and practice. It's all of the



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ROA_0979

1 providers, except for our poor friends at East
2 Cooper, have employed the hub and spoke
3 approach. East Cooper has just the one
4 location. I know they have some things in that
5 general area, but they haven't expanded out.
6 But Trident, Roper, and MUSC all have taken the
7 approach. You know, Roper has the Mt. Pleasant
8 Hospital, a spoke -- a small community hospital
9 as a spoke of their main hospital downtown.
10 They have St. Francis as a spoke in West
11 Ashley. It's grown. I think, you know,
12 initially it was much smaller and it's grown.
13 Services have expanded and are more
14 comprehensive. So, they were early on adopters
15 of that spoke by putting that hospital out
16 there. Trident ---

17 Q: Well, does Roper have a linac spoke?

18 A: They do. They have the Roper Berkeley linac in
19 Berkeley County. So, they identified that move
20 the resources off the peninsula for linear
21 accelerator services. They also moved
22 resources off the peninsula to St. Francis, so
23 they have a spoke there too. Although, I think
24 -- I think, based on what I understood from
25 project review, they're flipping it. That I



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ROA_0980

1 think St. Francis is going to be the hub for
2 cancer care and the Roper downtown is going to
3 be the spoke and the Berkeley is going to be
4 the spoke. But needless to say, it's the same
5 concept.

6 Q: What about Trident?

7 A: Trident has a similar approach. So, they have
8 the main hospital of Trident. They have the
9 spoke of Summerville. They have applied for
10 the spoke of the Berkeley County Hospital. You
11 know, they have a freestanding ED in Moncks
12 Corner. Roper has a freestanding ED in Moncks
13 Corner. Trident has another freestanding ED in
14 North Charleston. So, you know, it's not
15 uncommon, outpatient services, and sometimes
16 smaller inpatient services, to be the spoke
17 with a main hub at another location.

18 Q: All right. So, MUSC with this project is
19 attempting to implement a hub and spoke model
20 with respect to linac services.

21 A: They are. They're trying to expand their hub
22 and spoke. They have the hub at the Hollings
23 Cancer -- the main Hollings Cancer Center on
24 the peninsula. They have one spoke in East
25 Cooper. They have a distant spoke at



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ROA_0981

1 Georgetown. They're going to have another
2 spoke in Beaufort. So, they are doing that
3 now.

4 Q: And how is hub and spoke related to geographic
5 accessibility?

6 A: Well, the spoke is to improve geographic
7 accessibility. Rather than require everyone go
8 to the hub for all care, you put the spoke out
9 in the community to treat those people.

10 MR. DAYHUFF: Your Honor, we have one more most
11 important criterion to get through. Now, that
12 -- and then a few other sections. I just
13 wanted to know if now was a good time for a
14 break. We've been going since, I guess, 1:30.

15 THE COURT: Sure. Yeah. That's fine.

16 MR. DAYHUFF: I can plow on if you'd like, but I ---

17 MR. THOMAS: If we might take a quick break, Your
18 Honor.

19 THE COURT: Yeah. Let's take a short ten minutes.

20 (Off the Record)

21 THE COURT: We're back on the record in case number
22 18-07-0100. Mr. Dayhuff, resume your torture
23 of your witness.

24 MR. DAYHUFF: Thank you, Your Honor, I think.

25 Q: Mr. Levitt, I believe we were back at the old



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ROA_0982

1 deemed complete letter and we were down to the
2 most important criterion d, the medically
3 underserved individuals. Let's look at MUSC
4 Exhibit 73, which you asked us to pull up on
5 this issue.

6 **(Respondent MUSC's Exhibit Number 73 was introduced**
7 **into the record at this time.)**

8 Q: And where does this figure appear?

9 A: This is in the CON application..

10 Q: All right. And what does this figure
11 demonstrate with respect to this criterion?

12 A: It just looks at the household income by the
13 different categories, less than 10,000, 10 to
14 50, 50 to 100, 100 to 200, and 200 plus. And
15 what it shows is the Summerville area, eight
16 percent of the population is below \$10,000.
17 And keep in mind that's, I think, one of the
18 largest population bases. So, while it's eight
19 percent, kind of in the middle of the other
20 areas. North Charleston's nine percent, Moncks
21 Corner is ten percent. Those are, you know,
22 large population bases, so there are a number
23 of individuals there. I think the only thing
24 else that I would point out is, you know, the
25 peninsula, the number of individuals over 7,000



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ROA_0983

1 -- or I'm sorry over \$200,000, seven percent,
2 so it's a small population. There's a lot of
3 wealthy people, a lot of not so wealthy people,
4 but it's a very small population. And then I
5 guess the only other thing I would point out is
6 that East Cooper, if you look at East Cooper,
7 that was Mr. Sullivan's alternative, let's put
8 it there. That doesn't really help with
9 distribution to the lower income individuals.
10 Only five percent of the population is less
11 than 10,000 and then, including less than
12 50,000, it's only 33 percent of the population.

13 Q: All right. Let's look at MUSC 77.

14 **(Respondent MUSC's Exhibit Number 77 was introduced**
15 **into the record at this time.)**

16 Q: We heard some questioning and perhaps even in
17 Mr. Thomas' opening about the amount of charity
18 care provided by -- or proposed to be provided
19 by MUSC's linac. I wanted to know if you had
20 opinions about that and then -- actually we can
21 pull this down for a minute. The first
22 question, I guess, is, have you considered
23 MUSC's charity care with respect to the linac
24 service line?

25 A: Yeah. So, both generally and specifically the



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ROA_0984

1 MUSC utilization, obviously it's a safety net
2 hospital. It's a hospital authority, quasi-
3 governmental agency. It serves all commerce,
4 regardless of the ability to pay. It provides
5 a lot of indigent charity care. It provides a
6 lot of services that can't -- they aren't
7 reimbursed for. And then specific to linear
8 accelerator services, generally individuals
9 receiving radiation therapy have coverage. So,
10 they would either have Medicare, because the
11 majority are over 65, so they would have
12 Medicare. If they are low income, they would
13 have Medicaid. Or they'd have commercial
14 insurance. Or, if they have a debilitating
15 cancer, if they have cancer and they can't
16 work, they become disabled, they get insurance
17 through disability. So, the majority of
18 individuals receiving radiation therapy have
19 some form of coverage.

20 Q: And that has what effect on the indigent care
21 numbers or projections?

22 A: It's not going to be a large number. So, the
23 majority -- as I said, the vast majority would
24 have coverage, so there's not a lot of indigent
25 patients that don't have coverage.



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ROA_0985

1 Q: All right. Let's now put back 77. I think you
2 began by discussing MUSC's charity care more
3 generally.

4 A: Yes.

5 Q: What does 77 demonstrate?

6 A: 77 demonstrates the amount of MUHA, MUHA
7 indigent care, and their dollars and percent of
8 gross revenue, as required by the CON form.
9 And it shows the numbers going down. I think
10 it's going down for a number of reasons,
11 because of some accounting treatment of bad
12 debt. So, what used to be indigent care now
13 becomes bad debt. Also I think that some
14 people believe that the Affordable Care Act has
15 increased insurance, so there will be less
16 people without insurance.

17 Q: All right. Is it your health planning opinion
18 that the MUSC CON application satisfies the
19 medically underserved criterion?

20 A: Yes. Again, we serve all comers. We have
21 policies and procedures that were included in
22 the CON application that identify that we treat
23 people regardless of their ability to pay. And
24 that would extend to the Nexton location.

25 Q: All right. Let's go back to the deemed



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ROA_0986

1 complete. We're on our last criterion,
2 financial feasibility. Before we launch into
3 this, talk to me about how healthcare planners
4 analyze financial feasibility.

5 A: So, I think Mr. Sullivan mentioned, so there's
6 sort of two elements of financial feasibility.
7 There's short-term financial feasibility and
8 long-term financial feasibility. Short-term
9 financial feasibility refers to the ability of
10 the applicant to fund the project, do they have
11 the economic resources to expend the money that
12 they say they need to. Long-term financial
13 feasibility is, do the financial projections
14 indicate that the organization can continue to
15 operate in the future.

16 Q: Let's look at the CON application, DHEC Exhibit
17 1 at 160. And take a look at this, Mr. Levitt.

18 A: Sure.

19 Q: And identify it.

20 A: This is the -- an attachment to the CON
21 application. And it's the proof of funding, is
22 what we would generally call it, or evidence of
23 funding. And it's a letter dated March 3rd to
24 Louis Eubank, who I believe at the time was the
25 director of the CON Program, indicating that



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ROA_0987

1 the resources are available to fund the
2 project, the Nexton linear accelerator project,
3 signed by Greg Spurlock, who is the managing
4 member of MUSC Health Cancer Care Network, LLC.
5 He's also senior vice president at Alliance
6 Oncology.

7 Q: That's why I suppose there was a -- I think an
8 Alliance letterhead at the top of it?

9 A: Yes.

10 Q: All right. And let's look at the paragraph
11 that talks about the funding options. I recall
12 they were not certain about exactly what manner
13 in which they would fund the project. Does
14 that matter?

15 A: No. Because, again, remember this was
16 submitted in 2017. Now it's 2019. So,
17 depending on the -- you know, as it says in the
18 letter, depending on the interest rate
19 environment at the time of the loan
20 application, they'll finance the project costs
21 through an affiliate of MUSC Healthcare Cancer
22 Network, LLC or external financing. So, if
23 interest rates were to go down, it might make
24 sense for them to incur debt or, if interest
25 rates go up, it might make sense for them to



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ROA_0988

1 use cash or operating reserves or other form of
2 financing. I think what this shows is that the
3 applicant, MUHA, through their joint venture
4 with Alliance Oncology, management of the
5 project, has access to sufficient resources to
6 fund the project.

7 Q: All right. And does this documentation from
8 Alliance, in your opinion, satisfy the question
9 whether this, in the short term, will be
10 financially feasible?

11 A: It does.

12 Q: All right. Let's look at DHEC Exhibit 1 at CON
13 165. And tell us what that is.

14 A: This is the pro forma for the linear
15 accelerator at Nexton.

16 Q: All right. Why don't you tell us what you, as
17 a health planner, look for in a pro forma with
18 respect to the concept of long-term financial
19 feasibility? What are the most important
20 elements of this document?

21 A: Yeah. So, generally we would look at the
22 revenues and expenses, the contractual
23 adjustments. And that's what I did in this --
24 and I didn't prepare this. I reviewed it
25 quickly before it was submitted. And it showed



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ROA_0989

1 operating revenue of about three to three and
2 a half million dollars and expenses of about
3 2.7 to three million dollars. It showed a net
4 income of about 400 thousand dollars. And all
5 of those seemed reasonable for a single
6 accelerator, free-standing radiation therapy
7 site.

8 Q: I recall Mr. Sullivan, either at trial or in
9 his deposition, testifying that perhaps our
10 volume projection was a little low. Do you
11 recall that?

12 A: Yes.

13 Q: Well, what effect if he's right, if the volume
14 projection was a little low?

15 A: Well, the majority of the expenses are affixed,
16 so the expenses wouldn't change much. The
17 revenue would go up. So, volume goes up, net
18 revenue goes up, and the overall net income
19 would go up, so it would be more profitable.

20 Q: All right. Do you know what appears or what
21 comprises the various sub line items in this
22 pro forma?

23 A: No. I didn't prepare the application -- I
24 didn't prepare the projections. I reviewed
25 them quickly. I know there's a staffing



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ROA_0990

1 schedule that ties to the personnel expense,,
2 but I don't know specifically what elements
3 were in this. I looked at it more on a high
4 level, the lines that are highlighted. The
5 total expenses seemed reasonable for a single
6 center -- a single accelerator center.

7 Q: So, why don't you need to know what's in the
8 line items for the purposes of opining on the
9 financially feasibility, the sub line items?

10 A: Because, based on other applications and my
11 experience with other providers, those are
12 reasonable numbers. So, if something's
13 missing, then something would perhaps be
14 overstated. But just generally, I've not seen
15 a linear accelerator project that wasn't
16 financially feasible. I heard Mr. Gallati say
17 it's one of his most profitable service lines.
18 It's very profitable to the hospital. MUSC
19 operates a number of linear accelerator
20 locations, the peninsula, in Mt. Pleasant, I
21 know a lot about the Georgetown location. All
22 of those are operated in a positive manner.
23 And I'm not aware of any radiation therapy
24 center in South Carolina that's ever gone out
25 of business because it wasn't financially



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ROA_0991

1 feasible.

2 Q: Why is that? Why is it such a feasible service
3 line?

4 A: I think part of it ties back to what we had
5 talked about, that most individuals have
6 coverage, it's a good payer, unlike some other
7 services, it's more parody between a free-
8 standing radiation therapy center at a hospital
9 base. You know, for Medicare purposes,
10 hospital-based services are paid higher. So,
11 if you go to a hospital for an MRI, they get
12 paid more than if you went to a free-standing
13 imaging center for an MRI. But for radiation
14 therapy, the discrepance isn't the same.

15 Q: All right. The pro forma that we're looking
16 at, that was an attachment to the May 2017 CON
17 application?

18 A: Yes.

19 Q: All right. Did Mr. Sullivan, or anyone else
20 from Trident, contend during the DHEC review
21 process that our project was not financially
22 feasible?

23 A: No. Neither on the short term or long term.

24 Q: And you mentioned, I think, that a part of your
25 opinion rests upon you observing MUSC operating



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ROA_0992

1 other linacs that would be similar to this one.
2 What were you talking about?

3 A: Yeah. So, for instance they have the West
4 Ashley -- I'm sorry the Mt. Pleasant location,
5 East Cooper. It used to be on the campus of
6 East Cooper Hospital. Then they moved the East
7 Cooper Hospital, but the radiation therapy
8 center stayed. And they've been operating that
9 for 13, 14, 15 years. And it's not become a
10 financial burden to the level of which they
11 closed it. Tideland's Health is a joint venture
12 with MUSC for their single linear accelerator
13 -- currently single linear accelerator
14 location. It operates at a profit and it
15 doesn't pose a negative drain on either
16 organization. If you look at CON applications
17 for other linear accelerators, they all are
18 very consistent with these projections.

19 Q: What, if any, effect on the financial
20 feasibility or your opinions on financial
21 feasibility result from these being a joint
22 project between Alliance and MUSC?

23 A: Right. I think that, given Alliance's back
24 office resources as I called them, their
25 ability to build efficiently and effectively,



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ROA_0993

1 coding issues, that they would have a positive
2 impact as a partner on operations. They know
3 how to operate these centers, they do it well,
4 they make money. I do know that Tideland, a
5 number of years ago, had some questions about,
6 everyone else seems to be making a lot of money
7 off this and we're only making a little bit of
8 money off of it, it's because of some of those
9 issues, that they came in and did an
10 operational audit, identified some issues,
11 fixed them, and continue to be operating and
12 operating at a better manner.

13 Q: Does Alliance have any opportunity to obtain
14 linear accelerators at less cost than other
15 providers?

16 A: They do. So, obviously, you know, volume
17 pricing is always beneficial. So, to the
18 extent that Alliance Imaging -- or Alliance
19 Oncology is buying ten accelerators to put in
20 ten different locations throughout the world,
21 they're going to get a better price from the
22 vender than a provider who's only buying one.

23 Q: All right. Did Mr. Sullivan assert during his
24 trial testimony that this project is not
25 financially feasible?



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ROA_0994

- 1 A: No.
- 2 Q: All right. Let's go back to the deemed
3 complete for a minute and make sure there's
4 nothing left. I believe that was it. Good.
5 All right. So we've now been through the
6 criteria item five in the deemed complete
7 letter. I want to hit adverse impact with you
8 for a little bit, Mr. Levitt. Mr. Sullivan
9 opines that MUSC Nexton will adversely impact
10 Trident; isn't that right?
- 11 A: He said that, yes.
- 12 Q: Do you recall him testifying at his deposition
13 to that effect?
- 14 A: Yes.
- 15 Q: During DHEC staff review to that effect?
- 16 A: Yes.
- 17 Q: And I think at trial too, right?
- 18 A: Yes.
- 19 Q: All right. Did Mr. Sullivan do an adverse
20 impact analysis?
- 21 A: He did not.
- 22 Q: All right. Do you have any health planning
23 claims about Mr. Sullivan's claim of adverse
24 impact without having done an analysis?
- 25 A: I don't know how you can demonstrate adverse

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ROA_0995

1 impact without doing the analysis. So, in his
2 deposition he said he was waiting to hear my
3 explanation for the need method. I provided
4 that during my deposition. And he didn't come
5 up in trial in his Direct and demonstrate the
6 adverse impact; didn't calculate the number of
7 cases he thought Trident would lose; didn't
8 calculate the financial impact those lost cases
9 would have on the organization. And so he
10 didn't demonstrate that there would be any
11 impact on any of the existing providers,
12 including Trident.

13 Q: Have you ever seen DHEC staff or the
14 Administrative Law Court make a finding that a
15 CON project would adversely impact an affected
16 person or a competitor where the adverse impact
17 was not quantified as to volume or revenue?

18 A: I can't think of any, no.

19 Q: Let's look at MUSC Exhibit 75.

20 **(Respondent MUSC's Exhibit Number 75 was introduced**
21 **into the record at this time.)**

22 Q: All right. Now, you asked us to pull this up.
23 We've seen this before when we were discussing
24 our compliance with the 50-percent standard in
25 Standard 7. But you asked us to pull this up



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ROA_0996

1 in the context of adverse impact. What, if
2 anything, does this demonstrate on that topic?

3 A: Again, so it goes back to that other service
4 area linac line. So we projected that the
5 other service area linacs would have more
6 volume in the future with the Nexton Berkeley
7 linac in 2022 by the fourth year of the
8 projections than they had in 2016. So, we're
9 not taking cases away from anyone. We are
10 expecting that they would have more cases in
11 the future. Mr. Sullivan adopted this
12 calculation in some of his exhibits. He didn't
13 change that calculation to say no, no, no, it's
14 going to go down and here's how much it's going
15 to go down by and here's the impact on Trident.
16 So, you know, this demonstrates that the
17 volume's going to grow, the other providers
18 there's not to be any impact, and we just took
19 our proportional volume at MUSC just as we had
20 in the past.

21 Q: All right. Just let me make sure I understand.
22 Why does the fact that we go from 27 to 29 in
23 that other service area linacs line item mean
24 that Trident won't be adversely impacted?

25 A: Well, because there will be almost 3,000 more



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ROA_0997

1 treatments in the market than there were in
2 2016. So, we're not saying that we're taking
3 our 4,000 treatments from Trident. So, if that
4 were the case, that number would go down. The
5 other service area linacs would go down. Ours
6 would go up. And that would show the adverse
7 impact. That's not our assumption. That's not
8 our projection. And I haven't heard or seen
9 any other projections to the contrary.

10 Q: All right. Let's look at Trident Exhibit 9.
11 And I think this is what you just referred to.
12 Is this Mr. Sullivan adopting your other
13 service area linac's volume projections?

14 A: It is. So, he took the same numbers. The
15 difference on this one is he changed our
16 capacity. You remember he thought we shouldn't
17 have the capacity that we have through the
18 State Health Planning process, through our CON
19 applications, from 24,000 to 26,500, and
20 changes the occupancy. But he maintains the
21 other -- he used the same 1.6 percent growth
22 annually, population growth. That's all we
23 assumed, was that the volume in the market
24 would go up at the same rate as the population.
25 And it shows the same thing, 26,528 in 2016



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ROA_0998

1 going to 29,000, so, you know, almost 3500 more
2 treatments for the other provider.

3 Q: All right. During the DHEC review process,
4 Trident was challenging both MUSC and Roper's
5 Berkeley County linacs; is that right?

6 A: Yes.

7 Q: And that was settled, which we've heard
8 discussion of in this case.

9 A: Well, the Roper opposition was settled.

10 Q: That's right, because we're still here. You're
11 right. What effect, if any, did that
12 settlement between Roper and Trident have on
13 your opinions with respect to whether or not
14 adverse impact will result from MUSC's Nexton
15 linac, or Roper's for that matter?

16 A: Well, in project review Mr. Sullivan thought --
17 and Mr. Clements, I think, was there too --
18 that approval of either project, and obviously
19 both projects, would negatively impact Trident,
20 take patients away, their volume would go down,
21 and yet they allow Trident -- or they allow
22 Roper to move forward with their center. So,
23 they settled and said, you can go ahead and
24 build yours. I think if they truly believed it
25 was going to ---



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ROA_0999

1 MR. THOMAS: Objection, Your Honor. He's making --
2 he's speculated on what Trident truly believed,
3 so I don't think that's appropriate.

4 THE COURT: I agree.

5 MR. THOMAS: I let him get away with it earlier, but
6 not this time.

7 THE COURT: I'll sustain it.

8 MR. DAYHUFF: Fair enough.

9 Q: In your health planning experience, if a party
10 asserts adverse impact and then allows a
11 facility, about which they asserted adverse
12 impact, to go forward as a result of the
13 settlement, does that cause you to be more or
14 less persuaded by that adverse impact analysis?

15 A: Less. I think that, you know, the argument
16 again -- we talked about sort of the context,
17 and perhaps it's semantics, impact versus
18 adverse impact. So, if a party claims there's
19 going to be adverse impact if this project
20 proceeds and then they allow the project to
21 proceed, they, I think, have changed their
22 position that they don't think it would be
23 adverse anymore, that they may be impacted, but
24 not to a level that's adverse.

25 Q: All right. Now, there was some testimony --



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