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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM
THE ADMINISTRATIVE LAW COURT

Shirley C. Robinson, Administrative Law Judge

Case No. 17-ALJ-07-0441-CC
Case No. 17-ALJ-07-0444-CC
Appellate Case No. 2020-001072

Trident Medical Center, LLC d/b/a Trident Medical
Center and Summerville Medical Center,.....

Petitioner/
Respondent,

v.

South Carolina Department of Health and Environmental
Control and Medical University Hospital Authority d/b/a
MUSC Health Emergency Services,.....

Respondents,

Of Whom, Medical University Hospital Authority d/b/a
MUSC Health Emergency Services is

Appellant.

CareAlliance Health Services, d/b/a Roper St. Francis
Healthcare, Roper Hospital, Inc., Bon Secours-St.
Francis Xavier Hospital, Inc., Roper Mount Pleasant
Hospital and Roper St. Francis Berkeley Hospital, ...

Petitioner/
Respondent,

v.

South Carolina Department of Health and Environmental
Control and Medical University Hospital Authority d/b/a
MUSC Health Emergency Services,.....

Respondents,

Of Whom, Medical University Hospital Authority d/b/a
MUSC Health Emergency Services is

Appellant.

**RECORD ON APPEAL
VOLUME 3**

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Pleasant Hospital and Roper St. Francis Berkeley
Hospital*

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1 community is the preference.

2 Q: And so we just don't have enough space --
3 spaces in the local community for the various
4 levels of psychiatric care that we need to be
5 providing. And that causes boarding, among
6 other things.

7 A: Among other things, yes.

8 Q: All right. Now, I think, when we talked about
9 that, that's a problem that causes some
10 operational issues for you all?

11 A: Uh-huh (affirmative response).

12 Q: At times?

13 A: I think almost any hospital deals with ---

14 Q: Any hospital. Causes some of those key
15 metrics; LWOT, door to discharge to be longer
16 than they otherwise would be?

17 A: Could be a contributing factor.

18 Q: Right. And can cause wait times for folks with
19 regular medical conditions to be increased?

20 A: In theory it could, yes.

21 Q: Well, in theory and in actuality, right, it
22 happens?

23 A: Yeah. It could, yes.

24 Q: All right. MUSC's problems with psych holds,
25 more or less severe than what Roper's



1 experiencing?

2 A: I can't really speak to it.

3 Q: Don't know.

4 A: Yeah.

5 Q: Fair enough. The changes, MUSC's CON
6 application was filed in I think June.
7 Jennifer said July. She may be right. We made
8 some changes to that application that I think
9 we talked about. We changed the site location
10 from one side of I-26 to the other,
11 approximately a mile's difference. That change
12 from a geographic perspective has no
13 significance to you, does it?

14 A: Geographically? No.

15 Q: No. We dropped the CDU, which we talked --
16 which we heard about a moment ago. That was a
17 good idea that made the project better, right?

18 A: I don't know. I mean, from a cost perspective,
19 it dropped the cost.

20 Q: Right. And in fact, when we talked about it,
21 you and I talked about CDUs and the need for
22 them or the lack thereof.

23 A: Uh-huh.

24 Q: And at Sentara you had some CDUs and they
25 weren't really cost effective.



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1 A: Agreed. And I mentioned that earlier. For
2 15,000 or so visits it would be difficult for
3 me to see how that would ---

4 Q: Yeah. I mean, I think you said earlier it
5 just -- it didn't make a whole lot of sense at
6 that volume to have a CDU.

7 A: Yeah.

8 Q: I suppose from that perspective it made the
9 project better for us to drop it. All right.
10 We dropped the helipad. And that was a good
11 idea that made the project better too, right?

12 A: Yes.

13 Q: Yeah.

14 A: From a cost perspective.

15 Q: Because -- less cost. Well, and do we need a
16 helipad, do you think?

17 A: Well, I think I shared during my deposition I
18 rarely had helipads in my freestandings.

19 Q: Right. And you didn't -- why not?

20 A: Well, infrequent use and we could always clear
21 the parking lot and have a helicopter land.

22 Q: All right. And we heard some discussion of
23 that -- or did you hear the discussion Dr. Hall
24 had about that?

25 A: Yes.



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1 Q: Right. That we would plan to clear a parking
2 lot or designate an area.

3 A: Yes.

4 Q: Perhaps EMS would do that. That's a reasonable
5 way to handle air transport in an FED, isn't
6 it?

7 A: Yes.

8 Q: So did you hear yesterday that our current site
9 has an Applebee's on it?

10 A: Yes.

11 Q: Right. There was some discussion on that. We
12 get picked on a little about that. You heard
13 that we're going to knock down that Applebee's,
14 build a roughly 10,700 square foot FED, right?

15 A: That's what I heard. Yes.

16 Q: Does Roper have any FEDs that began life as
17 restaurants?

18 A: Our Northwoods location was a restaurant
19 location.

20 Q: What kind of restaurant, just so I have some
21 ammunition?

22 A: I believe it was some type of chicken wing type
23 place.

24 Q: Sufficed to say, despite that being the former
25 location of a restaurant, were you able to



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1 establish a high-quality FED there and provide
2 great services to folks?

3 A: Yes.

4 Q: So they should stop teasing us, right? You
5 don't have to answer that. All right. Let's
6 look at Exhibit 5, Roper Exhibit 5. And I
7 think it may be easier, Mr. Porter -- you could
8 do either one. But I've got it here, too. And
9 Dan can show it to you. But it's at tab 5 if
10 you want it. It's maybe four or five -- is
11 that good?

12 A: Yeah. It's here as well.

13 Q: All right. Now, this exhibit was proposed by
14 Roper. And it's a letter. But I want you to
15 review it and see if you can familiarize
16 yourself with it, rather than me telling you
17 about it.

18 A: Okay.

19 Q: All right. So do you know who Shannon Cantwell
20 is?

21 A: Yeah. Shannon is our regulatory affairs
22 specialist.

23 Q: All right. Did you work with -- or have
24 occasion to work with Shannon when you were at
25 Roper?



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1 A: Occasionally, yes.

2 Q: All right. And she was a regulatory affairs
3 specialist. Does that mean that she also
4 interacted with DHEC's CON and their regulatory
5 folks?

6 A: From my understanding, yes.

7 Q: All right. And this document appears to be,
8 but you tell me if I'm right, a document that
9 was sent to DHEC's CON program by Ms. Cantwell
10 to provide an update on that project, that was
11 one of your main priorities, the Roper St.
12 Francis Hospital Berkeley location; is that
13 right?

14 A: Correct.

15 **MS. HOLLINGSWORTH:** Your Honor ---

16 A: But this was several months before I came.

17 **THE COURT:** Mr. Dayhuff, Ms. Hollingsworth has an --
18 -

19 **MS. HOLLINGSWORTH:** I would just ask similarly to
20 yesterday that Mr. Dayhuff lay the foundation
21 for Mr. Porter's knowledge of this document,
22 other than just agreeing with Mr. Dayhuff's
23 summary of what the document is.

24 **MR. DAYHUFF:** We're laying the foundation, Your
25 Honor. But we'll keep going if we need to.



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1 **THE COURT:** Okay.

2 **MS. DAYHUFF:** And this is an exhibit proposed by
3 Roper.

4 **Q:** So when you came to Roper and became one of the
5 folks primarily responsible for the Roper
6 Berkeley Hospital location, I imagine you
7 familiarized yourself with the CON application.

8 **A:** To be open with you, I did not review the CON
9 application. I didn't feel there was a need
10 since it had been approved and was under
11 construction. So I just picked up the
12 construction and development.

13 **Q:** Got you. Did someone provide you information
14 about what had been approved, the nature of the
15 project, that kind of thing? I imagine they
16 did.

17 **A:** Very high level, yes.

18 **Q:** All right. And then did they provide you any
19 information about how you had to report
20 periodically to DHEC about the progress as you
21 get to the point where you're going to open up
22 this facility?

23 **A:** I know that they were I think quarterly reports
24 or something along that line that needed to be
25 provided.



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1 Q: All right. And this letter is a quarterly
2 report sent in by Roper regulatory to DHEC
3 about the hospital project. Take a look at
4 page 242. And just take a moment to look at
5 that. There are two -- this is a space summary
6 for the Roper Hospital. And there's two kind
7 of primary columns, CON Program, the CON
8 application ---

9 A: Uh-huh.

10 Q: --- and then Schematic Design. Do you see
11 those two things?

12 A: I do, yes.

13 Q: All right. And do you understand -- take a
14 look at -- take a look at the -- just a few
15 things here. Department square feet, total
16 building gross square feet at the bottom of CON
17 Program. Do you see that?

18 A: Uh-huh (affirmative response).

19 Q: What number is that?

20 A: The 138,750?

21 Q: Yes. That's the total square foot per the CON
22 program in 2008. Is 2008 when you understand
23 that the CON application was filed?

24 A: That's my understanding, yes.

25 Q: Okay. Look at Schematic Design, that column.



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1 A: Uh-huh.

2 Q: Go all the way to the bottom to the right of
3 138. What is the current design as of 2017?
4 What is the total square footage?

5 A: I see 115,194 and then at the bottom 33,089,
6 which includes the CUP and hospital functions
7 in medical office building.

8 Q: All right. Now, since you have been attuned to
9 the -- kind of the construction of this thing,
10 is this facility going to be 133,089 square
11 feet?

12 A: I think it's going to be roughly that, yes. I
13 know that there are -- we have our central
14 utility plant. I can't recall if the square
15 footage for that ended up at 13,000. And we do
16 have some hospital functions, mainly
17 administrative space, in the MOB.

18 Q: Okay. So, sufficed to say then, from the CON
19 2008, 138,000 square feet to what's going to be
20 designed now as probably a change of 5,000
21 square feet.

22 A: Okay.

23 Q: Is that -- do you think that's accurate?

24 A: Yeah. I know that there was a value
25 engineering process during the design to bring



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1 the project in line from a cost perspective.

2 Q: Now, take a look at the emergency department
3 line. We talked some about the emergency
4 department. And I think that's line seven. It
5 looks like -- if you look at the CON program in
6 2008, there's going to be 15 total ED rooms.
7 Do you see that?

8 A: Uh-huh (affirmative response).

9 Q: And how they're broken out, 13 treatment, one
10 isolation, one resuscitation, two triage?

11 A: Uh-huh (affirmative response).

12 Q: Then take a look at what's going to -- now the
13 schematic design in 2017.

14 A: Okay.

15 Q: Do you see that? What does it say?

16 A: 6,053.

17 Q: No, I'm sorry. How many total ED rooms?

18 A: It says 13 ED treatment, including isolation,
19 behavior health, and resuscitation, plus one
20 triage, assumes four peds rooms, type, but can
21 flex

22 Q: Okay. So it looks like the total number of
23 rooms that you are going to have in this ED is
24 13 instead of 15; is that right?

25 A: I don't know how this is -- if this is written



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1 13, and then they include the triage and then
2 peds rooms. So from this it says 15 to 13,
3 yes.

4 Q: Okay. Well, do you know how many ED rooms
5 you're going to have?

6 A: I've been told 15.

7 Q: All right.

8 A: And when I walk, so.

9 Q: All right. If it were 13 and just a different
10 configuration, would that be a substantial
11 change to your project from your perspective?

12 A: If it were 13 ---

13 Q: Thirteen.

14 A: --- today?

15 Q: Uh-huh (affirmative response).

16 A: It would be -- I don't know how to answer.
17 Substantially would be a change in what I
18 projected.

19 Q: Right. But would it be a change that would
20 materially effect your hospital's ability to
21 provide emergency care at that location?

22 A: Not day one, but it could impact future growth.

23 Q: Right. I mean, you may need those beds later.

24 A: Yes.

25 Q: All right. And that change in square footage,



1 is that material at all from your perspective?
2 If that change is indeed from 138 to 133, 5,000
3 square feet?

4 A: You know, I can't answer because I don't know
5 where these changes occurred. Is it a
6 different count of the square footage and
7 square footage that was accommodated in the ED
8 was picked up in another department that's
9 associated? So I would really need to see the
10 plans and see where the square footage is ---

11 Q: I would think a change from 15 -- if it was a
12 real change, from 15 to 13 and a change from
13 138 to 133 would not materially effect this
14 project.

15 A: I would say that's a reasonable assumption.
16 But I -- it's just an assumption of mine.

17 Q: Fair enough. Fair enough. Are you aware of
18 any change to the configuration of what is
19 inside the Roper Hospital from CON plan to now?

20 A: I'm ---

21 **MS. HOLLINGSWORTH:** Your Honor, if I could object
22 here. The witness has already said he didn't
23 review the CON application from 2008 since he
24 was with us in 2017. I think continuing to ask
25 him questions about what was in the application



1 and today is just -- there's no foundation.
2 The witness has already said he didn't review
3 the application from 2008.

4 **MR. DAYHUFF:** This witness could be aware of changes
5 in the configuration of the project. It was
6 his principal responsibility. He didn't read
7 the CON application. That's not the only way
8 administrators get information about a proposed
9 project and what's going to be developed. If
10 he says I don't know, he doesn't know, and then
11 that's fine.

12 **THE COURT:** The objection is overruled.

13 **MR. DAYHUFF:** Thank you.

14 Q: So the question was, are you aware of any
15 changes in the configuration of things in the
16 hospital that have occurred from the time --
17 you know, that now are different than what was
18 originally proposed?

19 A: I made those changes from the design documents
20 that were given to me. The design documents
21 were already approved before I got here.

22 Q: Okay.

23 A: So I can't tell you for sure.

24 Q: Fair enough. Are you aware of any changes from
25 the time you got there and were presented with



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1 design documents I guess in 2017 until now?

2 A: No major changes other than to account for the
3 potential cath lab that we were trying to
4 secure through the CON process.

5 Q: All right. And tell me about that change in
6 design.

7 A: Just sharing that we had the space identified
8 in terms of where we would place that within
9 the imaging services area.

10 Q: All right. And that was a change from the
11 design document you got?

12 A: I don't know if it was -- it was just confirmed
13 and hardwired that -- the shell space. That
14 was all.

15 Q: And was that a change in the design documents
16 or not?

17 A: The design document -- I cannot say for sure if
18 it was a change in the design document. It was
19 just an area of focus that I had, that since it
20 looked like we had a possibility of being
21 approved, let's make sure that we can quickly
22 accommodate it if approved.

23 Q: All right. You mentioned the -- kind of the
24 idea of the ED as the front door of the
25 hospital.



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1 A: Correct.

2 Q: What percent of admits do you get through the
3 ED?

4 A: It varies by location. Freestanding EDs may be
5 two, three, four percent. Roper downtown was
6 probably in the low to mid 20s because they had
7 a higher acuity patient population.

8 Q: Okay. Let's see, where were we? I gathered
9 that you are concerned that -- I think you
10 testified you're concerned that our -- if we
11 establish our FED -- if we establish our FED in
12 Berkeley County at the location, that it would
13 have the ability to affect Roper's ED services
14 is what you testified to, right?

15 A: Yes.

16 Q: All right. So when you were part of Roper's
17 administration, did that administration conduct
18 a formal analysis that estimates the lost
19 revenue that Roper could experience if the MUSC
20 FED were established?

21 A: No, I don't -- would not say that there was a
22 formal analysis.

23 Q: Did the Roper administration conduct a formal
24 analysis that estimates the loss of ED visits
25 that could occur if we establish the FED?



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1 A: No.

2 Q: Did the administration conduct a formal
3 analysis that estimates the effect that that ED
4 could have on your ability to staff EDs, either
5 from a physician perspective or a nursing
6 perspective?

7 A: I would not say it was a formal analysis, more
8 based on past experience and ---

9 Q: Well, we'll get there. We're just talking
10 about formal analysis right now. How about a
11 formal analysis by Roper administration that
12 estimates any type of adverse effect that the
13 ED could have on Roper's ED services?

14 A: No.

15 Q: Has Roper's administration conducted an
16 informal analysis that estimates an amount of
17 lost revenue, lost utilization, or lost ability
18 to staff, quantify any of those things?

19 A: We have done informal work to look at the
20 impact of Berkeley Hospital within our own ED
21 services and what could possibly occur with the
22 development of MUSC or Trident's freestanding
23 ED, but not a formal, engaged external
24 consultant.

25 Q: Well, and I'm talking about Roper



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1 administration right now.

2 A: I'm talking about ---

3 Q: Right?

4 A: Yes.

5 Q: So no formal analysis that quantifies lost
6 revenue, lost utilization, or some effect on
7 staffing ---

8 A: Well, in the staffing, specifically, ED nursing
9 is one of the toughest areas to recruit for
10 with OBG -- labor and delivery and surgical
11 services. So we have had discussions about the
12 impact on staffing.

13 Q: I understand. Discussions. And right now I'm
14 asking about have you quantified it. Could you
15 tell me, yeah, boy, if that FED goes in over
16 there, we would be concerned -- we would expect
17 it has the ability to or may effect us X amount
18 of utilization or S amount of revenue?

19 A: Not to that level.

20 Q: All right. And in fact the analysis you
21 described to me, the informal analysis, is kind
22 of broader than that, right? It's what's going
23 on in that entire market; MUSC.

24 A: MUSC.

25 Q: Trident.



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1 A: Yes.

2 Q: Right? Let's set the administration aside.
3 We've talked about administration and I
4 understand the testimony there. You mentioned
5 consultants. You have a consultant, a health
6 planner. Did you ask Ms. Platt or anybody at
7 Roper that you're aware of to conduct a formal
8 analysis that would estimate the amount of lost
9 revenue, utilization, or ability to staff that
10 could be caused by the FED?

11 A: I did not directly.

12 Q: Have you seen one?

13 A: I have not.

14 Q: And you haven't personally undertaken an
15 analysis of that type?

16 A: No.

17 Q: And in your deposition you were very candid
18 with me. You're worried about lots of new
19 facilities in that area, right?

20 A: Uh-huh (affirmative response).

21 Q: And quite frankly there may be the ability to
22 affect something somewhere, but you don't know
23 that it's going to affect any of your ED
24 services in a material way at this point, do
25 you?



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- 1 A: From my personal experience I feel it will,
2 yes.
- 3 Q: All right. But before you would say -- today
4 you said it has the ability to affect.
- 5 A: Uh-huh (affirmative response).
- 6 Q: Which is candid. Before you would say it will
7 affect, you'd want to analyze that further,
8 true?
- 9 A: Yes.
- 10 Q: The Roper Mt. Pleasant ED, it's pretty far from
11 MUSC's FED, isn't it?
- 12 A: I think as the crow flies, eight to ten miles.
- 13 Q: Okay.
- 14 A: Well, from which ...
- 15 Q: Mt. Pleasant to the proposed FED site.
- 16 A: Oh, to the proposed. Sorry, I thought you said
17 MUSC's downtown. It's more than eight to ten
18 miles. It's quite a bit.
- 19 Q: Maybe we can short circuit this. That -- our
20 FED, if we get to establish it, will not have
21 a material effect on an ED in Mt. Pleasant if
22 it's that far away, will it?
- 23 A: No, I would not see so -- see that occurring.
- 24 Q: If we get to establish our FED, it will not
25 have an effect on an ED in Moncks Corner that



1 is way to the north?

2 A: That I don't know. When I look at Berkeley
3 Hospital, about 50 percent of Moncks Corner's
4 patients originate from the Berkeley Hospital
5 market area.

6 Q: Okay. So, you would be concerned that perhaps
7 there's the ability to affect ---

8 A: Yes.

9 Q: --- that one. All right. How many miles away
10 is that one?

11 A: I think as the crow flies it's 11 to 12.

12 Q: Yeah. It's 11 to 12. It's kind of outside
13 that general area that you testified that an
14 FED usually draws from, the five to seven
15 miles.

16 A: I quantified it and said but that's where you
17 have density. Moncks Corner does not have
18 population density. It's ---

19 Q: Okay. All right. But, again, before you would
20 be able to say it would affect, you'd have to
21 do more analysis.

22 A: It -- again, we had done quite a bit of
23 analysis on that because we are curious about
24 what our own hospital at Berkeley will have on
25 MOncks Corner's ED.



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1 Q: That's right. You're worried about the new
2 capacity that you're bringing -- that your
3 hospital effecting Moncks Corner. That
4 hospital is closer to Moncks Corner than our
5 proposed FED, isn't it?

6 A: No.

7 Q: It's not? About the same?

8 A: I think your FED is about five to six miles and
9 Moncks Corner is about 11 to 12 miles.

10 Q: Okay. And maybe I'm confused by the geography.
11 How close is your proposed hospital in Carnes
12 Crossing to the Moncks Corner FED?

13 A: About 11 to 12 miles.

14 Q: All right. And we are closer?

15 A: Yes.

16 Q: Okay.

17 A: To the -- to our Berkeley hospital.

18 Q: I'm sorry.

19 A: Oh, I'm sorry.

20 Q: Is our proposed FED closer to the Moncks Corner
21 FED than your hospital or vice versa?

22 A: Our hospital is closer to Moncks Corner, but
23 not significant. I'd say maybe three to five
24 miles.

25 Q: Okay. It's proximity, even, what, 11 -- three



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1 to five versus 11, it would be more likely to
2 impact Moncks Corner than our FED, just by the
3 factor of, one, they're Roper patients and,
4 two, it's closer than our FED, fair?

5 A: Potentially, yes.

6 Q: Roper has a hospital ED in West Ashley. What
7 kind of volume are they doing? Pretty heavy.

8 A: Approximately 50, 52,000.

9 Q: Fifty-two thousand. I mean, there's no way
10 that a FED, if we get to establish it near
11 Summerville, is going to materially affect St.
12 Francis.

13 A: Well, when we look at the patient origination
14 data for St. Francis, we do have a number of
15 patients, a good percentage of patients that do
16 come from that Moncks -- I mean, the Moncks
17 Corner, Carnes Crossroad to St. Francis.

18 Q: Listen, I understand they come from there. But
19 is there any -- you wouldn't say that that
20 hospital ED location is going to be materially
21 adversely affected by ---

22 A: I don't think materially, no.

23 Q: Another question kind of related to that. Do
24 you think if we put in an FED at our location,
25 that it will cause the folks at any of the



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1 current EDs that are open -- the folks, the
2 nurses and the physicians -- to lose their
3 proficiency in emergency medicine?

4 A: I can't say that it would cause them to lose
5 their proficiency.

6 Q: They'd still be able to practice at the high
7 level that you're accustomed to them
8 practicing?

9 A: Yeah. But I do think there's a threshold in
10 volume that you would want to maintain.

11 Q: Sure. Back in 2017, MUSC and Trident both
12 filed CON applications for FEDs in Berkeley
13 County, right?

14 A: Yes.

15 Q: We talked about this at your deposition. Roper
16 opposed both.

17 A: That's my understanding, yes.

18 Q: Right. Opposed MUSC's application, opposed
19 Trident's. Roper made the same health planning
20 arguments against both, too much capacity, no
21 need. Despite having the same arguments
22 against both projects, Roper dropped its health
23 planning opposition to Trident's FED.

24 A: Uh-huh (affirmative response).

25 Q: Isn't that right?



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1 A: It's my understanding, yes.

2 Q: But retained its opposition to MUSC's FED,
3 right?

4 A: Correct.

5 Q: And that's why we're here I suppose. Part of
6 the reason Roper dropped that opposition, part,
7 was in return for Roper dropping its opposition
8 to Trident's -- part of the reason Roper
9 dropped opposition to Trident's FED was Trident
10 dropped its opposition to a cancer center that
11 you wanted to establish in that project that
12 you were primarily responsible for, your
13 hospital, right.

14 A: Right.

15 Q: And it made sense to you as an administrator to
16 trade that opposition because you needed a
17 cancer center in that hospital. It's a
18 treatment -- or a service line that you needed
19 to provide for your patients.

20 A: Yes. We wanted to have cancer services there
21 and Trident's freestanding ED was supporting
22 their hospitals that are currently in the
23 market.

24 Q: Right. Certainly just a part of the reason.
25 Cancer center, critical element of the care you



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1 wanted to provide there.

2 A: Correct.

3 Q: MUSC didn't oppose the cancer center in your
4 hospital, right?

5 A: I'm honestly not sure.

6 Q: Okay. But because Trident tried to stop you
7 from -- and you're sure they opposed it though,
8 right?

9 A: I'm sure they did, yes.

10 Q: Because they tried to stop you from having that
11 cancer center, they have a CON for an FED right
12 now, right?

13 A: Yes.

14 Q: You offered some testimony that you are
15 exploring transfer opportunities, exploring the
16 services that the Trident Health System offers,
17 or that Roper's exploring those?

18 A: We had meetings with some Trident leaders to
19 talk about our hospital opening and how would
20 patients be managed in that community,
21 specifically if they needed a service that the
22 Berkeley Hospital does not offer.

23 Q: Makes sense. So those discussions began when?
24 Before you left obviously, right?

25 A: Before I left. I think my meeting with Lisa



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1 and her team was kicked off maybe about six
2 months ago.

3 Q: And we heard some testimony about this. If --
4 it would make sense, wouldn't it, for MUSC to
5 wait until it gets approval to even start to
6 establish an FED before it goes out to have
7 those conversations to talk about transfer
8 relationships and capabilities? That would
9 make sense, wouldn't it?

10 A: Well, it's something you should evaluate early
11 in the process.

12 Q: We should do it right now before we have our
13 CON?

14 A: I'm just -- I would do it as part of your
15 planning process.

16 Q: Okay.

17 A: How would patients be managed.

18 Q: And so you would have done that maybe back in
19 2008 when you filed? You wouldn't have done it
20 that early.

21 A: I wouldn't have done it that early.

22 Q: All right. Is it unreasonable for us to wait
23 until we get our CON before we have those
24 conversations, as long as we do them?

25 A: I don't think it's unreasonable.



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1 Q: Same thing with transfer agreements -- I mean,
2 should we be negotiating transfer agreements?
3 We could do that once we get approved, right?

4 A: As long as they're in place prior to that.

5 Q: Because it's not going to -- if we get a CON,
6 I mean, how long is it going to take us to
7 establish an FED, to build it, roughly?

8 A: A year, year and a half.

9 Q: So you offered some thoughts, some observations
10 kind of about the market and about capacity and
11 things like that. Those were observations that
12 you offered from your perspective as an
13 administrator, fair?

14 A: Correct. Yes.

15 Q: So you're aware of folks that do health
16 planning as an expertise.

17 A: Yes.

18 Q: Right? We've got Kathryn Platt. We've got
19 David Levitt. And you're aware that those
20 folks for a living analyze populations, use
21 rates, geography, access, distribution, all of
22 those things as an expertise?

23 A: Yes.

24 Q: You don't purport to be an expert healthcare
25 planner, do you?



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1 A: No.

2 Q: You mentioned kind of the investments Roper had
3 made in that north area.

4 A: Uh-huh.

5 Q: The hospital's one. But things like
6 specialists and physicians and offices and
7 things of that nature, urgent cares and all of
8 those kinds of things Roper's doing. MUSC has
9 made similar investments in the same area; have
10 they not?

11 A: I am aware of some MUSC physician practices in
12 that market.

13 Q: Right. Practices, facilities, right, urgent
14 care?

15 A: In the Moncks Corner or the Summerville ---

16 Q: The north area.

17 A: I'm not aware -- not sure.

18 Q: Fair enough. How about a pediatric outpatient
19 center?

20 A: I am aware of down -- more in the North
21 Charleston area.

22 Q: MOBs of doctors?

23 A: Yes.

24 Q: And of course they propose a hospital, right?

25 A: Yes.



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1 Q: All right. Thank you, Doctor.

2 A: Thank you.

3 Q: I appreciate your time. Mr. Porter.

4 THE COURT: Ms. Hollingsworth.

5 MS. HOLLINGSWORTH: Did Ms. Biggers have any
6 questions?

7 THE COURT: I'm sorry.

8 MS. BIGGERS: No questions from DHEC.

9 THE COURT: Okay. And forgive the oversight.

10 MS. HOLLINGSWORTH: Your Honor, I have just a couple
11 follow-up questions.

12 MR. PORTER - RE-DIRECT EXAMINATION BY MS.
13 HOLLINGSWORTH:

14 Q: Mr. Porter, you were asked about -- the
15 discussion yesterday about capacity constraints
16 in the emergency department at MUSC. And you
17 were asked about the -- sort of using the FED
18 model to alleviate capacity constraints. Do
19 you recall that?

20 A: Yes.

21 Q: Okay. Have you -- in your experience of
22 developing a number of freestanding emergency
23 departments, have you planned a freestanding
24 emergency department based only on redirecting
25 your patients?



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1 A: No. Not only on that. Again, it may have been
2 a side effect of the development, but it was
3 not the sole purpose of the development.

4 Q: Okay. And then in your experience of planning
5 these multiple freestanding emergency
6 departments, have you been -- in any of those
7 emergency departments, were they over 20 miles
8 away or over 30 minutes away, distance?

9 A: No. The -- you know, one, you have the CMS
10 rule that keeps them within a certain
11 geography. But most of ours were within ten
12 miles of the base campus.

13 Q: Okay. You were asked about -- you were asked
14 to address testimony yesterday regarding the
15 MUSC market share in the north area. That was
16 what I couldn't remember earlier. The north
17 area was the description used yesterday. Do
18 you recall being asked about MUSC's market
19 share by Mr. Dayhuff?

20 A: Yes.

21 Q: And I believe you addressed that you didn't
22 have any idea as to whether those patients
23 worked downtown or had some other reason; is
24 that right?

25 A: Correct.



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1 Q: Let me ask you this. Do you have any knowledge
2 of what the acuity needs were or are of these
3 25 percent of the north area patients that show
4 up at MUSC ED downtown?

5 A: No. I understand it's reflective of their
6 entire population.

7 Q: Okay. And did you hear anything from Dr. Hall?
8 Did he have any knowledge that he shared
9 yesterday about what the acuity mix was of the
10 25 percent of these north patients?

11 A: If I recall, he stated that they were
12 reflected, but could be tied to some specialty
13 programs, LVADs and this, that, and the other.
14 He was talking about the different populations
15 of patients that do come to the MUSC ED.

16 Q: Okay. You were asked about the -- that there
17 were -- that Roper St. Francis had challenged
18 also the Summerville's application for a
19 freestanding emergency. Do you recall that?

20 A: Yes.

21 Q: And let me see -- and I believe you were asked
22 about -- that the testimony that you were
23 asked about in terms of why it was or that you
24 didn't oppose the decision to drop the
25 opposition to Summerville's freestanding ED.



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1 Can you tell me more? You started to say
2 something about Summerville's presence. Can
3 you explain a little more, why it may be
4 different between the two providers?

5 A: I think it's two-fold. One is our basic
6 physicians, we want to have comprehensive
7 services at the hospital and thought this was
8 a opportunity for us to have the comprehensive
9 cancer services at the hospital. The
10 Summerville freestanding ED was -- is
11 supporting a patient population in that market
12 where they're currently located. So it's not
13 a new market to them. So they're currently
14 providing the services in that market.

15 Q: Okay. And Mr. Dayhuff asked you about --
16 described to you, I guess, the impact, because
17 MUSC did not challenge the Trident freestanding
18 ED during the same period of time. Did MUSC --
19 was MUSC also proposing to add a linear
20 accelerator in Berkeley County?

21 A: It was my understanding. Yes.

22 Q: Did Roper St. Francis oppose MUSC's application
23 for linear accelerator services?

24 A: I'm trying to recall. I believe so.

25 Q: Okay.



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1 A: Actually it would probably be best for me to
2 say I'm not positive.

3 Q: Okay. All right. In terms of -- you were
4 asked about changes to the plans for Roper
5 Berkeley Hospital over the period of time, I
6 believe you said 2008 is when it was filed.

7 A: Yes.

8 Q: Is that right? The cath lab that you were
9 talking about and sort of evaluating to ensure
10 that that space would be able to serve that
11 purpose if we were approved; do you recall that
12 testimony?

13 A: I do, yes.

14 Q: Okay. I just want to ask you, there was a CON
15 application to add that service; is that right?

16 A: Yes. Can I clarify something about that?

17 Q: Uh-huh (affirmative response).

18 A: And now I recall. The change was we actually
19 have put -- are putting an IR lab in the space.
20 So when I picked up the project, we were not
21 planning to have the IR lab until we got the
22 cath lab. But we now have the IR lab. And the
23 cath lab would be activated with the addition
24 of the cath package. So, that was the change.

25 Q: And in evaluating sort of the cardiac cath



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1 services, which was not something in the
2 original application, there was a CON
3 application asking the Department for
4 permission to add a cardiac cath lab; is that
5 right?

6 A: Yes.

7 Q: Okay. I don't have any other questions. Thank
8 you.

9 **MR. PORTER:** Your Honor, I have one or two, if you
10 don't mind.

11 **MR. PORTER - RE-CROSS-EXAMINATION BY MR. DAYHUFF:**

12 Q: The IR lab, I don't know what that is.

13 A: Interventional Radiology.

14 Q: Well, we have to have permission to ---

15 A: Oh, I'm sorry.

16 Q: --- have you answer, I suppose.

17 **THE COURT:** No, I'll allow it. Because I was
18 wondering about that myself.

19 Q: Mr. Porter, what's the IR lab?

20 A: It's an interventional radiology lab.

21 Q: All right. And that IR lab had to be added to
22 the hospital as a result of the cath program.
23 No?

24 A: No.

25 Q: Explain that to me.



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1 A: An IR lab and a cath lab are essentially the
2 same. It's just a cath lab has a hemodynamic
3 system and a software package that allows you
4 to do cath cases on that.

5 Q: Thank you.

6 **MS. HOLLINGSWORTH:** With The Court's permission, we'd
7 like the witness to be excused.

8 **THE COURT:** Mr. Dayhuff?

9 **MR. DAYHUFF:** Oh, no objection.

10 **THE COURT:** Mr. Thomas?

11 **MR. THOMAS:** No objection.

12 **THE COURT:** Okay. And, Ms. Biggers, I'm assuming no
13 objection.

14 **MS. BIGGERS:** No objection.

15 **THE COURT:** Okay. Thank you, Dr. Porter.

16 **MS. HOLLINGSWORTH:** Your Honor, we have one other
17 witness, our director of emergency services,
18 Ms. Huntington. And then it would be our
19 expert witness, Ms. Platt. But I do think that
20 Ms. Huntington's Direct could be potentially an
21 hour to two hours. So given it's 11:21, I
22 wanted to check with you before we embark on
23 that.

24 **THE COURT:** Okay. Do you think we'll complete by
25 1:00?



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1 MS. HOLLINGSWORTH: I'm not certain.

2 THE COURT: Okay. Let's just try for that. We'll
3 target 1:00. Okay.

4 JOY HUNTINGTON, having been duly sworn, testifies as
5 follows:

6 COURT REPORTER: Please state and spell your first
7 and last name.

8 MS. HUNTINGTON: Joy Huntington, J-O-Y H-U-N-T-I-N-G-
9 T-O-N.

10 COURT REPORTER: Thank you.

11 MS. HUNTINGTON - DIRECT EXAMINATION BY MS.

12 HOLLINGSWORTH:

13 Q: Ms. Huntington, if you could -- and I believe
14 -- introduce yourself to The Court.

15 A: My name is Joy Huntington. I am a registered
16 nurse, currently the director of emergency
17 services for Roper St. Francis Healthcare.

18 Q: Okay. And if you will -- we have -- your CV is
19 Roper 8. This notebook right here, you should
20 at least have a paper copy. All right. Ms.
21 Huntington, could you give us your educational
22 background?

23 A: So my basic -- I graduated from high school in
24 '79, went on to college. Graduated with a
25 bachelor of science in nursing from Bob Jones



1 University in 1984. And then completed a
2 masters degree from the Medical University of
3 South Carolina, master of science in nursing in
4 1980 -- 1996. And then I also completed a
5 post-graduate certificate in healthcare
6 informatics from Duke University in 2014.

7 Q: Okay. And you have in front of you and we have
8 on the screen what has been marked as Roper St.
9 Francis Exhibit 8. Can you identify this
10 document?

11 A: This is my CV, yes.

12 Q: And does this CV accurately reflect your
13 educational background, your experience, and
14 your -- sort of your employment history and
15 activities related to your profession?

16 A: It does, yes.

17 Q: And we'll ask you some more questions about it.

18 **MS. HOLLINGSWORTH:** But Your Honor, I would ask that
19 Roper 8 be admitted in evidence.

20 **MR. DAYHUFF:** No objection.

21 **THE COURT:** It's admitted.

22 **(Petitioner Roper's Exhibit Number 8 was admitted**
23 **into the record at this time.)**

24 Q: And I believe -- Ms. Huntington, when you
25 introduced yourself, you are -- you mentioned



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1 you're a registered nurse. Is that right?

2 A: That is correct.

3 Q: How long have you been a registered nurse?

4 A: Since 1984, so 35 years.

5 Q: Okay. And has that -- have you always been in
6 South Carolina?

7 A: Yes, I have.

8 Q: And looking at your CV, which is the second
9 page of Roper St. Francis 8, it looks like it
10 starts at around 1984. So, can -- walk us
11 through, if you would, just your employment
12 experience once you received your certification
13 and licensure as a nurse.

14 A: Okay. I graduated in 19 -- May of 1984 and
15 began at the Medical University right after
16 that in the medical ICU. Worked for right
17 around a year in that ICU and then moved to the
18 Roper -- at the time, Roper Hospital, to their
19 ICU/CICU, coronary intensive care unit, and
20 worked in that field for probably another eight
21 months or so. Visited one night in the
22 emergency room and fell in love and so switched
23 to the ER in February of 1985 -- excuse me,
24 1986. And then have been in the ER in some
25 capacity or other since that time.



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1 Q: Okay.

2 A: In that period I went back to school, got my
3 master's degree in nursing and worked as a
4 nurse practitioner. So an advanced practice
5 nurse for a period of a few years and then
6 ultimately back to the ER. So, I mean, I've
7 kind of skipped ahead there and, you know,
8 skipped some of the other jobs. But that was
9 an advanced practice role. And then moved back
10 to the ER and took a job as a clinical manager
11 in the emergency room, called at that time a
12 clinical coordinator. Did another brief stint
13 as a nurse practitioner, all the same time
14 still working, working in the ER. Came back to
15 the ER in 2000 full time -- excuse me, 2005
16 full time as a clinical nurse specialist in
17 more of a support and advisory capacity to the
18 director of the emergency services. And then
19 she retired towards the end of 2017 and I moved
20 into that position.

21 Q: Okay. And that position is with Roper St.
22 Francis Healthcare?

23 A: It is, yes.

24 Q: Okay. And so looking at your resume, it looks
25 like you started out early in your career



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1 actually with the Medical University; is that
2 right?

3 A: I did.

4 Q: Okay. And you went to Roper St. Francis
5 Healthcare, but then also went back to the
6 Medical University for a bit?

7 A: I did.

8 Q: Okay. Has the entirety of your professional
9 nursing career since 1984 been in the
10 Lowcountry area?

11 A: Yes, it has.

12 Q: Okay. All right. And geographically where
13 would you describe that your time as a
14 registered nurse been within that Tri-County
15 area?

16 A: Primarily at the downtown facility, either MedU
17 or Roper. Although I have -- because of my
18 system relationship, have been actually at all
19 of the ERs; so Berkeley County, north area, all
20 of the -- West Ashley campus, all of those
21 facilities.

22 Q: Okay. All right. And looking at this, it
23 looks like, other than a brief return to MUSC,
24 you've been with Roper St. Francis since 1985?

25 A: Yes, that's correct.



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1 Q: All right.

2 A: And even during that return to MUSC, I still
3 was a Roper employee. So there really has been
4 the 34, 35 years of Roper.

5 Q: Okay. All right. Tell me about your, this
6 postgraduate education that you have.

7 A: At the time that I took over that, I was
8 working as a clinical specialist. So my focus
9 was highly aimed at projects and quality and
10 that sort of stuff. We were getting ready to
11 undertake EMR, electronic medical record
12 implementation. So two of them actually. We
13 moved from a system EMR to a freestanding, kind
14 of stand-alone application for the ER. And
15 then shortly after that, a year or so later,
16 moved to another system application. So we
17 needed someone that really had an understanding
18 of informatics in general to be able to help
19 implement those projects, much successful in
20 sort of carrying that out ourselves.

21 Q: So is that -- where did you receive that
22 education?

23 A: From Duke University.

24 Q: And is that education something that you use
25 sort of in a supervisory or management role?



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1 Is that why you took on that additional
2 education?

3 A: It was. Again, I was working as a clinical
4 specialist. But my primary role during those
5 two implementations was bringing those
6 electronic medical records up in the ER.

7 Q: Okay. Do you have any other professional
8 certifications?

9 A: I am a certified emergency room nurse through
10 the Emergency Nurses Association.

11 Q: Okay. So how long has it been that your
12 nursing career has focused on emergency
13 services?

14 A: Since 1986, so 33 years.

15 Q: Okay. And it looks like on page three of your
16 CV you've had some publications and some
17 presentations in the areas related to your
18 work?

19 A: Yes, that is correct. So we worked as a group
20 with a quality team to look at sepsis and look
21 at sepsis improvement within our facility, both
22 from an ER perspective and from a hospital
23 perspective. And worked to improve those
24 outcomes within our organization back when the
25 Surviving Sepsis Campaign first was kicked off.



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1 Dr. Hall mentioned that as well yesterday.
2 Specific to the ER evidence care of venomous
3 injuries in the emergency department; so snake
4 bites, spider bites, those kind of things that
5 are common to the Lowcountry. Just preparing
6 people for the summer things that happen. And
7 then we focused again on another sepsis
8 initiative specific to the cancer patient
9 receiving chemotherapy. It's a little bit
10 different. And then also a focus on our door-
11 to-balloon times in those patients having the
12 acute MI.

13 Q: Okay. So today you serve as the director of
14 emergency services, right?

15 A: I do, yes.

16 Q: And that's for the system?

17 A: Yes.

18 Q: And so when we talk about the Roper St. Francis
19 system, what does that include?

20 A: So Roper Hospital, Bon Secours St. Francis
21 Hospital, the Roper Mt. Pleasant Hospital, and
22 then the two freestanding EDs, the one at
23 Northwoods and the one in Berkeley County, and
24 then to be the addition of the Berkeley
25 Hospital.



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1 Q: Okay. And so your responsibility as director
2 of emergency services is all of those emergency
3 departments?

4 A: Correct.

5 Q: And you mentioned and I can see on your resume
6 that in 2017 you took on this role as director
7 of emergency services. The role immediately
8 prior to that, how did what you did as a
9 clinical specialist sort of relate to the
10 person that was serving as the director of
11 emergency services?

12 A: So much of what I did at that time was a
13 support function to her. But the data
14 analysis, the data collection, the monitoring
15 of our metrics and our outcomes, and
16 determining how we can pull those metrics and
17 outcomes and best track those metrics and
18 outcomes. So that's how I really became so
19 familiar with kind of our statistics and our
20 process measures, through that.

21 Q: You heard discussion yesterday. Performance
22 metrics, would that be a way to describe what
23 you're talking about?

24 A: Correct.

25 Q: And so since 2005 it's been a part of your job



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1 to understand and evaluate performance metrics
2 for emergency services ---

3 A: That's right.

4 Q: --- in the Tri-County area; is that fair?

5 A: Yes.

6 Q: And I think Mr. Porter gave us some dates, but
7 can you -- when were the freestanding emergency
8 departments established that you just mentioned
9 in the Roper St. Francis system?

10 A: So the Berkeley County freestanding ER was
11 established in 1992 and the Northwoods facility
12 was in 1989, '99. It's going to be 20 years
13 this year, so, yeah, it must have been '99.

14 Q: Okay. And you talked a little bit about what
15 you did as a clinical specialist. Describe
16 what your duties are as the director of
17 emergency services.

18 A: So I am responsible for the operational
19 activities of the emergency services in general
20 -- budgets, setting budgets, monitoring
21 productivity, monitoring quality outcomes,
22 establishing staffing patterns, hiring the new
23 staff. I may not actually hire every single
24 nurse, but certainly, you know, involved in
25 that process. Again, quality outcomes and just



1 sort of keeping physician relationships,
2 physician contracting, making sure that we're
3 all headed in the same direction. You know, it
4 really is such a challenge with five ERs, that
5 you want to allow them to keep their own
6 individual personality, but there's so much to
7 be said for kind of standardizing across that.
8 So it's really that sort of bigger, overall
9 view to make sure we're all doing the same
10 thing and heading in that same direction.

11 Q: Okay. And are you involved in any way in
12 planning related to ED services?

13 A: I am. Yes, I am.

14 Q: And so describe that for me.

15 A: Well, I mean, so my focus is going to be very
16 department, very local-specific. So I am not
17 highly in tune with what's going on out in the
18 population growth and that sort of stuff, but
19 more so on what's going on in the individual
20 ER, where our needs are, where additional
21 services would benefit us or where maybe
22 they're not needed, and sort of weighing out
23 the cost-benefit ratio of how our performance
24 with the addition of those services might be
25 altered.



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1 Q: Okay. And in thinking about those -- the
2 performance metrics or the data metrics, how
3 frequently do you review that sort of data?

4 A: Daily, sometimes hourly.

5 Q: Okay. And what are some things -- what are
6 some of the data points that you review?

7 A: So we always -- and much -- very, very similar
8 to the data that we saw yesterday from MUSC.
9 We look at volumes. We look at transfers. We
10 look at admissions. We look at EMS arrivals.
11 We look at our left without treatment or LWOT
12 rate. We look at our AMAs. We look at how
13 many patients would be transferred versus
14 admitted versus sent in the organization or
15 outside the organization. We also then look at
16 our throughput metrics as well. So how long it
17 takes a patient to get from arrival to
18 discharge for discharge patients, arrival to
19 discharge for admitted patients, that boarding
20 time, which is really looking at the time from
21 once the decision to admit them is made until
22 the time they actually get out of the ER to
23 their bed, that's the boarding time. We also
24 track our psych patient volume and the length
25 of stay for our psych patients. And other



1 pieces of those metrics, so how long does it
2 take us to get a patient to an ER bed, how long
3 does it take to get them to an ER for an ER
4 physician to see them.

5 Q: Okay. All right. And do you look at data like
6 volume by day?

7 A: Yes. Volume by hour a day, actually.

8 Q: Okay. And then what about in terms of -- do
9 you look at this data -- is it only system-wide
10 or are you looking at the different facilities,
11 the different departments?

12 A: Looking at the different facilities.

13 Q: Okay.

14 A: And system-wide, but ...

15 Q: Okay. So do you have any benchmarks or
16 anything that you measure your performance
17 metrics or data against?

18 A: Yes, we do. We benchmark with the EDBA, which
19 is the Emergency Department Benchmarking
20 Alliance, a group of -- and these are self-
21 reported statistics, so each facility self
22 reports. But it allows us to cohort with like
23 facilities. So because each of our ERs kind of
24 has their own uniqueness, freestanding very
25 different from, you know, the inpatient



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1 facilities and size is different, we compare
2 each of our ERs in their specific cohort group.
3 So this allows us to be able to benchmark
4 against a number of ERs across the country.

5 Q: Okay. And is that also something that you
6 regularly keep an eye on or look at how you're
7 comparing?

8 A: Yes. So their data is actually tabulated
9 annually. So it's -- you know, it's one of
10 those things you compare with annually rather
11 than daily.

12 Q: Okay. And so let's talk about some of those
13 most important metrics. And Dr. Hall, of
14 course, talked about a number of them
15 yesterday. So let's -- thinking about what Dr.
16 Hall talked to us about, what are some of those
17 performance metrics and what, if any, goals do
18 you have as the director of emergency service
19 for Roper St. Francis?

20 A: So the left without treatment rate is probably
21 the best sort of pulse of the health of your
22 emergency department and its ability to move
23 patients through, certainly one that CMS
24 monitors as well. Our specific goal for the
25 Roper St. Francis system is less than 1.5



1 percent. We manage to achieve that in all of
2 our ERs, most of them being less than one
3 percent. When you get beyond that -- you know,
4 what you're typically seeing when you see an
5 increased LWOT rate is that patients are
6 waiting in the waiting room for extended
7 periods of time. And that's particularly
8 concerning because you don't know what's wrong
9 with the people that are out in the waiting
10 room. You may -- you know, you try to send the
11 lower acuity people that can wait, you triage
12 them and determine, yeah, you're probably okay
13 to wait, but, you know, you just don't really
14 know what's out there. So the concern is that
15 the longer that you've got people waiting in
16 the waiting room, the more likely something is
17 to happen that could be detrimental.

18 Q: What are some of the other performance metrics
19 that you heard about yesterday or that you kind
20 of consider key metrics?

21 A: So door to doc is another one. And that's the
22 length of time from the time the patient
23 arrives until they actually are seen by a
24 physician. CMS has -- monitors that as well.
25 Benchmarks vary, depending on the size and



1 function of the ER. We certainly strive for
2 less than ten minutes. That's probably our own
3 internal benchmark when we benchmark against
4 the EDBA and other alliances. It can vary,
5 depending on the size of the ER, but definitely
6 should be 15 minutes or less.

7 Q: Any other ...

8 A: Yeah. When you look at arrival to discharge
9 for discharge patients, that gives you kind of
10 a sense of your overall productivity and
11 efficiency of an emergency department. So a
12 discharge patient should theoretically be out
13 within 180 minutes, just as kind of a global
14 benchmark. When you get longer than that, I
15 think you -- you know, you have to know that
16 there are some throughput issues within your
17 emergency department. Something's clogging up,
18 bottlenecking. And throughput can be affected
19 by -- you know, really by three things. Volume
20 certainly can affect throughput, but so can the
21 functions within the department. You know,
22 your lab processes, your ability to move other
23 patients through. So if you are, you know,
24 holding a population of patients, be it extreme
25 boarding for admitted patients or a psych



1 patient, those can cause bottlenecks and it
2 impact your ability to get your discharge
3 patients out -- seen and out. We also monitor
4 the arrival to discharge for the admitted
5 patient. But more specifically -- you know,
6 you will -- and Dr. Hall alluded to this
7 yesterday as well. An admitted patient takes
8 a little bit longer to work up, so they're
9 going to spend a little bit more time in the ER
10 making that decision. But then once that
11 decision to admit is made, you really should be
12 able -- an efficiently operating system, you
13 should be able to get that patient out in under
14 an hour. And so when you're holding admitted
15 patients for longer than that, you also know
16 you've got a throughput issue.

17 Q: Okay. And so tell me what you -- what would
18 you call that metric that you just described?

19 A: That's the boarding time.

20 Q: Okay.

21 A: We measure it from decision to admit to depart,
22 but it is the boarding time.

23 Q: Okay. So as we were looking at the scorecards
24 yesterday, boarding time would have been the
25 similar metric to what you're describing?



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1 A: Correct.

2 Q: All right.

3 A: CMS allows you to break that out by -- and
4 report that by cycles versus, you know --
5 versus non-cycles. So we all know that cycles
6 eat up a big chunk of that time, but they can
7 be considered kind of separately in the sense
8 of, you know, they don't count against you
9 quite as much, if you will.

10 Q: Okay. So I think you might have described
11 them, but yesterday we were using the phrase
12 length of stay. So, some of what you just
13 described are essentially length of stay
14 metrics?

15 A: That is correct.

16 Q: Okay. All right. And what are some of the
17 goals that you have for length of stay metrics?

18 A: It varies, depending on the type of facility.
19 So, freestanding goals will be shorter than the
20 inpatient hospital goals. The freestanding ERs
21 really should have a length of stay for admit
22 to discharge patient of about 180 minutes. The
23 inpatient facilities may go up closer to 200,
24 220, 240 minutes.

25 Q: Okay. All right.



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MOTION TO QUALIFY AS EXPERT:

MS. HOLLINGSWORTH: Your Honor, we would offer Ms. Huntington as an expert in emergency services operations in the Tri-County area.

MR. DAYHUFF: So I may be mistaken, but I wasn't aware of her being designated. Was she designated?

MS. HOLLINGSWORTH: I served -- I supplemented it I think last week. And I initially reserve -- my position, and I heard in the discovery response, that I consider Ms. Huntington's testimony in that regard, just responding to Dr. Hall and then Trident's witness. And since those depositions weren't done until the beginning of July, I had reserved that I may identify factor expert to respond to the other witnesses. And so I think that Ms. Huntington's testimony meets the necessary qualifications to be an expert. And we will give The Court some additional information on the emergency services.

MR. DAYHUFF: So, yeah, I object. We had a designation deadline for experts and she wasn't designated. So then when I took her deposition, she wasn't an expert witness. I



1 didn't do an expert deposition. I understood
2 what she was going to say just as I did with
3 the CEO. Dr. Hall, on the other hand, was
4 named pursuant to the expert witness deadline.
5 Trident offered expert witness testimony -- or
6 offered expert witnesses pursuant to that
7 deadline and so did Roper. She just didn't
8 name them. So you can't, whenever the
9 supplementation happened, name folks as expert
10 witnesses after those deadlines. She knew we
11 were having an expert emergency physician at
12 the appropriate deadline. So this violates The
13 Court's Scheduling Order and there's no
14 appropriateness of this now. She can certainly
15 offer her observations, as the other witness
16 did. That's how we took her deposition.

17 **MS. HOLLINGSWORTH:** And so to respond to that, Your
18 Honor, what -- in my discovery responses, in my
19 designations I reserved that I may seek to
20 offer expert -- fact or expert testimony in
21 response to the testimony of the other
22 witnesses. And by agreement and based on
23 availability, I was not able to take any
24 deposition of either the nursing expert of
25 Trident or MUSC's physician. Those happened



1 the first week of July. And so my position, as
2 I described in my supplement, was that her
3 testimony will be -- the testimony from her
4 deposition, I will not be exploring anything
5 outside of her deposition testimony. But I
6 believe that the factors that The Court
7 considers in terms of knowledge, skill, and
8 experience, that that testimony is expert
9 testimony. And, again, it is reserved. And I
10 am happy, if Counsel feels I am going outside
11 of her deposition, that we would raise that
12 with you. But I think that it's within the
13 scope of her deposition, but I think it
14 qualifies. And I did reserve the right to do
15 that. The depositions of his witnesses were
16 outside of the Scheduling Order, so I couldn't
17 do anything about that deadline having passed.

18 **THE COURT:** Okay. Briefly.

19 **MR. DAYHUFF:** The idea that we're offering her in
20 response to us, they are suing us. They offer
21 their folks. We're responding to them, so that
22 doesn't make sense. Both Trident and MUSC,
23 pursuant to this Court's Scheduling Order
24 deadline, said here are our experts. We've got
25 health planners. We've got physicians. And I



1 don't have a nurse, right. So that's another
2 reason why this would be really not
3 appropriate. And our position as a Respondent,
4 she's naming a nurse now. If she would have
5 done that perhaps pursuant to the deadline
6 months and months ago, we would have done that.
7 And it's not a question of her qualifications.
8 I think she's a great witness. I enjoyed
9 talking with her. The problem is, we didn't
10 take an expert deposition of this witness,
11 because she wasn't noticed to us. The idea
12 that you can reserve your right to go outside
13 the Court's Scheduling Order is not something
14 that a party can reserve. This Court ordered
15 expert deposition -- or experts months and
16 months ago. I don't remember when, but it was
17 probably this Court's first Scheduling Order
18 before we amended it. So I object to this,
19 Your Honor. I certainly don't object to her
20 offering observations, but it's too late to add
21 a new witness, a new expert witness.

22 **MS. HOLLINGSWORTH:** And Your Honor, I haven't added
23 a new witness. It's the same witness. And I
24 think what you'll find and have already seen,
25 that the testimony is the same nature of the



1 testimony that we heard yesterday from Dr.
2 Hall. And I certainly, again, submit that I
3 did provide notice to the parties about my
4 plans to respond. I didn't know what Dr. Hall
5 was going to say because I didn't get to take
6 his deposition, due to his availability, until
7 the first week of July and then I supplemented.
8 So I -- and I don't -- it doesn't change
9 anything about the nature because I'm not
10 offering her as an expert generally in the
11 field. It's very specific to what she's done
12 for 30 years for Roper St. Francis Healthcare.
13 And I think it would benefit The Court.

14 **THE COURT:** Mr. Dayhuff, yes.

15 **MR. DAYHUFF:** This is late. It's prejudicial
16 because we just found out. When did this
17 supplementation occur that she's going to be an
18 expert?

19 **MS. HOLLINGSWORTH:** Last week.

20 **MR. DAYHUFF:** Last week.

21 **MS. HOLLINGSWORTH:** It's the same notice.

22 **MR. DAYHUFF:** Yeah.

23 **MS. HOLLINGSWORTH:** And I said this supplement is
24 the same testimony.

25 **MR. DAYHUFF:** That is way, way too late. That's



1 when we exchanged exhibit lists. That's -- I'm
2 sorry, that's way too late. I know I can't
3 find our Scheduling Order deadline for experts,
4 but we had one. That's the time to name
5 experts because then I'll take a deposition
6 based on that. I didn't voir dire her on her
7 qualifications because she wasn't offered as an
8 expert.

9 **MS. HOLLINGSWORTH:** Your Honor, you know, I
10 certainly don't want to take up your time with
11 this. I mean, I think you'll hear her
12 testimony and give it the weight that you
13 believe it does. I would just note the
14 standing on the Scheduling Order, I think that
15 this is completely appropriate. It was
16 noticed. But if that -- that's the position on
17 the Scheduling Order, then I think that will
18 apply to a number of things as this next couple
19 of weeks go forward. But, I mean, I don't
20 think there's anything improper. I made it
21 clear in the discovery response. It's the
22 scope of her deposition, but I understand
23 Counsel's objection.

24 **THE COURT:** I'm going to admit her as an expert, but
25 you should keep your questions within the scope



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1 of your deposition.

2 **MS. HOLLINGSWORTH:** I will, Your Honor.

3 **THE COURT:** Okay.

4 **MS. HOLLINGSWORTH:** And I certainly will -- if
5 Counsel feels it's different, I'd be happy to
6 correct it. Thank you, Your Honor.

7 Q: Ms. Huntington, if you could, tell us again how
8 many emergency departments does Roper St.
9 Francis Healthcare have?

10 A: Currently five; three hospital based and two
11 freestanding.

12 Q: Okay. And describe -- can you just describe
13 geographically where the hospital-based
14 facilities are?

15 A: So there's one in downtown Charleston, right on
16 Calhoun Street. There's another one in Mt.
17 Pleasant on the -- sort of the northern end of
18 Mt. Pleasant. And then there is another one
19 West of the Ashley.

20 Q: Okay. And Calhoun Street, that's Roper
21 Hospital downtown; is that right?

22 A: That's correct.

23 Q: Okay. And how -- what is the size, how would
24 you describe the size of that emergency
25 department?



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1 A: So, it is a 24-bed emergency department.
2 Twenty seven licensed bed, but two of those are
3 being utilized by another department currently
4 right now, so they're not being used as ER
5 beds.

6 Q: All right. What about -- let's talk about in
7 West Ashley. Is that Bon Secours?

8 A: Yes, that's correct.

9 Q: And how would you describe the size of that
10 emergency department?

11 A: They are 30 beds.

12 Q: And Mt. Pleasant?

13 A: They are 12 beds.

14 Q: Tell me about Roper Berkeley Hospital.

15 A: The hospital that's coming online or the
16 freestanding ED?

17 Q: Fair. The Roper Berkeley Hospital that's
18 coming online in October.

19 A: Okay. It will be 15 beds. It's actually 14
20 rooms and two -- one of those rooms can have
21 two stretchers in it, so it's 15 beds.

22 Q: Okay. And your -- and I think you've described
23 it, but as Director of Emergency Services, your
24 responsibilities include that planned emergency
25 department?



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1 A: Yes.

2 Q: Okay. What about the two freestanding
3 emergency departments?

4 A: So the one in Moncks Corner or Berkeley County,
5 that was the first one online. And it is also
6 12 beds. It would qualify more as bays
7 sometimes than beds. They are curtains
8 dividing those spaces rather than walls.

9 Q: Is that the one that is from 1992?

10 A: Yes.

11 Q: And so that was established during your tenure
12 though with Roper St. Francis?

13 A: Yes, it certainly was.

14 Q: Okay. And tell us about Northwoods.

15 A: Northwoods is currently ten operating beds.
16 There are 15 beds that are built out. Five of
17 those remain locked as part of the CON
18 agreement. So there's ten functioning beds
19 right now.

20 Q: Okay. And Mr. Porter was talking about that
21 this morning. Is that that facility that's
22 recently re-opened?

23 A: That's correct. So they had flooding issues at
24 their original location. It flooded twice,
25 closed for the better part of a month and a



1 half both times. And between DHEC and everyone
2 else, our insurance said they would not rebuild
3 or renovate that facility any further, so we
4 were forced to find another location.

5 Q: Okay. Going back to the hospital-based
6 emergency departments, Roper downtown, Mt.
7 Pleasant, and the Bon Secours in West Ashley.
8 Are those emergency departments well utilized?

9 A: They are. They are well utilized. There is
10 still plenty of capacity at all three of those
11 spots where additional patients visit.

12 Q: And describe the capacity or what is available
13 at each of them.

14 A: So, the Roper Emergency Department can probably
15 accommodate an additional ten to 15,000
16 patients per year without having to add
17 additional space. The St. Francis Hospital,
18 they are closer to capacity than anybody else.
19 But they could definitely do another 5,000
20 patients a year. And they -- you know, and
21 they do. The volume tends to fluctuate. Very
22 seasonal volume here in Charleston anyway. So
23 vacations tend to be -- you know, we see a drop
24 in patient volume. Flu season you see --
25 sometimes you think, oh, no, there's no way



1 we're going to make it, you know. So it
2 fluctuates. And it's hard to -- you know,
3 sometimes it's hard to know exactly how busy do
4 you have to get before you add those spaces.
5 But you really do have to consider, you know,
6 how much bed availability you have 24 hours a
7 day. So rather than trying to do it to the flu
8 volume, you know, you're not going to add beds
9 just because flu is going to pick up. And then
10 the Mt. Pleasant emergency room, that's one of
11 our newest -- newer hospitals. They're
12 probably about 17, 18,000 patients a year and
13 could easily go to 25,000 patients a year
14 without -- probably even closer to 30 without
15 adding additional space.

16 Q: Okay. And same question for the freestanding
17 emergency departments.

18 A: So the Northwoods facility, believe it or not,
19 sees almost the same volume as the Roper
20 downtown facility. However, with it being such
21 a lower acuity type visit, those triage level
22 fours and fives that you've kind of talked
23 about, they can see more of them in that space
24 than what the downtown facility can see. So
25 they are currently -- they probably could add



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1 another 10,000 patients, even with the five
2 beds still closed. Certainly with that
3 capacity they are within three years. So
4 they're going to be allowed to open those beds
5 in '22, April of 2022. That will add an
6 additional, you know, 15,000 patient capacity.

7 Q: Okay. And what about the freestanding
8 emergency department in Moncks Corner?

9 A: They are seeing about 17,000 a year as well and
10 could easily add another 10,000 patients a
11 year. Their mix is a little different than the
12 other freestanding ER. And, you know, I think
13 that's partly related to how far they are from
14 community resources. You know, they're a more
15 rural area and so they see a little bit more
16 higher acuity patient than you would typically
17 expect to see in a freestanding.

18 Q: Do you have transfers out of your freestanding
19 EDs to hospital-based departments?

20 A: Yes, definitely.

21 Q: Where would you transfer a higher-acuity
22 patient that came to the Moncks Corner FSED
23 that needed a higher level of care?

24 A: It does depend on a number of things, how
25 critical the patient is. Of course, the most



1 critical you're going to send to the closest,
2 most appropriate facility. And you do have to
3 kind of coordinate with the patient and make
4 sure they -- you know, you may be sending them
5 some place they would prefer not to go, but --
6 you know, so you have to work to make sure that
7 they understand that. But other than that,
8 it's usually patient preference. And for the
9 most part, patients that come to our
10 freestanding departments are seeking care at
11 our facilities. So we would transfer to Roper
12 downtown.

13 Q: All right. What knowledge do you have about
14 the history -- Mr. Porter was asked questions
15 about the Roper Berkeley Hospital that pre-
16 dated him a good bit. Can you provide any
17 insight into the Roper Berkeley Hospital?

18 A: As far as the planning for its services or ...

19 Q: What do you know about the filing of the
20 application and the plan for that facility?

21 A: So I was not materially involved in the filing
22 of the application, but I was supporting at
23 that particular time, so helping to provide the
24 statistics and that kind of stuff, very much
25 aware that the application was going on. Very



1 much -- it was a long time ago. So it's been
2 a long time in the works. Aware that it was
3 going on, aware that it was being contested.
4 Sort of lost interest in it for a while,
5 because I was off doing other things. And
6 then, voila, suddenly it was approved after all
7 those years of kind of fighting over it.

8 Q: How -- what has been your involvement since --
9 well, the Certificate of Need and, as you said,
10 once it was approved, what has been your
11 involvement since that time?

12 A: So I have been involved mostly in assuring that
13 the design of the emergency department itself,
14 the layout of the emergency department, the
15 supplies that would be needed, the resources
16 that we would need to be able to operate, the
17 determinations of staffing patterns and staff
18 needs, physician contract negotiations and
19 needs, specialty -- the availability of
20 specialists as needed.

21 Q: Let's talk specifically about freestanding
22 emergency departments. And describe --
23 focusing on freestanding emergency departments,
24 if you could describe your experience in
25 working with freestanding EDs clinically and/or



1 administratively.

2 A: So I have been with Roper since our first foray
3 into the freestanding emergency department.
4 And I'll tell you, what I know of it, we were
5 one of the first in the state, if not the first
6 in the state. I wouldn't swear to that, but we
7 were very close to it. And it was even a new
8 concept in the nation at the time. It was just
9 not -- you know, not a thing that was done on
10 every street corner. So, you know, we started
11 with that. And in Berkeley County -- I can
12 tell you specifically in Berkeley County, we
13 were asked by the Berkeley County population to
14 bring our services to them. They were an
15 underserved area, challenged very much to get,
16 you know, resources that they wanted. And what
17 I heard over and over from them is we want a
18 choice. You know, we want to be able to choose
19 Roper. At the time that we established that
20 freestanding ER, we also established a rural
21 health clinic as part of that. So we were
22 serving very much an underserved population at
23 the time. The acuity matched what I would have
24 thought was appropriate for a freestanding ER
25 when -- you know, when we first started with



1 lots of the lower-acuity patients that you can
2 easily move in and out. As we've been in that
3 area, the acuity has changed and shifted a
4 little bit, but nevertheless it still maintains
5 the characteristics of a freestanding ER. The
6 real challenges with that were initially,
7 especially, was its isolation from the other
8 healthcare resources. So transporting to, you
9 know, the closest facility still required, you
10 know, sometimes an hour of transport either way
11 to get them to additional care.

12 Q: Okay. And so in terms of your administrative
13 duties with freestanding EDs, what would those
14 -- what would that include?

15 A: So, design, staffing, supplies, resources --
16 same as it would for a hospital-based.

17 Q: And what about sort of once it's ongoing? Not
18 just for planning or staffing. What are your
19 administrative duties for the FSEDs today?

20 A: So monitoring their productivity, monitoring
21 their performance metrics, quality.

22 Q: And who do you report to sort of in your
23 leadership chain?

24 A: I report to Pennie Peralta, who is the Chief
25 Nursing Officer for the Roper St. Francis



1 system.

2 Q: Okay. And you talked a little about -- first,
3 let me make sure. When you're talking about
4 acuity and patient mix, what -- we've heard a
5 couple of different ways of thinking about
6 that. Can you explain what your description is
7 of that?

8 A: As a nurse, I focus on the ESI, so the triage
9 acuity. And again, that's -- you know, it's
10 the easiest way. Because that's what -- when
11 the patient presents to you, that's what you
12 see. That's all you've got to work on.
13 Hindsight is the other one, you know, after
14 you've already done the work-up and it's
15 related more towards billing and sort of that
16 final diagnosis. But when that patient shows
17 up, they may end up kind of coding out as a
18 lower acuity level, but they may have walked in
19 with chest pain. So you still have to treat
20 them as a higher acuity when they first walk
21 in, until you rule out the fact that they
22 really aren't having a heart attack. So that's
23 where the difference is.

24 Q: What is ESI?

25 A: ESI is emergency severity index.



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1 Q: Okay. And then in terms of acuity level, how
2 many levels are there for the ESI?

3 A: Five.

4 Q: And what is the numerical significance?

5 A: So level one is the most critical. Level five
6 is the least critical. And it really is based
7 on anticipated resource utilization more than
8 anything.

9 Q: And then so using that acuity level
10 description, what is the acuity level that in
11 your experience has been appropriate for a
12 freestanding ED?

13 A: So if you could put up a sign and say come one,
14 come all, come -- fours and fives would be the
15 choice. You're going to get threes. You're
16 going to even get twos and ones. But you're
17 going to get the threes. Those are the ones
18 that are going to take a little bit longer to
19 sort of ferret out what's going on with them.
20 You use a little bit more resources. The twos
21 and ones -- and they may get discharged or they
22 may get sent on further to be admitted
23 somewhere else. The twos and ones most likely
24 are going to be admitted. They are your most
25 acute patients. And they're the ones that for



1 the most part EMS will bypass those
2 freestanding EDs and not even bring them there.
3 But it's sort of the uninformed public or the
4 scared public maybe that just sort of shows up
5 on your doorstep in those critical moments.

6 Q: And when you say they'll be admitted, is that
7 to somewhere else?

8 A: Correct?

9 Q: And what -- you gave us a description of how
10 Moncks Corner is maybe not what you would
11 expect with regard to acuity. What about
12 Northwoods? Can you kind of explain what that
13 patient population is like?

14 A: So Northwoods to me is the typical ideal
15 freestanding ED. In that area there's a large
16 percentage of patients who either don't have
17 medical homes, don't have well-established
18 medical homes, maybe are not as well funded as
19 others. And so they have high needs, but they
20 are relatively low acuity. So it's simple in-
21 and-out kind of stuff to be able to get them
22 in, screen them, meet their needs, and then
23 have them go on their way. It's a very
24 efficient process. If you try to put that same
25 mix in a regular community-based emergency



1 department or even, you know, a large trauma
2 center, they do tend to clog up your system,
3 because it's a whole lot easier to keep those
4 moving and keep the flow down than it is to try
5 and mix them in with your psych patients and
6 your more critical patients.

7 Q: Okay. Is that because the psych patients and
8 the more critical patients are at the hospital-
9 based departments?

10 A: Correct.

11 Q: Where -- tell us a little bit about the
12 geography for Roper Northwoods. Where does
13 that freestanding ED sit?

14 A: So it's on Rivers Avenue right at the -- almost
15 the border between North Charleston and Goose
16 Creek.

17 Q: And you've heard described this north area. Is
18 that within what you understand the north area
19 to be?

20 A: Yes, it is.

21 Q: What type of service area in your experience
22 has been sort of best served by having a
23 freestanding ED?

24 A: In my experience, for that -- especially that
25 particular area with its population and



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1 abundance of healthcare resources, most of
2 those patients are in a five to ten-mile radius
3 of that facility.

4 Q: Okay. And is Moncks Corner different than the
5 North Charleston, north area?

6 A: It is. It's less sparsely -- less closely
7 populated. And so -- and there are fewer
8 resources where that -- especially that
9 freestanding Berkeley ER, there are fewer
10 resources in immediate close proximity. So
11 they reach a population of patients more -- I
12 say more east of them, but I actually don't
13 know if on the map it's east, sort of that
14 Pineville area -- that come from a little bit
15 farther to them than you might see populate the
16 Northwoods ER.

17 Q: And in evaluating and monitoring the emergency
18 departments and the freestanding emergency
19 departments, do you have -- or do you review
20 any information about where the patients come
21 from, where they originate from?

22 A: Yes, we do. It's not something I do on a
23 regular basis. But definitely in preparation
24 for any kind of move or addition of services,
25 we look at those areas that are being served.



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1 Q: Okay. And the North Charleston freestanding
2 department, do you have any feel for kind of
3 how far away your patients come from to the
4 freestanding ED?

5 A: I think for -- typically on average about six
6 to ten miles.

7 Q: All right. And in terms of the amount of time
8 or the length of time for patients being in the
9 emergency department, is there a different
10 expectation for that length of time in the
11 freestanding ED versus the hospital based?

12 A: Yes. You're going to find the freestanding EDs
13 in my experience are closer to 60 minutes,
14 maybe up to 90 minutes. But 60 to 90 minutes
15 is probably routine.

16 Q: And why is that?

17 A: The efficiency of keeping -- having those low-
18 acuity patients that need less resources, not
19 getting bogged down with the more complex
20 patients really makes it very efficient.

21 A: Okay. What about that LWOT as I've heard it
22 described, that left-without-treatment rate, do
23 you -- in your experience is it typically
24 different between the two types of emergency
25 departments?



1 A: Yes. Our freestanding ERs have less than one
2 percent LWOT rate.

3 Q: And, again, what is that a function of?

4 A: It really is related to throughput, your
5 ability to move a patient from the time they
6 walk in the door to the time they walk out,
7 having the services that they need, efficiently
8 being able to meet those services. Where, you
9 know, if you've got a dozen patients and
10 they're all waiting on lab work, say, or
11 radiology -- radiology's probably a better
12 example. You know, if you've got several
13 patients that need those sorts of studies, then
14 all of a sudden everything's going to back up
15 while -- because they can only be doing one
16 person at a time. Where in a freestanding you
17 really use less of those resources. You have
18 them when you need them, but you utilize them
19 less and so you can sort of streamline and
20 process those patients very efficiently.

21 Q: Okay. We've heard a lot of testimony about
22 capacity, how that -- capacities and looking at
23 volumes. In using a metric of patients per
24 space per year, something we've heard, can you
25 tell me a little bit about your thoughts on



1 capacity?

2 A: Capacity availability -- are you talking about
3 the freestandings or are you talking about just
4 capacity ---

5 Q: So starting with a hospital-based emergency
6 department, what is your expectation on sort of
7 how many patients per space per year ---

8 A: Okay.

9 Q: --- you would put through the hospital based?

10 A: I think very similar to what we've heard. The
11 average inpatient hospital, kind of community
12 based can go anywhere from ideally 12 to 1500
13 patients per space per year.

14 Q: Okay.

15 A: As acuity changes, that may vary. Our downtown
16 facility, for instance, tends to be the
17 hospital that gets the STEMIs, the heart-cath
18 patients, the stroke patients, and very much
19 the elder population. So they're less likely
20 to be able to go up to that 1500 space than
21 maybe the Mt. Pleasant or -- the St. Francis
22 Hospital is better example even. With their 30
23 beds they are a really mix of low acuity and
24 regular typical ER patients that need to be
25 admitted. So their admission rate's about 12



1 percent, whereas the Roper downtown admission
2 rate's about 25 percent. So anytime you get an
3 admission rate of 25 percent, you're going to
4 -- you're moving patients through slower.
5 Where you've got an ER that only has about a 12
6 percent rate, they can move those patients
7 through faster. So they may be closer to 1800
8 to even 2,000 patients per bay per year.

9 Q: Okay. And the emergency department planned at
10 Roper Berkeley Hospital, do you consider that's
11 going to be more like the Mt. Pleasant
12 experience or the Roper downtown?

13 A: The Mt. Pleasant experience. I think it -- my
14 hunch is it will get there faster than Mt.
15 Pleasant did.

16 Q: Okay. Tell me, sort of that same question, for
17 a freestanding emergency department and its
18 capacity to see patients by space.

19 A: So the typical freestanding that ideally is
20 seeing the fours and fives with the occasional
21 threes, I would expect to see anywhere 2500 to
22 3,000 per bed per year. If you start to mix in
23 the more complicated patients in there, you're
24 going to slow things down and sort of lose the
25 benefit in effect of the freestanding.



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1 Q: And if you have more complicated patients in
2 there, does that mean you need to have more
3 resources in the freestanding ED as well?

4 A: Yes, it does.

5 Q: All right. Let's look at Roper St. Francis 4.
6 This document, Ms. Huntington, is this familiar
7 to you?

8 A: Yes.

9 Q: And you might have a paper copy.

10 A: Did you say 4?

11 Q: Yeah. What is this? If you can identify it
12 for The Court.

13 A: So it looks to me like the application for the
14 Certificate of Need for the Roper Hospital
15 diagnostics and ER at Northwoods.

16 Q: Okay. And are you familiar with the
17 application?

18 A: Yes, I am.

19 Q: Are you familiar with the circumstances that
20 led to the decision to file the application?

21 A: Yes, I am.

22 Q: Tell us a little bit about that.

23 A: So as I alluded to earlier, two years in a row
24 we experienced flooding in this emergency
25 department. The first one was related -- well,



1 there was the thousand-year flood and the
2 hurricane. I think the thousand-year flood
3 came first and then the hurricane came next,
4 but I can't tell you for sure. Either way, we
5 experienced flooding with water and raw sewage
6 floating in the hallway. So, it was not just
7 a little bit of flooding, it was significant.
8 That resulted in closing, renovating, literally
9 ripping out the entire sheetrock for the entire
10 building, replacing it, and then reopening. So
11 during those periods of time of being closed --
12 it's an interesting population. They are very
13 loyal. But when you close, they don't seem to
14 understand that you've kind of only closed
15 temporarily, you didn't close forever. So it
16 took us months, and even closer to a year the
17 second time to rebuild that growth, because
18 those patients were just like you're gone,
19 you're not there. And so it took a while to
20 build that back, very detrimental to us to
21 close for those periods of time.

22 Q: And the flooding, and I think you said it led
23 to closing of the facility?

24 A: It did, it did. For six weeks probably.

25 Q: Okay. Now, have you had -- at your other



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1 emergency departments, have you had to close
2 or, I think what we've heard in some of the
3 depositions, diversion? Have you ever had to
4 do that to your knowledge?

5 A: No. We occasionally divert on a case-by-case
6 basis for the patient meets level one trauma
7 criteria. So under a physician, you know,
8 recommendation, we may contact the Medical
9 University and say we need to send this patient
10 -- direct this patient towards you. But from
11 the standpoint of closing to divert and just
12 calling, you know, EMS and whoever and say
13 we're on divert, no. Other than for this.

14 Q: For the closing to renovate to repair the
15 flooding issues?

16 A: Correct.

17 Q: Okay. The Roper Northwoods, so it has -- the
18 replacement facility, is it in generally the
19 same area as the facility that was closed?

20 A: Yes. You can drive out at the end of Ashley
21 Phosphate to Rivers Avenue and look down the
22 road and almost see the new facility.

23 Q: Okay. And tell us again, how many bays are you
24 using at Roper Northwoods?

25 A: Ten currently, with five more to open in April



1 of 2022.

2 Q: Okay. And are you close to capacity?

3 A: There is still capacity. There is still room
4 to see more patients.

5 Q: Okay. All right. And you might have given us
6 some numbers earlier, but with your ten bays,
7 how many more patients could Roper Northwoods
8 treat each year?

9 A: They're seeing close to 30,000 right now, which
10 puts them close to capacity with those five
11 beds. However they can easily go up another
12 1500 to 2,000 patients a year before they need
13 to open up those additional beds.

14 Q: And when you talk about some of those numbers
15 -- and tell me again. We've talked a lot bout
16 your administrative roles, but what is -- have
17 you worked in these emergency departments at
18 Roper St. Francis?

19 A: Yes, I have.

20 Q: Tell me a little bit about the extent of your
21 kind of working time and not administrative.

22 A: Okay. So from 1986 until probably when I took
23 over -- even when I took over as a manager, I
24 still was doing significant day-to-day
25 staffing, 12-hour shifts, you know, 40, 60



1 hours a week of bedside nursing. That's where
2 I -- that's where I cut my teeth clinically and
3 definitely have worked in all of the
4 freestandings, both from a staffing, from a
5 charge nurse perspective and even as a manager.

6 Q: Okay. When was the last time -- how long has
7 it been since you've worked shifts in any of
8 the emergency departments?

9 A: Probably '96.

10 Q: Okay. So when the two freestanding EDs were
11 implemented, you did have shifts in those
12 departments?

13 A: I did. So I was in more of a management role.
14 We called them clinical coordinators at the
15 time, which is like the clinical manager, or
16 the nurse manager. However, a huge part of my
17 responsibility was being on call to fill
18 unanticipated vacancies and that sort of stuff.
19 So I literally, during those several years,
20 rotated from ER to ER, staffing and filling in
21 wherever the need was.

22 Q: All right. Let's see. And looking at the --
23 let's look at --

24 **MS. HOLLINGSWORTH:** If we could pull up Roper 44.
25 Exhibit in evidence.



1 Q: Before we get too distracted into the numbers,
2 kind of stepping back for minute. So we've
3 talked about the Roper St. Francis departments
4 throughout the Tri-County area and the
5 capacities and volumes, those good things. Is
6 it -- do you believe that there needs to be
7 more new capacity in sort of that north area
8 that we're talking about?

9 A: No. Not in my experience. There is still
10 plenty of capacity for the visits that are
11 occurring.

12 Q: Okay. And are you familiar with how the --
13 kind of the population has grown in this area
14 that you serve?

15 A: I am aware from discussion that there has been
16 population growth. I could not tell you rate
17 of population growth or how many people the
18 area is serving. That's just not something I
19 pay much attention to.

20 Q: And in your work that you do as director of
21 emergency services for Roper St. Francis, do
22 you interact with other professional-- nursing
23 professionals like yourself at the Medical
24 University or Trident Summerville facilities?

25 A: We do on occasion. There's no formal process,



1 but we are certainly familiar with each other,
2 yes.

3 Q: Okay. And with regard to the psychiatric
4 population, because we've heard a lot of
5 testimony about mental health volumes and their
6 impact in the emergency departments, do you
7 have occasion where you interact with other
8 persons in your role, the other providers?

9 A: Yes. I sit on a community mental health task
10 force that looks at trying to solve and find
11 solutions for the mental health population
12 across the Tri-County area.

13 Q: And is this -- sort of the issue of mental
14 health patients in emergency departments, is
15 that an issue faced by all of the emergency
16 departments at the hospitals in the area?

17 A: It is.

18 Q: Okay. Let's look at this Roper 44 that ---

19 **MR. DAYHUFF:** So, Your Honor, I think this exceeds
20 the scope of what this witness did during her
21 deposition. I don't recall this witness being
22 provided this document. And I imagine we're
23 now going to proceed into her offering opinions
24 about this document. So, as I understood Ms.
25 Hollingsworth, she was not going to exceed the



1 scope of the fact deposition and this would
2 exceed the scope.

3 **MS. HOLLINGSWORTH:** Your Honor, I'm not soliciting
4 opinions. The document's in evidence through
5 Dr. Hall. I'm just asking her about these
6 metrics. She's testified about the metrics.
7 And so this is my opportunity -- as a fact
8 witness I can ask her about the document that's
9 in evidence and to comment on it. I'm not
10 restrained in any means just because she has
11 opinion information. I'm not asking her to
12 give some sort of expert opinion on this. Any
13 witness -- I mean, it's no different than the
14 documents provided to Mr. Porter this morning
15 to look at. So I think the two issues are
16 completely unrelated. The document's already
17 in evidence.

18 **MR. DAYHUFF:** It's become different, Your Honor,
19 because she just qualified this person as an
20 expert witness at the 11th hour. If she's not
21 going to solicit this person's opinions about
22 this, why are we even looking at this? This is
23 not a Roper document. So it's got to be, what
24 do you think about these things? I mean, if
25 she wants to stipulate these aren't expert



1 opinions, I suppose, but she's trying to have
2 this both ways. She either can -- I think she
3 should be required to at least stick to the
4 deposition that we took.

5 **MS. HOLLINGSWORTH:** And, Your Honor, I want to be
6 clear, I haven't even asked her a question,
7 much less solicit an opinion.

8 **THE COURT:** That's why I'm going to let you ask the
9 question.

10 **MS. HOLLINGSWORTH:** She's a fact witness who's a --
11 I'm there's -- I'm asking her questions about
12 the metrics of the emergency department that's
13 already in evidence and she's -- her testimony
14 on it.

15 **THE COURT:** Let's hear the question she's asking.

16 **MR. DAYHUFF:** I just have a bad feeling it, but I'll
17 sit down.

18 **MS. HOLLINGSWORTH:** Okay.

19 Q: You were here yesterday, is that right, Ms.
20 Huntington?

21 A: I was.

22 Q: And you heard Dr. Hall's testimony about this
23 document?

24 A: I did.

25 Q: Okay. And I'm just trying to understand, does



1 this document have the similar-type data that
2 we've been talking about even in your testimony
3 so far with regard to performance metrics?

4 A: Yes, it does.

5 Q: Okay. And so because I think some words or
6 descriptions you use might be different than
7 what the Medical University use; is that fair?

8 A: That's correct.

9 Q: Does this report look exactly like what your
10 report look like?

11 A: Not exactly, but it is -- I look at it and
12 definitely -- boarder volume, for instance,
13 boarder is not a term that we use. However,
14 the metric is still measuring the same thing
15 that we measure from that decision to admit to
16 depart. So, yes. I mean, these are all very
17 familiar headings to me.

18 Q: Okay. And so I'm just trying to understand
19 what we've talked about. And this is the
20 document in evidence already. When we were
21 looking at average length of -- LOS, average
22 length of stay. I'm just trying to -- what
23 does that mean -- in Roper's emergency
24 department, what does the length of stay mean?

25 A: So length of stay is the point of time from



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1 arrival of a patient to department of a patient
2 and usually broken down by whether they were
3 discharged or whether they were admitted, maybe
4 whether they were a psych patient. But it is
5 from time in to time out.

6 Q: Okay. And so you similarly track information
7 like that; is that right?

8 A: That is correct.

9 Q: Okay. And tell me again -- boarder volume on
10 here, what does that, what is that metric in
11 your system that you're looking at?

12 A: So that is really the length of time from the
13 decision -- the point that the decision is made
14 to admit the patient until the time that they
15 depart. And it really is all reflective of
16 what's going on outside of your emergency room.
17 So how full are the inpatient beds, how -- you
18 know, how many beds do they have open, that
19 kind of stuff.

20 Q: And you said from the time the decision is made
21 to admit to the time they depart. Is that
22 depart the emergency department?

23 A: Correct.

24 Q: Okay. And are they -- but they're not
25 departing the facility, are they?



1 A: So that's a good question. The inpatient
2 facilities are really the only ones that track
3 what this is calling boarder volume. The
4 others are being transferred. So you really
5 are looking at -- you're looking at the same
6 metric, but they're leaving -- so the
7 freestandings, those same patients are leaving
8 the freestanding and going to another facility.

9 Q: And if your -- if you -- do you have a metric
10 or do you have a goal that you're looking at
11 within your system in terms of boarding time or
12 the time between the decision to admit and then
13 going to wherever that location is for
14 admission?

15 A: Yes. So our system goal is 41 minutes, which
16 is a little lofty. We achieve that probably --
17 we probably -- our median time across all of
18 the ERs is probably closer to 50 to 60 minutes.

19 Q: Okay. And so when you're -- when that -- when
20 you're higher than 41 minutes, what does that
21 mean for your system?

22 A: That means that there's something wrong,
23 there's something delaying getting the patient
24 out. And it can be a number of things. It can
25 be that you're waiting for those specialists to



1 come down to the ER to evaluate the patient and
2 sort of make that ultimate determination. It
3 could be that your inpatient beds are full and
4 you just don't have any place to move. It
5 could be that the inpatient beds aren't staffed
6 fully and aren't open and available. And, you
7 know, it could be that the ICU itself is full
8 and you're holding ICU patients for a long
9 period of time. But it almost always reflect
10 something outside of the ER span of control.

11 Q: Okay. And so would adding another emergency
12 department to feed into the inpatient system
13 lessen or exacerbate that boarding issue, that
14 time issue?

15 A: If you have a, for instance, a freestanding ER
16 that is seeing purely the fours and fives,
17 which you would expect for it to, then it
18 probably could help, because it might be
19 offsetting some of your -- you know, some of
20 your volume that's leaving without treatment.
21 But if you're mixing in that freestanding with
22 patients that you're working up and needing to
23 transfer down to admission, whatever problems
24 you've got in your ER that's not allowing you
25 to get those patients out are probably going to



1 be true for the other, for the freestanding as
2 well. So, you're either going to send them to
3 your ER, your hospital-based ER, and add
4 further to their problem or you're going to
5 hold them in your freestanding and clog up --
6 you know, clog up your freestanding as well.

7 Q: Okay. And we heard -- let's talk about
8 staffing. So what is your involvement in
9 staffing for the emergency departments in the
10 Roper St. Francis system?

11 A: So I've worked very closely with our team that
12 looks at staffing productivity to help design
13 the staffing models and what the ideal staffing
14 nurse/patient ratio and that sort of stuff,
15 determine that. And then, you know, determine
16 what our core staffing levels are needed,
17 anticipate when we need to add additional
18 staffing based on that productivity.

19 Q: And is that an ongoing responsibility?

20 A: Yes.

21 Q: Okay.

22 A: It's a daily responsibility.

23 Q: And so kind of explain for us, what type of
24 staff are needed in an emergency department?

25 A: So obviously registered nurses. And that's



1 probably the most cherished possession. I
2 mean, you can't have an ER if you don't have
3 nurses. You can't have an ER if you don't have
4 physicians. So those two are probably the most
5 essential staff. But then there's also
6 unlicensed staff; so emergency department
7 techs, there's access personnel, which are, you
8 know, responsible for registering the patient.
9 Those are essential as well.

10 Q: And I think you commented about some sort of
11 ratio. What was that?

12 A: So -- and it varies depending on sort of your
13 acuity, but the typical nurse/patient ratio in
14 an ER, an inpatient ER, is probably going to be
15 one patient to -- one nurse to three to four
16 patients. In a fast-track you probably could
17 to five patients to one nurse, maybe even a
18 little bit more than that.

19 Q: Okay. And do you similarly have ratios for the
20 unlicensed, like the techs?

21 A: They really are more -- no. No. You really --
22 you almost have those to nursing staff. So,
23 you know, every nurse has -- every two nurses
24 has a tech between them.

25 Q: Okay.



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1 A: They're assistant personnel. And while they
2 are very essential at keeping the flow going in
3 the department, there's not an established
4 patient ratio.

5 Q: So in your experience, in the manner in which
6 your staffing Roper St. Francis emergency
7 departments, the ratio is adjusting to the
8 acuity for the RN's piece of it?

9 A: Correct.

10 Q: Okay. And then the techs tie to that RN
11 determination?

12 A: Correct.

13 Q: And so what -- tell me a little bit about the
14 experience level for ED nurses that you're
15 looking for that's necessary.

16 A: So emergency department really is a specialty,
17 especially when you get into some of the
18 freestanding and smaller ERs where you have
19 only what I consider to be core staffing. I
20 mean, there -- you can never drop below two
21 nurses on a shift at any given time, because
22 you just can't. If one of them had to leave to
23 take a patient upstairs, that leaves one. And
24 if you only had one, that nurse wouldn't be
25 able to leave to go to the bathroom, to eat,



1 to, you know, do anything. So two nurses on at
2 any given time is the bare minimum, even if you
3 have no patients walking in the door at that
4 time. One physician on 24/7 is a bare minimum.
5 So in those places where your volumes may not
6 be so high that you really have just what I
7 consider to be that core staffing, they've got
8 to be the most experienced. Because at any
9 time that -- you know, that full arrest comes
10 in and if you've got somebody that can't carry
11 their share of the weight or -- you know, it's
12 all about teamwork. And if you've got somebody
13 that can't play as a fully functional part of
14 that team, you really are challenged to be able
15 to provide safe care. So experienced ER nurses
16 are essential in those settings. In the bigger
17 hospitals where you have more staff on, you can
18 absorb a little less experience, the new grad,
19 as we've been sort of kind of forced to look at
20 more recently. The nursing shortage has hit us
21 hard. I recall a time a few years back hearing
22 people say, oh, there's going to be a nursing
23 shortage come, you know, whatever year. And I
24 thought, how can they say that? You know, it
25 feels like we've got an abundance of nurses.



1 But all of a sudden we really did hit that
2 nursing shortage. And so finding skilled,
3 trained nurses is a challenge across the board.
4 And we are finding that we're having to look
5 towards those new grads. You bring them on
6 much farther in advance than you normally would
7 anybody else. So they take three to six months
8 to get them up to even a bare functional level
9 of an RN. And they put quite a drain on your
10 experienced staff, you know, because you always
11 know when you've got that less-experienced
12 person around that you're sort of having to
13 kind of support and bring along and keep an eye
14 on what's going on with them, because they're
15 likely to miss something, where the experienced
16 nurse might not.

17 Q: Okay. And how is it that you felt that the
18 nursing shortage -- how has that sort of come
19 to be in your experience?

20 A: So it used to be when somebody would leave to
21 -- well, first of all, your turnover rate, you
22 know, usually is -- and I wish I could really
23 give you a rate, but I can't. Turnover is
24 something that was relatively insignificant in
25 that, when somebody did leave, you just posted



1 the position and you had half a dozen people
2 that were interested and you had a nice pool to
3 pick from and, you know, you got to pick what
4 you considered to be the best. Now when those
5 positions are posted, you might go weeks
6 without an applicant. We -- when I started
7 this position in 2017, we had just brought on
8 two travelers in the system for the five ERs.
9 That was the first time we had looked at using
10 traveler or agency nurses in probably ten
11 years. There's a whole lot of reasons that you
12 don't want to use travelers. You're grateful
13 that they're there and available when you're
14 desperate for them. But they're a little
15 demoralizing to the staff. You know, they
16 don't always come with the same buy-in and
17 ownership of one of your own. So, you really,
18 really, really try to avoid that. So in 2017
19 we had to -- we're up to ten travelers now.

20 Q: And that's in the system today?

21 A: Yes.

22 Q: What about -- what role have you had in
23 staffing for the Roper Berkeley Hospital that's
24 opening October 4th?

25 A: So we began by identifying the nurse manager



1 for that position probably back in February.
2 And it has been primarily her role to interview
3 and identify and find those positions. We've
4 been relatively fortunate that we've been able
5 to get most of those core positions identified
6 and filled, but at the expense of sort of
7 stealing them in some cases from out other ERs
8 and working diligently to backfill those
9 positions and still at this point have not
10 backfilled all of those positions, so.

11 Q: What do you mean by stealing some from your
12 other ERs?

13 A: So, you know, you prefer to start, even with a
14 new ER and a new hospital, with people that are
15 experienced to your system and kind of
16 understand how your system works. So, rather
17 than bringing in 20 brand new nurses to the
18 Roper St. Francis system, we probably took at
19 least half of them from some of our other ERs.

20 Q: And half for the Roper Berkeley emergency
21 department?

22 A: That's correct.

23 Q: And so what do you know about the project that
24 MUSC proposed to the Department?

25 A: For the freestanding ER?



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1 Q: Yes, the freestanding ED.

2 A: I was -- actually participated initially in
3 that first -- it's not called discovery. What
4 ...

5 Q: Project review.

6 A: Thank you, yes. It felt like discovery to me.
7 The project review meeting with DHEC. And we
8 were there, Trident was there, MUSC was there.
9 So that was my first introduction to it.

10 Q: What do you recall about the project review
11 meeting?

12 A: I recall very clearly that the scope of the
13 project being a freestanding ED. I do recall
14 the location being the proposed Nexton, the
15 exit there off of the Nexton exit. I do recall
16 that there was a helipad proposed. And most
17 specifically recall the CDU discussion about in
18 conjunction with the freestanding ED.

19 Q: And what do you recall about the CDU
20 discussion?

21 A: So, you know, what I heard and what I garnered
22 from that conversation was a clear layout that
23 the aim was not to target additional patients
24 but to meet the needs of the medical
25 university patients in the Berkeley County area



1 and to facilitate getting them to where they
2 needed. So if they needed to be admitted, it
3 was sort of a staging platform, if you will, to
4 get them to downtown. Or, if they didn't need
5 to be admitted, to keep them from having to
6 come downtown and be able to send them back on
7 their way.

8 Q: And when you say that was what you gleaned, are
9 you referring to like the presentation made by
10 the Medical University?

11 A: Yes.

12 Q: Okay. Okay. And so this is the -- you were
13 present at the project review meeting and heard
14 everyone kind of give their positions on the
15 application; is that right?

16 A: That is correct.

17 Q: Okay. And since that time -- well, let me ask
18 you this. What is a CDU? What does that mean
19 in a freestanding ED?

20 A: So a CDU, a clinical decision unit, really
21 takes you after the point of the initial
22 arrival of the patient and the initial workup.
23 The ER physician usually has determined there's
24 something going on here. I can't say for sure
25 that this patient is ready to go home and be



1 discharged. I can't say for sure that this
2 patient needs to be admitted. Or I can say the
3 patient needs to be admitted, but I'm not
4 really sure what type of services he might
5 need. Maybe he needs to go straight to the OR.
6 Maybe he needs to go to an ICU instead of a
7 step-down unit or, you know -- so it really is
8 -- and/or you may have a patient that just
9 needs a little bit of extra extended care to
10 kind of see if they turn the corner and improve
11 and are well enough to go home.

12 Q: And the CDU, is that sort of a separate space
13 with its own resources?

14 A: Typically it is, yes. They're observation
15 beds, so they're typically built differently.
16 And my experience has been that they're not --
17 they may be a subsection of your emergency
18 department, but you're not doing -- you're not
19 doing both types of patient care in that area,
20 so you tend to cohort them together. You may
21 change the nurse-patient ratio or the tech
22 ratio to be able to more efficiently manage
23 those patients.

24 Q: Okay. And what do you know or what do you
25 recall from that presentation about the Nexton



1 area or the Nexton location that was proposed?

2 A: So I am geographically challenged, but I am
3 very aware that it was proposed to be in more
4 or less a medical complex where there were
5 other, you know, physician offices and that
6 sort of stuff. And that now it has been
7 proposed to move down the road to a -- not a
8 medical complex.

9 Q: And you were here yesterday, right?

10 A: Correct.

11 Q: So you've now been given access to information
12 about changes; is that right?

13 A: That's correct.

14 Q: So what is your understanding of the changes
15 that are kind of proposed for taking place for
16 the freestanding ED?

17 A: So, you know, I think from -- purely from a
18 freestanding ED perspective -- let's not even
19 talk about location and not even talk about
20 helicopter, but just purely from the scope of
21 services that were outlined initially for the
22 CDU versus the now ER with a fast track sort of
23 area. The CDU and the fast track, even though
24 the ER physician -- and this is what I believe
25 -- this is what I believe Dr. Hall was saying



1 yesterday when -- you know, when he was talking
2 about it not being substantially different.
3 The ER physician perspective, they're going to
4 evaluate a patient regardless of what their
5 complaint is. So the level of skill and the
6 level of expertise that the physician brings to
7 the bedside is no different for an ER patient
8 versus a CDU patient versus a fast-track
9 patient. However, in the ER itself and the
10 resources that are going to be applied, they
11 are vastly different. Your CDU patient in a
12 five-bed location is going to bring you about
13 3,000 patients a year in those five beds. And
14 that's just because the average CDU patient is
15 going to be a minimum of four hours to evaluate
16 that patient and make a decision, to a maximum
17 of ideally 24, unless you really are a very --
18 you know, not very good at making decisions or
19 getting the patient out. Those observation
20 stays are intended to be under 24 hours. And
21 so you really are limiting the amount of --
22 volume of patients you can get in and out of
23 those areas by using them as a CDU.
24 Alternatively, I also would say that you can't
25 staff them -- because of the way they're



1 staffed, you would be challenged to put other
2 ER patients in that space when you weren't full
3 with CDU patients. So, you know, you really do
4 limit the bed availability. A fast track, on
5 the other hand, would be closer to that 3,000
6 patient per bay capacity. And so five beds at
7 3,000 patients per -- you know, per day, 3,000
8 whatever, is going to be -- see a while lot --
9 15,000 patients a year versus the 3,000
10 patients a year for the CDU. So you're going
11 to move those patients through a whole lot
12 faster, you're going to see a whole lot more,
13 and they are going to need different kind of
14 resources, nursing resources.

15 Q: Okay. And going back to how we were using
16 categories related to acuity level. Are they
17 acuity levels different in the CDU patient or
18 the fast-track patient?

19 A: Yes. So your fast-track ideally are your fours
20 and fives. Your threes that made it into your
21 freestanding may be making up your CDU
22 patients. Once you get to the higher acuity
23 levels, the twos and ones, you probably know
24 those patients are going to need to be admitted
25 and you're going to get those out of there. So



1 your CDU is probably going to have your higher
2 acuity fours that after all is said and done,
3 yeah, you are a four and your threes that
4 you're trying to make a decision on whether you
5 can turn them around or need to admit them.

6 Q: Okay. And in your words and in your experience
7 at Roper St. Francis and as an emergency
8 services nurse in the Tri-County area, I'm
9 trying to understand -- give me your
10 descriptions of what -- what is a level one,
11 what is a level two on down? And, again, using
12 the triage levels.

13 A: Okay. So a level one is any patient that comes
14 in in full arrest is -- those are the critical
15 patients. So any patient that comes in in full
16 arrest, in pending full arrest, a STEMI patient
17 who is of time sensitivity that needs to go
18 immediately to the cath lab. So those that
19 involve time-sensitive critical interventions,
20 those are your category ones. Twos are easily
21 flipped into a one and almost as time
22 sensitive. But if you can act on them quick
23 enough, sometimes you can turn them around and
24 keep them from getting worse. So your
25 asthmatic patient who looks horrible when



1 they're coming in the door and wheezing, you
2 know, starts off as a two. And by the time you
3 give them a treatment, breathing treatment, and
4 do some interventions, things calm down and
5 they look a little bit better. Threes are the
6 -- but still those ones and twos almost always
7 are going to get admitted. And the ones --
8 ones very often don't make it to be admitted.
9 Let's just say that. They're that critical
10 that they may die before they actually get
11 admitted. Twos are likely going to get
12 admitted and they're probably going to get
13 admitted to the ICU. Threes are the ones that
14 are sort of in that you could go either way.
15 Sometimes you can turn them around. A nausea-
16 vomiting-diarrhea patient who looks bad when
17 they roll in the door and they're weak and, you
18 know, look like they're going to pass out, you
19 can turn them around with a couple of liters of
20 fluid and get them home and feeling better.
21 Sometimes they turn out to be -- that nausea,
22 vomiting, diarrhea really turns out to be
23 appendicitis and you have to admit them and
24 send them to the OR. So three is a very wide
25 range. Fours are the walking wounded I call



1 them. So any of, you know, your -- most of
2 your broken bones, sprains, that kind of stuff
3 fall into your four category where they're
4 going to use one or two resources. They may
5 get an x-ray and they're probably going to get
6 medicine and maybe a splint or something like
7 that. Fives typically you don't anticipate
8 utilizing resources. So you don't anticipate
9 doing lab work. Maybe appointed care, tests to
10 see if they're pregnant or something like that.
11 But you're not devoting significant resources
12 to them.

13 Q: Okay. And you commented one to two resources.
14 So is that sort of a way that you're thinking,
15 the number of resources used helps you
16 attribute an acuity level?

17 A: Yes.

18 Q: Tell me a little bit more about that. What
19 would be some of the resources that come to
20 mind when you're kind of counting those?

21 A: So that is the design of the ESI, the emergency
22 severity index, is -- the training for using
23 that is all based on resource utilization. So
24 -- and resources are -- anything is a resource.
25 So if I do lab work on a patient, lab is a



1 resource. If I do an x-ray on a patient,
2 that's a resource. If I give a medication to
3 a patient, that's a resource. It's a little
4 bit different if I give you a pill versus if I
5 need to start an IV on you and give you
6 medicine through an IV. Those are additional
7 resources. So resources are really all about
8 what kind of things you're going to have to do
9 for the patient.

10 Q: Okay. And thinking about the changes in the
11 project and what we now hear is a fast-track
12 rooms at the proposed freestanding emergency
13 department, thinking about the fast-track
14 rooms, are those rooms, in your experience,
15 designed for the fewer resource patients?

16 A: Absolutely.

17 Q: How would they be different than sort of the
18 full-treatment room?

19 A: So they may not have all of the same -- they
20 don't require the same life saving and
21 resuscitative and monitoring sort of equipment
22 that a full-treatment room may require. So you
23 may not have oxygen and suction at each one of
24 those bays. You may, but you may not. You
25 likely won't have cardiac monitors at each one



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1 of those -- at each one of those bays. The
2 idea is that you can treat them more
3 efficiently, cost contained, because they're
4 going to -- you're not going to be able to bill
5 for them at the same level that you bill for a
6 more acute patient, just because they don't
7 meet that medical criteria. And so if you can
8 dedicate a space where you can treat them
9 efficiently, it actually costs you less per
10 unit of service to care for them, to keep them
11 in sort of that isolated space with fewer
12 nurses than it does to bring them into the
13 mainstream, where your cost or expenses per
14 unit of service are naturally higher just
15 because you've got all of those resources.

16 Q: So, that's a function of the resources that
17 you've talked about?

18 A: Yes.

19 Q: We heard a good bit about -- well, what -- your
20 role with Roper Berkeley Hospital in the last
21 two years I guess, three years that it's been
22 being developed once approved, have -- and
23 thinking specifically about staffing and the
24 staffing to come. Do you believe that MUSC
25 establishing a freestanding emergency



1 department in Summerville will impact your
2 ability to staff or impact your staffing at
3 Roper Berkeley ---

4 A: Yes.

5 Q: --- Hospital?

6 A: Yes. We are pulling from the same pool.

7 Q: What about your other locations, Roper
8 Berkeley, Moncks Corner, or Roper Northwoods?

9 A: Yes, it will. They're pulling from the same
10 pool as well.

11 Q: And you talked about a nursing shortage. Does
12 that cover an area? Where do you -- in your
13 experience, what area does that nursing
14 shortage cover?

15 A: It's a nationwide shortage right now.

16 Q: Is emergency services trained nurses even more
17 difficult to find than RNs?

18 A: Yes.

19 Q: We've heard about the helicopter and the
20 decision to eliminate the helicopter. What has
21 been your experience with regard to helicopter
22 services at the freestanding emergency
23 departments?

24 A: We have two freestanding EDs, one of which has
25 a helipad. The reason that it has the helipad



1 is because of its remote location and the
2 difficult challenges in getting patients to and
3 from downtown or anywhere. We don't have one
4 at the Northwoods facility. I don't see -- I
5 don't see that as -- you know, the access, I
6 don't see that as a problem. It's different.
7 It's a change. But for the most part, the
8 freestanding ERs should be seeing low enough
9 acuity patients that they shouldn't really need
10 helicopter transport, except for those
11 occasional ones that you're surprised about.

12 Q: And you don't -- so it's Roper Northwoods that
13 doesn't have a helipad?

14 A: Correct.

15 Q: And so are you able to clear the parking lot
16 and have a helicopter land to do air transport?

17 A: We could, if we needed to. We have never done
18 that.

19 Q: Okay. And where -- how far away is sort of the
20 closest hospitals to Roper Northwoods?

21 A: So our own hospital is probably -- Roper,
22 probably 20 miles down the road. I really am
23 speaking out of my league when it comes to
24 distances. But it takes me about 20 minutes to
25 get there. Let's put it that way. And then



1 certainly, you know, Trident in that direction
2 at any given time of day might actually be
3 closer, depending on traffic. Easier to get
4 to.

5 Q: Okay. And do you have any role with transfer
6 agreements for any of the freestanding
7 emergency departments that you -- that fall
8 under your role?

9 A: Yes, I do, monitoring, maintaining, assuring
10 that we have them is part of my responsibility.

11 Q: And does the freestanding emergency department
12 have to have a transfer agreement with the
13 other hospital?

14 A: We do. We may fall under truthfully the
15 license of Roper Hospital in that transfer
16 agreement. So -- but we still have them. You
17 know, I'm not sure what the regulations
18 require, but we have them.

19 Q: Okay. In looking at -- we talked about the
20 impact on staffing. Are there other impacts
21 that you believe that MUSC's freestanding ED
22 would have on Roper St. Francis?

23 A: Yes. I mean, there's no question that the
24 patient population -- we're sharing the same
25 patient population, so I fully anticipate that



1 that will impact our volumes negatively.

2 Q: And do you know yet what the utilization of
3 Roper Berkeley Hospital's emergency department
4 will be?

5 A: No.

6 Q: Thinking about the utilization and we've talked
7 about what's in the area, do you -- in your
8 experience in that area, is there sufficient
9 capacity to treat the population now and the
10 growing population?

11 A: My experience is that there is, yes, capacity.

12 Q: And for -- we talked about Roper -- Moncks
13 Corner and Roper Northwoods. Both of those
14 locations, do you believe they could take even
15 more capacity than they're serving right now?

16 A: That is correct.

17 Q: About how far -- do you know how far the
18 proposed Summerville freestanding ED for MUSC's
19 Summerville freestanding ED on -- I think it's
20 on North Main Street -- is from the Roper
21 Berkeley Hospital?

22 A: I really don't. I think it's -- no, I really
23 don't.

24 Q: And in looking at the -- have you finished
25 staffing up Roper Berkeley Hospital?



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1 A: Enough so that I can sleep at night, yes. I
2 think there are still some point, pieces, parts
3 of people that need to be filled, but -- now,
4 the other places that we've borrow them from,
5 that's a different story.

6 Q: And I would say that's someone else's problem,
7 but it's probably not, is it?

8 A: It's not. It's not.

9 Q: Okay. All right.

10 MS. HOLLINGSWORTH: If I can just have one minute.

11 Q: Ms. Huntington, I appreciate your patience.
12 Please answer any questions any of the other
13 attorneys may have.

14 THE COURT: I think at this point before we move to
15 Cross, Mr. Dayhuff, we're going to take a
16 lunch. If you all would be back at 2:15, we'll
17 do Cross.

18 (Off the Record)

19 THE COURT: Mr. Dayhuff, you can begin your Cross
20 when you're ready.

21 MR. DAYHUFF: Thank you, Judge.

22 MS. HUNTINGTON - CROSS-EXAMINATION BY MR. DAYHUFF:

23 Q: Ms. Huntington, good afternoon.

24 A: Good afternoon.

25 Q: So we sat down together, what, a month ago at



1 your deposition?

2 A: I lose track of time.

3 Q: Talked about nursing and EDs. And then you
4 went and got yourself designated as an expert.

5 A: I'm sorry.

6 Q: Now, don't let that come between you and I.

7 A: We're good.

8 Q: Now, so let me mention this. I did object to
9 having you named as an expert. That was a
10 notice issue. I think you've got the
11 experience and the education to be able to talk
12 knowledgeably about your subject matter. So,
13 I just wanted that to be clear. Now, let's
14 start with those metrics that we've heard a lot
15 about. Door to doctor, your target for this
16 metric is six minutes or less I think, right?

17 A: Right.

18 Q: And across your system you are exceeding that
19 target, right?

20 A: (Nods head affirmatively).

21 Q: And what was the number?

22 A: Anywhere depending on -- depending on the type
23 of location, anywhere from three minutes to six
24 minutes.

25 Q: Okay. And did you hear Dr. Hall's testimony



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1 regarding door to doctor at his adult main ED
2 at MUSC?

3 A: I did.

4 Q: All right. Do you recall what that was?

5 A: I don't. I know it's on that piece of paper
6 and I do remember that it's longer than what I
7 would have expected.

8 Q: Do you remember 45 minutes?

9 A: I certainly would not argue with you if you
10 said ---

11 Q: All right. Fair enough. Door to discharge,
12 let's talk about your folks at Roper. Your
13 target range for this metric, I think you told
14 me at the deposition, was 90 minutes or less?

15 A: Correct.

16 Q: And I think you guys are exceeding that target.
17 You tell me.

18 A: At the freestandings, yes. So the target for
19 the freestandings is shorter than the targets
20 for the hospital-based ER.

21 Q: All right. So that 90 is a freestanding
22 target?

23 A: Correct.

24 Q: All right. What's the target for the hospital?

25 A: About 180.



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1 Q: All right. And your freestandings are
2 exceeding that target. And what's your rate
3 right now?

4 A: I easily -- you want minutes or you want how
5 often they exceed?

6 Q: Minutes.

7 A: Sixty, 61 ---

8 Q: Good. And your hospital EDs ---

9 A: They are ---

10 Q: --- are you below 180?

11 A: I'm sorry. They are probably, depending on
12 which hospital, anywhere from 120 to 180. Some
13 of them are a little bit longer.

14 Q: And did you hear Dr. Hall's testimony about his
15 adult ED door-to-doc time?

16 A: Yes. Yes, I think ---

17 Q: Do you recall what it was?

18 A: I think that's -- are you talking about door to
19 discharge or door to doc?

20 Q: I'm sorry, door to discharge. Yes.

21 A: Okay. Yeah. I think his target he said was
22 160 or 180. But they are 220, two something.

23 Q: Good. LWOT target, your target is what?

24 A: Less than 1.5.

25 Q: And across the system you're achieving that



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1 target -

2 A: Correct.

3 Q: --- or exceeding that target?

4 A: Doing better than that.

5 Q: All right. And is there a different FED LWOT
6 rate? It's lower, right?

7 A: Correct.

8 Q: And it's lower why?

9 A: Because it's more efficient and you should be
10 able to move patients through quickly.

11 Q: And did you hear Dr. Hall talking about his
12 LWOT rate for the adult main? Do you recall
13 that percentage?

14 A: I did. I heard as high as eight and five even
15 at one point.

16 Q: Right. I think he said five was what he was
17 currently experiencing and we saw an LWOT graph
18 that showed a peak at eight.

19 A: Correct.

20 Q: These metrics that Dr. Hall is experiencing at
21 his FED, do you have any reason to question
22 those numbers as being accurate?

23 A: No.

24 Q: All right. Those metrics are not good, are
25 they?



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1 A: No.

2 Q: No. And those metrics are caused by certain
3 things. And I want -- you heard some of that
4 testimony too, what's causing these metrics.
5 Just kind of walk through them -- high volume,
6 psych patient volume, boarding, both
7 psychiatric and inpatient boarding, complex
8 care and compartmentalized care at MUSC. Do
9 you agree -- and we don't have to go through
10 each of these conditions. We certainly can if
11 you want. But do you agree with Dr. Hall that
12 these conditions are the primary factors for
13 those bad metrics he is receiving or
14 experiencing at MUSC?

15 A: I don't have any reason to question that it's
16 his experience. Correct.

17 Q: Those things just generally, wherever you are,
18 can cause bad metrics, not just MUSC I suppose?

19 A: Correct.

20 Q: Right? All right. You also heard that Dr.
21 Hall's taking some steps or has taken some
22 steps with folks at MUSC to try to deal with
23 these issues. Surg protocols, you heard that,
24 right?

25 A: Yes.



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1 Q: E visits?

2 A: Yes.

3 Q: High tech bed board something or other that
4 keeps track of vacancies it sounded like?

5 A: Okay.

6 Q: Right. They spent some money on renovations,
7 maybe not as much as Mr. Thomas would like, but
8 some, right? You heard that testimony. And
9 they've worked with Roper to create what, to
10 help with the psych bed capacity issue.

11 A: So the -- that's where the task force comes in,
12 the Tri-County Crisis Stabilization, to sort of
13 get those patients out into some other
14 resources.

15 Q: Right. And the way I understood it was Roper
16 and MUSC and maybe others have come together to
17 actually fund some beds, crisis stabilization
18 beds; is that right?

19 A: That is correct.

20 Q: And is that ten beds?

21 A: I think they may have a little bit more
22 capacity than that.

23 Q: Uh-huh.

24 A: But probably tens the ---

25 Q: Do you know the capacity?



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1 A: You know, I'm thinking it's closer to 20.

2 Q: Okay.

3 A: But I could be wrong.

4 Q: Are all of those reasonable steps to take to
5 try to address the capacity issues, the
6 constraints they're experiencing?

7 A: Yes.

8 Q: Those steps haven't resolved the metrics and
9 the capacity issues, have they?

10 A: It doesn't sound like it.

11 Q: If you had a LWOT of five percent, that LWOT is
12 the pulse -- beating pulse of the ED, that's an
13 important metric for you.

14 A: Correct.

15 Q: Why is it an important metric?

16 A: Because it signals -- it signals the fact that
17 you have capacity constraints, throughput
18 constraints.

19 Q: Got you. And I think you explained earlier
20 it's very serious because people that are
21 leaving without receiving care may need care
22 and more than likely do need care, right?

23 A: Correct.

24 Q: And that's kind of dangerous. So that's a
25 serious thing. If you had that LWOT of five



1 percent or eight percent, you would probably do
2 lots of things, take a look at lots of things
3 to try to turn that around, I imagine, right?

4 A: I would.

5 Q: Some way, some how, try to turn that around.
6 Would one of the things on the list be I've got
7 to some way, some how, get some additional ED
8 rooms, some additional capacity? Would that be
9 on the list?

10 A: Not first.

11 Q: Right. You'd try some process things, you'd
12 try some staffing maybe, some reconfiguration.
13 Yes, yes, yes?

14 A: Yes. I mean, adding more space, adding more
15 beds, if you will, is not a solution when
16 you're looking at times that are outside of
17 what our typical standard benchmark. Those
18 prolonged times point to throughput issues.
19 And I don't think he said he didn't have
20 throughput issues.

21 Q: Sure.

22 A: But you fix the processes that are contributing
23 to the throughput issues, don't add more beds
24 to it, because then you're just throwing more
25 resources.



1 Q: Sure. But beds would be on the list, right, of
2 things you'd consider to address the issues?

3 A: Not until I fix my throughput issues,
4 truthfully.

5 Q: All right. So you'd try process fixes first
6 and then you'd consider, if you needed to, to
7 adding capacity. I mean, just logically,
8 right, if you add capacity somewhere, either at
9 that location or near that location or
10 somewhere that can offload some volume, if high
11 volume is one of your problems, that could
12 help.

13 A: If your throughput issues are related purely to
14 high volume, yes. If your throughput issues
15 are related to the fact that your patients are
16 staying in your department longer than what a
17 patient should stay in, then you need to fix
18 your process problems.

19 Q: Right. And sometimes it's really difficult to
20 fix those process problems, right, especially
21 when we're talking about moving people out,
22 psych folks out, because we don't have any
23 space.

24 A: Right.

25 Q: Right? It's a real difficult issue. So that



1 issue could be fixed or perhaps we look at the
2 other end and provide more spaces for folks who
3 are coming in to get ED care, because maybe we
4 can't build that new psych hospital right now,
5 right?

6 A: I would not do that.

7 Q: Okay.

8 A: I would not.

9 Q: You wouldn't add the space?

10 A: No. I'd do something about the psych patients.

11 Q: All right. You'd build the psych hospital
12 first?

13 A: probably.

14 Q: Okay. Which is more expensive do you think,
15 building a new psych hospital or doing an FED
16 in Summerville?

17 A: You want the real answer? I mean, I think
18 that's way more than monetary. There's way
19 more than money involved in that. There's --
20 you know, psych patients don't belong in an ED.
21 They -- it's an unsafe environment, it's a non-
22 therapeutic environment for them. So there's
23 a whole lot of reasons besides not having a bed
24 and not having a hospital to put them in to get
25 them out of the ED. So you're ---



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1 Q: No, I got it. We've got a big problem with
2 mental health, right? And unfortunately our
3 EDs are bearing a lot of that problem, aren't
4 they? And our prison system for that matter,
5 right?

6 A: (Nods head affirmatively).

7 Q: All right. Just a couple of questions I would
8 ask you. My understanding of your testimony,
9 a per room, per year volume for a hospital ED,
10 1200 to 1500 visits, fair?

11 A: Correct.

12 Q: Okay. And that's a lower capacity than the
13 visit capacity for an FED that you pegged at
14 3,000 -- 2800 to 3,000?

15 A: Correct.

16 Q: All right. And why is the hospital ED capacity
17 lower?

18 A: Acuity. More than anything, acuity.

19 Q: More complex cases, that was one of the things
20 on Dr. Hall's list as to why he's having some
21 capacity issues.

22 A: Correct.

23 Q: Right? All right. Roper's EDs, three hospital
24 EDs, right?

25 A: Correct.



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1 Q: Roper Hospital downtown, Bon Secours St.
2 Francis, and West Ashley?

3 A: Correct.

4 Q: Roper St. Francis Mt. Pleasant, right?

5 A: Correct.

6 Q: All right. And then you have, of course, your
7 new Roper ED coming online in October at Carnes
8 Crossing.

9 A: Correct.

10 Q: Two FEDs?

11 A: Correct.

12 Q: One is Roper Northwoods in North Charleston.

13 A: That is correct.

14 Q: And the other's Roper Moncks Corner, right?

15 A: Correct.

16 Q: It must be called something.

17 A: Roper Berkeley Day Hospital is how we know it,
18 but yeah.

19 Q: Day Hospital. Okay. Roper established the
20 Northwoods FED in part because Roper had a high
21 volume of low acuity patients in North
22 Charleston who were coming downtown for ED
23 services.

24 A: If you have something to base that on, I would
25 not argue with that. I was not part of that



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1 decision.

2 Q: Your deposition.

3 A: Okay. All right. There you go.

4 Q: That's what you told me at your ---

5 A: I wasn't part of the decision-making process
6 for that, so I'm ...

7 Q: I'm sorry. I don't know why I'm rushing. I
8 guess I want to get you back to Charleston.
9 Yes. At your deposition you told me that one
10 of the reasons this was established -- and
11 maybe you didn't make the decision -- to
12 establish the Northwoods FED was you had a high
13 volume of low-acuity patients from North
14 Charleston coming downtown for ED services,
15 right?

16 A: Correct.

17 Q: And establishing that FED made it easier and
18 more satisfying for those folks to get ED
19 services.

20 A: Correct.

21 Q: Made it more accessible for those folks to get
22 their low-acuity ED visits near to home.

23 A: Correct.

24 Q: Roper Moncks Corner FED -- I've already
25 forgotten the real name.



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1 A: Northwoods -- oh, Roper Berkeley Day Hospital.

2 Q: Roper Berkeley Day Hospital.

3 A: Correct.

4 Q: You established that FED in part to make ED
5 services more accessible for the folks in
6 Berkeley County?

7 A: Correct.

8 Q: And they're kind of up north, right, away from
9 the main urban, right?

10 A: Correct.

11 Q: Before you established that FED in Moncks
12 Corner, you had folks from Moncks Corner coming
13 all the way downtown to access Roper ED
14 services?

15 A: That's correct.

16 Q: And that's not a good thing. That's a long
17 trip from Moncks Corner to downtown.

18 A: Correct.

19 Q: A long drive.

20 A: Correct.

21 Q: Through traffic.

22 A: Correct.

23 Q: All right. I thought I had some other point.
24 I'm sure it'll come to me some time. All
25 right. Let's talk a little bit about service



1 area. I recall from our deposition together
2 and you mentioned it earlier, math challenged,
3 so I'll avoid some directions I hope. The Tri-
4 County area, Charleston, Berkeley, Dorchester,
5 it's your understanding the population is
6 growing in the past five years?

7 A: Correct.

8 Q: And, as we discussed at our deposition, you
9 agree that Charleston is kind of saturated from
10 a population perspective.

11 A: Exactly.

12 Q: And that population growth is expanding out
13 beyond Charleston into what had been previously
14 less populated areas.

15 A: Correct.

16 Q: North Charleston's growing rapidly.

17 A: Yes.

18 Q: As you go up 26 from North Charleston to Goose
19 Creek, Summerville, Nexton, those areas are
20 also growing.

21 A: I have no reason to doubt that, yes.

22 Q: Okay. And thinking about the volume that
23 you're experiencing at your existing EDs, if
24 you think about them all together over the last
25 three years, are you seeing more ED visits?



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1 Are you trending up across your platform?

2 A: Across the five ERs?

3 Q: Uh-huh (affirmative response).

4 A: Yes. I would not qualify it as a population
5 explosion or a growth explosion. It's been
6 gradually, almost -- I wouldn't call it flat,
7 but it has been a one and a half percent
8 increase a year, maybe.

9 Q: Okay.

10 A: Over the last three years.

11 Q: All right. Across your whole platform. Do you
12 believe that that modest trend line up is a
13 function of increased population or something?

14 A: I don't -- probably. I think there are so many
15 other dynamics that have played into ER volumes
16 and it's been a little hard to know exactly
17 what it relates to, you know.

18 Q: Population is a factor, right?

19 A: Right.

20 Q: Trending up, fair?

21 A: Yes.

22 Q: Okay. Your West Ashley ED is experiencing
23 particularly high volume ---

24 A: Correct.

25 Q: --- for the folks -- or for the facilities in



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1 your platform?

2 A: That is correct.

3 Q: You are at or exceeding capacity there.

4 A: Very close to, yes.

5 Q: And your West Ashley ED is experiencing more
6 volume than downtown, right?

7 A: That is correct.

8 Q: As we discussed at your deposition, part of the
9 reason that is so is that the downtown ED is
10 harder to get to than West Ashley.

11 A: That is correct.

12 Q: Roper's been adding ED capacity over the past
13 few years. Are you familiar with that?

14 A: With the new hospital coming online and the
15 addition of the extra beds at Northwoods, yes.

16 Q: Right. Roper Northwoods, let's start there,
17 rather recently attained a CON. And I think
18 you looked at the cover I believe during your
19 Direct.

20 A: Correct.

21 Q: To expand that FED from ten bays to what?

22 A: Fifteen.

23 Q: All right. And Roper's building, as you
24 mentioned, the new ED in the Carnes Crossing
25 Berkeley County Hospital, right?



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1 A: Correct.

2 Q: And will that have 15 or 13 rooms?

3 A: Fourteen. Fourteen rooms, 15 beds.

4 Q: Okay. So, has that changed ---

5 A: No.

6 Q: --- from original? Okay. So it's just a
7 different way of categorizing it?

8 A: Correct.

9 Q: Fair enough. And while we're on the topic of
10 change, are you aware of any changes in the
11 hospital configuration from when it was
12 proposed in '08 to what you're planning to do
13 now, major changes, material changes?

14 A: No. But that doesn't mean there weren't. It's
15 just I focus on the ER.

16 Q: Yeah. Well, let me make it more specific. Any
17 changes from what you proposed in the 2008 with
18 that hospital ED in Berkeley County and what's
19 going to be opened in October?

20 A: For the ER specifically?

21 Q: Uh-huh (affirmative response).

22 A: No. The only change that I'm aware of is the
23 -- and it's not space change, it's utilization
24 change. So originally I think the plan was for
25 MUSC to provide pediatric services in some of



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1 those rooms. And that agreement has ended.
2 And so they're not going to be there with their
3 peds ER in those bays.

4 Q: Okay. And that was proposed in '08 or do you
5 know?

6 A: I assume that it was proposed in '08, but I
7 really don't know. I don't know when that ---

8 Q: Fair enough. So we were talking about adding
9 capacity. We talked about Northwoods, up from
10 ten to 15. We're adding 15 rooms -- 14 rooms,
11 one space ---

12 A: Correct.

13 Q: --- at your ED in the new hospital.

14 A: Correct.

15 Q: All right. You're not adding space at your
16 West Ashley ED?

17 A: No.

18 Q: Despite high volumes.

19 A: Correct.

20 Q: Despite being at or a little above capacity
21 sometimes?

22 A: Correct.

23 Q: Instead, you're expanding in areas outside of
24 main urban areas, West Ashley, downtown.
25 You're expanding in Berkeley.



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1 A: Instead of ...

2 Q: At the main hospital EDs at Roper St. Francis
3 and Roper downtown.

4 A: There are no capacity constraints at those
5 facilities, so they're meeting the needs I
6 guess is what I'm saying.

7 Q: Okay.

8 A: There's not a need to expand.

9 Q: I see. You have no concern about MUSC
10 providing high-quality ED services or even
11 physicians or nurses.

12 A: Absolutely, no concern.

13 Q: Did you work in MUSC EDs?

14 A: No -- yes. Yes, I did briefly.

15 Q: Which one did you work at?

16 A: So I worked in a little four-bay trauma unit
17 before they became a full-fledged ER.

18 Q: Okay. And Roper provides high-quality ED
19 services?

20 A: Correct.

21 Q: Provides high-quality ED physicians and nurses?

22 A: Correct.

23 Q: All right. Now, do Roper's ED physicians teach
24 and practice emergency medicine residents?

25 A: Not in the sense that you hear at MUSC. So



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1 some of them come over and do student
2 experiences, shadowing experiences with a
3 physician, but not in an academic-setting type.

4 Q: And the students that shadow, are they medical
5 students or are they residents or both?

6 A: They could be both.

7 Q: Okay. And are you aware of any emergency
8 medicine physicians that work in Roper's EDs
9 conducting formal research within a
10 subspecialty area of emergency medicine as the
11 principal investigator?

12 A: No.

13 Q: FEDs -- you know, your FED is in Moncks Corner,
14 Northwoods -- stabilize patients and transfer
15 them downtown.

16 A: When needed, yes.

17 Q: Yeah, when needed. And that transfer could be
18 to Roper downtown?

19 A: Correct.

20 Q: Or MUSC downtown?

21 A: Correct. Or even Trident, so.

22 Q: Yeah. Trident not being downtown, but ---

23 A: Right.

24 Q: --- I'm sure they transfer there too. And I'm
25 thinking about downtown right now.



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1 A: Okay.

2 Q: And let's -- and so that's either from Moncks
3 Corner, way up in Berkeley, or from Northwoods,
4 which is North Charleston?

5 A: Correct, right at the border.

6 Q: Can those transfers be done safely and in a way
7 that doesn't compromise care?

8 A: Most of the time. If it does compromise care,
9 you find a different alternative.

10 Q: Sure. You may go to a different, closer
11 location.

12 A: Correct.

13 Q: Are you transferring sometimes cardiac -- folks
14 with cardiac issues ---

15 A: Yes.

16 Q: --- from those outlying FEDs all the way to
17 downtown Roper or MUSC?

18 A: Yes.

19 Q: And is that done safely without compromising
20 care?

21 A: Yes.

22 Q: Otherwise you don't make the transfer, right?

23 A: Correct.

24 Q: And I think you mentioned in your direct, but
25 if not correct me, that if someone comes into



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1 a Roper FED, most times they are going to get
2 transferred to, if they need a transfer, a
3 Roper facility. Is that true?

4 A: Correct.

5 Q: And that could be downtown Roper or it could be
6 West Ashley Roper?

7 A: Correct.

8 Q: And why is that?

9 A: Because that's usually where their care is
10 already established.

11 Q: All right. And also, I would think,
12 presumably, if they come find you and your FED,
13 they want to be treated at a Roper facility ---

14 A: You would think, yes.

15 Q: --- because they have -- they have other
16 choices.

17 A: Correct. And if they choose to go elsewhere,
18 you know, and that does happen -- no, my
19 doctors are at Trident, so I may go to Trident
20 or my doctor's at -- they go where they want to
21 go.

22 Q: Is it fair to say more often than not the folks
23 that you're transferring from your FEDs go to
24 your hospital facilities?

25 A: No. I don't think you can say that. So both



1 of those places probably transfer about one to
2 two percent of their total population. So
3 we're not talking a huge volume. I think it's
4 probably safe to say that close to half of
5 those go outside of the Roper system for any
6 number of reasons. Roper doesn't offer the
7 services, so therefore they may go to the
8 Medical University where the specialty is. Or
9 they do have primary care physicians that --
10 they came to us thinking it was a simple minor
11 problem and, guess what, you need to be
12 admitted. Oh, my doctors admit wherever. So
13 I would say it's probably close to half of the
14 patients we send out go outside of our system.

15 Q: Okay. So no more -- about 50/50? This is an
16 estimate.

17 A: Right. Correct.

18 Q: And out of that 50 percent that don't stay in
19 your system, is it 25 percent MUSC, 25 percent
20 Trident?

21 A: I ---

22 Q: If you don't know, it's okay.

23 A: Yeah, I don't know. I think it kind of
24 depends. Yeah, it depends on the day, depends
25 on the -- you know, so OB goes down to MUSC if



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1 it's, you know, high risk. So I think it just
2 kind of depends on the day.

3 Q: And it's okay if patients make a choice, right?

4 A: Correct.

5 Q: And in fact, when you established the Moncks
6 Corner FED, you wanted to give patients a
7 choice to choose Roper, right?

8 A: Correct.

9 Q: And what was their option before Roper and
10 Moncks Corner?

11 A: Probably the Trident system.

12 Q: And you don't doubt for a minute, do you, that
13 some folks in the north area, Berkeley County,
14 Dorchester County, North Charleston, want the
15 ability to get MUSC ED services closer to their
16 home?

17 A: I do not doubt that.

18 Q: Do you agree with Mr. Porter's 20 to 25
19 thousand ED visits are enough to cover the cost
20 of an FED? And if that's outside of your area,
21 that's okay.

22 A: I definitely think it depends on the makeup of
23 the patient mix, the -- you know, the payor
24 mix, the patient mix. So comparing our two
25 freestanding EDs, I think that's a fair



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1 generalization, but it's very much a
2 generalization.

3 Q: Sure. Does that 20 to 25,000 visits apply --
4 does it fit better with Northwoods or Moncks
5 Corner, based on the patient mix?

6 A: It probably fits better for Moncks Corner.

7 Q: Okay. So Roper opposes MUSC's FED. Also
8 opposed Trident's FED. Do you recall?

9 A: I do.

10 Q: But then agreed to stop opposing it. Do you
11 recall that?

12 A: I recall hearing that, yes.

13 Q: All right. One of the things you're worried
14 about is the shortage of RNs.

15 A: Correct.

16 Q: Particularly RNs I guess that work in the ED,
17 right?

18 A: Correct.

19 Q: All right. Before Trident agreed -- or before
20 Roper agreed to allow Trident to establish
21 another FED in the north area, were you
22 consulted about the effect that may have on RN
23 staffing?

24 A: Consulted by ---

25 Q: Anybody.



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1 A: I did not even have a discussion about it, no.
2 Did it cause me pause? Certainly.

3 Q: Okay. Have you done any analysis to attempt to
4 quantify the effect the FED would have on
5 staffing?

6 A: No, I have not.

7 Q: And is Northwoods the closest -- it's the
8 closest FED to our proposed FED, Roper FED?

9 A: Yes.

10 Q: All right. What -- do you have any vacancies
11 for nurses currently in the Northwoods FED?

12 A: Yes.

13 Q: How many?

14 A: I think two recent resignations, so I think
15 it's two.

16 Q: All right. Are you actively attempting to fill
17 those?

18 A: Yes. You know, it may actually be more.
19 There's a traveler there filling a vacancy now,
20 so I think there's probably three full-time
21 vacancies. Yes.

22 Q: And those are full-time vacancies. Do you --
23 have you filled the vacancies you do have at
24 that location with travelers?

25 A: There is a traveler filling a vacancy and then



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1 there are two additional vacancies, which may
2 very well get filled with travelers
3 temporarily.

4 Q: Yeah. I was going to ask you. Is that what
5 would happen if you aren't able to fill them in
6 a certain period of time, you turn to
7 travelers?

8 A: Yes.

9 Q: And while travelers aren't optimal, I think I
10 gathered from your testimony, do they provide
11 high-quality care?

12 A: I think your chances of finding a traveler who
13 can deliver high-quality care is equally as
14 possible as it is picking a brand-new nurse out
15 of thin air. You take your chances. I mean,
16 you may get good ones. You may not get good
17 ones. It's the last resort that I prefer to
18 do.

19 Q: Yeah. I suppose the first resort would be
20 grabbing an experienced nurse from somewhere
21 else.

22 A: Right.

23 Q: Maybe MUSC.

24 A: Right.

25 Q: Yeah. And you guys hire a lot from MUSC?



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1 A: We hire some from MUSC, yes. I think the
2 community is small enough that most everybody
3 has worked in multiple places.

4 Q: Sure. And MUSC trains nurses, right?

5 A: Correct.

6 Q: And you hire some of those new trainees?

7 A: Correct.

8 Q: Or new nurses, I suppose. Have you ever worked
9 a shift at an FED?

10 A: Yes.

11 Q: Good.

12 A: Many.

13 Q: So we talked a little about some of the
14 changes. Maybe I can knock out a few quickly.
15 The helipad change makes the project better
16 from a cost perspective.

17 A: I don't have a decision. You know, I don't
18 have a judgement about that, right or wrong,
19 one way or the other. I probably would have
20 made the same decision.

21 Q: All right. Fair enough. And the CDU,
22 eliminating the CDU made sense in light of the
23 nature of the FED.

24 A: I would agree that they are not -- they do not
25 offer the same level of care. It's different



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1 from what was proposed when I first heard the
2 plan.

3 Q: It is different. You're right. It's more
4 traditional ED care like you provide in your
5 Northwoods facility, right? No CDU there.

6 A: Correct.

7 Q: All right. And the original we proposed had 12
8 ED rooms and the current has 12 ED rooms?

9 A: Correct.

10 Q: All right. So there's really no difference in
11 the capacities of the two, right?

12 A: If you assume a room is a room is a room is a
13 room. If you designate rooms as separate from
14 fast track or CDU versus a regular room, it is
15 going to be different.

16 Q: Okay. Well, we have no CDU, so I don't want to
17 talk about CDU anymore. We do have fast track.
18 We could have done fast track, probably would
19 have, right, in a 12 bed, 12 room, originally
20 plan FED, right? Let me try it this way. That
21 FED that we originally planned a mile away
22 would have gotten some low-acuity folks.

23 A: Correct.

24 Q: Right? The threes, the fours, the fives. They
25 would have come in and could have been cared



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1 for in a fast-track manner, right?

2 A: Correct.

3 Q: The facility we now propose does have the word
4 fast track on certain places ---

5 A: Correct.

6 Q: --- in the schematic. We will get lower acuity
7 folks, three, fours, and fives, that we can
8 fast track. It's the same from a capacity
9 perspective.

10 A: From a capacity perspective, a fast track is
11 markedly different from the original proposal
12 of the CDU as far as capacity.

13 Q: Yes, I agree. CDU is different, right? People
14 stay in CDU beds.

15 A: Right.

16 Q: They get different kind of treatment. I guess
17 I'm now focusing just on the 12 beds we would
18 have had up there in the original proposal
19 versus the 12 beds we have now. There's no
20 capacity difference between those portions --
21 that portion of our old facility and our new
22 facility, right? The CDU is the difference.

23 A: Correct.

24 Q: And it's gone, right?

25 A: Correct.



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1 Q: And fast track, as we talked about, you know,
2 having some full-treatment rooms and fast-track
3 rooms, that's good for the patient that's
4 coming to the ED.

5 A: Correct.

6 Q: More efficient, contains cost.

7 A: Correct.

8 Q: So you offered some comment on your view that
9 the FED would impact not just staffing issues,
10 but I guess impact the other EDs from a
11 utilization perspective, I guess?

12 A: From a -- correct. I mean, it's going to take
13 volume from those ERs.

14 Q: All right. Now that's not an expert nursing
15 opinion, is it?

16 A: No. That's an experience opinion.

17 Q: All right. That's your observation based on
18 your experience.

19 A: Correct.

20 Q: All right. You don't hold yourself out to be
21 an expert healthcare planner, do you?

22 A: No, I do not.

23 Q: Who want to be a healthcare planner? Where's
24 David?

25 A: I don't know. I found it intriguing.



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1 Q: He needs to be here when I insult him. All
2 right. Just a couple more questions. So when
3 we first got together, you told me -- talked to
4 me about why you became an ED nurse. And you
5 mentioned a little about that today. Do you
6 remember how you phrased it with me? It's hard
7 to remember. Let's look at the ---

8 A: Oh, ED nurse versus other -- versus other kind
9 of nurses. Is that ---

10 Q: I'll read it to you and then we can go from
11 there.

12 A: Okay.

13 Q: If we could pull it up -- do we have the
14 switch? So my question, which is above that,
15 I think was why did you go into ED nursing?
16 Yeah, within nursing. Why'd you choose it
17 within nursing? That's right. So you
18 remember. So, let's see what you said. You
19 know, it's helping people at their most
20 vulnerable time, their most scary time, and it,
21 most of the time, is not really that scary. So
22 it was the ability to sort of step in and, you
23 know, catch somebody when they felt like the
24 world was coming to an end and help them
25 realize, you know, it's not. We'll fix this,



1 it can be fixed. I really like that answer,
2 because it highlights the compassion that I
3 want all providers to have. So, that
4 vulnerability and fear that emergency medical
5 conditions cause patients to experience, that's
6 very real for them.

7 A: Exactly.

8 Q: And as you said, it's often alleviated, at
9 least in part -- in most times, by getting that
10 patient to an ED who can communicate then with
11 a physician or a nurse, right?

12 A: Correct.

13 Q: Now, patients with emergencies feeling
14 vulnerable and scared, that's not a phenomena
15 limited to Roper ED patients, is it?

16 A: No.

17 Q: Trident and MUSC emergency patients feel the
18 same way?

19 A: Correct.

20 Q: If MUSC gets to establish an FED in
21 Summerville, those patients -- those MUSC
22 patients from that north area, who are choosing
23 MUSC for their ED care, who are feeling
24 vulnerable, who are feeling scared, will be
25 able to get to an MUSC emergency physician or



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1 nurse and receive that care of reassurance that
2 you used to provide much, much more quickly
3 than they can now; isn't that true?

4 A: Much more quickly by an MUSC facility than they
5 can.

6 Q: Right. And you would agree that's a
7 significant benefit for those patients that are
8 choosing MUSC ED services?

9 A: I would agree.

10 Q: And would you agree that's something we should
11 keep in the forefront of our minds in this
12 case?

13 A: I do, yes.

14 Q: All right. Thank you.

15 **MS. HOLLINGSWORTH:** Did you have questions?

16 **MS. BIGGERS:** No questions.

17 **MS. HOLLINGSWORTH:** Just don't want to jump off and
18 ...

19 **THE COURT:** Ms. Biggers, I have to apologize again.
20 I'm going to -- I promise you I'm not going to
21 overlook you next time.

22 **MS. BIGGERS:** It's okay. I know the monitors are a
23 little bit hiding me.

24 **THE COURT:** Yes.

25 **MS. HUNTINGTON - RE-DIRECT EXAMINATION BY MS.**



HOLLINGSWORTH:

Q: I just have a couple of questions. That was very powerful testimony there by Counsel there at the end. Just take a minute. I want to show you -- if you'll look at the Certificate of Need application, Joint Exhibit 1. And while we get situated again on the electronics, Ms. Huntington, can you just explain to us, what is a traveler nurse? We've used that phrase several times and I don't know that we really ever got sort of a definition.

A: Sorry. So they are usually assigned through an agency. So if I decided, you know what, I want to see something different in the world, I want to go try nursing in multiple places, I could sign up with an agency. And then they would post their vacancies and available travel assignments. I would pick one and then I would go to that place and staff. That's how it works on the nurse side. On the hospital side of things, when you can't fill vacant positions, you reach out to an agency and you say, I'm looking for a nurse to fill a 12-week vacancy, this shift, this facility. They post that out there. And then nurses who are



1 interested and available say, oh, you know,
2 pick me. And then you usually end up with two
3 or three candidates that you can choose from to
4 fill your vacancy.

5 Q: Okay. So it would be fair to say they're very
6 temporary or intended to be temporary fillers
7 of need?

8 A: Yes. They cost about twice -- you pay them
9 almost twice as much as what you'd pay for a
10 regular nurse. Now, they don't always -- they
11 don't pocket that because some of that goes to
12 the agency. But they're a much higher rate and
13 they're very costly to your organization.

14 Q: And up until a few years ago you weren't having
15 to use traveler nurses. Is that what you were
16 saying?

17 A: Correct.

18 Q: If you'll turn to the Joint Exhibit 1, the CON
19 application, it's page 56 of the application.

20 A: So section ---

21 Q: Look in the bottom right corner.

22 A: Section four? I mean, the ...

23 Q: And Mr. Dayhuff was asking you about -- he was
24 asking you about changes. He was talking to
25 you about what the kind of schematic or floor



1 plan was and then how it changed. Can you
2 recall him talking to you about that?

3 A: I do.

4 Q: And if you would, on here -- and it's a very
5 bad copy. I'm sorry. Can you kind of point
6 out maybe by color where the treatment spaces
7 are in this schematic? I guess it's -- oh, and
8 it's got a color legend. So the light blue
9 spaces, those are the treatment rooms in the
10 proposal that you heard about at project
11 review?

12 A: Correct.

13 Q: All right. And then where are the CDU
14 observation? Is that here on -- and I guess
15 you have to look at the color legend.

16 A: The dark blue to the right, yeah.

17 Q: So that's a whole other area off kind of to the
18 right column of the schematic page?

19 A: Correct.

20 Q: Those are five separate rooms, aren't they?

21 A: They are.

22 Q: I might see if I can -- since you were asked
23 about the new schematic, if you'll look at --
24 it's in Trident Exhibit 68. You should have a
25 notebook with a gold cover.



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1 A: 68 starts with Intuitive?

2 Q: Yeah. But I just want you to flip to page --
3 it says TMC 68-5. And it's a floor plan. You
4 got that? Okay. So we've seen it flash up on
5 the screen here during the trial. Do you
6 recall seeing that at times?

7 A: I do, yes.

8 Q: Okay. And is this your understanding of sort
9 of the new schematic, the new floor plan that's
10 being proposed by MUSC?

11 A: Yes.

12 Q: And Mr. Dayhuff was asking you about sort of
13 this change in the floor plan and how, if
14 anything, it could be different. As you look
15 at the spaces that are here in the sort of
16 original application proposal, and these
17 changed spaces here in the new floor plan, how
18 are they different to you?

19 A: So there's a full and a small. And I'm not
20 sure the difference between ---

21 Q: Yeah. I'm sorry for the double -- if you look
22 at the full 10,648 is what we've been provided.

23 A: Okay.

24 Q: So yeah.

25 A: And it is very hard to tell without color



1 what's what. But it looks to me like what I'm
2 seeing is this sort of fast-track area is kind
3 of grouped into more of a square there with
4 rooms surrounding each other. The layout has
5 changed, I mean, and that kind of makes sense,
6 so that to me there are distinct areas,
7 separated areas. And it would be challenging
8 to do -- to deliver the same level of care in
9 all 12 of those rooms, just because a group of
10 them are laid out a little bit more like a
11 fast-track ER that you would -- I mean, a fast-
12 track area that you would expect.

13 Q: So when you look at this floor plan, this
14 schematic, with the exam -- the word is hard to
15 see, but exam and then treatment at the bottom
16 for the seven spaces to the left in the bottom
17 and then you have the five clustered spaces
18 there to the right. And as you look at this
19 and from your experience, this is -- those
20 spaces are set up differently than what you
21 looked at in the application?

22 A: Yes.

23 Q: And when you're evaluating the differences
24 between these two, do you think about staffing
25 these two facilities differently?



1 A: Than the original application?

2 Q: Right, yes.

3 A: Yes, definitely.

4 Q: Okay. And when you kind of described about how
5 this might impact the delivery of care, what is
6 your expectation then for the smaller clustered
7 rooms off to the right? What is your
8 expectation about the patients that you would
9 treat in there?

10 A: That those would be the fast-track patients and
11 that there would be a higher volume of patients
12 moving in and out through there in a much
13 faster period of time, so. Those are your
14 vertical patients. They stay upright. They
15 need less resources.

16 Q: Okay. And on this schematic, even the rooms
17 are differently set up? There are more
18 resources, as it appears, on this left side in
19 the exam or treatment rooms?

20 A: That would be my expectation. Those would be
21 your potentially monitored beds.

22 Q: Okay. And in your work, in your experience
23 when it comes to emergency services, just using
24 the words fast track, does that have any
25 meaning to you in delivery of emergency



1 services care?

2 A: Yes, it does.

3 Q: Okay.

4 A: Literally, fast track is exactly what it says.
5 You fast track them to expedite their movement
6 in and out because you know they're not going
7 to need the resources. Again, you bring them
8 into the mix of the rest of the patients and
9 they get lost and you lose the benefit of fast
10 tracking them.

11 Q: I appreciate it. Thank you.

12 **THE COURT:** Ms. Huntington, I think that's it for
13 you. Thank you.

14 **MS. HOLLINGSWORTH:** Your Honor, I -- Roper's case,
15 we have one additional witness. That would be
16 our expert health planner. So she would
17 certainly be our longest witness. And as I
18 understand kind of what happens next in the
19 case, Trident's case would be presented next.
20 They have some witness availability issues.
21 They only have one witness that would be
22 available tomorrow. I would ask The Court
23 instead of having to start Ms. Platt at 3:00 in
24 the afternoon and break early -- or break
25 through her testimony -- and quite honestly, in



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1 part, having done the Cross of a medical expert
2 until late last night, I've just sort of run
3 out of time. If we could just have Ms. Platt
4 start in the morning, since that would be the
5 only other witness and Trident only has one
6 witness to go in the afternoon. I would ask
7 that The Court would consider just letting us
8 -- getting Ms. Platt and to put her up in the
9 morning.

10 **MR. THOMAS:** No objection from Trident, Your Honor.

11 **MR. WESTBROOK:** I just have a question.

12 **THE COURT:** Yes, Mr. Westbrook.

13 **MR. WESTBROOK:** I wasn't part of this call, so I'm
14 relying on Travis. So, Jennifer, you tell me
15 what the real facts are here. Does Kathy have
16 a plane to catch tomorrow? Did I understand
17 that correctly?

18 **MS. HOLLINGSWORTH:** Yes. So she has to leave late
19 tomorrow night.

20 **MR. WESTBROOK:** Oh, okay.

21 **MS. HOLLINGSWORTH:** So, she is here all day
22 tomorrow.

23 **MR. WESTBROOK:** Okay. All right.

24 **MS. HOLLINGSWORTH:** And I don't think she'll take a
25 full day, but I think that she'll take more



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1 than -- you know, I don't even know that her
2 Direct is less than two hours. So I'm just
3 trying to avoid breaking that up.

4 **MR. WESTBROOK:** Right.

5 **MS. HOLLINGSWORTH:** And as I understand it, Trident
6 has three fact -- three witnesses other than
7 their expert and only one is available
8 tomorrow. So, we would only have that one
9 other witness to do tomorrow anyway.

10 **THE COURT:** And that's a fact witness?

11 **MR. THOMAS:** Yeah. That's our CEO, Your Honor.

12 **THE COURT:** Okay.

13 **MS. HOLLINGSWORTH:** So, that would be a witness in
14 order, Mr. Porter, just a couple of hours. My
15 expectation is my case will be done tomorrow
16 anyway, but this would just allow me to have
17 some additional time and not break up her
18 testimony.

19 **MR. WESTBROOK:** Well, my only concern would be --
20 and, I mean, I run out of gas, so ---

21 **THE COURT:** Mr. Westbrook.

22 **MR. WESTBROOK:** Yes, ma'am.

23 **THE COURT:** You just got here.

24 **MR. WESTBROOK:** I'm old.

25 **MS. HOLLINGSWORTH:** And you left early last night.



1 And we were here until 7:30.

2 **MR. WESTBROOK:** I heard about it, though.

3 **MS. HOLLINGSWORTH:** He's been gone all morning
4 preparing. I've ben here putting up the case
5 the whole time.

6 **MR. WESTBROOK:** Your right. Well, point well taken,
7 Your Honor. But I just wondered if I would
8 have -- I just wanted to make sure I had time
9 to do a Cross. I don't think I'm going to do
10 a lengthy Cross, but she is an expert and an
11 important witness and it will be -- it's got to
12 be fairly long, so.

13 **MS. HOLLINGSWORTH:** I agree. I agree. And, you
14 know, I think she is our longest witness. I
15 don't want to go late tonight. Yesterday was
16 so ---

17 **MR. THOMAS:** I won't have any questions for her.

18 **MR. WESTBROOK:** Okay. I'm okay as long as you can
19 leave me enough time to do Cross.

20 **MS. HOLLINGSWORTH:** I feel certain you'll have time.
21 And Ms. Valentine, I think, is a pretty short
22 witness anyway. So I still think we'll
23 accomplish the same thing tomorrow. But
24 otherwise the alternative is we might be done
25 at 1:00. And I would just appreciate the extra



1 time. I'm just exhausted.

2 **THE COURT:** Okay.

3 **MR. DAYHUFF:** Could we also think about how the rest
4 of this is going to play out?

5 **THE COURT:** Yes.

6 **MR. DAYHUFF:** Because I think Will and I were
7 discussing. So -- and make sure this is okay
8 with The Court. It sounds we're fine with what
9 we propose for tomorrow. And then Thursday,
10 Will, is what?

11 **MR. THOMAS:** Joan Eccleston and ---

12 **MR. DAYHUFF:** Dr. Wendell.

13 **MR. THOMAS:** --- and Dr. Wendell, yes.

14 **MR. DAYHUFF:** Okay. And were we thinking just those
15 two and then doing Dan Sullivan on Friday?

16 **MR. WESTBROOK:** If that's what y'all want. Is that
17 the plan?

18 **MR. THOMAS:** I would imagine Dan will go up as
19 quickly and come down as quickly as Kathy. And
20 then do we start Maggie Friday is the question?

21 **MR. WESTBROOK:** So we would start Dan on Friday
22 morning then?

23 **MR. THOMAS:** That's what I was thinking.

24 **MR. WESTBROOK:** Okay.

25 **MR. DAYHUFF:** Do we really think we'll be able to



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1 get through Dan Sullivan? I'm just thinking --
2 -

3 **MR. THOMAS:** I don't know.

4 **MS. HOLLINGSWORTH:** In two days.

5 **MR. DAYHUFF:** Here would be my suggestion, as long
6 as The Court is okay. We do your two witnesses
7 on Thursday, your expert and your fact witness;
8 Dan on Friday; Maggie on Monday; Cawley on
9 Tuesday with Louder; David on Wednesday. Does
10 that work?

11 **MR. THOMAS:** I have no problem ---

12 **THE COURT:** Is that a schedule that you all can ---

13 **MR. DAYHUFF:** I think we can.

14 **MR. THOMAS:** I have no problem with that.

15 **MR. DAYHUFF:** It might result in, as we're having
16 today, a short day Thursday it sounds like.
17 Potentially.

18 **MR. THOMAS:** Which would be -- for a work day for
19 not only us in The Court. I mean, I know you
20 have other cases, Your Honor.

21 **MR. DAYHUFF:** Friday would probably be longer with
22 Dan Sullivan. Monday could be a little break
23 with Maggie. But I think this all would work.
24 And then I could tell Dr. Cawley when to be
25 here with certainty and Dr. Louder and I'll



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1 tell him that's Tuesday. That would help them.

2 **THE COURT:** Okay.

3 **MS. BIGGERS:** And that's fine with DHEC as well.

4 And we would plan -- that way DHEC would plan
5 on calling its witness Monday morning, first
6 thing Monday morning next week.

7 **THE COURT:** Okay. I love the way you all are
8 working together. That's lovely.

9 **MR. DAYHUFF:** We've been together so long, now we're
10 starting to get along.

11 **THE COURT:** Okay.

12 **MS. HOLLINGSWORTH:** Is that okay with The Court?

13 **THE COURT:** That's fine.

14 **MS. HOLLINGSWORTH:** And we'll start at 9:00 in the
15 morning again if that works for everyone.

16 **THE COURT:** Well, we will adjourn until 9:00 o'clock
17 in the morning.

18 **(Tuesday, July 23, 2019 the administrative hearing**
19 **ended at 3:15 p.m. and reconvened on Wednesday, July**
20 **24, 2019 at 9:02 a.m.)**

21 **DAY THREE - JULY 24, 2019**

22 **THE COURT:** Ms. Hollingsworth, are you ready to call
23 your witness?

24 **MS. HOLLINGSWORTH:** Your Honor, I think we're doing
25 a little bit of technical things. But what I



1 thought we could certainly still need to do, we
2 had designated yesterday morning the 30(b)(6)
3 deposition of Intuitive Health. We filed a --
4 what we received as the PDF draft. And if I
5 can approach, I have here for The Court ---

6 **THE COURT:** Yes.

7 **MS. HOLLINGSWORTH:** -- the bound for the court
8 reporter -- for The Court. And then we have a
9 thumb drive that has the exhibits from the
10 deposition.

11 **THE COURT:** Okay.

12 **MS. HOLLINGSWORTH:** So that would be for The Court.
13 And I think what I would propose for MUSC's
14 counsel, we haven't seen any objections to the
15 designations. So I think we'll do what we do
16 this morning, but still I think, even when
17 we're done with testimony next week, can agree
18 to pull exhibits that we don't need to have in
19 the record because they weren't referenced or
20 discussed.

21 **THE COURT:** I'm sorry. Proceed.

22 **MS. HOLLINGSWORTH:** So, as we had discussed
23 yesterday, we're happy to coordinate with
24 MUSC's counsel to address any objections they
25 have to certain exhibits or something like



1 that. We hadn't heard yet from them last
2 night. So what I propose -- just because this
3 is our last witness, so this would be one that
4 we are using, that material that we designated
5 yesterday. But what I would propose is, you
6 know, we've provided The Court a thumb drive of
7 all of the exhibits, but certainly once
8 testimony is done, we'd be happy to agree to
9 pull and make sure we, you know, delete and
10 pull from The Court's file anything that we
11 didn't use, just so that we avoid any
12 unnecessary documents that would be in The
13 Court record. But for now we've just provided
14 The Court everything to kind of see what all
15 ends up being discussed.

16 **THE COURT:** Okay. Mr. Westbrook.

17 **MR. WESTBROOK:** Yes, thank you. I have not -- I
18 guess we did get these designations last night;
19 is that right?

20 **MS. HOLLINGSWORTH:** No, yesterday morning.

21 **MR. WESTBROOK:** Yesterday morning. Okay. Well,
22 sorry.

23 **MS. HOLLINGSWORTH:** I'm sorry. It was Monday
24 morning. It was Monday morning at the start of
25 the hearing.



1 **MR. WESTBROOK:** Well, at any rate we don't have --
2 there may be certain exhibits that we have
3 objections to that may be included in the
4 objections we've already filed -- served to
5 your exhibits. But why don't we just take
6 those as they come. In terms of the transcript
7 of the deposition itself, I don't think we have
8 any objections. And what we would propose
9 though is just either the whole transcript just
10 come in or else I won't object -- we won't
11 object to your designations if you don't object
12 to ours, which we -- but we haven't made ours
13 yet. I don't know that we're going to make
14 any.

15 **MS. HOLLINGSWORTH:** Right.

16 **MR. WESTBROOK:** But we may want to do that in
17 rebuttal to some of the things he says. So I
18 ---

19 **MS. HOLLINGSWORTH:** We have designated the entire --
20 -

21 **MR. WESTBROOK:** Oh, you have?

22 **MS. HOLLINGSWORTH:** Yeah. We haven't eliminated
23 anything.

24 **MR. WESTBROOK:** I'm okay with that, but there may be
25 certain exhibits that I have objection to. I



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1 just don't know yet.

2 **MS. HOLLINGSWORTH:** So, yeah. What we can do is
3 just handle them as they come up and certainly
4 pull out anything that just ends up not being
5 addressed, just to reduce the documents in the
6 record.

7 (Petitioner Roper's Deposition Designation was
8 admitted into the record at this time.)

9 **THE COURT:** Okay.

10 **MS. HOLLINGSWORTH:** Your Honor.

11 **THE COURT:** Yes.

12 **MS. HOLLINGSWORTH:** Ready for our last witness, at
13 least for Roper St. Francis. We call Kathryn
14 Platt to the stand.

15 **KATHRYN MT. PLATT,** having been duly sworn, testifies
16 as follows:

17 **COURT REPORTER:** Please state and spell your first
18 and last name.

19 **MS. PLATT:** Kathryn, K-A-T-H-R-Y-N. I have two
20 middle initials, M-T. Platt, P-L-A-T-T.

21 **COURT REPORTER:** Thank you.

22 **MS. PLATT - DIRECT EXAMINATION BY MS. HOLLINGSWORTH:**

23 Q: Good morning.

24 A: Good morning.

25 Q: Ms. Platt, if you could, we have on the screen



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1 a document actually that was filed with the
2 affidavit you provided to The Court earlier
3 this year. Can you tell us what that document
4 is?

5 A: Yes. This is a copy of my CV.

6 Q: Okay. And we have that available. It's in The
7 Court's file. But if you could just kind of
8 give us, what is your educational background?

9 A: Sure. I have a bachelor's of science in
10 psychology from Emory University. And then a
11 MBA focusing in healthcare management and
12 finance from Boston University.

13 Q: Okay. And when did you get your kind of last
14 degree?

15 A: 1989.

16 Q: All right. And so since 1989, what have you
17 been doing?

18 A: Following grad school I started working with a
19 firm called Sullivan Consulting Group, which
20 you'll meet Mr. Sullivan later. And I worked
21 with his firm for 17, 18 years, doing
22 healthcare management consulting. And then in
23 2008 I started my own firm, Platt HMC. So for
24 almost 30 years I've been doing healthcare
25 management, consulting with a large



1 concentration in Certificate of Need assistance
2 and participation in proceedings such as this.

3 Q: Okay. And kind of describe for me what it is
4 -- what was it that you did for your healthcare
5 management and finance degree? Kind of
6 describe what that course of study is like.

7 A: Sure. So it was a specific program within the
8 MBA, the business school at Boston University.
9 So it had a full range of basic, you know,
10 business concentration classes and then an
11 overlay of specific healthcare management
12 classes in each of the different business
13 disciplines.

14 Q: Okay. And so both with regard to sort of the
15 -- tell me a little bit more about the finance
16 part of it.

17 A: Sure. So within the healthcare management
18 track, you could select sort of an area of
19 concentration where you took more classes. And
20 I picked accounting and finance. And so, you
21 know, in addition to sort of all the required
22 classes, the additional courses I took were
23 focused in accounting and finance. And then
24 while I was in graduate school, I also worked
25 as a budget and financial analyst at



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1 Massachusetts General Hospital. So I kind of
2 had the practical side of the finance
3 application while I was going through my grad
4 school program.

5 Q: Okay. And tell us a little bit more, before
6 you began your own consulting company, what it
7 is you did with Sullivan Consulting.

8 A: Sure. So I started as a entry-level consultant
9 right out of grad school and learned from Mr.
10 Sullivan all the basics of how to prepare a
11 Certificate of Need application, what went into
12 that, working with the clients to gather all of
13 the information necessary for preparing an
14 application, all of the contents. And that
15 would include South Carolina from, you know,
16 the very beginning, but then also all of the
17 other states in the southeast region. I worked
18 with him in opposing applications and then also
19 participating in cases such as this initially
20 in a support role to Mr. Sullivan and then
21 after a while testifying on my own. So while
22 I was there, I, you know, basically grew from
23 an entry-level consultant into having my own,
24 you know, clients and working sort of more in
25 a -- sort of a peer role to Mr. Sullivan.



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1 Q: And when did you start Platt HMC?

2 A: 2008.

3 Q: Okay. And then tell us how has your kind of
4 business work developed once you opened your
5 own consulting firm?

6 A: Sure. So, basically continuing to work on the
7 same types of project engagements, preparing
8 applications, working to oppose applications,
9 participating in CON appeal proceedings and
10 providing expert testimony. So sort of that
11 client aspect remained basically the same. You
12 know, some of the same clients that I worked on
13 with Mr. Sullivan came with me, some of them
14 stayed with Mr. Sullivan. And then, you know,
15 I obviously had additional new clients since
16 that time. But then I also took on sort of the
17 broader management of my own consulting
18 practice along with the, you know, client
19 engagement work.

20 Q: And tell me a little bit more about the health
21 plan. Setting aside sort of Certificate of
22 Need review, but talking a little bit more
23 about the health planning work that you do.

24 A: Sure. So, you know, health planning, it's
25 certainly applicable to Certificate of Need.



1 But the tools and skills that you use in health
2 planning apply to strategic decision making for
3 hospitals and other healthcare institutions;
4 market analysis, market research. So a lot of
5 those same factors and sort of methodologies
6 and data sources that you would use in a CON
7 context also apply to various other aspects of
8 healthcare management and decision making for
9 hospitals and other healthcare facilities.

10 Q: And to that point, you work for -- you do
11 health planning work for more than just
12 hospitals?

13 A: Yes. For pretty much every type of healthcare
14 facility. You know, hospitals; specialty
15 hospitals such as psych and rehab; outpatient
16 centers, ambulatory surgery, imaging centers;
17 long-term care like hospice, nursing home, home
18 health. So really the full gamut of -- you
19 know, types of healthcare services.

20 Q: And what about in terms of your clients? Do
21 you have clients other than hospital systems?
22 Do you work for physician groups?

23 A: Yes. Our clients are all types of hospitals:
24 From small rural hospitals, you know, to large
25 academic medical centers, to for-profit



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1 hospital systems; as well as, you know,
2 individual physicians, physician group
3 practices; you know, long-term care companies
4 such as nursing homes, again, and home health;
5 you know, companies that are developing imaging
6 centers, ambulatory surgery centers. So a wide
7 variety of types of clients as well.

8 Q: And I should have asked you this. Where do you
9 live?

10 A: I live in Atlanta, Georgia.

11 Q: And in what states do you focus your work?

12 A: Florida, Georgia, South Carolina, North
13 Carolina, Alabama, Tennessee, and Kentucky are
14 the -- I'd say the most concentrated work. And
15 then from time to time other adjoining states;
16 Virginia, West Virginia, Maryland, Mississippi.
17 So pretty much the whole southeast region.

18 Q: Okay. And now kind of focusing on -- what
19 states do you do your planning work in that
20 have Certificate of Need laws in some fashion?

21 A: All of those states do.

22 Q: Okay. And when you're doing health planning
23 and it's a service or a project or facility
24 that's covered by Certificate of Need, what are
25 some of the services that you provide to your



1 clients?

2 A: Sure. So I provide assistance in preparing the
3 CON. Sometimes we start early enough in on the
4 project that our guidance is provided in terms
5 of how they actually decide on, you know, the
6 aspects of the project, how it's going to be
7 developed, what size it should be, that type of
8 thing. Sometimes the client comes with a
9 project that's already fully assessed and
10 defined and then they just ask us to write the
11 CON application. We assist them through that
12 process. Again, if it's a client that's
13 opposing, we assist them in identifying what,
14 you know, their competitor is proposing and how
15 it might impact their existing operations. We
16 assist them, again, through the appeal process
17 in proceedings such as this. In between CON
18 projects, a lot of my clients are ongoing
19 clients that I've, you know, had for years and
20 years. So between sort of the major CON
21 projects, I'm helping them assess, again, the
22 market that they're working in, understanding
23 what their competitors are doing, so additional
24 planning work between the CON engagements.

25 Q: Okay. If you could, give The Court an overview



1 of the types of CON projects that you've worked
2 on in South Carolina, whether assisting with an
3 application or an applicant seeking a project
4 or even opposing a project.

5 A: Sure. And I've been in both roles, both
6 writing the application and assisting with the
7 application and then also opposing. Pretty
8 much everything that's covered under the State
9 Health Plan I've worked on at one time or
10 another over the last 30 years; you know, new
11 hospitals, various specialty hospital beds,
12 outpatients services, ambulatory surgery,
13 imaging services, freestanding ED, long-term
14 care, nursing home, home health. So, again,
15 pretty much everything that would potentially
16 require CON or be covered by the State Health
17 Plan in South Carolina.

18 Q: Okay. And in this proceeding, you are
19 assisting Roper St. Francis healthcare; is that
20 right?

21 A: Yes.

22 Q: How long approximately have you had a
23 relationship with Roper St. Francis and provide
24 health planning services?

25 A: Sure. So over 30 years. I've worked with



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1 Roper St. Francis, you know, in the past and
2 with Sullivan Consulting Group. But then in
3 the most sort of recent time period I've been
4 working for them since 2016 on a group of
5 projects.

6 Q: And has it only been to oppose projects of
7 other entities?

8 A: No. I've written applications with them as
9 well.

10 Q: Okay. All right. Can you think of or can you
11 identify some of the projects that you've
12 worked with Roper St. Francis on?

13 A: Sure. The most recent two have been for a
14 linear accelerator, which is cancer treatment
15 services, and for cardiac catheterization.

16 Q: Okay. And where were those projects? Or can
17 you tell us what facilities or locations those
18 were for?

19 A: Sure. Both of them were focused on bringing
20 services out to Berkeley County, which is the
21 same area for the proposed MUSC FSED.
22 Specifically trying to bring additional
23 services to the new Roper Hospital Berkeley
24 that'll be opening this October.

25 Q: Okay. And then what about -- we've heard about



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1 some various freestanding EDs. Have you
2 assisted Roper St. Francis with any of the
3 freestanding ED projects?

4 A: Yes. So I was prepared to assist them with
5 what was looking like it was going to be an
6 appeal of the relocation and expansion of their
7 Northwoods freestanding ED. But then that
8 settled before it went to trial. I helped them
9 with this project for MUSC from the opposition
10 standpoint. And then I've also helped them
11 with opposition to another freestanding
12 emergency department on James Island filed by
13 Trident or their affiliate.

14 Q: Okay. And so other than what you've just
15 talked about involving Roper St. Francis, have
16 you been involved in any other CON projects in
17 the Berkeley County, southern Berkeley County
18 area?

19 A: Yes. So I have previously worked with Palmetto
20 Primary Care, which is a large physician
21 practice, and filed CON applications for the --
22 in Berkeley County, specifically in the Nexton
23 area, for an MRI that was approved. And then
24 they filed with an affiliate an ambulatory
25 surgery center application, which they



1 ultimately decided to withdraw.

2 Q: And can you tell The Court a little bit about
3 your occasions to testify as an expert?

4 A: Sure. I have testified approximately 90 times
5 as an expert in either deposition or trial.
6 And I have been qualified as an expert and
7 testified in Florida, Georgia, North Carolina,
8 South Carolina, Alabama, Tennessee, and
9 Kentucky.

10 Q: What are -- and I know every state might kind
11 of use different language, but how would you
12 describe sort of the areas of expertise that
13 you've been proffered or designated as?

14 A: Sure. It's typically health planning, CON
15 preparation, an analysis. Sometimes the
16 designation includes the State -- you know,
17 State Health Plan or the equivalent in
18 different states and usually also financial
19 analysis or, you know, some type of a financial
20 designation.

21 Q: Okay. Have you ever been refused as an expert
22 witness by a court?

23 A: No.

24 Q: Okay. And in South Carolina, have you been
25 offered and accepted as an expert in



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1 Certificate of Need matters?

2 A: Yes, I have.

3 Q: Can you think of -- can you give us -- identify
4 a few cases where you've testified as an
5 expert?

6 A: So I guess most recently would have been a
7 cardiac cath hearing on behalf of Roper St.
8 Francis. I've been designated on ambulatory
9 surgery cases, neo hospitals, linear
10 accelerators, home health. It's hard to
11 remember them all, but, I mean, that's
12 certainly a few of them.

13 Q: Okay. And this is your CV that we've provided
14 to The Court, February 8th, 2019 with your
15 affidavit for some motions; is that right?

16 A: Yes.

17 Q: Okay. And is that document that you provided
18 The Court an accurate summary of your education
19 and experience?

20 A: Yes, that is.

21 **MOTION TO QUALIFY AS EXPERT:**

22 **MS. HOLLINGSWORTH:** Your Honor, we would offer Ms.
23 Platt as an expert in healthcare planning,
24 healthcare financing of the South Carolina
25 Health Plan.



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1 **MR. DAYHUFF:** No objection, Your Honor.

2 **THE COURT:** Okay. She's admitted.

3 **MS. HOLLINGSWORTH:** Thank you, Your Honor.

4 **Q:** So, Ms. Platt, you've been here for both days
5 that we've had the hearing so far; is that
6 right?

7 **A:** Yes.

8 **Q:** Okay. And you're familiar with the project
9 that we've been talking about?

10 **A:** Yes.

11 **Q:** All right. Let's go ahead and just pull up
12 Joint Exhibit 1, which is the DHEC record for
13 the CON. And I do think you have a printed
14 copy on the ledge there.

15 **A:** Okay.

16 **Q:** Okay. We've got the first page up on the
17 screen. But can you identify for The Court,
18 when was this application filed?

19 **A:** June -- I believe it's June 6th -- the dates a
20 little faded out -- 2019 -- I'm sorry, 2017.

21 **Q:** Okay. And if you could -- or do you recall
22 approximately when you began assisting Roper
23 St. Francis with regard to the MUSC health
24 application for the development of a
25 freestanding emergency department?



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1 A: I don't remember a specific day, but relatively
2 shortly after it was filed. So probably in the
3 July -- late June to July time frame of 2017.

4 Q: 2017, okay. And we'll talk some more about it
5 specifically, but if you'll turn to page 442.

6 A: Okay.

7 Q: Did you provide any materials to DHEC staff
8 during their review on behalf of Roper?

9 A: Yes, I did. This document starting at 442 is
10 an opposition filing that my firm prepared and
11 submitted to DHEC describing the basis for
12 Roper St. Francis' opposition to the MUSC FSED
13 project.

14 Q: Okay. If you could, very, very, briefly -- but
15 I think sort of at the very bottom of page 442,
16 but then with bullet points on 443, can you
17 sort of briefly describe the main points of the
18 opposition that you identified to the
19 Department on behalf of Roper St. Francis?

20 A: Sure. Well, we started at the bottom of 442 in
21 providing some background on the fact that
22 Roper St. Francis and its affiliates have a
23 hospital that is under construction in Berkeley
24 County that will offer emergency services in
25 very close proximity to the proposed FSED as



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1 well as a couple of other freestanding EDs that
2 already exist, again, in the vicinity. And
3 then we kind of identified that there are some
4 issues with the State Health Plan, that we
5 don't believe that MUSC can meet Standard 2 of
6 the South Carolina Health Plan and that there
7 is no community need for another freestanding
8 emergency department or more ED capacity within
9 the Berkeley County and the Tri-County area.
10 We criticized the application, that MUSC did
11 not adequately define its service area in the
12 proposed population it intends to serve and
13 that the location of the freestanding ED does
14 not meet a community need, it does not improve
15 access to care, or promote cost containment.

16 Q: Okay. And this was provided to the Department
17 when? What is the date of this?

18 A: July 21st, 2017.

19 Q: Okay. And did you also -- we've heard about a
20 project review meeting. Did you participate in
21 that?

22 A: Yes. We prepared a presentation. I attended
23 and presented at the meeting.

24 Q: Okay. If you'll turn to page 457 in Joint
25 Exhibit 1.



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1 A: Okay.

2 Q: Can you just describe what this document is
3 that starts at page 457?

4 A: Yes. This is the presentation that my firm
5 prepared, and that we presented to the DHEC
6 staff at the project review meeting.

7 Q: Okay. And just to kind of clear up maybe some
8 of the testimony we've heard over the last
9 couple of days. At the time of these filings
10 and during staff review, there was another
11 freestanding ED being proposed in the service
12 area; was there not?

13 A: Yes. At the same time there was another
14 freestanding ED proposed by an affiliate of
15 Trident HCA for a Summerville freestanding ED
16 located in very close proximity to the proposed
17 MUSC project and also, again, in close
18 proximity to the Roper St. Francis Hospital
19 that's about to open.

20 Q: Okay. And we've heard testimony and you're
21 aware that ultimately Roper St. Francis
22 withdrew its contested case challenge to that
23 Summerville FSED?

24 A: Yes.

25 Q: Did you have any role in the decision or



1 discussions related to Roper St. Francis'
2 decision to withdraw that contested case?

3 A: I did not.

4 Q: And I want to -- similarly, you had mentioned
5 assisting Roper St. Francis with a linear
6 accelerator for the Berkeley -- Roper Berkeley
7 Hospital; is that right?

8 A: Yes.

9 Q: And was there also an application submitted by
10 MUSC for a linear accelerator in Berkeley
11 County?

12 A: Yes.

13 Q: Where was that proposed to be located?

14 A: In the same Nexton community or area of
15 Berkeley County.

16 Q: And did Roper St. Francis file a contested case
17 challenge to the Department's approval of
18 MUSC's linear accelerator in Berkeley County?

19 A: It did not.

20 Q: Okay. All right. So we'll come back to the --
21 for the -- well, let me ask you one other
22 question, just so that we can have it in the
23 file. Turn to page 454, Joint 1.

24 A: Okay.

25 Q: And can you just identify for The Court what



1 this document is in the DHEC record?

2 A: This is another letter that was filed with DHEC
3 on behalf of Roper St. Francis following up
4 after the initial letter that my firm prepared.
5 And this is filed by Nexsen Pruet on behalf of
6 Roper St. Francis. So it follows up on some
7 specific sort of legal issues related to the
8 opposition.

9 Q: Okay. And does this -- does it appear this is
10 addressing Standard 2 under the Health Plan?

11 A: Yes. It's -- yes, it is. So that we had it --
12 we were addressing Standard 2 both from the
13 health planning standpoint in my opposition
14 letter and then also from a legal standpoint in
15 this filing.

16 Q: Okay. And what is the date of the letter?

17 A: It's July 31st, 2017.

18 Q: Okay. All right. Let's talk about the South
19 Carolina Health Plan.

20 A: Okay.

21 Q: What is the role of the Health Plan in the
22 Certificate of Need process?

23 A: Sure. So it is a planning document that's
24 updated every year to two years by the staff of
25 DHEC, along with community representatives from



1 various types of healthcare services and
2 facilities. So it's kind of a living document
3 that is updated. And it sets forth need
4 methodologies and standards for certain
5 services that require CON review. It lays out
6 considerations that the applicant must address
7 in their application. And it sets forth
8 certain project review criteria that are deemed
9 the most important for that particular service
10 in each chapter.

11 Q: Okay. And we'll talk about them more. But
12 just kind of tell us, what are the project
13 review criteria?

14 A: The project review criteria are set forth in
15 the regulations and they're the set of criteria
16 that apply to all CON applications and must be
17 addressed by the applicant, even if there are
18 not sort of service-specific considerations in
19 the State Health Plan for that service. So
20 they apply to every Certificate of Need
21 application.

22 Q: Okay. And where did you say that those are
23 found?

24 A: They are in Regulation 61-15.

25 Q: And what is Regulation 61-15?



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1 A: So that is the regulations that guide the CON
2 process. It sets forth sort of how the process
3 is run administratively, the time frames, the
4 deadlines. It sets forth the requirements of
5 the application and it sets forth the -- again,
6 the project review criteria that apply to all
7 CON applications.

8 Q: Okay. And so if I understood what you said,
9 with regard to the project review criteria,
10 there are project review criteria kind of
11 discussed in the Health Plan, but the, kind of,
12 criteria themselves are in the regulations; is
13 that right?

14 A: That's correct.

15 Q: Okay. All right. And we'll look at some
16 documents as we talk this morning. In terms of
17 -- and I think you did briefly kind of talk
18 about it, but in addition to the project review
19 -- first let me ask you, these regulations, are
20 they DHEC's regulations?

21 A: Yes, they are.

22 Q: Okay. And are they tied to the Certificate of
23 Need Act, the statute?

24 A: Yes, they are.

25 Q: Okay. And other than -- you talked about that



1 they have the project review criteria, but what
2 else is it that's in Regulation 61-15?

3 A: There are standards for each of the regulated
4 services for which there's a need methodology
5 or certain, again ---

6 Q: Ms. Platt, not the Health Plan.

7 A: Oh, I'm sorry.

8 Q: In the Certificate of Need regulations.

9 A: Yes.

10 Q: Other than the project review criteria, what
11 else do those regulations talk about?

12 A: They talk about the process, what the timing is
13 for the process, what are the required contents
14 of the application. It talks about things like
15 what is a substantial change, what do you, you
16 know, do procedurally at different points
17 during either the certificate review period or
18 afterwards. And the actual CON form itself and
19 the question in the form are set forth in the
20 regulations.

21 Q: And so just kind of overall, I mean, why does
22 an applicant need a Certificate of Need?

23 A: Well, there's a number of kind of overarching
24 themes that resulted in the development of the
25 CON program that started on a federal level and



1 then was retained by various states. And they
2 look at things like cost containment,
3 preventing unnecessary duplication of services,
4 which, again, sort of links to cost
5 containment, ensuring quality of care, ensuring
6 access to care both physically, geographically,
7 and financially to make sure all patients have
8 the ability to seek services. So those are
9 some of the basic kind of overarching tenants
10 that flow through the CON review criteria, the
11 State Health Plan. And they're very common
12 from state to state.

13 Q: And for South Carolina has our legislature
14 specifically said what our purposes are for our
15 Certificate of Need laws?

16 A: Yes.

17 Q: And we hear them talked about a lot, but to
18 kind -- what you just said, is it found in the
19 statute in terms of that there are sort of four
20 guiding points of our CON Act's purpose?

21 A: Yes.

22 Q: And if you could again, just specifically to
23 South Carolina, what are -- generally what are
24 those four guiding purposes?

25 A: Well, you're testing my memory. Definitely



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1 cost containment, I think quality of care,
2 accessibility, and ---

3 Q: You talked about it a moment ago.

4 A: Yeah.

5 Q: You've talked about cost containment.

6 A: And preventing unnecessary duplications.

7 Q: Right.

8 A: Yeah, the four things.

9 Q: Preventing unnecessary duplication. Guiding
10 the establishment of services ---

11 A: Yes.

12 **MR. WESTBROOK:** Objection, leading. Because Ms.
13 Platt got her answer wrong, so she's reading
14 from the statute. Leading.

15 **THE COURT:** Sustained.

16 **MS. HOLLINGSWORTH:** With respect, Ms. Platt has said
17 all of these things, but I have no problem.
18 She's already offered ---

19 **MR. WESTBROOK:** Objection. I don't believe she said
20 anything about public needs.

21 **MS. HOLLINGSWORTH:** We'll move on. We'll move on.

22 Q: Okay. So in terms of -- we've talked about the
23 regulations. And, again, we'll go through them
24 more. But what is it that an applicant must
25 establish in order to be approved for a



1 Certificate of Need?

2 A: Sure. So they have to -- they have to be
3 consistent with the State Health Plan. That's
4 a requirement. It's the first project review
5 criteria. And then they have to be consistent
6 on the -- DHEC has to evaluate them under the
7 other remaining project review criteria and
8 determine that, you know, they are consistent
9 to be approved.

10 Q: And you talked to us about Regulation 61-15.
11 Is that -- do I have the right document on the
12 screen?

13 A: Yes.

14 Q: And whose regulation is this?

15 A: It's DHEC's.

16 Q: Okay. And so what you were describing, the 61-
17 15, the regulations, is there where you find
18 that information, or those requirements that
19 you were describing?

20 A: Yes.

21 Q: Okay. All right. Ms. Platt, if you would,
22 would you just identify for The Court what
23 Chapter 1, Section 101 is in DHEC's Regulation
24 61-15?

25 A: Sure. So it first sets out the purpose of the



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1 CON regulations. And, again, these are
2 consistent with the statute. So to promote
3 cost containment, prevent unnecessary
4 duplication of services, guide the
5 establishment of healthcare facilities that
6 meet public needs, and ensure quality of care.
7 So those are the kind of overarching
8 principles.

9 Q: All right. And these -- are these the
10 regulations applicable to the project that
11 we're here about?

12 A: Yes.

13 Q: The freestanding ED project?

14 A: Yes.

15 Q: Okay. All right. Who creates -- or how is it
16 that the Health Plan comes to be?

17 A: So it's updated every year, again, to two years
18 -- most recently it's been annually -- by a
19 combination of the DHEC staff providing
20 materials and then a committee of basically
21 healthcare providers and other stakeholders
22 representing, you know, various perspectives of
23 the healthcare industry, weighing in on what
24 needs to change or be updated to reflect
25 industry trends.



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1 Q: Okay. And is that -- sort of that process
2 outlined in the CON Act statute?

3 A: Yes.

4 Q: All right. And, Ms. Platt, can you tell me --
5 Section 307 at the bottom. And, again, we're
6 still in Regulation 61-15. What is the
7 Department's obligation or authority with
8 regard to the approval of an application and
9 the Health Plan and the project review
10 criteria?

11 A: So it sets forth here in the regulation that
12 the Department may not issue a CON unless it's
13 found to be in compliance with the South
14 Carolina Health Plan as described in the
15 regulation, as well as the project review
16 criteria and other regulations.

17 Q: Okay. Let's look again at the 2015 South
18 Carolina Health Plan, which is Roper's Exhibit
19 55. Can you identify this document for The
20 Court?

21 A: Yes. This is the 2015 South Carolina Health
22 Plan that was adopted on August 13th, 2015.

23 Q: And you should have one in front of you, a hard
24 copy. But if you could flip through that and
25 let me know if that looks to be the document at



1 issue in this case.

2 A: Yes, it is. It's the South Carolina Health
3 Plan that was in effect at the time MUSC filed
4 their application for the freestanding ED.

5 **MS. HOLLINGSWORTH:** And, Your Honor, we would move
6 to admit Roper St. Francis 55 into evidence.

7 **MR. DAYHUFF:** No objection.

8 **THE COURT:** It's admitted.

9 **(Petitioner Roper's Exhibit Number 55 was admitted**
10 **into the record at this time.)**

11 Q: And I think you did just tell us, what was the
12 date that this Health Plan was enacted?

13 A: August 13th, 2015.

14 Q: And we looked at it a moment ago. The
15 application was filed June 6th, 2017; is that
16 right?

17 A: That's correct.

18 Q: All right. And let's just pull it up to
19 establish it in the record. Roper St. Francis
20 Exhibit 56, can you identify that document?

21 A: This is the 2017-2018 South Carolina Health
22 Plan.

23 Q: Okay. Would this be the Health Plan that
24 immediately followed the 2015 Plan?

25 A: Yes. It was enacted in June, June 9th of 2017.



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1 So basically three days after MUSC filed its
2 application. And so it was in effect at the
3 time of the decision on the MUSC project.

4 Q: Okay. And I believe you said three days after
5 the application was filed this was the Health
6 Plan in effect?

7 A: Yes.

8 **MS. HOLLINGSWORTH:** Your Honor, we would move to
9 admit Roper's 56.

10 **MR. DAYHUFF:** No objection.

11 **THE COURT:** It's admitted.

12 **(Petitioner Roper's Exhibit Number 56 was admitted**
13 **into the record at this time.)**

14 Q: And let's just go ahead and look up Roper St.
15 Francis 57 so that we can -- can you identify
16 this document, Ms. Platt?

17 A: This is the 2018/2019 South Carolina Health
18 Plan, enacted July 12th, 2018. And this is the
19 current plan that's in effect today.

20 **MS. HOLLINGSWORTH:** Okay. Your Honor, we would move
21 to admit Roper 57 into evidence.

22 **MR. DAYHUFF:** No objection.

23 **THE COURT:** Admitted.

24 **(Petitioner Roper's Exhibit Number 57 was admitted**
25 **into the record at this time.)**



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1 Q: Let's go back to 55. Ms. Platt, where is it
2 that we would find the standards that are
3 applicable to the application filed by MUSC?

4 A: There's an outpatient facilities chapter.
5 Under that chapter is a section on freestanding
6 ambulatory surgery -- I'm sorry. There's first
7 ambulatory surgery. And then right after that
8 is freestanding emergency department services.

9 Q: Okay. So the freestanding emergency department
10 is under the outpatient facilities chapter?

11 A: Yes.

12 Q: Okay. And what is it that health plan -- how
13 does the Health Plan describe what outpatient
14 facilities are?

15 A: So at the beginning it says outpatient
16 facilities provide community services for the
17 diagnostic and treatment of ambulatory patients
18 that are operated in connection with a hospital
19 or a freestanding facility under the
20 supervision of a licensed physician.

21 Q: Okay. And in the -- just to identify the page
22 in the record, that would be page 19 of the
23 exhibit, because we did produce the exhibit.
24 In the Health Plan, though, is that page, Roman
25 numeral XI-1?



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1 A: Yes, it is.

2 Q: And if we turn to Roman numeral XI-3, it should
3 be page 21 of the exhibit I think there at the
4 bottom, is that where the standards applicable
5 to this application begin?

6 A: Yes. Under emergency hospital services.

7 Q: Turning to the next page of the exhibit, kind
8 of midway down, what is it that is there in the
9 Health Plan?

10 A: So this is the section that sets out the
11 standards for freestanding emergency services
12 or it also refers to them as off-campus
13 emergency services. And it sets forth each
14 standard that apply to a CON application for a
15 freestanding ED.

16 Q: And in looking at this health plan, how many
17 standards are there for freestanding emergency
18 services in outpatient facilities?

19 A: There are six in the 2015 Plan.

20 Q: Are there other provisions in the Health Plan
21 applicable to freestanding emergency services
22 and outpatient facilities?

23 A: Well, so it goes down to then the project
24 review criteria. So after the standards, then
25 it sets forth the most important project review



1 criteria.

2 Q: Okay. So we're following you. We're on page
3 Roman numeral XI-5, page 23 of the exhibit.

4 A: Yes.

5 Q: If you could publish for the record what it is
6 -- what is that -- read into the record that
7 section that starts relative importance.

8 A: The following project review criteria are
9 considered to be the most important in
10 evaluating Certificate of Need applications for
11 this service, referring to freestanding
12 emergency departments. And it identifies five
13 criteria. The first one is compliance with
14 need outlined in this section of the Plan,
15 which is essentially referencing the standards
16 above.

17 Q: Okay.

18 A: Community need documentation; distribution and
19 accessibility, which is together; resource
20 availability; and financial feasibility.

21 Q: All right. And then what does it say below
22 those project review -- Relative Importance
23 Project Review Criteria?

24 A: Sure. It says the benefits of improved
25 accessibility will be weighed equally -- or



1 equally weighed, I apologize, with the adverse
2 effects of duplication in evaluating
3 Certificate of Need applications for this
4 service.

5 Q: Okay. Did the standards -- or did the section
6 of the Health Plan applicable to freestanding
7 emergency services departments change in the
8 Health Plan that was enacted three days after
9 the application was filed?

10 A: Yes. They did change a little bit.

11 Q: All right. Let's pull -- just go ahead and
12 just pull up, again, Roper St. Francis 56. And
13 we're looking at the 2017-2018 Health Plan.
14 Would you still go to the outpatient facilities
15 chapter?

16 A: Yes. It's still -- it's Chapter 10, Outpatient
17 Facilities. And then the first thing is
18 ambulatory surgery. And then following that
19 is, again, the section on Freestanding
20 Emergency Hospital Services.

21 Q: Okay. So we're -- turn to page 96 in the Plan,
22 which would be page 26 of the exhibit. Are you
23 there?

24 A: Yes.

25 Q: Okay. So let's look -- if you could, kind of



1 just describe for The Court how the section
2 related to Freestanding Emergency Hospital
3 Services change between the 2015 and the 2017
4 Plan.

5 A: Sure. So there are some aspects that are
6 exactly the same or, you know, very similar.
7 So the first criteria still -- or, I'm sorry,
8 standard is still the same, setting forth that
9 a Certificate of Need is required to establish
10 a freestanding emergency service. The second
11 standard is -- appears to be pretty much
12 exactly the same. All off-campus emergency
13 services must be an extension of an existing
14 hospital's emergency service in the same
15 county, unless the applicant is proposing to
16 establish a freestanding emergency service in a
17 county that does not have a licensed hospital.
18 And the hospital must have a license that is in
19 good standing and must be in operation to
20 support the off-campus emergency service. S,
21 that standard didn't change.

22 Q: Okay.

23 A: Then, number three, Regulation 61-16 will be
24 used to survey off-campus emergency services,
25 specifically including 24 hour/seven day a week



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1 physician coverage. That did not change at
2 all. And then number four, we heard some
3 discussion yesterday about written agreements
4 with emergency medical services. That did not
5 change at all.

6 Q: Okay.

7 A: And then number five did not -- I guess it
8 didn't make it through to the new Plan. And I
9 think it's kind of redundant, because it's just
10 setting forth that, you know, that it has to
11 meet the licensure standards, which is pretty
12 much the same as number three.

13 Q: Okay.

14 A: And then number six in my opinion was
15 essentially sort of rewritten in the paragraph
16 below number four. So it's -- there's not a
17 number five and six enumerated.

18 Q: Okay.

19 A: But in my opinion sort of the paragraph below
20 number four is essentially like a re-write of
21 six.

22 Q: Go ahead and if you'll publish -- let's start
23 with -- I see you have your hand between the
24 two versions ---

25 A: Yes.



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1 Q: --- which is good. If you could, read for The
2 Court what is Standard 6 in the 2015 Health
3 Plan?

4 A: Okay. It says ---

5 **MR. WESTBROOK:** Objection. There's no Standard 6 in
6 the -- this Health Plan.

7 **MS. HOLLINGSWORTH:** I asked the witness for Standard
8 6 in the 2015 Health Plan.

9 **MR. WESTBROOK:** I'm sorry. I thought you were
10 talking about this one. I apologize. Withdraw
11 the objection.

12 **MS. HOLLINGSWORTH:** Thank you, Counsel.

13 A: So number six in the 2015 Plan says the
14 applicant must demonstrate a need for this
15 service by documenting where the potential
16 patients for this proposed service will come
17 from and why they are not being adequately
18 served by the existing services in the area.

19 Q: Okay. And then if you could, in the 2017-2018
20 Health Plan, can you read that paragraph that
21 you described below the paragraph numbered
22 four?

23 A: Sure. So, again, this isn't numbered, but it
24 starts off the same way; the applicant must
25 demonstrate need for this service by



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1 documenting capacity constraints within
2 existing emergency departments in the service
3 area and/or a travel time of greater than 15
4 minutes to an existing emergency department in
5 the service area.

6 Q: Okay. Does the 2017-2018 Health Plan still
7 have relative importance project review
8 criteria?

9 A: Yes, it does.

10 Q: And what are the criteria identified for this
11 service in the 2017-2018 Health Plan?

12 A: So there are five and they're a little bit
13 different. So in the 2015 Plan -- is that
14 where you wanted to go first?

15 Q: No. I think you already read those into the
16 record. No, you're right. We should do that
17 So, if you would start with the 2015 Plan, what
18 are the criteria identified in that section of
19 the Plan?

20 A: Okay. So the first one is compliance with need
21 outlined in this section of the Plan. Number
22 two is community need documentation. Number
23 three is distribution accessibility. Number
24 four is resource availability. And number five
25 is financial feasibility.



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1 Q: Okay. And then if you -- what are the project
2 review criteria identified for this service in
3 the 2017-2018 plan?

4 A: So it starts with community need documentation.
5 It also has distribution and accessibility. It
6 adds medically underserved groups. It adds
7 record of the applicant. And it identifies
8 staff resources.

9 Q: Okay. And then does the 2017-2018 Plan also
10 have an additional provision below those
11 project review criteria?

12 A: Yes, it does. It adds a couple sentences here.
13 Actually, it adds one sentence. It says,
14 access to emergency medical services should be
15 available within 15 minutes travel time for the
16 majority of residents of the state. And then
17 it goes onto the same sentence from the 2015
18 Plan about weighing the benefits of improved
19 accessibility. And it says the benefits of
20 improved accessibility will outweigh the
21 adverse effects of duplication in evaluating
22 applications for this service.

23 Q: Okay. And do you -- can you give us your
24 opinion from sort of a health planning
25 perspective? What is the -- what is it that



1 the standards related to freestanding emergency
2 services consider important with regard to that
3 service?

4 A: Sure. Well, so one piece of it is related to
5 ensuring quality of care by referencing the
6 licensure requirements and the ability to have
7 transfer if the patient needs, you know,
8 additional services that are not offering by a
9 freestanding ED. And then the other piece that
10 sort of weaves through here is looking at
11 whether there's a need in the community for
12 additional emergency services in terms of
13 accessibility for the patient to be able to get
14 to those services.

15 Q: Okay. All right. And then let's look at the
16 2015 Health Plan, since that's the Health Plan
17 that was in effect for those two days for the
18 application. Is it your -- let me look at the
19 application. Is this the Health Plan that the
20 Department used for review of the MUSC
21 freestanding emergency department application?

22 A: Yes, it is.

23 Q: Okay. So let's -- looking at those standards.
24 So we're back at Roper St. Francis Exhibit 55.
25 And those standards, again, begin on page 22 of



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1 that exhibit, do you have any opinions
2 regarding the MUSC freestanding ED CON
3 application's compliance with the standards for
4 freestanding emergency departments?

5 A: Yes. So sort of big picture. My opinion is
6 that the MUSC project is not consistent with
7 Standard Number 2 and Standard Number 6.

8 Q: Okay. Let's look at Joint 1, again, the DHEC
9 record. If you would turn to page 27.

10 A: Okay.

11 Q: So that we don't have to kind of go back and
12 forth between documents. We're in the DHEC
13 record for the Certificate of Need application.
14 Can you describe -- explain generally kind of
15 where we are within the application when we're
16 looking at DHEC page 27?

17 A: Sure So, we're in the application form under
18 question number (11). And (11) is the one that
19 asks for the applicant to demonstrate the need
20 for the proposed project. So I'm looking --
21 I'm referencing page 20 of Joint Exhibit 1.
22 And it sets out what the applicant must
23 demonstrate under need for the project. And
24 then under -- typically under that question is
25 where an applicant would address specific State



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1 Health Plan, or South Carolina Health Plan,
2 standards if there are applicable standards for
3 the service for which they're applying.

4 Q: Okay. And in the work that you do and sort of
5 in the Certificate of Need language is this
6 section, the B(11) section, often called the
7 need analysis?

8 A: Yes. So I think that's kind of the shorthand
9 term that we use, that question (11) is -- you
10 know, we call it the need section or the need
11 analysis of that location.

12 Q: Okay. And when you're working, you as a health
13 planning consultant in addition to being an
14 expert, is this the section that you typically
15 work with your provider clients on?

16 A: Yes. This is -- yes. We're always involved in
17 working on this section of the application.

18 Q: All right. So let's turn, again, to page 27.
19 Is this where the applicant identifies and
20 discusses those standards in the Health Plan?

21 A: Yes, it is.

22 Q: Okay. And probably the easiest way to do this,
23 you mentioned, I believe, Standard 2 and
24 Standard 6; is that right?

25 A: Yes.



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1 Q: If you could, go ahead and just identify for
2 The Court what Standard Two is and then what
3 the response of the applicant was.

4 A: So standard two is that all off-campus
5 emergency services must be an extension of an
6 existing hospital's emergency service in the
7 same county, unless the applicant is proposing
8 to establish a freestanding emergency service
9 in a county that does not have a licensed
10 hospital. The hospital must have a license
11 that is in good standing and must be in
12 operation to support an off-campus emergency
13 service. So that's the question. And just to
14 give a little context, the hospital -- the
15 freestanding emergency department is an actual
16 hospital department, so that's why it has to be
17 linked to a licensed hospital. And then the
18 response here is the freestanding ED will be
19 licensed under and operated as a department of
20 MUSC, functioning as an extension of MUSC's
21 existing hospital-based ED. MUSC has a license
22 in good standing and is prepared to support the
23 freestanding ED.

24 Q: Okay.

25 A: So that's the response.



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1 Q: Okay. And in your opinion or what is your
2 opinion regarding MUSC's response to Standard
3 2?

4 **MR. WESTBROOK:** Objection, Your Honor. This Court
5 has already ruled as a matter of law that MUSC
6 complies with Standard 2 and that there is no
7 licensed hospital currently in Berkeley County,
8 which is where this testimony is headed. I
9 think it would be a waste of The Court's time
10 and completely irrelevant to go into this
11 point. That's already on the record in the
12 motions and the briefs that have been filed.

13 **MS. HOLLINGSWORTH:** With respect, I disagree that
14 the effect of the ruling denying summary
15 judgement was that I was precluded from
16 eliciting testimony at trial. I think I have
17 a right to develop the record here at trial.
18 And I don't have many questions on it. I
19 simply was asking what her opinion was.

20 **THE COURT:** But did you not develop the record when
21 you filed the motion? And I believe Ms.
22 Platt's affidavit was attached with her
23 opinion.

24 **MS. HOLLINGSWORTH:** Yes, Your Honor. So I simply
25 was going to put into the trial testimony her



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1 opinion on the standard, so that it's in the
2 trial record, Your Honor. That's all that I
3 intend to do.

4 **MR. WESTBROOK:** Your Honor, I would say that's
5 already been discussed and entered into the
6 record in great detail and in arguments and
7 briefs and Ms. Platt's affidavit and other
8 exhibits to their briefs. And we've got a lot
9 to cover today. And we have to get through
10 with Ms. Platt today because she's got a plane
11 to catch, I understand, first thing in the
12 morning.

13 **THE COURT:** And I agree. The matter's already been
14 settled.

15 **MS. HOLLINGSWORTH:** That's fine, Your Honor. I
16 would just need to proffer the two questions I
17 wanted to ask. That's all I had to go through.
18 It's actually not the issue that counsel's
19 talking about. That's why I would like to ask
20 my witness the question about -- simply I'm
21 asking her just the responsiveness of the
22 applicant to the standard. And that's not
23 asking her to opine on the summary judgement
24 matter at all.

25 **THE COURT:** Okay.



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1 Q: So Ms. Platt, if you would, my question to you
2 is simply, the applicant's response to Standard
3 2, what is your opinion about the response of
4 the applicant to Standard 2?

5 A: Well, in my opinion it's rather inadequate,
6 because it doesn't clearly identify that this
7 project is in Berkeley County and that MUSC
8 licensed hospital is in Charleston County. So
9 it doesn't really address the fact that MUSC is
10 not serving their own county, as set forth in
11 the standard, but in fact going to another
12 county and sort of completely ignores the fact
13 there is, you know, a hospital, Roper Hospital
14 Berkeley, that is under construction and
15 received CON approval to be developed with
16 emergency services in Berkeley County.

17 Q: Okay. Thank you. Let's look at the response
18 to Standard Six.

19 A: Okay.

20 Q: Which would be on the next page.

21 A: All right. So ---

22 Q: If you could, let's do the same thing. If you
23 would go ahead and just reiterate what the
24 standard is, which is here in the application,
25 and then identify for The Court's record what



1 the response is.

2 A: Sure. So the question is, or the standard, the
3 applicant must demonstrate need for this
4 service by documenting where potential patients
5 for this proposed service will come from and
6 why they are not being adequately served by
7 existing services in the area. So in response,
8 the applicant talks about the growth in the
9 area, the population in Berkeley County, the
10 growth of emergency services generally. It
11 does not at all identify that there are
12 existing emergency services in the service
13 area, that they're already serving Berkeley
14 County and service area residents. And it
15 doesn't address where the patients will come
16 from specifically and why they're not being
17 adequately served by the existing services,
18 because it doesn't even identify the existing
19 services that are in the area. So in my
20 opinion, the response doesn't answer or address
21 the standard for several reasons.

22 Q: Okay. If you would, read what the response is
23 into the record.

24 A: Sure. So the response, it says, it is a
25 challenge to address the growing patient base



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1 presenting to the ED and this challenge will
2 continue to expand as the service area
3 continues to grow. The demand for ED services
4 will continue to increase with service area
5 population growth, resulting in additional
6 capacity challenges and limiting the hospital
7 from further improving access to care. And it
8 doesn't say this, but I'm assuming it's
9 discussing MUSC. It's not discussing any of
10 the other existing providers. With this in
11 mind, MUSC proposes the development of a
12 freestanding ED in Berkeley County. The
13 project will enhance access and convenience,
14 promote quality of care, and increase patient
15 satisfaction. The need for the proposed
16 project is demonstrated throughout this
17 question and the Certificate of Need
18 application. So that appears to be the summary
19 of the response related to need for the
20 service. And then it goes on to discuss impact
21 on existing facilities, in which, again, it
22 doesn't actually identify the facilities that
23 are in the service area.

24 Q: Okay. Where in the CON application, whether in
25 B(11) or somewhere else, do you see MUSC



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1 address existing services not adequately
2 serving the proposed population?

3 A: I did not see anywhere in the original
4 application filing that there was even an
5 acknowledgment of the fact that there are other
6 emergency services in the service area, both
7 hospital-based emergency services or
8 freestanding EDs. And there are many of them.

9 Q: Okay. And what about -- where in the CON
10 application narrative, again, it could be B(11)
11 or somewhere else, do you see the documentation
12 of where potential patients will come from?

13 A: If you look on page -- if you look on Joint
14 Exhibit 1, page 22, there's a discussion of
15 where MUSC's patients come from. But there's
16 no presentation, analysis, or anything that
17 shows where the patients for this facility will
18 come from. So there's, you know, a discussion
19 of how many patients they expect to see, but
20 not where they come from, other than very
21 generally the Tri-County area.

22 Q: All right. So looking -- let's turn over to
23 page 25 of Joint 1 for the record. What is
24 this information here on this page of the CON
25 application?



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1 A: So the data here first presents the patient
2 origin, the total number of patients in, I
3 believe, the Tri-County area, from revenue and
4 fiscal affairs just in total. So I guess
5 that's served by all existing providers,
6 although those providers are not identified.

7 Q: Okay.

8 A: Then Figure 6 shows MUSC's historical ED volume
9 in total, regardless of where those patients
10 are coming from I believe. So it would include
11 the Tri-County area and anybody who's coming
12 from anywhere else. And then there's a
13 projection of MUSC's volume for an interim time
14 period and then the first three years of
15 operation of the proposed project in total.
16 Again, all patients coming from anywhere and
17 everywhere, so no specification of where those
18 patients come from, what the service area is.
19 So, again, no detail in my opinion as to where
20 the patients are coming from.

21 Q: Okay. And looking at Figure 7 in the
22 application, Historical and Projected ED
23 Volume, 2016 to 2021. Do you see that exhibit?

24 A: Yes.

25 Q: And it looks like there's one year that says



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1 actual. What year is that?

2 A: 2016.

3 Q: Okay. And what is the source for that number
4 that is presented?

5 A: Internal data, so that would be data in MUSC's
6 records.

7 Q: Okay. And what is the actual 2016 volume set
8 forth by the applicant?

9 A: 81,260 ED visits.

10 Q: Okay. And having heard the testimony over the
11 last couple of days, do you have an
12 understanding of what ED volume that
13 represents? We've heard about a couple of
14 emergency departments.

15 A: Sure. So it's my understanding that that's
16 total patients coming from everywhere and
17 anywhere and it includes patients going to the
18 adult ED, I guess as they've described it, the
19 Chest Pain Center, which is another adult sort
20 of segregated part of the ED, and the pediatric
21 ED. So all of those components together.

22 Q: Okay. And let's talk about on the next page.
23 If you could, just go ahead and describe for
24 The Court what it is on page 26 of the
25 application, sort of that -- what we call the



1 need analysis section.

2 A: Sure. So this map shows, I guess, the
3 concentration of patients served by MUSC,
4 again, in all of those categories, the, you
5 know, adult ED, the Chest Pain Center, the
6 pediatric patients. And kind of a heat map is
7 how I would describe it of where those patients
8 are coming from, with the dark green being the
9 sort of most dense area, moving out to sort of
10 the lighter green and then white areas where
11 very few patients come from. So there's no,
12 you know, actual data, no detail, but it kind
13 of graphically depicts the concentration of
14 services that MUSC is offering throughout the
15 Tri-County area.

16 Q: Okay.

17 A: And also it's really interesting to me that on
18 that map there are no other existing emergency
19 services, providers depicted, although there's
20 emergency services throughout that area.

21 Q: All right. And what is it -- how is it
22 described here -- sort of as a health planner,
23 how do you describe what it is, this
24 information that's set forth below that map you
25 just talked about?



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1 A: So it's generally described as patient origin,
2 where patients are originating from. But,
3 again, there's no data. It's just sort of a
4 graphic depiction of where the patients
5 originate that are going to the MUSC main
6 downtown emergency department.

7 Q: Okay. And then what is it that kind of goes on
8 under that section about what the project
9 proposes to do?

10 A: Sure. So it's assumed that current patient
11 origin patterns will remain generally the same
12 with a greater volume shifting from ZIP codes
13 in the service area that would have easy access
14 to the proposed facility, mainly ZIP codes in
15 Berkeley and Dorchester county, plus a small
16 number of ZIP codes in Charleston county. But,
17 again, like the ZIP code outlines aren't even
18 shown on the map. So there's no specificity,
19 again, to where those patients are coming from.
20 And then there's a general discussion of
21 redirection of patients by ZIP code with a
22 redirection percentage from 25 to 75 percent.
23 It says Dorchester county residents redirection
24 by ZIP code range from 25 to 75 percent.
25 Charleston county resident direction by ZIP



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1 code ranges from 0 to 60 percent. Berkeley 25
2 to 75 percent. Overall, approximately 21
3 percent of the historical emergency patients
4 treated at MUSC medical center are assumed to
5 seek care at the more convenient and accessible
6 proposed location. But you don't have any
7 information on what ZIP codes are included in
8 this and, you know, what redirection
9 percentages apply to each ZIP code. So no
10 specificity whatsoever about where the patients
11 are coming from.

12 Q: Okay. Is it your understanding then that these
13 numbers in this heat map is using the 81,260-
14 visit volume?

15 A: That's my understanding, that it's all
16 patients.

17 Q: And, again, those are from which kind of three
18 separate emergency departments?

19 A: The ---

20 **MR. WESTBROOK:** Objection. I think that's a
21 mischaracterization of prior testimony, that
22 these are three separate emergency departments.
23 I think the testimony was that there were three
24 locations. I think they're organized -- I
25 think Dr. Hall said they're organized as one



1 department.

2 **MS. HOLLINGSWORTH:** My apologies.

3 Q: Physically separated emergency departments.

4 A: Okay. So it's the main emergency department,
5 the Chest Pain Center, and the pediatric
6 emergency department.

7 Q: Okay. All right. And anywhere in this need
8 analysis or in the narrative, did you find any
9 information about the acuity experience of
10 those patients?

11 A: No. Again, it's all patients that are
12 currently using the MUSC EDs and all those
13 components that I just described, regardless of
14 the level of care they need or the acuity with
15 which they present to the emergency department.

16 Q: And what about any age classifications? Did
17 you have the information in the application
18 narrative?

19 A: No. There's no information about the age of
20 the patients, how many of these 81,000 patients
21 are pediatric patients, or versus adult
22 patients.

23 Q: Okay. We talked about project review. What is
24 project review? What's it for? What happens?

25 A: Sure. So, a project review meeting is held



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1 typically when there are opposition -- or
2 opponents to an application. And it gives both
3 the applicant and the opponents a chance to
4 address DHEC in a meeting, present additional
5 materials to support either the application or
6 the opposition. And DHEC can -- staff can ask
7 questions at that time if they'd like to as
8 well.

9 Q: Was there a project review meeting in this
10 application?

11 A: Yes, there was.

12 Q: And did you attend it?

13 A: I did.

14 Q: I think we looked at your slides. So let's go
15 ahead and just go to that section, page 457 of
16 the Joint Exhibit 1, DHEC record.

17 A: Okay.

18 Q: All right. And to your recollection, who all
19 attended or presented information at project
20 review?

21 A: I believe the presenters -- on behalf on Roper
22 St. Francis?

23 Q: What entities were there?

24 A: So there were representatives of the applicant,
25 MUSC. There were representatives of Trident



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1 Summerville. There were representatives of
2 Roper St. Francis. And then DHEC staff
3 members.

4 Q: And let's look -- could you turn, please, to
5 page 512 of the DHEC record? Can you identify
6 for The Court what this is?

7 A: Yes. This is the presentation at the project
8 review meeting that was provided on behalf of
9 MUSC, the applicant.

10 Q: And I think -- were you physically present at
11 the meeting?

12 A: Yes, I was.

13 Q: All right. And so were you present when -- is
14 this a PowerPoint presentation?

15 A: Yes.

16 Q: Okay. And you were present for the
17 presentation?

18 A: Yes, I was.

19 Q: All right. So by the time of the project
20 review, August 24, 2017, had you submitted the
21 opposition materials we talked about earlier to
22 the Department?

23 A: Yes. I believe they were submitted on July
24 21st, so those had already been submitted.

25 Q: Okay. So July 21st was your letter of



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1 opposition. And I think we looked at another
2 letter, perhaps July 31st, sent on behalf of
3 Roper?

4 A: Yes.

5 Q: Okay. So project review, August 24th. As a
6 health planner and information that you were
7 looking for, what did you learn during project
8 review about the application, the proposed
9 project?

10 A: Sure. So I'm assuming, in response to Roper's
11 criticism, we learned a little bit more about
12 the patients that MUSC proposed to serve.
13 There was a little bit more information
14 provided. If you look at page 19 of the
15 PowerPoint, which is Joint Exhibit 1 page 30
16 (sic), this is the first time where we see an
17 actual list of ZIP codes in the Tri-County area
18 and the number of visits MUSC has previously
19 provided by ZIP code and the assumptions of the
20 percentage they assume will shift or be
21 redirected to the new freestanding emergency
22 department.

23 Q: And have you seen this information anywhere in
24 the DHEC record before project review?

25 A: No.



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1 Q: And in looking at this slide that we have on
2 the screen, which is Joint Exhibit 1 page 530,
3 can you just explain to us what those four
4 columns are?

5 A: Sure. So it's really essentially sort of one
6 long table that's sort of wrapped around. But
7 it goes down the left-hand column and it
8 identifies each ZIP code by county, Berkeley,
9 Charleston, and then Charleston continues to
10 wrap around, and then Dorchester. It
11 identifies the number of visits that MUSC has
12 provided to patients who reside in each of
13 those visits. And as far as what can be
14 identified here, it's the total visit volume;
15 again, all acuity levels, pediatric, all
16 patients. Then the column that's entitled
17 Shift to Freestanding ED, there's a percentage.
18 And that's an assumption of a percentage of
19 patients by ZIP code that would shift. Instead
20 of driving downtown to the main MUSC FSED --
21 I'm sorry, the main MUSC ED, they would shift
22 and instead go to the freestanding ED. And
23 then when you multiply the visits times the
24 percentage, you get a number of visits that
25 would go to the proposed freestanding ED.



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1 Q: And what is the -- what is the total number of
2 visits, that column two, that these ZIP codes
3 comprise for MUSC emergency department
4 downtown?

5 A: It's 14,366.

6 Q: I'm sorry, the second column.

7 A: The total. 68,157.

8 Q: Okay. And then that number you just read, the
9 fourth column, what is that number?

10 A: That's the total that they assume would be
11 redirected to the freestanding ED, so 14,366.

12 Q: Okay. What is the source that is identified by
13 the applicant for this data?

14 A: Internal data.

15 Q: What is the -- where is the largest patient
16 count visits, what ZIP code is that coming
17 from?

18 A: For the proposed freestanding ED? It's ZIP
19 code 29406, which is in Charleston county. And
20 you can see, reading across, historically MUSC
21 provided 4,483 patient visits. Sixty percent
22 of those are assumed to shift. And there would
23 be 2690 freestanding ED visits expected to come
24 from that ZIP code.

25 Q: Okay. And if you would, flip back in the



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1 presentation, Joint Exhibit 1, to page 515 --
2 starting perhaps at 514.

3 A: Okay.

4 Q: It's kind of hard to read. The white
5 lettering, can you -- what does that slide say?

6 A: So this is a project overview. And this was
7 the part of the presentation that I believe
8 Sarah Bacik from MUSC providers, you know,
9 spoke to at the project review meeting.

10 Q: Okay. And then so the next slide, is this the
11 description -- does this slide summarize what
12 you heard at project review from MUSC about the
13 project?

14 A: Yes. It describes the components of the
15 project.

16 Q: What is the scope described as?

17 A: So the project scope says ten private treatment
18 areas, as well as one isolation treatment and
19 one resuscitation area. So that's a total of
20 12. The project also includes an
21 observation/clinical decision unit, or CDU,
22 space, as well as a helipad. And then
23 identifies the cost associated with the project
24 are 13.5 million.

25 Q: Okay. Do you recall who was present at project



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1 review on behalf of the Department?

2 A: Not everyone, but I know that Maggie Murdock
3 was there and Louis Eubank were there. There
4 may have been other staff member, but I recall
5 those two specifically.

6 Q: Okay. And the next slide provided and included
7 in the DHEC record, what are the highlights of
8 this slide?

9 A: The first thing is MUSC has tremendous support
10 for the project, as shown in the numerous
11 letters of support. It talks about the CDU,
12 the clinical decision unit, and it describes
13 what that is, that it's an option between
14 discharge from the ED and inpatient admission,
15 so that patients in the CDU can stay there
16 while it's being determined whether they need
17 to be, you know, transferred, discharged, you
18 know, or what kind of their sort of discharge
19 status would be. And it seems like one of the
20 goals of the CDU is to eliminate bottlenecks in
21 the ED and result in a more efficient usage of
22 treatment rooms. And I took that to imply that
23 it meant that was for the MUSC downtown ED.
24 And the CDU would decrease unnecessary
25 admissions, improve patient outcomes, reduce



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1 length of stay, and enhance patient
2 satisfaction. And it emphasize that this is a
3 unique feature, sort of unlike any other
4 proposed FED in South Carolina.

5 Q: What else is discussed on this slide?

6 A: It also talks about the helipad that will
7 provide air medical access, rapid delivery of
8 advanced medical treatment, improving morbidity
9 and mortality rates, and decreasing out-of-
10 hospital times. So that's, again, sort of
11 emphasizes a unique feature of this FED.

12 Q: Okay. And the last bullet point about the
13 proposed location is ideal for the project. Is
14 the next slide addressing the proposed
15 location?

16 A: Yes. It goes on to describe the location on
17 Joint Exhibit 1, page 517.

18 Q: And throughout the trial is this MUSC's
19 description of what we've called the Nexton
20 location?

21 A: Yes.

22 Q: And this Nexton location, earlier when you were
23 discussing having done -- having assisted
24 Palmetto Primary Care with some projects, were
25 they in the Nexton development that we're



1 talking about?

2 A: Yes. So I assisted them with an MRI
3 application that was approved to be developed
4 in that same area. And then they initially
5 filed an ambulatory surgery center application
6 that was withdrawn. But the goal there is
7 essentially to bring together a group of
8 medical services on this one campus to be
9 conveniently accessible to this large Nexton
10 housing area that's kind of a planned
11 community. So it's not only the residential
12 aspects, but other services that would be
13 available and proximate to the residential
14 community.

15 Q: Okay. And flipping over, page 520. While you
16 were at project review, did you hear from a
17 physician on behalf of MUSC?

18 A: Yes. Dr. Edward -- I don't know how you say
19 his last name -- Jauch.

20 Q: I think it's Jauch is what we've heard.

21 A: Jauch, yes.

22 Q: Okay. You heard what he had to say?

23 A: Yes.

24 Q: Okay. And then the next slide on page 521, who
25 is that that you heard from at project review



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1 on behalf of MUSC?

2 A: David Carroll, who's the executive director of
3 Palmetto Primary Care and who's been very
4 involved in their efforts to develop services
5 in the Nexton area.

6 Q: And who did he speak on behalf of?

7 A: MUSC.

8 Q: Okay. And then the next slide, who did you
9 hear from?

10 A: Mr. Levitt, who is the health planner for MUSC.

11 Q: Okay. These slides that follow and part of
12 which we just discussed, were those presented
13 by Mr. Levitt?

14 A: Yes, they were.

15 Q: Okay. And you can flip through these slides.
16 Anywhere at this project review -- I understood
17 you've got the ZIP code level redirection; is
18 that right?

19 A: Yes. For the first time we now have that on
20 Joint Exhibit 1 page 530.

21 Q: Okay. Do you have any information or did you
22 hear described any reasoning for why
23 percentages were selected, be it the 50, the
24 25, the 75, or the 60?

25 A: Not really, no specific basis for those



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1 assumptions were provided.

2 Q: Okay. And looking just a couple of slides over
3 at 533, Joint Exhibit 1, is this a discussion
4 of the MUSC downtown emergency department?

5 A: Yes. It's sort of describing the MUSC downtown
6 emergency department and what's sort of unique
7 about it in terms of it's a Level I trauma
8 center, it's obviously an academic medical
9 center, and, you know, how it's prepared to
10 handle the most complex cases, highly-trained
11 staff, you know, focused care not offered by
12 other providers, state-of-the-art equipment,
13 and specialties to support that emergency
14 department in every field.

15 Q: Okay. All right. And then following project
16 review, did you receive some additional
17 information through the DHEC -- submissions to
18 DHEC from MUSC?

19 A: Yes. There was a follow-up letter filed by
20 MUSC after project review.

21 Q: And I think it might be a little bit out of
22 order in the DHEC record, on page 507 of Joint
23 1.

24 A: Yes.

25 Q: If you could identify -- what is this document?



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1 A: So this is a letter filed by Mr. Levitt on
2 September 7th with DHEC. So that would be
3 following up from the project review meeting.
4 And it appears to respond to some of the
5 criticisms to their application that Roper
6 raised, among others.

7 Q: Okay. And just to give some context to some of
8 this information, just from having heard the
9 last couple of days of testimony, this Figure
10 1 in Mr. Levitt's letter, what does this data
11 represent?

12 A: So kind of just to set the stage, I believe
13 that this was filed in response to Roper's
14 criticism, my criticism, that no information
15 was provided about the acuity level of the
16 patients that are going to the MUSC emergency
17 department and how that might impact those
18 patients that would be appropriate to be served
19 in a freestanding ED. So apparently in
20 response to that, this table is provided
21 breaking down the 2016 81,000 visits. But it's
22 broken down by the billing code, you might say,
23 as opposed to the acuity index. I think we've
24 heard it described now by several witnesses.
25 This is sort of the back end, how the patient



1 gets billed, as opposed to what is the clinical
2 acuity and resource needs when they walk in the
3 door.

4 Q: Okay. So when we were going through -- these
5 aren't numbered. But in the testimony we've
6 heard where we've heard sort of level one,
7 level two, level three, right.

8 A: Right.

9 Q: So remind us again what the levels from high to
10 low or high acuity versus low acuity on the
11 building side versus the triage side.

12 A: Sure. So on the acuity level, the level that's
13 assigned when the patient arrives, level one is
14 the most acute, so that would be your trauma
15 patients, going down to level fives, which I
16 think were described, for example, things as
17 simple as a medication refill. So the highest,
18 most intense patients are a level one on the
19 acuity, sort of clinical side up front. And
20 then it's sort of flipped for the billing.
21 There's actually six billing codes. And the --
22 it's the opposite. So the most complex
23 services are like number five on the billing
24 side, going down to level -- I'm sorry, level
25 six going down to level one. So it's a little



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1 bit confusing because the shorthand for the
2 billing codes is flipped numerically from the
3 acuity codes.

4 Q: Okay. But this information, this data is not
5 using acuity codes or measuring the triage
6 acuity.

7 A: Correct. It's the billing label.

8 Q: All right. And just to help us again with
9 timing, look at page 545 of Joint 1.

10 A: Okay.

11 Q: And what is this document? Both the date and
12 sort of what is it about.

13 A: Okay. So this is a letter from DHEC to the
14 applicant on July 10th, 2017. And the purpose
15 of this is to notify the applicant that their
16 project has been determined to be complete for
17 review.

18 Q: Okay. And what is -- sort of from your
19 perspective, both as a planner and in review of
20 the application, what is the most sort of
21 important thing that you read that comes out in
22 this letter?

23 A: Sure. So it's a relatively standard letter
24 sent by the Department. And if you go on to
25 the next page, 546, it sets forth for the



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1 applicant what the Department considers to be
2 the most important review criteria that will be
3 applied to the project. You'll see it says the
4 most important being listed first, community
5 need document, then distribution,
6 accessibility. Third is medically underserved
7 groups. And fourth is financial feasibility.
8 And then it says all other relevant criteria
9 will be given equal importance.

10 Q: This was July 10th of 2017, right?

11 A: Yes.

12 Q: And so this letter was issued by DHEC before
13 project review, right?

14 A: Yes.

15 Q: And then flip to page 551 of Joint 1.

16 A: Okay.

17 Q: What is this document?

18 A: This is the decision issued on behalf of DHEC
19 on September 25th, 2017.

20 Q: Okay. And what was the decision?

21 A: The decision was to approve the project filed
22 by MUSC for the freestanding ED.

23 Q: Okay. How is the project described in the
24 subject line of the letter?

25 A: Project: Construction of a 15,300 square foot



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1 freestanding emergency department, FSED, in
2 Berkeley county at a total project cost of
3 13,584,161.

4 Q: Okay. So having -- we've kind of walked
5 through, would you agree, the highlights of the
6 CON application?

7 A: Yes.

8 Q: Okay. Have you continued to assist Roper St.
9 Francis since this time period in the
10 Department's decision to approve the CON
11 application?

12 A: Yes.

13 Q: So that would include during the contested
14 case?

15 A: Yes.

16 Q: Have you assisted Roper St. Francis during a
17 discovery period?

18 A: Yes, throughout.

19 Q: Okay. What -- in the chronology of the
20 contested case, what happened in January 2019,
21 which was at the time I think we were scheduled
22 for a trial in the third week of March 2019?

23 A: Well, there -- I guess there were a few things.
24 There was some discovery material provided that
25 I received that, I guess, raised some questions



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1 A: Yes.

2 Q: The Bates label -- these were documents
3 produced in discovery -- MUSC 04182 through
4 04190. Have you seen all of these documents
5 before?

6 A: Yes, I have.

7 Q: And can you kind of generally describe what
8 these pages reflect?

9 A: Sure. So the first page appears to be a
10 comparison of revised or updated project costs
11 for the MUSC FED project, comparing by category
12 the original CON cost versus an update that
13 changes pretty much every aspect of the project
14 by category, except for the medical equipment.
15 It changes the size of the facility, the square
16 footage of the facility, and then like the
17 construction cost per square foot.

18 Q: Okay. And in the column, the column titled
19 Original CON and the total, that number, what
20 is that number?

21 A: That's the original information that was
22 included in the CON application that was
23 approved by DHEC.

24 Q: Okay. That's the 13,584,117?

25 A: Yes.



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1 Q: And then the updated column, what is the total
2 for the project based on this information in
3 discovery?

4 A: 11,297,150.

5 Q: Okay. All right. And then -- so what else is
6 in this production that you were provided
7 through discovery?

8 A: So on the next page there's a letter from an
9 architect confirming what appears to be the new
10 construction cost for this updated or revised
11 project. Then there's a new drawing on page
12 three that identifies a different configuration
13 and a different number of treatment spaces from
14 the original application and a new square
15 footage, 10,648, which is a good bit smaller
16 than the 15,000 square foot in the original
17 project. On page four there's what appears to
18 be a new plot plan, placing this redesigned
19 project on a different site in Summerville.
20 That looks like it's prepared by the architect.
21 And then page -- pages five through eight
22 appear to be a proposed ground lease where an
23 entity called MUSC Strategic Ventures would
24 ground lease, I guess, what appears to be this
25 site -- new site from Luco Realty. It goes



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1 into some parameters of that. And then page
2 nine is -- it appears to be another drawing
3 placing the revised or redesigned emergency
4 department on the new site.

5 Q: And looking at the proposed ground lease, it's
6 MUSC 4186 in Trident's exhibit, it is page
7 five. What is the date of this document?

8 A: September 21st, 2018.

9 Q: And is it via email below that?

10 A: Yes.

11 Q: And what is the address for the property?

12 A: 1310 North Main Street, Summerville, South
13 Carolina.

14 Q: Is that the address for the project as we know
15 it is today the proposed location?

16 A: That's my understanding.

17 Q: Okay.

18 **MS. HOLLINGSWORTH:** Your Honor, I would move to
19 admit Exhibit Trident 56 into evidence.

20 **MR. WESTBROOK:** No objection.

21 **THE COURT:** It's admitted.

22 **(Petitioner TMC's Exhibit Number 56 was admitted into**
23 **the record at this time.)**

24 Q: And looking back at this exhibit, if you would,
25 that laid out -- that we've got the footprint,



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1 but then the next page is the test fit
2 document.

3 A: Yes.

4 Q: Page four of the exhibit. What is the
5 information provided here at the bottom of the
6 document under that schematic? Are you on the
7 right page?

8 A: Yes. It says it's from Intuitive Health,
9 prepared September 11th. It's in Summerville,
10 South Carolina. It says test fit with Fisher's
11 facility layout.

12 Q: Okay. And prior to receiving this document in
13 the discovery responses of MUSC in January of
14 2019, have you seen Intuitive Health referenced
15 anywhere before in the project materials?

16 A: Not that I can recall. It definitely wasn't
17 anywhere in the DHEC record in the original
18 application review.

19 Q: Let's look at Trident Exhibit 65. We might do
20 -- let's look at 67 first, Trident 67.

21 A: Okay.

22 Q: This document, also produced by MUSC, Bates
23 labeled MUSC 4475, what is this document and
24 what do you typically see this for in your CON
25 cases?



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1 A: This is -- it appears to be a -- minutes from
2 a MUSC Strategic Ventures Board of Directors
3 meeting held on December 20th, 2018. It
4 identifies who attended, that the meeting was
5 called to order at 3:02. A lot of it's
6 redacted, but on the second page it identifies
7 that MUSC Strategic Ventures moved to approve
8 a new ground lease located at 1310 North Main
9 Street in Summerville for the freestanding ED.
10 The purpose of this lease request is to move
11 the location of the currently contested
12 freestanding ED.

13 Q: Okay. And based on this document, was that
14 motion for approval granted?

15 A: Yes.

16 Q: And then let's look back at Trident 65.

17 A: Okay.

18 Q: In this document -- again produced in discovery
19 with the Bates label MUSC 4473, what is this
20 document?

21 A: This appears to be a little bit more
22 information about this location, 1310 North
23 Main Street, Summerville. And it shows a
24 aerial view of the site. And I believe it's
25 the middle building. There's a little label



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1 that says Mellow Mushroom and the Chick-Fil-A.
2 So Mellow Mushroom on the left, Chick-Fil-A on
3 the right. And I think the target property is
4 the middle one. It gives the property
5 description, 1.73 acres, that it's currently
6 owned by Luco Realty, and identifies a lease
7 amount. It also says Funding: MSV or its
8 affiliates, which I'm assuming MSV is the
9 medical -- MUSC Strategic Ventures. And then
10 there's an asterisk that says once operational
11 MUHA will sublease from JV ManageCo. So it's
12 the first time we're seeing, you know, some of
13 this information about this sublease and a
14 management company through discovery.

15 Q: Okay. And these documents with these Bates
16 labels, you would have received them on or
17 after their production on February 1st, 2019?

18 A: Yes.

19 Q: Had you seen anything prior to that date
20 discussing JV ManageCo?

21 A: No. And really nothing -- you know, the
22 Strategic Ventures Organization too was sort of
23 a new term that wasn't included in the
24 application.

25 **MS. HOLLINGSWORTH:** So, Your Honor, we would move to



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1 admit both Exhibit 65 and 67 on the Trident
2 exhibit list.

3 **MR. WESTBROOK:** No objection.

4 **THE COURT:** Admitted.

5 **MS. HOLLINGSWORTH:** Thank you, Your Honor.

6 **(Petitioner TMC's Exhibit Numbers 65 and 67 were**
7 **admitted into the record at this time.)**

8 Q: There were some other documents that we
9 received on that February 1st, 2019 production.
10 Let's look at Trident 68.

11 A: Okay.

12 Q: Turn specifically to page ---

13 **MR. WESTBROOK:** Your Honor, excuse me, and, Ms.
14 Hollingsworth, excuse me. I don't mean to
15 interrupt. But we're getting, I think for the
16 first time, a document that's labeled attorney
17 eyes expert only (sic). I don't think we have
18 discussed, unless you all did it while I was in
19 bed, how we're going to handle that. I think
20 in the past what's been done or what -- and
21 what I would move to do is that, when a
22 transcript of this is prepared, that we -- any
23 exhibits that are marked attorney/expert eyes
24 only or testimony about those, be identified by
25 the parties and sealed. I am not going to, at



1 this point, request for something that's also
2 been done in some trials, is to ask folks to
3 leave the room who are not attorneys and
4 experts when these kind of documents are
5 discussed. But I guess I -- I'm sorry, it
6 slipped my mind, but we probably should have --
7 I should have raised this issue at the
8 beginning of this morning or at some point
9 earlier in trial. This is the first time, I
10 believe, that such a document has come up. And
11 so I just wanted to see if we could talk about
12 that for a minute and get Your Honor's thoughts
13 about that and hear what my co-counsel feel
14 about that, because they're going to have a --
15 well, I don't know if you all have attorney
16 eyes expert -- expert eyes on the documents.

17 **MS. HOLLINGSWORTH:** So the confidentiality order that
18 the parties entered into prior to the
19 production of documents addresses what happens.
20 And it provides that the attorney/expert eyes
21 only designations don't have any impact on the
22 trial. So any documents that are relevant and
23 responsive and used in trial just are the
24 documents at trial. So our position would be
25 that we've address that in the confidentiality



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1 order, so it would not be our expectation that
2 there would be any sort of change to the
3 typical provision of the trial testimony and
4 exhibits.

5 **THE COURT:** Mr. Westbrook.

6 **MR. WESTBROOK:** Yes, ma'am.

7 **THE COURT:** If I'm looking at this particular
8 document, it's just comparing the footprint
9 that was originally submitted.

10 **MR. WESTBROOK:** Right.

11 **THE COURT:** So ...

12 **MR. WESTBROOK:** I don't see an issue with that --
13 with the footprint. It's other -- I guess
14 before we get into some maybe more sensitive
15 documents that are labeled -- have this label
16 on them, I wanted to raise this issue. And I
17 suppose what I would -- again, just try to
18 refine what I was saying a minute ago. At some
19 point what I'd like to do is identify the
20 documents -- and maybe this would be in the
21 form of a motion, to identify the documents
22 that have this label on them that we believe
23 are proprietary or highly confidential or
24 something of that nature, and ask that they be
25 put under seal. And even if -- again, I don't



1 anticipate this happening, but I'd like to
2 reserve the right, if a document like this that
3 is extremely confidential in some way and has
4 competitively-sensitive information, to even
5 reserve the right to file a motion at least or
6 to ...

7 **THE COURT:** Now, you all have exchanged exhibits
8 prior to the hearing.

9 **MR. WESTBROOK:** Yes.

10 **THE COURT:** And my question is why didn't you
11 identify these documents beforehand so that we
12 could have addressed this before we ---

13 **MR. WESTBROOK:** Your Honor, that's a very good
14 point. And I suppose because, again, I think
15 the -- we don't object to them coming into
16 evidence, but we object for them to be part of
17 the public record. That would be the
18 distinction. And I suppose that's my only
19 excuse for not identifying these beforehand,
20 other than they were identified by the label on
21 the bottom.

22 **THE COURT:** Do you have any idea how many of these
23 type documents that we have that's going to be
24 proposed as exhibits?

25 **MR. WESTBROOK:** I have a rough idea that there are



1 not that many, but -- at least not that many.
2 But that's -- yeah, I don't know what that
3 means. I mean, I would say that's ---

4 **THE COURT:** Ms. Hollingsworth, how many of them do
5 you have, expert ---

6 **MS. HOLLINGSWORTH:** I mean, I feel certain we -- I
7 would say we probably have a dozen maybe or
8 less than two dozen. What I would -- and what
9 Mr. Thomas -- I think what we would be
10 agreeable to discussing is the idea of the
11 documents themselves sort of within The Court's
12 record being provided some sort of continuing
13 protection, I don't think that we object to.
14 So, I mean, if that -- the issue being it's the
15 testimony, I don't want the witness testimony
16 to, you know -- so sort of later if the
17 testimony is under different records and
18 cloaked and all of that kind of stuff. But the
19 documents -- because what I understood you say,
20 you wanted the testimony ---

21 **MR. WESTBROOK:** The testimony. I would say part of
22 the transcript ---

23 **MS. HOLLINGSWORTH:** Right.

24 **MR. WESTBROOK:** --- if they're going into the
25 substance of what the document says. And if



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1 it's one of these documents that we think -- in
2 other words, if they're testifying about
3 material that is highly confidential, then I
4 would want to reserve the right to ask that
5 those -- that that part of the transcript be
6 put under seal. Now, whether I'm going to make
7 that request kind of remains to be seen with
8 how things go. If it's just a floor plan,
9 then, no, it's not -- I'm not.

10 **MR. THOMAS:** Your Honor, can I say something ---

11 **THE COURT:** Yes.

12 **MR. THOMAS:** --- just for the record? I think what
13 Mr. Westbrook is trying to say is what -- he
14 wants the transcript, the record, to be
15 confidential or basically a portion of it
16 sealed so that, say, some competitor, hospital
17 X from Anderson, South Carolina can't do a FOIA
18 request on this Court and then get that
19 transcript or at least the portions that are
20 marked ---

21 **THE COURT:** Right. That contains proprietary ---

22 **MR. THOMAS:** Yes, ma'am. The proprietary
23 information.

24 **THE COURT:** Yes.

25 **MR. THOMAS:** Isn't that right?



1 **MR. WESTBROOK:** Yeah.

2 **MR. THOMAS:** The only thing we would want is to make
3 sure that, you know, if there's an appeal of
4 this case, that we get to use everything in the
5 record and the -- you know, all the exhibits,
6 no matter what they're labeled. But I think
7 what Mr. Westbrook's asking for is just
8 protection that these aren't released. And I
9 think that's been granted before in other CON
10 cases. I've tried to get transcripts and then
11 told that I couldn't.

12 **THE COURT:** Mr. Westbrook, I don't have a problem
13 with sealing those exhibits that you've
14 objected to, based on them being proprietary,
15 being made part of the public record. I don't
16 have a problem with sealing, as well as the
17 portion of the transcript. We'll just need to
18 make sure that the court reporter is given
19 specific instructions, so that ---

20 **MR. WESTBROOK:** Thank you very much.

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

22 Q: All right. Ms. Platt, I wanted to ask you with
23 regard to Trident's Exhibit number 68 and to
24 those -- and we will do what I think was
25 suggested. Let's look first at page five of



1 that document.

2 A: Okay.

3 Q: All right. And on this document, the
4 information here, is this footprint familiar to
5 you?

6 A: Yes. The one on the left, it says Full, 10,648
7 square feet, I believe is the same as the one
8 that we looked at earlier. If I remember the
9 exhibit number. Yes, that's the one. From
10 Exhibit -- so 68 is the same as ---

11 Q: Exhibit 56?

12 A: Yeah, 56.

13 Q: Okay.

14 A: Yes.

15 Q: All right. And then I do not intend to ask you
16 substantive questions about this, but I do want
17 you to look at -- let me first get the right
18 page. Okay. If you'll look at page nine of
19 the exhibit.

20 A: Okay.

21 Q: What is the title at the very top of the page?

22 A: So this is an ER and urgent care financial
23 model.

24 Q: Okay. And would it be -- would you describe
25 this as a pro forma?



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1 A: Yes. It's a pro forma financial projection
2 with also utilization information included.

3 Q: Okay. And my question is simply had you seen
4 this financial model prior to this production
5 in February of 2019?

6 A: No.

7 Q: All right. And, again, not going into any
8 detail, but sort of as a health planner and
9 doing healthcare finance, is the information on
10 here familiar to you, just what this
11 information represents?

12 A: Yeah. The categories of information, the
13 categories of expenses, those terms are all
14 familiar to me.

15 Q: Okay. And so is this model or the manner in
16 which this information is presented and set
17 forth, is this similar to what the financial
18 model or pro forma looks like that's in the CON
19 application?

20 A: Well, some of the line item expenses are the
21 same, but as far as the actual information, I
22 mean, it's completely different. There's -- it
23 now appears to be two sets of types of
24 patients, urgent care and emergency. There's
25 different payor mix information than what was



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1 in the application, with commercial Medicare
2 and Medicaid broken out. There's, you know,
3 apparently different utilization numbers
4 driving the revenue, different expense
5 categories. And then this sort of structure
6 where it looks like there's the operation of
7 the HO -- of the ER and then essentially all
8 profit of the ER gets dumped out to this JV
9 Management Company. So that structure is
10 completely different from the application.

11 Q: Okay. And these words JV ManageCo., is that
12 the same language that we saw on that approval
13 document for the new property location?

14 A: Yes. It appears to be the same, you know, name
15 generally used to imply some type of a joint
16 venture management organization.

17 Q: Okay.

18 **MS. HOLLINGSWORTH:** And Your Honor, we would, with
19 an agreement that it could be within the sealed
20 documents, we would move to admit Petitioner's
21 -- Trident's 68 into evidence.

22 **MR. WESTBROOK:** No objection.

23 **THE COURT:** It's admitted.

24 **(SEALED: Petitioner TMC's Exhibit Number 68 was**
25 **admitted into the record at this time.)**



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1 Q: Ms. Platt, around this time period in February
2 of 2019, a couple of months ago, did you assist
3 Roper St. Francis with briefing and related to
4 some motions that we filed in this Court?

5 A: Yes.

6 Q: Okay. And as part of that, that exchanges of
7 information and in The Court's file, did you
8 have the option of -- opportunity to review
9 some affidavits?

10 A: Yes.

11 Q: Okay. If we could look at Trident's Exhibit 3.
12 This document is already in The Court's file.
13 It was attached to a briefing filed by the
14 Medical University. But have you had an
15 opportunity to review this affidavit?

16 A: Yes.

17 Q: And who is the affidavit ---

18 **MR. WESTBROOK:** Objection, depending on where the --
19 I thought she was saying something else. But
20 at her deposition, when I was questioning Ms.
21 Platt, she -- even though she had the -- had
22 had this affidavit since February, the
23 deposition I took of her, which was some time
24 several weeks later, she had not read the
25 affidavit. So I am going to object to her



1 offering any opinions about this affidavit,
2 since she had it long before the deposition and
3 had not read it, even though she acknowledged
4 that she had it in her file. So I don't know
5 where Ms. Hollingsworth is going with this, but
6 I don't think she can offer opinions on
7 something that she -- when I asked her at her
8 deposition, she couldn't offer any opinions on
9 it because she hadn't read it, even though she
10 had had it for a long time.

11 **MS. HOLLINGSWORTH:** Your Honor, I haven't asked the
12 witness to give an opinion on anything. I'm
13 simply establishing a timeline and establishing
14 the timeline of what was known about the
15 project and changes to the project. So I
16 haven't asked her to give us any opinions. I
17 did ask her if she's reviewed it and she has
18 reviewed it. I didn't ask her to tell me
19 whether it was before her deposition.

20 **THE COURT:** Okay. I'm going to allow you to proceed
21 for now.

22 **MS. HOLLINGSWORTH:** Thank you, Your Honor.

23 Q: And, Ms. Platt, this affidavit of Patrick J.
24 Cawley, M.D., which is marked as Trident's
25 Exhibit 3, but, again, is in The Court's



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1 record, I'm just asking you to identify or
2 explain for us what the changes to the project
3 are that were identified by Dr. Cawley.

4 A: Okay.

5 Q: And I believe ---

6 A: So they're on the second page. And it
7 identifies that the FED will be relocated .74
8 miles from the original site, which is
9 consistent with the new Summerville, 1310 Main
10 Street location. The reason for the relocation
11 is to provide better patient access. The new
12 site is in a shopping center in a space now
13 occupied by a closed restaurant, which will be
14 demolished. To save cost, MUSC has decided to
15 reduce the size from 15,300 square feet to
16 10,700. So that would be consistent with the
17 Intuitive drawing that recognizes about 10,700
18 square feet. Another change MUSC intends to
19 make involves the services. So they're going
20 to put urgent care services in the same
21 building with the freestanding emergency
22 department. And that's consistent with the
23 Intuitive information that we just looked at
24 with the new financial model that has both
25 emergency services and urgent care services in



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1 the financial projections. And then it says
2 these changes were not made until December
3 20th, 2018. I noted the last item, number ten,
4 talks about MUSC is considering, but has not
5 yet made, is whether it will contract for
6 management services company to manage the FED.
7 And I believe that's likely referring to this
8 Intuitive relationship. But then it says at
9 the bottom, any such management services would
10 not be any joint-venture type of structure
11 proposed by Intuitive in the produced
12 documents.

13 Q: Okay. And going back up to paragraph seven,
14 you described -- you identify what Dr. Cawley
15 explained about the reducing the size of the
16 FED?

17 A: Yes.

18 Q: What was the description of how the space would
19 be set up?

20 A: Sure. So it says instead of ten exam rooms, we
21 now plan to have seven exam rooms. And also to
22 save on cost, we've decided to eliminate the
23 proposed clinical decision unit and the
24 proposed helipad.

25 Q: In paragraph eight that you discussed regarding



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1 urgent care, the affidavit identifies that
2 urgent care services will be provided in the
3 FED; is that right?

4 A: Yes.

5 Q: Okay. At this -- during this time period and
6 really up until your deposition, had you been
7 provided any other financial pro forma for the
8 proposed project or the CON project?

9 A: So there was the pro forma that was in the CON
10 application and then the sort of Intuitive
11 version that we just looked at. And that's it.
12 So no other pro forma that would describe how
13 any of these changes might impact the project.

14 Q: Okay. Now, at your deposition that Mr.
15 Westbrook was just mentioning, were you told by
16 Mr. Westbrook or did you learn anything from
17 Mr. Westbrook about the financial projections
18 or pro forma for the project?

19 A: I guess I understood at my deposition from Mr.
20 Westbrook that MUSC was not going to be doing
21 that sort of urgent care model and that the pro
22 forma from Intuitive was sort of not applicable
23 any longer to the project.

24 Q: All right. Let's look at Trident Exhibit 76.
25 Would it be accurate to -- was your deposition



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1 in the first part of June of this year?

2 A: Yes.

3 Q: Exhibit 76, marked by Trident, I believe is in
4 evidence from Dr. Hall's testimony earlier this
5 week. Were you also provided this email
6 through discovery?

7 A: Yes.

8 Q: Okay. And the date of this email, July 2, 2019
9 -- so would you have received it after that?

10 A: Yes. I would have, I think, received it after
11 July 12yh.

12 Q: Okay. And what do you learn -- in your role,
13 what you're doing for Roper St. Francis, what
14 do you learn from this email that was produced
15 in discovery by MUSC?

16 A: So it looks like this is an email from Dr.
17 Cawley to Dr. Hall. And it says some confusion
18 has developed around our freestanding ED
19 project in Summerville. I believe the
20 confusion comes from the MUSC and Intuitive
21 Healthcare discussions that have come up during
22 the trial discovery phase and subsequent wrong
23 interpretation of these discussions by
24 attorneys for the opposing FSED project (sic).
25 I would like to clarify in this email some



1 points. And then going on to the next page it
2 says, as you are aware, our FSED is a standard
3 emergency facility. It will see both higher
4 acuity and low acuity emergency patients like
5 are seen in all emergency departments. We're
6 building the FSED to accommodate both of these
7 types of patients with higher acuity areas and
8 lower acuity areas of the building. It's very
9 common in all EDs -- or this is very common in
10 all EDs. As you know it's very -- a common
11 medical term to use urgent care to label low
12 acuity emergency care patients (sic). We are
13 not building an urgent care center. We are
14 building an FSED. That was originally the
15 plan, remains the plan. Nothing has changed in
16 the nature or types of services that will be
17 performed at this FSED and everything remains
18 consistent with our Certificate of Need
19 application. We plan to bill as per normal
20 emergency services/FSED expectations.

21 Q: Okay. And this is -- this email is from Dr.
22 Cawley to Dr. Hall, right?

23 A: Yes. That's my understanding.

24 Q: So what effect -- or what does this
25 information, sort of how does it impact your



1 review or even your opinions about the project?

2 A: Well, it adds a lot of confusion, because, you
3 know, we had originally a freestanding
4 emergency department with, you know, 12
5 treatment spaces for emergency patients, plus
6 the CDU. So a total of 17 spaces. It's now
7 moved to a new location. It's downsized. It's
8 reduced the number of treatment spaces. It's
9 eliminated the CDU. It at one point appeared
10 to add urgent care. The only pro forma or
11 utilization projections or anything we had
12 related to this sort of new, scaled down,
13 smaller project were that Intuitive financial
14 model. But then now all of a sudden we still
15 have the new location, the smaller size, the
16 fewer treatment bays, but we no longer have a
17 pro forma or utilization projections or
18 anything that relate to -- it's almost sort of
19 like the third iteration of what this project
20 might be. So it adds just yet another layer of
21 confusion to what is it that MUSC is really
22 planning to do?

23 Q: Okay. In looking -- are you aware that the
24 Intuitive Health entity -- there was a 30(b)(6)
25 deposition taken?



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1 A: Yes.

2 Q: And as I understood and we've heard some
3 testimony and argument from attorneys for MUSC,
4 but what is your understanding of sort of who
5 Intuitive Health is or what their role was for
6 MUSC?

7 A: Sure. So from what I've seen in discovery,
8 they are a -- essentially sort of a healthcare
9 consulting firm out of Texas that works with
10 healthcare systems to develop freestanding
11 emergency department services. They evaluate
12 site locations, identify, you know, potential,
13 you know, positive and negative aspects of
14 those locations. They develop utilization
15 projections and financial models for those.
16 And then work with health systems in a variety
17 of structures to develop and operate emergency
18 services. And they began talking to MUSC maybe
19 sometime in 2018 and have continued to talk to
20 them into this year through discovery,
21 providing information, providing the new
22 drawing for the, you know, new location, and
23 providing information to MUSC.

24 Q: Before we talk more about Intuitive, since I'm
25 trying to keep a little bit of our timeline,



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1 let me make sure I have you identify -- your
2 deposition was in June; is that right?

3 A: Yes.

4 Q: And you provided -- what did you provide to the
5 attorneys prior to your deposition?

6 A: I provided all of the materials in my files per
7 the discovery requests, as well as a set of
8 slides or, you know, draft exhibits based on
9 the information that I had available to me up
10 until the point of my deposition.

11 Q: And in your work in CON-contested cases, is
12 that typical that you provide slides to -- in
13 advance of your deposition?

14 A: Yes. Slides or exhibits, yes.

15 Q: Okay. All right. Let's take a look at Roper
16 Exhibit 7, which is on the screen. Can you
17 identify those for us?

18 A: Yes. This appears to be the set of exhibits
19 that I provided prior to my deposition.

20 Q: Okay. They have a Bates number on them, Roper
21 Platt 114 through Roper Platt 136. Does this
22 appear to be a complete set of the slides that
23 you provided in advance of your deposition?

24 A: Yes.

25 Q: And did Mr. Westbrook talk to you about these



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1 slides at your deposition?

2 A: Some of them, yes.

3 Q: And in fact they have a label on them. They
4 were an exhibit to your deposition; is that
5 right?

6 A: Yes. They were, yes, made a deposition
7 exhibit.

8 Q: June 5th of 2019, does that sound like when
9 your deposition was?

10 A: Yes.

11 **MS. HOLLINGSWORTH:** Your Honor, we would move to
12 admit Roper 7.

13 **MR. WESTBROOK:** No objection.

14 **THE COURT:** It's admitted.

15 **(Petitioner Roper's Exhibit Number 7 was admitted**
16 **into the record at this time.)**

17 Q: And, Ms. Platt, and certainly from a timing
18 perspective, but information, on the front page
19 what do you have listed in terms of sort of the
20 finality or not of these exhibits?

21 A: It says Draft - Subject to Revision.

22 Q: Okay. All right. So let's -- that was in
23 early June. And then of course we had
24 continued to engage in discovery; is that
25 right?



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1 A: Yes.

2 Q: Did you participate either by phone or review
3 afterwards at any depositions of other
4 witnesses in the case?

5 A: Yes. I listened by phone to Ms. Murdock, to
6 Dr. Cawley, and to Mr. Levitt. And then I've
7 read some sections of other depositions as
8 well.

9 Q: Okay. And did you -- Mr. Levitt's deposition,
10 was his before or after yours?

11 A: It was after mine.

12 Q: And did you receive or were you provided any
13 slides, other opinion information from Mr.
14 Levitt before his deposition?

15 A: No.

16 **MS. HOLLINGSWORTH:** The Intuitive Health, there was
17 a 30(b)(6) deposition and documents that were
18 produced. We have marked, Your Honor, the --
19 you have designated the deposition of Intuitive
20 Health Monday morning and have provided The
21 Court with a thumb drive of the exhibits. I do
22 not intend to ask about all of the exhibits, so
23 I certainly think after the fact the parties
24 can agree and work with the court reporter to
25 cull out those documents that we don't refer



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1 to. I do know the entirety of the transcript
2 was marked attorney/expert eyes only, so I
3 would be happy, if it's what counsel would
4 like, if you want to include the transcript as
5 one of the documents to be sealed or protected
6 from -- I don't know if you do.

7 **MR. WESTBROOK:** I don't. I think the Intuitive
8 deposition is outside the concerns that I had
9 expressed earlier.

10 **THE COURT:** Does that include all of the exhibits or
11 ---

12 **MR. WESTBROOK:** No, ma'am. I want to reserve my
13 right, depending on which exhibits Ms.
14 Hollingsworth pulls up, to potentially object
15 to those.

16 **THE COURT:** Got you.

17 **MS. HOLLINGSWORTH:** And could I beg your indulgence
18 for just one moment?

19 **THE COURT:** Yes.

20 **MS. HOLLINGSWORTH:** Okay. Thank you, Your Honor.
21 So what probably might be the most efficient,
22 since the deposition is -- the transcript is
23 here. And the benefit of you, as a fact
24 finder, is we don't have to go through that
25 delightful engagement of having someone sit on



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1 the stand and read it to us. But if I could,
2 what I would like to do is just pull up some of
3 the testimony that we would ask about and just
4 make it available for everyone to see, because
5 I don't think all of it is necessary by any
6 means.

7 **THE COURT:** Okay.

8 Q: To orient ourselves, this deposition was taken
9 July 18th of 2019. And you were aware that we
10 were taking this 30(b)(6) deposition?

11 A: Yes.

12 Q: And I think just prior to the deposition, had
13 Intuitive Health provided documents to Trident
14 in response to a subpoena?

15 A: Yes.

16 Q: So I would like to ask you -- and, again, kind
17 of reorienting ourselves, the only footprint
18 that we've seen and I think the footprint that
19 we've heard about in this hearing, is still the
20 footprint that we saw in the Intuitive Health
21 materials; is that right?

22 A: Yes, that's my understanding. That's the new
23 footprint and is still the footprint today.

24 Q: Okay. And how would you -- can you describe or
25 explain for The Court how the rooms -- like how



1 the rooms are kind of set up or delineated on
2 that floor plan?

3 A: On that floor plan there's seven rooms that are
4 labeled as freestanding emergency department,
5 you know, treatment rooms and then five
6 additional rooms that on the Intuitive
7 information are labeled as urgent care rooms,
8 for a total of 12 treatment spaces. And
9 they're sort of segregated from the seven ED
10 treatment rooms.

11 Q: And we've seen here in trial and heard from Dr.
12 Hall that the applicant, MUSC, describes those
13 five rooms differently; is that right?

14 A: Yes. Most recently we've now heard that those
15 rooms that were labeled urgent care are now
16 called fast track.

17 Q: And you were here yesterday. Ms. Huntington
18 testified about fast track rooms in
19 freestanding emergency departments?

20 A: Yes.

21 Q: All right. Okay. So if we could look at page
22 27 of the transcript. And I want to ask about
23 a term. We saw it in the Intuitive materials,
24 you know, not wanting to focus on any specific
25 detail, but this HOPD. What is an HOPD?



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1 A: It's a shorthand reference for a hospital
2 outpatient department. So it's a -- you know,
3 it's a department of a licensed hospital that
4 is focused on serving only outpatients, so
5 patients who don't go into inpatient beds. And
6 it's typically in a separate campus or a
7 separate location from the main hospital
8 campus.

9 Q: And this terminology, hospital outpatient
10 department, is that consistent with the Health
11 Plan categorizes freestanding EDs under
12 outpatient facilities?

13 A: Yes, it is.

14 Q: Okay. And so -- and I think it describes here
15 as -- well, and, again, let me identify for The
16 Court. So the 30(b)(6) deponent for Intuitive
17 Health was Thomas Matthew Herrmann, H-E-R-R-M-
18 A-N-N. And Mr. Herrmann explains in his
19 deposition a little bit about the hospital
20 outpatient department. If you'll look at line
21 19 and his description, is that consistent with
22 what you've just described in your
23 understanding of what a freestanding emergency
24 department is?

25 A: Yes. It's a clarification that it is a



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1 licensed hospital outpatient department. So
2 it's a part of a hospital.

3 Q: Okay. All right. And describe for me again
4 kind of what you know as of today about this
5 model that Intuitive Health has developed.

6 A: So in their model that I think they -- they
7 sort of call maybe a hybrid model, they operate
8 both the freestanding ED and then an urgent
9 care service, so that patients with the lowest
10 acuity would be served in the urgent care side
11 and billed differently. They would be billed
12 as urgent care service, whereas the patients
13 with higher acuity would be billed as an
14 emergency department service. They're sort of
15 co-located together in one facility.

16 Q: Okay. And is it -- Intuitive Health, they're
17 based in Texas, right?

18 A: Yes.

19 Q: Is Texas a CON state?

20 A: No, it's not.

21 Q: Let's look at page 30 of the deposition. And
22 so at page 30, Intuitive Health deponent is
23 asked to give some history to the company and
24 explain how their model came about.

25 **MS. HOLLINGSWORTH:** Probably just the easiest thing



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1 to do, again, because I don't think we need to
2 publish the whole testimony, if it is okay with
3 The Court, if Ms. Platt could just read the
4 answer that starts at line three on page 30 to
5 finish the question; would that be acceptable?

6 **THE COURT:** Yes.

7 Q: Ms. Platt, if you can just read the transcript
8 at page 30, line three, just that answer.

9 A: Yep. Started in 2008 in Frisco, Texas by three
10 physicians. They created a new concept.

11 Q: And I should have said the whole.

12 A: The whole?

13 Q: Yeah.

14 A: Keep going? How far do you want me to read?

15 Q: Just read that answer until we get to the next
16 question on page 31.

17 A: Okay. So in Texas there was an incredible
18 amount of competition with new freestanding
19 emergency departments. Most of them were
20 operating out of network, meaning they weren't
21 contracting with payors. And then most of them
22 were charging every patient that walked in the
23 door as an ER, which to their, you know, I
24 guess, defense, they are calling themselves an
25 emergency department. But when you put an



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1 emergency department in a retail-type setting,
2 it's very easy for patients to get confused as
3 to what kind of service they're going to get
4 from that facility. They understand when they
5 go to the hospital that there's an ER on the
6 wall, that it's an ER service. But what these
7 physicians have identified while working at a
8 couple of different freestanding emergency
9 departments, is that more than half the
10 patients that were showing up there really
11 didn't need ER-level services, yet they're
12 walking out with a two to \$3,000 bill. And so
13 they felt they could do it differently and so
14 they created their own location that was 100
15 percent in network and it offered ER and urgent
16 care in the same site. So if a patient came
17 in, they didn't really have to figure out
18 whether they really should go to an ER or an
19 urgent care anymore. They just come to our
20 location, they get treated, and they get the
21 right bill. So it's much lower cost to the
22 payor, lower cost to the patient, saves money
23 for everybody. Patients love it, high volume.
24 And that's why the business has been so
25 successful. It's one of the reasons.



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1 Q: Okay. And in the -- sort of applying that to
2 South Carolina, in your experience has South
3 Carolina had -- are there a lot of freestanding
4 emergency departments in South Carolina?

5 A: There are a good number in the Tri-County area,
6 but there's not that many sort of state-wide.
7 There's a few other places.

8 Q: Okay. In terms of that -- this model that's
9 discussed, are you aware of this model that
10 Intuitive Health uses being in any other
11 freestanding ED in South Carolina?

12 A: No, I'm not. And I'm not really familiar with
13 this model in any of the other freestanding
14 emergency department projects I've worked on in
15 other states as well.

16 Q: And at page 36 of Mr. Herrmann's deposition --
17 and we don't need to publish it, I just want to
18 point it out so that it's in the record --
19 would you agree with me that there's a
20 discussion sort of at the bottom of 36 and onto
21 37 about the sort of management, the joint
22 venturing model with the hospital and
23 Intuitive?

24 A: Yes. It describes that they worked with
25 healthcare systems, that they don't own the



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1 hospital outpatient department, that they can,
2 but they like to partner with the hospital and
3 create a management company that then sort of
4 jointly manages the freestanding ED.

5 Q: And looking, again, sort of the bottom of 36,
6 is it the management company that is
7 responsible for capitalization of the facility?

8 A: Yes. So in this model the management company
9 would, you know, pay the capital costs or the,
10 you know, investment in the facility itself and
11 then build the facility and use a developer to,
12 you know, build the lease space.

13 Q: Okay. And does that -- his description, is
14 that consistent with how that pro forma looked
15 like that you saw in the Intuitive material
16 produced in discovery?

17 A: Yes. It does appear to be consistent.

18 Q: But as we understand it from Dr. Cawley's
19 affidavit in February, that there is not a
20 joint venture model being pursued by MUSC with
21 Intuitive Health?

22 A: That's -- yes, that's my understanding.

23 Q: All right. The location that was approved by
24 the MS -- Strategic Ventures, MSV, when we look
25 at that document and the approval, that had the



1 JV ManageCo on it; did it not?

2 A: It did.

3 Q: And so we do know though that today the
4 proposal is still that location, 1310 North
5 Main; is that right?

6 A: That's my understanding.

7 Q: Okay. I'd like to look at page 42. And you
8 should have it in the excerpt I gave you.

9 A: Okay.

10 Q: And there is a discussion about the -- how
11 locations are selected in the -- sort of the
12 planning work that Intuitive Health does. And
13 I'll just read it, so that we can -- page 42,
14 there's a question. And so why do you look for
15 retail locations, you know, as opposed to, I
16 don't know, other accessible areas in a
17 community? What's the benefit of being there?
18 And Mr. Herrmann's response, answer, is, so our
19 -- you know, our model is built on that moment
20 of ouch. We call it the moment of ouch, which
21 is the patients all of a sudden, you know,
22 hurts themselves playing a sport or they start
23 feeling really sick.

24 And what we know about the location that
25 is still proposed by MUSC -- is it a retail



1 location?

2 A: Yes. It's definitely a retail location under
3 this type of definition set forth in the
4 Intuitive definition. It sits between two
5 other restaurant locations. The location is a
6 former restaurant location, the Applebee's
7 location. It is very close to a Wal-Mart. So
8 it's within a retail sort of park or
9 development.

10 Q: Okay. And on page 43 of the deposition, Mr.
11 Herrmann is asked people want to go in their
12 neighborhood?

13 And his answer, exactly. Somewhere easy
14 to get to.

15 Is the location, again, as you understand
16 it, is that location still the location that
17 was selected while Intuitive Health was working
18 with MUSC?

19 A: Yes. It's my understanding that MUSC selected
20 the new site in coordination with Intuitive
21 Health or maybe on the recommendation of
22 Intuitive Health.

23 Q: I'd like to have you look at what was marked as
24 Petitioner's 22 to the Intuitive Health
25 deposition. It has a Bates number of IH 162.



1 If you can show the bottom of that.

2 **MR. WESTBROOK:** I am going to object to this. If
3 Ms. Hollingsworth's ready, let me give you my
4 grounds for the objection. This goes back to
5 something that we'd argued before, Your Honor,
6 in another motion, one of the many motions
7 we've talked about, a few months ago or a few
8 weeks ago. As you know, the parties had an
9 email agreement, which not to -- we would not
10 -- that emails would not -- would be outside
11 the scope of discovery of the parties. And
12 based on that agreement we produced no emails
13 to our opponents. They produced no emails to
14 us. And the -- this is an agreement that we've
15 used with Trident for several cases. And this
16 is the first case we've worked with Roper on --
17 or with Ms. Hollingsworth's firm on this. But
18 while we did not object to the subpoena to
19 Intuitive, we did make the argument to Your
20 Honor that the subpoena should not cover emails
21 because it's a backdoor way of violating the
22 agreement. It's a backdoor way for them to
23 receive emails relative to this project that
24 MUSC sent back and forth to the third parties
25 and internal emails at MUSC, so that now,



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1 despite the agreement that we had, they have a
2 lot of emails from us about this project and we
3 don't have any of their emails. Now, I don't
4 think there are any particular smoking guns in
5 here that I'm concerned about, but just -- it
6 does violate the principal of the agreement
7 that we had, that we were not going to exchange
8 emails. We don't have any of their emails and
9 I'm not happy that they've gone a circuitous
10 route to get our emails. So on that basis, I'm
11 going to object.

12 **MS. HOLLINGSWORTH:** And, Your Honor, if I could hand
13 you a document, it's attached to -- we did
14 submit briefing on this issue right before
15 trial. That document right there, it's a copy
16 of the email that's attached to -- that is the
17 agreement of the parties -- well, among the
18 counsel regarding the case. It's attached to
19 the document. I can show it to you. But, Your
20 Honor, as you can see, the agreement was and is
21 that we would produce -- its emails will not be
22 produced by the parties except that responsive
23 documents attached to emails that are not
24 otherwise maintained or available in another
25 electronic or hard copy must be produced. And



1 so, as we explained to The Court when we
2 responded to this argument in our filing
3 before trial, as a threshold matter, nothing
4 about this agreement limits our rights to do
5 third-party discovery. There's nothing about
6 -- this just says -- what this says is it
7 limits the burden on the parties to do the time
8 and expense associated with searching and
9 producing just email communications. And that's
10 what it does. The parties don't have to
11 produce emails. But the most other important
12 caveat is, but if there are responsive
13 documents that only exist because they were
14 maintained or provided or received by way of
15 email, you have to produce those documents.
16 This agreement goes to burden and cost. It
17 does not go to kind of waving rights to receive
18 information. So it would be a
19 mischaracterization to say that this somehow is
20 an agreement of the parties to limit rights to
21 anything. And to this kind of point about we
22 don't have anyone else's emails, this isn't our
23 project, so it's very common, Your Honor, that
24 it's the applicant who would have more
25 information, because what we are trying to do



1 is obtain information about the project here,
2 we're trying to obtain information about
3 changes to the project. And so it's very, very
4 common that you have more information that the
5 applicant would produce simply because it's
6 their project.

7 **MR. THOMAS:** I would also add, Your Honor, because I
8 think I implicated in this, because we filed a
9 similar motion, is that obviously it doesn't
10 apply to the parties per the language right
11 there. It says the parties. So if we want to
12 go in that third-party discovery, we have not,
13 in any way, waived that. I would also say that
14 Mr. Westbrook's client, MUHA, has waived this
15 email agreement already, because they actually
16 produced the email of Dr. Cawley to Dr. Hall,
17 to the parties. So, they've actually waived
18 their own agreement for just the party's email.
19 But these aren't party emails. These are
20 third-party discovery and we didn't waive that.

21 **MR. WESTBROOK:** If I may briefly.

22 **THE COURT:** Yes.

23 **MR. WESTBROOK:** Couple things. To Mr. -- first of
24 all, let me address Ms. Hollingsworth's point
25 about attachments to emails. I agree



1 completely that attachments to emails were
2 outside the agreements. And attachments to
3 emails, if that's the only way they exist, they
4 should be produced. When I was giving my
5 opening statement and had all those where were
6 subtracting from the Intuitive documents, the
7 number, the vast number of -- that were emails,
8 I was not including attachments in those. I'm
9 talking about just email communications
10 themselves. But if there's an attachment
11 that's relevant, then the attachment has to be
12 produced. I understand that. That's not what
13 I'm talking about. As far as Mr. Thomas'
14 point, when I produced that email to Mr. Thomas
15 after I received it from Dr. Cawley, the first
16 -- I may have sent it to Mr. Summer -- whoever
17 I sent it to, I said without waiving our email
18 agreement, this is something you need to know
19 before the Hall deposition, because otherwise
20 you're going to be taken by surprise. So ---

21 **MR. THOMAS:** I stand corrected, if that's the case,
22 Your Honor.

23 **MR. WESTBROOK:** So our position is this. We had an
24 email agreement. This is -- while the email
25 agreement does say parties, this is a back door



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1 way of violating the spirit of that agreement,
2 so that's my objection.

3 **THE COURT:** Now, the email that you're talking
4 about, Ms. Hollingsworth ---

5 **MS. HOLLINGSWORTH:** Yes, Your Honor.

6 **THE COURT:** --- is an email between MUSC and
7 Intuitive, or ...

8 **MS. HOLLINGSWORTH:** Are you talking about the
9 agreement regarding emails?

10 **THE COURT:** No, no, no. Not the agreement, but the
11 actual email that you are -- I'm assuming that
12 you're getting ready to produce.

13 **MS. HOLLINGSWORTH:** No. So I -- in the Intuitive
14 deposition, during the 30(b)(6), the deponent
15 was asked about a number of documents that
16 Intuitive Health produced in discovery. And so
17 I certainly agree that, when it's just an
18 email, that MUSC would not have produced an
19 email ---

20 **THE COURT:** Right.

21 **MS. HOLLINGSWORTH:** --- that has no attachment. And
22 we have not -- and even in our discovery
23 motions, we did not make an argument that MUSC
24 should have produced emails that had no
25 documents. To the point though that I think



1 where we are -- and I haven't even -- I haven't
2 even been able to ask the witness what is
3 important about this exhibit I want to address.
4 The agreement of the parties to limit email
5 discovery because of the cost and the burden
6 has no relationship to not being able to obtain
7 information through a third party. I think it
8 is absolutely a mischaracterization of the
9 intent to say we're doing an end run to get
10 information by doing a third-party subpoena.
11 The agreement -- and I think it's clear in the
12 language that's proposed by MUSC's attorneys,
13 the parties won't produce emails, they have to
14 produce documents. And it's because the
15 parties wouldn't have to bear the expense and
16 the time associated with email review. That
17 has no bearing on whether or not we can conduct
18 third-party discovery. And I certainly think
19 you know in this case, Your Honor, it's our
20 position that we conducted third-party
21 discovery because we believe there was
22 responsive information, even documents, that we
23 were not being provided. And I would submit
24 that we've talked so far, and will continue to
25 talk about how that was, in fact, the case, and



1 the third-party discover has evidenced that.
2 So the reason for this examination and the
3 questions I'm going to ask the witness is about
4 documents that are discussed in the email. I
5 think it would be unfair to say, no, the email
6 gets cloaked, and therefore you won't know that
7 there were documents that should have been
8 produced that we didn't produce. And that's
9 essentially what MUSC wants to argue. So,
10 you're not entitled to any of their emails and
11 that's how you won't find out that there were
12 documents provided that we didn't produce to
13 you in discovery.

14 **THE COURT:** Mr. Thomas, did you have something?

15 **MR. THOMAS:** I concur with her argument.

16 **THE COURT:** Okay.

17 **MR. WESTBROOK:** And our position is this, the
18 documents that Intuitive has, they subpoenaed.
19 Intuitive produced a document, non-email
20 documents. That's perfectly fine. But emails
21 like this one, for example, the very first one,
22 which is between an MUSC employee and the
23 people who I presume are -- well, I know one of
24 them at least is an Intuitive employee, those
25 emails themselves should not be produced. Any



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1 documents that Intuitive has that they sent to
2 MUSC or that MUSC sent to Intuitive, as long as
3 they're relevant and there are no other grounds
4 for objections, I agree those should have been
5 and I think were produced.

6 **THE COURT:** Mr. Westbrook, I don't see this email --
7 this type email as being covered by your
8 agreement.

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

10 **MS. HOLLINGSWORTH:** Thank you, Your Honor.

11 Q: Ms. Platt, this document is an exhibit to the
12 30(b)(6) deposition. It's marked as
13 Petitioner's exhibit 22. And what I want to
14 direct you to and ask you, the date of the
15 email is Friday, May 4th, 2018. The sender is
16 Elizabeth Player with an email address of
17 playe@musc.edu. Do you see that email?

18 A: Yes.

19 Q: And the reason I'm asking you about this email
20 is because the email addresses two files.

21 I've uploaded two files to the MUSC box
22 file that you should be able to access. Please
23 let me know if you didn't get an email
24 invitation to the box folder.

25 Do you see that?



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1 A: I do.

2 Q: And then an email goes on to describe or
3 explain what those files were that were
4 provided to Intuitive Health; is that right?

5 A: Yes.

6 Q: And if you could, kind of generally explain to
7 me what information or data was provided to
8 Intuitive Health on May 4th, 2018?

9 A: So it looks like it's two files, both of which
10 are internal data from MUSC's emergency
11 department for fiscal year 2017, including data
12 that involves hospital charges for their ED
13 patients at a patient level, on a counter
14 level. And so it shows information by payor or
15 financial class. And then the second file
16 includes reimbursement. So it would be
17 basically how much is MUSC -- or have they
18 charged these patients for emergency services
19 and then how much did they get reimbursed or
20 paid for the services for emergency patients.

21 Q: Okay. And then let me ask you this, because
22 this is the purpose at this point that I want
23 to establish in the record. Were you provided
24 through discovery from MUSC these data files
25 that are referenced in this email?



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1 A: No. I have not seen them.

2 Q: Okay. All right. And the date of that email
3 was May 4th of 2018?

4 A: Yes.

5 Q: Okay. If we could look at another document,
6 HFPP 93. This would be a document that we
7 received through discovery served on HFPP. Can
8 you remind me who HFPP is?

9 A: It's a group called Healthcare Facility
10 Partners and they provide planning services for
11 healthcare facilities, they have like space
12 planning and facility planning, architectural
13 planning component. And I actually know the
14 company because they worked with the Palmetto
15 Primary Care group on the MRI and ambulatory
16 surgery center projects that I was involved in.

17 Q: And just to -- we'll go back to the timeline we
18 were at, but since this issue has come up, I
19 think it would be best to keep this testimony
20 together. I'd like you to look at the email
21 from Caroline Cotter. Her signature block says
22 senior planning associate and program manager
23 of facility planning. Do you see that email?

24 A: Yes.

25 Q: Okay. And what is the date of this email?



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1 A: This date is May 12th, 2017.

2 Q: Do you know who Georgeann Burns is?

3 A: I do. I actually worked with her fairly
4 closely on the two projects I did for Palmetto
5 Primary Care.

6 Q: Okay. And is she with HFPP?

7 A: She is.

8 Q: Okay. And do you know who Andrew Johanni is?

9 A: I don't.

10 Q: Okay. And Elizabeth Player, we saw her in the
11 prior email, right?

12 A: Yes, with MUSC.

13 Q: And then David Levitt, that's the health
14 planner for MUSC?

15 A: Yes, it is.

16 Q: Okay. And there is a description of a document
17 or data that's provided. Can you publish for
18 The Court what that is?

19 A: It says, I've attached a summary of MUSC ED
20 volumes from fiscal year '15 through '17 by
21 patient origin through May and annualized for
22 our levels one through three visits.

23 Q: Okay. And let me ask you this. Did you
24 receive in discovery a data file from MUSC that
25 the file was ED volumes from FY '15 to FY '17



1 by patient origin through May and annualized
2 for our levels one to three visits?

3 A: I did receive some data that had some of those
4 same contents, but not one that was summarized
5 in the way described here for level one to
6 three visits.

7 Q: So in terms of the data -- the file at issue
8 and discussed here, did you ever see this file?

9 A: I don't believe so.

10 Q: Okay.

11 **MS. HOLLINGSWORTH:** And so, Your Honor, this -- the
12 HFPP documents were identified, designated
13 perhaps by both of us. They were received
14 through subpoena on HFPP and produced right
15 before trial. So we would move those documents
16 to be admitted, the HFPP -- Trident Exhibit 36.

17 **MR. WESTBROOK:** The only objection I would have
18 would be the same one, based on the emails, but
19 you've already ruled on that. So I would
20 reserve that objection.

21 **THE COURT:** It's admitted.

22 **(Petitioner TMC's Exhibit Number 36 was admitted into**
23 **the record at this time.)**

24 Q: And I apologize for kind of taking us out of
25 the time period we were. I would like to look



1 back at the Intuitive deposition. What I'd
2 like to do is talk about the location that was
3 selected during this time that Intuitive was
4 helping MUSC. And so let's -- in the
5 deposition transcript I think is page 61. And
6 in his testimony, the 30(b)(6) witness talks
7 about Intuitive's sort of planning or thoughts.
8 Can you just explain or -- I'll read it so that
9 we make sure we're saying exactly what Mr.
10 Herrmann said. Mr. Herrmann testified, so when
11 we -- when we approach a hospital, we say -- we
12 always tell them that, quote, we're going to
13 take a look at your market, so what we consider
14 to be your primary service area, quote. So
15 within -- and actually it's not -- quote,
16 primary service area, quote, has a specific
17 definition. Really what we're saying is,
18 quote, we'll take a look at 35-mile radius
19 around each of your acute care facilities,
20 which is the limit of how far we can build one
21 of these, and we're going to show you where we
22 think there are opportunities to open a
23 successful combined ER/urgent care center,
24 quote. So that would be -- that's what that
25 would be.



1 And in the Intuitive documents, Ms. Platt,
2 did you see documents sort of analyzing the
3 market in the Summerville location?

4 A: Yes, I did.

5 Q: I want you to look at -- I want you to look at
6 what was marked exhibit eight to that
7 deposition. It has an Intuitive Health Bates
8 label of 89, looking at the third page. This
9 is one of the Intuitive Health productions for
10 the market. Is this sort of market analysis or
11 review consistent with what you saw Intuitive
12 Health describing?

13 A: Yes. That they looked at various market, sort
14 of sub areas within 35 miles of MUSC. And here
15 they define three different sort of sub
16 markets, Summerville, Goose Creek, and North
17 Charleston that are each color coded. And they
18 looked at within eight miles of kind of that
19 location, what the population is, the household
20 income, and the number of households.

21 Q: Okay. And Mr. Herrmann testified about this
22 document, at page -- starts at page 71 of his
23 deposition, but it goes on for several pages.
24 Let's just keep the exhibit up on the screen.
25 If you'll go to the second page of the exhibit



1 or page 90 I guess. I'm sorry. The Bates
2 label is Intuitive Health 90. It's exhibit
3 eight to the deposition. In his testimony, Mr.
4 Herrmann was asked about this document and the
5 circles and the color coding. And I will read
6 for The Court his description. It's at page
7 72, line 21. So what this shows is -- so
8 there's the legend. You'll notice that there's
9 a whole number of dots that come in four
10 colors. So each one of these dots represents
11 a retail area. So it might be a grocery store
12 anchor or something like a Wal-Mart or a
13 Target. And then the colors represent where
14 that particular grocery store anchor or retail
15 center falls in our ranking. So the yellows
16 are the top 25 percent. And then blue are the
17 next, so the second tier. Orange on the third
18 tier. And then any red dots are the bottom
19 four tier. And that takes into -- we have
20 fairly complex algorithm that includes things
21 like demographics, projected payor mix, also
22 household density. There's about 25 different
23 things that goes into that. So, that's one of
24 our criteria evaluation methodologies. That's
25 what those dots represent. And then you want



1 to show in relation to those dots what kind of
2 competition or alternative sites of care are
3 available in those areas. And those are
4 represented. We're just showing ERs and urgent
5 care centers.

6 And so this type of sort of analysis of
7 the market, Ms. Platt, is this how the market
8 was addressed or discussed in the CON
9 application?

10 A: No, not at all. There was nothing kind of --
11 well, first of all there was nothing that
12 identified any existing hospital emergency
13 services or urgent care centers throughout the
14 Tri-County area. There definitely wasn't sort
15 of this smaller look at sort of sub markets
16 around particular sites. There was just an
17 overarching sort of three-county area-wide
18 analysis. You know, there wasn't kind of this
19 focus on, you know, so the demographics
20 locally, immediately around the proposed area,
21 including, you know, the household income and
22 such as that. So it's very different than what
23 was contained in the application.

24 Q: Okay. And prior to receiving the documents
25 through the subpoena on Intuitive Health, which



1 would have been maybe July 12th of 2019, have
2 you seen any documents describing the market
3 area or the planning that went into the
4 location for the FSED?

5 A: There was one document in that same sort of --
6 I think it was a February packet that talked
7 about -- it defined a Summerville area and it
8 had some population numbers, but there was
9 nothing like this map and that Summerville area
10 was undefined in that. But this document I did
11 not see until after July 12th.

12 Q: And you're describing the Intuitive Health
13 packet?

14 A: Yes.

15 Q: Okay. And let's take a look at page 78 of the
16 transcript.

17 A: Okay.

18 Q: Mr. Herrmann, 30(b)(6) witness, was asked about
19 whether he had worked before with Equity, LLC.
20 And can you remind us who Equity, LLC is?

21 A: Well, in the context of the CON application,
22 Equity, LLC was going to be involved in
23 developing the original building in the Nexton
24 community where the freestanding ED was going
25 to be located.



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1 Q: And here in his response was -- he was asked
2 did you ever work with Equity, LLC?

3 His answer, well, we work with them in
4 Indiana right now. So they're opening --
5 they're our developer for the four sites there
6 and we're also working with them in Florida.

7 Question, but you're not working with them
8 in South Carolina?

9 Answer, we're not doing anything. We have
10 no business in South Carolina.

11 Question, okay.

12 Answer, MUSC told us they're not moving
13 forward with us on the Summerville location, so
14 we don't have anything in South Carolina.

15 Question, and when were you told that?

16 Answer, it's been well over -- I mean,
17 over six months probably.

18 Question, okay.

19 Answer, I don't know the exact date. It's
20 been quite a while.

21 Question, was it in 2018 or 2019?

22 Answer, it might have -- it could be early
23 2019. I don't know for sure if it was.
24 Probably early 2019.

25 At the time that we learned this



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1 information, that they were not doing anything
2 with MUSC, is that the first time that we've
3 heard that even the potential management
4 services arrangement was not going to happen?

5 A: Yes, it is. The affidavit that we read earlier
6 from Dr. Cawley indicated that they may have a
7 management agreement with Intuitive. So this
8 is the first time that I learned that they
9 weren't doing anything with Intuitive,
10 Intuitive wouldn't be involved in the project
11 at all.

12 Q: Okay. And Petitioner's exhibit 15 to the
13 deposition of Intuitive Health, which has a
14 Bates label IH 120, at the very bottom, on
15 April 12th, 2018, do you see an email from
16 Elizabeth Player to representatives of
17 Intuitive Health and copying Haylee McBrayer of
18 MUSC?

19 A: Yes.

20 Q: And April 12th, 2018. In the subject line is
21 MUSC emergency visit levels by payor, FY '17.
22 Do you see that?

23 A: Yes.

24 Q: And on the second page at the bottom of the
25 email, Intuitive Health 121, there is a



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1 description that starts, Hi. I have attached
2 a new file for your review. And then there's
3 -- I won't publish in the record what this
4 email says, but there's a discussion about an
5 attached data file with information, probably
6 utilization volume, financial information for
7 MUSC. Do you see that email?

8 A: I do.

9 Q: And my question to you is, in all of the
10 discovery we've received from MUSC in this
11 contested case, did you receive this data file
12 that was sent to Intuitive Health on April
13 12th, 2018?

14 A: I don't believe I did.

15 Q: Knowing what we know about the project and sort
16 of as we continue to learn, have you prepared
17 additional slides or, you know, reviewed your
18 deposition slides to try to finalize your
19 thoughts for this contested case hearing?

20 A: Yes, I have.

21 Q: And so these documents, we did those -- we
22 provided these to counsel I think yesterday
23 morning. Does that sound right?

24 A: Yes.

25 Q: Has -- we've numbered the slides just to try to



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1 help us follow along. They're Kathryn M.T.
2 Platt Exhibits and Demonstrative Presentation.
3 That DHEC CON Matter, that's the CON identifier
4 that's used by the Department for this FED
5 application?

6 A: Yes.

7 Q: And let's look -- we'll just go to the first
8 slide. All right. Page two. And, Ms. Platt,
9 what -- and really you'll be driving here, so
10 what is it about slide two that you want to
11 explain to The Court?

12 A: Sure. So this was a slide that I presented at
13 my deposition talking about the reasons why I
14 believe that MUSC project to be inconsistent
15 with Standard 2 of the 2015 South Carolina
16 Health Plan. And I just noted here in
17 particular that the Roper St. Francis Hospital
18 Berkeley will open as a licensed hospital in
19 Berkeley County on October 4, 2019. So
20 essentially there will be an open operational
21 emergency department probably by the time we
22 finish this case.

23 Q: Let's look at the next slide.

24 **MR. WESTBROOK:** And objection to the testimony and
25 to -- if this is going to be offered this



1 exhibit, same objection earlier, it's already
2 been ruled as a matter of law that MUSC does
3 comply with Standard 2. And that the fact that
4 RSF Hospital Berkeley hopes to open in October
5 is irrelevant to whether there is an existing
6 licensed hospital in the county now.

7 **THE COURT:** Sustained. Your objection is sustained.

8 **MS. HOLLINGSWORTH:** And, Your Honor, I would
9 certainly submit that, as to the slides, I
10 would maintain that slide as a proffer in the
11 event that I need to have a record
12 subsequently, because I think, again, even as
13 a proffer, I don't believe that the information
14 on slide two and her opinion in the denial of
15 summary judgement was the dispositive ending of
16 the issue, because it's still the same -- it's
17 our position that we still are entitled to
18 challenge the Department's review of the
19 application's compliance with all of the
20 standards. And your review of what does the
21 licensed hospital mean is not -- does not
22 encompass the entirety of an argument the
23 Department -- the Department's review of
24 Standard 2 among other specifications, would be
25 my position.



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1 **THE COURT:** Okay. And you're going to proffer?

2 **MS. HOLLINGSWORTH:** Thank you, Your Honor.

3 **THE COURT:** That's fine.

4 **MS. HOLLINGSWORTH:** And just as to that slide, so we
5 can continue. Okay.

6 **Q:** Let's just look at the next slide, slide three.
7 And if you could, Ms. Platt, tell us about
8 slide three.

9 **A:** Sure. So we kind of covered this before in the
10 context of the various South Carolina Health
11 Plans. So this is focusing on Standard 6 from
12 the 2015 Health Plan that was in effect at the
13 time that MUSC application was filed. And the
14 language here, the applicant must demonstrate
15 need for the service by documenting where
16 potential patients for this proposed service
17 will come from and why they are not being
18 adequately served by the existing services in
19 the area. And then, as I noted earlier, three
20 days after the MUSC CON was filed, the 2017-
21 2018 South Carolina Health Plan was adopted.
22 And then the current plans, the 2018 and the
23 2019 plan, and those plans both contain
24 language that I would -- in my opinion as a
25 health planner, is basically an update to



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1 Standard 6, providing additional clarification
2 that the applicant must demonstrate need for
3 this service by documenting capacity
4 constraints within the existing emergency
5 departments in the service area and/or a travel
6 time of greater than 15 minutes to an existing
7 emergency department in the service area.

8 Q: Okay. And thinking of the time line that we
9 have here, when the project location was
10 changed to the currently proposed location on
11 North Main Street in Summerville, what Health
12 Plan was in effect?

13 A: It would have been the -- let's see. I believe
14 it would have been the 2017-2018 Plan would
15 have still been in effect.

16 Q: And then today the Health Plan as we are here
17 at this hearing is which one?

18 A: The 2018-2019 Plan.

19 Q: Okay. And we are going to skip ahead just to
20 follow up on what we just were talking through.
21 Let's look at slide 25. So, we were talking
22 about the Health Plan, so I thought it -- let's
23 just kind of address -- you have some slides
24 related to -- some opinions related to the
25 project review criteria in the Health Plan; is



1 that right?

2 A: Yes.

3 Q: So if you could just go ahead and explain to us
4 these slides.

5 A: So this slide 25 basically is just highlighting
6 from the 2015 South Carolina Health Plan the
7 five project review criteria in the Plan that
8 are set forth as the most important in
9 evaluating Certificate of Need applications for
10 this service, specifically freestanding ED
11 services in the outpatient facility's chapter
12 of the State Health Plan. So these are the
13 criteria that I would think would be the most
14 important to the applicant in addressing, you
15 know, the contents of the application and then
16 also considered and addressed most thoroughly
17 by the Department and their evaluation.

18 Q: Okay. And they are identified up there. And
19 then what is the requirement of this section,
20 the standards there below number five, the sort
21 of -- well, let me ask you this: Do you find
22 -- in each of the standards for various
23 service, is there typically a discussion like
24 this in evaluating accessibility and adverse
25 effects?



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1 A: Yes.

2 Q: Okay. What is that requirement in this?

3 A: It says the benefits of improved accessibility
4 will be weighed -- or will be equally weighed
5 with the adverse effects of duplication in
6 evaluating Certificate of Need applications for
7 this service.

8 Q: Okay. And then -- so having just looked at the
9 relative importance of project review criteria
10 set forth in the 2015 Health Plan for FEDs,
11 let's look at your next slide. And what does
12 this tell us?

13 A: So as we talked about earlier, the Department
14 issued a letter on July 10th, 2017 deeming the
15 application for MUSC complete. And in that,
16 they set forth what they felt were the most
17 important review considerations. And that's
18 sort of a normal practice for the Department.
19 And at that time typically they include the
20 same criteria that are in the State Health Plan
21 or in the South Carolina Health Plan. They can
22 sometimes reorder the criteria and they can add
23 additional criteria, but in my experience they
24 typically include all of the criteria from the
25 appropriate chapter of the Health Plan.



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1 Q: Okay. And then so this slide, what -- was
2 there something different that you note on this
3 slide?

4 A: So in the 2015 Plan there's a project review
5 criteria highlighted as resource availability.
6 And for some reason the Department dropped that
7 criteria and didn't include it in their letter
8 to MUSC setting forth the most important
9 project review criteria.

10 Q: And so was there anywhere in the decision
11 letter from the Department where you saw a
12 discussion of resource availability by the
13 department?

14 A: No.

15 Q: Okay. And then, let's -- you have some
16 additional slides that follow regarding the
17 regulations?

18 A: Yes. So, this is starting to get into the
19 differences between the CON application
20 contents and then what we know now about the
21 MUSC project based on the various discovery,
22 both documents, and depositions up to date.

23 Q: Okay. What are those references, Part A -
24 Question? What are did that -- what are they
25 talking about?



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1 A: So this is referencing various parts of the CON
2 application. And, again, as I mentioned
3 earlier, the CON application form itself is set
4 forth in the regulation. So, there is a part
5 of the regulation called Part A. And it's sort
6 of a box with grids that goes over several
7 pages asking for very specific content
8 information on the application. So I have set
9 forth here, in part A, various questions where
10 the information that was in the application, in
11 the blue box, by question number is now
12 different based on the information we've
13 learned in discovery. And that includes the
14 address, the term of the lease. There's
15 another sort of difference there in the
16 application. It was a lease of a building
17 space and now it's essentially a land lease.
18 The owner of the building and/or space at the
19 time of the application was Nexton FSED, LLC.
20 Now the current site is owned by Luco Realty.
21 Originally the site was a 22-acre site with
22 three acres allocated to the project and now
23 it's a 1.73-acre site. Originally the
24 application was 15,300 square foot and now it's
25 10,700 square foot. So in terms of required



1 contents of the application, all of these
2 questions in part A have completely changed
3 from the original application.

4 **MR. WESTBROOK:** Object, Your Honor, to the
5 characterization that is on the screen and also
6 the last sentence that Ms. Platt said. That's
7 a legal opinion that these are required
8 elements. I'm confident that 61-15 Section 202
9 does not say anything about requirements of
10 these elements. They're part of an application
11 form. And I think actually Ms. Biggers
12 addressed this issue in her opening statement.
13 So, I don't think Ms. Platt -- she's a health
14 planner, she's an expert, she can talk about
15 health planning opinions. I don't think she
16 can give legal opinions. And that's what that
17 is.

18 **MS. HOLLINGSWORTH:** And Your Honor, my response
19 would be, if Mr. Westbrook's making an
20 assumption about what this means, these are her
21 slides and her opinion as a health planner.
22 And it's her position that, as a health
23 planner, she -- the requirement in the
24 application is the provide this information.
25 And let me point out, she is providing a



1 contrast between what the application -- what
2 the applicant put there and what it says today.
3 So there's no legal analysis or opinion. These
4 are her opinions as a health planner as to what
5 the applicant is required to put with the
6 materials. That's what she does for health
7 providers in this state all the time. And
8 she's just contrasting it from what the --
9 that's the actual document. She's not creating
10 these two -- it's just the information both
11 provided in the application and then what we
12 know in discovery. So I would disagree. He's
13 characterizing it as legal. It's not legal.
14 It's just her health planning opinion of a
15 regulatory requirement of the program.

16 **MR. WESTBROOK:** Your Honor, I don't have any problem
17 with Ms. Platt opining about what's in the blue
18 and the red box. But she's got up there on the
19 heading citing a regulation, 61-15 202 Required
20 Elements. That is saying that that regulation
21 requires these elements. That's a legal
22 opinion that she can't give.

23 **MS. HOLLINGSWORTH:** And, Your Honor, I would just
24 say you have every ability to -- she can't give
25 legal opinions. You wouldn't receive her



1 information as giving you a legal opinion. So
2 the fact that Mr. Westbrook may characterize it
3 that way, you have every manner in which you --
4 when you look at evidence and you give it the
5 weight it is, you would not -- this Court
6 absolutely could say, well, that's not a legal
7 opinion. But I would submit again, he's making
8 a characterization about her health planning
9 opinion that I think is very unfair and
10 improper. The Court will give it whatever
11 weight you want to give it.

12 **THE COURT:** And I agree with you. And I also agree
13 with you that it does appear from the language
14 that it is a legal opinion. But I agree with
15 Ms. Westbrook (sic), that I sit here and I will
16 make that determination if it's legal or as
17 part of her opinion as the expert.

18 **MR. WESTBROOK:** I understand, Your Honor. Thank
19 you.

20 **THE COURT:** Who is not qualified to give a legal
21 opinion.

22 **MS. HOLLINGSWORTH:** Thank you, Your Honor.

23 Q: If we could go through these, take a look at
24 the next slide, slide 28. These are all very
25 similar. And, again, if you could just remind



1 us, what are you comparing in the blue and the
2 red boxes?

3 A: Sure. I'm comparing the actual elements and
4 responses to questions in Part A of the
5 application for the originally filed CON
6 project to what I would put in those same
7 responses today based on the information that's
8 become available during the course of
9 discovery. And I guess in my opinion, as a --
10 if I were completing the application, these are
11 required responses in the CON application form.

12 Q: And let's -- just to make sure we address any
13 concerns, let's look at the regulation very
14 quickly. And just so that we can be sure that
15 we tie what your numbers on this slide are
16 referring to, is this -- what we've pulled up
17 on the screen, is this regulation 61-15?

18 A: Yes.

19 Q: And you testified earlier about this regulation
20 and how you use it as a health planner doing
21 Certificate of Need work?

22 A: Yes.

23 Q: Okay. And is -- section 202 on your slide, is
24 that the section 202 that's up there?

25 A: Yes.



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1 Q: And what is it that -- is this the section that
2 you were just describing in your testimony
3 about the application form?

4 A: Yes. That essentially the entire application
5 form is set forth in the regulation. So it
6 says application and then proposal page and
7 Part A questionnaire. And that's referencing
8 an appendix. And that's the questions in Part
9 A that are filled out by the applicant when
10 they're preparing and submitting a CON
11 application.

12 Q: And then section 202-1, when you were
13 describing what you as a health planner believe
14 you have to provide with an application, is
15 that addressed there, section 202-1?

16 A: Yes.

17 Q: And what does that say?

18 A: It says two copies of the application shall be
19 forwarded to the Department in the following
20 format and shall contain the following
21 information as applicable. The application
22 will be on eight and a half by 11 inch paper,
23 one side only, and three-hole punched on the
24 left side.

25 Q: And, again, just to make sure we orient for the



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1 record, you mentioned an appendix. Let's go to
2 page 29 of the regulation. Is this what you're
3 referring to by an appendix?

4 A: Yes, that's the appendix.

5 Q: And then turning to page 30 of the regulation.
6 Is that the Part A. Questionnaire that's
7 referenced on your slide?

8 A: Yes, it is.

9 Q: And then does it continue sort of with
10 additional information on pages 31 and 32?

11 A: Yes, it does. So all of that information has
12 to be completed as applicable when you file a
13 CON application.

14 Q: Okay. And then going back to page eight. Make
15 sure I address where. In the regulation where
16 we talk about Part A, Part B, is that here in
17 section 202 under part 2 and then it starts
18 with a series of provisions under 2.
19 Application?

20 A: Yes.

21 Q: Okay. Thank you. So you have a couple of
22 slides related to the information in Part A.
23 And going to slide 29, if you could just
24 briefly address what you have on slide 29.

25 A: Sure. So, again, this is moving on to Part B.



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1 We saw the questions in the regulation. And
2 this is more narrative-type responses. And so
3 I've just sort of summarized. In part B,
4 question 2, the project overview in the
5 original application, as I've said before, it's
6 15,300 square feet. It involved ten treatment
7 rooms, plus an isolation area and a
8 resuscitation area for a total of 12 treatment
9 spaces, plus an observation/CDU space. It was
10 to be located in the Nexton development,
11 adjacent to the new medical campus involving
12 primary and specialty care. Question 3, it's
13 a -- it was a \$13,584,161 project, including
14 unique and necessary aspects deemed to be the
15 CDU and the helipad.

16 So then now as we sit here today, to the
17 best of my knowledge from the discovery it's
18 now a 10,700 square foot facility with seven
19 treatment rooms, plus five urgent care spaces
20 that I believe they've also been re-labeled or
21 re-described in other aspects as fast-track
22 rooms. There's no observation/CDU space. It's
23 in an out-parcel retail location, adjacent to
24 a Mellow Mushroom and Chick-fil-a, although I
25 think the Mellow Mushroom is closed. And it's



1 now reduced to a ten million dollar project.
2 And what they had described previously with the
3 CDU and the helipad as unique and necessary are
4 abandoned, they're no longer part of the
5 project.

6 Q: And the Part A form -- let me ask you one
7 question. Is it your understanding that the
8 Department will deem a CON application complete
9 if the Part A information is not included?

10 A: I don't believe so. I think if it's -- if the
11 information's blank or missing, I would think
12 that they would deem it incomplete.

13 Q: Okay. And let's just keep going through your
14 slides, looking at slide 30.

15 A: Okay.

16 Q: And this is similar. Are you -- what are you
17 addressing here?

18 A: So, again, this is going through the narrative
19 responses of the application in Part B by
20 question and sort of summarizing what has
21 changed from the original application. So,
22 again, the details of the location for the
23 freestanding ED have completely changed. The
24 construction details have changed. It
25 apparently is going to be ground-up developed



1 now, whereas before it was going to be leased
2 space from, you know, a Nexton party, an
3 affiliate of Nexton. The ownership of the land
4 and building have changed. And I'm not sure
5 it's even completely clear at this point how
6 that's going to be structured, but it was clear
7 in the application. That's changed or somewhat
8 unclear or unknown. As far as a manger or
9 operator, I guess MUSC had not decided that
10 Intuitive would be -- whether they would be a
11 manager of the project or not. And that's --
12 I don't know where that stands exactly at this
13 point. But it appears there's not necessarily
14 going to be a management agreement with
15 Intuitive. As far as question 8(j), again, not
16 clear as to whether, you know, there's been a
17 decision made on Part B, question 8(j).

18 Q: Okay. And then the next slide. Is this
19 addressing changes to the need analysis?

20 A: Yes. So, as I mentioned before, question 11 is
21 the large section of the application with
22 narrative and analysis that we often describe
23 as the need section or the need analysis. And
24 the project overview in that section is
25 completely changed. And, you know, I've



1 mentioned these in elements before, but all of
2 these details that were included in the project
3 overview have completely changed and it's no
4 longer in the Nexton development, which was
5 described as an ideal location, given its
6 proximity to other planned and existing medical
7 services.

8 Q: All right. And slide 32.

9 A: So continuing to move through Part B, question
10 15, the financing is no longer clear. You
11 know, the lease agreement, which covered, you
12 know, sort of the building and the relationship
13 with Equity is no longer in place. And it's
14 unclear at this point how the project will be
15 funded and how they're financing the
16 development of the program.

17 The pro forma that was in the application,
18 including the -- it had to reflect the
19 utilization assumptions, the charge structure,
20 the reimbursement structure, and the expenses.
21 It's just no longer relevant because it's for
22 a larger facility with a different set of
23 services in a different location. So there's
24 essentially no, in my opinion, pro forma that
25 takes into consideration all the changes in



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1 this project, including the capital cost, the
2 appropriate depreciation, the lease agreement,
3 and that type of thing, interest payments.

4 The manpower budget that was in the
5 application in question 21 was established for
6 a facility that had 12 freestanding ED
7 treatment places, plus the CDU. That manpower
8 budget would no longer be relevant to the
9 smaller facility with a different arrangement
10 of types of services. So we don't have that
11 manpower budget for the new facility.

12 The letters of support for the
13 application, and there were -- they're
14 referenced in question 23, but then there in an
15 attachment to the application, they are, in my
16 opinion, completely obsolete now, because they
17 go into great detail about the location, the
18 positive aspects of that location, including,
19 you know, in the Nexton development and that
20 it's part of this sort of planned medical
21 campus. There are no -- there's no new support
22 that would indicate that the individuals
23 supporting the original project now supported
24 it in the new location.

25 Q: Okay. And then slide 33.



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1 A: Part C, again, is set forth in the regulation.
2 And this is another part of the application
3 that asks for very specific documentation about
4 the project that you typically provide as an
5 attachment. And there's a lot of information
6 requested, very specific to the site of the
7 project. In South Carolina a project is site-
8 specific. It's approved for the location in
9 the application, based on the contents provided
10 in the section. So, again, the site has
11 changed. They abandoned the original site.
12 There is no information available that would
13 confirm things that DHEC and the form require
14 in relation to zoning of the site, whether
15 utilities are available, and what the status of
16 those utilities are. And there is no
17 endorsement from the community, as there was in
18 the original application, in terms of the
19 positive aspects of the Nexton location.

20 Q: And then this last item with regard to Part C?

21 A: So another thing that's required as part of the
22 application is that there is documentation that
23 the governing board of the applicant entity
24 provide, you know, approval for the project as
25 described in the application. And in the



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1 original application there was a letter from
2 the MUHA Board of Trustees -- or an excerpt
3 from their meeting where they approved the
4 project as described in the Nexton location.
5 And we have no new approval letter from the
6 applicant entity.

7 Q: Look at slide 34. What is this information
8 that's being captured?

9 A: So in Part B there's a lot of specific
10 information about the ownership of the project.
11 And here it says the licensing entity -- the
12 licensed entity is governed by Medical
13 University Hospital Authority Board of
14 Trustees. And it identifies the chairman and
15 the mailing address for that entity.

16 Q: Your -- the next slide, 34, I think that's what
17 you were just describing that's in the
18 application?

19 A: Yes. So in response to Part C, question number
20 9, there's a letter signed by David J. Cole, to
21 Dr. Cawley saying that the Board of Trustees of
22 the Medical University Hospital Authority at
23 its meeting on May 18th, 2017, approved the
24 Certificate of Need application for the
25 freestanding emergency department located in



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1 Berkeley County. So that would have been, you
2 know, for the application and the project
3 described in the application.

4 Q: Okay.

5 **MS. HOLLINGSWORTH:** So, Your Honor, what we have
6 left is sort of just the slides that kind of
7 detail sort of the maps and the data. We can
8 just finish these through or if you wanted to
9 take a break, we could take a quick break. But
10 this is my very last section.

11 **THE COURT:** Go ahead and complete the section.

12 **MS. HOLLINGSWORTH:** I'm sorry?

13 **THE COURT:** I said, go ahead and complete.

14 **MS. HOLLINGSWORTH:** Okay. Wonderful.

15 **THE COURT:** And that would conclude your Direct?

16 **MS. HOLLINGSWORTH:** Yes, Your Honor.

17 **THE COURT:** Okay.

18 **MS. HOLLINGSWORTH:** I just wanted to kind of give
19 you that update that this is sort of the last
20 area and then I'll be done with Direct.

21 **THE COURT:** Okay. Just conclude your direct because
22 we're going to take a lunch break when you
23 complete that.

24 **MS. HOLLINGSWORTH:** Yes, Your Honor.

25 Q: Let's -- if you could, go to slide four. And,



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1 again, Ms. Platt, you drive this. If you could
2 just explain to The Court why you've created
3 these slides.

4 A: Sure. So as we talked about in the South
5 Carolina Health Plan in the Standard 6 and then
6 sort of the update to Standard 6, there's a
7 requirement that you look at the existing
8 emergency services in the service area and
9 their capacity. So just to kind of lay the
10 foundation, what I've done here is map and
11 identify. The red dots are the original MUSC
12 freestanding ED location. The second number
13 two dot is where it's been relocated to the
14 other side of the interstate. The blue dots
15 are all of the existing freestanding EDs,
16 approved freestanding EDs, in the Tri-County
17 area. And as you can see, there are six of
18 those scattered throughout the Tri-County area.
19 And one of which is the approved Summerville
20 FSED that's literally almost on top of the
21 locations for the MUSC project. Then the green
22 dots are all of the hospitals with emergency
23 department services, again, throughout the Tri-
24 County area. And one of those includes the
25 Roper Hospital Berkeley, which is, again,



1 clustered literally almost on top of the
2 proposed MUSC freestanding ED location. So,
3 just to set the stage how many different
4 emergency services providers are located
5 throughout the Tri-County area and then a
6 number of additional providers located much
7 closer to the proposed project, all of which
8 need to be considered in the need analysis for
9 this project.

10 Q: And then looking at the next slide.

11 A: So this slide simply puts a 20-mile ring around
12 the proposed location, just to kind of put in
13 context how far away some of these providers
14 are. Some of them are, you know, out at, you
15 know, 15-plus miles away. But there's, again,
16 a number of providers that are much closer,
17 located, you know, four to five miles away and
18 some that are, you know, within, you know, one
19 or two miles essentially of the proposed
20 project.

21 Q: All right. And then pick -- your next slide,
22 slide five. I think this is -- let me ask you,
23 some of the slides have a notation, updated
24 RSF7-5. Is that because the slide was also
25 part of your deposition slides?



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1 A: Yes. So it was part of my deposition slide.
2 And if I have just simply included it here,
3 then I just reference the page number from
4 RSF7. If I've made any kind of, you know,
5 updates or notations or whatever, then I've
6 called it, you know, updated.

7 Q: And what is this slide?

8 A: So this slide uses drive time and mileage from
9 Google Maps to identify the distance from the
10 new MUSC project location to each of the
11 existing and approved ED services in and around
12 the area. And those four providers that are
13 highlighted in yellow are within 15 minutes
14 travel time of the proposed location. And
15 going down into the ones that are in gold,
16 those are within 20 miles of the proposed
17 location. And the reason that I highlighted
18 the 15 minutes is because in the updated plan,
19 it speaks specifically to whether the provider
20 is within 15 minutes travel time are
21 accessible. So I wanted to highlight those and
22 first identify that there are four existing and
23 approved emergency services providers within
24 that 15 minute time and then I'll talk a little
25 bit more about the services and availability of



1 those providers.

2 Q: Okay. And in your opinion as a health planner
3 in evaluating a capacity or a need, do you
4 consider capacity that's been approved, but
5 might not yet be operational?

6 A: Absolutely. I mean, you can't sort of freeze
7 planning in time. Planning is a look forward.
8 And you consider a number of things going
9 forward; you consider population growth and
10 what you expect to happen in terms of, you
11 know, utilization changes. But you also have
12 to consider projects that have been planned and
13 approved and investments made by providers to
14 already address that population growth and
15 utilization growth. You can't just ignore, you
16 know, an approved provider that is developing
17 the very same service, you know, in the same
18 area.

19 Q: Okay. And the next slide, what is this slide?

20 A: So this slide looks at that question of
21 capacity. So for this instance I've used the
22 providers that are within 20 miles of the
23 proposed FSED at 20 driving miles. And those
24 also happen to be providers that are located
25 within the ZIP code area that MUSC identified



1 at project review as the ZIP codes from which
2 they would redirect patients. So in that ZIP
3 code area there are already six, seven, eight
4 existing and approved ER services providers,
5 whether it's freestanding EDs or hospitals.
6 This identifies all of the treatment spaces
7 that are either, you know, existing,
8 operational, approved or, like in the case of
9 Roper Hospital Berkeley, it's about to be open.
10 I've used a visit capacity per space of 2,000,
11 which is I feel appropriate, if not
12 conservative for a freestanding ED and for a
13 community hospital, based on various testimony
14 that we've already heard and deposition
15 testimony. And based on those existing
16 providers and approved providers, a visit
17 capacity of 2,000, the total area from which
18 MUSC expects to draw patients already has an
19 existing capacity of 334,000 visits per year.

20 Q: And in your opinion as an expert in health
21 planning and in the Certificate of Need, is
22 there any evidence of capacity constraints in
23 the service area of the proposed FSED by MUSC?

24 A: I have not seen any evidence or heard any
25 testimony that would indicate that there are



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1 capacity constraints among these providers that
2 are within the service area identified by MUSC
3 for where they will draw their patients.

4 Q: Okay. Let's look at the next slide. Does that
5 provide some data to support your opinion?

6 A: Yes. So there is data available from South
7 Carolina Department of Revenue and Fiscal
8 Affairs that collects information on emergency
9 services visits for all hospitals with
10 freestanding EDs. And you're able to obtain
11 this data from RFA at the ZIP code level. So
12 this is actual emergency services visits for
13 residents of the ZIP code area that MUSC has
14 defined for fiscal year 2016 and 2017. And you
15 can see there were 204,000 visits in 2016,
16 declining a little bit to 2,000 visits in 2018
17 (sic). And I've compared that to the existing
18 and approved capacity of 334,000. And you can
19 see only about 60 percent of the capacity would
20 be used.

21 Q: And let me -- because I think you misspoke.
22 You have FY 2016 actual. And what's the second
23 column?

24 A: '15 -- '17. I'm sorry if I misspoke.

25 Q: And then explain to us your first note under



1 that slide.

2 A: Okay. So to look out into the future, to say
3 is there enough capacity that's already
4 existing and approved to meet the growth,
5 because I think you're going to hear a lot
6 about how much growth there is in the area,
7 I've used the growth rate that MUSC used in
8 their application of a 1.7 percent annual
9 growth. And I've applied that to the service
10 area ED patient volume going out to 2022 to
11 2024, which should likely encompass the time at
12 which this facility would become operational.
13 And even with that growth, the projected ED
14 patient volume is about 211,000 and it
15 represents only 63 percent of the already
16 existing and approved capacity. So there is
17 plenty of emergency department capacity in the
18 service area to meet the needs currently and in
19 the future.

20 So in terms of need for project and the
21 State Health Plan requirement to look at
22 capacity constraints in the area, there are no
23 capacity constraints and no need for yet
24 another emergency services provider in the
25 area.



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1 Q: Okay. And when you say the area and your slide
2 says defined service area, explain again what
3 that is.

4 A: That is the ZIP code area that MUSC identified
5 from where they expect to draw their patients
6 in the project review presentation, the slide
7 that we looked at that went detailed ZIP code
8 by ZIP code of how they would redirect their
9 patient volume.

10 Q: All right. Let's look at the next slide.
11 Explain this slide to The Court.

12 A: Okay. So in the 2017-'18 Health Plan and
13 later, there is an accessibility discussion of
14 15 minutes, sort of the 15 minutes should be
15 the reasonable accessibility for emergency
16 services. So I have used our mapping software
17 here to draw a 15-minute drive time sort of
18 contour around the proposed MUSC location. And
19 you can see that is depicted in red within MUSC
20 facilities in the middle, along with the
21 Summerville approved FSED and the Roper St.
22 Francis Hospital Berkeley right in the middle.
23 And you can see that the blue, green, and
24 purple areas, this is the ZIP code area that
25 MUSC defined from where they would draw their



1 patients, so the service area. I color-coded
2 it with the purple reflecting where they expect
3 to get more than a thousand patients or more.
4 And I would call that their primary service
5 area. The green is 500 to 99 patients. And I
6 would call that sort of their secondary service
7 area. And the blue is the area that they've
8 included where they would get under 500
9 patients. And you can see that the area from
10 where they expect to draw is very broad, much
11 more broad than this 15 minute travel sort of
12 access standard.

13 And also, you know, there's been testimony
14 during discovery about what Intuitive thinks is
15 a reasonable draw for patients going to an
16 FSED. And they sort of said 13 miles. So in
17 my opinion, the area from which MUSC expects to
18 draw its patient volume, as presented in the
19 application, is unreasonably large for a
20 freestanding ED.

21 Q: Let's go to the next slide.

22 A: So here I captioned this MUSC's P Project will
23 Not Enhance Access. And, again, sort of
24 looking to that 15 minute drive time that's set
25 forth in the current South Carolina Health Plan



1 and then the one -- the 2017-'18 Plan that went
2 into effect three days after the application
3 was filed. The blue lines represent a 15-
4 minute drive time contour or sort of composite
5 around each of the existing approved -- and
6 approved freestanding EDs and hospitals. So
7 anyone who lives within the blue contour would
8 have access within 15 minutes to one of the
9 existing and approved providers.

10 The red is the 15 minute contour around
11 the proposed MUSC FSED. And you can see that
12 the red contour is completely engulfed in the
13 blue. So there is no part of the Tri-County
14 area for which this MUSC facility would enhance
15 travel access. No one is going to be able to
16 get to this location any faster than they would
17 be able to get to any other one of the existing
18 and approved hospital emergency services or
19 other freestanding EDs.

20 Q: Okay. And so having talked about those couple
21 of slides, in your expert opinion -- or what is
22 your expert opinion with regard to increased
23 access of the MUSC FSED proposal?

24 A: In my opinion, the MUSC project will not
25 enhance access from a geographic standpoint, a



1 travel time standpoint at all. It's basically,
2 you know, putting new capacity right in the
3 middle of already existing or approved
4 capacity. And given how much capacity is
5 already, again, existing or approved in the
6 area, there is no indication that there's going
7 to be any type of constraint in the future and
8 that patients would not be able to access --
9 and readily access those existing providers.

10 Q: Okay. Let's look at the next slide. And
11 identify this for The Court.

12 A: So this is, again, just essentially for backup.
13 This is the slide 19 from the project review
14 where this is the only place in which MUSC
15 identifies those ZIP codes from which they
16 project to draw patients. And they, again,
17 identify all of the patients that are driving
18 from these ZIP codes down to their downtown
19 emergency room or being transported by, you
20 know, ambulance or other mechanisms, including
21 adult patients, chest patients going to the
22 Chest Pain Center, pediatric patients. And
23 then they apply a percentage shift to each of
24 these ZIP codes, with no explication provided
25 in the application or project review, ranging



1 from 75 percent down to 25 percent. And,
2 again, there's not really any basis for the
3 shift, nor does it consider anything specific
4 about those patients and whether they would
5 even be appropriate to go to a freestanding ED,
6 whether they need specialty care, whether, you
7 know, they're trauma or too highly acute,
8 whether they ultimately need admission or
9 another type of service not available, and
10 whether they're a pediatric patient.

11 Q: Okay. Let's look at the next slide. So you've
12 described that last one sort of as a back-up
13 slide. So what is this slide?

14 A: So this takes the percent shift information
15 from MUSC and overlays it on a map. So, you
16 can just kind of put this in context. So you
17 can see that the ZIP codes in Dorchester
18 County, which are really all of those sort of
19 south of I-26, are all projected to shift at 75
20 percent. So essentially 75 percent of the
21 patients that have historically gone downtown
22 for care to the main tertiary trauma center are
23 now expected to shift to this freestanding ED.
24 I think that some of these are way too far out,
25 you know, very distant from the hospital and



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1 it's not realistic for 75 percent of them. If
2 they're already driving past multiple ED
3 providers and hospitals to go downtown, I
4 believe they're going downtown for a reason,
5 because it's a tertiary medical center, and I
6 don't think they're going to now change their
7 mind and stop at this proposed FSED.

8 But then as you get closer down to the
9 bottom, south part of this service area, you
10 still see some 75 percent from Dorchester
11 County. And those, again, they're starting to
12 get closer, they're kind of in between the
13 location of the proposed FSED and the downtown
14 hospital. So you have to question why patients
15 would choose to drive out, which is not
16 typically the patient flow, to a freestanding
17 ED with limited service offerings, compared to
18 driving downtown.

19 Q: Okay. Let's look at the next slide.

20 A: Wait. I want to point out one ---

21 Q: Oh, I'm sorry.

22 A: --- one ZIP in particular that's very unique.
23 There's a ZIP code at the very south end,
24 29406. It indicates a 60-percent shift. And
25 it's a funny little purple ZIP code that's I



1 think shaped like a boot. That ZIP code in
2 particular is I think very unusual from a
3 projection standpoint. Because, again, those
4 patients are located right next to Centre
5 Pointe Emergency, they are located closer to
6 downtown MUSC than they are to the freestanding
7 ED, and yet in this data MUSC assumes that 60
8 percent of those patients are going to choose
9 to go -- drive out to a new freestanding ED as
10 opposed to continuing to go downtown. And that
11 ZIP code, you'll see on the next slide,
12 contributes more patients to the projected
13 utilization than any other ZIP code in the
14 service area.

15 Q: And what county is that ZIP code in?

16 A: It's in Charleston County. It's not even in
17 Berkeley County.

18 Q: All right. Let's look at the next slide. So
19 as I understand, it's the same information,
20 you've put a different way of looking at the
21 number?

22 A: Yes. So instead of looking at the percentage
23 shift of patients, this looks at the actual
24 number of patients that MUSC projected in their
25 project review slide. And, again, you can see



1 that there are -- there's a projection of 2,690
2 patients who live in Charleston County, in
3 North Charleston, in that, you know, boot-
4 shaped ZIP code there, who they expect to turn
5 around and drive out of the area to this new
6 freestanding ED, away from the downtown
7 hospital. It just doesn't make any sense to
8 me. And, again, that contributes more patients
9 than any other ZIP code, including the home ZIP
10 code in which MUSC proposes to locate.

11 So in terms of a basis for their projected
12 utilization, where their patients are coming
13 from, the patient population that they've
14 identified they're going to serve, to me none
15 of this makes sense and it wasn't well
16 documented or described in the application.
17 And now that we have this new project, without
18 the CDU, without the helipads, and the things
19 that made it a unique and sort of higher level
20 of care, I mean, again, I think these
21 projections don't have even any relevance to
22 the new project. And yet we've seen nothing
23 else in terms of a new or updated projection
24 for the project.

25 Q: Okay. Let's look at the next slide.



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1 A: Okay. So as I mentioned before in some of the
2 Intuitive Health material, in the deposition,
3 Intuitive Health, when they're planning for a
4 freestanding ED, I believe that the quote was
5 that they usually look at a 13-minute area from
6 a travel-time perspective from which they would
7 expect to draw roughly 90 percent of their
8 patients. And that's depicted in the map on
9 the left that was part of the Intuitive
10 material. And you could see, that's a pretty
11 narrow area.

12 And then by contrast, as I've described on
13 the right, I've done a 15-minute drive time
14 around the MUSC site and compared that to all
15 of the ZIP codes from which MUSC projects to
16 draw patients. And they're projecting a much,
17 much larger draw, which is really -- it's
18 appropriate for a major tertiary medical
19 center, and, yes, those patients are driving
20 down to the main hospital, but it's not an
21 appropriate area for a freestanding emergency
22 service.

23 Q: Okay. And so what is ultimately your opinion
24 with regard to the proposed service area and
25 the redirection set forth by the applicant?



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1 A: I disagreed with the size of the service area.
2 I think it's too broad. I disagree with the
3 redirection percentages. And I'll get into
4 that in more detail. But I don't think that
5 the level of redirection is appropriate, given,
6 you know, the level of specialization of
7 services for which patients drive downtown for.
8 So in my opinion this information as
9 projection prepared by MUSC does not support
10 their proposed project.

11 Q: All right. And let's take a look at the next
12 slide.

13 A: Okay.

14 Q: Slide 15.

15 A: Okay. So in the application, the applicant
16 used historical data for MUSC's total emergency
17 room visits and projected a growth. So the
18 actual data at the time of the application was
19 2015 and 2016. They -- the first line is the
20 CON historical and projected data.

21 Q: Okay.

22 A: So they had historical, 79,000 visits in 2015,
23 81,000 visits in 2016, and then they projected
24 a growth trajectory of 82,000 in 2017, going
25 out to almost 84,000 by 2018. And that's



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1 depicted, that growth, as the blue line. So
2 the CON application shows this ongoing growth.

3 Since the time of the application, we now
4 have access to data, actual data for 2017 and
5 2018. And what that data shows is that in
6 reality, MUSC's volume has declined. So, it
7 went -- it dropped to 80,664 visits in 2017 and
8 then dropped again to 79,373. So one of these
9 really important growth factors that they
10 presented in the application has not
11 materialized at all. And, again, it sort of
12 renders the projections in the application
13 obsolete and inaccurate. And we have not
14 gotten any new projections that would take into
15 consideration this actual utilization trend.

16 Q: And let's make sure we point out the note with
17 regard to the 2018 data in discovery.

18 A: So the data that we received in discovery was
19 11 months of data for 2018. So that's just
20 annualized for one more month time period,
21 which is a common practice. But, it's -- you
22 know, it's, 11 to 12 months. It's pretty
23 accurate.

24 Q: Okay. Let's go to the next slide.

25 A: The other thing that I wanted to point out



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1 that's been happening since the time of the
2 application, you know, again, you're going to
3 hear about all of this growth in the area. But
4 what's happened over the last several years is
5 that MUSC's market share of the service area,
6 in particular in Berkeley and Dorchester
7 county, where they really are seeking to serve
8 patients with this new project, their market
9 share has actually declined. So the market has
10 grown, but their volume of patients coming from
11 Berkeley and Dorchester County has declined.

12 The top box shows all ED patients. So all
13 the patients that presented to MUSC that were,
14 you know, whether they were admitted or had
15 some other follow-up service at the hospital,
16 all discharge status, those numbers have
17 declined, one percent across Berkeley county,
18 1.2 percent change in market share across
19 Dorchester county. Then when you limit it to
20 just those outpatients, so ED patients that
21 come to the ED and leave, they're not admitted
22 -- and that would encompass most of the
23 patients you would expect to see at a
24 freestanding emergency department -- their
25 market share, first of all, is lower than all



1 patients. I think that reflects the tertiary
2 nature of the services downtown. But also
3 those outpatients -- that market share has
4 declined even more. So, in Berkeley County,
5 their market share has declined 1.6 percent
6 over the three-year period. And in Dorchester
7 county, 2.2 percent. So, the very population
8 that would be served by this freestanding ED,
9 MUSC is experiencing a declining market share
10 for those patients.

11 Q: Okay. Let's look at the next slide.

12 A: So, this analysis links to the discussion we
13 heard over the last couple of days with
14 relation to the acuity of patients that present
15 at the emergency room and then also those
16 billing codes. And they're not -- again,
17 they're not one in the same. So you can see
18 across the top I've identified the acute
19 patients as one. Going across down to the low
20 acuity patients is five. So that's the
21 distribution by acuity. And then the type of
22 visit is arrayed along the left-hand side,
23 starting with a brief visit all the way up
24 through comprehensive and critical.

25 And this is the information, this HB ER



1 visit type, the billing information that MUSC
2 presented to DHEC as opposed to the actual
3 acuity information. And you can see there's an
4 interesting distribution, because -- there's a
5 little bit of a correlation. You can have a
6 highly-acute patient, number one, who's also
7 getting a more costly, longer, comprehensive,
8 critical-care visit. And, again, you can have
9 very brief and limited visits for low acuity
10 patients. But there's all kinds of patients
11 that sort of cross over. So you might have,
12 you know, a high-acuity patient that only had
13 a limited visit. Or you might have a very low-
14 acuity patient, number five, that got a very
15 comprehensive visit.

16 So the information that was provided to
17 DHEC about acuity was not at all about acuity.
18 And the actual information about acuity and how
19 MUSC should have provided and analyzed the
20 information, again, was not reflected anywhere
21 in their application.

22 Q: Okay. Let's take a look at slide 18.

23 A: So looking at that acuity are the emergency
24 services index. I, again, arrayed them from
25 one through five, with one being the most



1 acute. And, again, this is MUSC's own data, so
2 it's for fiscal year 2016 actual, 2017 actual,
3 and fiscal year 2018 11 months annualized.

4 And what you can see is that the -- all of
5 the levels have had a decline in utilization.
6 The only level of care that has grown is level
7 two. And that's the second most complex or
8 acute level of care. And, again, those are the
9 patients, a large portion of which are admitted
10 or have some other kinds of follow-up services
11 needed, they need to go to surgery or they need
12 to go to cath lab. That is the only group of
13 patients that's growing and that's not a base
14 of patients that is most appropriately seen in
15 a freestanding emergency department.

16 So the very -- again, the very base of
17 patients that MUSC is attempting to serve, you
18 know, the threes, the fours, and the fives,
19 those patient volumes are declining.

20 Q: And those numbers that you're representing,
21 that's for the entirety of the MUSC emergency
22 department?

23 A: Yes. So that's everybody who's going downtown
24 for care, including all levels of care and
25 including pediatric patients.



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1 Q: And that's the same base that was used in the
2 application for the projection; is that right?

3 A: Yes. So the full base of patients was used as
4 the basis for the proposed shift in volume to
5 the freestanding ED.

6 Q: Okay. And your next slide is similar
7 information, but kind of addressing it in a
8 different way. Tell us about that.

9 A: Yes. So the acuity level is sort of what's
10 assigned at the beginning when the patient
11 arrives, how acutely ill are they. And I think
12 Ms. Huntington yesterday talked about the
13 resources that they think they're going to need
14 at the beginning of the visit.

15 This is the back end of the visit, what
16 happens to the patient at the end of their
17 emergency visit. Do they go home, which is the
18 first row, do they get admitted to the
19 hospital, are they admitted to a psychiatric
20 unit, are they observed, which would be sort of
21 that base of patients that would maybe go into
22 the CDU. And then there are just a few
23 miscellaneous ones.

24 The patients that would be most
25 appropriate to serve in a freestanding ED is



1 that top line, those that have their emergency
2 services and then are discharged home. And you
3 can see that for MUSC's actual experience, that
4 volume of patient is declining. So, again, the
5 very patients that would be most appropriately
6 served in a freestanding ED, that base of
7 patients is declining. Whereas there is
8 tremendous growth from the patients who need to
9 be admitted, which would generally be the
10 sicker, more acute patients, that's growing,
11 and the psychiatric volume is growing. And
12 those are patient populations that really
13 should not be and are not best served in the
14 freestanding ED.

15 Q: And as a health planner, would you use the
16 inpatient admission population or the
17 psychiatry admission population when you're
18 forecasting or planning utilization for a
19 freestanding ED?

20 A: I would not. I would focus on the lower acuity
21 patients and those that are discharged home as
22 my basis for the types of patients that would
23 be typically served in a freestanding ED.

24 Q: Okay. Let's look at the next slide.

25 A: This focuses on the pediatric patients. And we



1 heard description from Dr. Hall about their
2 pediatric emergency department, that's sort of
3 a separate area. And then it's going to be
4 expanded to a 20-bed -- or a 20-treatment space
5 area in the new Shawn Jenkins facility.

6 And, you know, MUSC operates this, you
7 know, sort of stand-alone children's hospital.
8 I mean, it's part of the hospital, but it's
9 very focused on just pediatric services and
10 segregated. And what was not mentioned
11 anywhere in the application is the volume of
12 pediatric patients that is included in this
13 base of overall emergency department patients.
14 And even look across the years based on, again,
15 MUSC's actual data that they provided in
16 discovery. And the percentage of pediatric ED
17 patients over the last several years has ranged
18 from roughly 27 to 28, almost approaching 29
19 percent of their patient base. And while some
20 of those patients would likely be served at a
21 FSED, a lot of them are driving those distances
22 down to MUSC because they are seeking
23 specialized pediatric care. MUSC has all of
24 the pediatric specialists downtown. But yet
25 this entire pool of patients, including those



1 pediatric patients, was included in the
2 projections and the planning for the FSED. I
3 don't believe that to be appropriate.

4 Q: All right. And I think your next slide has got
5 a lot of information on it, but it's really
6 just sort of a foundational slide for the next
7 one.

8 **MR. WESTBROOK:** And I'm going to, before we get into
9 that, offer my objection to the slide 21. And
10 the grounds for that is this. This is a new
11 analysis that Ms. Platt has done since her
12 deposition. The information on which this was
13 based was source information listed down here,
14 was produced long ago, as -- the source
15 information is MUSC 3919, which I believe was
16 produced as a spreadsheet that we reproduced in
17 July of 2018. And the CON application at page
18 530 is the other source. When I asked Ms.
19 Platt at her deposition did she have any
20 analysis, because she -- even in her
21 deposition, of course, she criticized Mr.
22 Levitt's ZIP code shift analysis on the same
23 basis that she's doing today, but she had no
24 alternative analysis to give. She had no --
25 what this has here, where she's adjusted the



1 redirection based on various factors that she's
2 talked about. When I asked her about that at
3 her deposition, she had not done an analysis,
4 even thought she had had 3919, which is the
5 source for 90 percent -- or 99 per cent of
6 this, since July 2018, a year ago. And so I
7 object to having, not being able to question
8 her about this at her deposition.

9 **MS. HOLLINGSWORTH:** And, Your Honor, certainly we
10 can use this in rebuttal, but I actually
11 disagree with Mr. Westbrook, because, if you
12 see that the analysis, it applies an assumption
13 related to how that acuity should be
14 redistributed, redirected, and you'll see she's
15 using the deposition of Dr. Hall. And so what
16 she has done is taken MUSC's physician witness
17 expert and his testimony regarding the types of
18 patients that would be appropriate for the
19 freestanding ED. His deposition I think was
20 July 3rd, Your Honor. And so, what she has
21 done is to take the information from his
22 deposition and applied it to the data in order
23 to give her opinion. And I think her giving
24 her opinion using -- doing her analysis based
25 on MUSC's physician witness testimony is



1 exactly what is appropriate for discussion here
2 at trial. We did not have any information in
3 earlier discovery about their witnesses or
4 expert's opinions and thoughts on acuity.

5 **MR. WESTBROOK:** Your Honor, nothing on page 80 of
6 Dr. Hall's deposition or anywhere else in his
7 deposition that I'm aware of estimates things
8 like 20 and 80 and 100 percent, these
9 percentages that she's using. That -- the data
10 that she's gotten here, the acuity levels, and
11 the pediatric, the age distribution, all of
12 that appears in the 3919, the big spreadsheet
13 that we produced in 2018. She could have done
14 this -- easily done this before her deposition
15 and she didn't.

16 **MS. HOLLINGSWORTH:** And, again, Your Honor, it's not
17 -- first of all, I would say we didn't have
18 this from MUSC at all. So she had no ability
19 to rebut or opine about how they applied
20 percentages to acuities. And it's Dr. Hall's
21 deposition testimony where he describes that
22 you're going to see the level fours and the
23 level fives and some threes. And so what she
24 does is she takes the testimony of their
25 witness and applies -- and actually is a little



1 bit more generous. But she's doing that as a
2 way to say, using the deposition testimony, and
3 that witness wasn't made available until July
4 3rd, and providing a slide depicting an
5 analysis of what that redirection would look
6 like. It wasn't information made available to
7 us. We didn't have any opinion from MUSC about
8 how acuity should be evaluated in a
9 freestanding ED.

10 **MR. WESTBROOK:** Ms. Platt already had her opinion
11 about how acuity should be evaluated. She gave
12 that opinion. But she didn't reduce it to
13 numbers. The data that's here is what's
14 important. And the data is what came in the
15 spreadsheet we produced. You know, I'd like to
16 see Ms. Platt show me where on page 80 of his
17 deposition Dr. Hall gave this information,
18 because I don't think it's there. I think it's
19 3919.

20 **MS. HOLLINGSWORTH:** Your Honor, he's had these since
21 yesterday. It is in his slide. Similarly to
22 new slides that we've gotten from MUSC --
23 again, it isn't about the data. MUSC's had the
24 data the entire time. They didn't provide us
25 acuity information in discovery. It wasn't



1 until the testimony of Dr. Hall. And she's
2 simply, as a health planning expert, using the
3 physician's testimony about what he expects to
4 see. I think this is entirely appropriate in
5 her Direct to talk about, this is what we've
6 heard from Dr. Hall, this is how you would
7 apply that to their data, and this is what you
8 would come up with.

9 **THE COURT:** Okay. I'm going to allow her to
10 continue with her testimony. Mr. Westbrook,
11 you can address this in your Cross.

12 **MR. WESTBROOK:** I will certainly Cross on it. But I
13 would also ask that -- I would object on the
14 basis that she needs to lay a foundation that
15 this witness has -- where this witness'
16 knowledge came from on this.

17 **THE COURT:** Okay.

18 **MS. HOLLINGSWORTH:** Thank you.

19 **Q:** Ms. Platt, could you explain to The Court, as
20 documented on the slide, where did you get the
21 information that you base this analysis on?

22 **A:** Sure. So the data is from MUSC 3919, which is
23 a large raw data file that was provided in
24 Excel format during discovery. So I have had
25 that data for quite a while. As far as looking



1 at it by acuity, you know, there hasn't been
2 any update to their projection since the time
3 of the application, other than the Intuitive
4 information, which I understand is no longer
5 relevant. So until, you know, hearing the
6 deposition testimony from Dr. Hall and
7 understanding from Mr. Levitt's deposition that
8 he hadn't done any other update, I didn't know
9 what data to even analyze, to look at, you
10 know, what would be the appropriate way to
11 project for this new project.

12 So this was developed after I listened to
13 Dr. Hall, I read excerpts of Dr. Hall, and then
14 listened to Mr. Levitt's deposition to now
15 understand what is the project today and how
16 would I, you know, project appropriately for
17 the project as it now exists or I guess to the
18 best of my knowledge of what they are
19 proposing.

20 **THE COURT:** I'm still not -- where did you get the
21 data?

22 **MS. PLATT:** The data was provided in discovery.
23 It's a data file for 3919. How it's summarized
24 here and then the application of the
25 percentages is based on my understanding from



1 Dr. Hall's deposition and my listening to Mr.
2 Levitt's deposition in which he didn't do any
3 other update. So based on that, I decided that
4 I would do what I thought was an appropriate
5 adjustment to their data for projection
6 purposes.

7 **MS. HOLLINGSWORTH:** And if I could, Your Honor, to
8 make sure it's clear.

9 Q: The data file that we're talking about, if you
10 were to print it out, do you have any idea how
11 many pages it would be?

12 A: Oh, thousands of pages. I mean, it's -- this
13 is just 2018 data. And there's, you know, like
14 80 -- 79,000 patient records. And the file
15 includes I think 2015, 2016, 2017, and 11
16 months of 2018. So it's just a huge -- you
17 know, it's got hundreds of thousands of patient
18 line items. So it's just raw data. There was
19 no analysis of that file. So then that's --
20 this is my effort to take that raw data and,
21 based on what I've learned in the depositions,
22 characterize what I think is an appropriate
23 acuity adjustment for the proposed project as
24 I understand it today.

25 **MS. HOLLINGSWORTH:** And, Your Honor, I would also



1 remind counsel that it was very clear at the
2 deposition that absolutely there may be
3 additional work done as we try to understand
4 the project and the proposal. And what Ms.
5 Hall's (sic) done is -- Dr. Hall, consistent
6 actually with his testimony here in Court,
7 where I asked him the same questions ---

8 **THE COURT:** Ms. Hollingsworth, you can continue.

9 **MS. HOLLINGSWORTH:** Okay. Thank you, Your Honor.

10 **Q:** There's a summary slide for this, is there not,
11 Ms. Platt?

12 **A:** Yes. So it just takes all the ZIP codes and
13 sort of rolls them up into a summary.

14 **Q:** Okay. And is that slide 32 (sic)?

15 **A:** Twenty-two, yes. Okay. So, this is the
16 summary, basically. So I have 2018 patients as
17 opposed to 2016 at the time of the application.
18 And I've arrayed them by acuity level, one
19 through five. And I have applied a percentage
20 that I think is appropriate to be served in the
21 freestanding ED, which would be none of the
22 level one, you know, highest acuity, sort of
23 trauma-type patients. Twenty percent of the
24 level twos, which, again, are pretty highly-
25 acute patients, many of which are admitted, 80



1 percent of the threes. And then 100 percent of
2 the fours and fives. And, again, I think
3 that's generally consistent with Dr. Hall's
4 deposition and his testimony earlier this week.
5 And based on that adjustment, the third line
6 down identifies the appropriate patients by
7 category and sums up to 18,591.

8 Q: And explain the weighted percent shift of
9 patients.

10 A: So I'm still using the very large service area,
11 larger than I think it should be, but I'm using
12 all of those ZIP codes identified at the
13 project review meeting, and the percent shift
14 that was identified at the project review
15 meeting. And when you apply the individual
16 shifts to each ZIP code, what you end up with
17 is a weighted average of 58.9 percent of the
18 patients from the service area is what MUSC
19 would project to shift. And what you end up
20 with is an acuity-adjusted base of patients
21 that's only 10,947. So a good bit lower than
22 what was projected in the application.

23 Q: Okay. Let's look at the next slide.

24 **THE COURT:** Ms. Hollingsworth, how many more slides?

25 **MS. HOLLINGSWORTH:** Just two slides and a couple of



1 concluding questions. I would say 15 minutes
2 or less, Your Honor.

3 **THE COURT:** Okay.

4 Q: Can you just explain this, the next slide?

5 A: Sure.

6 Q: Right? Or is this -- no, this is the one.

7 A: Okay. So, again, this is sort of looking at
8 what I think is an appropriate way of
9 projecting for the freestanding ED. So, again,
10 I've got MUSC's total service area visits for
11 fiscal year 2018, 24,537. If you were just to
12 apply the percentage shifts, which is that
13 weighted, you know, 58.9 from project review,
14 that would bring it down to 14,448. But I have
15 acuity adjusted it and brought the base down to
16 get rid of those highly-acute patients that
17 shouldn't go to a freestanding ED. I've
18 lowered the total base to 18,591 of acuity-
19 adjusted patients and then applied Mr. Levitt's
20 shift, the weighted shift, to get 10,950. And
21 that's about a 24 percent reduction for acuity.

22 And then we've heard some discussion that
23 there may be some pediatric patients served at
24 the freestanding ED. But a lot of those
25 pediatric patients that are going for



1 specialized pediatric care and they're choosing
2 MUSC because of its presence as a pediatric
3 provider, I've reduced that about -- again, 28
4 to 29 percent of the patients driving downtown
5 for pediatric services, I've reduced that by
6 ten percent, bringing it down to about 18
7 percent of the patients being pediatric
8 patients. And I've kind of corroborated that
9 with Ms. Huntington, that that's an appropriate
10 level of pediatric services based on the
11 experience of Roper and operating their
12 freestanding EDs. And when you make those
13 adjustments you bring the total projected
14 utilization down to 9,855, which is a lot lower
15 than the original CON projection of 15,129.

16 Now, I would say that this is still using
17 the very broad service area and the percentage
18 shifts that Mr. Levitt presented at project
19 review, which I don't agree with. I think that
20 the presented shift should be much lower. But
21 even just making these adjustments for the
22 appropriate types of patients, you're, you
23 know, well below the projections in the CON
24 application. When I look at what that sort of
25 split is for the Roper Northwoods freestanding



1 ED that exists, and you'd look at how many --
2 what percentage of patients are going to the
3 freestanding ED versus those that are
4 continuing to drive down to Roper and St.
5 Francis Hospital for full hospital care, it's
6 about a 25 percent patient base that stays at
7 the freestanding ED and 75 percent continue to
8 go on down to the hospital. So I would reduce
9 this even further for the freestanding ED,
10 because I disagree with the percentage shifts
11 that Mr. Levitt uses. And then you end up with
12 a volume that's far lower than the application.
13 And the need for the services in the
14 application is not supported by this analysis.

15 Q: And so have you received any other analysis
16 from MUSC or through their health planner
17 evaluating acuity or the redistribution plans
18 for the proposed ED?

19 A: There is some updated new analyses that I
20 believe were included in the exchange of
21 exhibits that we, you know, just literally got,
22 that talk about acuity. But there's nothing
23 where that information has been taken and
24 applied to newer 2018 data for anything that
25 you would consider to be sort of an updated or,



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1 you know, new projection. So we don't have a
2 current, I'd say, projection for the project as
3 it stands now in the new location in the new
4 scope of services and the new size. The only
5 actual projection from MUSC seems to be what's
6 still in the original application.

7 Q: And then the last slide. And we've actually
8 seen this I think in a demonstrative from MUSC,
9 but if you could tell us about the notes on the
10 slide.

11 A: This is just sort of orienting, you know, the
12 MUSC emergency departments downtown. And I
13 think what we've seen is the same map with the
14 Chest Pain Center, the main ED, and the
15 children's ED identified on the campus map.
16 And what I've done is add the location of the
17 new children's ED and the Shawn Jenkins Women
18 and Children's Hospital that should be coming
19 online I understand later this year, with that
20 additional 20 ED treatment spaces, just to make
21 sure that that's -- you know, that's an
22 important consideration, in my opinion, in
23 terms of any evaluation of capacity on the main
24 campus downtown.

25 Q: And in order to evaluate the financial



1 feasibility, are you able to give an opinion on
2 the financial feasibility of the project that's
3 been proposed in Court?

4 A: Only very generally, because, again, I haven't
5 seen anything that would be considered an
6 updated financial projection, as, you know,
7 would be required in the CON application, that
8 reflects any update to utilization, considering
9 acuity, considering the change of scope of
10 services to be offered in the freestanding ED,
11 considering what might be the charge mix
12 difference when you change the scope of
13 services in the ED, considering the reduced
14 size of the project, the staffing that would
15 need to be changed based on how much smaller
16 the facility is and eliminating the CDU, the
17 changes in financing of the project, it's no
18 longer going to be a leased space, I'm not sure
19 how it's going to be funded. There's been
20 nothing that I have seen that would provide a
21 new pro forma factoring in all of those
22 elements that have changed into this
23 application.

24 But generally if you reduce the volume of
25 patients, as I believe would be appropriate,



1 based on the analysis I just went through, I
2 think the feasibility of this project becomes
3 highly questionable.

4 Q: And the only pro forma that we've seen once the
5 location changed and the scope changed and the
6 footprint changed, that pro forma from
7 Intuitive has been disavowed by MUSC?

8 A: Yes.

9 Q: And you haven't received any other pro forma
10 after that?

11 A: No.

12 Q: And then with regard to staff resources and
13 resource availability, what is your opinion on
14 this application's compliance with that project
15 review criteria consideration?

16 A: So a couple of things. One, I think that the
17 agency should have considered staff resources
18 in their decision, which they did not, even
19 though that's one of the -- that resource is a
20 project review criteria identified in the State
21 -- in the South Carolina Health Plan as one of
22 those important for review of this type of
23 project. At the project review meeting, Roper
24 had an emergency room physician who came and
25 spoke, Dr. Waters I believe, and talked about



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1 the limited staff and the resources that are
2 needed for a new freestanding ED and presented
3 that as a concern to DHEC and it was not
4 addressed in the decision. We heard Ms.
5 Huntington's testimony about, again, the
6 limitations on resources, particularly trained
7 emergency room nurses. I think that's a
8 particular concern. And, again, I don't think
9 sufficient information has been provided by
10 MUSC to fully evaluate that, and I don't think
11 it was appropriately considered by the
12 department.

13 Q: And we've already talked about your opinions as
14 to the Health Plan standards. Do you have an
15 opinion as to whether the application complies
16 with the purpose of the CON Act?

17 A: I don't believe it does. I think it represents
18 an unnecessary duplication of existing
19 services. It's a costly project. I think it
20 will cause adverse impact to existing providers
21 and it doesn't enhance access to care. And
22 there's not a need for additional emergency
23 services capacity.

24 Q: And in evaluating the Department's decision and
25 the decision letter, what is your opinion



1 regarding the review of the Department -- of
2 the application as set forth in the record
3 that's available?

4 A: I don't believe DHEC really undertook any
5 meaningful analysis. If they did, none of it
6 is reflected in the decision letter. In
7 response to each of the project review criteria
8 that they noted, they simply regurgitated a
9 little bit of information from the application
10 and really made sort of no evaluation again or
11 analysis, and just simply said that it met the
12 criteria. And then, as I mentioned before,
13 they completely ignored and didn't address the
14 resources -- project review criteria that's set
15 forth in the South Carolina Health Plan. So I
16 don't think it's an appropriate evaluation of
17 this project.

18 Q: And with regard to the project as reviewed by
19 the Department have you been provided any
20 documentation of the Department approving the
21 changes to the project or concluding that the
22 changes to the project were not substantial;
23 have you seen any documentation of that?

24 A: No. I haven't seen anything that was formally
25 presented to the Department to say, here are



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1 all the aspects of this changed project all in
2 one place, that can describe to you every
3 single change we are making, and please give us
4 your opinion as to whether this constitutes a
5 substantial change. It's all sort of piecemeal
6 information through various parts of discovery,
7 none of which was formally presented to the
8 Department.

9 Q: And in your opinion as an expert in health
10 planning in the CON program in South Carolina,
11 do you believe the changes to the project that
12 we've heard about and we've talked through in
13 your slides, are those changes substantial
14 changes from the projects set forth in the CON
15 application?

16 A: Yes. There are substantial changes and there's
17 a substantial amount of information now that we
18 just don't know, because of some of the aspects
19 of the project that have changed. So it's no
20 longer anywhere near the same project that was
21 presented in the original application.

22 **MS. HOLLINGSWORTH:** If I could have one minute. I
23 think I'm done. Your Honor, that would
24 conclude my Direct Examination.

25 **THE COURT:** Before we move to Cross, Mr. Westbrook,



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1 we're going to take a lunch break here. We
2 will reconvene at 3:00.

3 (Off the Record)

4 **THE COURT:** Okay. Mr. Westbrook, you're ready and
5 we've got the witness back in place.

6 **MR. WESTBROOK:** All right.

7 **THE COURT:** Okay.

8 **MS. HOLLINGSWORTH:** Your Honor, if I could.

9 **THE COURT:** Yes, Ms. Hollingsworth.

10 **MS. HOLLINGSWORTH:** Very briefly and I hope The
11 Court will be pleased, Mr. Westbrook and I
12 conferred and resolved one of my objections.

13 **THE COURT:** That's the key word, resolved.

14 **MS. HOLLINGSWORTH:** It's all Mr. Westbrook. But I
15 would move to admit Ms. Platt's slides that we
16 walked through during her Direct. It would be
17 Roper's 59. And I am withdrawing the objection
18 that I had raised regarding Mr. Levitt's sort
19 of opinion slides that I got right before
20 trial. And so we've just agreed that the
21 slides of the experts will be able to come into
22 evidence.

23 **THE COURT:** Very good.

24 **MS. HOLLINGSWORTH:** If that's acceptable to The
25 Court.



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1 THE COURT: That's great.

2 MS. HOLLINGSWORTH: Subject to the objections Mr.
3 Westbrook did have as to some of them, but
4 otherwise we are offering them into evidence.

5 MR. SUMMER: I'm assuming Trident gets the benefit
6 of that barter.

7 MR. WESTBROOK: Well, maybe. I'm not sure what -- I
8 don't remember any exhibits of yours that ---

9 MR. SUMMER: Well, we'll have expert slides just
10 like you will. And so I'll pull my objections
11 down to your expert slides, if you won't object
12 to me putting ours in.

13 MR. WESTBROOK: I'll just say that's probably the
14 deal, but let's talk about it after.

15 MS. HOLLINGSWORTH: Thank you.

16 (Petitioner Roper's Exhibit Number 59 was admitted
17 into the record at this time.)

18 THE COURT: Good try, Mr. Summer. Okay.

19 MR. WESTBROOK: All right. Thank you, Your Honor.

20 MS. PLATT - CROSS-EXAMINATION BY MR. WESTBROOK:

21 Q: Ms. Platt, how are you?

22 A: I'm doing well. How about you?

23 Q: I'm doing well. So, Ms. Platt, let me start
24 off with a few easy ones. Well, maybe not.
25 You never know. But you agree that the



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1 population in the Tri-County area, particularly
2 Berkeley County, is growing; is it not?

3 A: Yes.

4 Q: And I think we put up a slide in the opening
5 that Mr. Levitt will probably use at some
6 point. I could put it up now if you'd like to
7 see it. But it says that Berkeley County is
8 the third fastest growing county in the state.
9 Do you disagree with that?

10 A: I don't.

11 Q: And the growth is particularly growing fast
12 along that I-26 corridor. Would you agree with
13 that?

14 A: There is a lot of growth along that corridor.

15 Q: And there is a lot of industry development,
16 Boeing and Mercedes and whatever, Google and
17 some other places I can't remember. But you
18 recall that?

19 A: Yes.

20 Q: Is that correct?

21 A: That's correct.

22 Q: All right. Thank you. And the overall growth
23 in emergency department visits has been --
24 let's take a look at what's been proposed as
25 MUSC Exhibit 37, just to -- so you'll know what



1 I'm talking about here. These are Tri-County
2 providers. And you've seen this slide before,
3 haven't you?

4 A: I believe I saw it with exhibits that were
5 presented on maybe July 12th.

6 Q: All right. And the green line there at the
7 bottom says total for all Tri-County providers
8 -- ED providers is 23 percent over that, what
9 is that, a six-year period. Is that -- do you
10 have any reason to dispute those numbers?

11 A: I don't have any reason to dispute the numbers.

12 **MR. WESTBROOK:** Let's look at exhibit, proposed
13 Exhibit 35, Dan.

14 Q: And this is MUSC's proposed trial Exhibit 35.
15 And, again, of the Tri-County, this is broken
16 down by county, it shows the last three years,
17 the growth in ED visits in Berkeley County is
18 over 17 percent. And you see the source down
19 there. Do you have any reason to disagree or
20 dispute those numbers?

21 A: Well, I have not been provided with any backup
22 data from MUSC. I'm familiar with that source.
23 So I guess without seeing the backup to
24 validate, I can't completely verify. But based
25 on the numbers on the page, the math



1 calculation is correct.

2 Q: Okay. And would that number shock you? Would
3 it surprise you to be if it was 17 percent if
4 you saw the underlying data and corroborated
5 that?

6 A: I mean, I know it's growing. You know, I can't
7 totally validate the 17 percent without having
8 been provided the underlying data.

9 Q: Is it your understanding that, of the three
10 counties that constitute the Tri-County,
11 Berkeley is growing the fastest in ED visits?

12 A: That doesn't surprise me ---

13 Q: All right.

14 A: --- because the population is also growing.

15 Q: Let's look at -- well, let's talk about MUSC
16 now for just a minute.

17 **MR. WESTBROOK:** And Dan, you can take that down,
18 please, sir.

19 Q: First of all, you know, I was looking through
20 your CV this morning and I've looked at it in
21 the past. You and I have known each other for
22 a while. You don't have any clinical
23 background or training, do you?

24 A: I don't.

25 Q: And you've never worked at an ED before, have



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1 you?

2 A: I have not. I've worked for a hospital, but
3 I've not worked in the ED.

4 Q: All right. Let's look at Roper's Exhibit 7,
5 which I think were your deposition trial --
6 deposition exhibits, excuse me.

7 **MR. WESTBROOK:** Dan, let's go to slide 18.

8 Q: I've just got two or three questions for you
9 about this, Ms. Platt. So did you prepare this
10 slide?

11 A: I did.

12 Q: Okay. And this is slide 18. It says at the
13 bottom Roper Platt 000131. And it's got for
14 fiscal year 2015, '16, and '17 annualized
15 MUSC's total bays with exclusion and total
16 bays. And the point, I suppose, of the exhibit
17 is, in the heading, the capacity of MUSC's
18 downtown ED. Is that a fair statement?

19 A: That is the title.

20 Q: Right. And is that the point of this, is to
21 show what the capacity is or to estimate what
22 the capacity is at MUSC's downtown EDs?

23 A: Well, this information -- in fact, this sort of
24 analysis, everything, came from MUSC 2164.

25 Q: Uh-huh.



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1 A: So the point of it was, in their discovery
2 material 2164 there were -- there was
3 identification of spaces, you might say, within
4 the downtown MUSC ED and there were a number of
5 different spaces that, in this discovery
6 material, were excluded, 20 in fact.

7 Q: Uh-huh.

8 A: And just considering what that does when you
9 look at capacity versus utilization rates when
10 you add back in those 20 patient spaces.

11 Q: And that's what -- by adding them back in,
12 that's where you got the 79; is that right?

13 A: Right. Well, I mean, I didn't -- I mean, I
14 didn't personally add them. The 79 and the 59
15 are in MUSC 2164. I just represented it both
16 ways ---

17 Q: Right. So ---

18 A: --- with and without exclusion.

19 Q: Okay. And the exclusions you're talking about
20 are the exclusions of those rooms down at the
21 note at the bottom that you were just
22 referencing that were not counted by MUSC as
23 emergency rooms, but you were -- I believe your
24 point, you correct me if I'm wrong, was that,
25 if you counted those 20 extra rooms, there



1 would be 79 bays and that would have an effect
2 on the capacity; is that right?

3 A: Yes. And those 20 that were excluded include
4 nine in the Chest Pain Center.

5 Q: Uh-huh.

6 A: So, I mean, those are -- I mean, I think we've
7 heard those as legitimate treatment spaces. In
8 fact, I think there's ten, according to Dr.
9 Hall.

10 Q: All right. And of those 20 though that are
11 listed down there, did you hear Dr. Hall
12 testify about those the other day?

13 A: Yes.

14 Q: And did you agree or disagree with any of his
15 testimony related to those spaces?

16 A: Well, and I guess generally I disagree with
17 leaving out the Chest Pain Center rooms. I
18 think all the spaces are spaces where a patient
19 can be served, so, I mean, I think there's --
20 when you're looking at capacity, you need to
21 consider them. And if you can -- especially if
22 you're going to consider the entire volume of
23 patients, then you certainly have to consider
24 the patients who are served in the Chest Pain
25 Center. It wouldn't be apples to oranges -- or



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1 it would be apples to oranges to count the
2 volume, but not count the treatment spaces.

3 Q: All right. I believe you've told me at your
4 deposition, you've never visited the MUSC --
5 any of the three ED areas at MUSC, have you?

6 A: I have not gone into them, no.

7 Q: All right. And these -- aside from the nine in
8 the Chest Pain Center, there -- it says six E
9 pods. Now, you're not familiar with an E pod,
10 are you? You don't know what that is, do you?

11 A: I haven't physically been in there. I've heard
12 the testimony about it.

13 Q: You heard the testimony about it. Until you
14 heard that, you didn't know what an E pod was
15 though, did you?

16 A: I knew -- it was described in Dr. Hall's
17 deposition and then again during his testimony
18 on Monday.

19 Q: All right. And then the BEH, are you any
20 clearer on what that is now?

21 A: Not that much clearer.

22 Q: All right. I believe that you were -- I think
23 you said at your deposition, and we can pull it
24 out if you need to, that you weren't sure, but
25 thought it might be bariatric. It's not a



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1 bariatric though, is it?

2 A: No.

3 Q: Okay. It relates to behavioral health?

4 A: Yes.

5 Q: Is that right? And the -- with respect to
6 whether these are -- is it your opinion that
7 all 20 of these spaces are available emergency
8 rooms that should be counted for the purpose of
9 analyzing capacity?

10 A: They are spaces that should be considered. And
11 especially, again, if there's volume running
12 through those rooms, which, you know, my
13 understanding is there is, then they should be
14 considered. Particularly the Chest Pain
15 Center, the E pod I understand is in use and
16 serving patients. I think that was referred to
17 as including pediatric patients. And then the
18 behavioral health, I mean, psychiatric patients
19 are in these numbers. So if you're going to
20 include the visits that are being served in the
21 treatment spaces, then it only makes sense to
22 me to include the treatment spaces in the
23 capacity calculation.

24 Q: All right. And so the count that Dr. Hall came
25 up with I believe was 67. Is that what your



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1 memory?

2 A: I believe that's what he said there is
3 currently.

4 Q: And do you think then that more than 67 should
5 be counted for the purposes of determining
6 capacity?

7 A: Well, I mean, there have been a lot of
8 different numbers thrown around at different
9 points in time through deposition ---

10 Q: Well, let me just focus on these numbers for
11 right now.

12 A: But the information from what Dr. Hall
13 testified to is the most current. And my
14 understanding there's 67. And my understanding
15 is that includes E pod and it includes
16 behavioral health and it includes this Chest
17 Pain Center.

18 Q: But you're not disputing the 67 being the
19 correct number?

20 A: I don't have a physical way of disputing that.

21 Q: Do you have any other way? Do you have a
22 psychic or mental or emotional way of disputing
23 that?

24 A: No.

25 Q: Okay. Thanks. All right. Now, CMS, there's



1 a slide that -- well, why don't we go to it.

2 **MR. WESTBROOK:** It's the same exhibit, Roper Exhibit
3 7, slide 12, I believe, Dan.

4 Q: And you and I talked about this a little bit at
5 your deposition, Ms. Platt. Well, I think I
6 have identified the wrong slide, Ms. Platt.

7 **MR. WESTBROOK:** So Dan, take that down.

8 Q: Let me just ask you this. CMS, it's my
9 understanding, and I learned this from you,
10 that CMS identifies 60,000 visits a year as a
11 very high ED volume. Is that correct?

12 A: That's -- they have categories for comparing
13 hospitals, and they group the hospitals into
14 various sizes of their ED based on volume
15 levels. And that's the cutoff for what they
16 group together as ERs that they describe as
17 high volume.

18 Q: High volume. And that would include, I think
19 you explained to me, a hospital. And if it has
20 any freestanding EDs that are departments of a
21 hospital, those would be included into the
22 hospital volume. Is that right?

23 A: As far as I know, they would be, because I
24 don't know that CMS has a way in that data set
25 to break out the freestanding volume.



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1 Q: All right. So that's your assumption, isn't
2 it?

3 A: That's my assumption.

4 Q: Now, in his deposition that you attended with
5 me, Mr. Sullivan, your old colleague, testified
6 about two folks or referenced two folks, Jon
7 Huddy and a woman named Sherri Welch. Do you
8 recall that?

9 A: Yes.

10 Q: And you were familiar -- you're familiar with
11 those two ---

12 A: Yes.

13 Q: --- folks as well; is that right? And I
14 believe I asked you to identify the national --
15 the most prominent national experts that you
16 were aware of in the field of FED or ED
17 operation and design. And you identified those
18 two -- the same two that Mr. Sullivan talked
19 about; is that correct?

20 A: Yes.

21 Q: And I believe you said that those are the only
22 two that really came to mind in that field;
23 would you agree with that?

24 A: Those are certainly the ones you would see most
25 often, yes.



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1 Q: Thank you.

2 **MR. WESTBROOK:** Let's look at MUSC's proposed
3 Exhibit 38, Dan.

4 Q: Now, this is a part of of Mr. Levitt's analysis
5 that I know you have a number of disagreements
6 with it. But I'm going to ask you a limited
7 question about this. For those ZIP codes right
8 there in the first column, do you see where it
9 says patient ZIP codes?

10 A: Yes.

11 Q: And then the next column that says FY 2015,
12 it's got the number of patients. And I believe
13 this is everyone's understanding, that from
14 that -- let's just take the first line out to
15 be simple. 29410 is the ZIP code. And this
16 chart represents, is this your understanding,
17 that in fiscal year 2015 1,384 patients living
18 in that ZIP code went to the MUSC ED on the
19 peninsula. Is that correct?

20 **MS. HOLLINGSWORTH:** Your Honor, I do want to -- I
21 would object to even this question. That slide
22 wasn't prepared by Ms. Platt and that data is
23 not data that we have access to. That's part
24 of what we'll be dealing with this Custom
25 Reports' data. So I don't think this --



1 there's no foundation for this witness to be
2 able to confirm numbers on this document. It's
3 not her document. She didn't compile the data.

4 **MR. WESTBROOK:** Well, let me lay a little foundation
5 if I may.

6 Q: Ms. Platt, at our deposition it was my
7 understanding, correct me if I'm wrong, that
8 you had no disagreement, no reason to dispute
9 the numbers of patients who, from these ZIP
10 codes, were represented in Mr. Levitt's ZIP
11 code analysis that actually went to MUSC. I
12 realize you have a number of other reasons that
13 you dispute his analysis, but the ones who
14 actually went to MUSC for ED services.

15 **MS. HOLLINGSWORTH:** And, Your Honor, I don't mean to
16 object. I would ask, Mr. Westbrook, could you
17 clarify that it's ED visits and not patients?

18 **MR. WESTBROOK:** Oh, I'm ---

19 **MS. HOLLINGSWORTH:** Is that what you're asking the
20 witness ---

21 **MR. WESTBROOK:** Right. I'm sorry. I'm completely
22 sorry.

23 Q: ED visits, not patients of course. Yes.

24 A: This analysis is something that I've seen for
25 the very first time after it was exchanged on



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1 July 12th. And I have no backup data provided
2 from Revenue and Fiscal Affairs. So I can't
3 evaluate any of the numbers on here. Now, I do
4 have data by ZIP code in MUSC 3919 that was
5 provided to me, nut this is not that source.

6 Q: Bear with me just a moment, please. All right.
7 Let's look at the slides, your latest slides,
8 Ms. Platt, that I think were admitted.

9 **MR. WESTBROOK:** I don't know as what exhibit number
10 though, Ms. Hollingsworth. The new ones that
11 we made a deal about.

12 **MS. HOLLINGSWORTH:** 59, I believe. Roper 59.

13 Q: Roper 59, let's take a look at those. You
14 testified about this slide before lunch, right?

15 A: Yes.

16 Q: Okay. So let me rephrase my earlier question.
17 It has a number of visits that are listed by
18 the ZIP code. Do you have any reason to dispute
19 the number of those visits that are listed?

20 A: I do not have any reason to and I have seen
21 that in the backup data, so I don't have any
22 reason to dispute that information.

23 Q: Thank you. Now, you have testified in an FED
24 case I know in Tennessee ---

25 A: Yes.



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1 Q: --- that we talked about. Are there any other
2 times when you've testified in an FED case?

3 A: Not that I can think of. I participated in,
4 you know, projects, but not that have gone to
5 hearing.

6 Q: Right. In Tennessee. That was the Baptist in
7 Memphis, right?

8 A: Yes.

9 Q: And you've worked -- in addition to this
10 application, what other ED applications have
11 you worked on? Excuse me, let me change that.
12 I'm sorry. What other FED applications have
13 you worked on?

14 A: I've worked on one in Alabama for East Alabama
15 Medical Center.

16 Q: Right.

17 A: And then I was working on the one for the
18 Northwoods application that was going to appeal
19 before it settled. I have worked in opposition
20 to one on James Island.

21 Q: And that's still ongoing, right?

22 A: And that's still ongoing.

23 Q: Okay. The one in east Alabama, I believe you
24 told me at your deposition that that involved
25 a shift. That was your application, correct?



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1 A: Yes.

2 Q: And that involved a shift based on ZIP codes
3 from one place to another; is that correct?

4 A: It did.

5 Q: In that application, did you make adjustments
6 for acuity or age?

7 A: I did not, because it was -- I mean, they were
8 sort of -- first, I didn't have all the data by
9 ZIP code at the level with acuity. But also it
10 was presumed that those lower acuity patients
11 would be the ones to shift and it was
12 considered in the percentage shift.

13 Q: All right. Let me ask you about a few of the
14 changes to the MUSC project. You testified
15 about some of those.

16 A: Okay.

17 Q: The two sites are about a mile apart; is that
18 your understanding?

19 A: Roughly.

20 Q: You think it's more or less than a mile?

21 A: I don't remember. I mean, when you look at it
22 on Google Maps driving it doesn't round off to
23 exactly a mile, but it's close.

24 Q: Have you -- you haven't visited either one of
25 those sites, have you?



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1 A: I have not.

2 Q: Okay. Now, with respect to the elimination of
3 the CDU and the helipad, you are aware that
4 Trident, in its petition and in other places,
5 criticized -- when those were going to be
6 components of the project, they were criticized
7 by Trident; is that correct?

8 A: That's my recollection.

9 Q: And you agreed with those criticisms, didn't
10 you?

11 A: I'm not sure that we filed anything that said
12 we agreed.

13 Q: Well, what did you personally believe?

14 A: I'm not sure that they were necessary, but they
15 certainly provided a different component to
16 that project that made it, you know, sort of
17 unique compared to a regular freestanding
18 emergency department.

19 Q: As a health planner -- regardless of, you know,
20 some of the marketing value of that, as a
21 health planner did you think those two
22 component added anything meaningful to the
23 project?

24 A: As I said, I think that they made it -- I think
25 differentiated it from most freestanding EDs



1 that I've seen to have those two, you know,
2 components.

3 Q: Let me ask you this. Let me ask you another
4 way. In your opinion as the health planner,
5 did having those two components help it satisfy
6 -- help MUSC's project to satisfy the
7 applicable criteria any better than if they had
8 not had it?

9 A: Not necessarily, but to satisfy the criteria,
10 the information that was provided involved --
11 if you take those out -- I'm trying to figure
12 out the best way to explain this. If you take
13 those out, then you no longer have the same
14 information appropriately available to
15 determine whether the project does meet the
16 rest of the review criteria or the review
17 criteria.

18 Q: Okay. I think I understand that sentence, but
19 let me go back to my question. Without taking
20 those out, while they are still in the project,
21 back when the application when you were at
22 project review, when you were first reading the
23 application, was it your opinion that the
24 addition of -- or presence of those two
25 components made it comply better with the



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1 criteria than it would have if they were not
2 there? Did it have any effect on your analysis
3 of compliance or not?

4 A: Well, I mean, I didn't think it complied with
5 those in. I don't -- but I think they added
6 sort of a unique nature that fit with the --
7 you know, the product description and the story
8 and the projection, everything that were all
9 kind of being presented to DHEC together.

10 Q: But even at the time, even with them, you
11 didn't think the project complied with the
12 criteria; is that what you just said?

13 A: Right. I mean, those weren't really a -- they
14 weren't really a -- they weren't really part of
15 my determination of whether they met the
16 criteria, which I don't think they did.

17 Q: All right. Thank you. Now, I believe you
18 testified on Direct and in your deposition, I
19 believe, that the size -- the different size of
20 the MUSC project, went down. It went from
21 whatever it was, 15,000 square feet to 11,000
22 something. Is that right? Does that sound
23 about right?

24 A: Yes.

25 Q: And that that change in the size would have an



1 effect on volume. Did I understand that
2 correctly?

3 A: It will have an effect on capacity. I mean,
4 part of the reason it went down is because the
5 number of treatment spaces went down. The CDU
6 was eliminated. The number of treatment bays
7 went down, so the capacity that can run through
8 it would change.

9 Q: All right. Aside from the CDU, is it your
10 understanding then that there are fewer
11 treatment spaces now than there were in the
12 application?

13 A: They're different, because there were 12 full
14 freestanding ED treatment bays in the original
15 application apart from the CDU and now there's
16 only seven. And then there's five spaces that
17 at one point were urgent care, now they are
18 labeled as fast track. They may or may not
19 have the same equipment available. So it's not
20 the same. It's not the same number of
21 treatments, equivalent treatment spaces.

22 Q: Are you familiar with the term fast track?

23 A: I am.

24 Q: Okay. Tell me what a fast track room is.

25 A: They are lower acuity rooms that -- they're



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1 more like the configuration of an urgent care
2 room. And lower acuity patients would go
3 through those rooms.

4 Q: All right.

5 A: And they're sort of segregated and set to the
6 side in the proposed plan.

7 Q: Did you hear Ms. Huntington's testimony
8 yesterday about fast track?

9 A: Yes.

10 Q: Did you agree with that testimony?

11 A: I agree with her testimony.

12 Q: All right. Did you hear Dr. Hall's testimony
13 about fast track?

14 A: I did.

15 Q: Did you agree with it?

16 A: Not all of it.

17 Q: Well, about fast track. Did you find that he
18 had a different view of what fast track is than
19 Ms. Huntington?

20 A: It was similar.

21 Q: How was it different?

22 A: Well, I mean, just every word that they used to
23 describe it was not exactly the same. I can't

24 ---

25 Q: I'm not looking for exact, you know, word for



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1 word. But was the essence of that -- do you
2 think they have a different understanding of
3 what fast track means?

4 A: Generally no.

5 Q: And so -- and you agree with that
6 understanding; is that correct?

7 A: Well, they're clinicians. So from their
8 perspective, you know, I don't disagree.

9 Q: All right. Now, when a CON is issued in South
10 Carolina, there's usually a period of time
11 before it becomes operational, is that correct,
12 whatever the project is?

13 A: Yes.

14 Q: All right. And the --

15 **MR. WESTBROOK:** Dan, let me ask you to put up, just
16 so we don't -- won't have to try to guess at
17 what this language is, Regulation 61-15, which
18 we've looked at before. And I think let's
19 start at -- I think it's Section 607, Dan.
20 Let's see if that's the right section.

21 Q: All right. Take a look at this, Ms. Platt.
22 You're familiar with this, aren't you?

23 A: Yes.

24 Q: All right. It says, Section 607. Periodic
25 Reporting of Certificate of Need



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1 Implementation. So is it your -- am I correct
2 in understanding that after a CON is issued,
3 the applicant -- the recipient at this point in
4 time after it's issued, has a year to implement
5 the project and that can be extended by
6 regulation, correct?

7 A: That's correct.

8 Q: And during this implementation period, the
9 applicant or the recipient, whichever you want
10 to call it, is required to submit quarterly
11 reports, correct?

12 A: That's correct.

13 Q: To DHEC?

14 A: Yes.

15 Q: All right. And I'm just going to read in for
16 the record the highlighted part. If I miss
17 anything, throw something at me. But the
18 applicant is required to submit a quarterly
19 progress report that corresponds with the
20 timetable included in the CON application
21 beginning 90 calendar days after receipt of the
22 Certificate of Need. And I'm just going to go
23 ahead and read the non-highlighted part too.
24 Failure to meet the timetable results in the
25 revocation of the CON by the Department unless



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1 a determination is made by the Department that
2 circumstances beyond the control of the holder
3 of the CON are the cause of the delay. You've
4 dealt with that before, haven't you?

5 A: Yes.

6 Q: And quarterly reports. Have you drafted
7 quarterly reports or overseen them?

8 A: I've overseen drafting of quarterly reports.

9 Q: Yes. And then number -- section two under --
10 Subsection 2, rather, says the applicant shall
11 report on, if applicable, any deviations from
12 the submitted application, correct?

13 A: Yes, with supporting documentation.

14 Q: With supporting documentation. Now, you -- let
15 me ask you about the Roper Berkeley Hospital
16 project. I know you've been involved in that;
17 isn't that correct?

18 A: No.

19 Q: Well, I know you didn't write the application,
20 but I thought -- you haven't had any
21 involvement in that?

22 A: I was not involved in the application or the
23 appeal.

24 Q: Okay. But you're familiar with what that
25 project is about, right? It's a new hospital?



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1 A: Very general, yes.

2 Q: Okay.

3 A: The status of where it is today and that it's
4 almost open.

5 **MR. WESTBROOK:** All right. Well, let me put up
6 Roper Exhibit 5. I don't know if this has been
7 admitted into evidence yet or not. But it's --
8 I know it's on your exhibit list and we didn't
9 object to it. So, we can just put it up for
10 demonstrative purposes if it hasn't been
11 admitted.

12 **MS. HOLLINGSWORTH:** I don't have an objection to it.
13 I just don't think Mr. Dayhuff offered it.

14 **MR. WESTBROOK:** Okay. All right.

15 Q: Well, let's look at Roper Exhibit 5. And it
16 says at the top -- I know you didn't prepare
17 this, so I'm going to limit to -- but it's
18 dated February 24th, 2017. It's to Louis
19 Eubank. And you know who Louis Eubank is,
20 don't you?

21 A: Yes.

22 Q: It says Director of the DHEC CON Program. He
23 used to be the director, right?

24 A: Right.

25 Q: And he's gotten promoted, I believe, since



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1 then. And it says Dear Mr. Eubank. The first
2 sentence says, this letter serves as the
3 required quarterly progress report regarding
4 the above referenced Certificate of Need issued
5 for construction of Roper St. Francis Hospital
6 - Berkeley, a 50-bed hospital. And let's go
7 down to the end of it. And it's signed by
8 Shannon Cantwell. You know Shannon Cantwell,
9 don't you?

10 A: I do.

11 Q: She's in the planning department at Roper,
12 Roper St. Francis?

13 A: Correct. Yes.

14 Q: And she used to be a DHEC employee many years
15 ago, right?

16 A: She did.

17 Q: So Ms. Cantwell is sending this quarterly
18 report to Mr. Eubank and DHEC. So have you --
19 let's take a look at the first page of this
20 report.

21 **MR. WESTBROOK:** Dan, if you'll take a look at or if
22 you'll kind of highlight -- not highlight, but
23 just make it where we can see it good. That
24 big paragraph, the one that begins the attached
25 space summary.



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1 Q: And the second sentence says, the following
2 functional changes were made during the
3 schematic redesign: Administrative offices,
4 the Board room, classroom space, Employee
5 Health and medical records were moved from the
6 hospital to the Medical Office Building for
7 cost purposes, 4,770 total square feet.

8 Now, that is -- they were moved, during it
9 says -- excuse me. These changes were made
10 during the schematic redesign. So -- and it
11 saved money and because it saved square
12 footage; is that your understanding of that
13 sentence?

14 A: That is generally my understanding.

15 Q: All right. Then it says, infusion services
16 were removed from the hospital to later phase
17 MOB. And MOB stands for medical office
18 building, right?

19 A: Yes.

20 Q: So those were services that were part of the
21 project that Roper has abandoned?

22 A: I guess they just plan to implement them later.

23 Q: Okay. Then it says, the central energy plant
24 was moved from the rooftop to a separate
25 building, reference enclosed schematics, in



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1 order to accommodate a future vertical
2 expansion. Now, none of that was in the CON
3 application, was it?

4 A: I mean, I wasn't involved in the application.
5 It appears that originally that central energy
6 plant was shown on the rooftop.

7 Q: And a cystoscopy room, endoscopy room, and a
8 special procedures lab were added to the
9 surgery department, schematic enclosed. So
10 those were different -- those are new services,
11 aren't they? And a special -- what is a
12 special procedures lab?

13 A: It's -- often it's sort of used for
14 interventional radiology.

15 Q: Okay. And then I'm going to skip the next
16 sentence and start with a sentence that says
17 note. Note that the special procedures lab
18 will be utilized as such until the appeal of
19 the Department's July 25th, 2016, decision to
20 approve a diagnostic cardiac cath lab is
21 resolved. If and when the CON for the cath lab
22 is issued, the cardiac equipment will be
23 purchased in order to convert the procedures
24 lab into a cath lab.

25 Now -- so these changes were made after



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1 the CON was issued, right? Isn't that what
2 they appear to be?

3 A: They are changes that happen after the CON was
4 completely done, all appeals, and the CON was
5 issued.

6 Q: And they're still subject to a regulation -- to
7 a DHEC determination about whether they are a
8 substantial change; isn't that correct?

9 A: They are.

10 Q: Do you consider these to be substantial
11 changes?

12 A: I don't.

13 Q: Let's look over on one of the attachments. The
14 first attachment for the letter, which is going
15 to be hard to read, can you see that on your
16 screen, Ms. Platt?

17 A: Yes.

18 Q: All right.

19 **MR. WESTBROOK:** And, Dan, we can take it a piece at
20 a time.

21 Q: At the very beginning, at the top it says Space
22 Summary DGSF/BGSF Program Comparisons. Now,
23 SF, I believe, stands for square footage.
24 Would you agree with that?

25 A: Yes.



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1 Q: Do you know what DG and BG stand for?

2 A: Typically it's -- the DG is departmental gross
3 and BG is building gross.

4 Q: All right. So what we have here is we have
5 this column that you see. It says CON Program
6 11/14/2008. And then if you move on -- and
7 there's several little columns under it. And
8 then you have Schematic Design 1/6/2017, which
9 is several years later. And the application
10 that Roper Berkeley filed, it took it a while
11 before the CON was issued, didn't it?

12 A: It was in litigation for a very long time.

13 Q: Right. And who was the litigant opposed to the
14 Roper Berkeley Hospital, by the way?

15 A: Trident.

16 Q: Trident? Okay. If you say so. So let me look
17 at --

18 **MR. WESTBROOK:** Let's go down to line seven where it
19 says Emergency Department, Dan.

20 Q: All right. Let's look at under the KPUs and
21 Comments column. It says 15 Total ED, 13
22 Treatment, 1 Isolation, and 1 Resuscitation for
23 a total of 15; is that right?

24 A: Yes.

25 Q: All right. And then -- so that was the plan in



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1 two thousand -- in the application, the 2008
2 application, correct?

3 A: That's what it says.

4 Q: Okay. And let's move on down that line to the
5 comments for the schematic design. And under
6 KPU's, Comments it says 13 Total ED Treatment,
7 Including Isolation BH plus Resuscitation.
8 What's BH, do you know?

9 A: I assume it's behavioral health.

10 Q: Makes sense. So it looks like -- would you
11 interpret that as being -- that it went from 15
12 to 13 total ED rooms, treatment rooms?

13 A: On this report. My understanding, based on
14 deposition testimony in this case, is that
15 they're developing 15.

16 Q: They're developing 15. Well, I mean, Ms.
17 Cantwell has been with them a long time, right?

18 A: Yes.

19 Q: And this is an important document, isn't it?

20 A: It is. But it's also dated. It's from 2017.

21 Q: All right. So in 2017, the plan was to go down
22 to 13.

23 A: That was the plan in 2017.

24 Q: All right. And is the plan now to go back up
25 to 15? Is that your understanding?



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1 A: My understanding, based on deposition
2 testimony, is that the hospital that's about
3 ready to open has 15.

4 Q: All right. So it was 15 originally, then it
5 went down to 13, and now it's back up to 15.
6 That's what I understand you to say?

7 A: That's my understanding.

8 Q: All right. Let's go down to line 11, please.
9 And on line 11, what's the departmental square
10 footage say there? It says -- and that would
11 be, yeah, in the departmental square footage.

12 **MR. WESTBROOK:** If you can bring it down Dan.

13 Q: It's 30,302; is that correct?

14 A: That's my understanding.

15 Q: All right. Let's move on over to the schematic
16 square footage. And is that 20,800?

17 A: It is.

18 Q: So, it went down 10,000 square feet?

19 A: Can you go over so I can see the rest of the
20 description there?

21 Q: Sure.

22 A: It did. But, I mean, this is not something I
23 had any involvement with. So I can't tell you
24 what that involved or why.

25 Q: I'm not asking you why. I'm just -- I just



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1 wanted to -- since this is your client and it
2 involves a document that was sent to DHEC -- it
3 appears from this document, do you think I'm
4 reading this correctly, that it went down by
5 10,000 square -- from 30,000 to 20,000? And
6 I'm -- you know, that's not ---

7 A: Do you mind zooming out so I can see the whole
8 document?

9 Q: Sure.

10 A: Do you have a copy that I can actually
11 physically look at?

12 Q: Sure. There you go.

13 A: Thank you.

14 Q: I tell you what, Ms. Platt, I'm going to give
15 you your own copy.

16 A: Okay. Thank you.

17 Q: There you go. Just make sure it's got
18 everything in there. Yes, there it is. All
19 right. So does it appear to you from line item
20 11 that this went down from 30,302 square feet
21 to 20,800 square feet?

22 A: It does. But I think you have to look at it in
23 the context of all of the departments, because
24 it looks as though they sort of redefined beds
25 as well. So it's not just the square footage



1 by itself.

2 Q: Right.

3 A: And again ---

4 Q: I see what you're talking about. Because it
5 also says on the comments there on that line
6 item -- well, for the original application
7 there were 36 M/S, which I'm guessing is
8 med/surge beds. Is that right?

9 A: Yes.

10 Q: And then in the more recent one, it's down to
11 24 med/surge beds; is that right?

12 A: Yes.

13 Q: And this is in the -- is this the med/surge and
14 ICU department? Is that the way you would
15 interpret that?

16 A: It looks like it, yes.

17 Q: So in that department they reduce the number of
18 med/surge beds by 12 and reduced the square
19 footage by over 9,000 square feet; is that
20 right?

21 A: Again, I don't know the details in this. I was
22 not involved in any way whatsoever. It does
23 look like the square footage went down and the
24 rooms were slightly moved around.

25 Q: All right. And the next line item, line item



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1 12, the department is L&D, C-Section, and
2 Postpartum department. Do you see that?

3 A: Yes.

4 Q: And then if you move over to the comments for
5 the earlier phase of the project, 8 LDRP. What
6 does LDRP stand for?

7 A: Labor, delivery, recovery, and postpartum.

8 Q: All right. And 2 Triage, 2 C-Sections, and 2
9 P/R, Well-Baby. What does P/R mean?

10 A: I don't know.

11 Q: Is it postpartum?

12 A: It might be postpartum recovery. I don't know.

13 Q: Okay. And then at any rate, it was 8 LD -- L,
14 labor delivery. What does the R stand for?

15 A: Recovery.

16 Q: Recovery. And the more recent one is half that
17 many, 4, correct?

18 A: That's correct.

19 Q: Triage has gone from 2 to 3. There are 3 Well-
20 Baby and 16 PP, which I'm assuming is
21 postpartum. Does that make sense to you?

22 A: Yes.

23 Q: Sixteen postpartum/AP/GYN. So a number of
24 changes there, right?

25 A: Well, the AP is typically antepartum, and GYN,



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1 which are essentially med/surge beds that
2 they're just grouping sort of with women
3 services all together. So that's -- if you
4 look at the line above, they simply moved
5 med/surge beds down to that women's services
6 category.

7 Q: All right. And down on 16, line item 16, the
8 Sterile Processing, for the department square
9 footage there it has -- is that -- it looks
10 like 2,053. Is that correct?

11 A: Yes.

12 Q: And it says by the comments it Supports 4 OR
13 and 2 C-Sections; is that correct?

14 A: Yes.

15 Q: And then on the newer, the 2017 plan, it's
16 3,690 square feet, and 4 ORs still, plus Future
17 ASC/Expansion. And ASC stands for ambulatory
18 surgery center?

19 A: Well, typically it does. But I -- I mean, I
20 think in this context it probably means future
21 ambulatory surgery for the hospital.

22 Q: Okay. All right. So an outpatient surgery for
23 the hospital then?

24 A: It appears.

25 Q: All right. And so there's nothing about



1 ambulatory surgery in the original, is there?

2 A: Well, I'm sure outpatient surgery was part of
3 the hospital. It's part of every hospital.

4 Q: Right. But it says future ASC/Expansion,
5 right?

6 A: That's what it says.

7 Q: Okay. And if you go on down just a little bit
8 of ways, there's a -- it says Total Building
9 Gross Square Footage. Do you see that? It's
10 not a numbered line item, but do you see where
11 that is?

12 A: Yes.

13 Q: And it looks like it's 138,750 in the original
14 ---

15 A: Yes.

16 Q: --- for the departmental square footage? And
17 that has been reduced to 115,000 and something
18 in the more recent one, right?

19 A: It is reduced. But then I think you see the
20 reconciliation at the bottom where they add
21 back in the functions that have been moved to
22 that MOB structure.

23 Q: Right. So there's an MOB structure that wasn't
24 there originally, right?

25 A: I don't know. I wasn't involved in drafting

