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**SC Court of Appeals**

THE STATE OF SOUTH CAROLINA  
In The Court of Appeals

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APPEAL FROM  
THE ADMINISTRATIVE LAW COURT

Shirley C. Robinson, Administrative Law Judge

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

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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.

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**RECORD ON APPEAL  
VOLUME 7**

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**TMC, ET AL. V. SC DHEC, ET AL.**

2005

1 changes -- let's start with the relocation,  
2 okay, and talk about that a little bit. Let's  
3 bring up MUSC what's been proposed as MUSC  
4 Exhibit 33. I don't think this is in evidence  
5 yet, correct. It is in evidence, okay. Good.  
6 All right. So MUSC Exhibit 33. You've got  
7 some green and blue and then you've got two red  
8 dots. What is that?

9 A: So this is a map showing the sort of proximity  
10 ---

11 Q: Uh-huh.

12 A: --- of the original site and the current site  
13 to the Nexton area.

14 Q: Uh-huh.

15 A: So it was never contemplated that the CD -- I'm  
16 sorry -- that the MUSC ED would be sort of in  
17 the center of Nexton. It was at the very edge  
18 of Nexton originally. Now it's across I-26  
19 less than a mile away so it's still as  
20 accessible to the -- it's not materially  
21 different as far as the access for those people  
22 as well as the rest of the surrounding area to  
23 access the freestanding ED. As a matter of  
24 fact the new site would be I think more  
25 accessible than the previous site.



**TMC, ET AL. V. SC DHEC, ET AL.**

2006

1 Q: Why is that?

2 A: Well because again the previous site was a  
3 little bit into Nexton ---

4 Q: Uh-huh.

5 A: --- so it wasn't off the main street, it wasn't  
6 as close to the interstate exits, wasn't as  
7 close to the I guess southwest side of 26 but  
8 it's still very close.

9 Q: Uh-huh.

10 A: So the residents on the north side or east side  
11 of 26 would still have access to the new  
12 proposed site.

13 Q: All right. And I-26 is that -- I can't see it  
14 from I am. Is that indicated there in that  
15 map?

16 A: It is. It's the I guess southwest border of  
17 Nexton.

18 Q: Uh-huh.

19 A: You can see it sort of -- I-26 kind of  
20 disappears in the section that's Nexton.

21 Q: Uh-huh.

22 A: And you can see just north of us is the new  
23 exit for Nexton. That's the Nexton exit, and  
24 then we're one exit south on 199.

25 Q: Exit 199. Okay. Let's look at slide 6,



**TMC, ET AL. V. SC DHEC, ET AL.**

2007

1           please. All right what does show, and what is  
2           this?

3       A:    This is a satellite phot of the old site and  
4           the new site and you ---

5       Q:    Which one's which, please?

6       A:    The one on the left ---

7       Q:    Uh-huh.

8       A:    --- is the old site. So this orientation is  
9           sort of upside down. I-26 is in the middle  
10          there going south would be up instead of north  
11          ---

12      Q:    Okay.

13      A:    --- which would be down, but just sort ---

14      Q:    You're just trying to confuse us.

15      A:    --- counter to normal mapping. This isn't a  
16          map this is a satellite photo.

17      Q:    Yeah.

18      A:    And so you see it's just across I-26 at the new  
19          site on the right versus the old site on the  
20          left.

21      Q:    Okay. And you've got -- what is that saying  
22          y'all are there on top of that arrow?

23      A:    It's approximately a thousand yards across.

24      Q:    Okay. About as far as Mr. Thomas could hit a  
25          golf ball right?



**TMC, ET AL. V. SC DHEC, ET AL.**

2008

1 A: Well it would be a world's record if he could  
2 hit that far but maybe he can.

3 Q: Okay. I've seen Mr. Thomas play golf.

4 **MR. THOMAS:** With the balance I could get it there.

5 Q: All right. So let's go -- this I believe is  
6 slide 7. Let's talk about -- you mentioned  
7 access a moment ago. Let's look at slide 8,  
8 please? All right. What is slide 8 showing?  
9 What are those red lines indicate?

10 A: So that's the -- those are the -- I believe the  
11 property lines and this is the proposed site,  
12 the current proposed site that everyone likes  
13 to call the Applebee's.

14 Q: Yeah.

15 A: The Applebee's.

16 Q: All right.

17 **MR. WESTBROOK:** And so the -- is that -- can you --  
18 is there a way to indicate, Dan, where the  
19 driveway is?

20 Q: All right. And what road is that or what  
21 street is that?

22 A: Yeah. So this is north Main Street ---

23 Q: Main?

24 A: --- just below that just sort of cut off on the  
25 picture there so driving on north Main Street



**TMC, ET AL. V. SC DHEC, ET AL.**

2009

1           you can turn directly into the parking lot for  
2           the freestanding ED that MUSC's going to build  
3           on this site.

4       Q:   Any reason you'd have to drive through the  
5           shopping center parking lot to get to that  
6           site?

7       A:   No.

8       Q:   The ---

9       A:   So there's access right off here. And if you  
10          go back to the last map, the satellite map ---

11      Q:   Yep. All right.

12      A:   --- you can see -- so this is -- that yellow  
13          dot on the right is right on Main Street. 17A.  
14          And you can turn directly off into the parking  
15          lot. So to get to the old site ---

16      Q:   Uh-huh.

17      A:   --- again you'd have to turn off 17A, go  
18          through a residential area. You can see it  
19          right there. Stop there. Those are  
20          apartments. Go past those down to the proposed  
21          site in the Greenfield Development. It hasn't  
22          been developed yet. It's just a field right  
23          now. So from an access standpoint getting off  
24          17A or getting off 26 ---

25      Q:   Uh-huh.





**TMC, ET AL. V. SC DHEC, ET AL.**

2010

1 A: --- and getting to the site, the new site is  
2 much more accessible than the old site.

3 Q: Let's look at slide 9, please. This appears to  
4 be a diagram. Why don't you tell us what it  
5 is?

6 A: Okay. I don't think this is the scale but this  
7 is the Freestanding ED placed where the former  
8 Applebee's is now.

9 Q: If it's not to scale what's the purpose of it?

10 A: Just to show the -- sort of take away that  
11 satellite photo and, you know, it's hard to see  
12 things. But this shows the direct access from  
13 17A or Main Street into the FED parking lot.

14 Q: Yeah.

15 A: And again not to scale. What's not shown here  
16 is that the 17A ---

17 Q: Uh-huh.

18 A: --- is -- it shows here there's three lanes.  
19 I think it's four or five lanes right there.

20 Q: Okay.

21 A: So it's very wide in each direction.

22 Q: Uh-huh.

23 A: So it -- there's a lot of easy access into the  
24 proposed site.

25 Q: All right. In terms of -- let's look at slide



**TMC, ET AL. V. SC DHEC, ET AL.**

2011

1           -- I think we skipped maybe, or I skipped,  
2           slide 7. Let's go to slide 7. So we're  
3           talking about -- this is a slide you've  
4           created, right?

5       A:    Yes.

6       Q:    Old location versus new location. And we've  
7           talked about access. Anything more you want to  
8           say about access at this point?

9       A:    No, I think that sort of summarizes what -- we  
10          talked about the better -- the increased  
11          access, the easier access of the new site  
12          versus the old site.

13      Q:    Uh-huh.

14      A:    The public visibility right on I-20 -- right  
15          off I-26, right on 17A ---

16      Q:    Uh-huh.

17      A:    --- versus back into the yet to be developed  
18          area ---

19      Q:    Uh-huh.

20      A:    --- of the old site. You know, it's obviously  
21          equal proximity between the two sites to the  
22          population. It's only a -- I think two minute  
23          drive between the two sites so ---

24      Q:    All right.

25      A:    --- if it were on the other side of I- -- if



**TMC, ET AL. V. SC DHEC, ET AL.**

2012

1           someone were on the other side of I-26 it would  
2           take them two minutes longer to get to our  
3           site, if they were the other -- south side, or  
4           west side of 26 it would be two minutes faster.

5       Q:     Uh-huh.

6       A:     And both sides are ideal for a freestanding ED.

7       Q:     Both sites are ideal? All right. Mr. Levitt,  
8           is -- can there only for you as a health  
9           planner be only one ideal?

10      A:     No. No.

11      Q:     Okay. Why not?

12      A:     Well ideal as I put it in the CON application  
13           as I generally refer to it means it's a good  
14           site.

15      Q:     Uh-huh.

16      A:     If both are good ---

17      Q:     Uh-huh.

18      A:     --- then both would be ideal.

19      Q:     Let's look at slide 10 for a minute, please.  
20           This is something that's been shown a few times.  
21           This is from what the application?

22      A:     This is from the project review meeting. I  
23           think this is also in the application.

24      Q:     All right.

25      **MR. WESTBROOK:**     And that sentence down at the



**TMC, ET AL. V. SC DHEC, ET AL.**

2013

1 bottom, let's highlight that, call that out,  
2 Dan?

3 Q: It says with this in mind the Nexton  
4 development is an ideal location for the  
5 proposed project. Now that's been called to  
6 our attention a couple of times during this  
7 hearing. So my question is, Mr. Levitt, did  
8 you author this?

9 A: Yes.

10 Q: If instead of the Nexton Development a  
11 substitution was something like, yeah,  
12 Summerville Main Street site, is that in your  
13 opinion and accurate statement?

14 A: Yes.

15 Q: All right. All right. Let's go to slide 11,  
16 please. It says ancillary effects of  
17 relocation and there are a number of points  
18 that I'm going to ask you about each one of  
19 those, but what do you mean by ancillary  
20 effects of relocation?

21 A: So because we're choosing a different site some  
22 things have to change. So we're not going to  
23 have a lease with Equity Partners because  
24 Equity Partners doesn't own the new site. So  
25 some things would change. One of the -- the



**TMC, ET AL. V. SC DHEC, ET AL.**

2014

1 first thing that would change would be a lease.  
2 So as I said we're not going to have a lease  
3 with Equity Partners at the old site, we'll  
4 have a lease with Luko who owns the new site to  
5 lease that land.

6 Q: The fact that the lease was a ten year lease  
7 and now it's a five year lease, what concerns  
8 do you have about that?

9 A: Well I don't have any concerns and actually the  
10 new lease is better, the old lease was ten  
11 years with I think two options to -- or no with  
12 two three options to renew or something. I  
13 don't remember the renewal lease of the old one  
14 but the terms of the new lease are longer. So  
15 we have a five year lease with three renewal  
16 periods and an option for up to eight renewal  
17 periods so that's like a 50 year lease on the  
18 land.

19 Q: All right. So does that -- well let's just  
20 take them all and then I'll ask you a summary  
21 question. What about the terms and scope of  
22 the lease that have changed?

23 A: Yeah, I think I may have slipped into that one  
24 on that last answer. So again it's -- the  
25 renewals are better on the land lease ---



**TMC, ET AL. V. SC DHEC, ET AL.**

2015

1 Q: Uh-huh.

2 A: --- than they were on the initial lease. So we  
3 have access to that site for at least 40 years  
4 if the lease is executed.

5 Q: Okay. The acreage of the land is different.  
6 Remind us has it gotten more acres or less  
7 acres?

8 A: Yeah, so the new site is slightly smaller. The  
9 initial site I think was -- it was a 20 acre  
10 tract where we were going to use three acres.  
11 Again it was Greenfield Development. Hadn't  
12 been developed yet. So of those three acres it  
13 wasn't determined at that point what was  
14 useable, what would need to be required for  
15 buffer or wetlands, etcetera. The new site is  
16 developed, has a building on it and is a little  
17 less than two acres and that's -- we know  
18 exactly what the space that can be used on that  
19 site is and it's adequate for the freestanding  
20 ED that's proposed.

21 Q: All right. Next on the list is zoning. Let me  
22 first ask you this, as a health planner in your  
23 experience how often with CON applications do  
24 you deal with zoning issues?

25 A: Well every single one of them because it's a



**TMC, ET AL. V. SC DHEC, ET AL.**

2016

1 requirement in the CON application.

2 Q: All right. Is that true in South Carolina --  
3 just in South Carolina or do other states have  
4 zoning requirements?

5 A: Other states have zoning requirements as well.

6 Q: All right. That apply to CON?

7 A: Yes.

8 Q: Okay. So the zoning in the original site was  
9 related to the Nexton planned unit development,  
10 right?

11 A: Yes.

12 Q: And what's the zoning for the new site?

13 A: The zoning for the current site is Berkeley  
14 County -- I think it may be Summerville -- B3,  
15 general business 3.

16 Q: Why don't we look at slide 12 and tell us what  
17 this is?

18 A: Yeah, so that shows it's Summerville zoning B3.

19 Q: All right. And what does that mean?

20 A: That means that based on the Summerville Zoning  
21 Ordinance B3 services whatever B3 services are  
22 allowed ---

23 Q: Uh-huh.

24 A: --- can be developed on that site.

25 Q: And what B3 services are allowed?



**TMC, ET AL. V. SC DHEC, ET AL.**

2017

1     A:     Hospitals.

2     Q:     All right.

3     A:     Hospitals fall under B3.

4     Q:     And this is a freestanding ED though isn't it?

5     A:     It's a freestanding ED but it's going to a

6            licensed department of the hospital.

7     Q:     Okay. So it's part of the hospital?

8     A:     It will be part of the hospital.

9     Q:     What's -- do we need to look at this on the

10           left? The green? What is that?

11    A:     The green on the left is what I pulled from the

12           Berkeley County Tax Assessment Office ---

13    Q:     Uh-huh.

14    A:     --- and it shows who owns the property. Again

15           this is the 1310 North Main Street which is the

16           proposed site, and you can see on the top left,

17           yeah, 1310 Main Street, and then top left, Luko

18           Realty.

19    Q:     Luko Realty up there, that's ---

20    A:     That who owns the property.

21    Q:     Okay. And ---

22    A:     And then to the -- above there the zoning

23           summary is the B3.

24    Q:     All right. Anything else on this page that you

25           want to call our attention to?





**TMC, ET AL. V. SC DHEC, ET AL.**

2018

1 A: No.

2 Q: All right. Should we go then to the next slide  
3 which I believe is 13?

4 A: Sure.

5 Q: All right. What is that?

6 A: So this is the Summerville zoning allowances.

7 Q: Uh-huh.

8 A: And you can see this is under B3 and medical  
9 urgent care is allowed. P meaning permitted  
10 under general business B3. Health care  
11 facilities, hospital in-patient facilities also  
12 permitted, and you can see the legend at the  
13 bottom. P meaning permitted use.

14 Q: P meaning permitted use. Okay. Let's go back  
15 now to slide 7. Take just a minute to get  
16 there. All right. You've talked about access.  
17 No, I'm sorry. I'm incorrect. Slide 11. All  
18 right. You've talked about the lease, the  
19 acreage, the zoning. What about financing?  
20 What -- how is that an ancillary effect of the  
21 relocation?

22 A: Well initially on the first site Andy Johanni  
23 and his team at Equity ---

24 Q: Uh-huh.

25 A: --- were going to build the building, and in an



**TMC, ET AL. V. SC DHEC, ET AL.**

2019

1 abundance of caution we submitted a letter from  
2 him saying that he has access to the funds.

3 Q: Uh-huh.

4 A: Normally if it's a third party developer  
5 building a building we don't have that because  
6 sometimes they don't want to provide that  
7 information. The same with ownership. A lot of  
8 times if a third party owns a building that a  
9 hospital wants to lease they won't disclose the  
10 owners, and DHEC has been okay with that  
11 because individuals don't want to be identified  
12 as an owner of a building.

13 Q: Why not?

14 A: For whatever reason. I guess they don't want  
15 their assets to be public. You know, so for  
16 instance they've formed an LLC for a reason.  
17 Perhaps sheltering liabilities or whatever.  
18 And we've had -- on some projects I've had some  
19 difficulty getting the ownership information,  
20 the specific ownership information, the  
21 individuals that own the LLC. But DHEC's  
22 perspective is it doesn't matter who owns the  
23 building as long as we have site entitled. We  
24 have ability to use that building. So  
25 financing for the initial project included some



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2020

1 finance -- a financing letter from Andy  
2 Johanni's group saying we have enough money to  
3 build the building. He's not building our  
4 building anymore so I heard ---

5 Q: Who is?

6 A: --- Dr. Cawley say ---

7 Q: Uh-huh.

8 A: --- that if we have to MUSC will pay for the  
9 building and building it or we could go with  
10 another third party developer to build the  
11 building.

12 Q: All right. Now we're going to talk about this  
13 issue of financing a little more later on in  
14 your testimony. I'm going to ask you about it  
15 when we get to the financial piece of the local  
16 criterion. But at this point anything else you  
17 want to say about financing with respect to it  
18 being an ancillary effect of the relocation?

19 A: No, it just changes -- so for CON purposes the  
20 13 million dollar project cost which was  
21 reduced to 11 million has always been included  
22 in the CON application as project costs. MUSC  
23 wasn't going to incur -- the applicant, MUHA,  
24 wasn't initially going to incur all of those  
25 costs because a developer was going to incur



**TMC, ET AL. V. SC DHEC, ET AL.**

2021

1           those. We included those in the application  
2           though regardless of who was spending the money  
3           and so now it's that same dollar amount, it's  
4           just a different source of funds for the money.

5       Q: All right. Your last entry there on this chart  
6           is shopping center versus medical campus. And  
7           why do you have medical campus in quotes?

8       A: Because that was -- at the time we submitted  
9           the application it was planned to be on a  
10          medical campus. There were going to be medical  
11          services on that campus. Lots of -- a number  
12          of projects were being developed to make it a  
13          medical campus and those -- many of those if  
14          not all of those projects have sort of been  
15          abandoned or are no longer moving forward. So  
16          the status of the medical campus at the old  
17          site is just a medical office building for  
18          Palmetto Primary Care.

19       Q: All right. And has that been opened -- built  
20          and opened yet?

21       A: It's not open yet, no. It's still being built.  
22          I understand that opening is imminent.

23       Q: Uh-huh.

24       A: But it's not open yet. So as we sit here today  
25          there's nothing being provided on that medical



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2022

1 campus. It's certainly not a medical campus  
2 and when, you know, I think at the end of the  
3 year, early 2020, the Palmetto Primary Care  
4 building will open and it'll have -- I think  
5 it'll have an MRI and that's it. You know, it  
6 might have some imaging services but there's  
7 not gonna be an ambulatory surgery center  
8 there. As we sit here today there's no  
9 radiation therapy on that campus. There's --  
10 the initial location for the community hospital  
11 was planned to be in that general area, the  
12 MUSC community hospital. It's since -- as Dr.  
13 Cawley said -- been moved further north up into  
14 the Nexton community so there is no medical  
15 campus there.

16 Q: Let's look at -- well I'm sorry -- is there  
17 anything else about this slide that you want to  
18 comment on at this point?

19 A: No, I think that covers it.

20 Q: All right. Let's go to slide -- go back, I  
21 believe, to slide 5. All right. So let's talk  
22 about the size and cost reductions for a moment  
23 or two. Let me ask you this, the reduction in  
24 size and the reduction in costs what is the  
25 significance of that to you as a health



1 planner?

2 A: That it fosters cost containment so I don't  
3 view that as an issue as far as substantial  
4 change, spending less is always good. Building  
5 less is okay. It's not unusual to go from a --  
6 what I would say -- conceptual phase. So those  
7 drawings that were submitted in the CON  
8 application -- I wouldn't even call them  
9 drawings but the -- the building information --  
10 -

11 Q: Floor plans?

12 A: --- the -- yeah, floor plans submitted in the  
13 CON application -- and even the ones that we've  
14 been seeing in the trial -- those are all  
15 conceptual, those aren't real schematic  
16 drawings. Those aren't designed by an  
17 architect. An engineer hasn't looked at those  
18 and that's what happens during the design phase  
19 as happened at Roper Berkeley Hospital. They  
20 had these conceptual drawings that they  
21 submitted in the CON application, they did the  
22 design phase, their architects sized the  
23 building more appropriately and the square  
24 footages went down. So that's not unusual.  
25 And so I think that to the extent that they



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2024

1 don't materially -- none of these changes  
2 materially impact the compliance with the  
3 review criterion and I think it's fine to make  
4 them.

5 Q: All right. Now in the original application  
6 that you submitted how many -- in the Berkeley  
7 County FED, MUSC's Berkeley County FED, how  
8 many treatment rooms -- emergency treatment  
9 exam rooms were there?

10 A: There were 12.

11 Q: 12. How many are there in the current plan?

12 A: Still 12.

13 Q: All right. And those 12 consist of two  
14 different categories, right?

15 A: Well they're labeled differently. There are  
16 seven treatment rooms ---

17 Q: Uh-huh.

18 A: --- actually I think there was like five  
19 treatment rooms. Two -- there's three  
20 different labels there.

21 Q: Why don't we look at the -- just so you won't  
22 have to try to remember -- let's look at MUSC  
23 Exhibit 29? Is this in evidence? We've seen  
24 this before. I believe it is in evidence. I  
25 think it came in with Dr. Cawley I believe.



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2025

1           And so -- just so -- yeah, and whatever you do,  
2           do not put your finger on this -- on that  
3           screen, okay? I'm going to let ---

4       A:     That's like saying wet paint. I gotta do it  
5           now.

6       Q:     We'll let Mr. Buff do this and you correct if  
7           he does anything wrong. Count up the -- on the  
8           -- to my left -- the treatment rooms and exam  
9           rooms on the -- listed there.

10      A:     Yeah, yeah, so this is what I was saying.  
11           There's three labels ---

12      Q:     Okay.

13      A:     --- so there's exam rooms ---

14      Q:     Uh-huh.

15      A:     --- and there you see them, those four, and  
16           then the isolation exam room ---

17      Q:     All right.

18      A:     --- and so exam is the isolation exam room, ---

19      Q:     All right.

20      A:     --- and then at the bottom there you've got the  
21           two treatment rooms.

22      Q:     Right.

23      A:     So those -- all those seven are the treatment  
24           exam rooms.

25      Q:     Now let me ask you this, they're labeled





**TMC, ET AL. V. SC DHEC, ET AL.**

2026

1           differently as you said.     Exam, Iso Exam,  
2           Treatment. Is it fair or not to call all of  
3           these emergency treatment rooms?

4     A:    Yes, it's fair to call them all emergency  
5           treatment rooms.

6     Q:    They're going to be providing -- they would --  
7           emergency services would be provided there?

8     A:    Yes, emergency service are gonna be provided in  
9           this whole facility.

10    Q:    Okay. Let's go to the other side and show me  
11           what you're talking about.

12    A:    Yeah, so those five are identified here as fast  
13           track -- and I think in the original drawing it  
14           was urgent care -- those are also treatment  
15           rooms.

16    Q:    All right. Now we've heard a lot -- I don't  
17           want to, you know, duplicate a whole lot of  
18           what's been said, but we've heard various  
19           witnesses testify. What's your understanding  
20           of a fast track room?

21    A:    It's also a treatment room for emergency  
22           service patients that are the lower acuity  
23           patients.

24    Q:    All right. Okay. Let's go -- well let me ask  
25           you this, we're not quite through with this



1           topic.

2       **MR. WESTBROOK:**   You can take that off the screen  
3           though, Dan.

4       **Q:**   We talked about reduced size.   Let me ask you  
5           about the cost.   In your experience how do  
6           states consider cost reductions in CON  
7           projects?

8       **A:**   Again it's consistent with cost containment.  
9           Spending less than you were approved is always  
10          a good thing.   I often caution my clients --  
11          and I think in this case there was included a  
12          contingency -- make sure we put a contingency  
13          in there because it gets to be a problem if we  
14          go over but it's not a problem if we come in  
15          under.

16      **Q:**   All right.       Did these costs and space  
17          reductions that you've been talking about, do  
18          they have any kind of effect in your opinion on  
19          whether this project will be able to accomplish  
20          what it set out to accomplish?

21      **A:**   No,   it's consistent with the original  
22          envisioned freestanding ED.   It's going to be  
23          a freestanding ED in Berkeley County to serve  
24          MUSC patients that have to continue to travel  
25          to the peninsula in the absence of this



1 project. It's gonna be a slightly smaller  
2 facility and hopefully a less expensive  
3 facility than initially contemplated.

4 Q: All right. Let's move on to another change.  
5 What's your understanding of why the CDU and  
6 the helipad were eliminated from this project?

7 A: Again consistent with what we had just talked  
8 about, the cost containment, it would reduce  
9 the cost of the facility and they had  
10 identified alternative ways to provide those  
11 same services. So for the helipad they  
12 identified the ability to use parking to land  
13 a helicopter if needed, parking area or an  
14 alternative landing zone for a helipad, and the  
15 CDU they decided they could treat those  
16 patients within an existing -- within the 12  
17 beds.

18 Q: All right. Now at the project review and in  
19 the application the CDU and the helipad were  
20 referenced, is that right?

21 A: Yes.

22 Q: All right. And let's look at -- let's go to  
23 the application. Let's look at Joint Exhibit  
24 1, page 8, please. What's that heading? MUSC  
25 Emergency Services and Differentiating Factors,



1 do you see that?

2 A: I do.

3 Q: All right. Differentiating factors. I want  
4 you to focus on that phrase for a minute. And  
5 this is Bates page 8. Why don't you review  
6 that quickly -- the language there -- just to  
7 yourself, Mr. Levitt, and when you're ready  
8 we'll go over to page 9.

9 A: Okay.

10 Q: All right.

11 **MR. WESTBROOK:** Let's go to page 9, Dan.

12 Q: And there are a number of bullet points there,  
13 some paragraphs. Did you -- is it -- this is  
14 -- I assume if you're the author of this --  
15 author of this application -- you drafted this,  
16 is that correct?

17 A: Yes.

18 Q: All right. And these differentiating factors  
19 that you list here, do you mention CDU or  
20 helipad?

21 A: No.

22 Q: What kind of things do you talk about? Don't  
23 give me exhaustive list, but just what are some  
24 examples of some of the things that you've  
25 listed here as differentiating factors between



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2030

1           this application and whoever?

2       A:     Yeah, I would generally say that sort of the  
3           specialized services and skills and abilities  
4           that MUSC possesses are identified here.

5       Q:     All right.   And those bullet points contain  
6           some of those -- why don't you just read two or  
7           three of those bullet points?

8       A:     State    of    the    art    equipment,    advanced  
9           specialists -- highly advanced specialists in  
10          every field of medicine -- and the last one,  
11          MUSC is able to provide specialists in  
12          virtually any field to the patient's bedside 24  
13          hours a days, 7 days a week, every day of the  
14          year.

15      Q:     All right.   So do you consider -- do you  
16          believe that the CDU and helipad were  
17          differentiating factors from say the  
18          Summerville FED or -- who are you -- first of  
19          all when you list it -- and let me strike that  
20          question and get back to it in just a second.  
21          But when you have the heading Differentiating  
22          Factors, differentiating from who or from what?

23      A:     In this case from all other providers in the  
24          state.

25      Q:     All right.   From all other providers in the



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2031

1 state. Do you believe that the CDU and helipad  
2 were differentiating factors?

3 A: Yes.

4 Q: All right. Why didn't you list them under this  
5 heading?

6 A: I don't think that they were the sort of  
7 important differentiating factors. They were  
8 differentiating factors in that it made the  
9 project different than other freestanding EDs -  
10 --

11 Q: Uh-huh.

12 A: --- in the state. So from that perspective  
13 they were differentiating.

14 Q: Okay. The important differentiating factors in  
15 your view as the author of this were listed  
16 where?

17 A: Under the column -- or the heading of  
18 Differentiating Factors.

19 Q: What we've just been looking at?

20 A: Yes.

21 Q: Okay. All right. Let's go to the Decision  
22 Letter, Joint Exhibit 1551. You're familiar  
23 with this letter aren't you?

24 A: Yes.

25 Q: All right. This is the letter from DHEC



**TMC, ET AL. V. SC DHEC, ET AL.**

2032

1 approving the application right?

2 A: Yes.

3 Q: I'm not going to ask you to look at this unless  
4 you need to. And this decision that DHEC  
5 issued granting -- approving the application --  
6 is CDU or helipad mentioned anywhere?

7 A: No.

8 Q: Thank you. Now we've been talking about  
9 changes to the project. As a health planner  
10 working in South Carolina and other states how  
11 do you go about determining whether -- or what  
12 would support your opinion one way or the other  
13 whether a change is substantial or not?

14 A: You know, generally it would be if the change  
15 would alter the way at which the project  
16 complies with the project review criterion.

17 Q: All right. Now based on that -- or anything  
18 else that you want to factor in -- my question  
19 is this, is it your opinion that any of these  
20 changes to this project, individually or  
21 collectively, constitute a substantial project  
22 change?

23 A: No, not at all. Again the intent was to  
24 provide freestanding emergency services in  
25 Berkeley County for MUSC. The project still



1 does that. It's still in Berkeley County less  
2 than a mile away from the original site. The  
3 same number of treatment beds. The same  
4 services will be offered to it's not -- it  
5 doesn't change the compliance with any of the  
6 review criterion. They aren't material changes  
7 and they're not substantial changes to the  
8 project.

9 Q: All right. I want to next ask you a few  
10 questions about some parts or elements of the  
11 project that are unchanged, all right? And  
12 let's do that by starting with slide 15. Mr.  
13 Levitt, you entitled this slide Opposition Red  
14 Herring - Elements Consistent with the  
15 Application and let's take these one at a time.  
16 Why is -- first of all what is pro forma, what  
17 are you talking about?

18 A: So the pro forma would be the income statement  
19 that we submitted in the CON application to  
20 demonstrate financial feasibility.

21 Q: All right. Has that pro forma statement or pro  
22 form budget changed?

23 A: No, it would remain the same. We could update  
24 it. You know, our projections are our  
25 projections. We don't think that moving it





1           less than a mile away that it would change the  
2           volume projections. So the projections would  
3           stay the same. The revenue would stay the  
4           same. The contractals would stay the same.  
5           Everything on the pro form would stay the same  
6           with the exception of the capital costs. So  
7           what we had in there for rent would go away and  
8           that would be replaced with depreciation, but  
9           they're both based off the same project costs.  
10          And frankly the new project is cheaper so it  
11          would be a little bit less so it would make it  
12          more profitable.

13        Q:    And when we get -- again when we go through the  
14               criterion later on, and particularly financial  
15               feasibility criterion, and I'm going to ask you  
16               to discuss the pro forma in more detail -- but  
17               my -- I think unless you have something else  
18               you want to say at this point let's move on to  
19               the second issue there. The second thing  
20               you've listed is staffing. All right. Has the  
21               staffing proposal in the MUSC application, is  
22               that still valid? Is that still the staffing  
23               proposal that you are working off of?

24        A:    Yes, just moving it -- again less than a mile  
25               away -- wouldn't change the staffing.



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1 Q: Okay. And the -- there was something raised in  
2 -- by -- with one of the witnesses earlier this  
3 week in reference to the staffing -- to the  
4 MUSC staffing in comparison with the  
5 Summerville freestanding ED staffing, do you  
6 recall that?

7 A: I do.

8 Q: Tell me what you remember and what your  
9 thoughts are on that?

10 A: So I think the question was raised about our  
11 staffing say that we had too much staff and it  
12 was because it had substantially more FTDs than  
13 the Summerville freestanding ED.

14 Q: Uh-huh.

15 A: And I guess my perspective is the opposite, is  
16 that we didn't have too many, they didn't have  
17 enough. So if you're comparing the two ours  
18 looks more than theirs because it is more than  
19 theirs because they don't have enough in their  
20 theirs. So that's the perspective on that.

21 Q: All right. And again we can get into a little  
22 more detail about that when we talk about  
23 financial feasibility, okay? All right.  
24 Urgent care. Is there anything inconsistent  
25 between our current urgent care plans and what



1           were announced in the application?

2       A:     No.

3       Q:     What about joint venture? In the application  
4           it said nothing about a joint venture. What's  
5           your understanding of the prospects for a joint  
6           venture in this project?

7       A:     Still no joint venture has been entered into.

8       Q:     All right. Are you aware of any plans -- did  
9           you hear Dr. Cawley or anybody else talk about  
10          any negotiations or plans to do a joint venture  
11          in the future?

12      A:     No.

13      Q:     Okay. Is -- have you seen anything indicating  
14          there's going to be a management company  
15          retained for this project?

16      A:     No. So initially in the application we said  
17          there's no management company, still no  
18          management company.

19      Q:     Now you heard Dr. Cawley's testimony the last  
20          couple of days right?

21      A:     Yes.

22      Q:     And what did he say about a management company?

23      A:     He said it might be something they looked at  
24          but they don't have a management company as we  
25          sit here today so there is no management



1 company.

2 Q: Intuitive Health. What's the role of Intuitive  
3 Health or what's your understanding of the role  
4 of Intuitive in this project?

5 A: They're no longer involved in the project.

6 Q: All right. So, Mr. Levitt, as the author of  
7 the project some of the -- you talked about  
8 gathering information or getting various people  
9 from MUSC and other places to gather  
10 information to you when you were putting  
11 together this application. One of those things  
12 that somebody I assume gathered for you -- you  
13 tell me if this is incorrect -- were support  
14 letters, right?

15 A: Yes.

16 Q: And there were a number of support letters  
17 presented with the project, correct? With this  
18 application?

19 A: There were.

20 Q: All right. The project has relocated, and you  
21 don't have to get more support letters?

22 A: No.

23 Q: Why not?

24 A: It wouldn't be necessary. So again it's  
25 relocating less than a mile away. It's still



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1           in Summerville, still off exit 199. Those  
2           individuals that supported the project to my  
3           knowledge still support the project. Some  
4           physicians that had signed letters I've spoken  
5           to so I know they support the project still.  
6           So at this point there will be no need to get  
7           additional letters of support.

8       Q:   We've talked about it -- you just mentioned  
9           that it's still in Summerville. So it was in  
10          Nexton and now it's in Summerville, isn't that  
11          correct?

12      A:   Well Nexton is in Summerville.

13      Q:   Oh.    Okay.    All right.    Has the zip code  
14          changed?

15      A:   Nope, same zip code.

16      Q:   All right. If this project -- and your opinion  
17          I think you've already stated is that there's  
18          been no substantial change, correct?

19      A:   Yes.

20      Q:   If there had been a substantial change would  
21          new support letters be needed?

22      A:   No.

23      Q:   Okay. And since there has been no substantial  
24          change in your opinion are new support letters  
25          needed.



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1 A: No, and like I said, I don't think either  
2 scenario you would need new support letters two  
3 years later on a project that was originally  
4 approved.

5 Q: All right.

6 **THE COURT:** Mr. Westbrook, ---

7 **MR. WESTBROOK:** Yes, Your Honor?

8 **THE COURT:** --- we're going to take a 15 minute  
9 break.

10 **MR. WESTBROOK:** Thank you, Your Honor.

11 **(Off the Record)**

12 **THE COURT:** Okay, Mr. Westbrook.

13 **MR. WESTBROOK:** Thank you, Your Honor.

14 Q: All right. Mr. Levitt, let's move on to  
15 another slide, please. Let's look at -- I  
16 believe this is slide 3. We've seen this  
17 before. You've given us an overview of this  
18 slide, the one that says Reasons for the  
19 Project, but I'd like to ask you to get a  
20 little more detail in your opinions about this.  
21 So let's start with the first one listed,  
22 Improved Access for MUSC Patients from North  
23 Area. And, Mr. Levitt, you've heard I believe  
24 -- or you're familiar -- how far is the  
25 proposed FED, the Berkeley County FED, the



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1           Summerville FED, from MUSC's hospital downtown?

2       A:     It's a little over 20 miles.

3       Q:     Okay.   It's over 20 miles.   And you've heard  
4           some criticisms of that?

5       A:     Yes.

6       Q:     All right.   In your opinion is that a problem?  
7           Is that too far?   Because it is going to be a  
8           Department at the hospital right?

9       A:     It is a department of the hospital and being a  
10           little over 20 miles is not a problem.

11      Q:     All right.   Let's look at slide 16 that you  
12           prepared I believe.   So we have drive times  
13           from FEDs to parent hospital EDs.   The first  
14           one says -- the first line says -- the  
15           organization try to start Moncks Corner FED in  
16           Trident Medical Center.   Tell us about that  
17           line item.   What are you doing there?

18      A:     So this is to show the distances and the time  
19           from the freestanding EDs to their host  
20           hospital.   So remember the freestanding ED is  
21           a department of a hospital.

22      Q:     Right.

23      A:     The Moncks Corner and the James Island FEDs --  
24           the Moncks Corner is a department of Trident,  
25           James Island proposed is to be a department of



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1 Trident. And so the organization is Trident.  
2 The starting point is the freestanding ED. The  
3 first line in that case is Moncks Corner FED  
4 and the ending is Trident Medical Center or the  
5 host hospital. And you can see it's 19 miles  
6 or 28 minutes.

7 Q: All right. Where did you get the miles and the  
8 minutes?

9 A: From Google Maps and that's the average drive  
10 time, 28 minutes.

11 Q: Okay. So that was from Trident to its Moncks  
12 Corner freestanding ED. The next one is from  
13 Trident to where?

14 A: It's from the James Island FED to Trident  
15 Medical Center. It's almost 22 miles, 21.7  
16 miles and 30 minute drive time.

17 Q: Now remind us what the status of Trident's  
18 James Island FED is?

19 A: It was approved by the Department and Roper  
20 opposed it so ...

21 Q: So it's in the ALC now?

22 A: It is.

23 Q: All right. And the next one is our project  
24 right? MUSC's project rather. What is that?

25 A: It is. It shows from our proposed location at





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1 Exit 199 to the main hospital is 23 and a half  
2 miles and 32 minutes.

3 Q: Okay. And the last one is what?

4 A: That's the existing Roper Moncks Corner FED to  
5 the Roper Hospital for which it's a department  
6 of and it's 33 and a half miles, -- sorry, 33.6  
7 miles and 50 minutes.

8 Q: All right. And in your opinion are any of  
9 these drive times or mileages between the host  
10 hospital and the freestanding ED problematical?

11 A: No. You know, 50 minutes is a long way, but  
12 the Medicare CMS requirements are 35 miles. So  
13 the provider base designation requirements by  
14 the federal government say the locations can't  
15 be more 35 miles apart to be considered a  
16 provider based entity. So Roper falls within  
17 that 35 miles. MUSC's well within at 23 miles.  
18 And these are driving miles so the CMS's actual  
19 distance -- so it would be further at sort of  
20 air miles or as the crow flies.

21 Q: Uh-huh.

22 A: So we're well within that as are these.

23 Q: All right. Now let me ask you about your  
24 analysis that put forward to DHEC in your  
25 application and the follow-up -- the project



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1 review and follow-up to DHEC. How did you --  
2 first of all, how did you come up with your  
3 service area for this project?

4 A: So we started with looking at MUSC's ED volumes  
5 where the patients that are being treated at  
6 MUSC are currently residing from the zip code  
7 from which they live.

8 Q: All right. The zip code from which they live.  
9 And then when you did that what did you find?

10 A: We identified areas of the -- significant  
11 distance to the MUSC peninsula from where they  
12 live and looked at the drive times from those  
13 areas. So where would it be -- from a zip  
14 code, from the geographic center of that zip  
15 code to the freestanding ED, how long would  
16 that take versus from the geographic center of  
17 that zip code to the MUSC peninsula hospital.  
18 And those areas that would have improved  
19 accessibility, in other words, shorter travel  
20 time to go to the proposed freestanding ED  
21 versus going to the hospital. We assumed those  
22 patients would choose the shorter travel time  
23 and go to the MUSC facility at Exit 199.

24 Q: All right. And in fact the word redirection is  
25 a common word used in health planning, correct?



1 A: It is.

2 Q: And what -- and it's been used in this hearing.  
3 I've heard it by various people. What is -- in  
4 the context of what you're talking about, what  
5 does redirection mean?

6 A: That those patients would redirect. That they  
7 would rather than travel to the peninsula they  
8 would redirect where they sought care to the  
9 new location at the freestanding ED. And I  
10 assume a range of redirection. I assume that  
11 the further away they were or the greater the  
12 savings -- time savings -- going to the new  
13 location versus the old location, a greater  
14 percentage of those would choose to do that.  
15 Some would still consider -- continue to go to  
16 the peninsula for certain reasons. Personal  
17 preference, acuity, you know, whatever the  
18 number -- whatever the reason. Not everybody  
19 that lives in a zip code would then say well  
20 you have to go to this freestanding ED, you  
21 can't go to the peninsula. So we assumed a  
22 percentage, and as I said, as the savings  
23 diminished -- the time savings diminished -- if  
24 it wasn't as big of a savings to go to the  
25 peninsula versus the freestanding ED I assumed



1           less would go -- less percentage would go to  
2           the new location and more of a percentage would  
3           continue down to the peninsula.

4       Q:    Let's look at an Exhibit that might help you  
5           explain the details of what you were just  
6           talking about. This is MUSC's proposed Exhibit  
7           40. All right. This is -- so proposed Exhibit  
8           40, did you create this?

9           **(Respondent MUSC's Exhibit Number 40 was introduced**  
10          **into the record at this time.)**

11       A:    Yes.

12       Q:    All right.     So the heading says proposed  
13           freestanding ED service area is based on shift  
14           of existing MUSC patients resulting in more  
15           convenient access to services they already seek  
16           at MUSC.     Now why don't you slowly -- I'm  
17           afraid there's a lot of numbers on here, a lot  
18           of columns.    So that's why -- I'm not trying to  
19           slow us down getting to lunch, but I do want to  
20           make sure that this is presented clearly.   Why  
21           don't you slowly walk us through this a column  
22           at a time?

23       A:    Okay.     So the first column is the zip code  
24           obviously.     The second code is the county  
25           associated with that zip code.   If we're going



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1           really slow I guess this would be the point  
2           that I would describe, some zip codes cross  
3           county lines ---

4       Q:    Uh-huh.

5       A:    --- so some zip codes are assigned depending on  
6           the source to one county versus the other.  
7           This is the sort of designation that I  
8           identified as county. It might be better to  
9           skip to the FED, meaning how many miles is it  
10          and minutes.

11      Q:    Uh-huh.

12      A:    At 5:00 p.m. on August 2nd, you can see in the  
13           bottom the note, how long does it take to go  
14           from the geographic center of that zip code to  
15           the proposed FED.

16      Q:    Uh-huh.

17      A:    And for that first one 29410 is was 13 miles  
18           and 22 to 45 minutes would be the average  
19           travel time. So Google Maps gives -- complies  
20           data ---

21      Q:    Uh-huh.

22      A:    --- that says here's on average with traffic  
23           and without traffic. This is the average  
24           travel time from that area to the designated  
25           address.



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1 Q: Okay.

2 A: The next set of columns are to MUSC downtown,  
3 meaning from -- again in that example, 29410 --  
4 to go from the geographic center of that zip  
5 code to the MUSC hospital. It's 14.9 miles or  
6 24 to 45 minutes.

7 Q: Uh-huh.

8 A: And so the savings for that zip code is -- it's  
9 about -- it's 1.8 miles closer to go to the  
10 freestanding ED and 2 minutes shorter to go to  
11 the freestanding ED.

12 Q: All right. And let's ---

13 A: So I did that analysis for all of those 25 zip  
14 code.

15 Q: Uh-huh.

16 A: And you can see with the exception of two zip  
17 codes in the center there, 29406 and 29419, all  
18 of the zip codes are closer geographically to  
19 the proposed FED site versus the MUSC hospital.  
20 Those two zip codes are -- it's a mile, a  
21 little over a mile, closer to the peninsula but  
22 the travel time is longer because of traffic.  
23 So you can see it's 9 minutes closer and 6  
24 minutes closer to go to the freestanding ED  
25 than to the peninsula hospital.



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1 Q: All right. Let me ask you about -- we'll look  
2 at a map in a minute -- but what's the -- these  
3 zip codes that you've listed here, where  
4 generally are they located?

5 A: Well you can see by the county it's generally  
6 the tri-county area. So Berkeley, Dorchester  
7 and three in Charleston.

8 Q: But it's not the entire tri-county area?

9 A: It is not.

10 Q: Okay. And do those zip codes include some post  
11 office box zip codes?

12 A: Yeah, there were I think two or three post  
13 office boxes that were incorporated into the  
14 zip code in which they were located.

15 Q: And why did you include the post office box zip  
16 codes?

17 A: Because information was reported that, you  
18 know, a patient reported that as their -- it  
19 was their mailing address -- so that's what  
20 shows up in the MUSC system as where the  
21 patient lives so we incorporated it into that  
22 zip code where the post office is located.

23 Q: All right. And let's see here, I think you've  
24 walked us through this. The one column that  
25 you haven't talked too much about yet that I'd



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1           like you to talk about is the percentage of  
2           shift.

3       A:     Right.

4       Q:     All right.     How did you come up with those  
5           percentages?

6       A:     So again we looked at geographic proximity and  
7           decided that sort of the three tiers, the 75  
8           percent, 60 percent and 50 percent to assume  
9           redirection from those zip codes.     So again  
10          that first example, 29410, we only assumed the  
11          lowest tier, 50 percent, of the patients that  
12          historically had gone to the peninsula would go  
13          to the new location.     You can see down at the  
14          bottom there Dorchester, mostly 75 percent  
15          because remember all of those are north --  
16          northwest of the freestanding ED so basically  
17          all of those patients would literally drive by  
18          Exit 199, our freestanding ED, to get to the  
19          peninsula.     So we assumed a larger percentage  
20          of those would stop because of the convenience  
21          and location.

22      Q:     Well let me pick up on the last thing you said  
23           because of the convenience and location.     What  
24           -- why would someone -- you've talked about the  
25           proximity in different drives, but is it -- are





1           there any other reasons why a person generally  
2           would prefer going to an FED as opposed to a  
3           hospital based ED?

4       A:   Well it could be -- well certainly for MUSC the  
5           -- what we call way finding. So when you go to  
6           the peninsula, MUSC Hospital, for services you  
7           have to find a parking spot, generally in a  
8           parking garage. You have -- it's literally two  
9           city blocks, the buildings. They're old  
10          buildings that have been connected so sometimes  
11          the connector doesn't go floor to floor, it  
12          goes from one floor to the other floor. So  
13          getting into the building is difficult, going  
14          where to go. We heard three locations, the  
15          adult ED entrance, the pediatric ED entrance,  
16          the chest pain entrance. Going to a  
17          freestanding ED, pull up and walk in, much more  
18          convenient.

19       Q:   Generally speaking are weight times shorter or  
20           longer at an FED or versus a hospital based ED?

21       A:   Well generally they would be short, you know,  
22           depending on ---

23       Q:   Shorter where? At which?

24       A:   I'm sorry, shorter at a FED than a freestanding  
25           -- or, I'm sorry, at -- a freestanding FED



1           versus the hospital. It's more convenience,  
2           easier, faster to get in and out versus a  
3           hospital where it's slower.

4       Q:    All right.

5       A:    Particularly with utilization and capacity  
6           constraints.

7       Q:    Let's look at slide 17, please. Unless -- well  
8           let me ask you this, Mr. Levitt, are you -- we  
9           done with that slide? The one we just looked  
10          at?

11      A:    Yes.

12      Q:    As far as you're concerned?

13      A:    I am.

14      Q:    Let's look at slide 17, please. All right.  
15           MUSC ED visit volume by service area zip code.  
16           All right. What does this show?

17      A:    So this shows that, as Ms. Platt had in her  
18           slide 21, that the 24,000 patients for visits  
19           from the zip codes we just identified, 24,537  
20           ED visits for residents of those zip codes.

21      Q:    Uh-huh. And ---

22      A:    Were treated at MUSC at the peninsula.

23      Q:    All right. Now again this is a -- forgive me  
24           for asking I guess it's an obvious question,  
25           but these are all the zip codes from where MUSC



1 gets its patients is it?

2 A: No this is just those 25 zip codes.

3 Q: All right. Okay. And let's look at -- I'm  
4 sorry -- before we go -- let's go back to  
5 Exhibit 40 for just a minute. Okay. This is  
6 not into evidence at this point. I'd like to  
7 move to admit MUSC's Trial Exhibit 40 into  
8 evidence.

9 MS. HOLLINGSWORTH: No objection.

10 MR. SUMMER: No objection.

11 THE COURT: Admitted.

12 MR. WESTBROOK: Thank you.

13 (Respondent MUSC's Exhibit Number 40 was admitted  
14 into evidence.)

15 Q: All right. Let's go to Exhibit 42 -- MUSC  
16 Exhibit 42. This is the map. All right. You  
17 were talking about this and the geographic  
18 relationships of these zip codes. Tell us what  
19 this map shows?

20 A: So this just graphically shows those zip codes  
21 and then color codes them to those shifts we  
22 talked about -- 25, 50, 60, 75 percent shift --  
23 of those residents to the proposed freestanding  
24 ED.

25 Q: All right. Now you've got some providers



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1 listed on here, is that right?

2 A: Yes.

3 Q: Now do you have -- are there a couple of  
4 providers that are missing?

5 A: Yes.

6 Q: All right. And what are those?

7 A: I think Center Pointe and Northwoods  
8 freestanding EDs are not on here.

9 Q: All right. Now first of all remind us, Center  
10 Pointe is ---

11 A: Center Pointe is the Roper freestanding ED in  
12 North Charleston.

13 Q: Center Pointe?

14 A: Oh, I'm sorry. Center Pointe is the Trident  
15 freestanding ED in North Charleston.

16 Q: And what is Northwoods?

17 A: Northwoods is the Roper freestanding ED in  
18 North Charleston.

19 Q: All right. Why aren't these shown on here?

20 A: You know, I don't know. We must have  
21 inadvertently left them off.

22 Q: All right. Any -- no particular design or  
23 reason or point to leave them off, is that what  
24 your saying?

25 A: No.



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1 Q: All right. Now with respect to these zip codes  
2 they're color coded on here. What do the color  
3 codes mean?

4 A: Again those are the percent shift. So we  
5 talked about, you know, Dorchester mostly being  
6 75 percent because those residents would travel  
7 -- most of those residents would travel past  
8 the proposed freestanding ED.

9 Q: All right.

10 A: The travel times would be shorter to the  
11 proposed ED than to down to the peninsula so we  
12 have a higher percentage there, and then as you  
13 can see as you get further away a lower  
14 percentage.

15 Q: All right. Now the MUSC FED -- the proposed  
16 FED for MUSC -- it's labeled on there as MUHA  
17 FSED.

18 **MR. WESTBROOK:** Yeah, Dan, could you show us that.

19 Q: Is that -- and where would that exactly -- or  
20 not exactly -- but where would it be? Is that  
21 an accurate representation, that last  
22 highlighted that Mr. Buff put up there?

23 A: Yeah, uh-huh.

24 Q: All right. Now, Mr. Levitt, for people in many  
25 of those zip codes to go to MUSC FED they would



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1           be driving past more or less -- I mean, maybe  
2           some of them directly pass and some of the less  
3           directly, but they would driving past a number  
4           of existing EDs, is that correct?

5       A:    Yes.

6       Q:    So what makes you think they would drive past  
7           existing     EDs, whether hospital based or  
8           freestanding, to go to MUSC's FED?

9       A:    Well they already are. So all of these people  
10           are driving past Summerville, past Trident,  
11           past Roper, Moncks Corner, past Northwoods,  
12           past all the existing providers now to go now  
13           to the peninsula so if they have a MUSC  
14           alternative shorter and closer, then they would  
15           choose to go there. If they're choosing MUSC  
16           as their provider of choice, rather than going  
17           all the way to the peninsula they'd go to Exit  
18           199.

19       Q:    All right. Zip code 29406. I believe that has  
20           been referred to as a boot-shaped zip code, is  
21           that right?

22       A:    Yes.

23       **MR. WESTBROOK:** And can we zoom in on that focus on  
24           that?

25       Q:    So show us where the boot is.



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1 A: So the boot is that sort of tan colored area.  
2 Trident Medical Center is locate in that 29406.

3 Q: Uh-huh.

4 A: And you can see from the geography the northern  
5 portion of the boot ---

6 Q: Uh-huh.

7 A: --- where Trident's located, and it's closer to  
8 the freestanding ED at Exit 199 than the  
9 peninsula. So to the extent that residents in  
10 the northern portion of that zip code would  
11 have access to the freestanding ED it would be  
12 shorter and closer to them.

13 Q: Uh-huh.

14 A: And even frankly the southern -- the heel of  
15 the boot -- isn't closer to the hospital. It  
16 might be a little closer to the hospital than  
17 to the proposed freestanding ED but not  
18 substantially.

19 Q: All right. What's the drive -- do you have the  
20 drive time between the heel and -- to those two  
21 potential sites?

22 A: No. So remember from the last one the center  
23 of that zip code is geographically closer to  
24 the peninsula by about a mile but it was 9  
25 minutes further I think. So, you know, the



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1 lower portion of the boot could be sort of  
2 equal distance travel time -- equally time,  
3 travel time or maybe a minute or two -- still  
4 closer to go to the FED than to the peninsula.

5 Q: Let's go back just for a moment to Exhibit 40,  
6 please. It's the one we just looked at. All  
7 right. Let's look at 29406, the one we were  
8 just talking about, the boot. All right. How  
9 many -- it's not -- it doesn't have what I  
10 thought it had. So ...

11 A: I think it's on 17.

12 Q: We'll go there in a minute but let me ask you  
13 this, of all the zip codes on this -- on your  
14 list of 25 zip codes -- which one does MUSC get  
15 the most patients from?

16 A: Yeah, if you go to page 17 -- I think we looked  
17 at that a second ago.

18 Q: Slide 17?

19 A: Slide 17.

20 Q: Oh, yeah, that one. Yeah, okay.

21 A: 29406 had over 4,000 visits from that zip code  
22 tot he peninsula.

23 Q: All right to the MUSC Hospital?

24 A: Correct. And again that's the zip code that  
25 Trident's located in so 4,600 -- 363 visits





1 chose to go to MUSC versus going to Trident in  
2 their own zip code.

3 Q: Okay. All right. Let's look at -- let's go  
4 now to -- well let me think -- MUSC Exhibit 42  
5 that's where we are. That's in evidence, is  
6 that correct? All right. Let's go to MUSC  
7 Exhibit 44.

8 **(Respondent MUSC's Exhibit Number 44 was introduced**  
9 **into the record at this time.)**

10 Q: 44. All right. MUSC actual fiscal year 2016  
11 ED visits and projected shift it says at the  
12 top. You've got your 25 zip codes listed. How  
13 is -- what's the difference between this chart  
14 and what we just looked at?

15 A: This would be -- I think it's a different time  
16 period. You mean versus page 17?

17 Q: Yeah.

18 A: Yeah, a different time period but generally the  
19 same data.

20 Q: Uh-huh.

21 A: So this was what was originally submitted to  
22 DHEC at project review I believe. What this  
23 adds is the percent of total FED -- the last  
24 two columns. So you can see the percent that  
25 that zip code represents of the total.



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1 Q: Uh-huh.

2 A: It's sorted from highest to lowest.

3 Q: Uh-huh.

4 A: And then the cumulative percentage just  
5 continues to add it up.

6 Q: All right.

7 A: So what this is to show is that the first seven  
8 zip codes ---

9 Q: Right.

10 A: --- from highest to lowest account for almost  
11 80 percent of the projected visits.

12 Q: Okay.

13 A: So the criticism that my 25 zip code service  
14 area is too large I think is refuted by this.  
15 So I think it's been positive that an FED is a  
16 much smaller service area. You know, five to  
17 seven zip codes account for 80 percent of the  
18 visits. Well that's what my zip service area  
19 also does. So I could have done it a little  
20 differently. I could have just said, okay,  
21 let's look at the seven largest zip codes,  
22 that's going to represent 80 percent of our  
23 visits. And then the rest of our visits, 20  
24 percent, are going to come from all other  
25 areas. Well this specifically identifies what



1           those other areas are.

2       Q:     All right.  Are you familiar with the term in  
3           migration?

4       A:     Yes.

5       Q:     What does that mean?

6       A:     So when -- in health planning you would define  
7           your service area and that's a pool of patients  
8           from which you draw and then in addition you'll  
9           have patients from outside that defined service  
10          area.  That would -- they would in migrate into  
11          the service area or be treated at your  
12          facility.  So if I had gone -- as I said if I  
13          had gone with that approach I'd say seven of  
14          these zip codes represent 80 percent of our  
15          patients.  20 percent would in migrate from out  
16          of area, meaning out of those seven zip codes,  
17          and we'd get to the same spot.

18      Q:     All right.  Let's go to -- let's -- excuse me.

19      **MR. WESTBROOK:**  I would like to at this point move  
20          that MUSC's Exhibit 44 be admitted into  
21          evidence.

22      **MS. HOLLINGSWORTH:**  No objection.

23      **MR. SUMMERS:**  No objection, Your Honor.

24      **THE COURT:**  Admitted.

25      **(Respondent MUSC's Exhibit Number 44 was admitted**



1     **into evidence.)**

2     Q:     All right.     Let's go now to MUSC's proposed  
3             Exhibit 45.

4     **(Respondent MUSC's Exhibit Number 45 was introduced**  
5     **in the record at this time.)**

6     Q:     All right.     What does this map represent?

7     A:     So this map represents those -- again the top  
8             ten zip codes.     So remember seven zip goods  
9             were almost 80 percent.

10    Q:     Uh-huh.

11    A:     Ten zip codes would be 90 percent.

12    Q:     Okay.

13    A:     So again -- so 90 percent of our patients are  
14             expected to come from these ten zip code.     And  
15             you can see it's clustered close around the  
16             proposed FED.     The one zip code, 29461, in  
17             Berkeley County is a very large geographic zip  
18             code because it's not very densely populated.

19    Q:     Which one is that?

20    A:     The top -- the very top zip code.

21    Q:     Uh-huh.

22    A:     29461.     So it looks like it's a broad --  
23             broader service area than it really is but  
24             there's not -- you know, it just a big zip  
25             code.     And that was, you know, toward the lower



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1           end of the top ten. But so then clustered  
2           around our proposed FED is where the majority  
3           of our patients -- this represents 90 percent  
4           of our patients would come from these ten zip  
5           codes.

6       Q:   All right. Are you familiar with the Center  
7           Pointe application?

8       A:   Yes.

9       Q:   All right. Do you recall what kind of service  
10          area Center Pointe had?

11      A:   I think the Center Pointe application showed I  
12          think a four or five zip code, you know, most  
13          of the Trident FED CON applications use four or  
14          five zip code service area. They say that  
15          counts for 80 percent of their volume and then  
16          another 20 percent. I looked at the actual  
17          data ---

18      Q:   Uh-huh.

19      A:   --- for Center Pointe and they actually get 80  
20          percent of their patients from seven -- Center  
21          Pointe is seven zip codes I think. Yeah -- no,  
22          Center Pointe's eight zip codes. They get 80  
23          percent of their patients from eight zip codes.

24      Q:   Okay.

25      A:   So their service area is actually an eight zip



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1 code service area from which they draw 80  
2 percent of their patients. And again mine was  
3 seven zip codes for 80 percent, ten zip codes  
4 for 90 percent.

5 Q: All right. Now do you recall -- I don't think  
6 we need to ---

7 **MR. WESTBROOK:** Well first of all let me before we  
8 move on let me move to admit Exhibit 45, MUSC's  
9 Exhibit 45 into evidence.

10 **MS. HOLLINGSWORTH:** No objection.

11 **MR. SUMMER:** No objection.

12 **THE COURT:** Admitted.

13 **(Respondent MUSC's Exhibit Number 45 was admitted**  
14 **into evidence.)**

15 Q: I don't think we need to pull this up unless  
16 you think it would help your -- explain your  
17 testimony -- but do you recall a map that's  
18 been put up -- I think it was during Ms.  
19 Platt's testimony that showed -- that talked  
20 about Intuitive using a 13 minute drive time to  
21 determine its service area?

22 A: I remember that map, yes.

23 Q: All right. What are your thoughts about  
24 Intuitive's 13 minute service area service  
25 area?



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1     A:     You know, that's -- that was their planning  
2             tool that they used initially.

3     Q:     That who used initially?

4     A:     Intuitive use.

5     Q:     Okay.

6     A:     I think it undersizes the market. I think it  
7             only shows like 100,000 people within that. I  
8             think the service area is broader than that  
9             and, you know, that -- as evidenced by, you  
10            know, Center Pointe and Moncks Corner. The  
11            only facilities for which I have -- only  
12            freestanding facilities for which I have any  
13            data through the discovery process shows that  
14            they draw from a broader area than 13 minutes.

15    Q:     Uh-huh.

16    A:     You know, eight zip codes for Center Pointe,  
17             seven zip codes for Moncks Corner. My proposed  
18             seven zip codes were 80 percent of the volume  
19             so I think that that 13 minutes was a Texas  
20             company's definition but it wasn't used by me.  
21             It wasn't used by MUSC, and they're no longer  
22             involved in the project.

23    Q:     Let's go to -- well let me -- I'm sorry, before  
24             continue to go there let me ask you a question,  
25             what is the American College of Emergency



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1 Physicians?

2 A: It's the professional organization that  
3 emergency physicians become Board certified  
4 through and are members of.

5 Q: All right. And is that an organization that  
6 you have dealt with in your health planning  
7 over the years?

8 A: Yes. Generally, you know, all sort of  
9 specialties have a college. American College  
10 of ---

11 Q: Uh-huh.

12 A: --- Cardiology. American College of Emergency  
13 Physicians. And those organizations are from  
14 which they are issued their Board certification  
15 and they issue guidelines and protocols for  
16 care in those different specialties.

17 Q: All right. Have you relied in your work in the  
18 past on American College organization,  
19 emergency physicians and all those areas that  
20 you were just referencing?

21 A: Yes.

22 Q: All right. And let's look at slide 19 and tell  
23 us what that is.

24 A: This is the summary from the American College  
25 of Emergency Physicians white paper on FEDs.





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1 Q: Uh-huh.

2 A: Freestanding emergency departments.

3 Q: All right.

4 A: And it talks about the requirements or the  
5 goals for an FED. And it obviously, you know,  
6 evaluates, stabilize any patient. Provide  
7 advanced diagnostic and laboratory facilities.  
8 Open 24/7 and staffed by emergency physicians.  
9 Same equipment as a hospital department. A  
10 full spectrum of specialists available as is at  
11 the hospital department, meaning all the  
12 different specialties. Orthopaedics,  
13 neurology, et cetera. The ability to treat all  
14 patients regardless of ability to pay. The  
15 EMTALA. They'd be subject EMTALA as well.

16 Q: Uh-huh.

17 A: And equipped to handle any medical emergency  
18 including heart attacks, strokes, and major  
19 trauma.

20 Q: All right.

21 A: And you can see some of these were incorporated  
22 into the South Carolina Health Plan. You know,  
23 for instance emergency physician 24/7 is also  
24 in the Health Plan.

25 Q: All right. What's your understanding of the



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1 MUSC Berkeley County freestanding ED if it is  
2 ultimately approved and becomes operational?  
3 How would it related to these American College  
4 of Emergency Physician standards or whatever  
5 you call it. Is standard the right word? What  
6 are these?

7 A: These are -- yeah, I guess I would call them  
8 standards. So they -- it will comply with all  
9 of them. It will offer all of these services  
10 in a manner in which it's described on this  
11 page.

12 Q: All right. Let's look at MUSC Exhibit 49,  
13 proposed Exhibit 49, not into evidence.

14 **(Respondent MUSC's Exhibit Number 49 was introduced**  
15 **in the record at this time.)**

16 Q: It says, fiscal year 2016 MUSC ED visits by  
17 acuity level. Proposed Berkeley FSED service  
18 area visits compared to MUSC total. All right.  
19 Mr. Levitt, take us again at a very deliberate  
20 place please for my sake and explain what this  
21 is.

22 A: So we looked at the data that's shown. So you  
23 can see at the bottom 24,472 ---

24 Q: Where does it say that?

25 A: Right there.



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1 Q: Oh, okay.

2 A: So those are the volume of patients from the  
3 service area. So remember that number was back  
4 on I think slide 17.

5 Q: All right. When you say service area are you  
6 talking about that 25 zip code area?

7 A: Yes, 25 zip code area. And you can see the  
8 81,260 is the total ED volume at MUSC. And we  
9 looked at the -- so the service area column  
10 looks at those 24,000 treatments and the MUSC  
11 total looks at the 81,000 treatments. And then  
12 we have by ESI, emergency service index,  
13 admission acuity. So this is the 1 where one  
14 is the sickest and 5 is the least sick.

15 Q: All right. Now we've heard about different  
16 acuity levels. Billing acuity and triage  
17 acuity terms. What is this? Explain what this  
18 is.

19 A: Again these are the triage acuity. The ESI  
20 triage acuity. So this is when a patient  
21 presents at the ER what level of care they're  
22 assigned to which translates into how quickly  
23 they're treated.

24 Q: Okay. All right. Go ahead.

25 A: So the issue had been raised, well all of these



1           24,000 people are going all the way down the  
2           peninsula. They're passing by all of these  
3           other alternatives because they're seeking  
4           specialty care at MUSC. So I looked at the ESI  
5           designation. So if that were the case they  
6           would be sick people. Sick people going down  
7           to the level 1 trauma center in a  
8           disproportionate rate than overall. So I  
9           looked at the percentage of level 1, those are  
10          the really sick people. The resuscitation  
11          people. And ---

12        Q:    What do you mean by resuscitation people?

13        A:    Meaning that they're not breathing or their  
14              heart has stopped. Or they're intubated I  
15              guess to help them breath. You know, without  
16              that they wouldn't be breathing. So you can  
17              see at the height of the peninsula there are  
18              274 total level 1s and that's .3 percent of the  
19              total, 81,000 visits.

20        Q:    Uh-huh.

21        A:    For the service area 70 people were level 1s  
22              that presented at the peninsula, again .3  
23              percent. So I looked at -- and the next level  
24              emergent would be sort of the not as sick as 1  
25              but still pretty sick, and 3,000 of those



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1 patients of the 24,000, 12.6 percent. A little  
2 higher than the 12 percent at the hospital  
3 presented. And I did that analysis down the  
4 line. Urgent care, less urgent and non-urgent.  
5 And you can see the percentages are all very  
6 consistent. So it's not as though the  
7 individuals from the service area have a high  
8 acuity than overall at MUSC.

9 Q: All right.

10 **MR. WESTBROOK:** At this point I'd like to move  
11 MUSC's Exhibit 49 into evidence, please.

12 **MR. SUMMER:** No objection.

13 **MS. HOLLINGSWORTH:** No objection.

14 **THE COURT:** Okay. Admitted.

15 **(Respondent MUSC's Exhibit Number 49 was admitted**  
16 **into evidence.)**

17 Q: Okay. Now let's go to MUSC's proposed Exhibit  
18 50.

19 **(Respondent MUSC's Exhibit Number 50 was introduced**  
20 **into the record at this time.)**

21 Q: All right. Proposed Exhibit 50. Fiscal year  
22 2016 MUSC ED visits and admissions by level.  
23 Proposed Berkeley FSED service area visits  
24 compared to MUSC total. So it looks like once  
25 again you're comparing those that were coming



1 from the 25 zip code service area for the FED  
2 to the peninsula, is that right?

3 A: It is. So I wanted to look at then so of those  
4 -- looking at sort of the next level of  
5 analysis -- so of those triage categories ---

6 Q: Uh-huh.

7 A: --- that were from the service area versus  
8 overall at the hospital, how many of those were  
9 admitted. So again that would give me an idea  
10 of are these sicker people coming down to the  
11 peninsula for inpatient services that would  
12 require as a result of their emergency illness.  
13 So again the level one, the resuscitation, the  
14 immediate care patients, of the 70 that came  
15 down 60 were admitted, 85 percent compared to  
16 75 percent of MUSC overall. So while that is  
17 ten percentage points different it's such a  
18 small number. So if seven less people were  
19 admitted it would be 75 percent instead of 85  
20 percent.

21 Q: You mean seven less people from which service  
22 area?

23 A: From -- and so if it were 54 instead of 60.

24 Q: Okay.

25 A: So six less people were admitted from the



1 service area on level 1 then it would the same  
2 percentage. And then going down you can see  
3 that percent admitted for the service area  
4 versus the hospital are all very comparable.  
5 63 versus 64 percent for level 2. 24 versus 24  
6 for level three. 2 and a half versus 2.4 for  
7 level 4 and .8 versus .6 for level 5.

8 Q: So what do you conclude from this?

9 A: That residence of the service area aren't  
10 bypassing the existing alternatives, you know,  
11 Trident, Summerville freestanding EDs to go to  
12 MUSC any differently than everybody that's  
13 choosing to go to MUSC. They're not higher  
14 acuity. They're not being more admitted to the  
15 hospital. They're seeking services just as all  
16 MUSC patients seek service from -- frankly from  
17 around the state ---

18 Q: All right.

19 A: --- but specifically from the service areas.

20 Q: Okay.

21 **MR. WESTBROOK:** And at this point I'd like move to  
22 admit MUSC's Exhibit 50 into evidence.

23 **MR. SUMMER:** No objection, Your Honor.

24 **MS. HOLLINGSWORTH:** No objection.

25 **THE COURT:** Admitted.



1 (Respondent MUSC's Exhibit Number 50 was admitted  
2 into the record.)

3 Q: All right. Let's go now to your slide 39,  
4 please. No?

5 MR. WESTBROOK: Apparently there is no slide 39.  
6 Let me confirm, I would just beg the Court's  
7 indulgence. All right. My apologies to  
8 everyone, especially Mr. Buff. Let's go  
9 instead to Roper Exhibit 59, page 17, and I  
10 believe this is already in evidence.

11 Q: All right. Okay. What do we have here?

12 A: So this was a slide that was shown that has the  
13 acuity, the triage acuity across the top and  
14 the building acuity for the rows. So again  
15 remember they are reversed so they're kind of  
16 in reverse order. So the high acuity triage  
17 number 1, the first one in the first row, brief  
18 visit would be the least sick people. So  
19 that's why no one who was identified on triage  
20 as a level 1 had a brief bill because they're  
21 all really sicker than brief. But what's  
22 interesting here is the variety of -- you know,  
23 so the triage is comin' in and the billing is  
24 going out. So the triage is what do you -- how  
25 sick do you think the patient is and the





1           billing is what did you do the patient, what  
2           services did you provide, how sick were they?

3       Q:    Well as a health planner why then -- why would  
4           you -- why wouldn't you pick one or the other?  
5           Why do you consider both?

6       A:    Well I think you can look at both and they give  
7           you different information, but I don't know  
8           that ones better than the other and I think  
9           that's what this highlights. So if someone  
10          came in level 1 -- remember that's a  
11          resuscitation patient, an immediate care  
12          patient ---

13       Q:    Let me ask you, when you say level 1 or level  
14           2 would always please say whether you're  
15           talking about a billing or a triage just so  
16           we'll understand?

17       A:    Sure. And in this slide they're only -- the  
18           ones that are numbered are the triage acuity 1  
19           through 5.

20       Q:    All right.

21       A:    The others aren't numbered but, yes. So if you  
22           come in with a triage acuity -- or if you came  
23           in to MUSC with a triage acuity of 1, meaning  
24           the immediate care or the resuscitation  
25           patient, the majority of those patients weren't



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1 the highest billed patients. So the lowest --  
2 the 68 patients -- that's the highest billing  
3 category. So, you know, 68 out of 200 -- only  
4 68 out of 200 received the highest billing  
5 category. So while they thought they were sick  
6 and they probably were, they needed to be  
7 resuscitated, they didn't get the highest bill.  
8 They didn't get the critical care bill. 106 of  
9 them -- the sort of single largest category --  
10 half of them got the comprehensive bill, 25  
11 percent go the critical care bill and the rest  
12 were among the other categories.

13 Q: All right.

14 A: And you can see that across the board. You  
15 know, one -- a triage acuity 1 has the most  
16 variance, the rest somewhat correlate. So for  
17 instance number 2, acuity number 2, the  
18 majority have the second highest bill. So they  
19 are the second highest acuity in triage and  
20 they have the second highest bill ---

21 Q: Uh-huh.

22 A: --- but you can see a number of them had lower  
23 billing acuity than a 2. So, you know, 648 had  
24 extended, 362 had intermediate -- and again  
25 these are going down the acuity scale going up



1 from the bottom.

2 Q: So just to use an example, the 372 that was  
3 just highlighted in that column, explain what  
4 that 372 exactly is.

5 A: So that's the intermediate bill, meaning  
6 intermediate services were provided. Based on  
7 their medical record the way the -- the way the  
8 process works is someone in billing goes  
9 through their medical record, identifies what  
10 services were provided to the patient. Based  
11 on what was provided they assign them to a ICD9  
12 code or a CPT code and that has an associated  
13 category and bill with it. So the more things  
14 that are provided to the patient, more services  
15 provided to the patient, the higher the bill  
16 obviously.

17 Q: And that's 372 patients are we talking about  
18 there?

19 A: 372 -- well patient -- I use patients and  
20 visits interchangeably because it is a patient  
21 that day. It could be the same person. The  
22 same person can go to the emergency room more  
23 than one time in a year, but I'd say patient or  
24 visit. 372 encounters. Someone walking into  
25 the ER and leaving the ER. It could be the



1 same person repeatedly, but 372 times someone  
2 came to an ER, but with a level 2 acuity they  
3 received an intermediate bill.

4 Q: All right. And so given this what's your  
5 conclusion?

6 A: I think the take away from this is there isn't  
7 a better measure so if someone were to say well  
8 you should use triage acuity and not billing  
9 acuity I think you can look at both and I think  
10 they're both meaningful but in different ways.

11 Q: All right.

12 **MR. WESTBROOK:** I beg the Court's indulgence just a  
13 moment. So this is already into evidence.

14 Q: Let's go to Roper 59, the same Exhibit but to  
15 a different page. Let's go to page 22. All  
16 right. The service area patients acuity  
17 adjusted redirection. I think we saw this  
18 during Ms. Platt's testimony a few days ago.  
19 Tell us why you're reexamining this chart?

20 A: Well the percentage distribution that's  
21 adjusted here -- I guess the percent  
22 appropriate line that's adjusted here -- the  
23 source on that is identified as Dr. Hall's  
24 deposition.

25 Q: Uh-huh.



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1     A:     And that's not what Dr. Hall said in his  
2            deposition. I think it was misinterpreted and  
3            consistent with my approach I don't think that  
4            it is appropriate to adjust the acuity  
5            redirection.

6     Q:     All right. Well let's take those one at a  
7            time. Why don't we start with Dr. Hall, okay?  
8            And what's your understanding of what Dr. Hall  
9            -- now obviously the transcript will speak for  
10           itself -- but what's your understanding of what  
11           Dr. Hall said?

12    A:     Yeah, so I think there's some misunderstanding  
13            so everyone is saying -- well I won't say  
14            everyone -- there's been a lot of testimony  
15            that says freestanding ED's are going to mostly  
16            treat levels 3s, 4s and 5s.

17    Q:     Okay.

18    A:     And that's accurate. Hospitals mostly treat  
19            levels 3s, 4s and 5s.

20    Q:     Uh-huh. You mean hospital EDs?

21    A:     Hospital EDs. Because that's the distribution.  
22            So you can see here prior to the appropriate  
23            adjustment on this slide -- what is that --  
24            14,000 plus 5,000 plus 800. So over 20,000 of  
25            the 24,000 visits were levels 3s, 4s and 5s.



1 Q: All right.

2 A: So of course the majority of the patients  
3 treated -- this is at the hospital ED ---

4 Q: Uh-huh.

5 A: --- are levels 3s, 4s and 5s. So that's what  
6 that statement means, not that only level 3s,  
7 4s and 5s are gonna be treated at freestanding  
8 EDs.

9 Q: All right.

10 A: And that's what Dr. Hall said in his  
11 deposition.

12 Q: Okay. And again the deposition transcript will  
13 speak for itself, but that was -- that's your  
14 understanding of what he said, right?

15 A: That the majority of the patients will be 3s,  
16 4s and 5s and that's true. Majority meaning  
17 most of the patients will fall in those  
18 categories but not levels 1s and 2s won't come,  
19 won't be treated there and -- or even 3s should  
20 be adjusted because they won't be treated  
21 there.

22 Q: All right. Well in this particular chart it  
23 does say zero percent are appropriate for level  
24 1, do you agree with that?

25 A: No.



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1 Q: Do you know what the source of that 0 percent?

2 A: Yeah, again that's from -- that's Roper's  
3 assumption on Dr. Hall's testimony because he  
4 said the majority of patients will be 3s, 4s  
5 and 5s.

6 Q: All right. Where does the 20 percent for level  
7 2 come from, do you know?

8 A: So again that was Roper's assumption. You  
9 know, they've -- I've been criticized I think  
10 I heard in the other cases that my redirection  
11 was made up. Well it wasn't made up. It was  
12 based on a series of assumptions just as I  
13 assume the zero -- the 20 percent and the 80  
14 percent were based on a series of assumptions.  
15 I disagree with those assumptions.

16 Q: All right. Have you seen any math calculations  
17 for the zero, the 20, the 80 and the hundred  
18 percent.

19 A: No.

20 Q: Let's -- so what's your conclusion about this  
21 chart right here?

22 A: That the top line, the 24,537 is the starting  
23 point for which patients would redirect or seek  
24 care at the freestanding ED, and it wouldn't be  
25 adjusted because all of those patients are



1 appropriate. We went through the American  
2 College of Emergency Physicians guidelines  
3 saying ability to treat all patients at a  
4 freestanding ED, have the same services  
5 available at a freestanding ED, have the same  
6 specialists -- access to the same specialists  
7 available at a freestanding ED. So all of  
8 these patients could be treated at a  
9 freestanding ED. I heard Dr. Wendell say he's  
10 treated trauma patients at a freestanding ED.  
11 Some of those patients were discharged home, so  
12 -- that would be a level 1 patients. Those are  
13 treated at freestanding EDs, can be treated at  
14 freestanding EDs. Dr. Hall in his deposition  
15 said he will have the staff resources and  
16 ability to treat all patients in a freestanding  
17 ED at all levels.

18 Q: All right. Well you would just -- so you're  
19 talking -- pursuant to the point you're making  
20 here you referenced again the American College  
21 of Emergency Physicians. Let's go to that  
22 document. Let's go to MUSC's proposed 48,  
23 please.

24 **(Respondent MUSC's Exhibit Number 48 was introduced**  
25 **into the record at this time.)**





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1 Q: Now what is this page with highlights? I mean,  
2 what does this represent? Where is this from?

3 A: Again this is from the American College of  
4 Emergency Physician white paper on freestanding  
5 EDs.

6 Q: All right. And this is something you relied on  
7 then to -- in fact you had a chart earlier that  
8 summarized some of these points, is that right?

9 A: Yes.

10 Q: Okay. All right. What's significant about the  
11 language on this page in terms of your opinion?

12 A: Yeah, so you can see where I've highlighted  
13 sort of the more important points that  
14 freestanding emergency departments can evaluate  
15 and stabilize any patients.

16 Q: Uh-huh.

17 A: It doesn't say only level 3s, 4s and 5s, or  
18 only a portion of level 3s, 4s and 5s acuity.  
19 It goes on to say -- it's not highlighted --  
20 but it goes on that next sentence they will  
21 arrange for transfer or additional care or  
22 hospital admission if needed. So again the  
23 criticism that we should have adjusted for  
24 admissions, patients that were admitted to the  
25 hospital should be considered in a freestanding



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1 ED. Well the American College of Healthcare --  
2 American College of Emergency Physician feels  
3 others. That we can treat and stabilize the  
4 patients and those that need admission can be  
5 transfer to a hospital for admission.

6 Q: All right. What's your next highlight there?

7 A: Freestanding EDs have advanced diagnostic and  
8 lab facilities capable of treating any  
9 emergency medical condition and always staff by  
10 emergency physicians.

11 Q: All right.

12 A: So again any medical condition not just 3s, 4s  
13 and 5s.

14 Q: All right. What's the next point?

15 A: They have the same equipment as a hospital  
16 emergency department but are physically  
17 separated from a hospital. Obviously 23 miles  
18 in Berkeley County is physically separated but  
19 we'd have the same equipment available. We've  
20 included a 64 slice CT in the proposed site and  
21 we have other lab and imaging equipment  
22 proposed in the site as well.

23 Q: All right. I think we've already talked about  
24 EMTALA so I don't need -- I'm not going to ask  
25 you to go there -- but that next sentence, next



1 highlight at least, makes a different point  
2 about required treatment, does it not?

3 A: Yes, the hospital is required to treat patients  
4 in the same manner as those treated at  
5 emergency -- in a hospital's emergency  
6 department. This means that patients have  
7 access to a full spectrum of specialists  
8 available at the main hospital.

9 Q: All right. And anything else from this  
10 document that you want to speak to at this  
11 moment?

12 A: Well, yeah, I guess on the third bullet point  
13 at the top?

14 Q: Uh-huh.

15 A: The second sentence, going there first would  
16 allow lifesaving medical treatment to begin  
17 sooner than going to a more distant hospital.

18 Q: Going where first?

19 A: To a freestanding ED.

20 Q: All right.

21 **MR. WESTBROOK:** All right. At this point I'd like  
22 to move to admit MUSC's 48 into evidence,  
23 please.

24 **MS. HOLLINGSWORTH:** And, Your Honor, we would object  
25 to Exhibit 48. Mr. Levitt is more than



1           entitled of course to rely on the information  
2           and he's testified to it, but I don't think  
3           that in terms of it coming in as evidence the  
4           Court has the benefit of actually hearing from  
5           several physician experts. Emergency physician  
6           experts including MUSC's physician. So I would  
7           submit, Your Honor, that this document, while  
8           again, more than suitable to be a part of Mr.  
9           Levitt's file and consideration for planning, I  
10          would submit it's not appropriate to come in as  
11          evidence and in fact in some ways particularly  
12          with the highlight I think it's contrary to the  
13          testimony we've heard from the physician  
14          experts.

15       **MR. WESTBROOK:**     Well it's consistent with the  
16          testimony of Dr. Hall who is our physician  
17          expert and I would say it's -- to the extent it  
18          is -- and I think it's consistent actually with  
19          their physicians as well -- to the extent there  
20          is an inconsistency, then it's for the Court to  
21          determine, make a factual finding on which one  
22          is more accurate or if there's one is more or  
23          less accurate than the other.

24       **MS. HOLLINGSWORTH:**   And, Your Honor, too, I do want  
25          to point out it's a -- some sort of website



1 print off and I'd submit that this is not the  
2 type of evidence that comes in under any sort  
3 of exception. It's not a learned treatise,  
4 it's not within his area of expertise. He's  
5 welcome to rely on it, but again, it doesn't  
6 necessarily come into evidence and I submit  
7 it's not appropriate to come into evidence.  
8 Particularly again where you have physician  
9 emergency room experts who have provided you  
10 testimony and you'll have that in your record.

11 **MR. SUMMER:** Your Honor, I would point also just to  
12 the rule of evidence -- it's 803 --  
13 specifically to the learned treatise exception.  
14 And what it does say is that he's entitled to  
15 rely upon it but it doesn't come in as an  
16 Exhibit. And that's 803(18) under the South  
17 Carolina Rules of Evidence.

18 **THE COURT:** Thank you, Mr. Summer. But I decided  
19 that I am not allowing it to come in as  
20 evidence but thank you.

21 **Q:** All right. Next go next to Trident Exhibit  
22 101, page 29, please. Problems with MUHA's  
23 assumed ED patient shifts. So I believe this  
24 was one of Mr. Sullivan's slides, is that your  
25 understanding?



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1 A: Yes.

2 Q: All right. And he's got some criticisms here.  
3 Let's take them one at a time. What's the  
4 first one and what's your response?

5 A: So again I think we've gone over this. The  
6 criticism was that we should adjust the acuity  
7 ---

8 Q: Uh-huh.

9 A: --- and not look at immediate or emergent  
10 patients or at least adjust for those patients.  
11 And I think from the information we just read  
12 as well as the testimony of the ER physicians  
13 that freestanding emergency rooms treat all  
14 levels of care so I don't think that those  
15 adjustments are valid -- or any adjustments are  
16 valid -- to the acuity.

17 Q: All right. And your second point?

18 A: Again we talked about this. It's factual. The  
19 largest population was urgent. Again I think  
20 that's factual. We talked about 3s, 4s and 5s  
21 being the vast majority of the patients treated  
22 at any emergency department, hospital or  
23 freestanding. At least the portion of those  
24 would be better served in a hospital based ED.  
25 There's no basis for that. Urgent patients --



1 I mean, I think just given the name of it,  
2 urgent, why would they need to go to a hospital  
3 for urgent services. That they -- I think  
4 that's a level 3 and a level 3 patient from an  
5 acuity standpoint really just requires more  
6 than one service so they come into the ED, they  
7 need a blood test and an x-ray and they have  
8 vital signs that are elevated. That doesn't  
9 require a hospital. It's perfectly well to be  
10 treated in a freestanding ED so I don't think  
11 those should be adjusted either.

12 Q: All right. Let's go to slide 20, please? All  
13 right. This is a terribly complex little  
14 thing.

15 A: Yeah.

16 Q: What is this?

17 A: So this is as I identified ESI or emergency  
18 severity index, emergency services index,  
19 triage level, and it shows how the patients are  
20 grouped into those categories one through five.

21 Q: All right.

22 A: So the first question is did the patient have  
23 a pulse? Are they breathing? Are they  
24 intubated or are they unresponsive?

25 **MR. SUMMER:** Your Honor, I am going to object to



1       this witness testifying. This would have been  
2       a great document for Dr. Hall to comment on but  
3       this is triage list for emergency medicine  
4       while I absolutely agree that Mr. Levitt is an  
5       expert in health planning he's not an expert in  
6       emergency medicine and there have been several  
7       physicians who have already been here and  
8       testified to the Court. This would be a  
9       document appropriate for that type of a witness  
10      and not for the health planner to go through  
11      and talk about. So that would be my objection  
12      is it's outside the scope of his expertise to  
13      comment on this. He can say that he looked at  
14      it and relied on it but I don't believe it's  
15      appropriate for him to comment on medical  
16      triaging. That's not his job.

17   **MR. WESTBROOK:** Your Honor, if I may?

18   **THE COURT:** Yes.

19   **MR. WESTBROOK:** The -- Doctor -- Mr. Levitt's many  
20      skills do not include -- I think we established  
21      IT forensics or emergency medicine. I agree  
22      with that. However, this -- he is not going to  
23      be offering any medical opinions. This is  
24      exactly the kind of information that Mr. Levitt  
25      or any other health planner, I think, would





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1           need to rely on in order to draft a CON  
2           application for ED services or to do -- or  
3           advise a client like MUSC on strategic planning  
4           for emergency department services. So I think  
5           if you allow him to go through this you'll see  
6           that he's not going to -- be offering any  
7           medical opinions he'll be offering, and if he  
8           does stray into medical opinions I would agree  
9           those would be inappropriate but I don't think  
10          he's going to do that. I think he's going to  
11          offer planning opinions based on this  
12          information.

13   **THE COURT:** Thank you. The objection is overruled  
14          at this time.

15   **MR. WESTBROOK:** Thank you.

16   Q: All right. Mr. Levitt, let's go once again a  
17          little slowly through this. If you have any  
18          medical opinions keep them to yourself. What  
19          do you start with there?

20   A: So, again, the patient presents in an emergency  
21          room and the question is do they have a pulse,  
22          are they apneic, meaning are they breathing, or  
23          are they intubated or unresponsive. And if the  
24          answer is yes to any of those then they're a  
25          level one or that immediate care level one, the



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1 highest triage level. Obviously if they're not  
2 breathing they need care right away. So then  
3 if the answer's no the flow chart says go down  
4 to are they a high risk patient? Are they  
5 disoriented, lethargic or show signs of  
6 confusion or are they in severe pain or in  
7 distress? If the answer is yes then they're a  
8 level two. If no, then you go down and just  
9 determine well, where are they? So if they  
10 don't -- if they're breathing, they're not in  
11 pain, they're not disoriented, they're not  
12 lethargic, all those other ones, you go down to  
13 the none and that would be a level five. So  
14 again someone comes in for a prescription  
15 refill they get a level five because they're  
16 not -- they're breathing, they're not  
17 disoriented and they don't need any resources.  
18 If they're breathing, not disoriented and they  
19 need a CT scan then they would -- that would be  
20 one service and they'd become a level four.

21 Q: You mean if they needed only a CT scan?

22 A: Only a CT scan or a blood test.

23 Q: Okay.

24 A: If they need a CT scan and a blood test then  
25 they would -- and their vital signs -- move



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1 over to the right a little -- their vital signs  
2 are in the danger zone, if they have high --  
3 elevated vital signs then they're a level two  
4 and if they don't they're a level three. So --  
5 -

6 Q: And the levels you're talking about, once  
7 again, these are acuity levels. Are these the  
8 triage or the billing acuity levels?

9 A: These are the triage levels. So again the  
10 scenario would be someone comes in, needs two  
11 services and has high blood pressure, they'd  
12 be a level two.

13 Q: Okay.

14 A: So again the second highest. If they need more  
15 than one service, they need a CT and a lab test  
16 but their vital signs are okay, they'd be a  
17 level three. And that's the category that was  
18 contemplated that some of those would be better  
19 to go to a hospital. So I think this sort of  
20 shows the acuity levels -- level -- all levels  
21 are appropriate for a freestanding ED and are  
22 treated in a freestanding ED.

23 Q: All right. Let's leave acuity behind us and go  
24 into another area that's been discussed and  
25 that's pediatrics. So what's your



1           understanding as a health planner on the  
2           ability of freestanding EDs to treat children  
3           or pediatrics which are defined as children  
4           under the age of what?

5       A:   Well it depends on the definition.   Some use 0  
6           to 15, ---

7       Q:   Uh-huh.

8       A:   --- some use 0 to 17.

9       Q:   All right.   Well you -- under either of those  
10          definitions can FEDs treat peds?

11      A:   Yes.   Again the freestanding ED is staffed by  
12          an emergency physician, the same doctor that  
13          would be in a hospital.   Same resources and  
14          staffing and equipment that we talked about are  
15          available to them.   Pediatric patients can  
16          present at a freestanding ED, the do present at  
17          a freestanding ED and are treated at a  
18          freestanding ED.

19      Q:   All right.   And we've mentioned Center Pointe  
20          a couple times today.   That's the Trident --  
21          one of the Trident freestanding EDs, correct?

22      A:   It is.

23      Q:   What's   your   understanding   of   Trident's  
24          treatment of pediatrics?

25      A:   They have dedicated pediatric ED treatment



1 spaces.

2 Q: How many?

3 A: I believe they have four. They have four  
4 dedicated pediatric treatment spaces.  
5 Pediatric patients are treated at their  
6 freestanding ED as they would at our  
7 freestanding ED.

8 Q: All right. And is -- have you heard the  
9 percentage of MUSC patients who are -- ED  
10 patients who are pediatric patients?

11 A: I think it was around 20 percent.

12 Q: All right. You want to -- let me ask you to do  
13 some -- take a look then at Roper Exhibit 59,  
14 page 20 for a minute just to refresh your  
15 memory, see if that would refresh your memory.  
16 All right. What kind of percentages of  
17 pediatric patients is shown there?

18 A: So it was in the 20s.

19 Q: In the 20s, your right.

20 A: It was 16 percent in 2014 and it's gone to 28  
21 percent in 2017.

22 Q: All right. Now given that I want to ask you to  
23 keep that in one part of your mind for a minute  
24 and we -- there's been plenty of evidence,  
25 testimony about the new children's hospital



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1 opening down on the peninsula, MUSC Shawn  
2 Jenkins Hospital building.

3 A: Uh-huh.

4 Q: What will the affect of Shawn Jenkins opening  
5 -- and I'm not asking for a detailed analysis  
6 at this point -- just generally what's going to  
7 be the effect of the Shawn Jenkins Hospital  
8 opening on -- given those percentages up there  
9 on the number of pediatric patients going to  
10 the MUSC FED if that opens?

11 A: It won't have any affect because Shawn Jenkins  
12 is on the peninsula so those patients that I  
13 think we saw maybe during Dr. Hall or  
14 somebody's testimony, the pediatric ED is in  
15 the main hospital now. It's going to move the  
16 Shawn Jenkins Hospital ---

17 Q: Uh-huh.

18 A: --- still on the peninsula so it won't affect  
19 the freestanding ED. I think what will affect  
20 the freestanding ED is in April of this year  
21 MUSC opened it's North Charleston Pediatric  
22 campus.

23 Q: Uh-huh.

24 A: So they opened an ambulatory surgery center and  
25 an imaging center and a medical office building



1 in North Charleston dedicated to pediatrics and  
2 that's closer to the freestanding ED than the  
3 Shawn Jenkins is so to the extent that resident  
4 of that area seek care at an MUSC facility  
5 outpatient services are going to -- outpatient  
6 surgery services are going to be moved from the  
7 peninsula to the -- have been moved from the  
8 peninsula to the north area. The mayor --  
9 Mayor Summey, the North Charleston mayor, they  
10 named it after him. It's the Summey ASC. Some  
11 people say Summey. I don't like to say Summey  
12 because of healthcare being sued, but Summey  
13 Healthcare ASC. And so pediatric patients are  
14 getting care in the North area now for services  
15 and it's a logical extension that they would  
16 seek emergency services in the North area as  
17 well and not go down to the peninsula.

18 Q: All right. Let's take a quick look back at the  
19 map that we've seen before today, MUSC Exhibit  
20 42. All right. So with respect to this map  
21 and the pediatric issue we've been discussing  
22 what's the relevance of this?

23 A: So this -- again we've seen this map before.

24 Q: Uh-huh.

25 A: We went through this map, and it shows the



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1 broader service area where the patients are  
2 going to come from and the redirection  
3 percentages to the freestanding ED.

4 Q: All right. And in terms of -- you were talking  
5 a moment ago about the MUSC pediatric -- new  
6 pediatric ambulatory surgery center and imaging  
7 center that's opening up. Where is that  
8 located again, and you said North Charleston,  
9 but where?

10 A: Yeah, it's ---

11 MR. SUMMER: Excuse me, counselor, didn't you  
12 correct this slide because isn't it still  
13 missing ---

14 MR. WESTBROOK: It is still missing. We did not  
15 correct it. We -- thank you for calling --  
16 well I'll tell you what ---

17 MR. SUMMER: Don't you have a corrected slide  
18 though? Didn't you have one ---

19 MR. WESTBROOK: We never corrected that. I am so  
20 sorry. Thank you. I need to consult with you  
21 about a few other things too. I didn't realize  
22 we had a corrected slide. I'm so glad to hear  
23 that. Thank you, Mr. Buff. I'm short changing  
24 you. Thank you, sir.

25 Q: So we have the Trident Center -- there it is,





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1           yes.           Trident   Center   Pointe   is   there.  
2           Wonderful.   And Roper Northwoods is there.   So  
3           where is this pediatric center that you've been  
4           talking about?

5   A:    It's near the Center Pointe.

6   Q:    It's near the Center Pointe.   Okay, good.   All  
7           right.   All right.   Good.   Let's go -- well  
8           before we bo to another -- I think you can  
9           leave that up there for a minute.   So, Mr.  
10          Levitt, in your opinion -- let me just ask you  
11          a few questions about your analysis that we've  
12          already talked about this analysis of shifting  
13          or redirecting -- however you want to call it  
14          -- MUSC patients from the North area to the new  
15          FED.   Should you have not considered or reduced  
16          your consideration of patients who are -- who  
17          go to MUSC now but who are ultimately admitted  
18          to a hospital?

19   A:    No, because as we said those patients can be  
20          treated at a freestanding ED.   If they need  
21          inpatient admission they can be transferred to  
22          a hospital.

23   Q:    All right.   What about patients who live in the  
24          North area but work downtown Charleston?  
25          Should you have factored that in?



**TMC, ET AL. V. SC DHEC, ET AL.**

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1     A:    No, because again people that live on the  
2           peninsula will also work in the North area so  
3           there's sort of cross migration that, you know,  
4           we -- you heard some testimony about the  
5           development in the area, the population growth  
6           in the area, the development in the area,  
7           Boeing, Mercedes, the airport, Volvo, Amazon,  
8           all of those are employers in the North area  
9           that people would travel to for work as well.  
10          So we didn't give an adjustment for people that  
11          live somewhere else and work there versus  
12          people that work there and live somewhere else,  
13          so.

14        Q:    All right. What about -- should there be an  
15           adjustment for patients from the North area who  
16           have physician affiliations at MUSC?

17        A:    No, because they will still have access to  
18           those physicians, those specialists that they  
19           want within the MUSC network, still have access  
20           to those physicians through telemedicine and  
21           other methods if they were to seek care at the  
22           MUSC freestanding ED.

23        Q:    All right. Now there's been testimony that  
24           MUSC wants to build a community hospital in the  
25           Nexton area, not too far from where the FED is



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1           proposed to be built.       There's been some  
2           criticism that you did not adjust your  
3           projections to account for patients who would  
4           go to that community hospital, is that  
5           justified criticism?

6       A:    No.    Well first of all that application was  
7           submitted after this application so ---

8       Q:    Okay.

9       A:    --- that community hospital project or  
10           application didn't exist when we submitted  
11           this.    Even today we wouldn't adjust it for  
12           that because they're going to be complimentary.  
13           So the community hospital is going to treat  
14           patients, the freestanding EDs going to treat  
15           patients and they're not mutually exclusive.

16      Q:    All right.   The -- let's look at slide 21 for  
17           a moment.   Tell us what this is, Mr. Levitt?  
18           Do you recall this?

19      A:    Yeah, this is from the Summerville freestanding  
20           ED application that was reviewed at the same  
21           time ours was ---

22      Q:    Right.

23      A:    --- the MUSC application.   And what it shows is  
24           -- the first sentence there is under adverse  
25           impact, it was the heading.



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2101

1 Q: Yep.

2 A: And it says the majority of the patients that  
3 Summerville FED will serve would otherwise be  
4 served at SMC. So again the criticism that my  
5 redirection, patients who would have gone to  
6 MUSC will go to our freestanding ED. They  
7 don't think that that would happen.  
8 Summerville thought that exactly what was going  
9 to happen for them. That their freestanding ED  
10 was going to the major -- the majority of those  
11 patients would be served at SMC meaning  
12 Summerville Medical Center.

13 Q: All right. Okay. Let's move to another topic  
14 and talk about something -- a phrase that I've  
15 heard a lot of this week -- capacity  
16 constraints. Let's start with a diagram, slide  
17 22, please? All right. This is obviously just  
18 a diagram. What does it show?

19 A: This is the peninsula, the downtown peninsula,  
20 showing the MUSC Hospital, the Ashley River  
21 Tower, the Shawn Jenkins Children's Hospital  
22 which is going to open in the fall, and then  
23 sort of in the middle of those are -- is Roper  
24 Hospital.

25 Q: All right. And why did you put Roper Hospital



1 in there?

2 A: Because it's the building right between those  
3 two facilities and I thought it was important  
4 to sort of highlight that there's an emergency  
5 room at Roper right across the street from the  
6 emergency room at MUSC.

7 Q: All right. Now with that in mind we -- there's  
8 been a lot of discussion by various people this  
9 week about the number of visits per emergency  
10 room that should be considered when trying to  
11 analyze capacity analysis. So tell me about  
12 why you used 1,250 in your analysis.

13 A: Well so a couple reasons. So generally 1,500  
14 to 1,250 is accepted as the capacity of an ED.  
15 I think you heard Mr. Sullivan say he uses --  
16 usually uses 1,500. MUSC's a little different.  
17 It's more on the lower end of the capacity  
18 because they -- it's an academic medical center  
19 that treats a lot of high acuity patients. A  
20 significant volume of behavioral health  
21 patients that have a very long length of stay  
22 in the emergency department. On average, you  
23 know, you heard Dr. Cawley say they have 20 to  
24 30 boarders, meaning patients in the ED, that  
25 need to go somewhere else but they're still in



1 the ED so that extends their length of stay.  
2 The behavioral health patients we saw from one  
3 of the Exhibits the average length of stay is  
4 36 hours so a day a day and a half they stay in  
5 the emergency room. So if you think about that  
6 if one patient stays 36 hours, a day and a  
7 half, you can only treat about 200 patients in  
8 that bed because they're there a day and a half  
9 so 365 days of the year divided by a day and a  
10 half equals about 220 or whatever the number  
11 would be. That's all you can treat in that one  
12 bed. So a capacity of 1,500 it's 200 not 1,500  
13 but overall those are just a portion of the  
14 patients. The MUSC information showed the  
15 average length of stay in 2018 in the emergency  
16 department was just over six hours so assuming  
17 that the room would need to be cleaned and  
18 disinfected after the one patient moves out  
19 before the next patients moves in, if you round  
20 that to seven hours per day if you can only  
21 treat, you know, in a 24 hour day if one  
22 patient stays seven hours then you can only  
23 treat between three and four patients in that  
24 room a day times 300 -- and that's assuming  
25 around the clock and ---



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1 Q: Uh-huh.

2 A: --- and even distribution. 365 days out of the  
3 year at seven hours per patient that's 1,252  
4 patients so that's pretty close to the 1,250  
5 that I used. There's also a source, his last  
6 name is Huddy, H-U-D-D-Y. He's published some  
7 ER -- emergency room planning guidelines and  
8 the Huddy guidelines have a range, a low and a  
9 high range and it's bifurcated by volume so he  
10 says, you know, if you have 30,000 ED visits  
11 the low range of beds are this and the high  
12 range of beds are that and he uses around 1,300  
13 on the low range and 1,700 on the high range so  
14 you can see the average is around 1,500 with  
15 MUSC being on the lower end, 1,250 to 1,300.

16 Q: All right. Now volume trends at MUSC, or the  
17 recent volume trend at MUSC, has been a topic  
18 of conversation., and when I say volume I'm  
19 talking about emergency department volume. How  
20 -- first of all, how would you characterize it  
21 generally for the last few years at MUSC?

22 A: MUSC's been pretty flat. It's right around  
23 80,000, depending on the source sometimes a  
24 little more, 84,000 to 82,000 to 79,000  
25 depending on the source, but it's been fairly



1 flat over the time period partly due to  
2 capacity constraints.

3 Q: All right. Let's look at Roper Exhibit 59,  
4 page 15 for just a moment, please? This was an  
5 Exhibit -- does that accurately reflect -- that  
6 line graph accurately reflect the volume trend  
7 for the last four years?

8 A: No, I think it's misleading. You know, I think  
9 the data's accurate but the scale, you can see  
10 the scale goes from 85,000 to 76,000 so I think  
11 it artificially shows this dramatic decline  
12 that doesn't frankly exist in reality.

13 Q: Well do you have a counter graph that you'd  
14 like to show?

15 A: I do.

16 Q: Let's look at slide 23, please.

17 A: So this shows a scale starting at zero which in  
18 my experience is sort of how you should show  
19 things. I think it becomes misleading when you  
20 change the scale to make it look as though  
21 there's this dramatic decline and you can see  
22 they're -- we were a little bit off on our  
23 projections. We thought the trend -- growth  
24 trend would continue based on population growth  
25 but we were fairly flat so the orange line is





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1           the actual data, the blue line was what we had  
2           projected in 2016 and you can see they're  
3           really not that far off.

4       Q:   All right.   Let's look at -- let's look at  
5           slide 24, please.   All right.   RFA volume data  
6           versus audit data.   First of all, what's RFA?

7       A:   RFA is the Department of Revenue and Fiscal  
8           Affairs.   It's a state agency of South Carolina  
9           that compiles demographic and healthcare  
10          information and it's publicly available  
11          information as well as providers can enter into  
12          a data use agreement to get some more specific  
13          information to help do market assessments and  
14          community needs assessments.

15      Q:   Okay.   And what audit are you talking about?

16      A:   These are the financial audits of MUSC, or  
17          MUHA.

18      Q:   MUHA.   All right.   And so you're comparing them  
19          -- that data for those three years.   What's  
20          your point?

21      A:   Yeah, so what we looked at was -- you know, as  
22          I said we've been around 80,000 visits.   That's  
23          what Dr. Cawley said.   The RFA data shows that  
24          78, you know, 79,000, 81,000, 79, almost 80,000  
25          in 2017.   The audit I think was talked about



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1 with Dr. Cawley yesterday saying that the audit  
2 showed declining volumes in ED and it does, but  
3 you can see this turning point's a lot higher.  
4 So the decline from -- it went from 82,000 in  
5 '15, 84,000 in '16 to a little over 82,000 in  
6 '17 so it did go up and down again in '17, but  
7 you can see the number's over 82,000 versus  
8 79,000 from RFA. So this is just to show --  
9 depending on the data source -- their different  
10 numbers, audit numbers, RFA numbers, and then  
11 what's not shown on here is JAR numbers which  
12 I'm certain are different than this, pretty  
13 close, and then probably discovery numbers from  
14 different sources. I know two sources in the  
15 discovery have slightly various numbers --  
16 slightly different numbers -- but they're all  
17 around 80,000.

18 Q: Okay. And when you say JAR once again what are  
19 you referring to?

20 A: That's the Joint Annual Report that the  
21 hospitals submit every year.

22 Q: It's submit to DHEC?

23 A: It's submit to DHEC, yes.

24 Q: All right. All right. Let's go to MUSC  
25 Exhibit 34. I think this has been admitted



1           into evidence. And the vetting says something  
2           about ED patient origin growth. Tell me what  
3           this shows you, Mr. Levitt?

4       A:    Yeah, so this shows that, you know, the issue's  
5           been raised well MUSC volume's flat and this  
6           again these are different numbers than what we  
7           just saw.

8       Q:    What are these numbers based on?

9       A:    These are the custom reports from RFA again.  
10           So -- consistent with the data use agreement to  
11           get numbers from RFA. It's consistent, you  
12           know, as I said, around 80,000. These show for  
13           2017 79,650 which is very close to the numbers  
14           on the last slide, but this shows the ED volume  
15           by county and you can see -- so while our  
16           volumes are fairly flat to slightly declining  
17           overall what's important is the first line,  
18           Berkeley County, we have -- had growth. 1,600  
19           almost 1,700 more visits from Berkeley County  
20           all the way down the peninsula. So while our  
21           overall volume may be flat, the Charleston  
22           volume's declining, the Berkeley County  
23           volume's increasing.

24       Q:    All right. And Berkeley County of course is  
25           where the project's located, right?



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1 A: It is and then adjacent, you know, portions of  
2 Dorchester County are close to the project as  
3 well and it also showed a modest increase.

4 Q: All right. Let's go to Trident Exhibit 101,  
5 page 12, please? All right. This is Mr.  
6 Sullivan's analysis, is that correct?

7 A: It is.

8 Q: All right. And why do you want to look at it?

9 A: Well I tink for two reasons. One is to show,  
10 you know, I think what this Trident analysis  
11 was to purport was that with the addition of  
12 Shawn Jenkins, the 20 beds at Shawn Jenkins,  
13 our capacity constraint problems will be  
14 solved. That we'll go down to 63 percent  
15 utilization assuming a 1,500 capacity or a 75  
16 percent utilization assuming a 1,250 capacity.

17 Q: Uh-huh.

18 A: And I think it's inaccurate for a number of  
19 reasons and we'll talk about those in a second.

20 Q: All right. Slide 25, please? All right. So  
21 is this your response to the chart we just saw?

22 A: It is. So ---

23 Q: All right. Let's walk through -- a lot --  
24 again a lot of numbers, a lot of calculations,  
25 so take us through this deliberately, okay?



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1 A: Yeah. So, the first column is the 67 beds that  
2 we currently have in the emergency department.

3 Q: Okay.

4 A: And that is, you know, comprised of the 29  
5 adult beds, 12 adult psychiatric beds, 10 -- or  
6 16 pediatric beds, and 10 chest pain center.

7 Q: Slow down.

8 A: Well I haven't gotten there yet, it's not on  
9 the slide. I'm just telling you.

10 Q: Okay.

11 A: So ---

12 Q: Well still slow down, okay? Because I'm not  
13 following you.

14 A: So that's where the 67 beds come from.

15 Q: Okay.

16 A: And then we are adding 20 Shawn Jenkins beds,  
17 and you heard Dr. Hall and Dr. Cawley testify  
18 that we can't -- or we're not going to using  
19 the four E pod beds ---

20 Q: Right.

21 A: --- so we're adding 20 but we're going to take  
22 away four ---

23 Q: Uh-huh.

24 A: --- for a total of 83 beds.

25 Q: Okay.



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1     A:     And I think it's important to look at what are  
2           those 83 beds. So again as I was going through  
3           a second ago, 29 adult beds, 12 adult psych  
4           beds, give us the 41 beds, the main ED.

5     Q:     Uh-huh.

6     A:     That's what we call the adult ED

7     Q:     Uh-huh.

8     A:     16 pediatric beds for 57 main hospital beds.  
9           They've identified ten chest pain center beds.  
10          I honestly think it's nine because one is  
11          triage but we'll count ten in here and we get  
12          67 beds.

13    Q:     Okay.

14    A:     So that's where the 67 beds we currently have  
15          come from.

16    Q:     Okay.

17    A:     So with the Shawn Jenkins addition we'll have  
18          83 beds, and those 83 beds will be 29 adult  
19          care beds. So no relief on adult, no  
20          additional adult care beds. We have 29 now,  
21          we'll have 29 with Shawn Jenkins.

22    Q:     Uh-huh.

23    A:     We have 12 adult psych beds now. The 16 former  
24          peds beds -- again we say we're not going to  
25          use four of those ---



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1 Q: Uh-huh.

2 A: --- the E pod rooms that are not optimal for  
3 care. So were' going to have 12 additional  
4 beds that were going to focused on psych care  
5 because of the -- you know, we said 36 hour  
6 length of stay and all of the reasons we talked  
7 about. So we'll have 24 psych beds, ---

8 Q: Right.

9 A: --- and that'll be 53 beds in the main  
10 hospital. So again ---

11 Q: Uh-huh.

12 A: --- we lose four beds because of E pod, ---

13 Q: Uh-huh.

14 A: --- still have the ten chest pain center beds,  
15 ---

16 Q: Uh-huh.

17 A: --- and then the 20 Shawn Jenkins beds. So  
18 that's where Mr. Sullivan gets his 83 beds but  
19 you can see we have no relief in the adult ED.  
20 We still have 29 beds. So the addition of  
21 Shawn Jenkins isn't going to help any capacity  
22 constraints in the adult ED with the exception  
23 of behavioral health because we don't have  
24 enough behavioral health beds now with the 12  
25 so we'll have more behavioral health beds but



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1 we still won't have any more adult beds.

2 Q: All right. You heard Dr. Hall testify?

3 A: Yes.

4 Q: Where did he say that the real problems with  
5 constraints and congestion are?

6 A: He said both in the adult and the psychiatric  
7 portion of the ED.

8 Q: Okay. All right. Let's go -- there was some  
9 discussion yesterday about a new CON  
10 application that MUSC has filed for 29  
11 additional beds, do you recall that?

12 A: Yes.

13 Q: All right.

14 **MR. WESTBROOK:** Mr. Buff, can you help us out there?

15 Q: So what is this, Mr. Levitt?

16 A: So this is from that CON application and it  
17 shows the occupancy of the beds at MUSC in the  
18 different areas that we have beds. So we have  
19 the Ashley River Tower at nine -- in 2018 at 90  
20 percent occupancy. The children's hospital in  
21 its current location at 83 percent occupancy.  
22 MUSC Medical Center -- that's the rest of the  
23 hospital -- at about 85 percent occupancy, and  
24 what we were referring to as the IOP, or the  
25 Institute of Psychiatry, at 109 percent





1 occupancy. So you can see the psych beds are  
2 full. That's part of the reason with the  
3 borders and psych problems in the ED, but  
4 overall we're at about 90 percent occupancy at  
5 the hospital, at MUSC. That's the highest  
6 occupancy of any hospital in the state, highest  
7 average daily census of any hospital in the  
8 state, and obviously we have capacity  
9 constraints on our inpatient beds.

10 Q: All right. So those 29 beds if they are  
11 approved -- they haven't been approved yet have  
12 they?

13 A: They have not been approved.

14 Q: If they are approved is that going to take care  
15 of the problem?

16 A: No. It will help. So the plan for the 29 beds  
17 is -- so the children's hospital is moving to  
18 the new Shawn Jenkins building, ---

19 Q: Uh-huh.

20 A: --- vacating portions of the hospital, and the  
21 backfill plan as we call it is to add licensed  
22 acute care beds in that space that's currently  
23 used for pediatric acute care beds to help  
24 relieve some of this capacities, capacity  
25 constraints. You know, we heard testimony



1       about I think it's 30, 33, 36 beds we've been  
2       approved for that we cannot implement because  
3       we have no space. Those are going to go into  
4       the vacated space from the children's hospital.  
5       The 29 beds that we've just applied for are  
6       also going to go into that space, but we're  
7       talking about 50 beds in a 704 bed hospital  
8       that's 90 percent occupied. It would take us  
9       down to about 82 percent occupancy if all those  
10      beds were operated and we had no increase in  
11      utilization. So unlike ED visits the hospital  
12      -- MUSC Hospital -- has had increasing  
13      admissions every year for the last five years  
14      and needs more space.

15    Q:   All right. All right. Let's go back to the  
16       topic of emergency volume -- emergency visit  
17       volumes and the growth in that. Let's go to  
18       MUSC Exhibit 35, proposed Exhibit 35. And so  
19       this looks like you've made some calculations  
20       by county. What's the blue line there show?

21    A:   So this shows the residents of those counties,  
22       the number of emergency room visits that they  
23       experienced and the sources -- revenue of  
24       fiscal affairs -- by county of residence. So  
25       this is regardless of where they sought care.



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1           14,000, almost 15,000, growth in ED visits for  
2           Berkeley County residents from 15 to 17. So  
3           you can see that's a 17 percent growth. 15,000  
4           more people sought emergency room care in  
5           Berkeley County -- or from Berkeley County.

6       Q:    Let's go to proposed Exhibit 37, please? And  
7           what does the green line show?

8       A:    So this shows the overall trends. Again this  
9           is an update to what we presented in project  
10          review and it adds one more year of data.  
11          There was a slight decrease in 2017 from  
12          409,000 to 404,000. The source of this is the  
13          JAR.

14      Q:    Uh-huh.

15      A:    You know, we talked about some of the issues  
16          with JARs, the accuracy. I heard earlier in  
17          the trial some testimony about the American  
18          Hospital Association has said that community  
19          hospitals are experiencing growth in emergency  
20          services. The National Center for Health  
21          Statistics identifies there's an increase in  
22          emergency services. The Revenue of Fiscal  
23          Affairs says that Berkeley County residents are  
24          experiencing an increase, this shows a  
25          decrease. You know, I'm not sure if there's an



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1 issue with the data but it would be counter to  
2 all the national and regional trends.

3 Q: All right.

4 A: But regardless of that, so from 2012 to 2017  
5 there was still 76,000 additional visits -- ER  
6 visits -- in the service area. So I think Ms.  
7 Murdock said there was explosive growth. I  
8 think that's what she's referring to. That's  
9 a lot of additional volume in a very sort  
10 period of time, and I think we talked about  
11 this on the last slide, the Trident growth from  
12 70 to 90,000, the year Center Pointe opened for  
13 2017 -- '16 to '17 most providers were flat to  
14 slightly declining. Trident was fairly flat,  
15 went down just a little bit, but Summerville  
16 went up by about 2,300, 2,400 patients. So,  
17 you know, this is a growth area. Those are the  
18 two closest hospitals to the proposed site.  
19 You can see their volume of growth. I think  
20 that's also explosive. Over 50 percent growth  
21 in a very short period of time, a four year,  
22 five year period. I think that indicates the  
23 utilization of the existing providers in that  
24 area is growing and that additional resources  
25 are needed.



1 Q: All right.

2 **MR. WESTBROOK:** And at this point I'd like to move  
3 to admit MUSC Exhibits 35 and 37 both into the  
4 record, please.

5 **MS. HOLLINGSWORTH:** No object, Your Honor.

6 **MR. SUMMER:** No objection, Your Honor.

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

8 **(Respondent MUSC's Exhibit Numbers 35 and 37 were**  
9 **admitted into evidence.)**

10 Q: All right. Let's see if we can run through  
11 these next four slides rather quickly. Excuse  
12 me, they're not slides. These are proposed  
13 Exhibits. Let's start with MUSC Exhibit 36.

14 **(Respondent MUSC's Exhibit Number 36 was introduced**  
15 **into the record at this time.)**

16 Q: The blue line shows what for Berkeley County's  
17 percentage of growth over the last few years?

18 A: Almost ten percent, about 9.6 percent. This is  
19 projected current five year projection so  
20 currently in 2019 it's expected to grow 9.6  
21 percent by 2025, ---

22 Q: Uh-huh.

23 A: --- and it's the third fastest growing county  
24 in the state.

25 Q: All right. Let's look at Exhibit 30, please,



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1 MUSC's 30.

2 **(Respondent MUSC's Exhibit Number 30 was introduced**  
3 **into the record at this time.)**

4 Q: The highlighted lines down at the bottom, what  
5 does that show?

6 A: Again, so these are the zip codes, the 25 zip  
7 codes that we identified ---

8 Q: Uh-huh.

9 A: --- as the source of patients. The growth in  
10 that area is 8 and a half percent compared to  
11 six percent for the state overall.

12 Q: Uh-huh.

13 A: And you can see many of the zip codes within  
14 the service area have double digit growth, 10  
15 percent, 10.2 percent, and the zip code we're  
16 located, in I think 483, is 8.8 -- 8.7 percent,  
17 so.

18 Q: All right. Let's look at Exhibit -- proposed  
19 Exhibit 31.

20 **(Respondent MUSC's Exhibit 31 was introduced into the**  
21 **record at this time.)**

22 Q: And, again, what does it -- these are the same  
23 zip codes?

24 A: Same zip codes grouped by county.

25 Q: Uh-huh.



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1 A: So you can see the Berkeley County zip codes,  
2 a 9.4 percent growth.

3 Q: Uh-huh.

4 A: You know, we talked about many of the double  
5 digit zip codes those are in the Berkeley  
6 County area, ---

7 Q: Uh-huh.

8 A: --- Charleston 8 percent and Dorchester about  
9 7 and a half percent.

10 Q: All right. And finally let's look at --  
11 finally for this section of the exam -- let's  
12 look at MUSC proposed Exhibit 32, please.

13 **(Respondent MUSC's Exhibit Number 32 was introduced**  
14 **to into the record at this time.)**

15 A: This is a heat map that shows the population  
16 growth by zip code with the darker color -- the  
17 darker red -- being the higher growth area at  
18 10 to, you know, as I said, double digits, 10  
19 to 10.2 percent versus the lighter color yellow  
20 being the lower percentage growth. And you can  
21 see the concentration of growth is in the area  
22 we're talking about. We talked a little bit  
23 about the Berkeley County zip code 29461. It's  
24 a broad geographic zip code so it looks like  
25 it's far away but it really just -- it starts



1           just next to where it says South Carolina.

2       Q:     All right.

3       A:     So that's the zip code that's included in that  
4           and you can see we're sort of right in the  
5           middle of all that growth.

6       Q:     Okay. All right.

7       **MR. WESTBROOK:** At this point I'd like to move to  
8           admit these four Exhibits that we've talked  
9           about. That's MUSC Exhibits 30, 31, 32 and 36  
10          into evidence, please.

11       **MS. HOLLINGSWORTH:** No objection, Your Honor.

12       **MR. SUMMER:** No objection, Your Honor.

13       **THE COURT:** They're admitted.

14       **(Respondent MUSC's Exhibit Numbers 30, 31, 32 and 36**  
15       **are admitted into evidence.)**

16       **MR. WESTBROOK:** Thank you, Your Honor.

17       Q:     All right. Mr. Levitt, let us talk about State  
18           Health Plan.

19       **MR. WESTBROOK:** Your Honor, let me just say right  
20           now I'm perfectly happy going forward. This is  
21           sort of a new area that I'm going into. I  
22           boldly predicted to my friends on our last  
23           break that I was half way through. It turns  
24           out I was seriously in error, but I don't have  
25           that much to go. I would say that I have less





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1           than an hour to go is my current estimate. I  
2           don't -- are we on the record? I'm afraid we  
3           are. So -- but I think it's going to be less  
4           than an hour and I'm happy going forward or I'm  
5           happy to break, whatever you prefer.

6   **MR. SUMMER:** We prefer to move forward so that we  
7           can prepare at lunch. That would be our  
8           preference.

9   **THE COURT:** Okay. I approve of that.

10 **MR. WESTBROOK:** That's fine.

11 Q: All right. State Health Plan. You're familiar  
12 with that document are you not?

13 A: I am.

14 Q: All right. Let's -- let me just first ask you  
15 about -- do -- what's your position -- what's  
16 your opinion, is there a licensed hospital in  
17 Berkeley County in your opinion?

18 A: No.

19 Q: All right. Let's go to Standard Six of the 200  
20 -- of the 2015 State Health Plan. Let's put  
21 that up on the screen. The applicant must  
22 demonstrate need for this service by  
23 documenting where the potential patients  
24 proposed service will come from and why they  
25 are not being adequately served by existing



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1 services in the area. All right, Mr. Levitt,  
2 does the MUSC project comply with that standard  
3 in your opinion.

4 A: Yes.

5 Q: Why is that?

6 A: Well we've demonstrated that the patients --  
7 we've identified the zip codes, the service  
8 area of where they're going to come from and  
9 why they're not being adequately served.  
10 They're traveling by those existing facilities.  
11 They're not being served by those existing  
12 facilities. Choosing to go to the MUSC  
13 Hospital and -- to seek care. So the existing  
14 resources aren't adequately providing services  
15 because they're choosing not to go there.

16 Q: All right. And the project changes that we  
17 spent a good bit of time talking about early in  
18 your direct today, do any of those changes that  
19 you discussed and that we discussed in your  
20 opinion affect this project's compliance with  
21 that standard negatively or positively?

22 A: No, they don't affect it. Those changes  
23 wouldn't affect where the patient's going to  
24 come from or why they're not adequately being  
25 served.



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2124

1 Q: All right. Let's look briefly at South  
2 Carolina Code 44-7-225 just for a little  
3 context. And it says the Department, the  
4 Administrative Law Court and the Court of  
5 Appeals shall consider -- shall consider the  
6 South Carolina Health Plan in place at the time  
7 the application was filed. What plan was that,  
8 Mr. Levitt?

9 A: The 2015 Plan.

10 Q: And may consider the current South Carolina  
11 Health Plan when making it's decision. What's  
12 the current South Carolina Health Plan?

13 A: Well the current one is 2018 but a new one's  
14 comin' out.

15 Q: When's the new one coming out?

16 A: I've been told it's eminent so ...

17 Q: You've been told by whom?

18 A: By Lewis Eubank, the Bureau Chief I guess for  
19 it. So it's imminent, the new plan's being  
20 developed.

21 Q: Have you reviewed the section on freestanding  
22 emergency departments in the interim plan or  
23 the new plan?

24 A: I haven't seen the interim plan, no.

25 Q: Okay. All right, then we won't ask you about



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1           that.    So let's -- let's look at since this  
2           Court may consider, has the discretion to  
3           consider, the current plan, let's look at the  
4           current plan for a moment. That's the 2018-19  
5           plan, is that right?

6   A:    Yes.

7   Q:    All right. I believe we've seen this language  
8           earlier this week or last week or sometime.  
9           And this is kind of a long sentence so I just  
10          want to ask you first to consider the first  
11          half of this sentence and the sentence is  
12          highlighted, the part that's highlighted and  
13          we'll get to the rest of the sentence later.  
14          It says, the applicant must demonstrate need  
15          for this service by documenting capacity  
16          constraints within existing emergency  
17          departments in the service area. All right.  
18          Let's -- so let's talk for a minute about  
19          capacity constraints within existing emergency  
20          departments in the service area. Let's start  
21          with Roper Exhibit 59, page 7, please. All  
22          right. Existing and approved ED capacity  
23          within 20 miles of MUSC FSED defined service  
24          area. All right. Now I know you have some --  
25          a number of comments about this -- is it --



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1           before we go to another slide is there anything  
2           want to discuss about this or point out about  
3           this?

4       A:     I don't think so.

5       Q:     All right. Then we shall move one. Let's go  
6           to slide 27 I believe it is. All right. So  
7           these are your revisions to Ms. Platt's  
8           capacity analysis that we just looked at, is  
9           that right? Or some of your revisions or ...

10      A:     Well I think this is the same. It's getting  
11           ready to be my revisions.

12      Q:     All right.

13      A:     So I think this is the same as the last slide  
14           we looked ---

15      Q:     All right. We're teeing you up for your  
16           revisions. So what are the first revisions you  
17           have. What -- let me ask you this, what about  
18           those -- the providers that are listed there.  
19           The first provider, Roper Hospital Berkeley,  
20           and your opinions should that be on this --  
21           part of this consideration?

22      A:     No. So if you're looking at the current health  
23           plan it says existing providers. So Roper  
24           Berkeley Hospital is not an existing provider.

25      Q:     Why not?



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2127

1 A: It's not open.

2 Q: Okay. And what about down the line there it  
3 says, Berkeley Medical Center. What is  
4 Berkeley Medical Center?

5 A: So Berkeley Medical Center is the Trident 50  
6 bed facility that was approved and it's also  
7 not open.

8 Q: All right. Is that the one in Moncks Corner?

9 A: Yes.

10 Q: And it's not open either?

11 A: No.

12 Q: So what would you do with those two facilities  
13 ---

14 A: Well if you're looking ---

15 Q: --- in this analysis?

16 A: If you're looking at existing providers you  
17 would take them off.

18 Q: Okay. All right. So do we have a slide that  
19 does that? How about going to -- is it 28?  
20 There you go. All right. So those are your  
21 redlines, is that right?

22 A: Correct. Redlines and then the resulting  
23 updated treatment space and capacity.

24 Q: All right.

25 A: So the other change we made was the visit



1 capacity.

2 Q: All right.

3 A: So in the previous slide of that 2,000 ---

4 Q: Uh-huh.

5 A: --- so we talked about using 1,500 which is  
6 basically as I mentioned the Huddy document  
7 that would be basically the average of the  
8 Huddy high and low. It's what Mr. Sullivan  
9 said he used -- uses as a guideline and it's on  
10 the high side for MUSC but we use that for all  
11 of these providers. You know, some of these  
12 providers are, you know, Trident Medical Center  
13 is not a community hospital. It offers  
14 tertiary services so, you know, I think this  
15 adjustment is reasonable and appropriate.

16 Q: All right. Let's go to Trident Exhibit 98 for  
17 a minute.

18 **MR. WESTBROOK:** Well, I'm sorry, before we go there  
19 -- I'm sorry. Dan let's see it.

20 Q: So when you make those adjustments, you take  
21 off the two approved but not yet operational  
22 hospitals, you make the adjustment to 1,500,  
23 how does it affect the bottom line there?

24 A: Yeah. So again it changes the treatment spaces  
25 to 139 and then using 1,500 it's 208,500.



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1 Q: All right. Let's talk about treatment spaces  
2 for a minute and to do that let's go to Trident  
3 Exhibit 98, please. All right. What's the  
4 significance of Trident Medical Center's ED  
5 beds, this chart here?

6 A: So Trident identified that Trident Medical  
7 Center had 46 ED treatment spaces. So if you  
8 look at the CON application to expand their ED  
9 they had 29 existing capacity which included  
10 one triage so I would really count them as 28.  
11 And the proposed CON was to add eight for a  
12 total of 37. Again that includes the triage so  
13 it's really 36 additional spaces for the  
14 emergency department.

15 Q: All right.

16 A: In there you can see they had six fast track  
17 beds included in the 28 or 29 ---

18 Q: Uh-huh.

19 A: --- they're adding six so that would give them  
20 12 fast track in the 36 or 37 total capacity.  
21 So when they said they had 46 ---

22 Q: Uh-huh.

23 A: --- I'm not sure where that number from because  
24 that's not what they were approved for in their  
25 CON application.





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1 Q: All right. So perhaps we'll hear from that on  
2 -- later in the case, but at this point based  
3 on the data that you've seen how many beds does  
4 it appear they have?

5 A: 36 treatment beds.

6 Q: All right. And so how would -- let's go to  
7 another slide to see how it affects the ED  
8 capacity analysis. Let's go to slide 29,  
9 please.

10 A: Right. So that 46 goes to 36 ---

11 Q: Uh-huh.

12 A: --- times 1,500 gives you 54,000 capacity and  
13 then the total capacity goes down by 1,500 to  
14 193,500.

15 Q: Okay. And finally let's go to slide 30,  
16 please.

17 A: Yes.

18 Q: All right. And what does slide 30 show?

19 A: So that -- those first three columns -- or four  
20 columns including the provider -- are the same.  
21 So it shows the 129 treatment spaces at 1,500  
22 capacity. 193,500 is their capacity. This is  
23 the actual utilization. The round numbers ---

24 Q: Uh-huh.

25 A: --- the 32,000 and the 15,500 come from the



1 trial. This is what they said in the trial as  
2 their ---

3 Q: What who said in the trial?

4 A: I believe that's what RN, the nurse, Ms.  
5 Eccleston I think or Huntington. It would be  
6 the Roper. The Roper numbers came from their  
7 testimony about their utilization at their EDs.

8 Q: So, again, you're talking about Ms. Huntington  
9 who testified here?

10 A: Yes.

11 Q: All right.

12 A: And she gave an estimate so I used those  
13 estimates because I don't have utilization. We  
14 asked for it in discovery, it was never turned  
15 over. Utilization by location for Roper.  
16 Trident did give us utilization by location so  
17 I used that information. So that's why we have  
18 precise numbers versus rounded numbers and you  
19 can see the total utilization of all these  
20 facilities, 224,000 visits with a capacity of  
21 193,000 puts them at a 115 percent utilization  
22 for full.

23 Q: All right. Now if I understand it correctly,  
24 Mr. Levitt, let's go back to the 2018-2019 Plan  
25 language that we were looking at.



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1     **MR. WESTBROOK:**   Sorry about that, Dan.

2     **MR. BUFF:**     The one from earlier?

3     Q:     Yeah, the one from earlier.     The 2018-2019  
4             language from the plan. And again this plan is  
5             relevant as I understand it -- correct me if  
6             I'm wrong -- only if this Court chooses to  
7             consider it, is that correct?

8     A:     Yes.

9     Q:     All right.     Capacity constraints within  
10            existing emergency departments in the service  
11            area, we just showed that slide that you based  
12            on your calculations of 115 percent, is that  
13            right?

14    A:     Yes.

15    Q:     What does that show?

16    A:     Well it shows that the existing emergency  
17            departments are capacity constrained. So, you  
18            know, in the absence of information obtained  
19            during discovery or in the trial, you know, as  
20            Ms. Murdock said, you don't know how many  
21            treatment spaces or what the volume is at the  
22            freestanding EDs. So you ---

23    Q:     Why don't you know that?

24    A:     Because they're reported on the JAR in total.  
25            So treatment spaces are never reported. So I



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1       guess you could find them through CON  
2       applications as I did to find Trident's volume  
3       of 36 versus what they said, 46 here. But I --  
4       you know, on the Trident JAR it shows around  
5       90,000 ED treatments. That includes the  
6       hospital and the two freestanding EDs. So I  
7       can't tell you if Center Pointe's capacity  
8       constrained from a occupancy percentages  
9       because number one, there's some argument over  
10      what the capacity is. The State doesn't  
11      identify it was it does for other services, for  
12      instance, cardiac cath. It says 1,250 per  
13      room. It doesn't say that for ED. But then I  
14      don't know how many ED spaces they have at  
15      Center Pointe but for the absence of the  
16      information I obtained in this trial. And then  
17      I don't know what -- of that 90,000 I don't  
18      know how many of those are at Center Pointe.  
19      So I can't tell you if Center Pointe's full or  
20      if Trident's full or if Moncks Corner's full,  
21      and I think it's a similar error -- or  
22      limitation I should say -- a similar limitation  
23      that Mr. Sullivan made when he said, well  
24      you'll have 83 treatment rooms so you're not  
25      full. Well you need to know where those 83



1 treatment rooms are and what the utilization is  
2 of those areas to determine if it's capacity  
3 constrained if you want to do a percentage of  
4 utilization. So I think the best you could do  
5 to meet this without that information is to  
6 talk about trends in utilization and we did  
7 that. We said volumes are growing. Now we  
8 have more information and we've done it even  
9 better to say not only are volumes growing,  
10 they don't have enough treatment spaces to  
11 treat their volumes.

12 Q: All right. Let's ---

13 A: Also I think it's evidenced by the fact that  
14 Trident filed a CON to add ED treatment spaces,  
15 and apparently they've added more ED spaces.  
16 They said they have 46 spaces three years ago  
17 or however long ago it was, they filed to add  
18 to 36. So they went from 28 to 36 to now 46.  
19 Summerville after MUSC and themselves -- well  
20 first they applied for a freestanding ED saying  
21 that the Summerville Hospital ED was full  
22 capacity constrained. They needed additional  
23 resources so they filed an FSED CON. Then  
24 after that and the MUSC CON was approved they  
25 filed another CON saying Summerville's capacity



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1           constrained and we need more resources. I  
2           think there's a lot of evidence out there to  
3           say the existing emergency departments in the  
4           service area are capacity constrained.

5       Q:   All right. Let me ask you to look at one more  
6           document on this issue and that is Trident  
7           Exhibit 20. This is a -- is this what's called  
8           a heat map?

9       A:   This is a heat map.

10      Q:   All right.

11      A:   And what it shows is the emergency visits --  
12           this is from 2014. You can see under the scale  
13           from the source and the date, 2014, and you can  
14           see the note in the top. This was -- Mr.  
15           Thomas presented this to Ms. Murdock and the  
16           note says Todd Gallati sent this over. Pretty  
17           interesting.

18      Q:   Who is Todd Gallait?

19      A:   Todd Gallati is the CEO with Trident.

20      Q:   All right.

21      A:   HCA.

22      Q:   So what's interesting to you about this map?

23      A:   That the high volume areas are where we're  
24           proposing our facility and where the other  
25           resources are being proposed because it's a



1 high volume area.

2 Q: Okay. Mr. Levitt, you -- the name Jim Reardon  
3 has come up two or three times in testimony.  
4 Just for the record who is Jim Reardon?

5 A: Jim Reardon's also an HCA executive in the  
6 Charleston area.

7 Q: All right.

8 A: Well at least he was. I don't know I assume  
9 he's still there.

10 Q: All right. Now could you summarize your  
11 opinion regarding the capacity constraints of  
12 existing providers in this area?

13 A: Well I think I did a little bit, a second ago,  
14 but ---

15 Q: You did.

16 A: So basically volume's growing in this area.  
17 HCA identifies this as a high volume area for  
18 emergency visits. The red, you know, the  
19 higher -- just like my heat map, the darker the  
20 color, the more volume. You can see some zip  
21 codes. Apparently they have as many as 31,000  
22 ED visits in a zip code. That's the high  
23 volume area. The population is the high  
24 population growth area. We talked about that.  
25 We looked at the trends in utilization



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1           available from JAR information. Showed the two  
2           providers closest to this area had the highest  
3           ED volume growth. We've seen CON applications  
4           being submitted to serve this area. The -- you  
5           know, ED expansions, freestanding EDs, new  
6           hospitals. It's clearly recognized that this  
7           is a growth area that needs additional  
8           resources.

9       Q:    Okay. Let's go back to the 2018 Plan I hope  
10           for the last time, I think for that last time  
11           and that set. So we can talk -- we've only  
12           focused on the first half of this sentence  
13           about capacity constraints. Let's start with  
14           the second half of the sentence with the phrase  
15           and/or. So that one has to demonstrate either  
16           capacity constraints or a travel time of  
17           greater than 15 minutes to an existing  
18           emergency department in the service area, is  
19           that right, Mr. Levitt?

20    A:    Yes. Under the current plan these are the  
21           standards and the second part is and/or.

22    Q:    And the current plan of course is not the 2015  
23           Plan. The 2015 Plan doesn't have this  
24           language, right?

25    A:    It does not.





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1 Q: Okay. And so let's look at Roper Exhibit 59,  
2 page 6 for just a minute. All right. This is  
3 a chart that was in -- that was discussed  
4 earlier during the Roper case. And so let's  
5 turn over to the -- or take -- turn our  
6 attention to the last column, the time and  
7 minutes. Because what I want to focus on here  
8 today is that 15 minute travel time that's  
9 mentioned in the 2018 Plan, okay? So it looks  
10 like it's only those top four.

11 **MR. WESTBROOK:** If you would cull out those top four  
12 line, Dan? Thank you.

13 Q: That have travel time under 15 minutes in this  
14 Roper Exhibit. Now once again the first line  
15 item, the first hospital listed there is MUSC  
16 Berkeley Hospital. That's the one that you  
17 talked about that's not approved yet -- or  
18 excuse me, has not been -- the CON hasn't been  
19 issued yet, right?

20 A: Correct. It was approved but it was appealed  
21 and it goes before the ALJ.

22 Q: All right. And so the two -- 2018 Plan talks  
23 about existing hospitals, correct?

24 A: It does. So those first two hospitals, the  
25 Berkeley Hospital -- MUSC Berkeley and the



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1 Roper Berkeley aren't existing hospitals so  
2 they should come off.

3 Q: All right. So we really should be focused on  
4 Summerville Medical Center and Trident Medical  
5 Center both of which are definitely existing,  
6 and the chart here says both are under 15  
7 minutes from the proposed FED, is that correct?

8 A: That's correct. That's what it says.

9 Q: That's what it says. All right. Let's look at  
10 your -- so you -- what's next -- well, let me  
11 see here -- have you prepared a slide to  
12 address that time?

13 A: Well there's first a guess an observation so --  
14 -

15 Q: Okay.

16 A: --- in this slide it says the Summerville  
17 Medical Center is 14 minutes away.

18 Q: Uh-huh.

19 A: In deposition -- in a deposition slide  
20 identical to this with some different numbers  
21 in it, it showed 18 minutes. So it said that  
22 Summerville was 18 minutes away, and I think at  
23 project review a very similar slide also shows  
24 Summerville at 18 minutes so more than 15  
25 minutes.



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1 Q: Well so -- all right. Well let's think about  
2 -- talk about Summerville for a minute. How  
3 can Summerville be 14 -- both 14 minutes and  
4 18 minutes away?

5 A: Well I think it depends on the time that you do  
6 the travel study. I think the 14 minutes is  
7 typically without traffic versus -- I think  
8 those other slides were done at a certain  
9 period of time and that's what it was at that  
10 period of time when they pulled it up.

11 Q: Have you yourself looked into the travel time  
12 from -- between Summerville Medical Center and  
13 the proposed MUSC site?

14 A: Yes.

15 Q: And what does that show?

16 A: So again using the same source, Google Maps,  
17 the -- looking at the Berkeley FED, the MUSC  
18 Berkeley FED to Summerville Medical Center, I  
19 looked in the morning and the afternoon.

20 Q: Uh-huh.

21 A: And instead of doing average without traffic  
22 this is the average with traffic.

23 Q: Okay.

24 A: So Google maintains data that says on this day  
25 at this time this is the average time and it



1 gives you a range.

2 Q: Uh-huh.

3 A: It gives you a low range without traffic and a  
4 high range with traffic. And so what we've  
5 shown here is sort of the other end of the  
6 spectrum. So what was shown on the last one  
7 was the low range without traffic, this is the  
8 high range with traffic. And you can see from  
9 the FED to Summerville at 8:00 a.m. is 26  
10 minutes with traffic. From FED to the Trident  
11 Medical Center at 8:00 a.m. is 28 minutes with  
12 traffic. From FED to Summerville at 3:00 p.m.  
13 is 30 minutes with traffic, and from the FED to  
14 Trident at 3:00 p.m. is 18 minutes with  
15 traffic.

16 Q: Do you recall what Dr. Hall testified was the  
17 peak time for the MUSC ED in terms of volume?

18 A: Yeah, I recall what he said and I've looked at  
19 that as well, that analysis and it's generally  
20 -- it's not unique to MUSC. Most hospitals the  
21 peak time is in the afternoon. 3:00 p.m. to  
22 7:00 p.m. is the peak time for ED volume.

23 Q: All right. So given this information do you  
24 believe that this meets the second part of that  
25 sentence? Let's go back to the sentence just



1           one last time. 2018 after the and/or, that 15  
2           minute reference.

3       A:     So if you look at peak travel time no it  
4           doesn't. The -- it's longer than 15 minutes to  
5           all existing providers.

6       Q:     Okay. All right. Mr. Levitt, let's talk about  
7           criterion. Specifically regulatory criterion  
8           in Regulation 61-15. The -- in this case  
9           there's been some discussion about the priority  
10          criterion that was selected by DHEC.

11      A:     Uh-huh.

12      Q:     Let's go to -- quickly to South Carolina Code  
13           44-7-190(b), please. How does this relate to  
14           the ordering of the priority criterion?

15      A:     I'm sorry?

16      Q:     I'm sorry. How does this relate to the  
17           ordering of priority criterion?

18      **MR. SUMMER:** I am going to object because he didn't  
19           let my client talk about the law. I don't know  
20           why his client gets to do so.

21      **MR. WESTBROOK:** I'm not sure what he's referring to  
22           with respect to his client. I don't --  
23           certainly again not asking for a legal opinion.  
24           I'm just asking for context. There's been a  
25           lot of discussion, a lot of criticism of DHEC



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1       for the criteria that were selected as the  
2       most important in this case, and so I'm asking  
3       Mr. Levitt as a health planner and his  
4       experience and as an expert in the South  
5       Carolina CON process about how DHEC goes about  
6       ordering criteria and what their authority to  
7       do so is.

8       **MR. SUMMER:**   That is a legal conclusion because,  
9       Your Honor, one of the things that we have  
10      raised in this case is that the State Health  
11      Plan, the law states that no application may be  
12      approved unless it is consistent with the State  
13      Health Plan.   The State Health Plan for this  
14      service lists specific numbered criteria.  
15      Whether or not the Department has the ability  
16      to change those four criteria.   There are 33  
17      criteria.   So they can add criteria and  
18      reorder other criteria.   But we believe -- and  
19      made the argument -- that as a legal conclusion  
20      they are -- they may not reorder the existing  
21      criteria that is stated in the Health Plan.  
22      That is a legal argument we've made to this  
23      Court, and my client wasn't allowed to talk  
24      about what the law is or ultimate conclusions.  
25      I don't believe this witness should be allowed



1 to do so as well.

2 **MR. WESTBROOK:** I'm certainly not going to ask him  
3 what the law is or his ultimate conclusion  
4 about the law. But I -- and certainly will  
5 make a legal argument opposing his legal  
6 argument on this issue. But I simply wanted to  
7 ask him as -- what's his understanding as a  
8 health planner when you're going about  
9 understanding what criterion apply to a project  
10 what the basis of that understanding is that's  
11 all.

12 **MR. SUMMER:** Same objection, Your Honor.

13 **THE COURT:** That's extremely -- yeah, that's  
14 extremely close.

15 **MR. WESTBROOK:** I will withdraw ---

16 **THE COURT:** Thank you.

17 **MR. WESTBROOK:** --- this slide, Your Honor.

18 Q: So let me ask you -- let's go to the specific  
19 criterion that we're talking about. The  
20 complete letter identified a number of priority  
21 criterion and let's take them one at a time  
22 starting with community need documentation.  
23 These are criterion from Section 33 of Exhibit  
24 61-15, is that correct?

25 A: Yes.



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1 Q: All right. So let's start with community need  
2 documentation. Now I would ask you to go  
3 through each one of these subsection in detail  
4 but maybe this is not the time. So let's --  
5 let me ask you this more generally. Is it your  
6 opinion that this project complies with this  
7 criterion?

8 A: Yes. So we've identified the population, the  
9 changes, we've demonstrated a need, and we've  
10 addressed the utilization of existing  
11 providers.

12 Q: All right. Let's go to Trident Exhibit 101,  
13 page 6, please. All right. Here's a Trident  
14 Exhibit saying why they believe that we don't  
15 comply with the criterion and I believe this is  
16 the point of this. So let's take these bullet  
17 points one at a time. No community need for  
18 MUHA's project. The first bullet point says  
19 Trident's Berkeley Medical Center with an ED is  
20 under development. What's your response to  
21 that?

22 A: The one in Moncks Corner?

23 Q: The one in Moncks Corner.

24 A: Yeah. I'm not sure how they're defining under  
25 development. It's been approved. They've done





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1 a number of extension on the CON, but it --  
2 there's no construction activity going on at  
3 that hospital for that location.

4 Q: All right. Is there -- have you seen any kind  
5 of evidence of a projected opening date that's  
6 anywhere been publicized? Are you aware of any  
7 projected opening date?

8 A: No.

9 Q: Okay. All right. The next bullet says MUHA's  
10 Nexton Hospital also will have an ED. What's  
11 the status of MUHA's Nexton Hospital?

12 A: So it's under appeal. It's been opposed by the  
13 same parties.

14 Q: Uh-huh.

15 A: And so we don't have a certificate of need for  
16 the Nexton Hospital.

17 Q: Do we know whether that hospital is going to be  
18 approved ultimately or not?

19 A: Well I would hope that it is.

20 Q: Uh-huh.

21 A: That's what I'm going to advocate for, but  
22 given the history of new hospitals, you know,  
23 the two Berkeley Hospitals were applied for in  
24 2008. We just talked about Berkeley Medical  
25 Center. Trident's Berkeley Medical Center



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1 doesn't have an opening date yet. The Roper  
2 Berkeley Hospital is I understand scheduled to  
3 open this year, 2019. So 11 years after they  
4 filed the applications. The Fort Mill Hospital  
5 I did that application in 2004. They're just  
6 gettin' ready. They've just gotten through all  
7 the appeals, gotten their certificate of need  
8 two months ago, a month ago, so we're ready to  
9 get started on that 15 years later.

10 Q: All right. So let's look at the third bullet  
11 point. Placing an FSED 23 miles from it's  
12 downtown EDs is not an effective way to  
13 decompress the downtown facilities. Now I  
14 don't think we need to go back over the slide  
15 that you had comparing that distance to some  
16 other distances, but is -- let me ask you this,  
17 do you agree with that bullet point?

18 A: No, it is effective. So the point is I think  
19 this perhaps would be more meaningful or closer  
20 to being accurate if we didn't already have  
21 patients from there. So saying that if you put  
22 something 23 miles away from where you are now  
23 that's not gonna help you. Well, no, it will  
24 help us because those patients that are further  
25 than 23 miles away travel all the way down to



1           the peninsula for care so the fact that it's 23  
2           miles away is a true factual statement but the  
3           fact that's not considered in that is so are  
4           the patients. The patients from that area are  
5           more than 23 miles away so it saves 23 miles  
6           for those patients to be treated at our FSED  
7           versus going down to the peninsula so it will  
8           decompress the facility because those patients  
9           -- 15,000 of the 80,000 patients that have  
10          previously gone to the peninsula will go to the  
11          new location.

12       Q:    So wouldn't it be more effective simply to  
13              renovate the MUSC facility downtown?

14       A:    More effective? Well, no, because ---

15       Q:    A more effective way to decompress the downtown  
16              facility wouldn't it just to renovate?

17       A:    No, it would be a different way, and I think  
18              they may try to do that as well. But, you  
19              know, MUSC is landlocked. It can't expand.  
20              It's -- you know, it's sort of used all the  
21              land available. The Shawn Jenkins and the  
22              Ashley River Tower are new facilities. They've  
23              been doing their best to decompress the  
24              inpatient facility by adding acute care bed  
25              towers. So they could do some minor



1           renovations downtown, we talked about those.  
2           We can't extend the footprint and so this is a  
3           better alternative to help address this.

4       Q:    How many CON's has MUSC applied for to renovate  
5           its facilities in the last few years that  
6           you're familiar with?

7       A:    Well, yeah, they haven't applied for any  
8           because it would require a CON.

9       Q:    Ah, okay. All right. Let's go to -- well let  
10           me ask you a final question before we move from  
11           this criterion in the community need criterion.  
12           The project changes to this project, how do  
13           they affect compliance with community need  
14           documentation.

15       **MR. WESTBROOK:** Let's go back, Dan, to the community  
16           need documentation criterion.

17       Q:    How do the project changes affect compliance  
18           with this criterion?

19       A:    It doesn't. They don't.

20       Q:    At all?

21       A:    They wouldn't affect any of that, no. Same  
22           target population, same population changes,  
23           same zip code, same need and same utilization.  
24           So, no, it wouldn't ...

25       Q:    It's not going to have a CDU or helipad, Mr.



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1 Levitt.

2 A: Well that wouldn't affect the compliance with  
3 this criterion.

4 Q: All right. Let's go through the distribution  
5 access criterion. All right. What's your  
6 opinion about this project's compliance with  
7 this criterion?

8 A: That it's not an unnecessary duplication.  
9 We've identified the medically under-served  
10 groups that we're going to serve. Historically  
11 MUSC as a safety net hospital provides a lot of  
12 services to the medically under-served.  
13 Medicare, Medicaid, indigent population.  
14 That'll be -- as a department of the hospital  
15 those services will still be available at the  
16 new location, and we've identified the location  
17 that it's going to be.

18 Q: Uh-huh.

19 A: So we comply with these access ---

20 Q: The changes, the new the new location, the less  
21 cost, the decrease in square footage, the  
22 absence of the CDU and helipad, how does that  
23 affect compliance with this criterion?

24 A: It wouldn't at all. It would -- the proposed  
25 project now and in the past comply with these



1 criterion in the same manner.

2 Q: All right. Let's go to the medically under-  
3 served criterion, please. This is criterion  
4 31. In the contest of -- I'm going to start  
5 off -- or your compliance, whether this project  
6 complies, but let's put on the screen -- to put  
7 this in context -- MUSC Exhibit 51, please.

8 **(Respondent MUSC's Exhibit 51 was introduced into the**  
9 **record at this time.)**

10 Q: This is a proposed Exhibit and what does this  
11 show, Mr. Levitt?

12 A: So this shows the payer mix of the -- of all  
13 patients and then the FED patients. So sorry,  
14 for consistency they're in a different order  
15 than the other ones with the total being the  
16 first column and the service area being the  
17 second column. But what it shows is the payer  
18 mix -- in other words the patients by -- or  
19 visits -- by payer ---

20 Q: Uh-huh.

21 A: --- and percentage of total of those represent  
22 for the total MUSC ED volume versus the 24,000  
23 we saw from the proposed service area. And you  
24 can see it's consistent. So the payer mix  
25 distribution it's not a better payer mix. The



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1 under-served groups, Medicaid, Medicare, same  
2 distribution from the service area that go  
3 downtown. So we expect it to be the same  
4 distribution as the proposed freestanding ED.  
5 Self pay, again, about 15 and a half percent at  
6 downtown MUSC, 15.4 percent for patients from  
7 the service area seeking ED services.

8 Q: All right. And we're talking about medically  
9 under-served that you've got three payers  
10 highlighted there. Their source is Medicaid,  
11 Medicare and self-pay. How does that related  
12 to the population of medically under-served?

13 A: That's generally identified as the indicator  
14 for medically under-served patients from a CON  
15 perspective.

16 Q: Let's look at MUSC proposed 52, please?

17 **(Respondent MUSC's Exhibit Number 52 was introduced**  
18 **into the record at this time.)**

19 Q: And again you've got some payers listed here on  
20 the left and then you have different  
21 categories, what's the point of this?

22 A: So this was a response to the criticism that we  
23 didn't provide payer mix information. So I  
24 wanted to see what Roper Northwoods CON  
25 applications projected their payer mix to be



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1           and what the Summerville FED CON application  
2           presented their payer mix to be and they didn't  
3           have anything in their applications to compare  
4           it to.

5       Q:   All right. Let's look at Joint Exhibit 1, page  
6           87. I'm sorry, before we go there let me just  
7           say I'd like to move into evidence MUSC  
8           Exhibits 51 and 52, the last two we just looked  
9           at.

10   **MS. HOLLINGSWORTH:** No objection, Your Honor.

11   **MR. SUMMER:** No objection.

12   **THE COURT:** They're admitted.

13   **MR. WESTBROOK:** Thank you, Your Honor.

14   **(Respondent MUSC's Exhibit Number 51 and 52 were**  
15   **admitted into evidence.)**

16   Q:   Let's go to Joint Exhibit 1, page 87. This is  
17           from the CON application, is that right?

18   A:   This is, yes, this is an attachment to the CON  
19           application. This is what we've been calling  
20           the pro forma and this shows the proposed  
21           indigent care projected at the freestanding ED.  
22           A little over \$4,000,000 in the indigent care  
23           and \$5,000,000 in bad debt.

24   Q:   And that's annually?

25   A:   That's annually out of a \$40,000,000 in





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1 charges. So, you know, four percent -- or I'm  
2 sorry, ten percent in indigent care, another  
3 ten percent bad debt. It shows the financial  
4 accessibility of the proposed ED.

5 Q: So how does bad debt relate to medically under-  
6 served?

7 A: Yeah, so medically under-served's are those  
8 that qualify under the indigent care plan based  
9 on their income and resources and bad debt is  
10 what we charge somebody and they don't pay us  
11 and we write it off, we don't expect to  
12 collect.

13 Q: All right. Is the zip code in which we're  
14 located -- in which the MUSC project is located  
15 -- is it in an medically under-served area as  
16 defined by CMS?

17 A: Well, you know, so they -- that was asked in my  
18 deposition and I hadn't looked at that because  
19 that's something that -- that's not what the  
20 medically under-served criteria is. But I did  
21 look at it and it is not in a medically under-  
22 served area, that zip code, but the zip code  
23 immediately to the west is. So, you know, a  
24 mile or two away is a MUA.

25 Q: What relevance does that have to -- whether it



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1           -- the facility was located in MUA, what  
2           relevance does that have to medically under-  
3           served criterion?

4       A:    I don't think it has any relevance.  It's an  
5           interesting statistic.  It was asked in my  
6           deposition, but that's not the criterion DHEC  
7           uses.  And it's the same zip code that the  
8           Summerville FSEDs proposed to be located so I  
9           find it ironic that they would criticize us for  
10          not being an MUA when they're in the same area.

11       Q:    What about health -- I know the acronym but I  
12           don't know what it stands for -- what is HPSA  
13           stand for, H-P-S-A?

14       A:    I think it's health provider service area, but  
15           it's the medically under-served designation if  
16           there's not enough physicians in the area.

17       Q:    Uh-huh.

18       A:    And, again, I didn't know it at my deposition  
19           but it turns out it is a HPSA.  It's a primary  
20           care HPSA.  Basically the whole State of South  
21           Carolina is a primary care HPSA with the  
22           exception of Florence and I think some -- oh,  
23           Lexington County.

24       Q:    All right.  Now the project changes, the  
25           relocation, the ancillary effects of that



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1 relocation that we went through, the reduced  
2 size, the reduced cost, the lack of a CDU and  
3 helipad, how do they affect compliance with the  
4 medically under-served criteria?

5 A: They wouldn't because again it's the same  
6 patient population to be served at either  
7 location in a smaller facility so it wouldn't  
8 have an impact on that at all.

9 Q: Let's go to the financial feasibility  
10 criterion. All right, that's a short one. The  
11 applicant must have projected both immediate  
12 and long term financial feasibility. Does this  
13 project comply in your opinion with this  
14 criterion?

15 A: Yes.

16 Q: All right. And why don't we look at the pro  
17 forma again which is Joint Exhibit 1, page 87.  
18 And it looks like you've selected certain line  
19 items from that pro forma budget. Start with  
20 personal debt operating revenue.

21 A: So that wouldn't change. You know, it might be  
22 updated because this was done two years ago so  
23 reimbursement rates may be higher than it was.  
24 You know, there'd be some inflation increase in  
25 rates. But conservatively holding it constant



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1           that's not gonna change because that's a  
2           product of volume. We don't expect volume to  
3           be any different than what we originally  
4           projected. So the revenue of about a little  
5           over \$8,000,000 is still consistent. Net  
6           income of about 2.7 million dollars again is  
7           consistent with what it would be at the new  
8           location. I think the net income might  
9           actually go up from these projections. We  
10          didn't make the adjustments. There was some  
11          criticism that we had too much staff. So to  
12          the extent we have less staff it would be more  
13          profitable. To the extent that we change the  
14          -- you know, the lease expense would go away  
15          probably. If we develop the facility our self  
16          the lease expense would go away. If someone  
17          else develops the facility we'd have a lease  
18          expense but it would be on a smaller facility  
19          so it would be lower because it's per square  
20          foot. The depreciation amount would change but  
21          it would change based on the cost of the  
22          project. So to the extent the project's  
23          cheaper the depreciation would be cheaper.  
24          Sort of a long way of saying that the capital  
25          expenses are in here either as lease and



1 depreciation or if we own the building it would  
2 be all depreciation but they'd be based on the  
3 same amount -- actually a lower amount -- from  
4 \$13,000,000 to \$11,000,000. So again it would  
5 have a positive impact on net income. So for  
6 all those reasons these projections are still  
7 valid and represent what would be the financial  
8 performance of the freestanding ED in Berkeley  
9 County.

10 Q: All right. There was -- it was discussed with  
11 Dr. Cawley -- I believe it's entered into  
12 evidence but I can't remember by whom -- that  
13 were MUHA's 2018 interim financial statements,  
14 do you remember those?

15 A: I do.

16 Q: There was a question raised about a negative  
17 \$2.8 million dollar number in there, do you  
18 recall that?

19 A: I do.

20 Q: All right. What's your -- remind us what that  
21 number represented.

22 A: I think that was negative net income at 2018  
23 from the unaudited financial statements, but I  
24 don't think it accurately reflect the financial  
25 performance of the organization.



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1 Q: Why not.

2 A: Because it -- if you go a couple pages further  
3 on in that audit it shows where that number  
4 came from but it shows from operations that  
5 MUSC made about \$18,000,000. It generate  
6 positive cash flow. Again those losses are  
7 based on pension liabilities not from  
8 operations so it's a nonoperating expense so  
9 the organization as a hospital makes about  
10 \$18,000,000, produces positive cash. That's  
11 what's most important. The cash flow from an  
12 organization, that's the money they can use to  
13 spend on other things, and even after those  
14 pension contributions they still have positive  
15 cash flow.

16 Q: All right. The -- once again, the changes that  
17 we've talked about to this project is it going  
18 to have any affect on compliance with financial  
19 feasibility criterion?

20 A: No.

21 Q: And is it your -- what is your opinion with  
22 respect to compliance for that criterion?

23 A: I think they've demonstrated it from a long  
24 term financial feasibility. We've showed  
25 positive debt income of about seven and a half



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1 million dollars. I think that's conservative.  
2 If you look at the Summerville FSED less than  
3 a mile away, same volume roughly, 15,000  
4 treatments, they made I think \$8,000,000 net  
5 income.

6 Q: Now the Summerville -- you said -- I'm sorry,  
7 what's less than a mile away?

8 A: The Summerville freestanding ED -- the proposed  
9 Summerville freestanding ED and their CON  
10 application, their financial projections.

11 Q: Now it's not less than a mile away from the  
12 MUSC site is it? The Summerville ---

13 A: Oh, the Summerville -- it's slightly more than  
14 a mile.

15 Q: Okay.

16 A: Roughly a mile, a little more than a mile from  
17 it. Then they showed 15,000 volume and like  
18 \$8,000,000 net income. So same volume, same  
19 service, same service area, same location.  
20 They think they can net \$8,000,000, I think  
21 \$3,000,000 is a reasonable projection.

22 Q: All right. We have gone through the four  
23 priority criteria that were identified by DHEC.  
24 I'm afraid we need to go through two more --  
25 sorry about that, Mr. Levitt -- because they



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1           are -- have been raised in this hearing by our  
2           opponent -- so let's start with the adverse  
3           effects criterion. So our opponent -- first of  
4           all, our opponent's have argued that we will  
5           take market share from existing providers. Is  
6           that -- what's your opinion on that?

7       A:    I think, you know, we made the assumption that  
8           the market share would be constant. I think in  
9           reality the market share will shift just as it  
10          has now so the -- to the extent MUSC's volume  
11          went down over the last few years that shares  
12          are -- our market share went down a little bit,  
13          somebody else's went up a little bit. I think  
14          that the market shares may shift not  
15          materially. I think some will go up, some will  
16          go down. But not at a material rate. That  
17          happens in any market in any given year. We  
18          are seeking to treat our patients at a location  
19          closer to their residence. We're relying on  
20          only our patients. We're not assuming a market  
21          share shift and therefore it won't have any  
22          impact on existing providers. Similar to the  
23          SMC freestanding ED -- we had the language up  
24          there -- their expectation is they are to treat  
25          patients that would have otherwise gone to the





1           Summerville Medical Center and the statement  
2           was in their application also they wouldn't  
3           have a material impact on other providers.

4       Q:   All right. Let's look at Trident Exhibit 101,  
5           page 41 for a moment, please. This is a map.  
6           What is it about this that you want to comment  
7           on, Mr. Levitt?

8       A:   Well so there was some criticism I think in my  
9           deposition -- and I think they maybe asked Dr.  
10          Cawley -- so people who used to go south won't  
11          go north or that we'd force them to go north.  
12          And I think our point is, well we wouldn't  
13          force them. They would choose to go north  
14          because it's more accessible and easier to get  
15          to. And so the issue though is that  
16          Summerville Medical Center's freestanding ED  
17          has the same problem. So they are relying on  
18          zip codes that are south where they're located.  
19          There's no facility north. So all of those  
20          people are traveling south to services either  
21          going to Trident or Summerville or Northwoods  
22          or Center Pointe or Roper Hospital or MUSC  
23          Hospital. So zip code 29456 is south of their  
24          facility. Those residents would have to travel  
25          north to get care when they would have



1 otherwise gone south to a hospital. 29458,  
2 those residents would have to go north to their  
3 proposed facility versus south. So it's just  
4 -- it's an unusual argument that people won't  
5 travel north or south. I think people travel  
6 in the direction to which the closest facility  
7 they want to seek care at is located, and as we  
8 said, those people seek care at MUSC and they  
9 would travel north to go to MUSC facility.

10 Q: All right. Let's look at the same Exhibit,  
11 101, and let's turn to page 43, please. And  
12 this is the -- an analysis that Mr. Sullivan  
13 prepared, is that right?

14 A: Yes.

15 Q: What do you want to comment about this?

16 A: So he assumes only a 25 percent shift from MUSC  
17 downtown. Well obviously I disagree with that.  
18 So that would represent 3918 -- that's 16  
19 percent redirection.

20 Q: Uh-huh.

21 A: So I think that's obviously way too low. Only  
22 16 percent of the patients that historically  
23 went to MUSC would go to the new facility. So  
24 I think there's a flaw in that assumption. But  
25 putting that aside, assuming only 16 percent of



1 the people who used to go to MUSC would go to  
2 the new center Trident projects that the impact  
3 would be about 10,000 treatments. They would  
4 lose 10,130 new treatments. The Trident health  
5 facilities would lose that if the new facility  
6 treated patients and got patients in the way  
7 they think it would. So 10,000 -- now remember  
8 those facilities include Summerville, Trident,  
9 the two hospitals, Center Pointe and Moncks  
10 Corner freestanding EDs. So all of those  
11 facilities combined had a 180,000 ED visits in  
12 2018. So Mr. Sullivan thinks that 10,000 lost  
13 treatments out of a 180,000 is material and  
14 that's less than they grew from 2017 to 2018.  
15 So if we did take 10,000 treatments from them  
16 they'd be above where they were last year. So  
17 it would not be adversely impacted.

18 Q: All right. Well let me clarify your opinion.  
19 Is it your opinion that that 10,000 is a  
20 reasonable number?

21 A: No.

22 Q: What do you think -- you think it's going to be  
23 more or less than that?

24 A: I think it would be substantially less than  
25 that and, you know, even at that high number I



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1 don't think that they'll have any material  
2 impact on them, even at that high number of  
3 10,000 it's not a material impact.

4 Q: All right. And the -- again the changes to  
5 this project how will it affect compliance with  
6 the adverse effects criterion?

7 A: It wouldn't.

8 Q: Okay. And the last criterion I want to ask you  
9 about is the staff resources criterion which  
10 was not included among the priority criteria.  
11 But -- and Ms. Murdock discussed the reasons  
12 for that.

13 **MR. WESTBROOK:** Do we have a slide related to that,  
14 Dan? Or resource availability I guess maybe  
15 that's what it is.

16 A: Can you go to the health plan? The 2015 Health  
17 Plan.

18 **MR. WESTBROOK:** Beg the Court's indulgence for just  
19 a moment.

20 Q: All right. It's -- so in the State Health  
21 Plan, the 2015 Health Plan -- it says resource  
22 availability. So is there a resource  
23 availability criterion?

24 A: No. So there was criticism that this criterion  
25 wasn't included in the decision letter or



1 review. Well there is no criterion. Resource  
2 availability isn't a criteria in 6115. So I'm  
3 not sure how she could include it -- or it  
4 could have been DHEC could have included it --  
5 when it doesn't exist.

6 Q: All right. Is -- what -- there is a staff  
7 resources criterion, correct? And there's been  
8 discussion about nursing -- about staffing  
9 shortages, do you recall that?

10 A: Well, yeah, I mean, yes. It's not a resource  
11 availability. There's a -- there are criterion  
12 in the plan called staff resources but that's  
13 different. That's in other parts of the health  
14 plan identified as a relative important  
15 criteria but that's not what this one is.  
16 That's -- it's close.

17 Q: So let's go. I understand what you said it's  
18 different, but let's see what the staff  
19 resourcing criteria -- criterion -- says  
20 though. So, you know, it's one of the  
21 criteria, whether it's one of the criteria  
22 prior to criteria or not, let me ask your  
23 opinion. Take a look at that. Does this  
24 project comply with this criterion staff  
25 resources?



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1     A:     It does. Obviously MUSC has availability and  
2           access to staff, both physicians, allied  
3           health, support staff, nursing and physicians  
4           to develop the project. They train a number of  
5           physicians and nurses -- a large number --  
6           every year. They have a -- we've provided --  
7           there's a response in the CON application that  
8           identifies our plan of getting staff and we  
9           have a track record of staffing our facilities  
10          and so we comply with this standard if it were  
11          to be applied to our CON application.

12     Q:     All right. Let's wrap your direct exam up with  
13           the CON Act and the purposes of the CON Act.  
14           I believe there have been -- has been testimony  
15           by other experts about the purposes of the CON  
16           Act. So I'm going to ask you to look at these  
17           four purposes one at a time. In your opinion  
18           as a health planner does this project, the  
19           Berkeley County FED project, promote cost  
20           containment?

21     A:     It does. That it provides access closer to  
22           where the residents live so eliminating the  
23           cost of travel and delay. It's a cost  
24           effective project. We've been able -- before  
25           we've even been issued the CON application



1 we've been able to reduce the costs by reducing  
2 the design so it does promote cost containment.  
3 The next purpose, prevent unnecessary  
4 duplication -- you know, I think it's been  
5 talked about. Whenever something new is  
6 developed, a new provider or a new facility,  
7 there is duplication in some degree, but the  
8 question is is it unnecessary. And I think  
9 this information demonstrates that it is a  
10 necessary project. We've identified need for  
11 it. We've identified the growth in the area  
12 both in terms of population ---

13 **THE COURT:** Excuse me, Mr. Levitt. Mr. Thomas and  
14 Mr. Summer, the talking is distracting.

15 **MR. SUMMER:** Sorry, Your Honor.

16 **THE COURT:** Okay. I'm sorry.

17 A: Sure. So we've demonstrated a need for the  
18 project, that there's a need in the area. The  
19 population is growing. The utilization of  
20 emergency services are increasing explosively -  
21 - has been on adjective -- I'd say very  
22 rapidly. 75,000 additional ED visits. So the  
23 need for additional resources are necessary so  
24 it's not an unnecessary duplication. The next  
25 purpose is establishment of healthcare



1 facilities to best serve the public needs. I  
2 think it's sort of related to that same concept  
3 that there's a need for additional resources in  
4 the area to serve the public. In this case the  
5 public that chooses MUSC for care, and this  
6 helps guide services for them closer to where  
7 they live and then high quality services I  
8 don't think there's been any question that MUSC  
9 provides very high quality services. And that  
10 same level of service would be provided at the  
11 freestanding ED. So for all of those reasons  
12 I feel that our proposed project complies with  
13 the purposes of the CON Act.

14 Q: So finally -- my final question, Mr. Levitt, if  
15 you could briefly summarize your overall  
16 opinion about this project?

17 A: I think we've demonstrated compliance with the  
18 statute, the regulations, the health plan, both  
19 in the CON application and in the information  
20 that's presented to the Court. I think it's  
21 clear that this is a high growth area that  
22 needs additional resources. All of the  
23 existing providers in the tri-county area -- I  
24 guess with the exception of East Cooper -- have  
25 identified this as a growth market that they





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1 all would like to serve and serve in a better  
2 way. They already serve those patients. MUSC  
3 was identified as the second largest high --  
4 second highest market share provider for ED  
5 services in the proposed area. Trident Health  
6 System with the two facilities and the two  
7 freestanding EDs up there has the highest  
8 market share, and that's to be expected because  
9 they have a presence in the market. We have  
10 the second highest without a presence in the  
11 market. People are traveling all the way down  
12 to the peninsula for care. So I think we've  
13 demonstrated a need for the project, the  
14 financial feasibility, the ability for us to  
15 develop the project and in compliance with the  
16 applicable criteria and for that reason I think  
17 it should be approved.

18 Q: Thank you, Mr. Levitt.

19 **MR. WESTBROOK:** No further questions for Mr. Levitt.

20 **THE COURT:** Okay. Thank you, Mr. Levitt. At this  
21 time we'll break for lunch. It's 1:45 so let  
22 reconvene -- just reconvene at 3:00.

23 **(Off the Record)**

24 **THE COURT:** Okay. Ms. Hollingsworth, you're going  
25 to lead this time.



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1 MS. HOLLINGSWORTH: It is my turn, Your Honor.

2 THE COURT: Okay.

3 MR. LEVITT - CROSS-EXAMINATION BY MS. HOLLINGSWORTH:

4 Q: All right. Mr. Levitt, good afternoon.

5 A: Good afternoon.

6 Q: We had a good lunch break. We will make the  
7 best use of your time. Let's see. There's so  
8 much paper. You -- we have kind of two  
9 different sets of slides that we received and  
10 jumped around a fair bit so I'm going to try  
11 very hard to figure out a way to make sense of  
12 that but I don't have any complete assurance.  
13 But let's kind of start with the application.  
14 Let's pull up Joint 1. And so as I understood  
15 your testimony you were the primary author,  
16 right?

17 A: Yes.

18 Q: Okay. And that document that you -- the work  
19 plan I think it was called?

20 A: Yes.

21 Q: That's right. That that was sort of a guide to  
22 work through collecting the materials that we  
23 wanted to finalize and follows as such as being  
24 in the application, is that fair?

25 A: Yes.



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1 Q: And is that a work plan that you use in most of  
2 your applications?

3 A: Not that specific work plan. Those are the  
4 areas of information that I need.

5 Q: Okay.

6 A: So, yes.

7 Q: But that type of a form -- it's almost like a  
8 tracking form -- that's your practice to do  
9 that, prepare one of those for your  
10 applications or no?

11 A: No.

12 Q: Okay. What would be different in some other  
13 applications you've done?

14 A: I wouldn't do a form. I would just send them  
15 the list of what I wanted and they'd send it  
16 back.

17 Q: Oh, so the Excel spreadsheet part of it might  
18 be a little different?

19 A: Yeah, I wouldn't do the Excel spreadsheet.

20 Q: Okay. Is that the only time you've done it or  
21 it just ...

22 A: Well we do it now. MUSC projects we do that  
23 most of the projects.

24 Q: Okay. That work plan -- so let's -- we were --  
25 you were talking this morning about the project



1           and you were asked the description -- I think  
2           it's on page 8 of the application. Yeah, it's  
3           CON 8. And do you recall the bottom half where  
4           it's -- where you started reviewing this  
5           morning the narrative regarding the projects?

6       A:    I do.

7       Q:    Okay. And then going to the top of the next  
8           page do you recall reviewing that this morning?

9       A:    Yes.

10      Q:    Okay. Let's look -- the section right after  
11           that though you didn't review project overview.  
12           What is the purpose of this part of the  
13           narrative?

14      A:    Well I think it's pretty self-explanatory.  
15           This is the project overview for the CON  
16           application.

17      Q:    Okay. Well how is -- what are some of the --  
18           what's the general description of the project  
19           that you provide in the application?

20      A:    The proposed freestanding ED located in Nexton  
21           development in Berkeley County.

22      Q:    Anything else?

23      A:    I'm not sure I understand your question. I  
24           mean, it's an overview. It talks about the  
25           project. That's the project we were



1 describing.

2 Q: Okay. So I'll help you out. So it looks like  
3 it says at the bottom of the first paragraph,  
4 MUSC proposes the development of a freestanding  
5 ED of approximately 15,000 square feet with ten  
6 private treatment room areas -- ten private  
7 treatment areas as well as one isolation  
8 treatment and one resuscitation area.  
9 Additionally observation slash clinical  
10 decision unit CDU space is included, is that a  
11 fair description of the project that you  
12 proposed in the application?

13 A: Yep.

14 Q: Okay. In that second paragraph you'll agree  
15 with me that it talks more about and the  
16 services that were going to be provided, right?

17 A: I think this is more generally describing  
18 freestanding EDs, but, yes, those services will  
19 be provided in our freestanding ED as well.

20 Q: Okay. And then that bottom paragraph, what is  
21 that part of the project that you're  
22 describing?

23 A: This describes the area that we're being --  
24 that where the location that this is being  
25 developed.



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1 Q: And what was that area that you described?

2 A: Well it describes the Nexton area with the  
3 hotels and the development in Phase 1 in  
4 Palmetto Primary Care.

5 Q: Okay. Let's go if we could, Vanessa, to page  
6 -- DHEC CON 21. And in this section of the  
7 narrative in the project overview you actually  
8 give a little bit more of description of the  
9 CDU itself, right?

10 A: The second paragraph describes the CDU, yes.

11 Q: Okay. And if you could -- and feel to just  
12 read it into the record instead of summarizing  
13 -- what is it that you have included there in  
14 your narrative?

15 A: You want me to read that second paragraph is  
16 what you're asking?

17 Q: Sure. Please.

18 A: That's what you're asking me to do?

19 Q: Yes, please.

20 A: A unique aspect of the proposed project is the  
21 proposed inclusion of a clinical decision unit,  
22 CDU. CDUs offer an option between discharge  
23 from the ED and inpatient admission. ED  
24 patients will be situated in the CDU until it  
25 is determined by medical staff that the patient



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1           should be admitted as an inpatient or  
2           discharged home. The clinical decision unit  
3           will eliminate bottlenecks in the ED and result  
4           in more efficient usage of the treatment rooms.  
5           CDUs decrease unnecessary admission and improve  
6           outcomes, renewed length of stay and enhance  
7           patient satisfaction. This feature is unique  
8           to the existing and proposed FSED in South  
9           Carolina.

10       Q:    So you'll agree with me that you described the  
11           CDU as unique feature, right?

12       A:    Yes.

13       Q:    Okay. To your knowledge is there any other  
14           freestanding ED in South Carolina that has a  
15           CDU today?

16       A:    Not currently, no.

17       Q:    Okay.

18       A:    Not a dedicated CDU.

19       Q:    Okay. And that middle line, was -- how is it  
20           that you intended this -- or that MUSC intended  
21           that the CDU would eliminate bottleneck in the  
22           ED, do you know?

23       A:    Well I think that's a general statement about  
24           CDUs, not necessarily this CDU that's in here.  
25           But the patient rather than being observed in



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1 a treatment space they'd be observed in a  
2 separate area.

3 Q: Okay. All right. And so you'd agree with me  
4 though that certainly beyond just the  
5 differentiating factors -- you've got factors  
6 earlier than that -- the CDU is described right  
7 here in the project overview on 21 -- page 21?

8 A: Yeah. And as we said it's a unique aspect, and  
9 I think I said on my direct it's a  
10 differentiating factor, it's just not an  
11 important one.

12 Q: Okay. Well actually on your direct as I recall  
13 you didn't discuss the CDU as one of the  
14 differentiating factors at all. That was why  
15 I thought ---

16 A: No.

17 Q: --- it might be something for us to discuss.

18 A: No.

19 Q: Let me ask you this ---

20 A: No, that's not what I did talk about in the  
21 direct.

22 Q: Okay. On the project overview the last  
23 sentence of the first paragraph is that where  
24 the helipad is addressed?

25 A: Yes. In the beginning it talks about it's





1 going to include a helipad.

2 Q: Okay. And what was the intent of having a  
3 helipad at the freestanding ED?

4 A: So that a helicopter could land on the helipad.

5 Q: Okay. That's it? Nothing about improving  
6 patient lividity or mortality rates?

7 A: Well that goes on in the talk about how  
8 aeromedical access does that not necessarily  
9 the helipad.

10 Q: Okay. Let's go to your project review slides.  
11 Go to Bates 516. At project review -- and I  
12 think you were here for Ms. Murdock's  
13 testimony, right?

14 A: Yes.

15 Q: So is it -- is your recollection consistent  
16 with hers in this slide that the CDU and the  
17 helipad both were points of discussion during  
18 the project review presentation from MUSC?

19 A: Sure. They were. I mean, they were in the  
20 application and the project review summarized  
21 the application.

22 **MS. HOLLINGSWORTH:** Your Honor, if I could just have  
23 a minute. There's a sheet of paper that I am  
24 trying to find and I am not being successful  
25 with it. Just one moment.



1     **THE COURT:**   Go ahead.

2     **MR. WESTBROOK:**   Your Honor, could I take this  
3                   opportunity to do something I forgot to do  
4                   earlier which is to move into evidence Mr.  
5                   Levitt's trial exhibits, those slides? There's  
6                   one slide of the group that I gave to other  
7                   counsel that I did not use which is slide 14.  
8                   So I'm not asking -- it's just a quote from the  
9                   Belfair case and so we can delete that, but I  
10                  would move into evidence all of the other  
11                  slides.

12    **MR. SUMMER:**    You used all of them?

13    **MR. WESTBROOK:**   I -- according to Mr. Buff I did. I  
14                   mean, it -- you know, it seemed -- I know the  
15                   time seemed to go so fast, but at any rate,  
16                   yeah, if Your Honor ...

17    **THE COURT:**    Any objection?

18    **MR. SUMMER:**    I don't have any objection other than  
19                   that it's for the purpose of showing what he  
20                   relied upon and what his opinions are. There's  
21                   a lot of hearsay in here because that's what  
22                   experts do ---

23    **THE COURT:**    Right. I understand.

24    **MR. SUMMER:**    --- and so it's -- as long as it's for  
25                   the purpose of what he relied upon and what his



1 conclusions are I don't have an objection.

2 **MS. HOLLINGSWORTH:** Your Honor, I -- there actually  
3 are going to be two slides that I will object  
4 to that we'll kind of deal with. So my  
5 preference if possible would be to at the end  
6 of cross or redirect just deal with it then so  
7 that whatever might happen with the slides  
8 through the testimony we can just be done with  
9 that. Rather than agree to them all now and  
10 then move to strike or something if we could  
11 just do his testimony and go through his slides  
12 and then we can decide which ones go in because  
13 I don't -- my position at least right now would  
14 be they wouldn't all -- there are some that I  
15 will an objection to.

16 **THE COURT:** Did you have objections to any that he  
17 used earlier?

18 **MS. HOLLINGSWORTH:** Yes. But they weren't in  
19 evidence, Your Honor. They were just  
20 demonstrative.

21 **THE COURT:** Okay. Did you make note of the ones  
22 that you ---

23 **MS. HOLLINGSWORTH:** Yes, Your Honor.

24 **THE COURT:** --- had a problem with?

25 **MS. HOLLINGSWORTH:** Yeah.



1     **THE COURT:** Let's take a look at them.

2     **MS. HOLLINGSWORTH:** Sure. I mean, that'd be fine,  
3         Your Honor. I'm happy to do that right now.  
4         If you can pull up -- and it is just I think  
5         two slides. Yeah, slides 12 and 13. So slide  
6         12 is zoning information that we -- so these  
7         slides, Your Honor, we received these last  
8         night about 7:00 o'clock or 6:50. These two  
9         slides related to zoning. I do not believe the  
10        Court should allow them in not only because  
11        they are -- as you see on this left here --  
12        unofficial zoning card, property zoning card,  
13        but on the next page on slide 13 -- and then I  
14        -- well we would have to swap -- the document  
15        that's used that's put up there on the screen,  
16        Your Honor, -- and if we can pull up, yeah.  
17        That is a draft ordinance. It has draft on the  
18        bottom of the page, draft of December 31, 2018  
19        that was covered up on the slide. And when you  
20        turn to the page that is used for the basis of  
21        the testimony or the opinion that this parcel  
22        is going to be zoned hospital if it had been in  
23        color what we would see is in this draft  
24        proposed ordinance this GB category, general  
25        business, is proposed to be healthcare facility



1 or hospital, but what we know is it's not yet  
2 GB at least in terms of the source documents we  
3 have. So this is a draft document. I don't  
4 know what the red means. The red appears to be  
5 to me that this is part of what's proposed,  
6 it's not the current. I don't know what it  
7 would be otherwise but right now it's B3 and we  
8 don't have any evidence of what B3 is so I just  
9 think, Your Honor, it would be improper to have  
10 this document in evidence and certainly as it's  
11 on the slide with the draft covered up and the  
12 font colors changes -- changed -- so that you  
13 don't see that it appears to be a proposed  
14 zoning designation. That's what appears to me  
15 when I look at the source documents.

16 **MR. WESTBROOK:** Your Honor, I have -- I didn't quite  
17 follow a part of what Ms. Hollingsworth said --  
18 but in terms of I would relate this back to  
19 what Mr. Summer said. In terms of something  
20 that Mr. Levitt relied on I would ask you to  
21 admit it and then if it, you know, Ms.  
22 Hollingsworth can cross Mr. Levitt about it in  
23 her rebuttal case evidence.

24 **THE COURT:** Yeah, I agree. I agree.

25 **MS. HOLLINGSWORTH:** Your Honor, if I could -- let me



1       -- if I could just one more thing a point on  
2       that, but that's fine, I appreciate that. My  
3       concern though, Your Honor, is the slide that's  
4       coming in -- that would come in -- does not  
5       disclose to you that it is draft or provide the  
6       color indications that that is not -- so  
7       there's an opinion now of what zoning is and  
8       it's -- if you look at what that slide, Your  
9       Honor, is it's -- it has covered up the draft  
10      on the sheet and it just represents that that  
11      is the zoning with the highlighting. I mean,  
12      Your Honor, I would submit this slide -- I  
13      don't think that this can come into evidence  
14      'cause it is making a representation of a fact  
15      when that is not fact. It's clearly marked as  
16      a draft.

17   **MR. WESTBROOK:** I don't have an objection to putting  
18      in the draft, including the draft part of that  
19      which, you know, the -- that would -- I don't  
20      know how many extra pages that would be but it  
21      seems like that could be added ---

22   **THE COURT:** Uh-huh.

23   **MR. WESTBROOK:** --- added to this and certainly  
24      those are already on the record now Ms.  
25      Hollingsworth's comments about it. Certainly



1           if to the -- you know, during her rebuttal and  
2           during her cross of Mr. Levitt she can elicit  
3           that for the record as well.

4   **MR. SUMMER:**    So you're willing to stipulate, Mr.  
5           Westbrook, is not offered for the truth of the  
6           matter asserted, it's merely offered because  
7           it's something he relied upon?

8   **MR. WESTBROOK:** Well, first of all, the -- I will  
9           look at the draft because I haven't seen that  
10          yet so I'm not going to make any stipulations  
11          at this point in time. I'm going to offer at  
12          this point that it is something that Mr. Levitt  
13          relied on and if it is something that he is --  
14          Ms. Hollingsworth through her cross or redirect  
15          can show was unreliable because it was a draft  
16          or from some other reason, that we can give it  
17          the weight it deserves.

18   **MR. SUMMER:**   Your Honor, I think we may need cross  
19           purposes here because my earlier reservation  
20           about the document was that it's only coming  
21           because it's something that he relied upon and  
22           it forms the basis of his conclusions. And I  
23           think Your Honor's already accepted that. So  
24           if that's the case it's not -- none of this is  
25           offered for the truth of the matter asserted,



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1           it's merely evidence of his opinion. And so if  
2           this underlying document is fallacious that can  
3           come out during the rest of the case. The mere  
4           fact that it came in doesn't mean that the  
5           Court has accepted it as though it's an  
6           authentic document.

7   **THE COURT:** Right.

8   **MR. WESTBROOK:** I think that's understood.

9   **THE COURT:** Yeah.

10   **MR. WESTBROOK:** Yeah.

11   **THE COURT:** Okay.

12   **MS. HOLLINGSWORTH:** But it was just those two  
13           slides, Your Honor, so I mean, I wouldn't have  
14           any other objection to what ---

15   **THE COURT:** Okay. I'm allowing them including those  
16           two slides but you're welcome to question him  
17           on it.

18   **MS. HOLLINGSWORTH:** Thank you, Your Honor.

19   **Q:** If you could a look at -- and I apologize that  
20           we might be jumping around between sort of the  
21           ---

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

23   **MS. HOLLINGSWORTH:** Yes, Your Honor.

24   **THE COURT:** I'm sorry. Mr. Westbrook?

25   **MR. WESTBROOK:** Yes, ma'am.





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1     **THE COURT:**    The Exhibit number for those -- the  
2                   slides?

3     **MR. WESTBROOK:**   60.

4     **THE COURT:**    60?

5     **MR. WESTBROOK:**   MUSC 60.   Thank you.

6     **(Respondent MUSC's Exhibit Number 60 was admitted**  
7     **into evidence.)**

8     **THE COURT:**    Okay.   Thank you.   Sorry about that.

9     **Q:**     If you could look at I believe it's MUSC  
10            Exhibit 34.   Mr. Levitt, this is a slide --  
11            this is some of the slides that you prepared  
12            right before trial, correct?   Well, actually,  
13            let me fix that.   I don't know when you  
14            prepared them but these are the slides provided  
15            to Roper St. Francis and Trident's counsel on  
16            July 12th, 2019, is that right?

17    **A:**     I don't know when they were provided.

18    **Q:**     Okay.

19    **A:**     But ---

20    **Q:**     Do you know when you prepared it?

21    **A:**     It wasn't long before the discovery deadline.

22    **Q:**     Okay.   So then this was available for your  
23            deposition but not produced?

24    **A:**     No.   I think my -- I don't remember the date of  
25            my deposition.   I hadn't prepared this prior to



1 my deposition.

2 Q: Okay. Your deposition was June 13th, 2019,  
3 does that sound familiar? It was a Thursday?

4 A: That would be a month ahead so, yeah, I  
5 probably worked on this the week before so July  
6 10th.

7 Q: Sure.

8 A: And you're talking June 13th so ---

9 Q: Right.

10 A: --- that's a month ahead of time.

11 Q: Yeah, the discovery deadline was June 14th,  
12 2019 that's why I was asking about your  
13 deposition.

14 A: I think that the Exhibit deadline was July 12th  
15 then. So this was turned over on the July 12th  
16 deadline. I prepared it after my deposition.

17 Q: We'll deal with that but the discovery deadline  
18 though so you did not provide these slides  
19 prior to your deposition, right?

20 A: No, I hadn't done them.

21 Q: Okay. And the custom reports source, and we've  
22 talked a lot about RFA or the revenue and  
23 fiscal affairs data that's available and it's  
24 my understanding -- so there's some RFA data  
25 that's publicly available, right?



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1 A: Yes.

2 Q: Okay. But then there's other data -- and I  
3 think you described it some on your direct --  
4 that you fill out certain forms and then  
5 receive information from RFA, right?

6 A: Yes, I guess I would describe it a little  
7 different. All RFA data's publicly available.  
8 Some data's available on their website, other  
9 data you have to submit data use agreements to  
10 get.

11 Q: Okay. So what do you mean by using custom  
12 reports in your source line?

13 A: That's the data use agreement that I've signed  
14 with RFA to provide provider -- I guess  
15 provider level data that the data use agreement  
16 prohibits me from releasing.

17 Q: Okay. And so based on your understanding of  
18 that agreement you did not provide any RFA data  
19 that you received in order to prepare these  
20 slides, is that right?

21 A: I didn't provide the underlying data because I  
22 actually called RFA, told them I was involved  
23 in a hearing and that it's been requested and  
24 they told me it would violate the data use  
25 agreement to provide that.



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1 Q: Okay. So tell me this, how do we know what you  
2 asked for in the report? Like how is it that  
3 we're able to figure out what was the scope or  
4 nature of the data you requested? Do you  
5 maintain the document that you submitted that  
6 outlines the data you're asking for?

7 A: Well it's a standard data use agreement form --  
8 -

9 Q: Right.

10 A: --- so it's all data that's available from the  
11 providers that it submitted to RFA. When I  
12 told them that it had been requested in a legal  
13 matter they said that ---

14 Q: Well -- and I -- I don't need to know what they  
15 said, that would just be hearsay. But I  
16 understand your reason for not providing it.

17 A: Uh-huh.

18 Q: My question is just how do we know exactly what  
19 data sets you asked for?

20 A: It's the same data sets that Roper and Trident  
21 have access to. So it's not a specific data  
22 set, it's the data set.

23 Q: Okay. So it's your position you asked for all  
24 data that RFA had?

25 A: No. Through my relationship with MUSC -- so



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1 first of all you have to be a provider. So  
2 MUSC has a data use agreement to get this data.  
3 I'm not sure as we sit here today who the  
4 principal investigator -- you have to identify  
5 a principal investigator at the facility and  
6 then you add supplements, individuals who also  
7 are able to have access to that data. MUSC  
8 adds me to their data use agreement so I can  
9 get data on behalf of MUSC. I would say a  
10 dozen or so hospitals in the state have the  
11 same data use agreement. I'm on their data use  
12 agreements as well so I have access to that  
13 data for the purposes of that client. It is a  
14 standard report. There are certain variables  
15 that are available, certain variables that  
16 aren't available. And those variables are  
17 available and depending on the project I'm  
18 working on -- if I'm working on an inpatient  
19 project they give me the inpatient -- what they  
20 call the inpatient data. They have a section  
21 for ED data. So this is the ED section data.

22 Q: Thank you for that answer. Okay. Let's look  
23 at MUSC 36. And here we have the top ten --  
24 the fastest growing counties, is that right?

25 A: Yes.



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1 Q: Okay. Now how many freestanding emergency  
2 departments are in York County, do you know?

3 A: One.

4 Q: Do you know how many are in Greenville County?

5 A: Today? None.

6 Q: Okay. And they have a population -- a current  
7 population of 518,000?

8 A: Correct.

9 Q: And how many freestanding emergency departments  
10 are in Lexington County?

11 A: You know, I don't think there's any licensed.  
12 They have some urgent care centers throughout  
13 the county, but I don't think there's a  
14 licensed freestanding ED in Lexington County.

15 Q: Okay. All right. Let's talk for a minute  
16 about that Exhibit 30 and I guess slide 11 of  
17 MUSC safety and the draft ordinance. What was  
18 the reason that you chose the draft ordinance  
19 to include on -- I guess slide 12, sorry.

20 A: Slide 12 isn't the draft ordinance.

21 Q: Oh. 13? Thank you.

22 A: That's what I was able to find on the internet  
23 for the zoning for Summerville city I guess.  
24 I mean, the municipality of Summerville.

25 Q: Okay. And then -- and it's hard to tell here



1 with the change in the font but on the document  
2 did you -- how did it impact your opinion if at  
3 all that the healthcare facilities, hospital  
4 inpatient facilities, is actually in red as  
5 proposed permitted use? How did that impact  
6 you rendering your opinion on zoning for the  
7 current proposed location?

8 A: Yeah, I guess I would see it differently. I  
9 don't know anywhere where it says that red is  
10 proposed because the new districts are  
11 proposed, those aren't in red. And then  
12 everything would be proposed under the  
13 district, right? So you referenced BG as being  
14 proposed to be medical and healthcare  
15 facilities. B3 is the actual zoning, the  
16 current zoning. Previous districts. So  
17 everything's proposed so I don't think the red  
18 means proposed.

19 Q: Okay. Well so what information do you have to  
20 explain what the red is? Which of course you  
21 didn't represent it on your slide but we have  
22 in the original documents. The red is  
23 something different, right?

24 A: Well you said it was, I don't know what the  
25 difference is.



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1 Q: Okay. So you've based your opinion on this  
2 draft document and you don't know why some  
3 things are red and some things aren't?

4 A: Correct.

5 Q: Okay. And you didn't have any other  
6 information available that you could find other  
7 than this draft ordinance, right?

8 A: I thought this showed what it needed to show so  
9 I didn't look for any other information.

10 Q: You thought rendering your opinion on the draft  
11 ordinance was sufficient?

12 A: Yes.

13 Q: Okay. In terms of the financing were you here  
14 for the part of Dr. Cawley's testimony  
15 regarding the change in funding for the  
16 building that the MUHA Board of Trustees would  
17 have to approve that funding piece if it  
18 switched over to the medical university?

19 A: I'm not sure that's exactly what he said. I  
20 was here for his testimony about funding, yes.

21 Q: Okay. So what did -- you'll agree with me that  
22 he said that he needs to have additional  
23 approval from the Board of Trustees for the  
24 medical university to get funding for the  
25 building, right?





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1 A: To fund the building. At the point in time to  
2 which they have to expend dollars he would have  
3 to get approval.

4 Q: Okay. So as we sit here today who is going to  
5 develop the building?

6 A: I don't think that's been decided yet so it  
7 could be a third party developer or MUHA.

8 Q: Okay. That work plan -- and it was unclear to  
9 me that the underlying -- that document, the  
10 spreadsheet itself -- is that your underlying  
11 document or Ms. Cotter -- and I'm sorry I  
12 missed her married name.

13 A: Maloof.

14 Q: Maloof. Is that Ms. Maloof's underlying  
15 document that was created or is that yours that  
16 -- who created the spreadsheet itself?

17 A: I believe she took the information I requested  
18 and created the spreadsheet from what I asked  
19 for.

20 Q: Okay.

21 A: Or someone in her department.

22 Q: At MUSC?

23 A: Yes.

24 Q: Again my apologies for jumping around. If we  
25 could take a look at what is now MUSC 6531. As



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1 I understood your testimony, Mr. Levitt, you  
2 testified that Roper St. Francis did not  
3 produce data in discovery?

4 A: By location, correct.

5 Q: Okay. And this might be hard to do but can we  
6 look at Roper St. Francis Exhibit 6? So this  
7 is the data file produced in discovery by Roper  
8 St. Francis. Is that familiar to you?

9 A: It is. The point on this is Roper Number 10 is  
10 the hospital. That also includes Moncks Corner  
11 and Northwoods.

12 Q: Okay. So you weren't able to discern that the  
13 department code is different for the different  
14 emergency departments licensed under Roper  
15 Hospital?

16 A: You mean column C the department number?

17 Q: Right.

18 A: Yeah, no, I didn't go through -- I mean, if you  
19 go down to the very bottom of this ...

20 Q: The 3501?

21 A: Yeah, no, all the way to the bottom.

22 Q: Uh-huh.

23 A: So I didn't go through -- keep goin' all the  
24 way to the bottom. No, wrong way. All the way  
25 to the bottom. Down. Keep goin'.



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1 Q: She's scrolling. She's working on it. Go all  
2 the way to -- and see if you can pull it up.

3 A: I didn't go through 384,000 rows of data to see  
4 -- I did a pivot table based off the location  
5 because I -- that's what we asked for, the  
6 location. And if you see the department there,  
7 so Mt. Pleasant's 3,500 and then I just saw at  
8 the very bottom East Cooper was 3,500. Or I'm  
9 sorry, Mt. Pleasant was 3,500 and Roper's  
10 3,500. So both have a department of 3,500 so  
11 I'm not sure that would help me either.

12 Q: Sure. So if you had scrolled through though  
13 and looked at the department codes for  
14 Northwoods in Berkeley then you would have been  
15 able to discern the data that you left off of  
16 this slide 30, right?

17 A: I didn't leave it off slide 30.

18 Q: Emergency department Northwoods?

19 A: You said did I leave it off slide 30 -- that I  
20 left it off -- I didn't leave that off slide  
21 30.

22 Q: So, Mr. Levitt, in your testimony you said  
23 Roper didn't provide the data required in  
24 discovery. You'll agree with me that we  
25 provided the data of utilization of Roper



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1 Northwoods, right?

2 A: I see that now. I did not see this when I was  
3 reviewing the 384,000 rows of data.

4 Q: Sure. Because that's why you guys love pivot  
5 tables, right?

6 A: I don't -- I don't -- I'm not real good with  
7 pivot tables but all those people do, yes.

8 Q: Okay. All right. So you'll agree with me  
9 though that the -- on your slide actual  
10 utilization that would not be correct. What  
11 you're using is from the testimony a what some  
12 sort of average or estimate that was provided  
13 during testimony, right? As opposed to the  
14 data previously provided?

15 A: Well I would hope that the testimony's close.  
16 Otherwise your witness was giving wrong numbers  
17 to the Court.

18 Q: So, Mr. Levitt, you'll agree with me that  
19 actual utilization and your testimony that  
20 Roper didn't provide the data in discovery  
21 would be incorrect, right?

22 A: I did not identify that they had provided it by  
23 location in discovery.

24 Q: Thank you. Will you agree with me that when  
25 you were working on outstanding items for the



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1           CON application that was filed with the  
2           Department in this case back in 2017 that part  
3           of the items that you advised MUSC that you  
4           still needed were included verification of  
5           zoning and verification of utilities?

6       A:    I think that was on the to do list.

7       Q:    Okay.

8       A:    The work plan because that's part of the CON  
9           application, and we submitted that information  
10          in the CON application.

11      Q:    Okay.   And it's your understanding isn't it  
12           that the floor plan that's being proposed is  
13           based on the intuitive model that we've heard  
14           about in Court, right?

15      A:    As we sit here today it's based on that but it  
16           will be modified when they do the design phase.

17      Q:    Okay.    So it's your testimony they'll be  
18           further changes to the floor plan than what's  
19           been disclosed in Court?

20      A:    Well there may be.   It will be refined just as  
21           the Roper Hospital floor plan was changed.   And  
22           I think that the Intuitive -- what we're  
23           calling the Intuitive floor plan -- is a pretty  
24           typical freestanding ED floor plan.   It looks  
25           a lot like the Summerville FED floor plan too.



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1 Q: Okay. And as I understand it you don't have  
2 any knowledge do you of the stacking resources  
3 other than what you've testified to about  
4 MUSC's ability to recruit nurses, right?

5 A: I'm not sure I understand your question.

6 Q: Okay. So I'll ask again. You don't have any  
7 knowledge or opinion about the impact that  
8 might be felt by other providers from the MUSC  
9 proposed emergency department?

10 A: Well I have -- I heard the testimony that the  
11 Roper Berkeley Hospital's fully staffed. So to  
12 the extent that that -- or nearly fully staffed  
13 -- so to the extent that there's an issue that  
14 Roper Hospital wouldn't be able to find staff  
15 to staff well they have been. They have done  
16 it. And in all of their CON applications and  
17 all of Roper's CON applications and all  
18 Trident's CON applications they all identify  
19 not having an issue staffing. That everyone is  
20 able to staff their proposed projects without  
21 a problem. So I don't think that anyone would  
22 have a staffing issue.

23 Q: Okay. But of course save for what the  
24 testimony that's been here in this Court last  
25 week, right?



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1 A: I didn't hear any testimony that it would be  
2 difficult. I heard the Roper nurse say she  
3 staffed her hospital, a whole hospital. And I  
4 heard the Trident nurse say I think as a result  
5 of staffing an entire hospital she lost two  
6 staff and none of them were ED staff.

7 Q: Okay. And you haven't -- just to make sure we  
8 understand -- we've looked in the redirection  
9 percentages based on fiscal year -- maybe  
10 fiscal year 2016, is that what you used for  
11 that project review?

12 A: I believe so.

13 Q: Okay. And that was based on data that you  
14 received from MUSC, right?

15 A: Yes.

16 Q: And I think you've acknowledged there appears  
17 to be -- multiple sources seem to have a couple  
18 different versions of some of these numbers, is  
19 that fair?

20 A: Yes.

21 Q: The visit volumes?

22 A: Yes.

23 Q: Okay. And even within the discovery responses  
24 from MUSC some of the spreadsheets didn't quick  
25 tick and tie, is that fair?



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1 A: Yes.

2 Q: Okay. Do you have any particular knowledge why  
3 -- what might have caused some of those  
4 discrepancies?

5 A: You know honestly I don't. You know, I noticed  
6 Trident I think for the exception of one year  
7 they all matched. Roper, you know, without  
8 looking at -- by location because I didn't  
9 realize it was in there -- but the Roper total  
10 from that data, meaning Roper, Roper Northwoods  
11 and Roper -- no Moncks Corner -- the total of  
12 those also didn't match the JAR but it was  
13 close just like MUSC's was.

14 Q: Okay.

15 A: So everybody has data issues, it's not unusual.  
16 I would say 100 percent of the JARs that are  
17 submitted to DHEC have an error in them just  
18 because it's hard to get this data in a  
19 consistent format and that's just something we  
20 have to deal with when we do health planning.

21 Q: Okay. And it's my understanding that when you  
22 were working on your projections and on the  
23 application that you did not evaluate whether  
24 people in downtown Summerville were having  
25 trouble with access to emergency services,





1 right?

2 A: Well I didn't need to evaluate that because  
3 24,000 people -- or 24,000 times people from  
4 that general northern area came all the way  
5 down to the peninsula for emergency services.

6 Q: And you didn't look at what percentage of the  
7 people in Summerville set -- I'm sorry, met --  
8 the medically under-served group's definitions,  
9 right?

10 A: No, but I looked at our payer mix using  
11 medically under-served groups of Medicare,  
12 Medicaid and indigent care at the volumes  
13 there. We presented it today. The mix of  
14 patients there compared to overall MUSC is  
15 consistent. So, you know, it just seems some  
16 -- disingenuous to say that we're going to go  
17 to Exit 199 and not serve medically under-  
18 served population when Summerville Medical  
19 Standing is building a freestanding ED at Exit  
20 199 and they attested that they would serve  
21 medically under-served groups. They comply  
22 with that criteria. Roper's building a  
23 hospital in that general area five miles away.  
24 When they filed that application they said they  
25 were going to serve medically under-served



1 groups. And now the question is, well are you  
2 going to be in that location and serve  
3 medically under-served groups. And of those  
4 three applicants I think MUSC has a better  
5 history of serving medically under-served  
6 groups.

7 Q: Okay. And as I understood your testimony this  
8 morning you -- it's your position as a health  
9 planner that you do not consider approved  
10 projects when you're evaluating I guess need or  
11 compliance with the health planner of the CON  
12 Act when you're working on another project,  
13 right?

14 A: Well no I think it depends on the project and  
15 the standards. So what I testified earlier  
16 today wasn't that. What I testified earlier  
17 today was that the standard in the plan says  
18 look at existing providers. So when you would  
19 look at an existing provider you don't look at  
20 an approved provider, a non-operational  
21 provider.

22 Q: Okay. And that argument has been made by  
23 medical university against Roper Berkeley  
24 Hospital in other cases, right?

25 A: MUSC made that argument against Roper Berkeley?



1 Q: Uh-huh. 'Cause you participated in that  
2 argument in the MUHA case in front of Judge  
3 Anderson, right? And offered an affidavit that  
4 an approved under construction hospital is not  
5 an existing hospital?

6 A: I'm not sure which case you're referring to.

7 **MR. WESTBROOK:** Objection, Your Honor. I don't see  
8 what the relevance is to what was testified in  
9 some hospital case is with this with respect.  
10 I mean, what he testified about was the  
11 language of the State Health Plan provision  
12 which says existing. That's all he testified  
13 to and so I don't know why we're going here.

14 **MS. HOLLINGSWORTH:** Your Honor, it's a case among  
15 the same parties with the same expert and he  
16 offered that opinion in support of a motion and  
17 I think it's relevant to address that same  
18 opinion that he's had in that case just to have  
19 that information here in the record. It's the  
20 same party that's the same argument that this  
21 position being that Roper Berkeley can't be  
22 considered existing.

23 **THE COURT:** Okay. Ms. Hollingsworth, that's an  
24 issue that's already been addressed by me.

25 **MS. HOLLINGSWORTH:** Oh, thank you, Your Honor. I'm



1 not making an argument on a licensed hospital,  
2 Your Honor. I'm just -- this is his health  
3 planning opinion that as a hospital under  
4 construction you're not considered for planning  
5 purposes. I'm not even addressing Standard 2  
6 or a licensed hospital is related.

7 **MR. WESTBROOK:** Your Honor, I think this is the same  
8 issue. I don't think she's asking specifically  
9 about Standard 2 but she -- but it's the same  
10 issue. Is it a licensed existing hospital.  
11 And I don't even think he's giving his opinion  
12 -- and another part of the testimony in his  
13 direct he gave his opinion about that, but on  
14 this he's just reading from the sentence in the  
15 State Health Plan which says existing. It  
16 doesn't say anything else.

17 **MS. HOLLINGSWORTH:** That's fine, Your Honor. I'll  
18 withdraw the question.

19 **THE COURT:** Okay.

20 **MS. HOLLINGSWORTH:** We'll have the information.

21 Q: Mr. Levitt, were you -- you're aware -- you  
22 heard the testimony from the Department's  
23 witness that the Department does include  
24 approved projects when they're evaluating  
25 proposed applications for new servicing



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1 facilities, right?

2 A: I think it would depend on the service and what  
3 the standards in the plan say. So some say do  
4 -- that you would consider it, others say  
5 existing and some are frankly I think silent to  
6 it.

7 Q: Okay. And as I understand your reason for the  
8 project is that it improves access for MUSC  
9 patients from the north area, is that right?

10 A: That's one of the reasons, yeah.

11 Q: Okay. And then one of them too is that there  
12 are capacity constraints on the peninsula?

13 A: Yes.

14 Q: Okay. Thank you.

15 **MS. HOLLINGSWORTH:** I have no further questions,  
16 Your Honor.

17 **MR. LEVITT - CROSS-EXAMINATION BY MR. SUMMER:**

18 Q: And I only got a couple. One, you're not an  
19 M.D. doctor, right?

20 A: Not a licensed M.D., no.

21 Q: Okay. Don't have a nursing license do you?

22 A: Nope.

23 Q: Never worked as a nurse anywhere did you?

24 A: No.

25 Q: All right. You never worked as a doctor



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1           anywhere did you?

2       A:     No.

3       Q:     Okay.    Have you ever physically been inside  
4           Trident Hospital?

5       A:     Yes.

6       Q:     Have you ever been in their emergency  
7           department?

8       A:     Yes.

9       Q:     And when was that?

10      A:     I would say the most recent would have been two  
11           years ago maybe.

12      Q:     So were they under construction or had they  
13           started construction yet in the ED?

14      A:     I think they might have been under  
15           construction.

16      Q:     Under construction.   Okay.   So have you been  
17           there since they finished construction?

18      A:     No.

19      Q:     Okay.   Let me take you to -- I'm trying to --  
20           I was an English major so math isn't my thing.  
21           Let me start with -- can you look at slide 30,  
22           please, ma'am?   I'm just looking at your slide  
23           30 and I want to make sure I understand this.  
24           This is your corrected slide so this is what  
25           you think the numbers in terms of capacity are,



1 correct?

2 A: Yes.

3 Q: All right. Okay. And you think 1,500 per room  
4 is appropriate?

5 A: Yes.

6 Q: Okay. We're going to come back to this, but I  
7 want to go next to Trident 1. And I'm going to  
8 go to page 1-008. There you go. First of all  
9 this toggling seems to be such a chore. Tell  
10 the Court what Trident 1 is?

11 A: It is the Summerville Medical Center  
12 certificate of need application to expand  
13 emergency and ancillary support services.

14 Q: And what's the date on that application,  
15 please, sir?

16 A: It was submitted November 7th, 2017.

17 Q: All right. November 7th, 2017. I believe you  
18 have been present for all of the testimony that  
19 we've had to endure in this case, right?

20 A: I missed the one yesterday.

21 Q: Okay. You were here for Ms. Valentine were you  
22 not?

23 A: I was.

24 Q: You understand that that project is under  
25 construction but not completed, correct?



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1 A: Yeah, I think they've broken ground on it.

2 Q: Okay. Look if you will I want to pull up the  
3 ED breakdown on that page. Can we do that,  
4 Vicky Lynn? There we go. So existing capacity  
5 is what's there today added with being what the  
6 CON approved, correct?

7 A: Yes.

8 Q: And then total capacity is what they're going  
9 to have in the future, right?

10 A: Yeah, adding those two together.

11 Q: Right. So existing capacity is what they have  
12 today. So they have 22 adult rooms and six ped  
13 rooms and one triage. Would you consider that  
14 28 or 29 rooms? What would you consider that?

15 A: Yes, 28 or 29 rooms.

16 Q: Okay.

17 A: 28 treatment rooms, if you include triage 29.

18 Q: And you can treat in triage if you're busy  
19 can't you?

20 A: You could.

21 Q: Okay.

22 A: You could treat in the hallway or in the lobby  
23 or whatever.

24 Q: All right. So for the benefit of the doubt  
25 we'll err on the high side and say 29, you good





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1 with that number?

2 A: I'll give it to you.

3 Q: Let's go back to slide 30, please. All right.  
4 So if we're looking -- what year period is  
5 this, do you know? Is this '16, '17 numbers,  
6 do you know?

7 A: I believe it's '18.

8 Q: '18 numbers. Okay. So and 29 rooms actual  
9 utilization was 72,398. So how many is that  
10 per room?

11 A: Well based on their current rooms or their  
12 projected rooms?

13 Q: Current rooms because the other ones aren't  
14 there yet are they?

15 A: No.

16 Q: So the 72,398 could have been achieved in the  
17 most of 29 rooms, correct?

18 A: Correct.

19 Q: So what was their actual utilization per room?

20 A: Almost 2,500.

21 Q: Right. And you still think 1,500's a good  
22 planning number?

23 A: Well, yeah, 'cause they said they've gotta add  
24 29 to 46, whatever that is. I wasn't a math  
25 major either but I do love numbers. It's



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1 almost 20 more rooms they've gotta add. So  
2 2,500 per room is too many. That's why they  
3 filed a CON application to add more rooms.

4 Q: All right. But under your -- so let's redo  
5 their capacity numbers 'cause if they only had  
6 29 -- what's 29 times 1,500?

7 A: 43,500.

8 Q: Right. So you believe actual capacity is  
9 43,500, correct?

10 A: For the 29 rooms that would be the comfortable  
11 capacity to treat patients.

12 Q: Okay.

13 A: So it doesn't mean that they stop treating  
14 patients when they get to 1,500, it means their  
15 capacity constraint. And so just as I said  
16 they submitted the CON application to relieve  
17 that capacity's constraint. They added  
18 additional rooms and they added the  
19 freestanding ED to help relieve that capacity  
20 constraint.

21 Q: Well I'm still a little confused 'cause they  
22 were able to do 2,500 per room -- and were you  
23 here for Ms. Eccleston's testimony?

24 A: Yes.

25 Q: And did you hear her state that their door to



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1 doctor time -- to the time you see a doctor to  
2 be treated -- is less than 10 minutes?

3 A: I heard her say that.

4 Q: Okay. Do you have any reason to doubt her?

5 A: No. I didn't see any empirical data that  
6 showed that but if she said I have no reason to  
7 not believe it.

8 Q: Okay. I'm just trying to figure the numbers.  
9 Another number I've got some questions about,  
10 if we could go to MUSC 17. And I'd like to go  
11 to page 3 of that. Do you recognize this  
12 document?

13 **(Respondent MUSC's Exhibit Number 17 was introduced**  
14 **into the record at this time.)**

15 A: Yes.

16 Q: Okay. Page 3 is -- is it page 3? Boom, there  
17 we go. What is page 3?

18 A: The pediatric ED score card.

19 Q: I've got to get better glasses. All right. So  
20 I got calendar months -- 2016, right? Calendar  
21 year?

22 A: Yes.

23 Q: And the total peds visit was 24,499. You got  
24 a pen and paper?

25 A: Yes.



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1 Q: Great. Can you jot that number down for me.  
2 That's the total number of peds visits for 2016  
3 at the Medical University of South Carolina,  
4 your client, right?

5 A: Yes.

6 Q: Okay. Let's go back to your slides and let's  
7 look at -- I'm going to find it. I would like  
8 to go to -- man, you have a lot of slide.  
9 Slide 25. And again I want to just talk about  
10 existing 'cause you like existing. Let's just  
11 talk about what exists today. We've been  
12 talking about what exists today so let's talk  
13 about what exists today at your client. And  
14 that is really -- that middle column isn't it?

15 A: Yes.

16 Q: That middle column is what exists today. And  
17 how many total PD bays or treatment areas are  
18 there?

19 A: 16.

20 Q: And you remember Dr. Hall -- you believe Dr.  
21 Hall's testimony, right?

22 A: Yes.

23 Q: Okay. And you remember Dr. Hall said that four  
24 of those bays are a pod that are used just for  
25 psych, remember that?



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1 A: Yes.

2 Q: And he said the do about 100 a month, 1,200 per  
3 year. Do you remember that testimony?

4 A: I don't remember that but I don't disagree. I  
5 believe you.

6 Q: Okay. Do me a favor then and back out that  
7 1,200 from the total 24,499 because it's  
8 imbedded in that number, right? Those 1,200  
9 psych for children would be inside of that  
10 24,499?

11 A: Yeah, yeah, I mean it's on that score card too  
12 I think. So we can go back to the score and  
13 look to see if that 1,200 number's right but  
14 I'll take your word for it.

15 Q: Indulge me.

16 A: Yes.

17 Q: All right. So if we do back those rooms out  
18 that means you're only using 12 rooms to treat  
19 the remainder of the population, right?

20 A: Yes.

21 Q: All right. And so how many visits per room is  
22 that?

23 A: It's 1,941 per room, and I think what that  
24 shows is that's why we're adding more rooms, 20  
25 rooms, at the new Shawn Jenkins.



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1 Q: Well they must not do much teaching in those  
2 rooms if they do 1,941.

3 A: Well they -- you know, again, that's assuming  
4 that your 1,200 is accurate. I don't know if  
5 more behavioral health visits were treated in  
6 those rooms, but they do do a lot of treating.  
7 They're capacity constrained. I think this  
8 highlights our very argument that we're  
9 capacity constrained on the peninsula. We need  
10 more ED space.

11 Q: And you're going to get those 12 rooms in  
12 October?

13 A: No, we'll have 20 total in October. If we have  
14 12 now that's only eight more. And then we'll  
15 have hopefully the 12 in North Charleston,  
16 Summerville.

17 Q: Those 16 rooms will be vacated when Shawn  
18 Jenkins opens, right?

19 A: And they'll be used for psych patients, yes.

20 Q: And that's their decision. They could them for  
21 other things if they wanted to, right?

22 A: They could but they have a psych issue and this  
23 is going to address that element of the  
24 capacity for help -- hopefully help -- address  
25 that aspect of the capacity constraints on the



1 peninsula.

2 Q: I'm still confused with math. They've got the  
3 largest psych hospital in the State of South  
4 Carolina. They more beds and they can't move  
5 them out of that ED fast enough to get into  
6 those hundred beds?

7 A: You saw the hundred bed are a 108 percent  
8 occupied. So they a hundred -- they have a lot  
9 of beds but they're all full. And I think  
10 that's probably why your client is building a  
11 psych hospital -- or at least has been approved  
12 to build a psych hospital -- to help alleviate  
13 that. MUSC supported that, they did not oppose  
14 it because there needs to be more psych  
15 services in the area and Trident hasn't built  
16 that yet.

17 Q: Well they also could have applied for those  
18 beds or 90 psych beds in the plan and they  
19 didn't apply for a single one of them did they?

20 A: They had nowhere to put them.

21 Q: Nowhere to put them.

22 A: I guess we could have put them up in North  
23 Charleston but I think you guys might have had  
24 a little heartburn on that.

25 Q: Well I hear your argument about there's nowhere



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1 to put anything but MUSC has an advantage about  
2 real estate that no other hospital that's  
3 participating in this proceeding has. You know  
4 what that is?

5 A: Not off the top of my head.

6 Q: They have the power of eminent domain. They  
7 can condemn any property they want, did you  
8 know that?

9 A: No, I did not know that and that had never been  
10 raised so in the 20 years that I've been  
11 working with them we have been trying to figure  
12 out the puzzle pieces on the peninsula. I'm  
13 not sure that that's accurate. If it is no one  
14 there may know about it because we were going  
15 to use the VA Hospital site for our expansion.  
16 We couldn't get them to agree with us. I think  
17 if we had eminent domain we'd just take it,  
18 right? They didn't do that. We wanted to move  
19 into the Charleston Memorial Hospital site and  
20 the McClellan Bank site. We bought those. If  
21 they had eminent domain why would they pay for  
22 them? So, I mean, it's an interesting concept  
23 but there's nothing left. I guess if you're  
24 suggesting that we use that eminent domain  
25 power to take Roper maybe we should do that.





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2218

1     **MR. SUMMER:**   I'd just draw the Court's attention to  
2                   59-123-9.

3     **Q:**       Now you had not done an acuity analysis until  
4                   this week, correct?

5     **A:**       No, I looked at the billing acuity and  
6                   submitted that at project review.

7     **Q:**       Right. All of your slides that we've gone  
8                   through today I hadn't seen them until last  
9                   night so if you've done them before then --  
10                  this acuity analysis that we've looked at --  
11                  and you did two different ones -- was done for  
12                  trial today was it not?

13    **A:**       I'm not sure which acuity analysis your talking  
14                  about. Which pages?

15    **Q:**       Sure, we can do that. You had not done one at  
16                  the time of your deposition, correct?

17    **A:**       I hadn't done an acuity analysis of the  
18                  patients by zip code. But as I said at project  
19                  review, as a follow-up to project review or  
20                  maybe at project review -- I know it was a  
21                  follow-up to project review -- I had submitted  
22                  the billing acuity information to the State.

23    **Q:**       That was at -- those top ten billing codes? Is  
24                  that what that was?

25    **A:**       No, no, I looked at the billing codes and a



1       fraction of the percent of the patients fall in  
2       the highest acuity billing code and I submitted  
3       that to DHEC to review as part of the CON  
4       application because during project review we  
5       were criticized saying look included these  
6       trauma patients which we didn't necessarily  
7       include direction, but I wanted to show DHEC  
8       even if we did we're talking about a fraction  
9       of a percent. If we were to take them out they  
10      wouldn't have a material impact on any of the  
11      projections. So that was done in 2017.

12     Q:    But that's the only acuity that you looked at  
13           prior to trial, right?

14     A:    Yeah, prior to developing my exhibits for the  
15           trial, yes.

16     Q:    Okay. If we could pull up -- now you really  
17           got me 'cause now we're going to do accounting.  
18           Let's go to page 87 of the DHEC records. Can  
19           you pull that up? Do you remember talking  
20           about this on direct?

21     A:    Yeah, the pro forma budget? Yes.

22     Q:    Okay. We really don't know what the pro  
23           forma's going to look like until MUSC makes  
24           some decisions about how they're going to do  
25           this project, fair statement?



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1     A:     Maybe with some sort of detailed granularity  
2           but generally it will look like this because  
3           the capital expense is in here. Lease expense  
4           and depreciation we have at -- you know, for  
5           year three -- I guess the first full year of  
6           three, which is 2023. We have over \$900,000 in  
7           capital costs. So whether we lease it and pay  
8           rent or we build it and book it as depreciation  
9           in interest that's an adequate number. By  
10          comparison the Summerville FSED which is about  
11          11,000 square feet and about \$11,000,000 had  
12          \$500,000 in capital costs so it would be the  
13          same and we have double that. So to the extent  
14          that we change the structure of owning it  
15          versus renting it we've got enough capital  
16          costs to cover it so if anything it would go  
17          down and we'd have more net income.

18        Q:     You'd agree with me that you probably  
19                capitalize -- again, I'm going back to Dr.  
20                Cawley's testimony. We may build it ourselves,  
21                we may have it built to suit. We may a  
22                developer, we may not. At the end of the day  
23                we don't know what the University intends to do  
24                in that regard yet do we?

25        A:     No, and it's not unusual to -- for projects to



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1 change in that aspect. You know, the two other  
2 freestanding ED's that are being developed by  
3 -- two of the other freestanding ED's that are  
4 being developed by parties not in here. The  
5 one in Coastal -- the Coastal Carolina  
6 freestanding ED in Jasper County and the  
7 Piedmont freestanding ED in York originally had  
8 contemplated a third party developer buying the  
9 land and building the building. Both of those  
10 changed to the hospital buying the land  
11 building the building. Not determined to be a  
12 substantial change. Didn't have a material  
13 impact on the pro forma. And the Coastal  
14 freestanding ED is opening next week.

15 Q: Good. That wasn't my question. My question is  
16 if we -- if MUSC decides to build this we've  
17 got a lease expense -- a ground lease expense  
18 that's going to run -- and what is that is  
19 about 190 a year?

20 A: Yes, \$190,000.

21 Q: So we know we've got that and if they build it  
22 and they have to depreciate it you'd be  
23 basically depreciating and you'll capitalize as  
24 much as you can, right? You're going to  
25 capitalize the cost of construction, interim



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2222

1 interest, anything else you can on the front  
2 end, fair statement?

3 A: Yes.

4 Q: Okay. Even if it's a \$12,000,000 project you  
5 may be capitalizing 13,000,000 before you open  
6 the door, fair statement?

7 A: Depending on the interest rate and how they  
8 structure it. If they use existing reserves  
9 there wouldn't be any interest expense or  
10 construction loan or anything like that so it  
11 would depend. The \$11,000,000 I think included  
12 an imputed value of the land so, no, I think it  
13 would be lower than that.

14 Q: So let's just say it was 12,000,000 just for  
15 the sake of argument, okay?

16 A: Well that's high, but okay.

17 Q: All right. Does 11 make you feel better?

18 A: Well what I'm saying is the 11 also includes  
19 the land so it would lower than that.

20 Q: So you -- 11,000,000 cost includes the annual  
21 fee ---

22 A: No, no, the 11,000,000 cost includes the  
23 imputed value of the land.

24 Q: And discounted to present value?

25 A: No. No, it's the fair market value of the land



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1           because that's what you gotta do for CON ---

2       Q:     Now that's completely different from a tax  
3           computation.     From a tax computation you're  
4           going to expense the 190 per year and you're  
5           going to have debt for building the building,  
6           correct?

7       A:     You are but you're confusing the starting  
8           point.     So the \$11,000,000 isn't the starting  
9           point for tax computations as you called it.  
10          So the \$11,000,000 that we put in the  
11          additional information that we submitted in  
12          discovery saying this is the new cost of the  
13          new project, \$11,000,000, includes land costs  
14          so you've just identified it exactly right.  
15          You don't count that.     So that would come out  
16          of the \$11,000,000 so the starting point if it  
17          were a \$2,000,000 land value would be  
18          \$9,000,000 not more.

19      Q:     All right.     So let's use nine.     Are you going  
20           to take nine ---

21      **MR. WESTBROOK:**     Objection.     Let him finish.     He  
22           wasn't finished with his answer.

23      Q:     Is 9,000,000 your answer?

24      A:     I think I was finished.

25      Q:     Okay.



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1 A: Close enough. I'll let you ask the next  
2 question.

3 Q: Okay. The next question would be then you're  
4 going to have to reflect depreciation. If the  
5 hospital pays for it itself you would reflect  
6 depreciation on a straight line depreciation in  
7 your pro forma, fair statement?

8 A: You would reflect depreciation on the income  
9 statement depending on whatever method they  
10 use, you know, the double declining. Some of  
11 them use digits, straight line, whatever the  
12 method is. But again, back to my original  
13 point is Summerville Medical Center had  
14 \$500,000 in capital costs. Using all of those  
15 same accounting treatments they said they were  
16 going to spend \$11,000,000 to build a  
17 freestanding ED and they showed \$500,000 in  
18 capital costs. Why would we be any different?

19 Q: Because probably they're using a lot cash on  
20 hand.

21 A: Well MUSC may do that as well or they may get  
22 some bond funding and use that because it's  
23 this fungible asset. So when people say well,  
24 you know, we're gonna get a loan on this, well  
25 if they have a line of credit or if they have



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1 cash and they use it for this versus something  
2 else there wouldn't be an interest expense  
3 necessarily associated with this project. So,  
4 you know, HCA would use capital because all  
5 capital -- the cash is swept from the  
6 facilities to corporate. So Summerville  
7 doesn't have any money, corporate gives it to  
8 them. So they would be imputed the cost of  
9 capital. I guess, you know, the bottom line is  
10 -- we could talk a lot about these accounting  
11 treatments -- but if Summerville said they were  
12 going to have \$500,000 in capital costs on  
13 \$11,000,000 freestanding ED there is not reason  
14 to believe we would have substantially higher  
15 than that, and what we have in the pro forma is  
16 substantially higher than that. So I think  
17 we've conservatively estimated the costs. If  
18 anything they're going to go down. So even if  
19 you take the \$500,000 Summerville said and you  
20 add to it \$190,000 land lease that's \$690,000.  
21 We had \$675,000 in lease expense in there so  
22 we've covered it.

23 Q: So your position is no matter what the expenses  
24 are you've got proxies in place, it's  
25 overstated, it's not an issue to you?





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1     A:     Yes.

2     Q:     Okay.

3     **MR. SUMMER:**   If I can beg the Court's indulgence for  
4             just a minute.

5     Q:     If you'd be so kind as to answer any questions  
6             that Mr. Wicevic may have?

7     **MR. WICEVIC:**   Your Honor, DHEC has no questions.  
8             Thank you.

9     **THE COURT:**   Thank you.   Anything else?

10    **MR. WESTBROOK:**   No redirect.   Thank you.

11    **THE COURT:**   Okay.   Thank you, Mr. Levitt.

12    **MR. LEVITT:**    Thank you.

13    **THE COURT:**    Okay and Mr. Summers.

14    **MR. SUMMERS:**   Yes, ma'am?

15    **THE COURT:**    You all do have a rebuttal case and also  
16             Ms. Hollingsworth, right?

17    **MR. SUMMER:**    We do, Your Honor.

18    **THE COURT:**    Okay.   And your witnesses are here?

19    **MR. SUMMER:**    Witnesses are here but we've gotten a  
20             lot of stuff last night and today that we'd  
21             like to have time with our witnesses to review  
22             so if we could start first thing in the morning  
23             we would certainly appreciate it, Your Honor.  
24             Thank you.

25    **MR. WESTBROOK:**   That's fine.



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1 THE COURT: Okay. 9:00 in the morning.  
2 (Thursday, August 1, 2019 of the administrative  
3 hearing ended at 4:15 p.m. and hearing reconvened on  
4 Friday, August 2, 2019 at 9:07 a.m.)

5 DAY TEN - AUGUST 2, 2019

6 THE COURT: Good Morning. Please take your seats.  
7 Okay, if everyone is ready. We'll reconvene  
8 the hearing. Ms. Hollingsworth. Oh, I'm  
9 sorry.

10 MS. GLOBER: Emily Globber. We call Kathy Platt.

11 MS. PLATT - DIRECT EXAMINATION BY MS. GLOBER:

12 THE COURT: Okay. Ms. Platt, you are still under  
13 oath.

14 Q: Good morning, Ms. Platt. How are you?

15 A: I am doing well.

16 Q: Good. So you've created some reply slides for  
17 us today, right?

18 A: Yes.

19 Q: Okay. We'll go to -- just go through these  
20 quickly. You've been working for ---

21 MR. WESTBROOK: Objection, Your Honor.

22 THE COURT: Yes.

23 MR. WESTBROOK: Sorry to be so quick, Ms. Globber,  
24 but I think it would save time, be more  
25 efficient to go ahead and get my objection out



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1           now. I haven't had a chance to look at all  
2           these slides closely because we just got them  
3           about a half hour ago, but I've looked at this  
4           first one and enough of the others to know that  
5           a lot of these are not in rebuttal and what I  
6           would -- the basis of this objection is that  
7           rebuttal testimony or reply testimony as it's  
8           sometimes called, should be limited to rebuttal  
9           of matters raised by the defense rather than to  
10          complete the plaintiff's case in chief. In  
11          other words, there's no rehashing that's  
12          allowed in rebuttal. A reply -- I'm quoting  
13          from a case, State v. Pratter -- can't talk,  
14          422 South Carolina 96. It's a 2017 case but I  
15          think there's plenty of case law on this.  
16          Reply testimony should be limited to that which  
17          refutes or rebuts testimony presented by the  
18          defendant, or in this case, the respondent.  
19          Mr. Levitt, nor any of our other witnesses,  
20          presented testimony about Roper St. Francis's  
21          history going back to the 19th century or the  
22          number of employees they've had, the number of  
23          medical staff they had, the facilities they  
24          had, this is just the first slide. There are  
25          a number of slides of those that we received



1           this morning that are not any attempt to rebut  
2           the position of the evidence offered by MUSC.  
3           It's simply trying to complete the case in  
4           chief of Roper and so we would object to this  
5           slide and any other slide and I think we can  
6           take those up individually as they come along,  
7           of course, but I just want to make that general  
8           objection at the outset.

9       **THE COURT:**   How many slides to we have, Ms. Glober?

10      **MS. GLOBER:**   Total slides we have 30.

11      **THE COURT:**   30 slides.

12      **MS. GLOBER:**   And the first, these background slides  
13           are simply setting forth the various  
14           facilities, all of which have been discussed  
15           throughout the case, just setting forth the  
16           hospitals -- just to clear up the record about,  
17           you know, when the various facilities were  
18           opened.       There's been a little bit of  
19           confusion, I believe, on some of the facilities  
20           and it's just three slides, Your Honor, just  
21           with simple background listing the facilities,  
22           setting the groundwork for the slides that are  
23           going to come next.

24      **MR. WESTBROOK:**   And, Your Honor, ---

25      **MS. PLATT:**       All of the facilities have been



1           discussed.

2       **MR. WESTBROOK:**   And, Your Honor, I would say, yes  
3           they have been discussed.       They've been  
4           discussed by the plaintiff, excuse me, by  
5           petitioner, their case in chief. They haven't  
6           been discussed by MUSC in its defense. Again,  
7           and it's not just the three background slides  
8           at the front. I think this goes throughout  
9           their slides. Not every one of their slides do  
10          I have an objection to, but quit a few of them  
11          because they're not rebutting arguments that we  
12          made or evidence that we've presented. Now  
13          again, I don't expect you to make a blanket  
14          ruling on that but we can take that by, you  
15          know, slide by slide but I just want to prepare  
16          you that unless you, you know, cut me off or  
17          sort of generally or disagree with me generally  
18          at the outset that we're going to have a number  
19          of objections to these slides.

20       **THE COURT:**   Okay, thank you.

21       **MR. WESTBROOK:**   And I personally would start with  
22           this one.

23       **THE COURT:**   And you will start with this one. Ms.  
24           Glober, I'm gonna let you proceed with at least  
25           ---



1     **MS. GLOBER:**   Okay.   Thank you.

2     **THE COURT:**   And Mr. Westbrook, I will entertain your  
3                   objections as she presents the slides.

4     **MR. WESTBROOK:**   Thank you.

5     **MS. GLOBER:**   Thank you, Your Honor.

6     **Q:**       So Ms. Platt, you've been working for Roper St.  
7                   Francis for many years.

8     **A:**       Yes.

9     **Q:**       Okay.   And on this first slide, what do we need  
10                  to have here.

11    **A:**       Sure.   So the reason that I included the slide  
12                  was just to give a little background because I  
13                  think there's been a number of times where MUSC  
14                  in their case basically said, oh their doing  
15                  exactly what Roper did, they're just, you know,  
16                  going out to Berkeley County because, hey,  
17                  Roper did it.   And what I want to show here is  
18                  basically that there's been an ongoing plan  
19                  over the years for the Roper St. Francis system  
20                  to grow and reach out beyond the peninsula and  
21                  that the Roper St. Francis Berkeley is the  
22                  latest of that.   It's, you know, was approved  
23                  finally in 2016 after eight years or so of  
24                  appeal and it's finally opening.   And that  
25                  can't be disregarded and also Roper St. Francis



1 Berkeley was, you know, planning for the  
2 community out there long before, you know, it  
3 was the, you know, thing to do and that MUSC is  
4 not doing exactly the same thing. Roper  
5 specifically moved beds out there and it was an  
6 institutional need for hospital beds which is  
7 a different type of planning that what we've  
8 got here for freestanding ED.

9 **MR. WESTBROOK:** And, Your Honor, I would just say  
10 that MUSC did not, if I recall in the evidence,  
11 saying that over the years Roper has planned --  
12 addressing Roper's plans to move off the  
13 peninsula, I don't recall any evidence saying  
14 that MUSC and Roper are doing exactly the same  
15 thing. I don't recall that.

16 **MS. GLOBER:** Your Honor, there was definitely  
17 testimony, well Roper did it, Trident did it  
18 and these slides are just going to that.

19 **MR. WESTBROOK:** The testimony I think Ms. Glover is  
20 talking about is that in a particular CON  
21 application, or particular CON applications  
22 from Roper and Trident, they used a similar,  
23 sort of, redirection analysis that MUSC is  
24 using in this case, patient shift, that in  
25 other words, that we'll only be serving our



1 existing patients. That was the testimony, not  
2 any, sort of, broader plan or strategy to move  
3 off the peninsula.

4 **MS. GLOBER:** And I would just add, Your Honor, that  
5 there were slides that crossed Roper Berkeley  
6 off the list of providing -- these slides are  
7 just going to the fact that this has been a  
8 plan for many years. This hospital is about to  
9 open and this just sets forth the various  
10 facilities and goes to the amount of services  
11 and the investment that Roper has made in this  
12 area.

13 **MR. WESTBROOK:** And the slides that she's referring  
14 to that cross Roper off the list were related  
15 to whether Roper was an existing provider or  
16 not. The State Health Plan, the 2018 State  
17 Health Plan language about 15 minutes or  
18 capacity constraints within the area referred  
19 to existing providers and the reason that we  
20 were crossing those off the list is because  
21 Roper Berkeley Hospital is not an existing  
22 provider in that area.

23 **MS. GLOBER:** And we would dispute so -- and Ms.  
24 Murdock testified that she does consider  
25 approved providers in her review of CON





1 applications, existing is not the same as  
2 licensed hospital.

3 **THE COURT:** Okay. Now what would you be showing  
4 with this slide. Tell me again.

5 **MS. GLOBER:** This slide just shows the various  
6 emergency services. It's just laying some  
7 background because all of these have been  
8 touched on and it shows the investment that  
9 Roper has made in the area to provide emergency  
10 services. It's just one more slide that goes  
11 to the freestanding ED, both of which have been  
12 touched on and there's just been a little bit  
13 of confusion. I know one person said  
14 Northwoods wasn't open and operating. That's  
15 not the case. We're just trying to clear up  
16 some of the things that were unclear.

17 **THE COURT:** Okay. Now, correct me if I'm wrong, but  
18 I believe we've heard earlier testimony about  
19 the status about Northwoods and the other  
20 emergency departments that's operating in the -  
21 - that we've earlier heard testimony about  
22 those as well as their current status.

23 **MS. GLOBER:** Right. There was just a little bit of  
24 confusion. I think someone testified that they  
25 weren't sure if Roper Northwoods was actually



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1 open after it relocated. And it is open and  
2 operating and we just wanted to clear that up,  
3 Your Honor. That's all these slides are doing,  
4 just setting forth all the facilities that have  
5 been discussed by every party, including MUSC.

6 **THE COURT:** Okay. Yeah.

7 **MR. WESTBROOK:** I would simply say, the nature of  
8 rebuttal testimony would be something like  
9 this, MUSC witness, Levitt, or Collie or  
10 whoever it is, testified so and so. In fact,  
11 here's evidence contradicting or arguing that,  
12 that testimony is incorrect or incomplete.  
13 That's not what this is. This is filling in  
14 their case in chief. It's a rehash of issues  
15 that have already been discussed in their case  
16 in chief. That's the basis of our objection.

17 **THE COURT:** Okay. I'm overruling your objection.  
18 We'll allow her to.

19 Q: The last slide on this -- hopefully we can get  
20 through this quickly. So Ms. Platt, what do  
21 you have on this slide?

22 A: So again, I think this is just to clarify some  
23 of the perhaps confused testimony previously  
24 regarding the two freestanding EDs that Roper  
25 already operates, Roper Hospital Diagnostics



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1           and ER in Berkeley, is, you know, almost 27  
2           years old.       It's been out serving that  
3           community, you know, obviously for a very long  
4           time and Roper has made the investment to go  
5           out to Berkeley County and serve that  
6           community. The Roper Hospital Diagnostics and  
7           ER Northwoods, it's opened in '97 so it's, you  
8           know, over 20 years old as well and it is  
9           reopened in it's new location where it  
10          recently, you know, relocated and was approved  
11          to expand. Again, just showing the amount of  
12          investment that Roper made in their ER services  
13          to serve the same community proposed by MUSC.  
14          And in my opinion, that can't be disregarded  
15          and that's essentially what MUSC argued through  
16          their expert health planner.

17       Q:    Thank you. And we heard a lot about population  
18              growth. Do you remember that testimony?

19       A:    Yes.

20       Q:    And are there -- what does this map show? What  
21              are the pins on this map.

22       A:    Sure. So the pins are approved freestanding  
23              EDs throughout the State of South Carolina as  
24              well as including the MUSC project that we're  
25              here about. And the shading comes from the



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1 U.S. Census Bureau and it shows the areas of  
2 the state with high concentrations of  
3 population and population growth. And the  
4 point is that there are a number of large  
5 communities, cities, within the state, like,  
6 for example Columbia and the Greenville area  
7 that are densely populated, also rapidly  
8 growing that have little or no FSEDs and it's  
9 not the norm, you know, to approve more and  
10 more and more freestanding ED capacity which  
11 is, sort of, what we have here in the tri-  
12 county area. There's, you know, now going to  
13 be more freestanding EDs in the tri-county area  
14 than any other part of the state.

15 **MR. WESTBROOK:** Same objection, Your Honor. Again,  
16 Mr. Levitt's testimony is consistent with this.  
17 I recall Mr. Levitt saying that with respect to  
18 FSED's in the State of South Carolina, they  
19 were concentrated in the area that we're  
20 talking about today, the tri-county area and  
21 the Horry County area. This is not rebutting  
22 anything that MUSC said. It's actually  
23 consistent with what MUSC said. It's something  
24 that they talked about in their case in chief.  
25 It's simply a rehashing of material and



1 information that's already been presented.

2 **MS. GLOBER:** Your Honor, I would just say that Mr.  
3 Levitt population growth and that a  
4 freestanding ED was necessary to address that  
5 population growth and this map rebuts that and  
6 says there are areas that are densely populated  
7 with high populations that do not have  
8 freestanding EDs. It's not necessary to have  
9 a freestanding ED in a densely populated area.

10 **THE COURT:** That is not what I got from Mr. Levitt's  
11 testimony. He did talk about the population  
12 growth in that area and there are also other  
13 densely populated area that don't have  
14 freestanding EDs, such as Lexington County and  
15 whatever. But at this point, what I'm hearing  
16 from Ms. Platt is basically the same testimony  
17 that I heard from Mr. Levitt. She's basically  
18 confirming what Mr. Levitt said, not giving  
19 anything that's counter to it.

20 **MS. GLOBER:** Okay, Your Honor, we can move on from  
21 that one.

22 **THE COURT:** Okay, thank you.

23 Q: Okay, this next slide that you created,  
24 timeline of CON approvals and issuances by  
25 DHEC, what do we have here on this slide?



1     A:     Again, this just sets forth the number of CON  
2           approvals adding emergency services capacity to  
3           the Berkeley County and surrounding area and I  
4           think that, again this goes to my opinion that  
5           when you're planning for a new service, a new  
6           location for emergency services you can't just  
7           disregard the prior approvals.     We've got  
8           multiple freestanding EDs, ED expansions and  
9           new hospitals with ED services already  
10          approved, investments already made to serve the  
11          growing population in the area and they can't  
12          just simply be disregarded as MUSC would like  
13          to do.   And I think that's consistent with my  
14          understanding of Ms. Murdock's testimony that  
15          in terms of community need and health planning  
16          you have to consider both existing and  
17          approved facilities.

18    **MR. WESTBROOK:**   Your Honor, same objection.   A large  
19          part of Mr. Levitt's testimony was that there  
20          had been a number of applications in this area  
21          approved in recent years and in fact, this very  
22          slide I believe was used in Ms. Platt's direct.  
23          I've seen this slide before I know that.   So  
24          again, it's not rebutting testimony by Mr.  
25          Levitt or any other MUSC witness.   There's



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1 nothing disputed about these dates on this --  
2 or the fact that these applications were  
3 approved and again, Mr. Levitt -- a major  
4 portion of his testimony was talking about  
5 these applications. And I remember crossing  
6 Mr. Sullivan and Ms. Platt about these  
7 applications as well. So this is just another  
8 rehash.

9 **MS. GLOBER:** Your Honor, this goes directly to ---

10 **THE COURT:** Ms. Globler ---

11 **MS. GLOBER:** Yes.

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

13 **MS. GLOBER:** Thank you.

14 Q: So as a health planner, do you take into  
15 account approved facilities?

16 A: Absolutely. Planning is a forward looking  
17 approach and you have to consider what's  
18 already in place in the market, what's being  
19 developed, the investments the providers are  
20 making, the capacity that has already been  
21 approved to meet the same growth in population  
22 that MUSC claims they're gonna serve. So as a  
23 health planner, it's very critical that you  
24 consider both existing and approved. And in,  
25 you know, facilities that are eminently coming



1           online.

2       Q:     And this slide shows those various facilities?

3       A:     Yes. This is just simply a reminder that these  
4           facilities, existing and approved, are  
5           throughout the service area identified by MUSC.

6       Q:     And if you remember yesterday when Mr. Levitt  
7           was testifying about the various capacity at  
8           some of these facilities and you used the  
9           capacity per space of 1,500, what's your  
10          opinion about that, the use of 1,500 visit  
11          capacity per space?

12      A:     Sure. So this response to Mr. Levitt's  
13           analysis where he first went through and he  
14           completely discounted Roper Hospital Berkeley  
15           and Berkeley Medical Center, both of which are  
16           approved hospitals with ED capacity with, you  
17           know, Roper Hospital Berkeley coming online in,  
18           you know, October 4th. So basically, two  
19           months from now. And the first thing he did  
20           was cross those out. And I disagree with that.  
21           Those are approved facilities. Approved to  
22           serve the growth in Berkeley County that need  
23           to be considered in planning. The next thing  
24           is he used a flat 1,500 capacity for every  
25           single type of facility, every single type of





1 operator. And I completely disagree with that.  
2 I think there is a lot of evidence in the  
3 record from clinical witnesses, people who are  
4 working at these facilities and I have  
5 substituted their testimony on capacity in  
6 here. So for Roper Hospital Berkeley, I'm fine  
7 with the 1,500. That's consistent with Joy  
8 Huntington's testimony for that community  
9 hospital. Trident Medical Center and  
10 Summerville Medical Center are both HCA  
11 hospitals. There's testimony setting forth  
12 that HCA uses a capacity standard of 2200, so  
13 I've used that for those two hospitals.  
14 Trident Monks Corner and Center Point, the  
15 other two HCA facilities, there's testimony in  
16 the record that as freestanding EDs they  
17 actually can operate at a higher capacity than  
18 the hospitals and that's the track record of  
19 the HCA hospitals so I've substituted 2,500 for  
20 each of those facilities. For the two Roper  
21 freestanding EDs, Northwoods and Moncks Corner,  
22 the testimony from Joy Huntington supported  
23 3,000 visits and that's consistent with the  
24 application for the relocation and expansion of  
25 Northwoods that was approved by The Department.



1 That CON application used 3,000. And then for  
2 Berkeley Medical Center, I assumed it would be  
3 again a community hospital operated by HCA and  
4 used the 2,200 HCA capacity standard. So there  
5 has to be a recognition that different types of  
6 facilities operated by different types of  
7 providers, with different experiences, have  
8 various capacities. And so I've simply  
9 substituted those based on the testimony of the  
10 clinicians that we heard and when I recalculate  
11 the new area capacity, which is fully  
12 encompassing of all existing and approved  
13 providers, is 384,500. And that's the capacity  
14 that I feel needs to be considered when you're  
15 planning for additional new facilities in the  
16 service area.

17 Q: And why are there higher capacity numbers for  
18 the freestanding EDs?

19 A: One of the main reasons is that they don't  
20 serve the same level of complexity of patients.  
21 And I would disagree with Mr. Levitt on this  
22 point. They tend to serve the lower acuity  
23 patients that have shorter visits and so the  
24 throughput can be a lot faster. And again, I  
25 believe that is consistent with the testimony



1 of multiple clinical witnesses that we heard  
2 over the course of the hearing.

3 Q: What other evidence is there regarding the  
4 capacity of some of these facilities?

5 A: Sure. So I think the point of Mr. Levitt's  
6 testimony where he re-calculated capacity with  
7 this low 1,500 standard, he tried to show that  
8 every single provider basically was over 100  
9 percent of capacity, which is just not  
10 reasonable. And if have heard no direct  
11 evidence that patients are somehow impacted by  
12 capacity challenges by these facilities, you  
13 know, that they can't get in, there's excessive  
14 wait times. So yesterday afternoon while Mr.  
15 Levitt was testifying, I looked at what the ER  
16 wait times are for the four HCA facilities in  
17 question, because they post their ER wait times  
18 every half an hour on their website. And these  
19 four facilities, Mr. Levitt claims are  
20 operating well over 100 percent capacity, yet  
21 they have wait times of anywhere from two to  
22 eight minutes, which is certainly extremely  
23 reasonable and very efficient. So, I think it  
24 goes to the credibility of Mr. Levitt's claims  
25 that all of these facilities are way over 100



1           percent capacity when you can walk into these  
2           ERs and be seen that quickly.

3       Q:     And did you check the wait times at different  
4           times ---

5       A:     Yes.

6       Q:     --- in the afternoon and evening?

7       A:     I did. And I think that Mr. Levitt's testimony  
8           was the busiest time in the ER was, like, 3:00  
9           o'clock in the afternoon to 11:00 o'clock at  
10          night, or maybe that's some combined testimony  
11          from some of the clinicians. So I checked all  
12          evening last night until 11:15 p.m., and the  
13          wait times were relatively the same throughout  
14          that entire time. I think at one point Trident  
15          might have gone up to seven minutes, Moncks  
16          Corner actually went down, Summerville went  
17          down, Center Pointe might have been three  
18          minutes. So I mean, everything was under 10  
19          minutes throughout the entire evening.

20      Q:     So is it your opinion that the folks in this  
21           area are being effected by these alleged  
22           capacity constraints at these facilities?

23      A:     Again, I haven't seen any evidence to suggest  
24           that there are capacity constraints at these  
25           facilities that would impact patients ability



1 to access care.

2 Q: Going to the next slide, what is this slide  
3 show?

4 A: So again, responding to Mr. Levitt's  
5 calculation where he used the 1,500 visit  
6 capacity for every single type of facility and  
7 operator, I've recalculated again the capacity  
8 based on what I've heard in the testimony this  
9 week and identified across the board a capacity  
10 for 384,500 total visits in the service area.  
11 I've used the actual utilization for 2018  
12 provided through discovery for Roper and  
13 Trident and compared that and you can see for  
14 the existing providers, nobody is over 75  
15 percent. Some of them are in the 60s, Roper  
16 Moncks Corner is at 51 percent, so there is no  
17 capacity constraint at any of these facilities.  
18 And then you have to consider additionally the  
19 capacity that's coming online with the approved  
20 Roper Hospital Berkeley and the Berkeley  
21 Medical Center. And this slide doesn't even  
22 include the Trident Summerville freestanding ED  
23 that would add additional capacity. So,  
24 there's just no question that there's plenty of  
25 capacity in this area to meet not only the



1 current needs but the projected growth and  
2 utilization associated with the population  
3 growth in the area.

4 Q: And for the Roper data, what did you rely on  
5 for that?

6 A: I used the discovery data that was provided  
7 that showed, you know, each hospital and the  
8 departments that were the freestanding EDs. So  
9 that was provided in discovery.

10 MS. GLOBER: Your Honor, I would just move to admit  
11 Roper St. Francis Exhibit 6, which is the Roper  
12 ED volume listed down there as a source, just  
13 so it's in the record as an underlying document  
14 for this data.

15 MR. WESTBROOK: I'm sorry, I'm confused. Roper  
16 Exhibit 6 is what now?

17 MS. GLOBER: It's this one right here, it's Roper  
18 254, Roper ED volume, just as the underlying  
19 data for the actual utilization.

20 MR. WESTBROOK: All right. From Roper Exhibit 254?

21 MS. GLOBER: No, that's the Bates Number.

22 MR. WESTBROOK: Oh, okay.

23 MS. GLOBER: It's Roper Exhibit 6 on the designation  
24 list.

25 MR. WESTBROOK: Oh, okay. So that's a Bates page



1 from Roper Exhibit 6. I got you.

2 **MS. GLOBER:** Well, it's an Excel spreadsheet.

3 **MR. WESTBROOK:** Oh okay.

4 **MS. GLOBER:** I believe. So, the Excel spreadsheet  
5 entitled Roper 254, it's designated as Roper's  
6 Exhibit 6.

7 **MR. WESTBROOK:** Let me just check this for a moment.  
8 No objection.

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

10 **(Petitioner Roper's Exhibit Number 6 was admitted**  
11 **into evidence.)**

12 **MS. GLOBER:** Thank you.

13 Q: We saw this slide yesterday, is that right?

14 A: Yes.

15 Q: And what changes have you made to this slide?

16 A: Sure. So, the previous slide looked at the  
17 capacity available in the service area, which  
18 I think is the appropriate way to plan for  
19 community need for a new freestanding ED. MUSC  
20 spent a lot of time trying to, you know, link  
21 in their capacities -- alleged capacity  
22 constraints at their main campus on the  
23 peninsula. You know, that to me is not how you  
24 plan for community need but nonetheless, they  
25 presented the information so this basically



1       recaps Mr. Levitt's computation of how many ED  
2       beds or spaces MUSC as downtown. And I'm not  
3       going to dispute the number of bays. There's  
4       been a lot of testimony on that but what he did  
5       not do is compare the number of bays to the  
6       number of visits at MUSC downtown. And when  
7       you look in the middle column at the number of  
8       actual 2018 visits for MUSC in total and  
9       compare it to the 67 existing ED beds, they're  
10      operating at 1,264 visits per bed, which is  
11      well below the 1,500 that Mr. Levitt, sort of,  
12      universally used, indicating that there's  
13      plenty of beds or treatment spaces available at  
14      MUSC based on that standard. And then the  
15      right-hand slide basically shows that when this  
16      new children's hospital comes online, and they  
17      add an additional 20 beds, which is undisputed,  
18      and you take, you know, just kind of round up,  
19      there are 80,000 visits per year, you're down  
20      at 964 visits per bed or per treatment space.  
21      So, well below a 1,000, well below Mr. Levitt's  
22      defined capacity. So again, there's no  
23      physical treatment space capacity issue at the  
24      main hospital. Now, there may be operational  
25      issues. I'm not gonna dispute that there are





1 patients with bed holds and other, you know,  
2 throughput issues, bed issues, other  
3 constraints but they're not -- it's not a  
4 function of just simply the number of treatment  
5 spaces in their emergency department.

6 Q: What does this slide add to the -- does that  
7 slide add to the previous slide?

8 A: Yes.

9 Q: Okay.

10 A: So basically this goes one step further and  
11 adds the proposed 12 freestanding ED beds in  
12 the, I guess, the newest version of the MUSC  
13 project for a total of 95 treatment spaces  
14 throughout the MUSC system. And again, if  
15 there's, you know, approximately 80,000 visits  
16 according to MUSC's data and RFA data, and the  
17 proposal is that there's simply a shift from  
18 the downtown ER to the freestanding ED, you're  
19 still talking about serving the same base of  
20 80,000 visits but now you're serving them in 95  
21 treatment spaces and that would be an average  
22 of 842 visits per bed or treatment space, which  
23 is far, far below the capacity standard that  
24 Mr. Levitt identified at 1,500. So, you know,  
25 I think there's plenty of treatment spaces



1           today at MUSC and basically the freestanding ED  
2           that they proposed, it duplicates their own  
3           capacity unnecessarily and their gonna have way  
4           more treatment space than they need as a system  
5           based on their visit volume.

6       Q:    Okay. This slide I believe is showing the zip  
7           codes. Is that right?

8       A:    Yes. This is the zip codes in the service area  
9           identified by Mr. Levitt.

10      Q:    Okay. And what did you take from his slides.  
11           What are your thoughts on his service area?

12      A:    So, this is his defined service area and it  
13           shows the number of patients that are being  
14           served by MUSC and this, you know, broad area.  
15           And I think the takeaway from this is that this  
16           project as it's been defined and the service  
17           area has been defined the projected utilization  
18           was defined in the application, is really not  
19           focused on serving Berkeley County, although  
20           that's the claim that they're going out to  
21           Summerville to serve the explosive growth in  
22           Berkeley County. The reality is, in this  
23           service area that they've defined there's more  
24           patients coming from this one zip code in  
25           Charleston County than any other zip code. And



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1           that overall, there's more patients projected  
2           from Dorchester County than there are from any  
3           other part of the service area. So again, it's  
4           not really a Berkeley County project.

5       Q:    In looking at the zip code 29406, how many  
6           patients are projected there?

7       A:    This is actually the total volume that MUSC  
8           already serves but when they apply their shift  
9           percentage, it ends up being the largest  
10          percentage of patients coming from that zip  
11          code and it's a North Charleston zip code  
12          compared to any other zip code in their service  
13          area.

14      Q:    And what other facilities are in that zip code?

15      A:    So, Trident Medical Center is in that zip code  
16           and Roper Northwoods already exist in that zip  
17           code and then Center Pointe is basically on the  
18           zip code line.

19      Q:    And is this a map of Berkeley County?

20      A:    Yes, it is.

21      Q:    What's shown on this map?

22      A:    So, this shows, you know, all of Berkeley  
23           County and basically identifies that MUSC is  
24           proposing to put their freestanding ED on the  
25           very edge of Berkeley County. It's basically



1           about a third of a mile from the Dorchester  
2           County line. And as we have seen in many maps,  
3           right in the middle of a cluster of existing  
4           and approved ED services. So in my opinion,  
5           this project's not about serving Berkeley  
6           County, which is a large geographic area. It's  
7           about MUSC trying to capture market share in  
8           the midst of other competing providers and  
9           trying to serve really Dorchester County.

10       Q:     And is this Dorchester County?

11       A:     Yes.     And again, it shows the MUSC FSED  
12           location literally on the Dorchester County  
13           line.

14       Q:     Turning to access, do patients in this service  
15           area have access issues?

16       A:     Not that I ---

17       **MR. WESTBROOK:** Your Honor, another objection. This  
18           was a major point of their case in chief.  
19           Either this map or a map similar to this were  
20           used in their case in chief and that was their  
21           argument. I'm not saying they can't argue  
22           that, I'm saying they've already argued that.  
23           It's not rebutting Mr. Levitt's testimony.  
24           It's just a continuation of their argument from  
25           their original case in chief, Your Honor.



1 Q: Well this is -- Your Honor, this would be  
2 rebutting his testimony about the new standard  
3 in the 2017-2018 Health Plan and then the  
4 current about the fact that the 15 minute drive  
5 time, whether patients have access to a  
6 provider within 15 minutes and I believe that  
7 it was unclear about what that standard says  
8 and it was presented the fact that the  
9 freestanding ED has to be 15 minutes from  
10 another facility where as really the standard  
11 is about whether patients are 15 minutes from  
12 an emergency service or from a freestanding ED.  
13 So, that is what this slide is going to is  
14 addressing the access issue in direct response  
15 to Mr. Levitt's testimony, specifically about  
16 the 15 minute drive time.

17 **THE COURT:** Your objection is overruled.

18 **MS. GLOBER:** Thank you.

19 Q: Okay. So this map is a little confusing so  
20 can you help us understand what this is that's  
21 showing?

22 A: Sure. So, back to Mr. Levitt's testimony, he  
23 measured a 15 minute drive time from the  
24 proposed location to the other emergency  
25 departments in the area and his suggestion was,



1 first that there weren't any other providers  
2 within the 15 minutes, which I disagree with.  
3 But in my understanding of the standard, the  
4 goal is that it's a 15 minute travel time for  
5 a patient and can they access emergency  
6 services within 15 minutes. So the blue  
7 outline is basically a composite 15 minute  
8 drive time showing the area within the tri-  
9 county where patients have access to at least  
10 one or more emergency department within 15  
11 minutes. And you can see the red outline,  
12 which is the 15 minute drive time for patients  
13 around the proposed MUSC FSED, it's completely  
14 engulfed in the blue drive time contour. So  
15 there are no patients that will be served by  
16 the MUSC FSED that don't already have access  
17 within 15 minutes to one of the existing  
18 emergency departments in the area. And for  
19 that reason, when you're planning for a  
20 freestanding ED, you have to look at the  
21 capacity for all of these providers and what is  
22 the capacity that they have available, as I did  
23 previously, and I've demonstrated that there's  
24 plenty of capacity at these emergency  
25 facilities, both hospitals and freestanding EDs



1 to meet the needs to the patients within this  
2 drive time area.

3 Q: Speaking of drive time, what have you corrected  
4 on this slide?

5 A: Sure. So, Mr. Levitt yesterday suggested that  
6 there really weren't any existing emergency  
7 services within 15 minutes of the proposed MUSC  
8 facility. And first of all I disagree that you  
9 would overlook the approved facilities that are  
10 clearly within 15 minutes, the Summerville  
11 freestanding ED and Roper Hospital Berkeley  
12 that are approved. Obviously the Roper  
13 Hospital Berkeley about to come online, those  
14 are within a matter of a couple of miles of the  
15 proposed site so you can't disregard those.  
16 But when you look at the other existing  
17 facilities, Mr. Levitt suggested that  
18 Summerville Medical Center and Trident Medical  
19 Center were 26 and 28 minutes away from the  
20 proposed MUSC facility at peak traffic times.  
21 So I did exactly what I understood that he did  
22 and I chose on Goggle Maps an 8:00 a.m.  
23 departure time and I came up with a, you know,  
24 a 12 to 24 minute time from MUSC Berkeley  
25 Emergency Department to Summerville Medical



1 Center and a 10 to 16 minute travel time at  
2 8:00 a.m. from MUSC Berkeley freestanding ED  
3 location to Trident Medical Center. So, I'm  
4 not sure how he got such excessive drive times  
5 but at least in my review of the Goggle Maps,  
6 there are facilities that are easily within 15  
7 minutes, you know, maybe not every single day  
8 at every single moment, but well within a  
9 reasonable range to be considered a 15 minute  
10 travel time.

11 Q: Help us understand what this table shows  
12 please.

13 A: Sure. So this goes to again my disagreement  
14 with Mr. Levitt's suggestion of the percentage  
15 shift from each zip code in his defined service  
16 area from patients on the peninsula in the MUSC  
17 Emergency Department, the shift that he assumes  
18 will happen to the freestanding ED. So the  
19 column on the right, kind of, goes and it  
20 defines, you know, his service area as he  
21 defined it and it shows the percentage shift  
22 that he's assumed for each zip code. So what  
23 I've done to test that is I looked at the  
24 actual data for Roper Northwoods, provided in  
25 discovery, and Roper Northwoods is a perfect





1 example of what the shift really will probably  
2 be for this MUSC FSED. It's right in the same  
3 general area as the proposed MUSC facility.  
4 It's linked to a downtown, you know, hospitals  
5 that provide a higher level of service, so I  
6 would expect that the shift percentages for  
7 Northwoods would provide a very, very direct  
8 analogy to what you will see for MUSC. So,  
9 I've taken the Roper Northwoods actual data and  
10 defined it's service area exactly the same was  
11 a Mr. Levitt. I've put the top six zip codes  
12 in the primary service area, the next four in  
13 the secondary service area and then beyond that  
14 the broader, you know, zip codes where they  
15 draw very few patients in the tertiary area.  
16 And then, I calculated the actual split of  
17 patients between how many patients continue to  
18 drive downtown to the main hospital verses  
19 those that chose the freestanding emergency  
20 department. And you can see that the  
21 percentage shift you might call it or the  
22 percentage of patients that are choosing the  
23 freestanding ED over continuing to drive  
24 downtown to the main hospital is lower than  
25 what Mr. Levitt assumed in every single zip



1 code except for the top zip code, where it's  
2 pretty close, 64 percent and 60 percent, and  
3 one of the secondary service area zip codes  
4 where Mr. Levitt chose 25 percent. But in  
5 every other case, the percent shift is a good  
6 bit lower, sometimes quite a lot lower, 20  
7 percent or more lower. And most importantly if  
8 you look at the tertiary zip codes, the broad  
9 area that MUSC claims to serve, only seven  
10 percent of patients from Roper Northwoods  
11 tertiary service area are choosing to stop on  
12 the freestanding ED as opposed to driving  
13 downtown. If they're going to chose to drive  
14 that far from these distant locations, they're  
15 making a choice to go to a full service  
16 hospital department. So the actual shift is  
17 seven percent compared to MUSC's weighted  
18 average for their tertiary zip code of 61  
19 percent. And overall, across the board, what  
20 we're seeing is the percent of patients who  
21 choose the freestanding ED over driving further  
22 downtown to the hospital is 25 percent and I  
23 think that's pretty consistent with my  
24 understanding of Mr. Sullivan's testimony that  
25 he thought 25 percent was an appropriate



1 composite shift and by contrast MUSC has an  
2 average shift of about 60 percent. So, I think  
3 this goes to the fact that MUSC has overstated  
4 the amount of patients that they claim will  
5 shift and in reality the patients are not going  
6 to shift. If MUSC builds their facility,  
7 they're going to have to take market share from  
8 existing providers.

9 Q: We hear a lot about acuity, remember that  
10 testimony. And what type of acuity -- there  
11 are two different types, what type of acuity do  
12 you have in this chart?

13 A: Sure. So we heard the testimony of the ESI  
14 level, the acuity one through five where it's  
15 the patient's triage level when they walk in  
16 the door. And then we heard the billing data  
17 which is, sort of, how they're charged on the  
18 back end based on their resource utilization  
19 and the it's the opposite, the highest level is  
20 the six and the lowest level is the one. So,  
21 this is the billing level data and that's what  
22 I had that was available and comparable between  
23 the Roper discovery data and the CON  
24 application data was provided by MUSC. And  
25 even though they're not exactly the same type



1 of acuity, there is some overlap that the most  
2 acute patients on the acuity scale tend to have  
3 the highest resources and then therefore the  
4 highest, you know, billing level data. So,  
5 what I did was -- and let me set the stage of  
6 what this is responding to. I think Mr. Levitt  
7 testified yesterday that he believed the  
8 distribution of patients by acuity level in a  
9 freestanding ED would be pretty similar to  
10 hospital distribution. I think he was trying  
11 to quote Dr. Hall and basically suggest that  
12 the reason you have more patients in the lower  
13 levels of care is because that's simply a  
14 representative of the distribution overall.  
15 But that's a lot different than the testimony  
16 that I understood from most of the clinicians  
17 or from the clinicians I heard where the  
18 freestanding EDs definitely serve a higher  
19 concentration of low acuity patients. It's not  
20 a comparable apples to apples comparison to,  
21 you know, a hospital such as MUSC. So again,  
22 to test that point I took the data from  
23 discovery for Roper and I broke out Roper  
24 Hospital, Roper Berkeley freestanding ED, Roper  
25 Northwoods freestanding ED and you can see



1 consistent with the testimony we heard from the  
2 clinicians that the yellow, high acuity  
3 patients, they comprise 31 percent of Roper's  
4 patients where 68 percent are in the low acuity  
5 category. And when you look at Roper Hospital  
6 Berkeley, way out in Moncks Corner, you have  
7 14.7 high acuity and 85 percent low acuity.  
8 And I think that's consistent with Ms.  
9 Huntington's testimony that sometimes they get  
10 higher acuity patients out there in Moncks  
11 Corner that would probably still be better  
12 served at a full hospital ED but just because  
13 they're so far away, that's the closest stop  
14 and they get a little bit more of those high  
15 acuity patients, but clearly less than Roper  
16 Hospital. And then, Roper Northwoods, which  
17 again is the most analogist to MUSC in a  
18 similar area with a similar distance to the  
19 downtown hospital, you can see that the high  
20 acuity patients only represent 7.5 percent of  
21 their total patient base and 92.5 percent of  
22 their patients are in the lower acuity  
23 categories. So I compared that to what MUSC  
24 represented in their CON application, which was  
25 basically the implication that the freestanding



1 ED would match the acuity distribution of their  
2 hospital. And based on the data in the CON,  
3 the implication is that 41 percent of the  
4 patients that the FSED would serve are higher  
5 acuity and 58.9 percent are lower acuity  
6 mirroring the high acuity level of the tertiary  
7 medical center downtown. Because acuity was  
8 not taken into consideration in any way in  
9 their projections and in their shift  
10 percentages. So, I just don't think that's  
11 reasonable. I think that in reality what would  
12 shift to the MUSC FSED would be the lower  
13 acuity patients and much smaller percentage of  
14 the total base of MUSC's patients consistent  
15 with the actual experience of Roper Northwoods.  
16 So again, this goes to the credibility of the  
17 utilization projections presented by MUSC for  
18 their freestanding ED.

19 Q: In your opinion, how should acuity been  
20 considered in the utilization projections?

21 A: In my opinion, MUSC should have significantly  
22 discounted the higher acuity patients first and  
23 then chosen a lower percentage of overall shift  
24 in patient volume, consistent again with Roper  
25 Northwoods actual experience. And if that's



1           how they had done their projection, they either  
2           would not have had enough volume to support the  
3           project to demonstrate community need or they  
4           would have had to take patients from existing  
5           providers and take additional market share as  
6           opposed to assuming all of this would occur by  
7           simply a shift of their own patient volume.

8       Q:    So, we've heard a lot about changes and at this  
9           point, what are the changes that you have  
10          heard?

11       A:    Okay, so ---

12       Q:    Throughout the case.

13       A:    So, throughout the testimony the things that I  
14           can confirm that are changed about this project  
15           are the location and not just the distance but  
16           in my opinion a pretty significant change in  
17           the environment from a medical campus to a  
18           retail out parcel, which I think changes the  
19           nature of the freestanding ED. I think that in  
20           a retail setting, there's a lot greater  
21           possibility of a confusion and a  
22           misunderstanding that it's an emergency  
23           department, not an urgent care center. So I  
24           definitely think the location, not just the  
25           distance, the type of location changes the



1 nature of the project. We heard that the  
2 building is now going to be built by some party  
3 that's undisclosed, undecided and that just the  
4 land is going to be leased. In the original  
5 application, the building in it's entirety was  
6 going to be leased. So, that's a change and a  
7 major unknown.

8 **MR. WESTBROOK:** Objection, Your Honor. Same  
9 objection. A great percentage of Roper's case  
10 in chief through Ms. Platt and other witnesses  
11 was about the changes. As I recall in her  
12 original trial slides, I think the last seven  
13 pages were documenting changes to the project,  
14 things like, location, ownership, and size and  
15 square footage. This is a rehash and I would  
16 object on those grounds, it's not appropriate  
17 for rebuttal testimony.

18 **MS. GLOBER:** Your Honor, this is in response to the  
19 changes we've learned through MUSC's witnesses  
20 in their defense. This is simply what this is  
21 responding to.

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

23 Q: Please continue.

24 A: Okay. So, we've, you know, now confirmed that  
25 the project will be smaller. You know, and





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1           again I think it's important to confirm what  
2           we've heard during the hearing because during  
3           discovery it was a little unclear what the  
4           status of the project was at different times  
5           throughout, you know, the course of this year.  
6           So again, based on what we've heard during the  
7           hearing we now have confirmation that the  
8           project is quite a lot smaller, 30 percent  
9           reduction in the size of the facility, the  
10          treatment spaces have changed from 17 total  
11          treatment spaces to 12, so the utilization  
12          projections haven't been changed to reflect  
13          that but it's a much smaller facility in terms  
14          of its capacity. The service offerings have  
15          changed specifically, there's no CDU and  
16          helipad that would allow for higher acuity  
17          potentially, you know, higher acuity patients  
18          to be served. And instead, a fast tract  
19          service has been added in 5 out of 12 treatment  
20          spaces, which again is focused on low acuity  
21          patients and changes the nature of the types of  
22          patients they would serve. There's been some  
23          things that have happened in the market that  
24          have, sort of, been disregarded. You know,  
25          again there was no market analysis presented to



1 DHEC, no identification of all the providers in  
2 the service area, what their capacity is, the  
3 first time we saw anything having to do with  
4 service area capacity was in Mr. Levitt's  
5 testimony rebutting my analysis. So, none of  
6 that was presented to DHEC or no independent  
7 analysis. You know, Roper Berkeley Hospital is  
8 now about to open. It still was a little ways  
9 away at the time of the DHEC decision but, I  
10 mean, we're on the eve of this, you know, new  
11 hospital, a significant investment opening and  
12 I feel like that has to be considered and has  
13 not been considered by MUSC in any of their  
14 analysis. And now the Trident Summerville  
15 freestanding ED is approved and that, you know,  
16 that was pending at the same time as the  
17 original application. So all those things in  
18 terms of market capacity I think have to be  
19 considered and were not considered by MUSC. In  
20 terms of MUSC's own capacity, what's happened  
21 since the time of the application is that their  
22 own ED volume has declined year over year and  
23 that has not again been taken into  
24 consideration by MUSC. Their volume of service  
25 area patients has been declining and they have



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1 not taken that into consideration. They've now  
2 added 20 additional ED spaces within their  
3 downtown capacity and that's about to come  
4 online. And it may have been approved at the  
5 time but now again, it's about to come online.  
6 And that needs to be considered. And, they've  
7 put forth a CON for these new beds downtown,  
8 which was just filed at the beginning of July  
9 and should help to alleviate any of their  
10 concerns that they're having on the main  
11 campus. So again, a number of factors that  
12 have happened in relation to the MUSC capacity  
13 on the main campus that we really haven't heard  
14 any consideration of in their case. And then  
15 a big concern for me is support for the  
16 project. They're no longer in Nexton and they  
17 were very integrated into that medical campus.  
18 That was touted as a really important piece of  
19 their project. Their linkages with Palmetto  
20 Primary Care, PPC Physicians, they had a lot of  
21 letters of support from PPCP that all talked  
22 about the location in Nexton where PPCP has a  
23 major base of their services and that is no  
24 longer part of this project and we haven't seen  
25 anything to validate that base of support for



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1           the project.     So, you know, these are the  
2           significant changes that I think have occurred  
3           and been confirmed throughout the course of  
4           this hearing and it really changes the entire  
5           nature of this project.

6       Q:     What is your opinion on some of the information  
7           we don't know and how it affects this project?

8       A:     Sure.   So, I don't even think you have to get  
9           to, sort of, the substantial change issue.   I  
10          think it's substantially changed but I don't  
11          think you even have to get there because we're  
12          not at the point where we even have an  
13          approvable project because so much information  
14          is now missing about this newly defined MUSC  
15          project.   You know, as we heard in testimony,  
16          the building ownership and how it will be  
17          developed has not even been decided.   The  
18          source and mechanism of funding has not been  
19          decided.   They don't have a defined manpower  
20          budget and those are all required elements  
21          under Regulation 61-15 Section 202, you know,  
22          Part B of the CON application.   All of those  
23          are required elements of a CON application  
24          defining a project, and we have none of that  
25          information now.   Going on to Part C, the



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1           programmatic information which is really the  
2           mechanism for asking a lot of specific  
3           information about the project, we don't have a  
4           plot plan of the new site, we don't have zoning  
5           documentation, we don't have documentation of  
6           utilities. Usually in a CON application you  
7           have a letter from each of the utility  
8           companies indicating that they serve the site,  
9           will serve the site and will serve the proposed  
10          type of project on the site and we don't have  
11          any of that for the new site. We don't have  
12          community endorsement of the project on the new  
13          site and I think really critically, we heard  
14          testimony that we don't have governing body  
15          approval for the project as it's defined today.  
16          And again, that's a required element of the CON  
17          under Regulation 61-15 Section 202. So, as we  
18          sit here today, we don't even have a complete  
19          project to determine whether it's approvable.  
20          If this information was all submitted to DHEC  
21          today, there would be blanks in the application  
22          and they could not deem the application  
23          complete much less issue a decision.

24        Q:     And as someone who's prepared CON applications,  
25                would you include all of this information when



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1           you submit the CON application?

2       A:    Yes, absolutely.   All of that information is  
3           required and if I didn't have all that  
4           information I would have to tell my client, we  
5           can't submit yet.   We have to wait until you  
6           get all of that information and all of that  
7           documentation and then we can submit a complete  
8           application.

9       Q:    We saw a version of this yesterday.   Is this  
10          adequate zoning documentation?

11      A:    No, not in my opinion.   You know, this is a  
12          draft plan for zoning and it talks about some  
13          proposed changes to the zoning in the  
14          Summerville area, but in my opinion this is not  
15          adequate documentation that you would submit as  
16          part of an application to confirm the status of  
17          zoning for a proposed project.

18      Q:    If you look at the box with the text, what does  
19          that say in that first sentence?

20      A:    The town of Summerville is in the process of  
21          updating the zoning ordinance and land  
22          development regulations into a UDO.

23      Q:    And so where did that box come from?

24      A:    It came from the website for Summerville and it  
25          says the update will take approximately 18 to



1           24 months and this was published in December of  
2           2018. So, this is an ongoing process and it  
3           doesn't validate the current status of the  
4           zoning or what might have to occur in order to  
5           develop the proposed project on the new site.

6       Q:    Okay. Moving on to compliance with the health  
7           plan, the project review criteria, we've heard  
8           a lot about these throughout this week. What  
9           standard to you have on this slide?

10     A:    So this is Standard 6 of the freestanding ED  
11           chapter of the 2015 health plan.

12     Q:    Okay. And what's your opinion as to this  
13           project's compliance with Standard 6?

14     A:    Sure.

15     **MR. WESTBROOK:** Objection again. In her direct, Ms.  
16           Platt testified in her letters to DHEC, they're  
17           a part of the DHEC record contain Ms. Platt's  
18           arguments about why in her opinion this does  
19           not comply with Standard 6, another rehash.

20     **MS. GLOBER:** This is simply again responding to the  
21           testimony that came out this week. There's new  
22           information here in direct rebuttal to the  
23           information that she has heard this week.

24     **THE COURT:** I'm going to allow you to continue.  
25           Your objection is overruled.



1     **MS. GLOBER:**   Thank you.

2     **Q:**       Okay.   So in regards to, I like to think of  
3               this as two prongs.

4     **A:**       Yes.

5     **Q:**       Do you agree?   Okay.   And what's the first  
6               prong of Standard 6?

7     **A:**       Sure.    So I guess just set the stage of  
8               Standard 6, and I see it as two prongs too.  
9               The first is, you know, the applicant must  
10              demonstrate need for the service by documenting  
11              where potential patients will come from for  
12              this proposed service.   So the first piece I  
13              have here is no demonstration of need.   So,  
14              again, the utilization projections have not  
15              been updated for the passage of time,  
16              everything we saw presented by MUSC is, you  
17              know, still set in 2016 data.   They've ignored  
18              that MUSC's service area volume has declined.  
19              They've ignored that MUSC's market share has  
20              declined.   They continue to have made no  
21              adjustment for the acuity of patients or a  
22              large percentage of pediatric patients that are  
23              included in their patient base they propose to  
24              shift.   They've made no adjustment for their  
25              protection for the size of the freestanding ED,





1        which has reduced significantly and their  
2        change in service offerings with the fast track  
3        with will be much more focused on low acuity  
4        patients, you know, eliminating the CDU and  
5        helipad. You know, they continue to project,  
6        as they did in the application, that more  
7        patients are going to come from Dorchester  
8        County than Berkeley County, so again, this  
9        project is not about explosive growth in  
10       Berkeley County. In fact I think Mr. Levitt  
11       said that Dorchester was having very, you know,  
12       moderate patient growth or population growth.  
13       And again, the single zip code from which they  
14       project to draw the most patients, you know,  
15       still from the CON application 'cause they  
16       haven't updated anything, is a North Charleston  
17       zip code, not a Berkeley County zip code. So  
18       based on what they've presented in their case,  
19       I don't believe that they've demonstrated a  
20       need for the project. Then moving on to the  
21       second, sort of, prong of Standard 6 is they  
22       have to demonstrate why the patient base, why  
23       they are not being adequately served by the  
24       existing services in the area. And we have no,  
25       in my opinion, reasonable or valid evidence



1       that the existing services in the area are  
2       inadequate. Again, there's been no evidence of  
3       capacity constraints for any of the emergency  
4       departments in the service area, we haven't  
5       heard any concerns about excessive wait times,  
6       patients being unable to get the care that they  
7       need. And in fact the information I presented  
8       today showed that wait times at the supposedly  
9       highly utilized emergency departments are  
10      extremely reasonable. In their capacity  
11      analysis first of all the first time we've seen  
12      a capacity analysis from MUSC is in Mr.  
13      Levitt's presentation which was basically  
14      rebuttal to my capacity analysis. There was  
15      never any capacity analysis of the service area  
16      presented to DHEC. And in that analysis MUSC  
17      ignores approved projects. And again, given  
18      the level of investment that existing  
19      facilities have made in, you know, developing  
20      ED capacity in the service area, I don't think  
21      you can just ignore those and I think that's  
22      consistent with DHEC's testimony. And then,  
23      you know, I think the bottom line is when you  
24      look at the capacity in the service area, both  
25      existing and approved, based on the testimony



1 of the clinical witnesses and the capacity of  
2 their own facilities, it's my opinion that  
3 adequate capacity already exists in the area  
4 and is already approved to meet the grown and  
5 demand for the service area. So in my opinion  
6 the project does not meet Standard 6 and does  
7 not comply with the Health Plan.

8 Q: Moving to the project review criteria, what's  
9 the first project review criteria that we're  
10 looking at here?

11 A: Sure. It's 2C community need. And, again,  
12 they have to show the need for the target  
13 population and clearly define the assumptions  
14 and methods used to determine need. And, you  
15 know, as I've already gone through, I have a  
16 lot of concerns about their assumptions and  
17 methods to show need. But I think most  
18 importantly with respect to this, the -- two of  
19 the main issues I heard from MUSC is, you know,  
20 that their patients are choosing to go to MUSC  
21 and they want to make those services more  
22 convenient and that MUSC has capacity  
23 constraints on the peninsula. And in my  
24 opinion MUSC's perceived patient desire and  
25 choice to go to MUSC on the peninsula is not



1 community need. Community need has to reflect  
2 all of the patients in the community, the  
3 public need, not just the patients who are  
4 choosing to drive to MUSC. And then, again,  
5 I've talked in detail about the MUSC capacity  
6 constraints on the peninsula. If they're  
7 having, you know, issues with throughput and  
8 delays, they are, you know, overall an  
9 institutional issue, not a community need. And  
10 I don't believe they would be remedied by  
11 adding more treatment spaces. I think they  
12 have plenty of treatment spaces. And then, you  
13 know, again, finally the utilization  
14 projections, I don't believe they're reasonable  
15 and they have not been well documented. Their  
16 assumptions are not documented.

17 Q: And is there anything in the freestanding ED  
18 section of the Health Plan, those standards or  
19 the project review criteria as a whole  
20 addressing patient desire or patient choice?

21 A: No. No, I don't believe patient desire or  
22 patient choice are anywhere in the project  
23 review criteria that I recall. And, you know,  
24 when you look at the standards of the Health  
25 Plan for freestanding EDs it really does talk



1       about a community need and access to care for  
2       our community.     You know, there are some  
3       services in the State Health Plan where you  
4       calculate sort of an institutional need like  
5       bed capacity, you look at the needs of the  
6       specific institution.       But freestanding  
7       emergency services is not one of those sets of  
8       standards in the State Health Plan.     It's  
9       really about what are the needs of the broader  
10      community.

11     Q:     Okay.     And is this another subsection of the  
12             community need project review criteria?

13     A:     Yes.

14     Q:     Okay.     And what is this subsection address?

15     A:     It talks about, again, community need  
16             documentation and says, current and or  
17             projected utilization should be sufficient to  
18             justify the expansion or implementation of the  
19             proposed service.     So this is the criteria  
20             where you would -- or the -- yeah, the criteria  
21             where you would evaluate the utilization  
22             projections set forth by the applicant and, you  
23             know, this is kind of reiterating the points  
24             that I've already made.     But there's just so  
25             many short comings of the assumptions behind



1 the utilization projections for the facility.  
2 You know, just the mere fact that we've had two  
3 years passage of time and they haven't even  
4 bothered to update the utilization projection,  
5 not only for more current data, but of the  
6 changes in their project. And, you know, the  
7 original methodology was flawed, it's not  
8 doubly flawed by, you know, the fact that they  
9 have not adjusted for the new project and the  
10 passage of time. So I don't believe, in my  
11 opinion, the project meets the project review  
12 criteria for community need and they have not  
13 adequately documented the utilization  
14 projections for the project.

15 Q: Okay. And next project review criteria,  
16 distribution accessability. What is this  
17 project review criteria go to and has it been  
18 met?

19 A: It goes to a couple of things. The first piece  
20 is unnecessary duplication of services, and  
21 that's actually mentioned in sort of both of  
22 the two prongs here. In my opinion this  
23 project directly duplicates existing and  
24 approved services in the service area and, you  
25 know, in the original decision MUSC in its



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1 application and DHEC in its decision failed to  
2 even acknowledge the other service area  
3 providers that are both existing and approved.  
4 And, you know, that's to me a failure to even  
5 consider and appropriately address this  
6 criterion. The -- all the freestanding EDs  
7 proposed in the service area, there's existing,  
8 there's approved, there's also hospitals that  
9 are approved. All of those need to be  
10 considered and all of them were approved to  
11 meet this supposedly explosive growth in the  
12 area. So you can't just ignore them and say,  
13 oh this growth is still out there and we're  
14 going to address it. Projects have already  
15 been approved to meet that growth and it would  
16 be a direct unnecessary duplication to approve  
17 more capacity to meet the same growth.

18 Q: Okay. And moving onto 3B.

19 A: So in terms of under-served areas MUSC's expert  
20 yesterday testified that he didn't even look at  
21 medically under-served groups or areas in  
22 Summerville and he basically admitted that the  
23 location was not a medically under-served area.  
24 And in the DHEC decision they only considered  
25 MUSC's track record at their main hospital and



1           didn't consider the specific project and how it  
2           related to under-served areas.

3       Q:     And where do you get the last bullet point,  
4           where do you get the not the proposed project,  
5           where's that requirement coming from?

6       A:     The last bullet point is basically coming from  
7           the decision, from DHEC's decision.     They  
8           didn't look at specifically whether the project  
9           was going to be an under-served area or how it  
10          was going to address under-served patient  
11          populations, it just looked at MUSC's track  
12          record.

13      Q:     And in relation to the language of the project  
14           review criteria 3B, does that have anything  
15           about the track record in it?

16      A:     No. It looks -- it says the proposed service,  
17           which is, you know, the project should be  
18           located so that it may serve medically under-  
19           served areas and should not unnecessarily  
20           duplicate existing services or facilities.

21      Q:     So in your opinion was this aspect of -- or  
22           this project review criteria met?

23      A:     No. I don't believe either prong of 3 was met.

24      Q:     Okay. And if we can pull up, this is -- comes  
25           from MUSC Exhibit 9 page 422, we pulled out two





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1           pages, it's a 400 page document. So we pulled  
2           out two pages and it's Roper St. Francis  
3           Exhibit 62.

4           **(Petitioner Roper's Exhibit Number 62 was introduced**  
5           **into the record at this time.)**

6           Q:     And I can give you a copy.

7           **MS. GLOBER:**   May I approach, Your Honor.

8           **THE COURT:**   Yes.

9           A:     Thank you.

10          Q:     And what is -- what is this letter?

11          A:     So this is a letter from DHEC to an applicant,  
12                 Grand Strand Regional Medical Center for a  
13                 freestanding emergency department project in  
14                 2015. This is the standard letter that the  
15                 Department sends out to an applicant when it  
16                 deems a project complete and then it identifies  
17                 the relevant project review criteria and the  
18                 order in which they will be evaluated on page  
19                 2. And I think the focus here is on number --  
20                 or letter D resource availability as a review  
21                 criteria. And that's consistent with the  
22                 language of the 2015 South Carolina Health  
23                 Plan. I think the testimony yesterday from Mr.  
24                 Levitt is that there's not a project review  
25                 criteria that's called resource availability.



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1           And there may not be one that actually says the  
2           word, resource availability, in the title but  
3           there's certainly several project review  
4           criteria that speak to resource availability in  
5           various forms. You can see 21 A through C, 21  
6           A, 22, 23 A and B and 24. So again multiple  
7           project review criteria link to resource  
8           availability which is set forth as a criteria  
9           in the South Carolina Health Plan for  
10          freestanding emergency departments.

11       **MS. GLOBER:** And, Your Honor, I would move to admit  
12          Roper St. Francis Exhibit 62. And again this  
13          is two pages from MUSC's Exhibit 9 but MUSC's  
14          Exhibit 9 is the whole CON record, over 400  
15          pages which haven't been used. So we just  
16          pulled the two pages from that record.

17       **MR. WESTBROOK:** No objection, Your Honor.

18       **THE COURT:** Admitted.

19       **(Petitioner Roper's Exhibit Number 62 was admitted**  
20       **into evidence.)**

21       **MS. GLOBER:** Thank you.

22       **Q:** Okay, going back to your slides. So with --  
23          with those resource availability project review  
24          criteria we just looked at in mind ---

25       **THE COURT:** Ms. Globber?



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1     **MS. GLOBER:**   Yes, ma'am?

2     **THE COURT:**   The exhibit that you just moved into  
3                   evidence, what's the number of the Exhibit  
4                   Number?

5     **MS. GLOBER:**   It's 62.

6     **THE COURT:**   Okay.

7     **MS. GLOBER:**   Sorry about that if I went too fast.

8     **Q:**       So back on your slide.   So we just looked at  
9                   the resource availability that was set forth in  
10                  that DHEC record.   And what -- which one of  
11                  those do you have on this slide?

12    **A:**       Sure.   So again I think that the project has to  
13                  be reviewed under multiple project review  
14                  criteria that linked to resource availability.  
15                  But the one I want to focus on here is 23B,  
16                  adverse effects on other facilities,  
17                  specifically the staffing of the proposed  
18                  service should be provided without  
19                  unnecessarily depleting the staff of existing  
20                  facilities or services causing an excessive  
21                  rise in staffing cost due to increased  
22                  competition.   And I guess in terms of the  
23                  testimony that we've heard this week I think it  
24                  confirms that there are significant staffing  
25                  shortages in the area and really in South



1 Carolina as a whole, particularly when it comes  
2 to, you know, highly trained nurses and we had  
3 testimony even, or presentation at the project  
4 review meeting that here were physician  
5 shortages and specifically emergency department  
6 physician shortages. So as a result of those  
7 staffing shortages there's been an increase in  
8 the use of traveling nurses at Roper Hospital,  
9 Roper St. Francis which result in more costly  
10 care, the opening of approved projects such as  
11 the Roper Hospital Berkeley is already putting  
12 strains on those limited resources and we've  
13 got additional projects that are approved  
14 coming online that will put further strain on  
15 those limited resources. I think Mr. Levitt  
16 really downplayed that and says, hey they've  
17 been able to, you know, staff Roper Berkeley  
18 but ignored the testimony from Ms. Huntington  
19 that that's left gaps back at the main hospital  
20 because they've been shifting nurses out to the  
21 new hospital. And, again, another unnecessary  
22 facility will just put further strains, you  
23 know, on this already limited resource and  
24 likely take staff from other existing  
25 providers. So in my opinion the MUSC project



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1 is not consistent with this project review  
2 criterion.

3 Q: Continuing to look at resource availability, is  
4 21A one of the project review criteria that was  
5 in this DHEC record that's Roper Exhibit 62?

6 A: Yes.

7 Q: Okay. And what does that project review  
8 criteria address?

9 A: So it addresses support services and equipment  
10 necessary to implement and sustain the proposed  
11 project. And here's another one of these  
12 places where we have a change that does not  
13 have complete documentation. So, you know, the  
14 project's moving away from this planned medical  
15 campus to a new location where it doesn't have  
16 the same support around it of other medical  
17 services and physician practices. And then  
18 they drastically change the project from, you  
19 know, 17 treatment spaces to 12 and from, you  
20 know, the higher level CDU care to low acuity  
21 fast track care. And yet we don't have any new  
22 equipment list that would address how the  
23 equipment needs would need to be changed to  
24 address the revised new project. So I don't  
25 think that the project meets this project



1 review criteria either.

2 Q: Then we heard yesterday MUSC's reasons for the  
3 project. And what's your opinion as to each of  
4 these reasons that were given?

5 A: Okay. So the first item that MUSC noted was  
6 they were gonna improve access for MUSC  
7 patients from the north area. And really what  
8 this goes to again is patient choice, not  
9 community need. And that's not found in any of  
10 the project review criteria. The sub-points  
11 under that were, you know, this population  
12 growth that we've heard, this explosive growth  
13 with no consideration, in my opinion, that the  
14 previously approved projects were planned to  
15 address that very growth and we have capacity  
16 approved and coming online to meet that growth.  
17 Again, just completely disregarded by the  
18 applicant and really disregarded by DHEC as  
19 well. We also heard, you know, this growth,  
20 this big growth in ED volume in the area but a  
21 failure to recognize that MUSC's ED volume has  
22 declined over time. So, you know, those I  
23 guess kind of all go to need for the project  
24 and I don't think they've fully captured here  
25 many of the factors that are already in the



1 market, occurring in the market. And so I  
2 disagree with those reasons for the project.  
3 Then we heard a lot about capacity constraints  
4 on the peninsula. And again if you look at the  
5 treatment spaces that are approved and coming  
6 online at the MUSC main campus they have plenty  
7 of treatment spaces to meet their volume. So  
8 their constraints that they're facing, any  
9 operational issues are not linked to their ED  
10 treatment spaces. And in fact adding 12 more  
11 spaces with this freestanding ED will just  
12 dilute their volume over more spaces and, you  
13 know, as I calculated well below 1,000 visits  
14 per treatment space. So that's not a basis for  
15 need. It's kind of a -- I guess it's a red  
16 herring the capacity issues that they're having  
17 downtown relate to other factors, beds,  
18 throughput, other kinds of concerns. And the  
19 last piece is this teaching element, which was  
20 never discussed really in the application.  
21 It's sort of undefined. We don't really know  
22 what the plans might be for any teaching to  
23 occur at the freestanding ED. You know it's  
24 sort of irrelevant, it doesn't address any  
25 project review criteria. So again, that's not



1 a reason for the project to be approved. So  
2 basically each of the reasons that they've set  
3 froth is either, you know, sort of inaccurately  
4 presented, ignores other factors or doesn't go  
5 to one of the project review criteria. And I  
6 don't think the project should have been  
7 approved and I don't think it can be approved  
8 as we sit here today based on the new project  
9 that is not fully defined.

10 Q: And is there any teaching element in the  
11 standards of freestanding EDs in the Health  
12 Plan?

13 A: No, there's not.

14 Q: So this is just your conclusion slide. What  
15 are your overall opinions in regards to this  
16 project's compliance with the applicable  
17 regulations and sources of law?

18 A: Sure. So based on everything that I've  
19 presented, it's my opinion the MUSC  
20 freestanding ED fails to comply with the South  
21 Carolina Health Plan, specifically Standard 6  
22 of the freestanding ED standards. And I've  
23 discussed a number of reasons for that. I also  
24 believe that the project fails to comply with  
25 the South Carolina CON regulations and project





1 review criteria. There's not sufficient  
2 information as we know it today about the  
3 project to meet the requirements of 61-15-202.  
4 And as I've gone through in detail, the project  
5 doesn't meet multiple project review criteria.  
6 And then finally the MUSC FSED project violates  
7 the purposes of the CON program. It's not cost  
8 effective, it's unnecessary duplication and it  
9 doesn't meet the public need. And I think kind  
10 of most importantly patient choice doesn't  
11 equal public need and that's really what their  
12 project is about. It's about serving their own  
13 patients and facilitating patient choice. But  
14 that's not public need.

15 **MS. GLOBER:** Your Honor, I would at this time move  
16 to admit these slides as Roper Exhibit 63.

17 **THE COURT:** There was one slide ---

18 **MS. GLOBER:** Oh, right. I don't have it numbered.  
19 Slide 5 I believe. I believe this is the slide  
20 that you ruled upon.

21 **THE COURT:** And you don't have them numbered? Slide  
22 2 I believe wasn't admitted.

23 **MS. GLOBER:** Your Honor, I believe it ...

24 **THE COURT:** I'm sorry

25 **MS. GLOBER:** I believe it was this slide that we had



1           a question about or that you had a question  
2           about.

3       **THE COURT:**   What number is this?

4       **MS. GLOBER:**   This is slide 5 of the entire Exhibit,  
5           Roper 63.

6       **THE COURT:**   Okay.   Okay, you'll remove that one and  
7           you can address the others.

8       **MS. GLOBER:**   Thank you very much.

9       **THE COURT:**   Mr. Westbrook.

10      **MR. WESTBROOK:**   Yes, Your Honor.   In addition to  
11           slide 5 I don't believe that slides -- I know  
12           slide 2 was on the screen, I don't know if Your  
13           Honor ruled on that.   I objected to slide 2.  
14           Slide 3 -- 3 and 4 I don't think appeared on  
15           the screen, if they did I missed them, but I  
16           would object to 3 and 4.   And I think all my  
17           other objections you have overruled.   So that  
18           would be where I am right now, objecting to 2  
19           through 5.

20      **MS. HOLLINGSWORTH:**   We have a copy, Your Honor.

21      **MS. GLOBER:**   We have a copy, sorry.   My copy is all  
22           marked up.

23      **THE COURT:**   Okay.   I think we've got it sorted out.  
24           Okay, slide 4 and 5 come out.   And other than  
25           those, Mr. Westbrook, your objection to the



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1 others are overruled and I allow them to come  
2 in.

3 (Petitioner Roper's Exhibit Number 63 was admitted  
4 into evidence.)

5 MS. GLOBER: Thank you, Your Honor. And those are  
6 all the questions we have.

7 THE COURT: Mr. Westbrook?

8 MR. WESTBROOK: Your Honor, could I -- could we take  
9 a short break now?

10 THE COURT: Yes.

11 MR. WESTBROOK: Thank you.

12 THE COURT: Let's do 10 minutes.

13 (Off the Record)

14 THE COURT: Okay. Mr. Westbrook?

15 MR. WESTBROOK: Thank you, Your Honor.

16 MS. PLATT - CROSS-EXAMINATION BY MR. WESTBROOK:

17 Q: Ms. Platt, just a few questions please. Let me  
18 ask Mr. Buff to put up the 2018 Plan or a  
19 portion of the 2018 Plan up on the -- we've  
20 already looked at this before and I think a lot  
21 of your testimony related to this. The  
22 applicant must demonstrate -- and this is --  
23 let me just be clear, this is from the current  
24 State Health Plan. Do you recognize this  
25 language?



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1 A: Yeah, it's from the current plan. It was also  
2 in the 2017, 18 plan.

3 Q: Right. Two plans after the 2015 both have this  
4 language, right?

5 A: Yes, that's correct.

6 Q: Okay. All right, good. So the applicant must  
7 demonstrate a need for the service by  
8 documenting capacity constraints within  
9 existing emergency departments in the service  
10 area and or a travel time of greater than 15  
11 minutes to an existing emergency department in  
12 the service area. So it's your understanding  
13 that this Court -- that DHEC had the option of  
14 considering the Plan -- the 2017, 2018 Plan, is  
15 that correct, is that your understanding?

16 A: I think that they had the ability to consider  
17 this, which I believe is essentially giving  
18 more specificity to the Standard 6 in the 2015  
19 Plan.

20 Q: And you -- and you would agree that the Court  
21 has the option of considering this language,  
22 but as with DHEC, it's not mandatory, is that  
23 ---

24 A: Yes.

25 Q: --- your understanding? Okay. And that in the



1 middle of that sentence there's an and/or. So  
2 you would agree with me that that is -- an  
3 and/or is essentially or, is it not?

4 A: Yes.

5 Q: Okay. And so with the first part, the part  
6 before the and or, it says, the applicant must  
7 demonstrate need for this service by  
8 documenting capacity constraints within  
9 existing emergency departments in the service  
10 area. Now I understand your testimony about  
11 considering approved emergency departments, but  
12 again, the language here just says existing,  
13 correct?

14 A: The language says existing but I believe my  
15 testimony's consistent with what I understood  
16 from Ms. Murdock, particularly in her  
17 deposition, that in relation to this standard  
18 they have to consider everything that's  
19 approved as well. You can't plan in isolation  
20 and ignore facilities that are approved  
21 investments made, so it does say the word  
22 existing but my understanding and my health  
23 planning belief is that you have to consider  
24 all existing and approved emergency  
25 departments.



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1 Q: All right. And the second half of that  
2 sentence after the and or says, and or travel  
3 time of greater than 15 minutes to an existing  
4 emergency department, isn't that right?

5 A: It does say the word existing.

6 Q: And, Ms. Platt, I understand you're position on  
7 this. But that is the State Health Plan, that  
8 is amended -- I believe you testified about  
9 this but if you didn't let me just ask you,  
10 isn't it true that the State Health Plan in  
11 South Carolina is amended ever year or two?

12 A: Yes. That's correct.

13 Q: It's required to be amended every two years but  
14 it's often amended, particularly in recent  
15 years, annually, isn't that right?

16 A: That is correct.

17 Q: And this could be amended to add the word  
18 approved, could it not?

19 A: It could be but I -- and I think that would be  
20 helpful for clarity, but I think that it maybe  
21 say the word existing but it's very clear from  
22 a health planning standpoint that you can't  
23 ignore the prior actions of the Department.  
24 Those are existing certificate of need, you  
25 know, approvals for facilities that are



1 bringing capacity to this area.

2 Q: Well ignoring is -- for health planning  
3 purposes is one thing, but compliance or  
4 mandatory compliance with State Health Plan  
5 language is another, isn't it? I mean the  
6 State Health Plan, it's a long process that's  
7 done every year or every two years, does it  
8 not? There's a committee, there's ultimately  
9 there's approved by the DHEC board. Isn't that  
10 a deliberative process that takes several  
11 months every time it's undertaken?

12 A: Yeah, I think it usually takes a couple of  
13 months.

14 Q: Well there are public hearings, are there not?

15 A: There are.

16 Q: And people are allowed to -- interested or  
17 affected people or anybody can submit  
18 suggestions about language, isn't that true?

19 A: Anyone could, that's true.

20 Q: And the Department presumably considers those  
21 suggestions carefully, wouldn't you think that  
22 to be true?

23 A: I would think so.

24 Q: All right. And ultimately decisions are made  
25 about those. You don't happen to know do you



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1           whether any issues or whether language was  
2           submitted with respect to this plan or the  
3           preceding plan about changing that language or  
4           expanding on that language existing or defining  
5           that word existing, you don't know that, do  
6           you?

7       A:    I don't know any specific comments that were  
8           suggested.

9       Q:    All right. Okay, let's go to slide 6 from Ms.  
10          Platt's trial exhibits please, the one that we  
11          looked at today. Just a couple of quick  
12          questions. You referenced Center Pointe here,  
13          the 2016 date for the CON approval, and I  
14          assume what that means is staff approval?

15       A:    Yes.

16       Q:    Okay. And then the CON issued in 2017,  
17          correct?

18       A:    Yes.

19       Q:    Ms. Platt, I was under the impression that  
20          Center Pointe opened in 2014, is that  
21          incorrect?

22       A:    I think that would be a better question for a  
23          Trident witness in terms of the history. That  
24          may have been an expansion.

25       Q:    All right. All right, well we can ask Mr.





1 Sullivan about that perhaps.

2 A: Okay.

3 Q: But sitting here today you're not sure whether  
4 that's an expansion or an opening?

5 A: I don't know the -- when it actual- -- you know  
6 when it was officially opened.

7 Q: All right. I believe you and others have  
8 talked about the medical campus in Nexton that  
9 was going to be the site of the original -- the  
10 original site for the MUSC proposal. What is  
11 that medical campus currently consist of?

12 A: I know they have CON approval for an MRI there  
13 that was planned as part of an imaging center.  
14 And they have plans for physician offices as  
15 well. I think there was a proposal for  
16 radiation therapy by MUSC. I don't know  
17 whether those are open fully yet. I know those  
18 were planned.

19 Q: All right. The -- at this point do you know  
20 what's on that site?

21 A: I don't know what's open today.

22 Q: All right.

23 **MR. WESTBROOK:** Let's look at Ms. Platt's slide 17  
24 from her trial exhibits, Dan.

25 Q: And, Ms. Platt, do you -- can you read that



1           okay, do you need a copy of your ---

2       A:     I can read it.

3       Q:     Okay, good.   That is actually not the slide  
4           that I wanted.    Let me see which one I'm  
5           talking about.   Hang on a second.   Sorry about  
6           that.   That's -- I think this is slide 17 but  
7           it's from the rebuttal exhibits that you went  
8           through during your testimony.

9       A:     Okay.

10      Q:     And you recognize this, don't you?

11      A:     I do.

12      Q:     All right.   This relates to the drive time, the  
13           15 minute drive time issue, is that right?

14      A:     It relates to, I guess, the suggestion by Mr.  
15           Levitt that the drive time at question is from  
16           one emergency facility to another emergency  
17           facility.

18      Q:     All right.   And it -- but it relates also to  
19           that language that from the current State  
20           Health Plan, the 2017 State Health Plan that we  
21           just looked at, does it not?

22      A:     Sort of.   I mean that in my opinion is patient  
23           travel time, not the time frame driving from  
24           one emergency department to another emergency  
25           department.   It's the drive time for -- where



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1 patients can come from to access services in 15  
2 minutes.

3 Q: I see. All right. Well whatever it relates  
4 to, let's take a look at the numbers up here.

5 A: Okay.

6 Q: And in particular let me ask you to look at the  
7 two big boxes at the bottom. The one on my  
8 left, that relates to Summerville Medical  
9 Center, correct?

10 A: Yes.

11 Q: And the drive time that you've got there, it  
12 says typically 12 to 24 minutes ---

13 A: Yes.

14 Q: --- is that right? And this is the arrival,  
15 right under that it says arrival around 8:24  
16 a.m., is that correct?

17 A: Yes.

18 Q: And then on the other box which is Trident  
19 Medical Center, correct?

20 A: Yes.

21 Q: And that was typically drive time 10 to 16  
22 minutes, is that right?

23 A: Yes.

24 Q: And arrival about 8:16 a.m., is that correct?

25 A: Yes.



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1 Q: all right. So both those ranges for Trident  
2 and Summerville start under -- the low end of  
3 the range is under 15 minutes but the high end  
4 is over, correct?

5 A: Right. But again, in my opinion, that's not  
6 the travel time that's at issue. It's not the  
7 travel time between one emergency department to  
8 another emergency department. My point was  
9 just that these are a good bit lower than what  
10 Mr. Levitt included in his slide.

11 Q: All right. And with respect to moving off the  
12 peninsula, you would agree with me, would you  
13 not, that MUSC has a number of health care  
14 facilities or medical campuses or medical  
15 projects, let me just say that, off the  
16 peninsula currently, right?

17 A: They have some physician offices, I mean they  
18 do have some affiliated services off the  
19 peninsula.

20 Q: They have a pediatric imaging center and  
21 ambulatory surgery center in North Charleston,  
22 correct?

23 A: That -- I understand that from the testimony,  
24 yes.

25 Q: They have medical office buildings, is that



1 correct?

2 A: That's my understanding.

3 Q: Radiation therapy centers?

4 A: I'm trying to think of where the locations are.  
5 I'm not -- I can't recall off the top of my  
6 head exactly where the radiation therapy  
7 services are located.

8 Q: And do they have pediatric -- are you familiar  
9 with the term after hours?

10 A: Yes.

11 Q: All right.

12 A: It's essentially urgent care with extended  
13 hours.

14 Q: Essentially urgent care with extended hours.  
15 Those, they have pediatric after hours urgent  
16 care centers off the peninsula, don't they?

17 A: That's my understanding.

18 Q: All right. And imaging centers?

19 A: I believe they have some imaging services.

20 Q: Off the peninsula, right?

21 A: Yes.

22 Q: All right. With respect to the equipment at  
23 the new location versus the original location,  
24 you heard Dr. Hall's testimony, did you not?

25 A: Yes.



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1 Q: And I think I asked you on cross at one time  
2 whether you agreed generally with Dr. Hall's  
3 testimony. Can you think of anything you  
4 didn't agree with?

5 A: I mean it was a pretty long testimony.

6 Q: It was.

7 A: I can't really recall, you know, every single  
8 thing. In general I agree. I can't think of  
9 specific ---

10 Q: All right. Well that is a broad question, I  
11 apologize. Let me ask you about the -- his  
12 testimony with respect to the equipment. Did  
13 you hear Dr. Hall say that the equipment in the  
14 new project would be substantially the same as  
15 the equipment in the old project?

16 A: I did hear that was his opinion.

17 Q: And do you disagree with that opinion?

18 A: It would include the same types of equipment.  
19 But in terms of what DHEC looks for and what  
20 the CON application requires, I mean it would  
21 have some elements of the same equipment but it  
22 would have to be a new list specific to the  
23 size of the facility and the service offerings  
24 for the facility. And I think he talked about  
25 some maybe lack of clarity even in terms of



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1           what -- how the fast track rooms would be  
2           equipped. Maybe I'm forgetting or, you know,  
3           his testimony but ---

4       Q:   Well his testimony, his transcript we don't  
5           have it in front of us but it'll speak for  
6           itself ---

7       A:   Yes.

8       Q:   --- of course. With respect to his comments on  
9           his description of fast track rooms, I think I  
10          asked you that on cross, you don't disagree  
11          with his description with what the function of  
12          the fast track rooms are, do you?

13      A:   My recollection is that they were for serving  
14          lower acuity patients and I would not disagree  
15          with that.

16      Q:   All right.

17      **MR. WESTBROOK:** And let's take a look at Ms. Platt's  
18          slide 10 please, from her reply slides.

19      Q:   Now on slide 10 you have a number of facilities  
20          listed, let me just ask you to look on the  
21          third line, Ms. Platt, where it says  
22          Summerville Medical Center. And look on over  
23          to the last column the percent of occupancy is  
24          68 percent, is that right?

25      A:   Yes.



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1 Q: All right. And this is based on an analysis  
2 that you did that you described in your  
3 testimony. I'm not going to ask you to redo  
4 that or to use a word that was invented by  
5 somebody, I don't remember who, rehash that.  
6 I'm not going to ask you to do that. So the 68  
7 percent for Summerville Medical Center  
8 occupancy, now Summerville Medical Center had a  
9 CON application that was approved for  
10 freestanding emergency department the same day  
11 or roughly the same day that MUSC's FSED  
12 application was printed, isn't that right?

13 A: Yes.

14 Q: And then a few months after that Summerville  
15 Medical Center submitted an application to  
16 expand it's ED, right?

17 A: They did.

18 Q: And that application was later granted, is that  
19 correct?

20 A: Yes.

21 Q: And I know you didn't write those applications  
22 so these might be questions for our friend Mr.  
23 Sullivan, but you've reviewed those  
24 applications, have you not?

25 A: I have but it's been a while since I've looked





1 at them.

2 Q: All right. But didn't -- wasn't one of the  
3 reasons listed in both those applications that  
4 the projects were needed was that those -- that  
5 Summerville was constrained in its ED volume  
6 and its ED capacity, isn't that correct?

7 A: I do recall some description of their high  
8 level of utilization but was also coupled with,  
9 I believe, growth in there utilization trends  
10 as well as specifically for the freestanding ED  
11 as I recall there was a projection that  
12 included additional market capture. So the  
13 anticipation of growth, not just in terms of  
14 population but market capture as well. So I  
15 don't think it was just capacity constraints.

16 Q: Wasn't that growth and that market capture  
17 described in that application as being minimal  
18 or -- maybe not minimal but wasn't it -- wasn't  
19 the prime- -- wasn't the word primary used to  
20 describe that most of their volume had come  
21 primarily from treating their own patients?

22 A: I don't recall the specific language but I  
23 think that would probably be a better question  
24 for Mr. Sullivan.

25 Q: Do you recall that concept being used? I



1           understand you wouldn't just remember the  
2           specific language, but wasn't that the concept  
3           that it would be primarily a shift of their own  
4           patients?

5       A:    I don't recall that specific language.    What  
6           I'm recalling is the quantitative utilization  
7           projections that apply to market share or  
8           market capture rate to the area as a whole to  
9           project utilization.

10      Q:    All right.    Ms. Platt, MUSC patients, it's a  
11           strong opinion of your's that you emphasized  
12           particularly in the later slides was that MU-  
13           -- that patient choice is not a criteria,  
14           correct?

15      A:    It's -- that language is not in any of the  
16           project review criteria.

17      Q:    That language is not in there.    And that -- but  
18           MUSC patients, wouldn't you agree that by  
19           numbers that have been submitted in this --  
20           you're -- it's true isn't it that over 24,000  
21           patients a year are from the north area as  
22           we've described the north area are actually  
23           traveling down to MUSC to get ED services,  
24           isn't that right?

25      A:    They ---



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1 Q: They're already making that choice, aren't  
2 they?

3 A: They are choosing that. But I guess the other  
4 factor that's sort of imbedded in there is that  
5 some portion of those patients likely are  
6 working in Charleston and are not necessarily  
7 driving from their home zip code when they're  
8 making that choice.

9 Q: All right. Some people who live in Charleston  
10 are working at the Volvo and Mercedes and  
11 whatever the other plants are around I-26 in  
12 that area, wouldn't you agree?

13 A: That is true.

14 Q: Yeah. And you don't dispute that population,  
15 not just in Berkeley County, but along that I-  
16 26 corridor is growing as those industries move  
17 in there, isn't that correct?

18 A: It is growing, I don't dispute the population's  
19 growing.

20 Q: All right. And in terms of the emergency  
21 services growth, the tremendous growth that's  
22 been seen by Trident in Summerville, that --  
23 those are the two -- that has been, I don't  
24 know if you like the word explosive or not, but  
25 certainly there's been a lot of emergency visit



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1 growth in that area, isn't that correct?

2 A: There has been a lot of growth and there have  
3 been projects approved both new facilities and  
4 expansions to meet that growth.

5 Q: And the growth -- the greatest growth by  
6 Trident and Summerville -- Trident and  
7 Summerville both are Trident Health System,  
8 right?

9 A: Yes.

10 Q: And they are the ones that own the most EDs in  
11 that area, isn't that correct?

12 A: Is your question whether Trident ---

13 Q: Trident Health Systems.

14 A: --- owns the most? I guess what is the area  
15 that you're defining?

16 Q: Well we've talked about the north area, so  
17 that's what I'm talking about. I mean Trident  
18 has a freestanding ED in Center Pointe, right?

19 A: Yes. That's ---

20 Q: In North Charleston?

21 A: --- in Charleston.

22 Q: North Charleston. They have a freestanding ED  
23 in Moncks Corner, right?

24 A: Yes, and Berkeley County.

25 Q: And Berkeley County. They have a hospital



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1 based ED at each of their two hospitals, right?

2 A: Yes.

3 Q: All right. And they're the two hospitals that  
4 have had the most growth in ED visits, right?

5 A: If you're looking across the tri-county area I  
6 think that those two do have the highest level  
7 of growth.

8 Q: All right. Now constraints at MUSC, I heard  
9 your opinion about that and I think what I  
10 heard you testify on direct this morning was  
11 that those constraints -- any capacity  
12 constraints at MUSC are not linked to ED  
13 services. Is that what I heard you say?

14 A: No, that's not what I said.

15 Q: Well I'm sorry. Let me rephrase 'cause I don't  
16 think you said that either. I think what you  
17 said, but again maybe you'll disagree, is that  
18 the capacity constraints are not linked to ED  
19 spaces, is that right?

20 A: Correct.

21 Q: All right. Now once again did you hear Dr.  
22 Hall say that those constraints were linked to  
23 ED spaces?

24 A: He gave quite a lot of testimony about what's  
25 happening at those EDs.



1 Q: Uh-huh.

2 A: And I think he factored in a lot of things  
3 that were affecting the operations of the  
4 emergency department including bed capacity and  
5 bed holds because they can't get patients out  
6 of the emergency department into beds. So it's  
7 -- if you just quantitatively look at the  
8 number of spaces and the volume in a perfect  
9 operational world if there weren't bed  
10 constraints or other things, they should have  
11 plenty of ED spaces.

12 Q: All right. Well again this is something that  
13 the transcript, when we get a transcript can  
14 speak for itself, so I'm just asking you to go  
15 by your memory and if you don't have -- if you  
16 don't remember that's -- I understand that of  
17 course. Isn't it true that Dr. Hall, Dr.  
18 Cawley and Dr. Wendell all testified capacity  
19 constraints at MUSC down the peninsula were  
20 linked, had -- were rooted in ED space issues?

21 A: That's not what I heard. I heard that  
22 constraints were related to a lot of different  
23 factors including bed capacity constraints that  
24 affected overall throughput through the ED. So  
25 it's not just as simple as ED spaces.



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2312

1 Q: All right. Now the -- MUSC, of course, is an  
2 academic medical center. The teaching aspects  
3 of that -- of MUSC, you're -- are you generally  
4 familiar with those?

5 A: Yes.

6 Q: All right. And that's -- I guess that's  
7 similar to other academic medical centers  
8 around the country that you've worked with or  
9 ---

10 A: It should be similar.

11 Q: All right. And the teaching aspects of that  
12 where you have physicians who teach residents  
13 and interns and students as part of the service  
14 process, would you agree that that whole  
15 process of the academic aspect of a teaching  
16 hospital is intended to improve quality of  
17 care?

18 A: I mean it's generally related to quality but  
19 also to, I guess, really future quality of  
20 training clinicians. I'm not sure that it has  
21 a daily impact on the patients being seen by  
22 those training physicians, but you would hope  
23 it would improve quality of care in the future.

24 Q: You would hope it would improve quality of care  
25 in the future. That would be the goal, would



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1           it not?

2       A:     I think that's the goal of education, yes.

3       Q:     And that's the premise behind academic medical  
4           centers, is it not?

5       A:     Generally, yes.

6       Q:     And in terms of improving quality care in the  
7           present as opposed to just the future, would  
8           you defer to physicians or do you have your own  
9           opinion about that?

10      A:     I would -- I guess I would defer to physicians  
11           for specific clinical quality issues.

12      Q:     All right. I don't have any other questions.  
13           Thank you.

14      **MS. BIGGERS:**    I don't have any questions, Your  
15           Honor.

16      **THE COURT:**    Okay. Did you have anything?

17      **MS. GLOBER:**    No further questions.

18      **THE COURT:**    Okay. Thank you, Ms. Platt. Any other  
19           rebuttal witness?

20      **MS. HOLLINGSWORTH:**   No, Your Honor.

21      **THE COURT:**    Okay. Mr. Thomas.

22      **MR. THOMAS:**    Your Honor, Trident would call its  
23           rebuttal witness, Dan Sullivan to the stand.

24      **THE COURT:**    Okay. Mr. Sullivan remember you were  
25           previously sworn.





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2314

1 MR. SULLIVAN: Thank you.

2 MR. SULLIVAN - DIRECT EXAMINATION MY MR. THOMAS:

3 Q: Morning, Mr. Sullivan.

4 A: Good morning.

5 Q: You heard yesterday Mr. Levitt testified about  
6 section B12 in the alternatives, correct?

7 A: I did.

8 Q: I believe he referenced, you know, maintaining  
9 the status quo, they could expand downtown,  
10 that was an alternative, they could do nothing  
11 or they could build out in Summerville, is that  
12 your recollection?

13 A: Yes.

14 Q: Okay. And he stated that these were adequate  
15 for purposes of B12, do you agree with that?

16 A: I do not.

17 Q: Why not?

18 A: Well there's documents that have come into  
19 evidence in this case that show that MUSC  
20 actually formally did an analysis of where to  
21 locate a freestanding ED and it identified  
22 additional sites in the area. I mean those  
23 were specific alternatives that they actually  
24 had considered. Those were not presented in  
25 the application.



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2315

1 Q: And was the best site Mount Pleasant in that  
2 score card analysis?

3 A: It was. And then another one I think that  
4 scored high was in Goose Creek.

5 Q: Okay. All right, Mr. Levitt spoke a lot or  
6 testified a lot to project changes yesterday  
7 and I want to discuss some of those, I don't  
8 want to plow too much back into what Ms. Platt  
9 has already done. Before I go any further, you  
10 heard the testimony of Ms. Platt today,  
11 correct?

12 A: I did.

13 Q: Do you agree with her testimony?

14 A: I do. I mean I -- she covered a lot of the  
15 same ground that I was going to cover. I mean  
16 I agree with her conclusions, specifically as  
17 they relate to the consistency of this project  
18 with the State Health Plan and with the  
19 relevant project review criteria.

20 Q: And do you adopt her testimony today?

21 A: I do.

22 Q: Okay. But I do want to still go into a few  
23 areas that -- where your testimony was  
24 specifically opposed. Now let's see here. One  
25 thing Mr. Levitt testified to was he indicated,



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1 I believe that CON projects change all the time  
2 and that the sequence of events involving  
3 MUSC's project is not necessarily unusual. Do  
4 you recall that testimony?

5 A: I do.

6 Q: Do you -- does your experience tell you that --  
7 do you agree with his testimony?

8 A: I do not. I mean I would agree in part that  
9 projects do from time to time change. But I  
10 think most of us in this room have been doing  
11 this for decades. I don't recall a project  
12 where there's been this many changes and this  
13 much uncertainty two years after the  
14 application was filed.

15 Q: And is this a slide that you created?

16 A: I did. I created it last night.

17 Q: Okay. Can you take the Court through this  
18 slide please?

19 A: Sure. And what I was really trying to -- you  
20 know in my own mind I was just trying to get  
21 time frame and the types of changes and I  
22 started off calling it the evolution of the  
23 project and then I realized the project hasn't  
24 really evolved, it's sort of meandered if you  
25 will so I called it an odyssey. The initial



1 project -- we don't need to go through all of  
2 this again.

3 Q: Sure.

4 A: But it had certain elements in it. On 12/'18  
5 apparently MUSC met with DHEC and, you know, in  
6 December of '18 and said, we're taking out the  
7 CDU, getting rid of the helipad, you know,  
8 downsizing the facility, really stripping this  
9 down to a, you know, sort of a freestanding ED  
10 that looks like a lot of other freestanding EDs  
11 that are in South Carolina. So it was a fairly  
12 significant departure from what they had put in  
13 their application. And then, you know, being  
14 on the other side we weren't fully aware of all  
15 the changes that were being made so Dr. Cawley,  
16 in response I think to various requests, filed  
17 an affidavit, I think motions that were filed,  
18 filed an affidavit that said, no it's gonna be  
19 in this downsized project that we talked about.  
20 It's not gonna have a helipad, it's not gonna  
21 have a CDU but it's gonna be a hybrid model.  
22 And there's been a lot of discussion about the  
23 hybrid model, that's something that was  
24 identified in the discussions with Intuitive  
25 Health between MUSC and Intuitive Health. And



1           that would be regular emergency services in  
2           conjunction with urgent care services in a  
3           single facility. And so that's what we thought  
4           we were dealing with at the time we were  
5           preparing, you know, for our depositions and  
6           getting ready for this hearing. And then there  
7           was an email that was sent to Dr. Hall, I think  
8           it was July the 2nd, that said, well we still  
9           have the same downsized project, we still  
10          aren't going to do the CDU and the helipad but  
11          we are going to abandon the hybrid model and  
12          we're going instead to fast track services,  
13          which would be sort of lower acuity emergency  
14          services which are different from urgent care  
15          services in terms of how they're regulated and  
16          how they're reimbursed, and essentially the  
17          project wasn't changing from the original CON  
18          application. I mean that struck me as odd  
19          because the original CON application was for a  
20          much different project than what he was  
21          describing in that email. And then I've had  
22          the benefit of sitting through all two weeks of  
23          this hearing and hearing the various witnesses  
24          testify on behalf of MUSC. And I think today  
25          this was my understanding of where we are and



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1           that is that we have the same downsized  
2           project, I believe that the fast track is still  
3           in place, but we don't know whether the  
4           facility's going to be leased or constructed by  
5           MUSC, we don't know whether a third party  
6           developer is going to be involved, there's no  
7           definitive financing plan in place right now,  
8           may or may not include a management company.  
9           And again, after two years with over a year's  
10          worth of consultation with Intuitive, the  
11          applicant still hasn't decided on what the  
12          project is. You know, a certificate of need is  
13          not a sort of a blank check that says,  
14          generally you can do emergency services and you  
15          can kinda do whatever you want, you know, once  
16          you get the CON. And I agree with Ms. Platt  
17          that I think the lack of specificity in this  
18          project really makes the project incomplete at  
19          this point. There's significant omissions and  
20          so I think she did a good job of detailing what  
21          those omissions are. So I mean here we are  
22          today trying to evaluate a project where  
23          virtually nothing has been updated from the  
24          original application despite the fact that  
25          there's been multiple changes made in the



1 project. All of those changes would have had  
2 impacts on portions of the application. And so  
3 I think it's highly unusual in my experience to  
4 see this level of change occur prior to the  
5 time that the CON is actually issued and  
6 certainly to see the level of uncertainty that  
7 continues to surround this project.

8 Q: Okay.

9 **MR. THOMAS:** Ms. Mitchell, would you go to Mr.  
10 Levitt's slide 4 that he presented yesterday?

11 Q: All right. Do you recognize this slide from  
12 Mr. Levitt's presentation yesterday?

13 A: I do.

14 Q: Okay. And I -- what it purports to show are  
15 all the different changes at the Roper Hospital  
16 Berkeley project, correct?

17 A: Correct.

18 Q: Okay. And I believe he was kind of using this  
19 to say, look projects change, Roper's own  
20 project changed in significant ways or perhaps  
21 insignificant ways, I guess. And so with  
22 respect to MUSC's changes, nothing to see here.  
23 Do you agree with that position?

24 A: I do not.

25 Q: Okay. Why not?



1       A:     First of all, what Roper described in a CON  
2             application is it was going to construct a 50  
3             bed acute care hospital at a specific location  
4             in Carnes Crossing in Berkeley County. That's  
5             still the project today. The fact that it was  
6             filed 11 years ago, I mean there would  
7             necessarily be some changes that would be made,  
8             but the changes that are being made are being  
9             done within the context of the same project.  
10            I mean they're not fundamentally changing what  
11            they presented to DHEC in terms of what they  
12            were gonna do. It was gonna be an acute care  
13            hospital, it was gonna have outpatient  
14            services, surgical services, imaging services,  
15            all those things are still the same. They  
16            reduce the med surg beds initially by 12, but  
17            they still are providing the same level of care  
18            that they were proposing to provide in the  
19            original application. So I think this is more  
20            of a reflection of a project that's been on an  
21            extended review process and then certain  
22            changes had to be made.

23       Q:     Did DHEC approve these changes that were made?

24       A:     Yeah. And that was the other thing I was gonna  
25             say is that these changes were actually





1 presented to DHEC. DHEC had the opportunity to  
2 review the changes and determine whether or not  
3 these changes represented a substantial change  
4 or not. Obviously DHEC determined that they  
5 did not represent substantial changes. I think  
6 the testimony is pretty clear in this case that  
7 nothing formally has been presented to DHEC and  
8 so you know if this board were to recommend  
9 approval of this application I'm not sure what  
10 they would be approving. Would they be  
11 approving the original project since no changes  
12 have been formally put in front of DHEC, which  
13 would be location in Nexton for a facility  
14 that's larger and with different complement of  
15 rooms? Are we approving this modified with  
16 uncertain pieces?

17 Q: Just looking -- some of these changes up here,  
18 the fact that an atrium is eliminated. Does  
19 that -- in your experience as a health planner  
20 -- you've reviewed this application, correct?

21 A: I have, yes.

22 Q: Yeah, is the loss of an atrium kind of a  
23 critical part of that project?

24 A: It's not. I mean it's certainly -- that's more  
25 of the aesthetic aspects of the projects rather



1       than the function or clinical aspects of the  
2       project. So, you know, some of these things  
3       like administration being eliminated, I'm sure  
4       they're going to have administration at the  
5       hospital but whether or not it's located  
6       physically inside the building is not critical  
7       to the function of the hospital.

8       Q: And were the components that were listed in the  
9       application and the project review meeting  
10      slides that we've already seen that are in  
11      evidence obviously such as a CDU and helipad  
12      and Nexton location, were those considered  
13      critical aspects of MUSC's project?

14      A: They were from MUSC's perspective. They were  
15      emphasized significantly -- I was at the  
16      project review meeting, they were emphasized  
17      consistency at the project review meeting as  
18      being important factors to consider in  
19      reviewing these projects. At this point I  
20      think we did not know whether DHEC was going to  
21      review these projects, you know, as competing.  
22      And we'll never be able to turn back the clock  
23      and know to what extent those elements which  
24      MUSC said made this project different from any  
25      other freestanding ED project in South Carolina



1 influence DHEC in its final determination about  
2 whether these were competing projects or not.

3 Q: Some testimony I heard from Mr. Levitt  
4 yesterday said that the project cost went from  
5 13 million to 11 million, and I guess with the  
6 13 million they were going to lease so they  
7 weren't actually going to incur a cost of  
8 construction but now they might so there would  
9 be a depreciation expense, and he just somewhat  
10 said that nothing really to see here, this is  
11 not a big change. What are your thoughts on  
12 that testimony?

13 A: Well I've been involved in a lot of projects  
14 and sometimes we've had to make modifications.  
15 But typically accompanying those modifications  
16 are revised sets of project cost schedules and  
17 financial projections. The finan- -- the only  
18 financial projections that are in this record  
19 for this project are the financial projections  
20 that were presented in the original application  
21 for a different project, different size,  
22 different scope of services. I think Mr.  
23 Levitt would like to ignore the fact that  
24 certain things have changed, but without  
25 knowing whether you're gonna lease the facility



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1 or construct it and finance it, you know, we  
2 don't know exactly how that ripples through.  
3 The fact that now 40 percent of the treatment  
4 areas in the building are gonna be for fast  
5 track whereas before there were 12 bays  
6 dedicated to emergency services plus a 4 bed  
7 CDU I think, 4 or 5 bed CDU, which was gonna  
8 basically serve a higher level of patient, and  
9 I don't know exactly what revenues were  
10 associated with the observation time that the  
11 patient would have in those -- in those CDU  
12 beds. And now we're talking about a facility  
13 that's going to be emergency services with a  
14 significant proportion of fast track. How does  
15 that alter the revenues? The project cost did  
16 go down but the revenues should go down as  
17 well. Will the revenues go down by a greater  
18 amount than the expenses went down? We don't  
19 know the answer to any of those questions  
20 because nobody has put these together. Mr.  
21 Levitt also tried to sort of take a short-hand  
22 approach and said, well the Summerville project  
23 is for about the same project cost and their  
24 capital cost were only half a million dollars  
25 and so our number must be fine. Well



1           unfortunately doesn't work that way in health  
2           care planning and finance. Everybody has a  
3           different approach to how they operate  
4           facilities, how they staff facilities, how they  
5           finance and construct facilities. I dare say  
6           the HCA might have a little bit better access  
7           to capital than MUSC being a very large company  
8           with the annual capital budget in the billions  
9           of dollars. And so I don't think you can look  
10          at the Summerville financial projection and  
11          make any conclusions about how that would  
12          reflect on the ultimate operations of a project  
13          opened by MUSC. One other thing is that HCA is  
14          the largest operator of freestanding emergency  
15          departments in the country. The last list I  
16          saw they had about 90 freestanding emergency  
17          departments. They have four operating in South  
18          Carolina, two are operated by Trident right  
19          now. They have a wealth of experience in  
20          operating these things. MUSC has no  
21          experience, whether they bring in a management  
22          company or not, they may need a management  
23          company to help them get off the ground, but  
24          there's a level of expense associated with the  
25          management company. There's management fees



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1 associated with the management company.  
2 There's management fees associated with that.  
3 They may have a different idea about how the  
4 facility is staffed and how the charges are  
5 set.

6 Q: Is the question of the management company use  
7 still an open question?

8 A: It is. I mean if I heard Dr. Cawley's  
9 testimony correctly, he said that was still  
10 something that was under consideration.

11 Q: Okay. How about this idea that Mr. Levitt  
12 testified that going from 13 million to 11  
13 million dollar project cost, and that's good,  
14 that's cost containment. Do you agree with  
15 that sentiment.

16 A: You know, in and of itself I don't think we can  
17 make any judgements about a reduction in cost  
18 if the reduction in cost also means a reduction  
19 in services. And in this case it does. You  
20 know, again, I'm sure Mr. Westbrook's going to  
21 ask me on cross, you didn't think that the CDU  
22 and helipad were particularly important to  
23 begin with, and I didn't. But MUSC did. And  
24 if the nature of the project is changing as a  
25 result of cost cutting efforts, that's



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1 something that should be taken into  
2 consideration in the overall evaluation of the  
3 project.

4 Q: Okay. I believe Mr. Levitt was kind of going  
5 through and talking about how the CDU and the  
6 helipad and maybe the Nexton location weren't  
7 very important aspects in terms of changes.  
8 And he said that the DHEC decision letter  
9 doesn't reference these particular components  
10 of the project. Do you recall that testimony?

11 A: I do.

12 Q: Okay. Do you have any thoughts or opinions  
13 about that?

14 A: Well the DHEC decision letter doesn't list a  
15 lot of things that were important I think about  
16 the project.

17 Q: Such as?

18 A: For example, there was no analysis in the DHEC  
19 decision letter about whether or not the  
20 existing providers in the area were adequately  
21 serving the needs of the population, you know,  
22 in the service area that MUSC was proposing to  
23 serve. I never saw an analysis. I mean Ms.  
24 Murdock described when I think she said she did  
25 sort of on the fly, but I never saw anything in



1 the record that showed that DHEC ever  
2 considered the needs of the population or  
3 whether existing providers were able to address  
4 those needs. So, I mean, if we want to talk  
5 about things that were missing from the letter,  
6 there was also no consideration given to  
7 adverse impact associated with MUSC's project.  
8 And that which I thought was a critical  
9 consideration when a provider that has, I think  
10 I my direct testimony I described the fact that  
11 their market share in the core area around the  
12 facility is about 7.4 percent. So they're  
13 going into an area where almost 93 percent of  
14 the patients are going somewhere else and  
15 plopping a facility down, and then to assume --  
16 even Ms. Murdock said she didn't agree with  
17 MUSC's assumption that they were only going to  
18 serve their existing patients. She assumed  
19 that they were gonna shift market share away.  
20 But there was no discussion of that in the  
21 decision letter. So I think the decision  
22 letter had a number of pieces that were absent.

23 Q: There was some discussion about staffing and I  
24 believe Mr. Levitt was asked on direct about  
25 the -- how MUSC was staffed and I don't know if





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1           they specifically referenced the 19 nurses that  
2           were there, but I believe what he said is, well  
3           that doesn't tell me that MUSC's overstaffed.  
4           What it maybe tells me is that Trident Center  
5           Pointe is maybe understaffed or the SMC  
6           freestanding ED. What are your thoughts about  
7           that?

8       A:   Well I would say that I believe that Trident  
9           and Summerville have direct operational  
10          experience with freestanding emergency  
11          departments. They have facilities that are --  
12          for example Center Pointe is doing over 20,000  
13          visits a year. I think they have a pretty good  
14          idea about how many staff are required in order  
15          to operate these facilities. So I think the  
16          staffing levels that are reflected in the MUSC  
17          application I think are reflective of the fact  
18          that one, they had a different model at the  
19          time that they filed the application, they had  
20          a CDU which would obviously be somewhat staff  
21          intensive because they would be observing  
22          patients in those rooms. And two, just the  
23          lack of experience in developing and operating  
24          one of these facilities.

25       Q:   Would MUSC have received -- MUSC's freestanding



1 ED received revenues associated with the CDU?

2 A: That I'm not clear on. It's -- hospitals do  
3 get some reimbursement for observation services  
4 that they provide. How that would function in  
5 a freestanding emergency department I've never  
6 addressed that particular issue before.  
7 Certainly wasn't discussed in the application  
8 or set out in the assumptions.

9 Q: And just for the record, you mentioned HCA a  
10 couple of times earlier in your testimony.

11 A: Yes.

12 Q: Can you just for the record state what HCA is  
13 and what the relationship is to Trident in  
14 Summerville?

15 A: Sure. I mean HCA is the largest operator of  
16 hospitals and related facilities in the world.  
17 Both Summerville and Trident are affiliates of  
18 HCA. I won't say that HCA is the parent but  
19 they're affiliates of HCA. But ultimately  
20 that's the corporation that provides resources  
21 and oversight to the Trident and Summerville  
22 facilities.

23 Q: Right. And you heard testimony from Maggie  
24 Murdock I believe in her direct that she  
25 believed she had the ability to kind of add and



1 delete from the relative importance criteria  
2 that's in the State Health Plan for particular  
3 services. Do you agree with that conclusion?

4 A: Yeah, again from the health planning  
5 perspective, not from a legal perspective. You  
6 know, you're required to be -- you know, the  
7 regulations say you're required to be  
8 consistent with the State Health Plan. Well it  
9 doesn't say, the parts of the State Health Plan  
10 that you like and that you can pick and chose  
11 components of the State Health Plan. It says  
12 you have to be compliant with the State Health  
13 Plan and those criteria that are identified in  
14 the State Health Plan or part of the State  
15 Health Plan, and that would in my view, that  
16 would be the starting point for what the  
17 priority criteria would be in reviewing the  
18 application. If Ms. Murdock wanted to then add  
19 additional criteria and reorder those criteria,  
20 I mean I think that would be well within their  
21 purview.

22 Q: Okay. Bear with me.

23 **MR. THOMAS:** Ms. Mitchell, can you go to David  
24 Levitt slide 16 from yesterday?

25 Q: This is slide 16 that Mr. Levitt spoke to



1           yesterday I think to the proposition that these  
2           drive times are right in line with other  
3           hospitals. Do you have any opinions about this  
4           particular slide and his testimony regarding  
5           this?

6       A:    Sure. I do. And, you know, I guess my opinion  
7           would be that, you know, it's really sort of an  
8           apples and oranges comparison. For example if  
9           you look at Trident Moncks Corner -- and for  
10          that it's same purpose, Roper St. Francis  
11          Moncks Corner FED, Moncks Corner is an area  
12          that has been devoid of health care services.  
13          Very few providers locate in that area, very  
14          few health care service is available for the  
15          population there. Many years ago, and I don't  
16          remember, I think Roper's been out there for 17  
17          or 18 years and I think Trident went out a few  
18          years after that, they were bringing not only  
19          emergency services but imaging services and  
20          other types of services to that community. If  
21          we look at the Trident James Island, that's a  
22          proposal to develop. There is no freestanding  
23          ED, there is no hospital on James Island nor  
24          any of the adjoining sea islands such as  
25          Kiawah, Seabrook and so forth that go down the



1 coast. In fact there's no freestanding ED in  
2 West Ashley which is also on that side of the  
3 Ashley river. And so what Trident was  
4 proposing to do was to bring a facility that  
5 wasn't present in that community to that  
6 community. Let's contrast that now with the  
7 MUSC Berkeley project. We know that there are  
8 five freestanding EDs either existing or  
9 approved that will be serving that same general  
10 market. We know that within less than four  
11 miles there's going to be a brand new hospital  
12 with a full service emergency department  
13 opening up in very close proximity to the MUSC  
14 project. And another distinction is that both  
15 Roper and Trident drew significant numbers of  
16 patients from the Moncks Corner area at the  
17 time they went out there. MUSC has a  
18 relatively small footprint in that north area  
19 that they have described. And so just looking  
20 at drive times doesn't tell you anything, that  
21 doesn't demonstrate a need. And the point of  
22 developing these other facilities, by Trident  
23 anyway, I can speak to that, was not to offload  
24 volume. Trident didn't expect that they were  
25 going to get any volume relief by opening up a



1 freestanding ED on James Island. They expect  
2 that most of that volume is gonna come from  
3 other providers who were serving those patients  
4 in inpatient facilities. And so for MUSC to  
5 take the position that they can build something  
6 23 and a half miles away and that's going to  
7 have a significant impact on alleviating  
8 capacity constraints at their facility, just  
9 makes no sense.

10 Q: And in terms of this particular slide, number  
11 16 of Mr. Levitt's, it doesn't contain the  
12 start of the Center Pointe freestanding ED of  
13 Trident Medical Center does it?

14 A: It does not.

15 Q: Does it contain Moncks Corner -- Roper Moncks  
16 Corner to Roper Berkeley does it?

17 **MR. WESTBROOK:** Objection, leading.

18 **MR. THOMAS:** You know, Your Honor, I'd ask for the  
19 same courtesy that was granted to Mr. Westbrook  
20 or maybe it was Mr. Dayhuff. I'm just trying  
21 to kind of get through this as quickly as I can  
22 and kind of the same courtesy was afforded to  
23 my opposing counsel here the other day. So I  
24 can sit there and ask him just open ended  
25 what's missing from the slide in terms of this,



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1           but I was just trying to move us along and  
2           hopefully get us out early afternoon.

3   **THE COURT:**   You make a very tempting offer.

4   **MR. THOMAS:**   I'll rephrase, Your Honor.

5   **THE COURT:**   Thank you.

6   Q:   Is there anything else missing in terms of this  
7       slide that you might include, Mr. Sullivan?

8   A:   Sure. I mean in general my experience has been  
9       that hospitals tend to build freestanding  
10      emergency departments in relatively close  
11      proximity to the facility. I mean for example  
12      the Center Pointe project I think was about six  
13      miles from Trident, six or seven miles from  
14      Trident. I believe that the Summerville  
15      project, Summerville freestanding ED is about  
16      six or seven miles from both Summerville and  
17      Trident. And so these facilities are being  
18      located in areas where the hospital's already  
19      serving the patients from that area, they want  
20      to improve access to those patients and they're  
21      primarily impacting themselves with the  
22      project.

23   Q:   Okay. Go to -- bear with me here -- MUSC  
24      Exhibit 40 if we could. You heard Mr. Levitt  
25      testify yesterday extensively about the patient



1 shift analysis, correct?

2 A: I did.

3 Q: Okay. It's about to come up here. There we  
4 go. And you recall this slide from yesterday,  
5 Mr. Sullivan?

6 A: I do.

7 Q: Okay. Do you have any thoughts or opinions  
8 with respect to the quote unquote convenient  
9 access or more convenient access for the  
10 patients they already serve as it's kind of  
11 presented in this exhibit?

12 A: I do

13 Q: What are they?

14 A: Well there's an essential element missing from  
15 this exhibit and that is where are other  
16 providers of emergency services? The only  
17 thing this exhibit measures is how far it is  
18 for patients to either go to the proposed  
19 freestanding ED site or to MUSC downtown.  
20 Ignores the fact that there are multiple  
21 providers or emergency services that are in  
22 significantly closer proximity to each of these  
23 zip codes that he's looked at and the travel  
24 times would be very very small and certainly  
25 closer to go those facilities than they would





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1           be to go to MUSC downtown. So, I mean, what  
2           this slide tells us, one thing is patients are  
3           going downtown for some reason other than  
4           geographic proximity to a facility. And  
5           there's got to be a reason why a patient -- you  
6           know, we heard sort of a litany of problems  
7           with the emergency department at the medical  
8           university downtown, you know, with the  
9           difficulty in parking and with way finding and  
10          inadequate facilities and long waits. And yet  
11          patients are going down there from distant  
12          places, which would lead one to believe that  
13          either there's a reason such as they work  
14          downtown and they happen to need ED services  
15          and they showed up at MUSC or they're going  
16          down there for a particular reason. You know,  
17          I think we've heard different reasons put forth  
18          such as they have an existing relationship with  
19          the specialist at MUSC downtown, they feel like  
20          they're going to get a different type of care  
21          if they go to an academic teaching hospital.  
22          Whatever the reason is it's not a reason of  
23          lack of access to care. And so I think this  
24          analysis is really, I mean, misleading in a  
25          way, but I mean really not valuable from a



1 health planning standpoint because it doesn't  
2 really provide any information about how much  
3 access these folks have to emergency care.

4 Q: Okay. Mr. Levitt testified that, you know,  
5 that zip code 29406, the North Charleston zip  
6 code where Trident is actually located, said  
7 there were 4,000 patients that use MUSC from  
8 that zip code. Do you have any thoughts that  
9 well that somehow kind of provides a reason or  
10 basis -- one of the reasons to put up a  
11 freestanding ED in the north area 'cause these  
12 patients are already just driving right by  
13 Trident Medical Center. Do you have an opinion  
14 about that?

15 A: I do. If those patients are driving by Trident  
16 and they're driving by Northwoods and they're  
17 driving by Center Pointe. I think the  
18 likelihood of them in significant numbers going  
19 to a freestanding ED that's located north of  
20 them and, Your Honor, I don't know how familiar  
21 you are with Charleston, but you know, in  
22 Charleston the gravitational pull is generally,  
23 you know, coming down I-26 from the west to the  
24 southeast into Charleston. And so for patients  
25 to go in the opposite direction is a little bit



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1 unusual. I mean it can happen and certainly  
2 for short distances it can happen. But what it  
3 tells me is that those folks see something  
4 about MUSC downtown that's different from the  
5 other types of providers that are out there and  
6 a freestanding ED is going to be something less  
7 than a level 2 trauma center like Trident.

8 Q: Well Mr. Levitt also testified, if I heard  
9 correctly, that some of the busiest times for  
10 a freestanding ED are between 4:00 p.m. and  
11 7:00 p.m. Did you hear that?

12 A: I think he said 3:00 to 7:00.

13 Q: Okay, 3:00 to 7:00. What's happening going  
14 from east to west on I-26 between 3:00 and 7:00  
15 p.m. in Charleston, South Carolina?

16 A: Well that's generally when the rush hour is  
17 beginning and has been talked about, there's  
18 been a tremendous amount of economic  
19 development out in the northern part of  
20 Charleston. And so you have folks who live in  
21 the north area who work closer into Charleston  
22 who are commuting back and then you also have  
23 people for a variety of other reasons that are  
24 moving up. And having -- I grew up in  
25 Charleston, I have a little home there now and



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1 I drive I-26 at all times of the day and it's  
2 very very crowded. I think the likelihood of  
3 folks who lived in 29406 for example down by  
4 Trident, which is off of exit 205 just to put  
5 some context to it, and six miles up the road  
6 is where the freestanding ED is going to go.  
7 I just think people are not going to want to go  
8 during those busy times to that particular  
9 freestanding ED. It's just not going to be  
10 geographic accessible. It would actually  
11 probably be faster for them to go into town at  
12 that point in the day because the traffic into  
13 town is significantly less dense than it is  
14 going out of town.

15 Q: Isn't 29406 also -- is it kind of -- Mr. Levitt  
16 described it as a boot shape?

17 A: It is.

18 Q: So there's a large -- is there a large portion  
19 under that's actually south of Trident Medical  
20 Center?

21 A: It is.

22 Q: Well south?

23 A: It is. It's a pretty densely populated  
24 section.

25 Q: Okay. All right. Now I think Mr. Levitt



1           challenged this idea of the Intuitive 13 minute  
2           drive time service area. He stated, I got it  
3           correctly, I was taking notes as fast as I  
4           could, but that this was Intuitive's planning  
5           tool and it undersizes the market, and he  
6           believes that the service area's actually  
7           broader than that. And this is just a Texas  
8           company, and, you now coming into South  
9           Carolina. Do you have any opinions as to that  
10          line of testimony, Mr. Sullivan?

11       A:     I do.

12       Q:     What are they?

13       A:     Well, I mean, first of all the Medical  
14           University engaged in a lengthy period of  
15           discussions with Intuitive. Dr. Cawley I think  
16           testified regarding several different changes  
17           that were made to the project with a result of  
18           the input that he received from Intuitive. For  
19           example the location moving from the medical  
20           campus at Nexton to a retail site, you know,  
21           over by the old Applebee's. That was in  
22           Intuitive recommendation. The idea of  
23           downsizing the project, getting rid of the CDU,  
24           that was an Intuitive recommendation. The idea  
25           of having a hybrid model which was what the



1 medical university was originally planning to  
2 do after their discussions with Intuitive, that  
3 came directly from Intuitive in a model that  
4 they developed in other parts of the country.  
5 So why they would accept their advice on all  
6 these other critical aspects of the project and  
7 then reject their analysis that the patients  
8 were likely to come from a 13 mile radius just  
9 doesn't seem logical. In addition Intuitive  
10 actually has significant experience in  
11 operating freestanding emergency departments  
12 and they apparently -- they developed a fairly  
13 sophisticated model for projecting where  
14 they're likely to draw their patients from. So  
15 I think there's really no basis for -- you  
16 know, in my experience patients tend to come  
17 from relatively close proximity to freestanding  
18 EDs. That's what Intuitive was saying. I  
19 don't know why MUSC would reject that advice.

20 Q: And Mr. Levitt presented, I think, a couple of  
21 exhibits. I don't necessarily want them up on  
22 the screen. But Exhibit 49 and 50 dealt with  
23 ED visits and admissions levels and acuity  
24 levels, and stated that, you know, this is  
25 obviously the -- consistent with what they



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1 think is going to be experienced at the  
2 freestanding ED if they're approved. Did Mr.  
3 Levitt, to your knowledge, ever consider the  
4 number of patients that were dropped off by EMS  
5 for instance at MUSC?

6 A: Not in any of the documents that I reviewed.

7 Q: Okay. Did you see any analysis that kind of  
8 played into the overall admission level at  
9 MUSC?

10 A: Yes. I mean there were several documents and  
11 I did my own analysis as well that showed that  
12 I believe Dr. Hall testified that 25 to 26  
13 percent of all patients who appear at the MUSC  
14 ED get admitted. I think there was other  
15 analysis that showed on the adult side -- I  
16 think he said that was for adults, I'm sorry.  
17 Overall that it was about 22 percent. And  
18 there are a couple of different exhibits that  
19 tie back to that 22 percent number. And I  
20 think we heard testimony from more than one  
21 witness that freestanding EDs typically have  
22 admission rates in the two to three percent, I  
23 mean maybe as high as four of five percent  
24 range. But to think you're gonna have the  
25 exact same experience -- now that was Mr.



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1 Levitt's conclusion apparently is that the  
2 patients from the service area look just like  
3 the overall patient population that MUSC  
4 serves, 22 percent of the patients from the  
5 service area are admitted to the hospital once  
6 they go to the ED. But yet he made no  
7 adjustment to say, well we're not going to get  
8 all of those patients because the patients who  
9 need to be admitted, a lot of those are sicker  
10 and they're probably going to go to the  
11 hospital for services. And similarly with the  
12 -- you asked about an ambulance arrivals. I  
13 think in my initial direct testimony I had an  
14 exhibit that talked about the fact that  
15 ambulance to all EDs is around 14 and a half  
16 percent of the patients who show up at an ED  
17 come by ambulance. From this particular  
18 service area I think it's around 22 percent.  
19 So again it's a higher percentage of people, 50  
20 percent higher percentage of people coming by  
21 ambulance to the hospital from this service  
22 area.

23 Q: To the MUSC hospital?

24 A: The MUSC hospital, which may explain why  
25 they're going there, because, you know, they're





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1           being transported by ambulance, and that they  
2           would be -- they would be less likely to  
3           utilize a freestanding emergency department if  
4           they're in an ambulance.

5       Q:     Right.     So here just -- we have put up  
6           Respondent's MUSC Trial Exhibit 17 and this is  
7           for their adult ED, we have 49,825 ED visits  
8           and I believe it's from 2016. Do you see that,  
9           Mr. Sullivan.

10      A:     I do.     Yes, sir.

11      Q:     And then the -- then you've got volume arrived  
12           by ambulance of those 49,000 is 12,851, do you  
13           see that?

14      A:     I do.

15      Q:     Okay.    And is that significant?

16      A:     That is significant.   That's about 30 percent  
17           of the -- just for the adults.

18      Q:     Right.

19      A:     And this also has the 22 percent admission rate  
20           on here as well on the third line on this  
21           exhibit.

22      Q:     Right.    And did you see any type of adjustments  
23           made for that in Mr. Levitt's analysis that he  
24           presented yesterday?

25      A:     Mr. Levitt staunchly believes that there should



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1           be no adjustments made to the population. I  
2           think I just disagree with that.

3       Q:     Okay. And what -- what's the ED admit rate for  
4           Center Pointe?

5       A:     I believe the testimony was that it was about  
6           between two and three percent.

7       Q:     Okay. And do you believe that MUSC's  
8           freestanding ED experience would be similar to  
9           that?

10      A:     I would, particularly since they stripped out,  
11           if you will, the CDU, which they said was going  
12           to allow them to serve a higher level of  
13           patients.

14      Q:     Okay. Let's see here.

15      **MR. THOMAS:** Can you put up TMC Exhibit 101 and go  
16           to page and go to page 29 for me please?

17      Q:     Is this your slide that has previously  
18           summarized your testimony on this, Mr.  
19           Sullivan?

20      A:     It is.

21      Q:     Okay. We can move on from that. I think we've  
22           talked through that one enough. Mr. Levitt  
23           brought up some testimony yesterday about  
24           freestanding EDs and their ability to treat  
25           pediatric patients, do you recall that line?



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1 A: I do.

2 Q: Okay. And I believe he even referenced that  
3 Center Pointe maybe had some dedicated  
4 pediatric ED bays. What thoughts if any do you  
5 have regarding Mr. Levitt's testimony about  
6 that?

7 A: Well sort of I guess a couple different things.  
8 Certainly pediatric patients can go to a  
9 freestanding ED. I mean there's no reason they  
10 can't except for the fact that the medical  
11 university's opening up a brand new Shawn  
12 Jenkins Children's Hospital that's going to  
13 have a highly specialized pediatric emergency  
14 department and Dr. Hall I believe testified  
15 both in his deposition and at this hearing that  
16 he expected a significant percentage of  
17 pediatric patients to continue to go back to  
18 the downtown facility to the pediatric  
19 emergency department down there. Pediatric  
20 patients represent almost 30 percent of the  
21 total ED volume that's going to MUSC. It's  
22 about 29.something percent in the most recent  
23 year. So let's say significant means half. 15  
24 percent of the volume is coming from the  
25 service area would likely not go to a



1 freestanding ED in that area, and it may be an  
2 even greater percentage.

3 Q: For ped services?

4 A: For ped services.

5 Q: Okay.

6 A: 'Cause I mean I know from my own standpoint  
7 that if I have a very sick infant I'm going to  
8 go to the place where they can get the highest  
9 level of care.

10 Q: Did you see any adjustments in Mr. Levitt's  
11 analysis for pediatric ED visits?

12 A: He made none.

13 Q: Okay. Mr. Levitt also talked about this new  
14 MUHA hospital in Nexton that would be very  
15 complementary to a freestanding ED just three  
16 or four miles away. Do you have any opinion  
17 about that?

18 A: I do.

19 Q: And what is it?

20 A: I don't think it would be complementary, I  
21 think it would be duplicative. Dr. Cawley also  
22 weighed in on that. He said that, when asked  
23 about whether the development of the hospital  
24 would eliminate the need for the freestanding  
25 ED and why would he keep the freestanding ED



1 open? He said, well they serve a different  
2 patient population. And Mr. Levitt seemed to  
3 be following that same line of thought by  
4 saying they'd be complementary. Well both the  
5 freestanding ED and the Nexton hospital  
6 application said they were going to serve  
7 patients who were going downtown to MUSC now.  
8 And so they were both targeting the same  
9 patient population. If there's a different  
10 patient population that's going to be served by  
11 the freestanding ED rather than the one that's  
12 going downtown now to the hospital ED.  
13 Obviously that's coming from somewhere other  
14 than from MUSC's historical patient base.

15 Q: Now in the Nexton hospital application what did  
16 MUSC say it was going to do with the  
17 freestanding ED at the Nexton location?

18 A: It said that once the new hospital opened up it  
19 would stop providing emergency services. And  
20 there may have been implication that it was  
21 going to be an urgent care center or provide  
22 primary care or something like that.

23 Q: Okay. So they're now moving it and I believe  
24 a slide of Mr. Levitt, which my ability to  
25 drive a golf ball was placed at issue. But



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1           showed that it was moving 1,000 yard away. So  
2           not even a mile as the crow flies, correct?

3       A:     Correct.

4       Q:     Okay. Well if the location differences aren't  
5           material, is it your understanding that this  
6           new location is going to remain open?

7       A:     That's what Dr. Cawley testified to.

8       Q:     So close it at Nexton, make it an urgent care  
9           center. 1,000 yards away they're going to keep  
10          it open?

11      A:     Right.

12      Q:     And no substantial change in location?

13      A:     No substantial change and no duplication with  
14          the hospital based ED service.

15      Q:     That's their position?

16      A:     That's their position.

17      Q:     Okay. What's your position?

18      A:     My position is it's pure duplication. I mean  
19          first of all if they were going to close it to  
20          begin with it made no sense to build a  
21          freestanding ED, you know, in my opinion. But  
22          if they're going to leave it open then they're  
23          basically duplicating the services and they're  
24          magnifying the adverse impact they're going to  
25          have on existing providers in the market 'cause



1           they're going to have to take the patients from  
2           somebody else if they're going to have any  
3           utilization.

4       Q:    Okay.  I -- you know, you don't have to go into  
5           this too deeply, but -- because I believe you  
6           adopted Ms. Platt's testimony.  But do you  
7           believe 1,500 across the board is a reasonable  
8           ED visit capacity number, you know, regardless  
9           of the type of ED and that type of thing?

10     A:    Yeah.  I don't.  I mean, you know, I use 1,500  
11           as a rule of thumb in planning, you know, just  
12           when I'm looking -- just doing a quick pass at  
13           capacity.  But, you know, from the testimony  
14           I've heard in this proceeding there's valid  
15           reasons why a different capacity number should  
16           be applied to different types of facilities.  
17           We've had the folks who actually operate these  
18           EDs, you know, from both Roper and from Trident  
19           come in and testify about what their affective  
20           capacities are.  I mean certainly their  
21           experience is better than using just a rule of  
22           thumb of 1,500.

23     Q:    Okay.

24     **MR. THOMAS:**  I'd like to -- can you put up this  
25           Exhibit, Trident -- the floor plan?  The



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1 existing treatment areas?

2 Q: Okay. Mr. Sullivan, I'm showing you what's had  
3 been marked, but what would that be? Like,  
4 103?

5 **(Petitioner TMC's Exhibit Number 103 was introduced**  
6 **into the record at this time.)**

7 Q: What do you understand this to be?

8 A: This is a floor plan of Trident's existing  
9 emergency department treatment areas.

10 Q: Okay. Where'd you get it from?

11 A: I got it from Trident and from Joan Eccleston.

12 Q: Okay. And why did you request this  
13 information?

14 A: Well Mr. Levitt yesterday testified -- he  
15 testified that he thought the correct number to  
16 use for Trident in terms of ED treatment rooms  
17 was 36.

18 Q: Okay. Have you reviewed this floor plan?

19 A: I have.

20 Q: Okay. And did you count the number of  
21 treatment areas?

22 A: I did.

23 Q: Okay. And how many did you come up with?

24 A: 48.

25 Q: So she was actually wrong?





1 A: Yeah.

2 Q: Okay. She understated the number. And this  
3 area right here that's got something like the,  
4 I guess, orange highlighting, what do you  
5 understand that to be?

6 A: That's the fast track area.

7 Q: Okay. And how about this red -- the red  
8 shading here up at the top?

9 A: That's an expansion of the fast track. That --  
10 the head walls were put into the walls in the  
11 corridor and then there's, as I understand it,  
12 there's curtained off areas there where  
13 stretchers can be placed. And so that -- you  
14 know, during times of peak utilization they're  
15 able to use those as additional bays. They're  
16 fully equipped, you know, to accommodate  
17 emergency departments.

18 Q: Okay. And in terms of adding ED rooms or bays  
19 or beds, do -- is that something that's  
20 required -- does it require a CON if you do it  
21 within the same space from DHEC?

22 A: No. I mean I think Mr. Levitt testified to  
23 that yesterday.

24 Q: All right.

25 **MR. THOMAS:** Let's go to TMC 101, this is Dan's



1 slide -- I believe it's 12.

2 Q: All right. Mr. Levitt had some comments about  
3 your slide with respect to the capacity with  
4 the opening of Shawn Jenkins Hospital. Do you  
5 have any opinions with respect to what he said?

6 A: Sure. I mean his -- as I recall his testimony  
7 he had a slide that said, well let's look at  
8 the number of bays by individual area. We've  
9 got 29 adult bays that serve just pure  
10 emergency patients. We have 12 bays that  
11 handle adult psychiatric patients and so forth.  
12 And he was, you know, basically saying, we have  
13 to consider the -- where the bays are located.  
14 But he didn't present any capacity analysis by  
15 individual category of bays and he didn't  
16 challenge the basic math that's shown on this  
17 slide, and that is -- and this is consistent  
18 with something that Ms. Platt testified to  
19 earlier and that is if they have 83 treatment  
20 bays, however they choose to use those they  
21 have ED capacity for 124,500 patients using a  
22 1,500 span. They're even using Mr. Levitt's  
23 lower standard which I don't agree with. But  
24 they're not bursting at the seams at Medical  
25 University. They have available capacity



1           there. And as Ms. Platt testified, if you add  
2           12 more associated with the freestanding ED  
3           then they're going to have even more capacity.  
4           So I would agree that the problems that they  
5           have with their emergency departments go beyond  
6           just not having an adequate number of treatment  
7           bays.

8       Q:   Well we also heard testimony that I believe Mr.  
9           Levitt refuted that I believe there's a new --  
10          MUSC's been approved for 33 beds, a CON has  
11          been approved, they just applied for 29 beds so  
12          I guess that'd be 62 med surg beds ---

13       A:   Right.

14       Q:   --- that would go in the areas that are going  
15          to be vacated by the children's hospital once  
16          they move into Shawn Jenkins, I guess in the  
17          Fall or Winter. And if I heard correctly said  
18          that Mr. Levitt didn't think that was really  
19          going to help throughput from the ED. Do you  
20          have an opinion as to that?

21       A:   Yeah, I do.

22       Q:   What is it?

23       A:   It's hard to imagine they wouldn't benefit  
24          throughput. It's almost a 10 percent increase  
25          in their overall acute care bed capacity. It



1           -- they talk about the fact that they have 20  
2           to 30 boarders in the emergency department.  
3           And I understand they have boarders elsewhere  
4           too, but the 20 to 30 in the emergency  
5           department would all of a sudden have 62 new  
6           inpatient spaces that potentially would be  
7           available to them. And that would also help  
8           alleviate some of the boarding problems they  
9           talked about in the OR or wherever else they  
10          were having those types of issues.

11       Q:    Okay. And so basically Mr. Levitt said that 20  
12           new beds aren't really a -- 20 new ED beds at  
13           Shawn Jenkins really weren't going to do  
14           anything with capacity, right?

15       A:    Right.

16       Q:    And that 63 med surg beds weren't going to do  
17           any capacity, is that what he said?

18       A:    Yes.

19       Q:    But somehow 10 freestanding ED beds or 12, 7  
20           and 5 are? Is that your understanding?

21       A:    Yeah. I mean to me -- and they're located 23  
22           miles away. I mean it just doesn't make good  
23           health planning sense.

24       Q:    Okay. I don't think I need to show the  
25           exhibits but I believe they're MUSC exhibits 35



1           and 37 which indicates population growth in the  
2           Berkeley, Dorchester, Charleston area and that  
3           I believe Mr. Levitt showed a slide that showed  
4           over a five year period there were 75,974  
5           visits worth, and that that was somehow  
6           justification for yet another freestanding ED  
7           in addition to the one that has already been  
8           approved.

9           **MR. WESTBROOK:**                   Objection,           objection.  
10           Mischaracterization and once again leading.

11           **MR. THOMAS:**   Well it's not a mischaracterization.  
12           If he wants me to put the slides up I can  
13           certainly do that. But, Your Honor, I think we  
14           heard Mr. Levitt testify population growth and  
15           75,000 ED visits were a justification -- at  
16           least one justification for this project. And  
17           if I heard that wrong and I typed it down wrong  
18           yesterday as I heard it I apologize.

19           **MR. WESTBROOK:** No apologies necessary, I just don't  
20           want you to lead. So ...

21           **MR. THOMAS:** Well the setup is this is what I heard,  
22           what do you agree about it? I'm not, you know,  
23           I mean -- this is what I heard, do you have an  
24           opinion to rebut that? I mean that was Mr. --  
25           he's taking an opposite point. He wanted Ms.



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1           Glober to sit there and basically not do a  
2           setup, now I'm trying to do a setup for the  
3           Court to move us along but, you know, let's go  
4           to the Exhibit. We'll do it the hard way.

5           **THE COURT:**   Okay.

6           **MR. THOMAS:**   I withdraw.   Let's go to Exhibit 35  
7           please.

8           Q:   All right.   And this is a slide showing what,  
9           Mr. Sullivan?

10          A:   This is showing emergency department visit  
11          growth in the tri-county area compared to South  
12          Carolina as a whole.

13          Q:   What has been happening if anything with  
14          population in the north area?

15          A:   Population has been growing.

16          Q:   Okay.   Let's go to Exhibit 37, MUSC 37.   Mr.  
17          Sullivan, can you -- have you seen this Exhibit  
18          37 before?

19          A:   I have.

20          Q:   What is the title of the Exhibit?

21          A:   Tri-County Area Hospitals Trend and Emergency  
22          Department Visits 2012 to 2017.

23          Q:   What is the raw growth total for total all tri-  
24          county area providers?

25          A:   75,974.



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1 Q: Okay. Now is it your understanding -- well  
2 what did Mr. Levitt use this information for  
3 yesterday?

4 A: He was -- he was sort of looking at the growth  
5 in emergency department visits as a  
6 justification for the addition of their  
7 project, talking about the fact that the tri-  
8 county area had seen 75,000 growth. There was  
9 population growth in the -- in this area around  
10 where the proposed freestanding ED was located,  
11 and that that would support the development of  
12 a freestanding emergency department in that  
13 area.

14 Q: Okay. Do you agree with his conclusion?

15 A: I do not.

16 Q: Why not?

17 A: Looking at those factors alone is insufficient  
18 to determine whether or not that there's a  
19 need. Without belaboring the point, there's  
20 been a lot of testimony about the new capacity  
21 that's coming into the area. We have 40  
22 approved emergency department rooms coming in  
23 to serve the population in this area. And that  
24 additional capacity based on Ms. Platt's  
25 calculations earlier about what the existing



1 capacity is is more than adequate to  
2 accommodate the growth. If we look at this  
3 slide that's up on the screen now we can see  
4 that the growth has slowed in recent years.  
5 There was a big jump up in volume that occurred  
6 between 2012 and the 2015. And then we began  
7 to see the growth slow down a bit in '16 and  
8 then actually decline in 2017. And so there's  
9 no indication that there's going to be the same  
10 sort of dramatic increase in ED visits going  
11 forward. But even if there is we have a new  
12 hospital coming on board with 15 emergency  
13 department rooms. We have a freestanding ED at  
14 the Summerville facility and we have the  
15 expansion at Summerville Medical Center that  
16 can accommodate that growth.

17 Q: Okay. Thank you, Mr. Sullivan.

18 **MR. THOMAS:** Put up MUSC Exhibit 32 please.

19 Q: Do you recognize this heat map from Mr.  
20 Levitt's testimony yesterday?

21 A: I do.

22 Q: Okay. What if anything is missing from this  
23 heat map?

24 A: Well a whole bunch of facilities, both existing  
25 and approved facilities. You know if we look





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1           at the distribution of facilities we can see  
2           that this -- the darkest red color area has a  
3           number of facilities located in it or about to  
4           be located in that same highest growth area.  
5           And again simply looking at the fact that  
6           there's been or projected to be population  
7           growth tells you nothing about the needs of the  
8           population for additional services in that  
9           area.

10       Q:     Okay.       Mr.   Levitt   spoke   to   Standard   6  
11               yesterday, do you recall that?

12       A:     I do.

13       Q:     And he believes that MUSC's project complies  
14               with Standard 6, is that fair?

15       A:     He does.

16       Q:     Okay.   And I believe you testified that MUSC  
17               identified the service area zip codes and why  
18               the patients from there are not adequately  
19               served, do you recall that testimony?

20       A:     I do.

21       Q:     Okay.   And one of the reasons I note he  
22               provided that because patients will drive right  
23               by existing facilities, do you recall that  
24               testimony?

25       A:     I do.



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1 Q: Do you agree with that testimony in terms of  
2 supporting the idea that the project complies  
3 with Standard 6?

4 A: I do not agree with that.

5 Q: Okay. Why not?

6 A: As I mentioned earlier, the fact that patients  
7 are driving past existing facilities is patient  
8 choice for some reason. And again, I don't  
9 know all the reasons why they are. But it's  
10 not due to lack of access. And while putting  
11 a freestanding ED in the location proposed by  
12 MUSC might improve convenience for some of  
13 those patients who might choose to stay closer  
14 to home, I don't think a significant percentage  
15 will, but some might, that in and of itself  
16 does not establish a need. To use the phrase  
17 that your partner uses often, it's called a  
18 certificate of need, not a certificate of  
19 convenience. Merely the fact that it's going  
20 to improve convenience for certain patients who  
21 choose to go farther away to receive care when  
22 they could receive that care in a closer  
23 location does not establish a need for a new  
24 facility in that particular market. And as,  
25 you know, we've already talked about there's



1           going to be ample capacity in that market to  
2           accommodate the number of patients who require  
3           emergency services.

4       Q:    What percentage of the patients from that north  
5           area market don't travel to MUSC?

6       A:    As I mentioned earlier, about 93 percent of the  
7           patients stay -- go to other facilities other  
8           than Medical University. So it's not as if  
9           there's this dramatic out-migration of patients  
10          from the north area as they described it. You  
11          know, the area around the proposed location of  
12          the facility which are the patients who are  
13          going to be most advantaged from a geographic  
14          standpoint by the facility, MUSC only has about  
15          a seven percent market share in that area. And  
16          therefore it's going to have a relatively minor  
17          impact in terms of improving access for a small  
18          number of people and it's going to adversely  
19          impact the existing and approved providers in  
20          the area. And that's exactly the analysis that  
21          the State Health Plan asked the Department to  
22          make. And that is the benefits of improved  
23          accessability should be equally weighed with  
24          the adverse affects on existing facilities.  
25          Well in this case there's virtually no



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1 improvement in accessibility. So why would you  
2 want to incur any adverse affects on existing  
3 facilities when you're having almost no impact  
4 on access.

5 Q: Okay.

6 **MR. THOMAS:** Before I forget, Your Honor, I ask that  
7 TMC or the floor plan that I identified earlier  
8 come into evidence as TMC Exhibit 103.

9 **MR. WESTBROOK:** No objection, Your Honor.

10 **THE COURT:** Admitted.

11 **(Petitioner TMC's Exhibit Number 103 was admitted**  
12 **into evidence.)**

13 Q: All right. You heard some testimony yesterday  
14 about this 15 minute travel time that's set  
15 forth I believe in the standards in the  
16 subsequently published State Health Plans. Do  
17 you recall that?

18 A: I do.

19 Q: Okay. What is your understanding, Mr.  
20 Sullivan, of what that 15 minute travel time  
21 represents?

22 A: I concur with Ms. Platt. It represents the  
23 ability of patients to get to emergency  
24 services within 15 minutes. It's not measuring  
25 the distance between facilities if you will.



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1           So I think the way that Mr. Levitt was  
2           presenting it is is he was saying, well there's  
3           no facility within 15 minutes of where we're  
4           proposing to put our particular facility. I  
5           thought Ms. Platt did a very good job with her  
6           math and showing that there's no area around  
7           that proposed site where patients aren't within  
8           15 minutes of a particular facility.

9       Q:    Okay. All right. We've heard -- we heard  
10           testimony from Mr. Levitt and other DHEC  
11           witnesses about this idea of Standard 6 and  
12           existing provider. And that the Department  
13           shouldn't consider for purposes of that  
14           standard and existing provider. However that's  
15           in the State Health Plan, correct? That's in  
16           the standard.

17    A:    That's right.

18    Q:    Okay. Is there -- are there other concepts  
19           within health planning and CON act that would  
20           require the Department and others to consider  
21           future providers, not, you know, the folks that  
22           are coming online?

23    A:    Sure. The State Health Plan is probably not as  
24           artfully worded as it could be. But if we take  
25           it literally that you can only consider



1 existing providers, that's not the end of the  
2 conversation because there's a number of other  
3 standards. For example the community need  
4 standards. If you -- certainly under community  
5 need you would take into consideration the fact  
6 that there were approved providers who were  
7 coming online that were gonna serve the same  
8 population that a new applicant was proposing  
9 to serve. I think Ms. Platt also mentioned  
10 under resource availability there was a  
11 standard that says, is there going to be  
12 unnecessary duplication of existing resources  
13 in the market area. So, you know, I could  
14 probably -- if you've got the book out I could  
15 probably point to several others. But the  
16 avail- -- the presence of approved projects has  
17 to be considered in the overall calculus of  
18 whether a project is needed or not. And I  
19 think it squarely comes in under community need  
20 because to do so would create absurd results.  
21 You could approve -- have 15 approved  
22 freestanding EDs in a relatively small  
23 geographic area, and then the next applicant  
24 comes in and says, pay no attention to those,  
25 there's no existing provider in the market, so



1           you have to approve us.

2       Q:     In terms of the CON Act and its purposes, is  
3           there a concept in the CON Act that speaks to  
4           this idea of existing versus non-existing  
5           services.

6       A:     Sure.     I mean it talks about unnecessary  
7           duplication and unnecessary duplication has to  
8           be broader than just what's actually  
9           operational right now because DHEC took into  
10          consideration at the time that it approved a  
11          provider what the existing providers were,  
12          whether there was a need for another provider,  
13          and they approved a provider to address that  
14          need. You have to take that into consideration  
15          when you're assessing the need for the next  
16          provider to come in.

17      Q:     Okay.    Mr. Levitt talked a little bit about  
18           medically under-served groups and I believe he  
19           testified that MUHA serves a lot of medically  
20           under-served groups, do you recall that?

21      A:     I do.

22      Q:     Okay.    Not withstanding that testimony, does  
23           that indicate to you that medically under-  
24           served groups are not already adequately being  
25           served in the service area?



1     A:     It does not. And, you know, I think, you know,  
2           there's sort of two parts when you're  
3           addressing the medically under-served criteria.  
4           I mean one is to demonstrate that you're an  
5           organization that's financially accessible to  
6           those medically under-served populations. But  
7           more importantly is to show that your project  
8           is actually going to improve access to  
9           medically under-served populations. I think  
10          consistently people have testified throughout  
11          this hearing the medically under-served groups  
12          for emergency services have an advantage that  
13          they don't have for other types of healthcare  
14          services and that's the EMTALA statute that  
15          requires emergency departments to treat  
16          patients regardless of their ability to pay.

17        Q:     Just for the record, just because you're a  
18                Medicare patient, does that mean that you're a  
19                medically under-served?

20        A:     I don't believe so. I'm a Medicare patient.  
21                I don't feel medically under-served. But I  
22                don't think generally I wouldn't put Medicare  
23                in the broad category of medically under-  
24                served. There's certainly a sub-component of  
25                Medicare folks who are medically under-served





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1           but ---

2       Q:     Sure.

3       A:     --- not all.

4       Q:     All right.

5       **MR. THOMAS:** I'm going through my outline and trying  
6           not to duplicate what Ms. Platt's already said,  
7           Your Honor.

8       **THE COURT:** Okay.

9       **MR. THOMAS:** Just bear with me here.

10      Q:     You heard some testimony from Mr. Levitt  
11           yesterday regarding your slide that's, I  
12           believe it's TMC 101 page 43 about the adverse  
13           impact on Trident Health Facilities and that he  
14           -- it was his opinion that that didn't really  
15           constitute a material adverse impact. Do you  
16           have any opinions as to that?

17      A:     I do.

18      Q:     What are they?

19      A:     Well a loss of 10,000 visits -- and you have to  
20           put in perspective where these visits would be  
21           lost from and they would be lost from the area  
22           surrounding the medical center's proposed  
23           freestanding ED. That's the same area that  
24           Summerville freestanding ED is gonna draw from.  
25           And so these 10,000 visits would be two thirds



1 of the projected volume for that Summerville  
2 freestanding ED. So that would have a dramatic  
3 impact on their operations. And 10,000 ED  
4 visits is -- you know, despite the fact that  
5 the Trident facilities overall serve about  
6 180,000 patients, that's a material -- a number  
7 of patients in terms -- when you look at it in  
8 term -- when you look at it from the standpoint  
9 of revenues, if you look at it from the  
10 standpoint of volumes that are going through  
11 facilities. It's gonna have an impact both in  
12 terms of reducing revenues, altering staffing  
13 patterns in these facilities if they have fewer  
14 patients and ultimately reducing the level of  
15 resources they'll have in the future to  
16 reinvest in other services.

17 Q: And the adverse effects in the project review  
18 criteria, my understanding is a balancing test.  
19 What is your -- do you have any opinions about  
20 that?

21 A: Yeah, I think I talked about that earlier.  
22 It's the balancing between acc- -- improving  
23 access and adverse effects on existing  
24 facility. In this case I think the balance is  
25 way out of wack. You know, this project is



1           going to adversely impact existing facilities  
2           and provide virtually no improvement in access.

3       Q:     Okay. I believe Ms. Murdock testified that she  
4           found a community need because based on her  
5           analysis she thought that the market could  
6           easily support two freestanding EDs, do you  
7           recall that testimony?

8       A:     I do.

9       Q:     Do you agree that that is somehow the standard  
10          for community need?

11      A:     It is not.

12      Q:     Okay. Why not?

13      A:     Whether or not a particular market might be  
14          able to absorb another provider is different  
15          from whether or not there is a community need  
16          for services. I mean I can draw a service area  
17          in different parts of South Carolina where  
18          there's no providers in that service area. So,  
19          you know, I can put two providers in there and  
20          they can serve the need. But that ignores the  
21          fact that there are many other providers that  
22          may be located just on the periphery of that  
23          area that are serving significant numbers of  
24          patients and serving them well. So simply  
25          looking at the service area and not considering



1           the totality of what's available to meet that  
2           need. In addition, not -- I saw no analysis  
3           that considered what the impact of the approved  
4           capacity would be. I think that analysis just  
5           falls short.

6       Q:    Okay. And I believe that Ms. Murdock also  
7           testified that she did not believe that adverse  
8           impact was necessarily a market share issue.  
9           Do you agree with that testimony?

10     A:    I do not. And typ- -- I've probably done, I  
11           don't know, a couple hundred adverse impact  
12           analyses in my career. The starting point of  
13           every adverse impact analysis is are you going  
14           to lose anything, are you going to lose  
15           patients, are you going to, you know -- and the  
16           only way you can measure whether you're going  
17           to lose patients or not is looking at what the  
18           existing market share is of providers and  
19           whether or not that's going to be altered by  
20           the approval of a new provider. So that's not  
21           the end of the analysis but it's certainly the  
22           beginning of the analysis. You would also  
23           consider other factors, you know, such as  
24           impacts on staffing availability and so forth  
25           have been talked about in this hearing. But



1 looking at loss of market share is the most  
2 direct way to measure whether or not a new  
3 project is gonna adversely affect an existing  
4 provider.

5 Q: Okay. In terms of -- Mr. Levitt clearly stated  
6 that he believes that the CON application  
7 complies with the CON act. Do you agree with  
8 that?

9 A: I do not.

10 Q: And could you just briefly summarize for the  
11 Court why you do not?

12 A: Sure. I don't believe that there's any  
13 demonstrated public need for a new facility.  
14 I believe this project is going to adversely  
15 affect existing providers in the market for all  
16 the reasons that we've already talked about.  
17 I don't believe it contributes to cost  
18 containment because it's an unnecessary  
19 duplication, not only of existing resources in  
20 the market, but of MUSC's own Nexton hospital  
21 project. And I believe it has the impact on  
22 quality because by diminishing volumes at other  
23 facilities that were relying on that volume  
24 when they made significant investments in their  
25 own facilities can ultimately affect the



1           quality of care that's being provided.

2       Q:     And do you believe that the -- based on your  
3           testimony previously and today that -- do you  
4           agree with Mr. Levitt's testimony that the  
5           project complies with the most important  
6           project review criteria set forth in the State  
7           Health Plan?

8       A:     I do not.

9       Q:     And just a brief analysis and then you're done  
10           with me.

11      A:     Sure. With obviously no community need for the  
12           project I do not believe that the project has  
13           demonstrated financial feasibility for the  
14           reasons I've already talked about, doesn't  
15           improve distribution of services, doesn't  
16           improve access to the medically under-served  
17           groups and it has an adverse effect on staff  
18           resources in the market place.

19      Q:     Okay. I have no further questions for you, Mr.  
20           Sullivan, but I have a feeling Mr. Westbrook  
21           does.

22      **MR. WESTBROOK:** Oh, let's just go home. Your Honor,  
23           could we have 10 minutes?

24      **THE COURT:** Yes. That's what I was about to say,  
25           take a 10 minute break before we move to your



1                   ...

2                                   (Off the Record)

3   MR. SULLIVAN - CROSS-EXAMINATION BY MR. WESTBROOK:

4   Q:    All right, Mr. Sullivan, home stretch I guess.  
5           Mr. Sullivan, let me ask you about fast track  
6           services. You'd agree that fast track services  
7           are in fact emergency services, right?

8   A:    They are.    I mean they're the lower acuity  
9           emergency services.

10   Q:   And CDU services are observation services, not  
11          emergency services, isn't that correct?

12   A:    I mean I guess they're an extension of  
13          emergency services. They're observing patients  
14          who came in for emergency treatment and they're  
15          staying around to determine whether or not they  
16          need to be admitted.

17   Q:    Isn't there an essential difference though  
18          between CDU spaces and treatment spaces for  
19          emergency services?

20   A:    I guess ---

21   Q:    One's observation and one's treatment, right?

22   A:    I mean in terms of designation whether the  
23          rooms are physically different I'm not sure.  
24          But yeah, I mean in terms of intended purpose,  
25          yes, they're different.



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1 Q: And the FE- -- excuse me, the Summerville FED  
2 application and the Summerville ED expansion  
3 application which you and I discussed during  
4 your cross-exam a few days ago, once again you  
5 did both those applications, right?

6 A: I did.

7 Q: And part of the need analysis in each of those  
8 applications was it not was to relieve capacity  
9 constraints?

10 A: True.

11 Q: All right. And is 68 percent occupancy rate  
12 enough to generate capacity constraints?

13 A: It would not. I mean the 68 percent in Ms.  
14 Platt's slide included the additional rooms  
15 that have been approved but not yet opened. I  
16 think if you'd have used the original 29 rooms  
17 it would have shown that the utilization was  
18 very high.

19 Q: Staffing issues with MUSC's project, now if  
20 less staff is needed than is -- than what is  
21 projected, that would be less expense that  
22 would be incurred, is that correct?

23 A: True.

24 Q: All right. And if less staff is needed than  
25 what is projected, that would be less risk with





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1           respect to the nursing shortage, wouldn't that  
2           be correct?

3       A:     True.

4       Q:     Remind me, minor point perhaps but point's the  
5           operative word, when did Center Pointe open?  
6           That was your project, right?

7       A:     Yeah, the application was 2013 and I believe it  
8           opened at the end of '14 or the beginning of  
9           '15.

10      Q:     All right. Was there another CON application  
11           for Center Pointe two or three years later that  
12           you're aware of?

13      A:     I wasn't involved in it if there was.

14      Q:     Would you have been involved in it? Isn't that  
15           your expectation? You think they're sneaking  
16           around behind your back?

17      A:     Every now and then they slip on in that I'm not  
18           involved in. But I don't recall one, no.

19      Q:     All right. Is -- just verify for me, I think  
20           we've heard a lot of testimony about that. Is  
21           there in fact in Regulation 61-15 a criteria  
22           called resource availability?

23      A:     It is not. I mean I think the letter that Ms.  
24           Platt addressed in her testimony is the way  
25           that I've usually seen that handled. It



1 specifies specific criteria to address that  
2 concept.

3 Q: Okay. Multiple -- taking from multiple  
4 criteria, right, a piece here, a piece there,  
5 a subsection here, a subsection there, patch  
6 something together to say maybe this is  
7 resource availability?

8 A: Well I mean it's been pretty consistently done  
9 by the Department in the past. Not just in the  
10 context of freestanding EDs but in terms of  
11 other projects where resource availability was  
12 a concept. You know typically what the  
13 Department does is they identify the actual  
14 sub-parts of the project review criteria that  
15 they think are applicable to that standard.

16 Q: But they didn't do that here did they?

17 A: They did not.

18 Q: All right. And there's no -- once again, just  
19 to verify, there's no -- or just to confirm,  
20 there's no criteria anywhere listed in the  
21 Regulation entitled resource availability, is  
22 there?

23 **MR. THOMAS:** Objection, asked and answered, Your  
24 Honor.

25 **MR. WESTBROOK:** Well I didn't understand his first



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1           answer.

2       Q:     Was that a yes or a no, Mr. Sullivan?

3       A:     I agree with you.

4       Q:     Thank you.

5       **THE COURT:**   Okay.

6       Q:     All right.   So MUSC I believe you said has a  
7           small footprint in the north area, right?

8       A:     They do.

9       Q:     Comparable to Trident's small footprint in  
10          James Island, correct?

11      A:     Actually Trident's footprint is smaller on  
12          James Island.

13      Q:     Thank you, Mr. Sullivan.   MUSC is -- you don't  
14          have any issues with quality of care provided  
15          by MUSC do you?

16      A:     I do not.

17      Q:     And wasn't MUSC rated the top hospital in South  
18          Carolina for quality by US News and World  
19          Report last year?

20      A:     I think I saw that on one of their  
21          applications, yes.

22      Q:     Thank you.   The MUSC is the only academic  
23          medical center in South Carolina, is that  
24          right?

25      **MR. THOMAS:**   Your Honor, I'm going to object.   I



1 think I got this one right because I didn't ask  
2 anything about the quality of MUSC or nor did,  
3 you know, I don't think Mr. Sullivan testified  
4 about it. And I do think that in a rebuttal  
5 case the cross is limited to what is within the  
6 rebuttal case. He cannot just go out and start  
7 cross-examining willy nilly on any issue that's  
8 been before the Court. That's my  
9 understanding.

10 **MR. WESTBROOK:** Your Honor, I don't know anything in  
11 the rules that says -- supports what Mr. Thomas  
12 just said. The only thing I know about cross  
13 is that it's unlimited -- the scope is  
14 unlimited. So that's what I'm going by.

15 **MR. THOMAS:** I don't have a case but I don't think  
16 it's unlimited in the rebuttal case. I think  
17 it's limited to what we went into on rebuttal  
18 at this point.

19 **MR. WESTBROOK:** I don't know of any case that says  
20 that, I don't know of any rule that says that.

21 **MR. THOMAS:** I'd like to brief it then. I hate to  
22 say it, I'm sorry.

23 **THE COURT:** We don't need to go there. I tend to  
24 agree with you, Mr. Thomas because this is a  
25 rebuttal case. So let's try to keep the scope



1 of your questions narrow.

2 **MR. THOMAS:** Thank you.

3 **THE COURT:** So I sustain your objection.

4 Q: All right. Now Intuitive's proposed 13 minute  
5 area, you did testify about that right?

6 A: I did.

7 Q: The problem is I'm mixing -- I can't remember  
8 this morning to last week. It all runs  
9 together at this point. But Intuitive -- do --  
10 to your knowledge does Intuitive partner or do  
11 any work with any other academic medical  
12 centers?

13 A: I'm trying to remember Mr. Herman's deposition.  
14 I don't recall to be honest.

15 Q: Did Mr. Herman indicate that Intuitive has any  
16 facilities or any business going on in South  
17 Carolina?

18 A: I think he said there were opportunities but he  
19 had no actual projects going on.

20 Q: All right. So they're not representing any  
21 hospitals in South Carolina or working with any  
22 hospitals currently in South Carolina to your  
23 knowledge?

24 A: To my knowledge, no.

25 Q: All right. And academic medical centers like



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1           MUSC would have a broader reach than they  
2           typical Intuitive kind of freestanding ED  
3           partner, wouldn't that be true?

4       A:   Well the hospital would typically have a  
5           broader reach.       I'm not sure that a  
6           freestanding ED would have a broader reach.

7       Q:   All right. Give me just a second. All right.  
8           With respect to acuity, you talked about acuity  
9           with Mr. Thomas, correct?

10      A:   I did.

11      Q:   All right. Do you agree that a freestanding ED  
12           can evaluate and stabilize any patient?

13      A:   They can.       Ideally the most seriously ill  
14           patients would bypass the freestanding ED and  
15           go directly to a hospital.

16      Q:   Do you agree that freestanding EDs are open  
17           24/7 and always staffed by emergency  
18           physicians?

19      A:   Yes.

20      Q:   Do you agree that freestanding EDs have the  
21           same equipment as hospital emergency rooms?

22      A:   They should, yes.

23      Q:   And that's consistent with Dr. Hall's testimony  
24           in this case, isn't it?

25      A:   Right. I think -- I mean the licensure regs



1           are exactly the same for freestanding EDs and  
2           hospitals.

3       Q:     And Dr. Hall testified about the accessibility  
4           of the MUSC freestanding ED to specialist via  
5           telemedicine and other ways at the downtown  
6           hospital did he?

7       A:     He did.

8       Q:     I think we've established that MUSC's FSED is  
9           just like all FSEDs, I'm mixing my acronyms  
10          now, FSEDs and FEDs, I never can get those  
11          straight.     But whatever it is, they're all  
12          subject to EMTALA right?

13      A:     They are.

14      Q:     And that means that indigent patients are going  
15          to be served if they enter the door, right?

16      A:     True.

17      Q:     And would you agree that FSEDs are equipped to  
18          handle medical emergencies even heart attacks  
19          and strokes and major trauma if the patient is  
20          brought to them?

21      A:     Sure.     I mean they should be equipped to  
22          stabilize and transport.

23      Q:     All right.     The -- you talked about, with  
24          respect to pediatrics, the Jenkins -- new  
25          Jenkins Children's Hospital down on the



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1 peninsula. And referenced Dr. Hall's that a  
2 significant percentage would go to Jenkins and  
3 I think you suggested well let's say  
4 significant means half. That was your  
5 assumption, not Dr. Hall's right?

6 A: Sure.

7 Q: Okay. So significant, we don't know if that  
8 means 50 percent, 25 percent or 75 percent,  
9 right?

10 A: We don't.

11 Q: We just don't. Nevertheless Mr. Hall -- Dr.  
12 Hall never gave some indication in his  
13 testimony, right?

14 A: Yeah. He did not try to put a number on it.

15 Q: All right. Now you talked about the  
16 duplication between the MUSC FED and the MUSC  
17 community hospital, right?

18 A: Right.

19 Q: All right. Now the community hospital is being  
20 challenged by Trident right now, correct?

21 A: True.

22 Q: And that -- well Trident and Roper, right?

23 A: Yes.

24 Q: I think so. That goes to trial this fall,  
25 correct?





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1 A: I think the whole month of November.

2 Q: Lucky you, Mr. Sullivan. So the -- obviously  
3 if MUSC loses that at the ALC or loses it on  
4 appeal, not that I'm predicting that, but if  
5 that happens there would be no duplication,  
6 would there?

7 A: Not with -- not within MUSC itself. There  
8 would still be duplication with the other  
9 providers, but not ---

10 Q: I understand.

11 A: --- within MUSC.

12 Q: I'm talking about your point that the hospital  
13 would duplicate -- the hospital ED would  
14 duplicate the freestanding ED. That wouldn't  
15 happen if the community hospital is not  
16 approved, right?

17 A: Sure. I mean if they wanted to withdraw that  
18 CON we probably wouldn't be here today.

19 Q: And generally speaking, hospital EDs are --  
20 have longer wait times than freestanding EDs  
21 by a long shot, isn't that right?

22 A: Not always by a long shot, but typically  
23 they're longer because they're dealing with a  
24 more complex patient base.

25 Q: Right. And the hospital EDs are generally less



1 convenient than FEDs right?

2 A: Generally they're located as part of a broader  
3 campus.

4 Q: All right. And with respect -- I'm gonna be  
5 jumping back and forth. Sorry, this is not a  
6 particularly tightly organized exam here. But  
7 keep you guessing perhaps.

8 A: Okay.

9 Q: The -- you recognize Mr. Huddy as a leading  
10 expert in the field, don't you?

11 A: I do.

12 Q: And when I say the field I mean the field of  
13 emergency room planning and design and health  
14 planning, is that correct?

15 A: Yes.

16 Q: All right. And in fact I believe that you  
17 along with somebody named Sherry Welch were the  
18 only two experts in this area that you could  
19 identify as the leading ones, isn't that  
20 correct?

21 A: Right.

22 Q: All right. And Mr. Huddy's guideline we talked  
23 about the 1,500, I think he has a range of  
24 1,500 to maybe up to 1,800, is that right?

25 A: Yeah. And if you read the entirety of his book



1           he really describes it as you have to kind of  
2           look at the situation, you know you have to  
3           look at the dynamics of the individual  
4           facility. But he was giving a range of what he  
5           typically sees.

6       Q:     And that's 1,500 to 1,800, right?

7       A:     Correct.

8       Q:     Okay. Now the additional 29 med surg rooms, if  
9           the latest MUSC application is approved, those  
10          29 rooms, they're going to alleviate capacity  
11          but they're not going to have any affect on  
12          psych patients are they? None of those are  
13          psych beds, right?

14      A:     Not to my knowledge, no.

15      Q:     Wasn't that the testimony of Dr. Cawley?

16      A:     Yes. It would not have a direct impact. I  
17           mean it would have a sort of a secondary impact  
18           if you will. If you had medical boarders in  
19           the emergency department along with mental  
20           health patients, you would eliminate some of  
21           the backlog in the emergency department that  
22           may allow them to accommodate the mental health  
23           patients to a greater extent.

24      Q:     All right. Thank you. Bear with me a sec.  
25           Now adverse impact.



1     **MR. WESTBROOK:**     Can we pull up Mr. Sullivan's  
2                             adverse impact analysis? I believe it's 43,  
3                             slide 43.

4     Q:     Is that right?

5     A:     Sounds right.

6     Q:     Adverse impact -- adverse impact, adverse  
7                             effects, do you use those terms  
8                             interchangeably?

9     A:     I do.

10    Q:     Okay. So -- I may do that the same. So  
11                             adverse impact is an important issue to you,  
12                             right?

13    A:     It is.

14    Q:     All right. And this adverse impact analysis  
15                             that you did was not presented to DHEC though,  
16                             right?

17    A:     It was not.

18    Q:     All right. And it was not produced to MUSC  
19                             until about a week ago, right before your trial  
20                             testimony, is that right?

21    A:     I think that's true, yes.

22    Q:     All right. And the sources for that, the MUHA  
23                             CON application, the SCRFA office data and SMC  
24                             FSED CON application, you've had access to  
25                             those sources for a long time, right?



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1 A: I have.

2 Q: All right. Now adverse impact, there's a  
3 criterion that we've talked about called  
4 adverse effects, it's in 61-15, right?

5 A: Correct.

6 Q: That's -- you know what number that is?

7 A: I don't.

8 Q: I don't either. But that's okay. It's in  
9 there. We know about it. And so that  
10 criterion was not identified by DHEC among the  
11 priority criteria, correct?

12 A: Right. I mean I think we criticized that in  
13 our case in chief.

14 Q: Right. But in addition to that there's this  
15 balancing test that is mentioned in the State  
16 Health Plan on I think every service or  
17 virtually every service about improved access  
18 and adverse impact, correct?

19 A: Right. You have to balance those two.

20 Q: You have to balance them and I think they're  
21 required, DHEC is required to show in the plans  
22 how they weigh those, whether they're equally  
23 weighed or one outweighs the other or something  
24 like that, right?

25 A: Yeah. I mean I think that the language I often



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1           see    is    that    the    benefits    of    improved  
2           accessability will be equally weighed with the  
3           adverse effects on the existing facilities.

4       Q:    All right. And that's what it says in the 2015  
5           Plan, isn't it?

6       A:    It is.

7       Q:    All right. So you have this little seesaw with  
8           a little fulcrum in the middle and they're sort  
9           of equally weighed, right?

10      A:    Correct.

11      Q:    All right. And the new plan, the plan that  
12           came after the 2015 was the 2017, 2018 Plan,  
13           does that sound right?

14      A:    Yes.

15      Q:    And then there's one since then 2018, 2019  
16           Plan, right?

17      A:    Correct.

18      Q:    And the language in those plans say that  
19           improved access will outweigh -- for  
20           freestanding EDs should outweigh adverse  
21           impact, doesn't it?

22      A:    Could you show me that? I mean I just don't  
23           recall.

24      Q:    Sure.

25      **MR. WESTBROOK:**   Mr. Buff, let's put up the 2018,



1           2019 Plan.

2       Q:     That's the current plan.     And read that  
3           highlighted sentence for me, Mr. Sullivan.

4       A:     The benefits of improved accessibility will  
5           outweigh the adverse effects of duplication in  
6           evaluation applications for the service.

7       Q:     All right. Now that's not the plan that was in  
8           effect when this application was submitted,  
9           right?

10      A:     It was not.

11      Q:     But there's been discussion about that this  
12           Court should consider this plan, but I just  
13           wanted to clarify or wanted to ask your opinion  
14           about that if the Court considers this plan,  
15           that's the balancing test between improved  
16           accessability and adverse affects that it would  
17           consider, is that right?

18      A:     Sure.     If they were to consider this plan  
19           that's the language in this plan.

20      Q:     Now I think it's your opinion but you can  
21           correct me if I'm misstating that there is --  
22           would be no improved access if MUSC's FED is --  
23           becomes operational, right?

24      A:     I think my testimony was there would be a small  
25           number of patients from MUSC who might see



1 improved access but within the context of the  
2 broader healthcare market there would be no  
3 meaningful change in access.

4 Q: Because isn't it your opinion that when you  
5 analyze adverse impact, you don't really look  
6 at individual facilities as much as you look at  
7 the healthcare system as a whole. Isn't that  
8 your understanding or belief?

9 A: I don't know if I've ever said it that way. I  
10 think the starting point is how it affects the  
11 system as a whole.

12 Q: Right.

13 A: But obviously at some point you have to look at  
14 how it affects individual facilities in  
15 assessing how it affects the area as a whole.

16 Q: All right. And when you look at individu- --  
17 when you do look at individual facilities  
18 there's this number of 10,000 that we looked at  
19 that was a projection of lost ED visits that  
20 either -- that I think Ms. Platt made or you  
21 made.

22 A: I made that.

23 Q: That was your's okay. And of course Mr. Levitt  
24 disagrees with that number. But even if it's  
25 true, you also agree in analyzing adverse





1           impact, don't you, that future growth is not --  
2           that an existing provider isn't guaranteed in  
3           any way to sort of holding onto future growth,  
4           its share of future growth, isn't that right?

5       A:   Actually I usually look at it both ways.   I  
6           usually look at it, what would the impact be  
7           based -- including future growth and also what  
8           would it be if you did not assume -- if you let  
9           future growth offset the impact.

10      Q:   Well isn't one way you look at it that if the  
11           new project is approved would the new project  
12           take you below in terms of volume where you are  
13           currently?   Isn't that a valid way of looking  
14           at it?

15      A:   That's certainly one way to look at it.

16      Q:   All right.   And isn't that a way that you have  
17           looked at it in the past?

18      A:   I have looked at it and I've also looked at it  
19           the other way and that is how much would you  
20           lose of the future growth as well?

21      Q:   So you just go with the wind, Mr. Sullivan, is  
22           that what you're saying?

23      **MR. THOMAS:**   Objection to that characterization.

24      **MR. WESTBROOK:**   I'll withdraw that.

25      A:    I mean I think it's just trying to show the



1 range of potential impact.

2 Q: All right. The range of potential impact

3 A: Yes.

4 Q: All right. And in this particular case, if  
5 there were to be a shift of 10,000 patients to  
6 MUSC from the Trident facilities, how many  
7 patients between, let's say 2017 -- I think the  
8 last two years we have data, between 2017 and  
9 2018. About how many visits did Trident's ER  
10 grow? Do you recall?

11 A: It wasn't a huge jump in that particular  
12 period.

13 Q: It's about 10,000 wasn't it?

14 A: I didn't remember it begin 10,000 in that one  
15 period. But they had a pretty significant jump  
16 when Center Pointe opened. But my recollection  
17 is that it was a little bit less than 10,000.  
18 But I don't recall the numbers exactly.

19 Q: All right. Well I think there are exhibits  
20 somewhere that must -- surely must show that.  
21 So I think that's already in the record so we  
22 won't go back to try to find those. 93 percent  
23 of some area, the north area or some area you  
24 looked at around the north area, you said that  
25 93 percent of ED patients don't go to MUSC,



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1 right?

2 A: Right. That's that area we defined as the  
3 service area for Summerville's freestanding ED.

4 Q: Okay. That's what, four zip codes?

5 A: I think there were five when we split out the  
6 new zip codes.

7 Q: All right. But from the north area you don't  
8 dispute do you that there are 24,000  
9 approximately -- over 20,000 patients a year  
10 for the last several years that have been  
11 driving down to MUSC for ED services, right?

12 A: I mean if you define the north area as MUSC has  
13 which includes, I mean, a very broad geographic  
14 region.

15 Q: Well I guess I'd define it the same way that  
16 Mr. Thomas, I think, has. I think we've been  
17 using that consistently as being Berkeley  
18 County and portions of Dorchester County and  
19 North Charleston.

20 A: Yeah. But, I mean, for example there's parts  
21 of Berkeley County for example that are like  
22 Bonneau and Jamestown that are way up Highway  
23 17, you know, to the north. I wouldn't  
24 consider them to be the north area in the usual  
25 meaning in Charleston.



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1 Q: All right. Well I'll defer to you on the  
2 Charleston -- where to look for things, but the  
3 -- but the point is that MUSC has documented,  
4 and you don't dispute these numbers, do you,  
5 that from the service area that Mr. Levitt --  
6 those 25 zip codes that he listed, 24,000  
7 patients a year have been and are driving to  
8 MUSC for ED services?

9 A: I would agree with that.

10 Q: They've been doing that for years and they're  
11 going to keep on doing that, aren't they?

12 A: Likelihood is they will.

13 Q: Yeah. And if -- unless there's an MUSC FED  
14 built up in Berkeley County, right?

15 A: Yeah, some fraction of those patients might use  
16 the freestanding ED.

17 Q: And MUSC patients are -- I mean they're part of  
18 the community right?

19 A: They are.

20 Q: All right. So if they're going to continue  
21 doing that, going to MUSC unless an FED is  
22 built, that is something -- isn't that beyond  
23 a choice? Isn't that something that they --  
24 they're -- if their options are go to a local  
25 Roper or Trident provider, keep on going down



1 to MUSC 23 miles or whatever the mileage is  
2 from their zip code, that's a significant  
3 portion of the community, isn't it?

4 A: It's -- I mean it's a very disbursed community.  
5 I mean they're not all 24,000 people living in  
6 one community, you know, like a five mile  
7 radius. They're spread over a very broad  
8 geographic area. And secondly that's sort of  
9 planning in a silo if you will. You're looking  
10 at just what one provider's patient population  
11 is, and you're not considering all the other  
12 resources that are in the market.

13 Q: Bear with me just a second, Mr. Sullivan.

14 A: Sure.

15 Q: Let's look at -- well I don't think we need to  
16 look at it, let me just ask you first and then  
17 we'll go from there. Talking about medically  
18 under-served groups, I think Mr. Thomas asked  
19 you about whether Medicare should be included  
20 in there or not. You and I are both Medicare  
21 beneficiaries at this point of our lives. So  
22 what does the regulation say about Medicare,  
23 the regulation, in fact the criterion for  
24 medically under-served groups? Doesn't it say  
25 -- and I can put this on the screen ---



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1 A: It does include Medicare in the description.  
2 Q: Right.  
3 A: I guess my point was that not all Medicare  
4 patients are medically under-served.  
5 Q: I understand. And you didn't understand that  
6 to be Mr. Levitt's point, did you?  
7 A: No. He just said Medicare, Medicaid and self  
8 pay are usually the under-served groups. And  
9 I think we were just putting a finer point on  
10 that.  
11 Q: All right. Okay. But you would follow with  
12 what the -- if the regulation says give  
13 consideration to Medicare patients you wouldn't  
14 disagree with that, would you?  
15 A: No.  
16 Q: Okay. All right.  
17 MR. WESTBROOK: Your Honor, if I could beg your  
18 indulgence for just a moment.  
19 Q: No further questions. Thank you.  
20 MR. THOMAS: Just one or two, Your Honor. Oh, did  
21 you have any ...  
22 MS. BIGGERS: No, I don't have any questions.  
23 MR. SULLIVAN - REDIRECT EXAMINATION BY MR. THOMAS:  
24 Q: Just to clear up. Mr. Westbrook just indicated  
25 or asked you a question about these 24,000



1 patients coming from the north area. Is it  
2 your id- -- understanding that it's patients or  
3 is that visits?

4 A: Well that is visits and there may be a smaller  
5 number of patients because I think I testified  
6 earlier in my direct that some of these  
7 patients may go to the emergency department  
8 more than once in a given period. And so we  
9 don't know the exact number of patients.

10 Q: Mr. Westbrook asked you a couple questions  
11 about adverse impact and when you decided to  
12 create a slide. When did you actually know  
13 what this project was in its final form, or do  
14 you?

15 A: Well I still don't know exactly. But as I look  
16 through the exhibits that were prepared by  
17 MUSC, you know, in exchange, that gave me a  
18 little better idea about what they're claiming  
19 their project was and also gave me a little  
20 better idea about, you know, what they were  
21 gonna say about the ability of -- to shift  
22 patients. And once I saw they really weren't  
23 changing their basic approach then I did the  
24 adverse impact.

25 Q: Yes, sir. Mr. Westbrook asked you a couple of



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1           questions about the new beds that are going to  
2           come online at MUSC and, you know, what affect  
3           if any that would have on I guess the  
4           psychiatric patients. But -- you were here for  
5           Dr. Hall's testimony?

6       A:     I was.

7       Q:     Okay.     Didn't one reason that he gave for  
8           backup in their ED was problems getting  
9           patients discharged from the med surg bays?

10      A:     Yes.     Yeah, the lack of available acute care  
11           bed capacity resulted in a backlog in the  
12           emergency department, and so this addition of  
13           a total of 62 additional beds should relax that  
14           constraint if nothing else and then allow  
15           patients who require a medical surgical  
16           placement to get out of the ED faster.

17      Q:     Okay.     With respect to the Huddy Study I  
18           believe you just testified that you have to  
19           look at the dynamics of the area and the  
20           facilities, correct.

21      A:     Right.

22      Q:     Okay.     And what, after having looked at the  
23           dynamics of the facilities in the north area,  
24           what if any opinions do you have about that,  
25           the capacity?





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1     A:     I thought that Ms. Platt did a good job of  
2           summarizing what the testimony was from the  
3           various folks who actually operate these  
4           facilities.    So I mean I think that taking  
5           specific knowledge and actual experience the  
6           facilities is probably the best way to evaluate  
7           capacity.

8     Q:     Okay.    And then last questions I hope.    Mr.  
9           Westbrook asked you a couple of questions about  
10          staffing at the beginning of his cross.    And  
11          specifically about MUSC's number of staff that  
12          they at least were going to utilize and that if  
13          they used less staff that would be less expense  
14          and probably less impact on surrounding EDs, do  
15          you recall that testimony?

16    A:     I do.

17    Q:     Okay.    Have you seen any updated staffing plan  
18          other than what is in the CON application of  
19          this case for MUSC?

20    A:     I have not.

21    **MR. THOMAS:**   No further questions, Your Honor.

22    **THE COURT:**    Thank you.

23    **MR. THOMAS:**   And I would ask that Mr. Sullivan be  
24          dismissed.

25    **THE COURT:**    I don't see any need for Mr. Sullivan to



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1 stay with us any longer.

2 **MR. SULLIVAN:** Thank you, Your Honor.

3 **THE COURT:** Thank you for coming. That concludes  
4 your case

5 **MR. THOMAS:** We rest our rebuttal and our case.

6 **MS. HOLLINGSWORTH:** And I'd ask that Ms. Platt be  
7 permitted to leave once we're all done here.

8 **THE COURT:** Okay. Thank you. Ms. Platt, you're  
9 excused as well.

10 **MS. PLATT:** Thank you.

11 **INSTRUCTIONS:**

12 **THE COURT:** And okay. As a wrapper I think you all  
13 agreed that you would waive closing arguments?

14 **MR. THOMAS:** Yes, Your Honor.

15 **THE COURT:** Okay.

16 **MR. THOMAS:** Unless you want us to. That's a joke.

17 **THE COURT:** And I think because both sides will be -  
18 - well actually presenting proposed orders.  
19 Okay. Now I guess the logistics of that, we  
20 have to determine about how long it's going to  
21 take us to get the -- 'cause I know you all are  
22 not going to be able to start working until we  
23 get the transcript.

24 **MR. THOMAS:** Yes, ma'am.

25 **THE COURT:** Okay. Do you have any idea how long it



1           might be?

2       **COURT REPORTER:**   For one week I usually -- three  
3           weeks to four. For two weeks -- I mean I know  
4           the first week they've already started working  
5           on it but I don't know how far they've gotten.

6       **THE COURT:**   Okay, okay. That's what I was wondering  
7           since you all split up, it was two.

8       **COURT REPORTER:**   Right.

9       **THE COURT:**   Okay, okay. So we'll look at 30 days  
10          until we get the transcript.

11       **COURT REPORTER:**   Roughly.

12       **THE COURT:**   Roughly 30 days. Okay. Well if ---

13       **COURT REPORTER:**   That's what we'll shoot for.

14       **THE COURT:**   Okay. We're gonna shoot for that 30  
15          days. Now one of the things I would love to --  
16          that we could accomplish here is we can get  
17          these proposed orders in before you all go into  
18          the November hearing. And once you all get the  
19          transcript at a minimum how much time do you  
20          think you'll need to work on those proposed  
21          orders?

22       **MR. DAYHUFF:**   What's the date -- start date of the  
23          trial?

24       **MR. THOMAS:**   Like November 3rd.

25       **MR. DAYHUFF:**   I think we could prepare a proposed

