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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

The Honorable Ralph King Anderson, III
Chief Administrative Law Judge

APPELLATE CASE No. 2020-001323

ADMINISTRATIVE LAW COURT CASE No.: 18-ALJ-07-0358-CC
ADMINISTRATIVE LAW COURT CASE No.: 18-ALJ-07-0360-CC
ADMINISTRATIVE LAW COURT CASE No.: 18-ALJ-07-0366-CC

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

v.

South Carolina Department of Health and Environmental Control and
Medical University Hospital Authority, d/b/a MUHA Community Hospital,.....Respondents,

AND

Walterboro Community Hospital, Inc., d/b/a Colleton Medical Center,.....Appellant,

v.

South Carolina Department of Health and Environmental Control and
Medical University Hospital Authority, d/b/a MUHA Community Hospital,.....Respondents,

AND

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

v.

South Carolina Department of Health and Environmental Control and
Medical University Hospital Authority, d/b/a MUHA Community Hospital,.....Respondents.

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1 DANIEL J. SULLIVAN, having been duly sworn, testifies
2 as follows:

3 MR. SULLIVAN - DIRECT EXAMINATION BY MR. THOMAS:

4 Q: Good morning, Mr. Sullivan.

5 A: Good morning.

6 Q: Could you ---

7 THE COURT: Hold on. Hold on. All right. Go
8 ahead.

9 MR. THOMAS: All right.

10 Q: Could you, please, just once again, state your
11 name for the record?

12 A: Daniel J. Sullivan.

13 Q: Okay. Where do you live, Mr. Sullivan?

14 A: In Alpharetta, Georgia. Part-time in
15 Charleston, South Carolina.

16 Q: Okay. What company do you work for, Mr.
17 Sullivan?

18 A: Sullivan Consulting Group, Inc.

19 Q: Okay. How long have you been working for
20 Sullivan Consulting Group, Inc.?

21 A: Just about 30 years.

22 Q: Okay.

23 A: Yeah.

24 Q: What do you do for a living, Mr. Sullivan?

25 A: I am a healthcare management consultant.

1 Q: Okay. And who do you represent in this
2 proceeding or who do you test- -- here
3 testifying on behalf of?

4 A: Trident Medical Center, Summerville Medical
5 Center and Colleton Medical Center.

6 MR. THOMAS: Let's pull up TMC 96.

7 (Trident Exhibit Number 96 was referenced at this
8 time.)

9 Q: I'm putting your CV up on the screen and I'd
10 only ask you to refer to it if there's
11 something you can't remember when -- within
12 your education and employment history.

13 A: All right. I probably won't need it, but.

14 Q: Okay. So, let's start with your educational
15 history, Mr. Sullivan. Can you take the Court
16 through that?

17 A: Sure. Undergraduate degree in economics and
18 public policy studies from Duke University.
19 Master in Health Administration from Duke
20 University.

21 Q: Okay. And when -- when did you get your
22 Master's in Health Administration from Duke
23 University?

24 A: 1980.

25 Q: Okay. And why don't we start with your

1 employment history since -- you know, from your
2 Master's in Health Administration going
3 forward, please.

4 A: Well, the -- I guess the first job I had was at
5 Duke Med- -- Duke University Medical Center and
6 I was working there while I was undertaking my
7 Master's studies. And so, that was really my
8 first healthcare related job and that started
9 in 1974 and went through 1980. I had a variety
10 of positions there. It started with more
11 menial ones and became more of an assistant
12 administrator in the latter years there, was
13 involved more in sort of planning, internal
14 planning, for the Medical Center. In -- in
15 1980, when I got my Master's, I joined a
16 healthcare management consulting firm. It was
17 a national firm called Amherst Associates, Inc.

18 Q: And could I stop you one second?

19 A: Yes.

20 Q: You said you worked for -- at Duke Medical
21 Center?

22 A: Yes.

23 Q: Is that an academic medical center?

24 A: It is.

25 Q: Okay.

1 **A:** And Amherst Associates was a national firm. I
2 worked in the Atlanta office of Amherst. And
3 Amherst was involved in a variety of health
4 planning and health finance related activities.
5 And on the health planning side, we did things
6 such as market analysis for healthcare
7 services, projections of future utilization for
8 various types of healthcare services, strategic
9 planning for -- for healthcare organizations.
10 And this was pretty early on in the Certificate
11 of Need process. We began to write CON
12 applications back in -- at that time. And
13 then, on the finance side, Amherst was heavily
14 involved in doing financial modeling for
15 healthcare organizations and also doing
16 financial feasibility studies for -- for use in
17 tax exempt bond issues. And so, we worked with
18 hospitals and nursing homes primarily in
19 preparing financial feasibility studies that
20 were used in conjunction with bond offering
21 circulars. And -- and we also did some
22 strategic financial planning for organizations,
23 debt capacity analysis and then, segued into
24 cost accounting analysis sort of in the latter
25 part of my career with Amherst. Amherst merged

1 with the firm of Ernst and Young. Well,
2 actually, the firm of Ernst and Whinney, which
3 became Ernst and Young. And I was there for
4 just a couple of years. After the merger with
5 Arthur Young, I decided that I wanted to do
6 something a little -- on a little smaller
7 scale. And so I set up my own company,
8 Sullivan Consulting Group, in 1990. And the
9 type of work that I'm doing through Sullivan
10 Consulting Group through this day is similar
11 though in a somewhat different vein because
12 healthcare has changed somewhat, but I still do
13 primarily healthcare finance and healthcare
14 planning type activities.

15 Q: Why don't you -- why don't we take those kind
16 of one by one. Why don't start with healthcare
17 planning and then we'll talk about finance.

18 A: Sure. On the planning side, today my -- I
19 probably do much less in the way of strategic
20 planning for healthcare organizations. Most of
21 my planning work is -- is market analysis.
22 Someone's considering undertaking a particular
23 type of venture or a new facility or whatever
24 and I may do some demographic analysis and
25 utilization analysis and projections. I do

1 work in terms of preparing Certificate of Need
2 applications for various types of healthcare
3 services. I mean, over the years, I've -- I
4 think I've prepared a CON for just about any
5 kind of healthcare service that's regulated in
6 -- and I work primarily in the southeastern
7 United States, but -- and that's where most of
8 my CON work is in the southeastern United
9 States. And then, on the finance said, most of
10 my work again on the finance side is in the
11 context of the Certificate of Need program. I
12 prepare financial projections for CON
13 applications and also evaluate projections done
14 by other parties in conjunction with CONs.
15 From time to time, I may have a client that
16 just calls me up independently and says, could
17 you run some numbers from a financial
18 standpoint of whether this project looks like
19 it might be viable or not viable.

20 Q: Okay. Have you ever worked on a project where
21 HUD financing was in play?

22 A: I have, just on a couple of occasions. One was
23 -- and these were several years ago. One was
24 -- there was a Congressman named Claude Pepper
25 who -- some folks might remember, he was pretty

1 -- pretty colorful. He wanted to reopen a
2 hospital that had closed in the inner city of
3 Miami in what's called Liberty City, which was
4 an economically depressed area and they did not
5 have ready access to healthcare. And HUD
6 financing was -- was really the only option
7 that was available to them. And so we were
8 engaged to do a feasibility study and to kind
9 of work with the other parties who were trying
10 to bring this hospital back to life and pulling
11 together a -- a financing for this hospital.
12 And we got several steps down the road in terms
13 of contacting banks and began to work with the
14 other parties in completing the application
15 process to HUD, but for a variety of political
16 reasons, I think the project stalled out and we
17 never actually completed the HUD financing.

18 Q: Did -- can you just let the Court know a little
19 bit about what -- what HUD financing means?

20 A: Sure.

21 OBJECTION:

22 MS. CRUM: Your Honor, there's not been a foundation
23 laid that he knows anything about HUD
24 financing.

25 MR. THOMAS: Other than the fact that he worked on a

1 project that involved HUD financing and did a
2 feasibility study.

3 MS. CRUM: Yes, sir. Mr. -- Mr. -- Your Honor, Mr.
4 Pepper, I remember Claude Pepper because I'm
5 old enough to remember him and he was a very
6 colorful man, but I think he died in like 1991
7 or 2 or something like that and that's when the
8 project was done. There's been no foundation
9 that Mr. Sullivan knows anything about the HUD
10 financing and the HUD requirements have changed
11 between 1990 and 2018 or '19. I mean, he can
12 tell us what was going on back then.

13 MR. THOMAS: I think -- I think those are great
14 questions ---

15 THE COURT: I think ---

16 MR. THOMAS: --- for cross-examination, Your Honor.

17 MS. CRUM: Your Honor, I've -- I'm objecting on a
18 foundation.

19 THE COURT: Well, I think he's laying a foundation
20 for this from what I'm hearing right now, so I
21 overrule that objection at this point.

22 **A: And I had occasion again, a little more**
23 **recently, I think this was in the -- probably**
24 **in the 2002, 2004 time frame, working with a**
25 **small hospital in upstate West Virginia,**

1 Buckhannon, B-U-C-K-H-A-N-N-O-N, West Virginia.
2 Small rural hospital wanted to undertake some
3 capital plans, but didn't really have access to
4 traditional financing because of the state of
5 its financial statements. And so we -- we
6 began again to investigate their ability to
7 borrow money, you know, through a HUD
8 mechanism. And -- and so, we -- again, we --
9 we talked to some banks; we began to pull
10 together the basic information that was
11 required to -- to apply for HUD financing.
12 But, again, there were other factors that came
13 into play and before we completed the
14 transaction, the hospital decided they couldn't
15 go forward with the project.

16 Q: Okay. Well, if you were exploring HUD
17 financing, did that -- did you have to do any
18 exploration to exactly what HUD financing was?

19 A: Sure. I mean, you know, we -- you had to know.
20 I mean, there were -- you know, I certainly was
21 aware that there were two different types of
22 financing that were available to healthcare
23 entities. It was the Section 232 program was
24 primarily for nursing homes and Section 242
25 program for hospitals. You had to try to get

1 familiar with the -- with the regulations and
2 what was required of an applicant for, you know
3 -- and HUD really is a long guarantee. I mean,
4 HUD is not -- HUD doesn't loan the money
5 directly. It provides a guarantee and you have
6 to find a third party lending institution, you
7 know, that would -- that would actually lend
8 the money. But with the -- with the federal
9 government's guarantee on -- on the debt. And
10 so we had to look at the regulatory scheme and
11 try to understand what was required of -- of an
12 applicant, you know, to obtain that type of HUD
13 guarantee.

14 Q: Did you feel that you had the education and
15 background with your degrees from Duke and your
16 previous work at Amherst to -- to review
17 regulations and determine how that financing
18 would work?

19 A: Sure. I mean, I -- and I will -- I will freely
20 admit I'm not an expert in the process of
21 taking an application step-by-step through the
22 -- you know, the ultimate, you know, delivery
23 of -- of the guarantee and up to the -- to the
24 bank. And certainly, I'm aware of the
25 requirements of the applicant, you know, in

1 this case, you know, my hospital clients, what
2 the requirements were on their end and in terms
3 of what they had to try to demonstrate. And,
4 certainly, I do feasibility -- I've done
5 feasibility studies for 40 years. So -- and,
6 you know, and I -- and I reviewed the
7 regulations again more recently, you know, as
8 they relate to HUD financing and just to try to
9 refresh my recollection in terms of what was
10 required.

11 Q: Is the hospital program still the 242 program?

12 A: I believe it is, yes.

13 Q: Okay. Let's -- why don't you tell the Court a
14 little bit about your CON work that you've been
15 doing with Sullivan Consulting.

16 A: Well, I mean, I've -- as I said earlier, I mean
17 I've worked on all kinds of CON applications.
18 I've probably prepared applications in 17 or 18
19 different states. A number of those have been
20 in South Carolina. They've involved things
21 like new hospitals, new nursing homes, new
22 technology like radiation therapy, MRI, home
23 health agencies, hospice agencies. You know,
24 the whole gamut of things that go on. And --
25 and you know, my involvement, you know, in some

1 cases it involves preparing the application
2 from A to Z. In some cases it may be preparing
3 a portion of the application, the financials or
4 the need analysis in the application. And
5 then, from time to time, I get asked to
6 participate in proceedings like this where I'm
7 -- I'm not actually preparing an application,
8 but I'm reviewing an application filed by
9 another party and offering opinions on that
10 application.

11 Q: Tell the Court a little bit about your -- your
12 CON work for new hospitals, Greenfield
13 hospitals.

14 A: I mean, over the years, I've probably been
15 involved in 35 or 40 new hospital CON
16 applications across the country. Specifically,
17 in South Carolina, I can think of three
18 projects. One, going back to the early days of
19 my consulting, was in Greenville, South
20 Carolina. I believe it was -- I remember it
21 was right around the time of the 1987 stock
22 market crash. So, it was a women's hospital --
23 women's hospital in -- in Greenville County.
24 St. Francis Hospital wanted to move beds from
25 one side of town to the other to create a

1 women's hospital. I was also involved in a
2 project where Georgetown Memorial Hospital was
3 seeking to establish a hospital up in the
4 Waccamaw neck area of Georgetown County, and it
5 was called Waccamaw Community Hospital. And
6 both of those two projects were approved. I
7 worked with University Hospital out of Augusta,
8 Georgia, who wanted to develop a new 50-bed
9 hospital in -- in Aiken County. That project
10 was denied. And then one that I -- I thought
11 about last night, I wasn't involved in the
12 preparation of the application, but I testified
13 in the proceeding. One of the longest cases in
14 South Carolina history and that was the York
15 County case where there was a -- a three party
16 fight over a new hospital in York County. And
17 I testified on behalf of Piedmont Hospital in
18 -- or Piedmont Medical Center in York County in
19 support of its application for a new hospital.

20 Q: We're all familiar with that case, so.

21 A: Yes.

22 Q: Tell the Court about your work with academic
23 medical centers to include CON work.

24 A: Yeah. I've -- I've worked from time to time
25 with academic medical centers over my career.

1 I mean, some -- some of our work early on was
2 in terms of financial planning and I was -- you
3 know, for example, we did work with Vanderbilt
4 University Medical Center and some financial
5 modeling work. Charleston Area Medical Center,
6 we've done a lot of financial work with them
7 over the years, debt capacity analysis,
8 evaluations of different product lines that
9 they were considering going into. Also,
10 preparing CON applications, a number of CON
11 applications for Charleston Area Medical
12 Center. West Virginia University Medical
13 Center, I've worked with them quite extensively
14 over the last 15 or 20 years, and done a number
15 of CON applications for them. Worked with
16 University of Alabama in Birmingham, primarily
17 in CON preparation for them. Shands Medical
18 Center, which is University of Florida teaching
19 hospital in Gainesville, Florida, I've done a
20 number of projects for them. Tampa General
21 Hospital in Tampa, Florida, I've done a number
22 of projects for that particular facility. I've
23 actually gone back and done a little bit of
24 work for my old -- original job and -- at Duke
25 University Medical Center, I've done a couple

1 of little projects for them. There's probably
2 others, but I mean, I've worked with academic
3 medical -- University of Tennessee Medical
4 Center in Knoxville, I've worked with them, so.

5 Q: Okay. Have you ever been qualified as an
6 expert in a court of law before, Mr. Sullivan?

7 A: I have.

8 Q: In what areas?

9 A: Typically, in health planning and healthcare
10 finance in South Carolina and then some other
11 states, too, I've been qualified also as an
12 expert in the Certificate of Need program for
13 that particular state.

14 Q: If you had to estimate, how many times have
15 been qualified as an expert by a court of law?

16 A: Something north of 150. I -- I don't know the
17 exact number.

18 Q: Okay. And how about in South Carolina?

19 A: I would think that would be in the range of 30-
20 plus times. I think so.

21 Q: And -- and how about by the judge that's
22 sitting before you today?

23 A: I remember one case.

24 Q: Okay. Was that the CRCC Gwinnett case?

25 A: It was.

1 Q: Okay. Overall, Mr. Sullivan, how many years of
2 experience do you have in healthcare planning
3 and finance?

4 A: If you count my time at Duke, going on 46
5 years.

6 Q: Okay. If you had to ballpark it, how many CON
7 applications have you developed or opposed in
8 the tri-county area and the tri-county area is
9 Berkeley, Dorchester, and Charleston?

10 A: I mean, over the years, again, probably more
11 than 30.

12 Q: Okay. And what facilities would those various
13 applications have involved?

14 A: Well, I've worked with just about everybody.
15 I've worked with Medical University; I've
16 worked with Roper Hospital; I've worked with
17 East Cooper Medical Center; I worked with
18 Trident and Summerville Medical Centers. And
19 I haven't worked with St. Francis when they
20 were an independent hospital, but other than
21 that, I think I've worked with all the other
22 hospitals.

23 Q: Okay. Do you have knowledge about the
24 particular market that's involved in this case?

25 A: I believe I do. I mean, I -- as I said, I've

1 worked there extensively over the last 40
2 years. I grew up in Charleston. I still have
3 -- we're there part-time now. Pretty familiar
4 with the healthcare providers, distribution of
5 healthcare providers. You know, I've done an
6 extensive analysis of data in terms of market
7 share and utilization patterns and so forth.
8 I -- I feel like I have a pretty good
9 familiarity with the market.

10 Q: Okay. And what kind of opinions have you given
11 as an exp- -- a qualified expert in a general
12 sense in this court in the past?

13 A: I mean, generally, it's been those same areas
14 I mentioned earlier, healthcare planning,
15 healthcare finance and the South Carolina CON
16 program.

17 Q: Okay. Have you given opinions regarding the
18 standards in the State Health Plan?

19 A: I have. Maybe -- typically, in my testimony,
20 I would start with the purposes of the South
21 Carolina CON Act and talk about how a project
22 may or may not fit within the context of that.
23 I would also look at the State Health Plan,
24 generally, but also specifically to the
25 specific standards that govern a particular

1 type of project. Then I would also look at the
2 project review criteria that are adopted by the
3 Department of Health and Environmental Control
4 and -- and particularly focusing on things like
5 consistency with the State Health Plan,
6 community need for the project, financial
7 feasibility, ability of the applicant to
8 complete project, adverse affect on existing
9 facilities, unnecessary duplication, those --
10 those concepts kind of run throughout most of
11 my testimony.

12 Q: Okay. Explain to the Court without venturing
13 into any opinions at this time, but what --
14 what you did in this case generally to develop
15 your opinions or what -- in other words, what
16 would they be based on?

17 A: Well, I mean -- I mean, part of it is based on
18 my experience and training, you know, and
19 working in South Carolina for four decades.
20 But I reviewed the DHEC record in this case.
21 I reviewed the State Health Plan, the relevant
22 State Health Plan, and I believe that's the
23 2017-2018 and the -- and the standards in that
24 Plan that relate to the development of new
25 hospitals. I've reviewed the project review

1 criteria. I've also reviewed the entire DHEC
2 record in this proceeding. I've reviewed
3 discovery materials, particularly those
4 produced by the Medical University and by
5 Trident, Summerville and Colleton, and, to a
6 more limited extent, to some of the Roper St.
7 Francis documents. I've done extensive data
8 analysis. I've looked at joint annual reports
9 of hospitals. I've looked at the Revenue of
10 Fiscal Affairs Office detailed utilization data
11 as it relates to patient origin for individual
12 facilities, market shares of individual
13 facilities, trends in utilization of -- of
14 individual providers. And -- so I mean, I've
15 -- I've done a fair amount of review and
16 analysis in preparation for this proceeding.

17 Q: Tell the Court a little bit about your
18 familiarity with the State Health Plan and --
19 and how you work with it.

20 A: Well, I mean, the State Health Plan is, you
21 know, I think it's been testified to previously
22 that the one thing you have to do if you file
23 a CON is you have to be consistent with the
24 State Health Plan in South Carolina and, you
25 know, that's a mandatory requirement. And so

1 the State Health Plan is always the starting
2 point of any analysis I do. I -- I -- you
3 know, I've -- I've reviewed the state -- you
4 know, the draft State Health Plans come out
5 periodically. I review those. Certainly, from
6 time to time, I've made comments on -- on
7 drafts and suggested changes to the State
8 Health Plan. I was involved, I think -- I
9 believe it was in 2012 there was a task force
10 created by South Carolina to evaluate the --
11 sort of retooling the South Carolina CON
12 process to streamline certain aspects of it.
13 I think some folks, including me, agreed that
14 certain parts of it perhaps are cumbersome and
15 the certain services that should -- should not
16 be regulated or should be regulated in a
17 different way. I served on that task force.
18 So, I'm -- I'm very familiar with the State
19 Health Plan. I -- it's a basic tool that I use
20 anytime that I'm preparing an application or if
21 I'm opposing an application.

22 Q: Okay. How about the Certificate of Need
23 regulations, the project review criteria in 61-
24 15, do you have occasion to reference that in
25 your work?

1 **A:** **I do. You know, the -- that starts with the**
2 **State Health Plan because in most chapters of**
3 **the State Health Plan there's priority project**
4 **review criteria that are listed at the end of**
5 **the chapter. And -- and so, that would be the**
6 **starting point for my review of the criteria.**
7 **And then when an application is deemed**
8 **complete, the Department lists in the complete**
9 **-- in the deemed complete letter those criteria**
10 **that it views as most important in the review**
11 **of the application. So, I would certainly look**
12 **at those, but -- but generally, I would look**
13 **at, you know, the breadth of all of the CON**
14 **criteria in evaluating a project, just to see**
15 **whether or not a project, you know, was**
16 **consistent or inconsistent with -- with most of**
17 **the major considerations. They're not all**
18 **applicable to all projects.**

19 OFFER AS EXPERT:

20 MR. THOMAS: Your Honor, at this time, I'd offer Mr.
21 Sullivan as an expert in the areas of
22 healthcare planning and finance in the South
23 Carolina CON program.

24 MS. SHOUN: Sorry, Your Honor. No objection. Thank
25 you.

1 MR. WICEVIC: No objection.

2 MS. CRUM: Thank you, Your Honor.

3 THE COURT: Save you for last.

4 MS. CRUM: Thank you. But I hope not least.

5 THE COURT: No.

6 MR. SULLIVAN - VOIR DIRE EXAMINATION BY MS. CRUM:

7 Q: Mr. Sullivan, let me ask you just a few
8 questions here.

9 A: Sure.

10 Q: I think you said you did some work for Duke
11 Medical Center ---

12 A: I did.

13 Q: --- in 1980.

14 A: I did some work for them subsequent to that and
15 it's ---

16 Q: Let me go back. You first testified for
17 working for them in 1980, didn't you?

18 A: Yeah. From '74 to '80, I did at that time.

19 Q: And so -- not to date either one of us, but
20 that was almost 40 years ago. It will be next
21 year, right?

22 A: It will.

23 Q: Okay. When is the last time you worked with a
24 academic medical center to develop a Greenfield
25 hospital?

1 **A:** Let me think about that for a second. I'm not
2 sure that I have worked with an academic
3 medical center for a Greenfield hospital.

4 **Q:** Now, let's talk about HUD just a minute. With
5 HUD, tell me how the regu- -- first, you said,
6 you recently reviewed the HUD regulations?

7 **A:** Well, I think I have some in my exhibits. Some
8 ---

9 **Q:** And you did that -- you did that when?

10 **A:** Over the last two to three months.

11 **Q:** Okay. And you've never worked with HUD
12 regulations -- excuse me. You have not worked
13 with the current HUD regulations before, have
14 you?

15 **A:** Not for a client, no.

16 **Q:** Okay. Well, then, if you haven't worked for
17 them with a client, well then how have you
18 worked for them?

19 **A:** I mean, other than, you know, reviewing them in
20 preparation for this case, I have not worked
21 with them since the -- that earlier time in the
22 2002-2004 time frame.

23 **Q:** And so what you're going to give us is your
24 opinion of the -- or your interpretation of the
25 HUD regulations, correct?

1 A: Only in a very limited sense.

2 Q: Tell me what that limited sense is?

3 A: About whether or not this particular project
4 that the Medical University has proposed -- you
5 know, what -- what test does it have to meet,
6 sort of preliminary tests that it has to meet
7 before it can proceed with HUD financing.

8 Q: And that is based on your interpretation of the
9 HUD regulations, correct?

10 A: It is.

11 Q: Now, you worked on HUD with Representative
12 Pepper in 1990, right?

13 A: That's about the right time frame.

14 Q: Do you know how the HUD regulations have
15 changed -- well, first off, do you know how the
16 HUD statute has changed since 1990 to, say,
17 2019?

18 A: I -- I don't have a specific knowledge of that.

19 Q: All right, sir. Do you know how the HUD
20 regulations have changed since 1990 and 2019?

21 A: I don't.

22 Q: Okay. I think you also said you worked -- and
23 by the way, that project never went to
24 fruition, did it?

25 A: It did not. We prepared a feasibility study

1 and it -- I don't recall the reason, but for
2 some political reason, the project didn't go
3 forward.

4 Q: Do you know whether or not HUD accepts a CON
5 issued for purposes of need?

6 A: I know that ---

7 Q: The regulations do?

8 A: I know one of the requirements that I looked at
9 was that if there's a approval process in a
10 state that determines the need for the project,
11 then the applicant is required to have received
12 approval through that state process.

13 Q: Just like here?

14 A: Sure.

15 Q: And that's, again, based on your interpretation
16 of the HUD regs.

17 A: Well, I'm just -- I'm just reading what it
18 says.

19 Q: All right.

20 A: Yes, ma'am.

21 Q: Good. In 2004, '05, you worked in West
22 Virginia?

23 A: right.

24 Q: And that project didn't go through either, did
25 it?

1 **A:** It did not.

2 **Q:** Do you know how the HUD regulations or the HUD
3 statute may have changed since 2004-05?

4 **A:** I don't.

5 **Q:** Do you know how the regulations may have
6 changed since 2004-05?

7 **A:** I don't.

8 **Q:** Okay. Have you ever actually opposed a commun-
9 -- a hospital -- a Greenfield Hospital built by
10 an academic medical center before?

11 **A:** Let me think about that.

12 **Q:** I mean, other than this one.

13 **A:** Sure. I have in Jacksonville, Florida. Shands
14 Jacksonville Medical Center is a academic
15 medical center and they proposed a hospital in
16 North Jacksonville and I -- I mean, they
17 proposed and I opposed it.

18 **Q:** When was that?

19 **A:** About three or four years ago.

20 **Q:** Okay. And who were you working for?

21 **A:** Memorial Hospital in Jacksonville.

22 **Q:** So, it is a not-for-profit, a for-profit?

23 **A:** It's a for-profit; it's an HCA facility.

24 **Q:** You've never opposed a new hospital in South
25 Carolina before, have you?

1 **A:** Well, I'm in the process of opposing one right
2 now and ---

3 **Q:** I said ---

4 **A:** And ---

5 **Q:** I'm sorry. I used the word before.

6 **A:** No. I mean, in -- in Beaufort County there's
7 a proposal by Beaufort Memorial and Medical
8 University to develop a quote, micro-hospital
9 in Beaufort County and I'm -- I'm in the
10 process of opposing that.

11 **Q:** You talked about a number of projects that you
12 had done for academic medical centers and y'all
13 talked about you had done some work for MUSC or
14 for the -- for the Medical University, you
15 said.

16 **A:** I have.

17 **Q:** Was that for the Medical University of South
18 Carolina or for Medical University Hospital
19 Authority?

20 **A:** It was for Medical University of South
21 Carolina. It was prior to the formation of
22 MUHA.

23 **Q:** I see. And what was that for?

24 **A:** As I recall, it was primarily related to their
25 efforts to obtain external tax exempt bond

1 financing and we prepared feasibility studies
2 for them. And I believe this was in the late
3 '80s or early '90s. And -- and I think that we
4 assisted them on one CON application back in
5 that same time period, so.

6 Q: Mr. Sullivan, you talked about the State Health
7 Plan standards. In your -- you've defined the
8 service area in this CON case, haven't you?

9 A: I have.

10 Q: And that service area is based on a time drive,
11 is it not?

12 A: Yeah. I mean, it's not the service area that
13 I would have developed independently, but it
14 was an attempt to reshape the service area that
15 the Medical University had put forth in its
16 application, so.

17 Q: But it's based on drive time, is it not?

18 A: It is.

19 Q: Okay.

20 MS. CRUM: Your Honor ---

21 A: Could -- could I add -- could I add one thing
22 that ---

23 Q: Sure.

24 A: I -- I failed to mention, in terms of opposing
25 a new hospital project, I believe you and I

1 opposed St. Francis' effort to build a new
2 hospital on James Island.

3 Q: Are you talking about back in -- when the
4 Supreme Court issued that opinion in 1987?

5 A: Yes.

6 Q: Okay. I'd forgotten about that. Thank you for
7 reminding me. Is that the current Bon Secours?

8 A: No. It -- it was -- it was an independent
9 hospital at that time. It ---

10 Q: Okay.

11 A: --- merged with Roper after that.

12 Q: Okay. All right.

13 OBJECTION:

14 MS. CRUM: Now, Your Honor, I'm going to object to
15 Mr. Sullivan's expert opinions under Rule 702
16 with regard to any testimony about HUD. It's
17 clearly based on his interpretation of the law.
18 Under 702, experts not only have to be
19 qualified, but each opinion has to be based on
20 a reliable basis and express legal opinion. He
21 doesn't have a reliable basis for any HUD
22 testimony. He worked on projects back in the
23 1990; it never was completed. He worked on a
24 project in 2004-05; it wasn't completed. He
25 can't even tell you the differences between the

1 HUD statute and the HUD regulations from '90,
2 2004-05, until today. And his sole basis for
3 his opinions are based on his reading of the
4 law. And, Your Honor, that is your province,
5 not the province of Mr. Sullivan. In addition
6 to that, Your Honor, the State Health Plan
7 Standard 5 requires that the applicant in this
8 case choose the location based on patient
9 origin data. No where does it say an
10 artificial drive time. He has -- he is
11 attempting to use an artificial time -- drive
12 time and not base it on historical data. Your
13 Honor, I think that to the extent that he is
14 going to testify that there is not a community
15 need, and he said he was, this is not --
16 whether or not the MUSC institutional need is
17 a public need is not for Mr. Sullivan to opine
18 upon. That is for the Court's interpretation
19 of public need. It's not a definition in the
20 CON Act. So, Your Honor, I -- I would object
21 to his being qualified as an expert in those
22 areas.

23 MR. THOMAS: Okay. Where do I begin? I don't know
24 what the CON laws were like in 1980, Your
25 Honor, but I think I have a pretty good -- I

1 think I have pretty good knowledge about them
2 now. I don't think what the laws were in 1990
3 and what the laws are today regarding HUD or
4 the regulations take away from his -- his
5 ability to review those regulations and to
6 offer an opinion on them. He has 45 years of
7 health planning and finance experience. He has
8 worked with the HUD regulations before. And if
9 they have changed, you know, then he can -- he
10 can -- I think he can pivot with that. I think
11 all of that goes to the weight of his testimony
12 and not whether or not he can give an opinion
13 on it, Your Honor. With respect to the -- the
14 reliable basis for HUD testimony, again, he's
15 going -- he's testified that he's already
16 reviewed the regulations. There are -- you
17 wrote -- you're writing a book on statutory
18 interpretation. You know, he has to be able to
19 look at that and perhaps give an ultimate
20 opinion as to whether or not there's adequate
21 need in the service area. That's part of the
22 HUD regulation. So, I think as a health
23 planner, he can certainly state ---

24 THE COURT: And that's a factual application.

25 MR. THOMAS: Right. There's a factual application.

1 Not only that, with the adequate need, Ms. Crum
2 brought it up. She brought up the whole idea
3 that a CON application is -- perhaps would be
4 a basis for whether or not the agency, the
5 federal agency, believes there's an adequate
6 need. Well, that's one of the things we're
7 here today talking about, whether or not that
8 CON application is indeed valid. So, again, I
9 think he can certainly give testimony regarding
10 the app- -- the factual applications of what
11 HUD requires to this Court. And that's what
12 we're asking him to do. And -- because the
13 beauty of this whole thing, but it's maybe not
14 been said, is that their quote, unquote expert
15 in HUD financing can't even given an opinion to
16 this Court as to whether or not that's
17 guaranteed. That's in the CON application. He
18 said in the CON application that HUD financing
19 is not guaranteed. So, again, that goes to the
20 weight. As to this -- this thing about
21 Standard 5 and Mr. Sullivan, he's going to give
22 a dissertation and, in fact, already has in his
23 deposition about why MUSC does not meet
24 Standard 5, Your Honor, because, as Ms. Crum
25 said, it goes to proximity or -- excuse me, it

1 goes to the ability to show a community need
2 and where your patients are going to come from,
3 and adverse impact. Well, that's exactly what
4 he's going to testify about. He -- MUSC, and
5 you've heard a lot about this from Mr.
6 Richardson, but MUSC or MUHA has premised their
7 entire utilization model on redirection of
8 existing patients. Redirection of patients from
9 Seabrook Island, from Mount Pleasant, from the
10 very tip of the peninsula on -- where East Bay
11 meets South Battery. The -- those are the type
12 of things he's going to actually testify about.
13 That's the Standard 5. That's a standard in
14 the CON application that he's -- that he's very
15 -- excuse me, in the State Health Plan that
16 he's very familiar with. So, I think trying to
17 say that he's not an expert in Standard 5 and
18 can't give an opinion on whether or not there's
19 a need is completely inappropriate, Your Honor.
20 So, I would ask that her -- that Ms. Crum's
21 arguments be denied.

22 MS. CRUM: Your Honor, first off, that's not
23 exactly what I said about Standard 5 and what
24 I asked. Under Rule 702, in addition to be --
25 having specialized knowledge, a witness

1 qualifies and is an expert by knowledge, skill,
2 experience, training or education. The HUD
3 experience that Mr. Sullivan testified to was
4 in the initial planning of -- of two HUD
5 projects that did not go through and he can't
6 tell the difference between what happened then,
7 so that's no experience. And his review of the
8 law today -- of the regulations, so and -- you
9 know, as to whether or not there's a guarantee,
10 Your Honor, that's a legal question and we'll
11 get to that.

12 THE COURT: I can cut ---

13 MS. CRUM: And I'm not going to ---

14 THE COURT: I can cut to the chase with some of
15 this.

16 MS. CRUM: Yes, sir.

17 THE COURT: Is ---

18 MS. CRUM: Can ---

19 THE COURT: Hear me out and then, you can respond --

20 -

21 MS. CRUM: Yes, sir.

22 THE COURT: --- to it. Is I find that he's an
23 expert in healthcare planning and hospital
24 finance, generally. Regarding the HUD issue,
25 that goes much to the weight and his

1 experience. Now, you -- and it depends on what
2 he's going to testify to. And I'd think I'd
3 like to hear that as we move along, because if
4 he's going to -- he certainly has experience in
5 the past. He is experienced in healthcare
6 planning and finance of which he's utilized or
7 has had some experience in HUD. And I think I
8 -- I'm going to wait on the rest of his HUD
9 testimony to see how it develops, then I'll
10 allow you to respond.

11 MS. CRUM: Yes, sir. And just make I make a
12 continuing objection.

13 THE COURT: Well, you don't have to make a
14 continuing objection because you can object at
15 the appropriate time ---

16 MS. CRUM: All right.

17 THE COURT: --- regarding the HUD testimony.

18 MS. CRUM: And -- and just for a clean record ---

19 THE COURT: Because I really haven't resolved that
20 all the way.

21 MS. CRUM: All right, sir. And just for a clean
22 record, I want to make sure that it's clear
23 that my objection regarding Standard 5 has to
24 do with the patient or the use of patient
25 origin data versus an arbitrary drive time.

1 THE COURT: Well, that's ---

2 MS. CRUM: Yes, sir. I just want to make sure ---

3 THE COURT: --- that's the weight ---

4 MS. CRUM: Yes, sir. I just want to make sure the
5 record's clear ---

6 THE COURT: Yeah.

7 MS. CRUM: --- as to what my 702 objection is.

8 THE COURT: Yeah. Okay. Proceed.

9 MR. THOMAS: Thanks, Your Honor.

10 Q: Okay. Mr. Sullivan, you may have already
11 stated this, but just so we have clarity for
12 the record, what is the applicable health plan
13 for this particular project as you testified?

14 A: It is the 2017-2018 South Carolina Health Plan

15 Q: Okay. And -- and what's your understanding of
16 what standard or standards apply?

17 A: Well, the primary standard that applies is
18 Standard 5 in the 2017 Plan, so.

19 Q: Okay. And -- and what's your understanding of
20 Standard 5?

21 A: That -- that an applicant can relocate beds or
22 relocate bed need, as Medical University is
23 proposing to do in this case, if it meets
24 certain conditions. And -- and one of those
25 would be that if it demonstrated that based on

1 patient origin data and other considerations,
2 that there would -- there is a need for the
3 proposed facility at that specific site that
4 they have chosen.

5 Q: Okay. Did you do an analysis of patient origin
6 for MUSC?

7 A: I did. In fact, the entirety of this project
8 really relates to this patient origin analysis
9 that the Medical University and its expert did
10 and -- and what I did is simply said that the
11 service area that was defined in the
12 application was -- was much too broad. And so,
13 I said, let's -- using the same patient origin
14 data, I said, let's -- let's reduce the size of
15 the service area to something ---

16 Q: Whoa. Whoa. Wait. One second. So, you were
17 talking about reducing the size.

18 A: I just reduced it down to what I felt was a
19 more realistic and its -- its -- I used a -- a
20 travel time standard as a way of -- of reducing
21 it, but it's still based on patient origin
22 data. And, in fact, the applicant itself used
23 patient origin data to determine where -- where
24 and what number of patients have -- I mean, I
25 used drive times to determine what proportion

1 of patients it was gonna draw from various
2 areas that it said it was going to serve.

3 Q: Okay. So, you used a different drive time
4 study?

5 A: I did.

6 Q: Okay. You heard the testimony of -- the expert
7 testimony of Mr. Brett -- Brett Johnson. Do
8 you agree with his analysis and conclusions
9 regarding MUHA's proformance?

10 A: I do. I -- I thought he -- he was right on
11 target in his findings regarding the
12 proformance.

13 Q: Would you -- do you adopt them?

14 A: I did.

15 Q: Okay. You heard Mr. Richardson's direct
16 examination. Generally -- generally, in
17 agreement with his testimony?

18 A: I am. You know, we -- I think we -- we covered
19 some of the same ground in terms of discussion
20 about lengths of stay and so forth and some of
21 the problems with the lengths of stay assumed
22 by the Medical University. And I -- you know,
23 I generally agree that there's not a need
24 demonstrated for a -- for a new hospital. So,
25 I would adopt that testimony.

1 **Q: Okay.**

2 MR. THOMAS: Let's go DHEC Exhibit 4, please. The

3 2017-2018 Health Plan.

4 (DHEC Exhibit Number 4 was referenced at this time.)

5 **Q: Mr. Sullivan, let me if you -- if you're able**

6 **to read it on the screen and certainly,**

7 **portions can be blown up, but what I'm**

8 **interested in here is the -- there we go. Is**

9 **the service area for ---**

10 MR. THOMAS: --- and can we get the total from that

11 added as well, so the -- for the service area,

12 you'll need to go down a little bit. There you

13 go.

14 **Q: All right. Mr. Sullivan ---**

15 THE COURT: What page number are you on?

16 MR. THOMAS: We are on page, for the record, Your

17 Honor -- sorry.

18 MS. CRUM: It's 27.

19 MR. THOMAS: 27.

20 MR. THOMAS: Thank you, Ms. Crum.

21 THE COURT: Go ahead.

22 **Q: All right. Mr. Sullivan, did -- did you review**

23 **the South Carolina Health Plan that's to this**

24 **project?**

25 **A: I did.**

1 Q: Okay. So, now, what is the -- what is the
2 total bed need for Berkeley, Charleston and
3 Dorchester County at the time?

4 A: The total bed need was for 1,798 beds.

5 Q: Okay.

6 A: Then the existing supply was 1,811, so there
7 was an excess in the three -- you know, the
8 three -- you know, Charleston -- the Charleston
9 area is a little bit unique in the state in
10 that it's a multi-county plan- -- or was a
11 multi-county planning area. But when you sum
12 all the individual hospital bed need numbers,
13 you come up with an excess of 13 beds in the --
14 in the tri-county area.

15 Q: Okay. And -- and what was MUSC's bed need at
16 the time?

17 A: It was 147.

18 Q: Okay. And you talked a little bit about the
19 applicable planning area for MUHA being the
20 tri-county service area, and you mentioned it
21 was somewhat unique. What -- what makes it
22 unique?

23 A: Well, in -- in many other parts of the state,
24 the individual counties are -- are the planning
25 areas. It's not the only one that's a multi-

1 county, but this is -- generally, it's a county
2 specific analysis in the State Health Plan.
3 And I think it's -- it's been traditionally
4 done as a tri-county planning area because of
5 the fact that the county boundaries aren't
6 really significant in the way the patients flow
7 for healthcare services. For many years, all
8 of the hospitals, with the exception of two
9 relatively rural hospitals in Dorchester and
10 Berkeley counties, were in downtown Charleston.
11 And so patients tended to travel to downtown
12 Charleston for healthcare. When Trident -- you
13 heard the whole history and I won't go through
14 it again, but when Trident was constructed,
15 that was -- to close down those two rural
16 hospitals and to bring services closer to the
17 Dorchester Berkeley population and also to
18 portions of North Charleston where there was no
19 immediate hospital availability. So, again,
20 the concept has always been a regional concept
21 rather than a county specific concept in
22 planning for the need for -- for beds in -- in
23 this particular community.

24 Q: Okay.

25 MR. THOMAS: And if we could pull up DHEC 5, the

1 2018-2019 Health Plan and page -- again, I
2 believe that's 27.
3 (DHEC Exhibit Number 5 was referenced at this time.)

4 **Q:** All right. Now, it's -- what's different in
5 terms of the service area in this Health Plan,
6 if anything?

7 **A:** Yeah. In -- in the next year's State Health
8 Plan, the Department broke apart the three-
9 county planning area and have identified -- is
10 now going to calculate bed need on a county-
11 specific basis. And that's what this Health
12 Plan shows.

13 **Q:** And how does the Department calculate bed need
14 on a county-specific basis?

15 **A:** Well, the current methodology is driven by the
16 utilization of individual hospitals in the
17 county. So, in this case, if we look at
18 Berkeley County, for example, it has zero bed
19 need because there was no hospital open in
20 Berkeley County at the time the Plan was
21 adopted. Charleston County, obviously, has
22 lots of hospital beds and Summerville is the
23 only hospital in Dorchester County.

24 **Q:** Okay. So, what's the bed need -- what's the to
25 be added or excess bed need for -- or beds for

1 **Berkeley County?**

2 **A:** Zero.

3 **Q:** Okay. And how about Charleston County?

4 **A:** Charleston County shows a need of 20.

5 **Q:** All right. And then Dorchester County?

6 **A:** A need of two.

7 **Q:** Okay. Does the State Health Plan determine bed
8 need based on any type of ratio analysis of
9 beds to population by county?

10 **A:** They do not.

11 **Q:** Okay.

12 **A:** That -- that approach was used very early on in
13 the CON -- evolution of the CON program, but
14 virtually every state that I work in now is a
15 band -- bed to population approach to -- to bed
16 need planning because it -- it's fraught with
17 difficulties.

18 **Q:** Okay. Bed -- the way that hospitals have
19 developed in the tri-county area over the
20 years, would it be prudent to apply such a --
21 a methodology to the tri-county service area?

22 **A:** It -- it would not. You know, the county
23 boundaries, as I said, are not particularly
24 meaningful as it relates to the -- the patient
25 flow for -- for healthcare services when you

1 consider the fact that -- that Trident's
2 located about a mile or so from the Berkeley
3 County line. Simply putting a wall up at
4 Berkeley County and saying, we're going to
5 ignore the Trident beds, makes no sense.
6 Similarly, the recognition that a portion of
7 those patients are going to travel to tertiary
8 and quaternary care facilities outside of the
9 counties, for example Berkeley County, you
10 wouldn't want to have a uniform bed to
11 population ratio because not all of the
12 services of those residents need -- are gonna
13 be provided in that county. The Medical
14 University sits in a unique place in the
15 healthcare system in the Charleston area and in
16 South Carolina in providing highly specialized
17 services. And so some patients are going to
18 leave the county to go to larger centers and,
19 to a lesser extent, to Trident, which is a
20 tertiary facility. And that's appropriate.
21 You know, certain services need to be
22 regionalized on a multi-county basis. And so
23 assuming that there's a one size fits all ratio
24 that can be applied to every county just, you
25 know, sort of defies the -- you know, the

1 actual way that healthcare is delivered in
2 South Carolina.

3 Q: By -- by simply having a bed need in the State
4 Health Plan, does that give a hospital the
5 ability to place a hospital anywhere it wants
6 in a given service area?

7 A: No. I mean, certainly, they have the ability
8 to -- to seek approval in any portion they
9 want, but they're -- they're bound -- you know,
10 in my view from a health planning perspective,
11 they're bound by -- by Standard 5, which says
12 that they have to demonstrate that there's
13 actually a need at that specific site for --
14 for the hospital. So, they are limited by the
15 fact that they have to put the beds in a place
16 where there would be a demonstrated need for
17 those beds.

18 Q: Okay. When was this CON application submitted,
19 Mr. Sullivan?

20 A: This CON application was submitted December
21 2017.

22 Q: Okay. Did you do a thorough review of the
23 application?

24 A: I believe I did, yes.

25 Q: Okay. Can you describe just generally what the

1 project entails?

2 A: Sure. I mean, it's -- it's a new hospital, 128
3 acute care beds, includes a range of outpatient
4 services, ancillary services, it'll have an
5 emergency department, and it'll be located on
6 a -- on a site on Nexton Parkway or the Nexton
7 Boulevard; I -- I forget which, which is about
8 three and a half miles off of I-26 in Berkeley
9 County in what I would consider to be sort of
10 southeastern Berkeley County, and so.

11 Q: Okay. Did you -- did you state the project
12 cost? If you did, I missed it.

13 A: I'm sorry. I didn't. \$325 million.

14 Q: Okay. What's the focus of the hospital in
15 terms of acuity level?

16 A: The applicant talked about the fact that it
17 would be serving what they term non-tertiary
18 patients. And it would be patients age 16 and
19 over. And then they would also have an
20 obstetrics program that would serve mother's
21 requiring OB care. It would not have a high --
22 an advanced neonatal care. It would have a
23 Level I neonatal service, which is basic well
24 baby care.

25 Q: Okay. We've heard a little bit about academic

1 medical centers. Are you aware of any specific
2 standards in the State Health Plan, the CON
3 regulations, relative to academic medical
4 center?

5 A: I am not.

6 Q: Okay. Well, based on your -- your review of
7 MUSC's patient origin data, what's your
8 understanding of where the -- the patients for
9 the MUHA Nexton site are coming from on a kind
10 of county-wide basis, per county basis?

11 A: Well, the majority of the patients that the
12 hospital proposes to serve will be Charleston
13 County residents. And those will come from
14 throughout Charleston County including North
15 Charleston, the peninsula of Charleston, what
16 they call the Sea Islands, which would be James
17 Island, Johns Island, Seabrook, Kiawah.

18 Q: Don't forget Folly.

19 A: Folly, yeah. It's a -- I guess that is a
20 separate town on James Island. And then -- and
21 then the West Ashley area, which is, you know,
22 Charleston and everything is defined by east or
23 west depending on which river you have to
24 cross, but if you cross the Ashley River to the
25 west, that area over there, which is one of the

1 first suburban areas to grow out of Charleston.
2 And then they also will get -- will get about
3 a -- about 20 -- between 20 and 25 percent of
4 their patients from Dorchester County. And
5 then the -- Berkeley County population,
6 depending on what set of statistics you look --
7 look at, is somewhere between 16 and 22 percent
8 of the overall patients that the hospital will
9 serve. So, this hospital is really not a
10 Berkeley County hospital because the majority
11 of the patients are going to come from either
12 Dorchester or Charleston County.

13 Q: Okay. Now, according to the CON application,
14 is MUHA relying on new patients or new market
15 shared for utilization of the facility?

16 A: They are not. The -- the basic premise of the
17 application is that all of the patients that
18 will go to the new hospital, that will, just
19 for context, will be located 28 miles away from
20 the main campus on the downtown Charleston
21 peninsula. All of the patients will be
22 redirected from the downtown facility to the
23 proposed Nexton Hospital.

24 Q: Okay.

25 MR. THOMAS: Can we pull up DHEC 1 -- Exhibit 1,

1 page 1000, please?

2 (DHEC Exhibit Number 1 was referenced at this time.)

3 Q: Are you familiar with this document, Mr.

4 Sullivan?

5 A: I am.

6 Q: Okay. Is this the deemed complete letter?

7 A: It is.

8 Q: Okay.

9 MR. THOMAS: Can we got to the next page, please?

10 Q: All right. I believe it was dated maybe May --

11 May 21st, 2018. Do you recall when you

12 received the letter?

13 A: Well, I was -- I was asking repeatedly if it

14 had been issued yet and the first time I

15 received it, I believe, was on July 10th, 2018.

16 Q: Okay. And in terms of -- what are the project

17 review criterias that are set forth as the most

18 important?

19 A: A is compliance with the South Carolina Health

20 Plan. B, community need documentation. Three,

21 distribution accessibility, and C -- C -- I

22 said C is distribution of accessibility. D is

23 ability to complete the project.

24 Q: Okay. And did you have any impressions of --

25 of the letter at the time when you read it with

1 respect to project review criteria?

2 A: Well, I did. I -- I noted that it omitted two
3 of the priority criteria that were listed at
4 the end of the chapter on acute care hospitals,
5 specifically for projects of this type, and
6 those seemed to be two critical criteria that
7 they left off. Those being cost containment
8 and adverse affects on -- on other facilities.
9 You know, for a project that costs 328 -- \$325
10 million and was proposing to plop 128 beds down
11 four miles away from a hospital that was under
12 construction at the time, that being Roper St.
13 Francis Berkeley, and in relatively close
14 proximity to Summerville and to Trident, it
15 seemed to me that considering the adverse
16 affects should be one of the highest priority
17 considerations in -- in evaluating the project.
18 And also, in -- in the -- in the State Health
19 Plan after the criteria are listed, it says
20 that there should be -- there should be equal
21 weight given to improvements and accessibility
22 and the adverse affects on existing facilities.

23 Q: I've called up, Mr. Sullivan, DHEC Exhibit 4,
24 Page 12.

25 (DHEC Exhibit Number 4 was referenced at this time.)

1 Q: Are these the relative or the project review
2 criteria deemed as most important in evaluating
3 this type of project?

4 A: They are.

5 Q: Okay. And -- I think you said this, but which
6 ones do you recall that were not on the -- on
7 the letter, the deemed complete letter?

8 A: Well, five, the record of the applicant; six,
9 cost containment; and seven, adverse affects on
10 other facilities. I -- I thought the most
11 important omissions were six and seven, cost
12 containment and adverse affects.

13 Q: How many parties opposed the project during the
14 review period, do you know?

15 A: There were five separate parties that opposed
16 it.

17 Q: Do you remember -- recall who those were?

18 A: Sure. It was Roper St. Francis, Regional
19 Medical Center of Orangeburg, Summerville
20 Medical Center, Trident Medical Center, and
21 Colleton Medical Center.

22 Q: Okay.

23 MR. THOMAS: Let's go to DHEC Exhibit 1, page 703.

24 (DHEC Exhibit Number 1 was referenced at this time.)

25 Q: Mr. Sullivan, what is -- what is this document

1 that's in the DHEC record?

2 A: This was a letter that I wrote on July 18th,
3 2018, that expressed my concerns with the --
4 the MUHA application for the Nexton project
5 based on my review of the -- of the record and
6 other materials.

7 Q: Do you need to see a copy of this? Do you want
8 a hard copy at all, that's 20 pages long?

9 A: I'm good.

10 Q: Okay. Can you give the Court -- can you
11 summarize your positions generally that you
12 submitted to the Department?

13 A: Sure. I mean, generally, I found that the
14 project was not -- in my view, was not
15 consistent with the South Carolina Health Plan.
16 I didn't believe that the project had satisfied
17 Standard 5 of the Plan. I didn't believe that
18 the -- the project had documented a community
19 need for the service given that it was putting
20 it in close proximity to another brand new
21 hospital and then, also, in proximity to other
22 facilities that had available capacity. I did
23 not believe that the project would improve the
24 distribution of healthcare services in the area
25 for some of the same reasons I just mentioned.

1 I believe that the project would have an
2 adverse impact on existing providers. That
3 being the Colleton, Trident and Summerville, as
4 well as Roper St. Francis Berkeley. I didn't
5 believe that the applicant had -- had
6 adequately demonstrated its ability to complete
7 the project. That gets into the whole issue of
8 financing and the -- and the level of -- of
9 debt and the pretty broad array of proposed
10 capital expenditures that MUHA had -- had --
11 had already announced. Didn't believe the
12 project was financially feasible. I believe
13 that utilization projections, in particular,
14 were significantly overstated for the -- for
15 the new hospital. I believe that the -- with
16 respect to the adverse impact, I did a separate
17 little analysis to show what happened in the
18 Mount Pleasant area when an unnecessary
19 hospital, Mount Pleasant Medical Center or
20 Mount Pleasant Hospital, was approved at the
21 same time that East Cooper Medical Center was
22 in the process of replacing its hospital, and
23 the fact that it resulted in two underutilized
24 facilities in the same market.

25 Q: How did you know about those projects?

1 **A:** Well, I wrote the application for East Cooper
2 to replace its facility and I opposed the
3 application by Roper St. Francis.

4 **Q:** Okay. I didn't mean to cut you off.

5 **A:** That's all right. And the -- and so overall,
6 I mean we -- we -- I thought we did a -- a
7 fairly detailed evaluation of -- of the project
8 State Health Plan and the -- the most important
9 project review criteria. If I didn't say
10 adverse impact, I mean, I believe it would have
11 an adverse impact on -- on those providers I
12 mentioned earlier.

13 **Q:** Have any of your positions changed since your
14 writing of that letter back in July 18 of 2018,
15 so more than year ago?

16 **A:** They have not changed. In fact, I think they
17 probably are more deeply felt now than they
18 were back in that time because I've got more
19 information to -- to analyze.

20 **Q:** Okay. Mr. Sullivan, what is a project review
21 meeting?

22 **A:** A project review meeting is, you know, it is an
23 optional meeting that DHEC can call when a
24 project -- typically, they're projects of some
25 magnitude and projects where there is

1 opposition to the project, where DHEC can allow
2 both the applicant and the opposing parties to
3 come to Columbia and to make presentations to
4 the DHEC staff to give them sort of their views
5 on why the project should be approved and why
6 the project should not be approved. And in --
7 you know, so those -- those types of meetings
8 are held, as I said, most typically for
9 projects that are, you know, of some
10 significant size or import.

11 Q: Was there -- was there a project review meeting
12 in this case?

13 A: There was not.

14 Q: Okay. Did you have any impressions of that?

15 A: Well, I thought it was very unusual for a new
16 hospital. I mean, new hospitals -- when it
17 comes to impacting the healthcare system, new
18 hospitals probably have the greatest impact on
19 the healthcare system of any other type of
20 project. And the fact that this was gonna be
21 128-bed hospital and it was gonna be located
22 within a short distance of another hospital
23 that had been previously approved by DHEC, that
24 being Roper St. Francis, and another -- and --
25 and maybe 15 miles away from a hospital that

1 had been approved for Trident up in Moncks
2 Corner, and was opposed by five different
3 entities, I was quite shocked when I found out
4 there would not be a project review meeting.

5 **Q:** **Okay.**

6 MR. THOMAS: Let's go to DHEC Exhibit 1, Page 1009,
7 if we could.

8 (DHEC Exhibit Number 1 was referenced at this time.)

9 **Q:** **All right. Do you recognize this letter dated**
10 **July 23rd, 2018, Mr. Sullivan?**

11 **A:** **I do.**

12 **Q:** **What -- what is it?**

13 **A:** **This is the decision letter on the MUHA Nexton**
14 **project.**

15 **Q:** **Okay. In terms of the decision letter, can you**
16 **give the Court your opinions about what your**
17 **impressions were at the time you reviewed this?**

18 **A:** **Well, I mean, obviously, I disagree with the**
19 **ultimate conclusion, which is that the project**
20 **should be approved. But I thought that the --**
21 **the level of analysis that went into the**
22 **decision letter I thought was -- was not deep**
23 **enough to really -- to touch on the key issues**
24 **that I believe should have been considered by**
25 **DHEC in evaluating this project.**

1 MR. THOMAS: Okay. Let's pull up TMC 138 and I

2 think we're about to get into that.

3 (Trident Exhibit Number 138 was referenced at this

4 time.)

5 Q: All right. Did you prepare this exhibit, Mr.

6 Sullivan?

7 A: I did.

8 Q: Okay. What -- what does it contain?

9 A: It's really a summary of my opinions and
10 analysis.

11 OBJECTION:

12 MS. CRUM: Your Honor, I'm -- I'm going to object to
13 this document. It's -- he says it's a summary
14 of his opinions and analysis. It is, in fact,
15 his actual report, which he testified to in his
16 deposition. An expert report is hearsay and is
17 not admissible, Your Honor. And -- and ---

18 THE COURT: It hasn't been offered yet. He hasn't -
19 --

20 MS. CRUM: All right.

21 THE COURT: He hasn't even gone into it yet.

22 MS. CRUM: All right, sir.

23 THE COURT: But I note your preliminary shot across
24 the back.

25 MS. CRUM: All right, sir, thank you.

1 MR. THOMAS: I do plan to offer it into evidence,
2 Your Honor. I guess we can do that. We can
3 have the argument at the time I try to do that,
4 but I'm using it as a demonstrative exhibit,
5 much in the way Mr. Richardson used his slides
6 as a demonstrative exhibit. And I believe that
7 the case of State v. Kozisek that states
8 demonstrative exhibits are admissible if they
9 supplement the witness's spoken description of
10 the transpired event, clarifies some issue of
11 case, or are more probative than prejudicial.
12 Now, I'm -- I would say that ---

13 THE COURT: That's that Nebraska case now?

14 MR. THOMAS: That's the Nebraska case that you had
15 already cited with Mr. Richardson's slide deck
16 or his -- his demonstrative and I would rely on
17 the same case. And what you're going to hear
18 is Mr. Sullivan's -- this is a -- basically, a
19 demonstrative that he will take the Court
20 through on the various points of his
21 disagreement with the Department's decision.
22 The bases, there are many different documents
23 in here that summarize other documents that
24 were produced in discovery that we will also be
25 moving into evidence as we get to them. And

1 we'll show the Court and we'll provide a basis
2 for the admission of those underlying
3 documents, as well.

4 MS. CRUM: Mr. ---

5 THE COURT: Well, I think we've got two issues. One
6 is the utilization of the demonstrative exhibit
7 as -- for demonstrative purposes and the second
8 is as mentioned. Right now, I'm not going to
9 deal with the admission because it's not being
10 offered.

11 MS. CRUM: All right. So, what -- Your Honor, I
12 will just point out that I will have to be
13 standing up and objecting throughout. And I --
14 I apologize in advance for that, but, for
15 example, this document has deposition testimony
16 in it, summary of deposition testimony
17 regarding HUD, for example, that Mr. Sullivan
18 is going to attempt to rely on. That's
19 hearsay. So, I'll guess I just have to pop up
20 and down at each one, Your Honor.

21 MR. THOMAS: As you know, Your Honor, experts can
22 rely on hearsay if it's of the type of ---

23 THE COURT: Well, they can rely upon it, but they
24 can't necessarily have it admitted into
25 evidence.

1 MR. THOMAS: Right.

2 THE COURT: That's a -- a separate issue. For
3 demonstrative purposes, I don't know if you
4 should be putting up hearsay, statements of
5 other witnesses.

6 MR. THOMAS: Well, I could pull the deposition
7 testimony out and ask him to read it because it
8 does support his opinion, but what I've done is
9 just put in a slide for ease of reference ---

10 THE COURT: Yeah.

11 MR. THOMAS: --- for the Court.

12 THE COURT: Okay.

13 MS. CRUM: Your Honor, he can't just read the
14 deposition opinion when it's not in evidence
15 and rely on it because it's still hearsay.

16 MR. THOMAS: He absolutely can ---

17 THE COURT: I would like you to -- just as you
18 object think about whether A, the purpose of
19 the objection and whether there's going to be
20 any prejudice as a result of this demonstrative
21 exhibit.

22 MS. CRUM: All right, sir.

23 THE COURT: Thank you.

24 **Q: Okay. Let's see. Mr. Sullivan, did you**
25 **provide -- sorry -- prepare this presentation?**

1 **A:** **I did.**

2 **Q:** **Okay. And generally, tell the -- tell the**
3 **Court what you did in terms of preparation of**
4 **the exhibit.**

5 **A:** **Sure. I mean, I -- I -- I think I laid out**
6 **earlier all of the materials that I reviewed.**
7 **And so what I tried to do in -- in this exhibit**
8 **was to sort of structure it around different**
9 **topics primarily related to the -- the key --**
10 **either the South Carolina Health Plan or to**
11 **what I viewed as the key project review**
12 **criteria that were applicable to this project.**

13 **Q:** **Okay. Have you made any substantive revisions**
14 **to this since your -- your deposition?**

15 **A:** **I have not. I think the only thing that --**
16 **that we have done, I think is we've put exhibit**
17 **numbers on some of these pages to reference**
18 **underlying documents that went into the -- into**
19 **a particular slot.**

20 **Q:** **The trial exhibit.**

21 **A:** **Trial exhibit numbers.**

22 **Q:** **Okay. Okay.**

23 **MR. THOMAS:** **Go to the next page 2, please.**

24 **Q:** **You prepared this slide regarding the con- --**
25 **whether or not the project is consistent with**

1 **2017-2018 South Carolina Health Plan?**

2 **A:** **Right. And, you know, we -- we talked about**
3 **earlier that MUHA does have a need for 147 beds**
4 **and I'm not disputing that. The -- the**
5 **planning area as a whole based on the State**
6 **Health Plan had a negative bed need of 13. I**
7 **believe and that there was a mistake in the**
8 **Health Plan in that it omitted 50 beds that**
9 **were approved for Berkeley Medical Center, you**
10 **know, on behalf of Trident Health. And if we**
11 **corrected the bed need number, it would be**
12 **actually a negative 63.**

13 **Q:** **Okay.**

14 **MR. THOMAS:** Can we go to the next slide?

15 **OBJECTION:**

16 **MS. CRUM:** Your Honor, I -- I'm going to object to
17 this specific page because it talks about that
18 there was a need identified for MUHA in
19 downtown. That is Mr. Sullivan's
20 interpretation of the Plan and whether or not
21 institutional need is -- is also a public need.
22 So, I don't think that's a reliable statement.
23 I don't think that that qualifies for 702 and I think
24 it's a legal opinion and I'm going to state my
25 objection for the record.

1 THE COURT: All right. But you're not objecting
2 necessarily to the exhibit, but to the
3 testimony. I'm -- I'm not following.

4 MS. CRUM: I'm objecting -- I'm objecting to bullet
5 one on the exhibit. He did not offer any
6 testimony on that. He just simply said that
7 there was a need for 147 beds and didn't
8 address whether or not there was a -- that was
9 quote, MUHA in downtown, as opposed to was that
10 a need for the entire service area.

11 THE COURT: Okay.

12 MS. CRUM: The whole -- a part of this case, Your
13 Honor, is about location.

14 THE COURT: I get that.

15 MS. CRUM: Yes, sir.

16 MR. THOMAS: All of it's about location.

17 MS. CRUM: And so -- well, I thought we also heard
18 it was about pay -- need, too, but John -- I'm
19 ---

20 THE COURT: Well.

21 MS. CRUM: I'm objecting to that bullet.

22 THE COURT: Well, whether it's needed at the
23 location, pretty well summarizes it.

24 MS. CRUM: Yes, sir. Yes, sir.

25 MR. THOMAS: Your Honor, I'm -- I mean, first of

1 all, I don't think that's a reasonable
2 objection. That's a question for cross-
3 examination. The thing is the next slide, if
4 we could go to it, is -- actually shows the bed
5 need. It's taken straight out of the State
6 Health Plan. One of the questions I was going
7 to ask him was about MUSC's bed need. So ---

8 THE COURT: I overrule the objection right now
9 because he's just giving his opinion and I'm
10 taking it as his opinion.

11 MS. CRUM: All right. So, my ---

12 THE COURT: And not fact. You're -- you're
13 addressing the ---

14 MS. CRUM: My concern is that if this is admitted
15 into evidence and ---

16 THE COURT: But it's not yet, you know. This is why
17 ---

18 MS. CRUM: I -- I understand, but I need to go ahead
19 and object now because if I don't, I have
20 preserved my objection, Your Honor.

21 THE COURT: I think you will have -- once he offers
22 it into evidence, then you can tell me ---

23 MS. CRUM: Yes, sir.

24 THE COURT: --- why it should not be admitted then.
25 It's just simply now, he's test- -- giving his

1 opinion and this is just a demonstrative
2 exhibit ---

3 MS. CRUM: All right, sir.

4 THE COURT: --- relating to that -- that opinion.

5 MS. CRUM: All right, sir.

6 THE COURT: Yeah. I'll definitely hear you, Ms.

7 Crum. Ms. Crum. Ms. Crum.

8 MR. THOMAS: Liz.

9 THE COURT: I will ---

10 MS. CRUM: I'm sorry. I thought you were finished.

11 THE COURT: I'll hear you at the appropriate time
12 when he offers it.

13 MS. CRUM: All right, sir. Yes, sir. I thought --
14 I had heard that. I'm sorry.

15 THE COURT: Okay.

16 MS. CRUM: I should have acknowledged that.

17 THE COURT: All right.

18 **Q: Okay. Mr. Sullivan, do you recognize this page**
19 **here?**

20 **A: I do.**

21 **Q: Where's it from?**

22 **A: It's from the 2017 and '18 South Carolina**
23 **Health Plan.**

24 **Q: Okay. And I think we looked at this earlier,**
25 **but there is -- it says MUSC Medical Center and**

1 it says 147 beds, correct, as a bed need?

2 A: It does.

3 Q: Okay. You referenced earlier in your earlier
4 slide that you believe that the need is
5 identified for MUHA in down- -- in the downtown
6 -- on the downtown campus, did you not?

7 OBJECTION:

8 MS. CRUM: Your Honor, I am objecting to leading
9 questions.

10 MR. THOMAS: I -- I don't think that was an improper
11 leading question. I asked him if he'd just
12 done ---

13 THE COURT: I -- I think ---

14 MR. THOMAS: --- what he did.

15 THE COURT: I overrule that. He -- he -- it wasn't
16 about -- we'll see -- you can give -- you can
17 do leading questions when you're directing a
18 witness toward a topic and I think -- that's
19 how I perceived it, not as ---

20 MS. CRUM: When he ended with did you not, I think
21 that makes it a leading question as opposed to
22 saying am I correct or something like that.

23 THE COURT: Yeah.

24 MS. CRUM: In addition to that, Your Honor, he is
25 giving his opinion, again, as to whether this

1 bed need has to be utilized only downtown or
2 somewhere else in the tri-county area.

3 THE COURT: Okay.

4 MR. THOMAS: I don't have a response to that because
5 he's allowed to give ---

6 THE COURT: I overrule it at this point and time.

7 MR. THOMAS: Okay.

8 **Q: Where do you believe that MUSC's bed need has**
9 **been generated from, Mr. Sullivan?**

10 **A: From its facility located in downtown**
11 **Charleston.**

12 **Q: Why?**

13 **A: Well, that's the only facility that it operates**
14 **that provides inpatient services. The -- the**
15 **calculation that's utilized in the South**
16 **Carolina Health Plan calculates the need for an**
17 **individual hospital. It doesn't -- doesn't**
18 **have a separate area wide need calculation. It**
19 **only calculates the need for an individual**
20 **hospital.**

21 **Q: Can you explain to the Court the concepts of**
22 **institutional versus community need?**

23 **A: Sure. An institutional need simply means that**
24 **a -- a particular facility, a program,**
25 **perceives that there is a need for it to**

1 undertake some type of activity, build a new
2 building, add a new service, what have you.
3 But it's done only the context of that
4 particular organization. Community need looks
5 broadly at the -- the population in a given
6 planning area and determines on a -- on a -- on
7 a more global basis what the needs are and then
8 moves from there to determine whether or not a
9 particular project would fit within that
10 broader concept of -- of community need.

11 Q: Okay. So, if a hospital, and we referenced
12 this earlier -- so, if a hospital itself has a
13 need and there are many other hospitals in the
14 service area, again, just on that basis alone,
15 is that hospital entitled to either add beds at
16 its own facility or at another location?

17 A: It -- it has that right under the state --
18 under the current South Carolina Health Plan.
19 It can add them to its existing facility or it
20 can seek to add those beds at a different
21 location.

22 Q: And can it do without applying for a CON?

23 A: It cannot.

24 Q: Okay. And what other things must it show in
25 order to -- in order to create the -- the new

1 hospital or the wing of an existing hospital?

2 A: Well, it has to -- I mean, not only is there a
3 bed need, but it has to show there's community
4 need and you have to go through all of the
5 other criteria showing that it's financially
6 feasible, that you've considered alternatives,
7 and this is the -- the best alternative, less
8 costly. That it's -- it's going to improve
9 access and distribution of -- of healthcare
10 services. All of the various review criteria.

11 Q: Okay. So, there's not just unlimited to
12 license to add a bed if you have a bed need?

13 A: No.

14 Q: Add beds or create a new hospital.

15 A: No. You still have to meet other criteria.

16 Q: Okay. Next slide is Number 4. MUHA's Project
17 -- it's entitled MUHA's Projects Not Consistent
18 with the 2017-2018 South Carolina Health Plan.
19 Can you explain this opinion?

20 A: Sure. And without reading the whole criterion
21 into the record, I think the -- the most
22 relevant part of this is the last sentence and
23 that is the applicant must justify through
24 patient origin and other data the need for a
25 new hospital at the chosen site. So it has to

1 -- it's not just that we have a general need
2 and we can put the beds where we want. They
3 have to show it at the chosen site and then --
4 then, show the potential adverse impact of the
5 new hospital at the chosen site and what that
6 would have on existing hospitals in the service
7 area.

8 Q: Okay. And what standard is this, just for the
9 record?

10 A: Standard 5 out of the acute care bed need
11 chapter.

12 Q: Okay. And what -- what are your opinions on
13 whether MUSC meets this particular standard?

14 A: Well, I think -- I think they fail in -- in
15 sort of two parts of -- of this particular
16 standard. First of all, I don't believe that
17 they've documented a need at the chosen site;
18 and secondly, I don't believe that they've
19 adequately demonstrated what the adverse impact
20 is gonna be on existing facilities.

21 Q: Okay. We'll get into a little bit more than
22 that. Let's go to the next slide. Would you
23 explain to the Court what this slide is about?

24 A: Well, now I'm moving sort of away from the
25 State Health Plan and I'm talking about

1 community need more generally, and whether or
2 not -- and I think this relates back to the
3 State Health Plan in that community need would
4 also, I -- I believe, allow the applicant to
5 demonstrate that the chosen site was an
6 appropriate one. And so they're -- they're
7 seeking to put a hospital in this particular
8 location, in the Nexton development. They --
9 you know, there's no need generally in the
10 service area for -- for additional beds; we
11 know that from the calculations. And
12 typically, when you try to show a community
13 need, you're trying to address some kind of
14 access problems. And then the three most common
15 areas is geographic access problem. The
16 service area residents have to travel long
17 distances to receive a particular type of
18 service. Capacity access means there was not
19 enough of a particular service to meet the
20 needs of the population. Or financial access,
21 that lower income individuals aren't able to
22 access services because of financial barriers.
23 And I don't believe any of these considerations
24 support the MUHA project.

25 Q: Let's talk about these -- these three -- or

1 these three access concepts. Are those health
2 planning concepts?

3 A: Yeah. I mean, these are ones that I've used
4 throughout my career. I mean, I -- you know,
5 in -- at times when I've had a project where I
6 felt there was an access problem in the -- in
7 the community, it usually fell into one of
8 these three categories, you know, geographic,
9 capacity or financial.

10 Q: Okay. And this is -- just for the record, this
11 is slide 5 of this demonstrative, TMC 137. Or
12 excuse me, 138. And with respect to the
13 community need for a new hospital and these
14 access concepts, Mr. Sullivan, are any of them
15 institutionally specific?

16 A: They are not. They look beyond the walls of an
17 individual institution. You know, the -- the
18 ideal project is one where the institution's
19 specific needs mesh with the -- the needs of
20 the community -- the broader needs of the
21 community.

22 Q: Okay.

23 MR. THOMAS: Go to Slide 6 of 138, please.

24 Q: This slide also dresses community need. Can
25 you explain to the Court what your opinions are

1 here?

2 **A:** Sure. Well, the basic building block of
3 determining needs for almost any type of
4 project is to first to find the area that the
5 project will service. And so, the service
6 area, you know, is a key consideration in -- in
7 any project and in this case, you know, my view
8 is that MUHA's Nexton service area as defined
9 in the application is -- is unreasonably too
10 large. It includes 94 zip codes. As I talked
11 about earlier, it includes all -- virtually --
12 well, it includes all of the tri-county area
13 and also includes portions of other counties
14 outside of the tri-county area where they
15 expect to draw some patients. And the service
16 area was done from an institution-specific
17 standpoint. It wasn't done with consideration
18 of what -- where the existing hospitals were
19 located. It wasn't done with consideration of
20 how far patients would have to travel to the
21 proposed new hospital or whether or not those
22 patients would actually be closer to MUHA's
23 downtown facility than they would be to the --
24 to the Nexton Hospital.

25 **Q:** Why would you want to consider those types of

1 factors?

2 A: Well, because in -- in terms of setting up an
3 area that you could reasonably draw a material
4 number of patients from -- and I believe -- and
5 I -- someone said and I think in this hearing
6 so far that -- that location and distance are
7 key factors in -- in whether or not a patient
8 will -- will choose a particular healthcare
9 facility for a service. There's a -- there's
10 an old -- old planning methodology, it's called
11 Riley's Law of Retail Gravitation, and Riley's
12 Law says -- it was based on Newton's Law of
13 Gravitation, you know. And what it says is
14 that the willingness of a -- of a patient to
15 travel to a facility is a function of the
16 distance and the scope of services that are
17 being provided. You know, Riley's Law says
18 that if you have a shoe store, for example --
19 if a shoe store only carries two lines of
20 shoes, people aren't going to drive very far.
21 But if you have a -- a giant big box warehouse
22 shoe store, people might drive from 30 or 40
23 miles away to go to that store to use it. Same
24 with hospitals. If you have a hospital like
25 MUHA that offers a broad range of services,

1 services that aren't offered generally by other
2 hospitals.

3 Q: Is this the downtown hospital?

4 A: The downtown hospital. Patients are going to
5 travel a long way to go -- go to that facility.
6 As you narrow the scope of services down, the
7 -- the attractiveness of that hospital to
8 patients diminishes. And -- and so, in this
9 case, there was no weight given to where
10 existing hospitals were located and how far
11 patients had to travel to those existing
12 hospitals and particularly, to -- to MUHA
13 itself in the downtown area and coming up with
14 a projection number of patients and before
15 that, the percentage of patients that would
16 shift from a particular zip code.

17 MR. THOMAS: Let's go to the next slide please.

18 This is number 7, in 130- -- Exhibit 138.

19 Q: What is this map of?

20 A: Well, this was basically taking the tri-county
21 area and dividing it into the subregions that
22 MUHA developed in its applications. So, for
23 example, Moncks Corner is a good portion of --
24 of Berkeley County. A lot of it is national
25 forest or land around the lakes. It's very

1 rural and doesn't have a lot of people in it.
2 Summerville includes all of Dorchester County,
3 I believe, and some portions of Berkeley
4 County. North Charleston includes parts of
5 Charleston County and parts of Berkeley County.
6 West Ashley is all Charleston County and then
7 the Sea Islands would be all in Charleston
8 County, but that would be what we talked about
9 earlier -- would be James Island, Johns Island,
10 all those coastal islands. And -- and so, this
11 was sort of the basic framework that was set up
12 in the application to -- to categorize, you
13 know, where the patients were coming from and
14 so, you know, we can sort of evaluate the
15 reasonableness of, you know, whereas
16 Summerville is relatively close to the
17 hospital.

18 Q: Can I stop you real quickly?

19 A: Yeah.

20 Q: Where is the proposed MUHA hospital going to
21 be?

22 A: It's going to be in what's called the
23 Summerville area.

24 Q: Okay. Is that the red dot there?

25 A: It is the red dot and it's in Berkeley County,

1 but it's defined as the Summerville subarea.

2 Q: Okay.

3 A: Well, so residents in that Summerville area and
4 even portions of the Moncks Corner area might
5 potentially go to that hospital given the
6 proximity, certainly the ones on the eastern
7 side of the Summerville area. As you get into
8 North Charleston, you can see, you've got two
9 other hospitals already located in North
10 Charleston, and most of that population is
11 going to be closer to those two hospitals. And
12 as you get to the southern part of the North
13 Charleston region, you can see that those
14 patients are actually going to be closer to the
15 downtown facility. On the Sea Island, all of
16 those patients with the exception of -- of a
17 very small part of -- well, actually, I think
18 all of those patients are going to be closer to
19 the downtown MUHA facility. And then, in West
20 Ashley, generally patients are going to be
21 closer to the downtown MUHA facility than they
22 will be. And then -- and their application
23 indicates that, you know. And -- and at East
24 Cooper, you have the same situation where the
25 population is concentrated in the East Cooper

1 areas, the area closest to the peninsula of
2 Charleston, and those folks are going to be
3 closer to the downtown facility than they are
4 to the MUHA Nexton facility.

5 Q: Okay. Is this -- did this map come out of the
6 CON application less the blue and red dots?

7 A: Yeah, it did. I -- I put the dots on it.

8 Q: Okay. And who -- who developed these sub-
9 market or these shaded colored areas?

10 A: I believe Mr. Levitt took credit for that, and
11 so.

12 Q: Okay. And what are those supposed to
13 represent?

14 A: I think from the purposes of analyzing where
15 patients are going to come from, I think the
16 sort of broadly defined areas that were closer
17 to or farther away and were used in determining
18 what percentage of patients from those areas
19 would shift to the new hospital.

20 Q: Okay.

21 MR. THOMAS: Let's go to slide 8 in TMC Exhibit 138.

22 Q: Can you explain to the Court what you've done
23 here ---

24 A: Sure.

25 Q: --- and why you did it?

1 **A:** Sure. And another important aspect of whether
2 there's a need for a new hospital is how many
3 actual patient days are you going to have to
4 accommodate in that hospital because patient
5 days determines how much capacity you need.
6 How many patients are going to be on a bed --
7 in a bed on a given day. And the -- in the
8 MUHA application, they assumed lengths of stay
9 for non-tertiary patients in a community
10 hospital was located 28 miles away from the
11 tertiary hospital. That would be 5.2 days for
12 non-tertiary medical/surgical patients, 2.9
13 days for obstetric patients, and overall 4.7
14 days. And these lengths of stay are more
15 similar to what you would see at MUHA or
16 Trident or Roper, which are tertiary facilities
17 and inconsistent with the lengths of stays that
18 you would see at community hospitals like
19 Summerville, East Cooper and Mount Pleasant.

20 **Q:** Okay. What about this -- this idea that maybe
21 it's going to be a higher length of stay
22 because Nexton will be affiliated with an
23 academic medical center?

24 **A:** Well, I -- I -- I mean, unless that means that
25 academic medical centers are less efficient in

1 serving patients, there's really no reason to
2 think that patients who would be appropriate to
3 go to a community hospital would have a
4 substantially longer length of stay then they
5 would at other community hospitals. Also, we
6 have to recognize that in each of these zip
7 codes where they assume patients are going to
8 shift, they didn't assume all of the patients
9 are going to shift. They just assumed a
10 portion of the patients are going to shift and
11 ostensibly, the patients who are going to
12 shift, would be those patients who are of lower
13 acuity, who wouldn't need the services of a --
14 of a tertiary or quaternary type facility like
15 the Medical University. I think there was some
16 questions earlier on about DRG categories. The
17 applicant defined DRG categories as being non-
18 tertiary and meaning that they are lower
19 acuity. But even within an individual DRG,
20 there might be varying ranges of acuity within
21 that DRG. So, some patients may be higher risk
22 because of comorbidity, because of age, because
23 of prior procedures that they've had done.
24 Those types of patients, in my view, would be
25 more appropriate to go to the downtown

1 facility. And the fact that these patients in
2 some cases are traveling 25 or 30 miles to go
3 to Medical University and bypassing existing
4 hospitals would lead you to believe that at
5 least some of those feel like they need the
6 services of a -- of a larger academic medical
7 center. So, you would expect that the
8 population that you would serve at the
9 community hospital would be the patients on the
10 lower end of the acuity scale, even within
11 these non-tertiary DRGs. And lower acuity
12 usually translates into lower length of stay.

13 Q: Okay.

14 MR. THOMAS: Let's go to the next slide, 9, TMC
15 Exhibit 138.

16 Q: Is this a -- a worksheet that was developed?

17 A: Yeah. This is a -- this is actually the
18 projections summarized from the MUHA Nexton
19 application. So, they weren't presented
20 exactly this way in the application, but I just
21 took the various pieces and put them together
22 and showed that they project that based on --
23 and I think there's a typo on the second and
24 third charts that should say 2- -- 2017 base as
25 it does in the first chart.

1 Q: Okay.

2 A: Yeah. So, I can just correct that.

3 Q: Talking about the first column there in the ---

4 A: Yeah.

5 Q: --- two lower charts?

6 A: Yeah. The way the applicant went about it is
7 they took 2017 data and assumed that it would
8 -- what the shifts would be based on zip code
9 by zip code percentages, and then that was
10 their base number. And then they grew that
11 number based on population growth. And then
12 they -- just to confuse everything even more,
13 they had a ramp-up. So, they assumed that only
14 a portion of that volume would be achieved in
15 year one, a little bit more in year two, and
16 then more in year three. And I bumped ahead
17 the projections from the application because
18 we've had a significant delay in the -- in this
19 project, so I believe that based on the
20 schedule in the application, 2025 seemed like
21 a reasonable first year of operation for the --
22 for the facility.

23 Q: Okay. And ---

24 MR. THOMAS: Can we go to TMC Exhibit 26, please?

25 (Trident Exhibit Number 26 was referenced at this

1 time.)

2 Q: Did you review this document, Mr. Sullivan,
3 with respect to your analysis here? Does this
4 document look familiar to you?

5 A: It does. This is -- this is one of a number of
6 spreadsheets that were produced in discovery by
7 the Medical University and this one happens to
8 sum to the exact number of discharges that were
9 shown, you know, in the -- in the application
10 for -- projected for the new facility.

11 Q: Okay.

12 MS. CRUM: Excuse -- excuse me. I was trying to
13 find that in the -- Exhibit 138?

14 MR. THOMAS: Right.

15 MS. CRUM: Can you show me where it is? I just
16 couldn't find the page.

17 MR. THOMAS: Exhibit 138.

18 MS. CRUM: Yeah.

19 MR. THOMAS: Page 9. It should be in the chart
20 there. Page 9.

21 MS. CRUM: I don't have that.

22 MR. THOMAS: Let's see here. It's MUHA RFP4703 is
23 TMC ---

24 MS. CRUM: Okay. Okay.

25 MR. THOMAS: --- Exhibit 26.

1 MS. CRUM: Gotcha. Thank you. Sorry.

2 Q: And so, did -- did you review this document at
3 -- in order to form a basis of your opinion?

4 A: I -- I did. This was a summary that showed the
5 breakdown of the projections by the subareas
6 that we were talking about earlier. And so
7 this is -- this is one of the documents that I
8 reviewed in reviewing the -- the utilization
9 projections.

10 MOTION TO ADMIT:

11 MR. THOMAS: I -- I would ask that TMC 26, which is
12 the internal court papers of MUSC for the CON
13 application be admitted into evidence.

14 MS. SHOUN: No objection.

15 MS. CRUM: Your Honor, you know, I -- I don't know
16 where he got them. I don't know if that was
17 the final document. We produced lots of pages
18 and I don't know if that was in the original
19 draft or it was moved along the way. And
20 unless he can identify for us when they were
21 produced, I -- I have no way to object or not
22 object to them, Your Honor, because I don't
23 know what they are. Now, if -- if it's
24 something that's in our CON application, I
25 certainly have no objection to it.

1 THE COURT: Well, the issue is you don't object or
2 you don't state that you did not produce it.
3 You're just saying you don't know when it was
4 produced.

5 MS. CRUM: Yes, sir. Oh, we produced it. There's
6 no question. I don't know when it was
7 produced. I don't know if it was one of the
8 original documents we -- we were working on,
9 one of our work papers. I don't know what
10 context it was used in. And if it's one of the
11 work papers, then, it's not reliable to use in
12 -- in this. It should be used in the -- we
13 should be using what was used in the
14 application. That -- that's my issue is I
15 don't know at what stage of our CON process --
16 of our CON application process, I'm sorry, Your
17 Honor, this was actually created or who created
18 it.

19 MR. THOMAS: Well ---

20 MS. CRUM: Yeah.

21 MR. THOMAS: Your Honor, I would say that she can
22 certainly review it and cross examine Mr.
23 Sullivan on it. He said he reviewed it and it
24 ticked and tied to the CON application. They
25 should know when they produced it because

1 they're the ones that produced it. It's got an

2 MUHA ---

3 THE COURT: Well ---

4 MR. THOMAS: --- bates number on it.

5 THE COURT: --- it's your document. I'm going to
6 allow it to come into evidence, but you can
7 cross examine him on when it was produced and
8 -- and unless Mr. ---

9 MR. THOMAS: No objection.

10 MS. CRUM: He hasn't laid a foundation that he even
11 knows what it is other than ---

12 THE COURT: Right.

13 MS. CRUM: --- it was produced by MUHA.

14 THE COURT: Can't -- can't remember that one way or
15 the other.

16 MR. THOMAS: Yeah. And I -- I'd even make -- I'm
17 sorry, Judge.

18 THE COURT: No tell me, did ---

19 MR. THOMAS: I asked him if he had reviewed it and
20 he said he did and it ticked and tied to the
21 CON application ---

22 THE COURT: Well, you said it was produced by DHEC.
23 I mean ---

24 MR. THOMAS: No. MUHA.

25 THE COURT: MUHA.

1 MR. THOMAS: Yes, sir.

2 THE COURT: He hasn't, so I'd say lay a foundation.

3 But I -- the foundation would be -- well, go
4 ahead for me.

5 MR. THOMAS: Yeah.

6 Q: So, Mr. Sullivan, did you review this document?

7 A: I did.

8 Q: Okay. And what do you understand it to be?

9 A: It was part of the production that MUHA
10 provided that was sent to me. This was based
11 on the Bates number on the page. You can see
12 the -- the document numbers. This was one of
13 thousands of MUHA documents that I reviewed.

14 Q: Okay. And when you reviewed this, did -- did
15 it match up with the CON application data that
16 you had reviewed?

17 A: It did.

18 Q: Okay.

19 MR. THOMAS: Your Honor, it's their business record.

20 THE COURT: It's admitted.

21 (Trident Exhibit Number 26 was admitted into
22 evidence.)

23 MR. THOMAS: Okay. Thank you. Let's go to the page
24 10 of the TMC 138.

25 Q: Can you inform the judge of what's happening on

1 this page?

2 A: Yeah. This -- this is a summary of average
3 length of stay data that came from the joint
4 annual reports of hospitals. I believe those
5 are all included in Trident Exhibits 147
6 through 153.

7 Q: Okay. And why did you do this particular
8 analysis, Mr. Sullivan?

9 A: Well, a long time ago we were talking about
10 length of stay and so, I -- I wanted to -- I
11 wanted to look at what the lengths of stay were
12 for other hospitals in the -- in the tri-county
13 area.

14 Q: Okay. Why'd you want to do that?

15 A: To test the reasonableness of the length of
16 stay that was put forth by MUHA for the Nexton
17 Hospital.

18 Q: And what'd you find?

19 A: Well, what I found is that length of stay in
20 the Charleston area has been relatively stable.
21 It's gone up a small amount over the years be
22 -- between 2012 and 2018. And what I found is
23 that when you look at the length of stay, the
24 longest lengths of stay are at the Medical
25 University, at Roper Hospital and at Trident.

1 And we -- I think we've already heard a lot of
2 testimony about those hospitals being more
3 comprehensive than some of the other hospitals
4 in the community. But if we look at the other
5 hospitals, it would be more community
6 hospitals, we can see that Bon Secours St.
7 Francis has an overall average length of stay
8 and this is total length of stay, OB, non-
9 tertiary, all of that, 3.7, Mount Pleasant 3.0,
10 East Cooper 2.9. So, that -- in my mind, that
11 raised a significant question and Mr.
12 Richardson's already talked about some of this,
13 as well, of whether an overall 4.7 length of
14 stay really made sense for a community hospital
15 such as being proposed in Nexton.

16 Q: Okay. And you see -- did you rely on the JAR
17 reports to -- in forming your opinion about the
18 length of stay -- the average length of stays
19 for these facilities?

20 A: I did.

21 Q: Okay.

22 MOTION TO ADMIT:

23 MR. THOMAS: Your Honor, I'd like to move into
24 evidence Trident Exhibits 147 through 153,
25 which are the Joint annual reports that Mr.

1 Sullivan relied on.

2 MS. SHOUN: No objection, Your Honor.

3 MS. CRUM: Your Honor, I -- I just ask if he'd

4 identify which JARs those were and I may not

5 have an objection. I -- I haven't memorized

6 the exhibit list.

7 MR. THOMAS: No problem. Fair enough, Your Honor.

8 **Q: Can you identify which JARs, what years you**

9 **relied on for these particular facilities?**

10 **A: Yes. 2012 through 2018 for all of the**

11 **hospitals listed on -- on this particular page,**

12 **page 10 of my exhibits.**

13 **Q: Okay.**

14 MS. CRUM: I don't have an objection, Your Honor.

15 THE COURT: They're admitted.

16 (Trident Exhibit Numbers 147 through 153 were

17 admitted into evidence.)

18 MR. THOMAS: All right. Let's turn to page -- if

19 you could go to page 11 of 138.

20 **Q: And what is this, Mr. Sullivan?**

21 **A: This was trying to sort of decompose the**

22 **information in the JARs a little bit more. And**

23 **so what I did is I said lets look at non-OB**

24 **because OB typically has a shorter length of**

25 **stay than other types of patients. And lets**

1 look at what the lengths of stay are excluding
2 OB. And if you remember MUHA for Nexton
3 assumed that its length of stay for its non-
4 tertiary medical/surgical patients, which is
5 what I was trying to replicate here, was going
6 to be 5.2 days. And if we look at this
7 particular chart, this also includes some
8 tertiary patients. So, this -- this -- you
9 can't -- from the JARs you can't pull tertiary
10 and non-tertiary out. But Trident's length of
11 stay as a tertiary provider is only 5.0 days,
12 which is lower than what they're projecting for
13 this community hospital. Roper, another
14 tertiary hospital, is 4.9 days. Again, below
15 the level that was projected for the Nexton
16 Hospital. And the community hospitals that
17 we'd looked at, Bon Secours, Mount Pleasant,
18 East Cooper, have materially shorter lengths of
19 stay than what was projected for the -- for the
20 Nexton Hospital for this category of patients.

21 Q: All right.

22 A: So, that -- that gave me great concern.

23 Q: Okay.

24 MR. THOMAS: Let's go to -- to the next page. Page
25 12, please.

1 Q: And how about this?

2 A: This is looking solely at OB, obstetrics
3 services, and -- and if you recall, the Nexton
4 assumption was 2.9 days. And when I looked at
5 the other providers, only MUSC had a length of
6 stay that was greater than 2.9 days. All of
7 the other providers had lengths of stay that
8 were less than 2.9. In fact, the highest other
9 provider was Summerville with 2.6. They had --
10 have a Level II neonatal nursery, which the
11 Nexton Hospital will not have. And the other
12 ones were all in the 2.3 to 2.5 -- 2.2 to 2.5
13 range, so.

14 Q: What -- what drives -- what, if anything,
15 drives MUSC's OB average length of stay as
16 being the highest here?

17 A: They're a regional perinatal center.

18 Q: Can you explain to the Court what that is?

19 A: Sure. They provide the highest level of care
20 in terms of both for mothers who are
21 experiencing problems prior to the delivery of
22 the babies and in the treatment of the -- the
23 neonates after they're delivered. And so they
24 have -- they're the only providers of -- of
25 Level III and Level IV neonatal services in the

1 Low Country and many hospitals transfer high
2 risk mothers and high risk babies to -- to MUHA
3 for -- for treatment and so you would expect
4 their length of stay to be longer.

5 Q: Okay. So, what would you expect -- well, let's
6 go to the next page, I think.

7 A: Right.

8 Q: Yes. Page 13.

9 A: Yeah.

10 Q: On page 23 of TMC 138, what -- what are you
11 opinions with respect to this?

12 A: Well, what I -- what I did is after looking at
13 all that data, you know, my assumption was that
14 I'm going to go sort of on the high end of the
15 community hospital range and I'm going to
16 assume the med/surg length of stay would be 4.3
17 days, which is still a lot higher than East
18 Cooper and Mount Pleasant. And the OB would be
19 2.5, which would be on the high end of the
20 range of the -- the non Medical University
21 providers. And if we made that one change to
22 the projections in the application, that would
23 drop the projected occupancy rate by ten
24 percent. If we go to the next page.

25 Q: Okay.

1 **A:** You can see what happens.

2 **Q:** Page 14.

3 **A:** Page 14.

4 **Q:** Okay.

5 **A:** The overall length of stay for the hospital
6 would then fall to 3.9, that's in the third
7 chart at the bottom. And the occupancy rate
8 would drop from over 57 percent as presented in
9 the application to 47.7 percent. So, that one
10 change alone would say that we're proposing a
11 bill to a 128-bed hospital, but by the third
12 year of operation, it won't even be half full.

13 **Q:** Okay.

14 **A:** And I -- and I think that's just the beginning
15 of the problems with the -- with the
16 utilization projections.

17 **Q:** Okay.

18 THE COURT: You said that overall length of stay
19 should be 3.9?

20 **A:** 3.9. Yes, sir.

21 THE COURT: And then what was the rest of -- repeat
22 that again where I understand it.

23 **A:** The -- if you use ---

24 THE COURT: The rest ---

25 **A:** --- if you use that 3.9 length of stay, that

1 drops the overall occupancy rate for the all
2 128 beds by the third year down to 47.7
3 percent, which is about a ten percent ---

4 THE COURT: Okay.

5 A: --- reduction in occupancy over the projections
6 in the application.

7 Q: Okay. Let's go to the next page.

8 THE COURT: How does that affect the CON
9 application?

10 A: Well, it affects it in a number of ways. I
11 mean, certainly, it calls into question about
12 why they would want to have 128 beds when they
13 weren't even going to be using half of them
14 after three years. It has a -- also, has an
15 effect on the -- on the financial projections
16 in the applications.

17 THE COURT: Well -- so, let's say the occupancy was
18 3.9 -- either -- length of stay was 3.9 and the
19 occupancy -- well, let's just go with that,
20 3.9. What would be the projected size need for
21 the hospital?

22 A: Well, if you ---

23 THE COURT: It's a 128 beds now. How would that
24 equate to your opinion?

25 A: Well, assuming that the hospital were needed to

1 **begin with ---**

2 THE COURT: I'm not. I'm just going with, okay it's
3 needed.

4 **A: Okay. Then if you would divide the -- the**
5 **State uses for hospitals of that size a 65**
6 **percent occupancy target. So, if you divided**
7 **the 61.1 average daily census on this page 14**
8 **by .65, I think you'd get a number around 92 or**
9 **93 beds.**

10 **Q: But -- but there's more, isn't there?**

11 **A: There's more.**

12 **Q: All right. Let's go to page 15 of TMC Exhibit**
13 **138. And this is your analysis of the**
14 **redirection and the shift, Mr. Sullivan?**

15 **A: Right. And I'm using the word shift, the**
16 **ability to shift patients from going to the**
17 **downtown facility to the Nexton facility. I**
18 **believe the percentages that were employed were**
19 **unreasonable. I think in some cases they were**
20 **arbitrary. And in other cases, they simply**
21 **defy logic. And I think that's -- that's best**
22 **displayed by looking at some of these**
23 **particular sub-areas that we talked about**
24 **before.**

25 **Q: Can I stop you real quickly?**

1 **A:** **Sure.**

2 **Q:** **Just for clarity of the record since the Judge**
3 **was very interested in the average length of**
4 **stay analysis, did that analysis assume**
5 **redirection of MUSC as set forth in the**
6 **application?**

7 **A:** **It did. It didn't change anything about the**
8 **projected number of discharges.**

9 **Q:** **Gotcha. All right. So, I didn't mean to cut**
10 **you off, but I did want ---**

11 **A:** **Yeah.**

12 **Q:** **--- that clarification. So, explain what --**
13 **what ---**

14 **THE COURT:** Well, you also characterized my interest
15 as very interested. I simply ask questions.
16 But go ahead.

17 **(Laughter)**

18 **MR. THOMAS:** Point noted, Your Honor. All right.

19 **A:** **You know, and when -- when you begin to break**
20 **down the -- the projected shift of patients by,**
21 **you know, by zip code and by subarea, you -- I**
22 **think you begin to see some of the flaws in the**
23 **projections themselves. So, for example,**
24 **patients living on the Charleston peninsula,**
25 **they assume that 30 to 35 percent of those**

1 patients, depending on which zip code you were
2 in, would be redirected to the Nexton Hospital,
3 even though they would be in some cases within
4 walking distance of the Medical University's
5 downtown facility. And -- and then, when we
6 look at the West Ashley area, for example, the
7 majority of the West Ashley area is materially
8 closer to the downtown peninsula hospital.
9 East Cooper, it would be easier for those folks
10 to get to the downtown hospital generally based
11 on where the population mass is, which is
12 closest to the peninsula. The Sea Islands are
13 all very distant and you know, when you look at
14 the drive times in the application. In some
15 cases you have patients traveling almost an
16 hour to get to the Nexton Hospital and you're
17 assuming that the 30 to 35 percent of those are
18 going to that as opposed to driving 20 minutes
19 downtown. Orangeburg, you know, why would
20 patients in Orangeburg who are already
21 bypassing all these hospitals want to go to a
22 -- a hospital in -- a community hospital in
23 Nexton? And some of these hos- -- some of
24 these zip codes are significant contributors to
25 the overall projected -- the number of

1 discharges for the project.

2 Q: Okay. Let's go to the next slide, which I
3 think is maybe -- what -- what is this, Mr.
4 Sullivan?

5 A: This was -- this was information that was
6 presented in Appendix N to the MUHA Nexton
7 application. And this shows by grouping these
8 color codes, I think are indicating groupings
9 of zip codes where -- what percentage of the
10 patients will shift from the downtown MUHA
11 facility to the Nexton facility. And so, it
12 starts at the top at 65 percent and then it
13 gradually goes down to 55, then 35, and then
14 30. You know, if we go to the next page, it
15 goes down to ten percent in here. And I
16 believe in -- Mr. Levitt's correct in his
17 deposition exhibits, he corrected this slide
18 and said that these ten percent category
19 patients really should have been two percent
20 patients.

21 Q: And do -- do you agree with the correction?

22 A: I -- I don't know. I mean, he did the
23 analysis, but I mean, it certainly is more
24 logical that it would be a much smaller number
25 than ten percent, but this was what was

1 presented in the application. This is what I
2 was working with, you know, when I reviewed the
3 application.

4 Q: Okay. And let's turn to page -- let's go to
5 slide 18. And what -- explain to the Court
6 what you've done here.

7 A: Yeah. I -- well, I happen to live on the
8 Charleston peninsula part-time, so I -- I
9 thought it -- you know, just for illustration
10 purposes, it might be good to focus on these
11 particular zip codes. And when you look at
12 29401, which as you mentioned earlier, is the
13 southern tip of the peninsula, that is a 39-
14 minute drive time according to the application
15 -- the Nexton application. And yet, 35 percent
16 of those patients are going to shift to the new
17 hospital, even though -- I mean, I -- I live in
18 29401, I can drive to the Medical University in
19 five minutes, maybe seven minutes on a bad day.
20 It just doesn't make any sense. 29425, even
21 though it doesn't have very many patients in
22 it, that's the home zip code for -- for the
23 Medical University.

24 Q: That's where it sits.

25 A: That's where it sits, so when -- why would

1 anybody drive to Nexton, you know, from there
2 and then, similarly, as you look around, you
3 know, the peninsula as a whole, there's just no
4 logic. I mean, will you get some random
5 patients going up there, probably. But it's
6 not going to be a material source of -- of
7 volume for -- for this new hospital. And then
8 you could say the same thing about the Sea
9 Islands. You could say the same thing about
10 Mount Pleasant.

11 Q: Okay. Let's go to the next slide, slide 19.
12 What is this?

13 A: This is just a -- a map that depicts a little
14 more detail where 29401 is and it's the -- it's
15 the lighter shaded area that has an outline
16 around it. But really stops at Calhoun Street
17 in Charleston and then this area south of
18 Calhoun Street.

19 Q: Okay. Where's the Medical University on this
20 map?

21 A: It's the little -- it's the little -- it's the
22 little grey box that has its own zip code, you
23 know. So, it -- I'm sorry. No, it's just
24 north of Calhoun Street. That's -- that's a
25 different zip code. That's the Calhoun

1 Charleston I think there. And so, but the
2 Medical University is up here just to the
3 north, and it's ---

4 Q: Okay. So, in -- in terms of directionally,
5 north, south, east, west, where is the 29401
6 zip code in relationship to the Medical
7 University?

8 A: It's south.

9 Q: Okay. Let's go to the next page. Slide 20 of
10 TMC 138. All right. What -- what are you
11 trying to show here?

12 A: Well, again, you can kind of see that the 29401
13 is outlined on this map at the tip of the
14 peninsula. And it just kind of shows you from
15 a -- you know, from a zoomed out perspective
16 how far these folks would be expected travel.

17 Q: All right. Where -- what is the representation
18 of MUHA Nexton on this slide?

19 A: It's the red dot that's up towards the top of
20 the -- top center of the -- of the map, so.

21 Q: What's your understanding of how many miles
22 away that is from the 29401?

23 A: It's a -- you know, 26 to 28 miles, so.

24 Q: I'm going to remove slide 21, since I know that
25 that's taken objection. But did you hear any

1 testimony in this case that you were either
2 present for or listened to on the phone about
3 the reasonableness of, say, for instance, that
4 particular zip code, 29401?

5 A: Sure. I reviewed the deposition testimony of
6 Dr. Cawley, who is the Chief Executive Officer
7 of MUHA. And he indicated in -- in his
8 deposition that he didn't think he was
9 reasonable that 30 percent of the folks who
10 lived in 29401 would travel to the Nexton
11 hospital.

12 Q: Okay. Let's go to the next slide, which is 22.
13 And then this slide talked about the -- the
14 draw from various areas. Can you explain to
15 the Court what your opinions are regarding
16 where the hospital will draw patients from?

17 A: Yeah, I mean, I think, like most hospitals,
18 they're going to draw the most patients from
19 the areas immediately surrounding the hospital.
20 You know, we saw that when Mr. Gallati was
21 testifying a couple of days ago that the core
22 of his service area was -- with the zip codes
23 he was contiguous to or in very close proximity
24 to -- to Trident. You know, given the range of
25 services that are going to be offered at

1 Nexton, as I mentioned earlier, again, it's
2 more likely the patients who -- who require
3 more specialized care are going to continue to
4 travel downtown rather than seek care at the --
5 at the new facility. I mean, it appeared to
6 me, this is my opinion, that they were trying
7 to minimize the adverse impact on existing
8 providers by diffusing the service -- you know,
9 where they were drawing their patients from
10 over a very broad geographic area, rather than
11 what I think would be logical and assume that
12 most of their folks are going to come from the
13 area North Charleston, Summerville, and
14 portions of Berkeley County, and so.

15 Q: Okay.

16 MR. THOMAS: Let's go to slide 23 in TMC 138.

17 Q: Tell the Court about the focus on -- where you
18 believe the -- MUHA Nexton's focus is?

19 A: Yeah. I mean, there's -- the application talks
20 a lot about Berkeley County, the needs in
21 Berkeley County, and the fact that Berkeley
22 County patients aren't being adequately served,
23 but when I took -- I tried to recreate from the
24 discovery documents, Mr. Levitt's analysis and
25 then we tried to roll those patients up into

1 counties based on his description of which zip
2 code was in which county. And some of the zip
3 codes, granted, overlapped county boundaries.
4 It appears that 80 percent of the patients,
5 based on my analysis of -- of his work papers,
6 would be from Charleston and Dorchester County
7 and only 15 percent would be from Berkeley
8 County. So, and -- and Charleston and
9 Dorchester County are already well served by
10 existing providers, and so. And if we go to
11 the next page, that's just a summary ---

12 Q: Slide 24?

13 A: 24 is just a summary of my analysis and you can
14 see that Berkeley non-tertiary is 15 percent,
15 OB is 18.8. It's about 16 percent overall
16 between the two categories, and you can see
17 that Charleston and Dorchester together are
18 about 79 to 80 percent.

19 Q: Okay.

20 MR. THOMAS: Let's go to slide 25.

21 Q: You address in this slide, I believe, the --
22 the -- the decanting or decompression. What
23 are your opinions regarding decompression of the
24 downtown utilization for MUHA?

25 A: Sure. I mean, that -- that was a -- a theme

1 that went throughout the application that the
2 downtown hospital was -- was highly utilized.
3 And I'm not -- I'm not -- I'm not disputing
4 that they have high occupancy downtown, but
5 whether this hospital is going to really solve
6 that problem, I think the application itself
7 says the community hospital will slightly
8 alleviate these constraints, but MUHA will be
9 -- remain full downtown. So, in terms of a --
10 a vehicle to reduce the occupancy rate
11 downtown, this isn't necessarily the most
12 effective vehicle. And when you step back from
13 a health planning perspective and say, well, if
14 you really want to decrease the utilization of
15 a facility, is the solution to that to build
16 one 28 miles away or 26 miles away depending on
17 where you are. But -- and to me that -- the
18 greater likelihood is that it's going to
19 attract patients from other hospitals than it
20 is going to redirect patients from -- from
21 MUHA.

22 Q: Okay. And in terms of that quote that you
23 pulled out of there, what -- from what was the
24 source of that?

25 A: That was from the application on page 38 of the

1 application.

2 Q: Okay. And I think you referenced on slide 26
3 more about this.

4 A: I do.

5 Q: Okay. Explain to the Court what you've
6 isolated and why.

7 A: Well, you know -- and I don't believe that the
8 application really discussed what other
9 alternatives there were. I mean, it had a very
10 brief discussion of alternatives, but it didn't
11 really go -- get into the detail of whether or
12 not they can -- they can address that high
13 utilization through other means. And one of
14 the things that we saw -- one of their
15 consultants in a -- in a report that they had
16 prepared, talked about the fact that -- that
17 MUHA's purchase of the four -- I say CHS here,
18 that's Community Health Systems Hospitals, in
19 other parts of South Carolina, have the
20 potential to decant, using the MUHA word,
21 decant this patient volume by allowing those
22 patients who are now traveling to the -- to
23 Charleston to be served in their local
24 communities instead of in -- having to travel
25 to Charleston and receive care.

1 **Q: Okay.**

2 MR. THOMAS: And let's go to Trident Exhibit 71.

3 For the record, MUHA production document 16849.

4 (Trident Exhibit Number 71 was referenced at this
5 time.)

6 **Q: And did you review this document that was
7 produced by MUHA?**

8 **A: I did.**

9 **Q: What is the title of the document, Mr.
10 Sullivan?**

11 **A: Report to MUSC Board of Trustees proposed
12 purchase of CHS Health Systems.**

13 **Q: Okay.**

14 MR. THOMAS: And can you go to 16849? I'm sorry.
15 That's the new 71-016.

16 **Q: And you've got a quote on the page here, Mr.
17 Sullivan. Did you pull the quote out of this
18 document?**

19 **A: I did.**

20 **Q: Okay. And did you -- did you review -- who is
21 Kaufman Hall as you understand it?**

22 **A: I -- I know those guys. I've worked with them
23 before. They're financial advisors. They do
24 financial advisor work for lots of hospitals
25 and hospital systems.**

1 **Q: Okay. Do you understand this to be a business**
2 **record of MUSC?**

3 **A: Yes.**

4 **Q: Okay.**

5 **MOTION TO ADMIT:**

6 **MR. THOMAS: Your Honor, I'd like to move into**
7 **evidence Trident Exhibit 71.**

8 **MS. CRUM: No objection, Your Honor.**

9 **MR. WICEVIC: No objection.**

10 **THE COURT: Admitted.**

11 **(Trident Exhibit Number 71 was admitted into**
12 **evidence.)**

13 **MR. THOMAS: All right. Let's go to the next**
14 **slide, 27, of TMC 138.**

15 **(Trident Exhibit Number 138 was referenced at this**
16 **time.)**

17 **Q: You have some opinions about how a MUHA may be**
18 **able to address capacity needs. Can you**
19 **explain those to the Court, Mr. Sullivan?**

20 **A: Sure. Rather -- rather than build a distant**
21 **community hospital, it would seem that**
22 **exploring options on its existing campus, might**
23 **be a more affective way to deal with the**
24 **current occupancy issues that they have.**
25 **Excuse me one second. There ---**

1 MS. CRUM: Your Honor, we've been going about two
2 hours. We would have no problem taking a
3 break. I don't want interrupt the flow.

4 THE COURT: How much longer are you going to be?

5 MR. THOMAS: Oh, I got a little while, Your Honor.
6 I'm sorry.

7 THE COURT: Well, you want us to take a lunch break
8 right now?

9 MR. THOMAS: It's 11:45. Sure.

10 MS. CRUM: Do you want to get through exhibit and
11 then we'll ---

12 MR. THOMAS: I mean, I can keep going. I -- I have
13 no problem with that, Your Honor. I just -- I
14 understand ---

15 THE COURT: This exhibit is 83 pages.

16 MR. THOMAS: 83 separate exhibits. It is -- but a
17 lot of it, Your Honor, is -- we get to some
18 pretty hefty spreadsheets that takes, you know,
19 several different pages up that we would be
20 able to go through rather quickly.

21 THE COURT: What also concerns me is down the road,
22 I -- Ms. Crum's going to object to this coming
23 into evidence. There's aspects of this exhibit
24 that I would see admitting. There's aspects
25 that I don't and I don't look forward to going

1 through all these slides, but I guess that's
2 where we're going to be headed.

3 MR. THOMAS: Well, and I was going to make a
4 suggestion on that, Your Honor. I mean, you
5 know, you know that this man's an expert. If
6 it would assist the trier of fact having this
7 in evidence when you know it's an expert.
8 These are facts. He said this into the record.
9 So, I -- frankly, I just don't see -- I can
10 understand if it's a jury trial, that would be
11 one thing, but you know, based on the case that
12 we've already cited and that you used with Mr.
13 Richardson's slides, I believe that -- I just
14 don't see the prejudice to the other slide
15 here. I don't see it.

16 THE COURT: They're allowed to object.

17 MR. THOMAS: Sure.

18 THE COURT: Part of my ruling on Mr. Richardson
19 though was that they didn't object and they
20 utilized all that and then they objected at the
21 tail end. This time, they objected at the
22 beginning and I'm going to have to weigh all
23 that in, but did you want to say something real
24 quick and then we'll move on?

25 MS. CRUM: No, sir. I just was going to say I had

1 seen Mr. Sullivan needs some water ---

2 THE COURT: Okay.

3 MS. CRUM: And I'm fine moving on and if we have any
4 hope of finishing today with this witness, we
5 probably need to go ahead and finish this
6 exhibit.

7 THE COURT: Okay. Well, then ---

8 MS. CRUM: Would just be my thought.

9 MR. THOMAS: Yeah.

10 THE COURT: Well, let's just take a short break
11 then.

12 MR. THOMAS: Okay. Thank you, Your Honor.

13 (Off the record from 11:47 a.m. until 12:03 p.m.)

14 THE COURT: Y'all be seated. All right.

15 MR. THOMAS: Your Honor, Ms. Crum and I were
16 discussing in the break that I think that we
17 could reach a compromise and what we would do
18 is just remove the narrative portions of the
19 TMC 138 but keep in the maps and the charts and
20 graphs that would maybe help Your Honor during
21 the review of this post trial.

22 THE COURT: So, you're going to remove the, then,
23 and not the charts?

24 MR. THOMAS: Yeah. No. Yeah. We'd keep the charts
25 in because they're ---

1 THE COURT: Yeah. Well, I -- because in some of the
2 charts were summaries of exhibits and under the

3 ---

4 MS. CRUM: Yes, sir. Yes, sir.

5 THE COURT: --- Rules of Evidence summaries come in.

6 MS. CRUM: Yes, sir.

7 THE COURT: And that's why I was ---

8 MS. CRUM: Yes, sir. And -- and ---

9 THE COURT: So, y'all are thinking along the lines
10 of what I was thinking ---

11 MR. THOMAS: Yes, sir.

12 THE COURT: --- that that comes in.

13 MS. CRUM: And what -- Your Honor, what we had
14 suggested as opposed to slowing everything down
15 now, is that over lunch we would go through and
16 see what all we could pull out. And then, to
17 the extent, there was a specific exhibit that
18 was a chart or something that I had an
19 objection to, we could deal with it then and I
20 -- I think that would just absolutely speed
21 this thing up.

22 THE COURT: Okay. Well, let -- yeah. Y'all are
23 thinking along the lines of what I was
24 thinking.

25 MR. THOMAS: Yes, sir.

1 THE COURT: Especially on any of the charts where he
2 takes an exhibit and summarizes it.

3 MS. CRUM: Yes, sir.

4 THE COURT: What is that rule, 1?

5 MR. THOMAS: Rule 1006.

6 THE COURT: I was going to say 1005. I'm close.

7 MR. THOMAS: Within one, Your Honor. That's close
8 enough.

9 THE COURT: Okay. All right.

10 MR. THOMAS: All right. Back on the record. Let's
11 go to page 27 of TMC 138, please.

12 MR. SULLIVAN - CONTINUED DIRECT EXAMINATION BY MR.
13 THOMAS:

14 **Q: All right. We talked about capacity needs and**
15 **how MUHA can address them, I think before we**
16 **took the break. Can -- can you give the Court**
17 **your opinions on that, Mr. Sullivan?**

18 **A: Sure. You know, one option that I -- you know,**
19 **one alternative I didn't see, you know, really**
20 **explored in any depth in the application, is**
21 **the fact that when they open the Shawn Jenkins**
22 **Children's Hospital in the Women's Pavilion,**
23 **which I don't know exactly when, but some time**
24 **supposedly before the end of the year this**
25 **year, they're going to be vacating a number of**

1 beds and they already have received approval to
2 backfill 33 medical/surgical beds in the space
3 that's being vacated by the women and
4 children's project. And they have another
5 application pending for another 29 beds to --
6 to backfill in that space. And they -- one of
7 the documents that was produced, which was, I
8 guess, Trident Exhibit 89, was a MUSC, CHUH,
9 preliminary backfill plan, which talked about
10 some other opportunities in that space for
11 backfilling. So, I mean, that obviously, you
12 know, and -- as far as I can tell, there's been
13 no study made of exactly how many beds could be
14 accommodated in that -- that vacated space.

15 Q: And that vacated space is -- is where?

16 A: It's in the Children's Hospital.

17 Q: The existing Children's Hospital?

18 A: The existing Children's Hospital.

19 Q: And so, did -- did you review the 29-bed CON
20 application for MUSC?

21 A: I did.

22 Q: Okay. And is that what formed your opinion
23 regarding backfill of those 29 beds in the --
24 the old Children's Hospital area?

25 A: Yes.

1 **Q:** **Okay. Do you recall what the project -- total**
2 **project cost of that project was?**

3 **A:** **I don't. It was relatively inexpensive though.**
4 **I mean, I -- in the grand scheme of things.**

5 **Q:** **Okay.**

6 **MOTION TO ADMIT:**

7 **MR. THOMAS:** Now -- and -- Your Honor, I'd like to
8 move in Trident Exhibit 160, which is MUSC's
9 Certificate of Need application for 29
10 additional beds. It is not the full
11 application, Ms. Crum. It looks like it's
12 sections A through E and there's maybe a couple
13 of the attachments like the pro forma.

14 **MS. CRUM:** Your Honor, I -- I don't have any
15 objection to his moving that in. I would
16 reserve the right to supplement with additional
17 pages from the application as necessary.

18 **MR. THOMAS:** No objection, Your Honor.

19 **MS. WICEVIC:** No objection.

20 **MS. SHOUN:** None, Your Honor.

21 **THE COURT:** It is admitted.

22 (Trident Exhibit Number 160 was admitted into
23 evidence.)

24 **MR. THOMAS:** Go to the next slide, please.

25 **Q:** **All right. This is more about the capacity**

1 needs. Can you explain what you've done on
2 this page, slide 28.

3 A: Yeah. I -- I reviewed the depositions of Sarah
4 Bacik, who's I think their VP for strategy at
5 MUHA, and -- and Ms. Smith, who's the architect
6 with LS3P. And there was some discussion about
7 a masters facility plan that identifies
8 potential areas for developing new buildings on
9 the MUSC campus. I think the -- as I
10 understand it, the first phase of the plan with
11 developing was called ART building, Ashley
12 River Tower. The second phase was the Women's
13 and Children's Tower. And there has been --
14 there's at least some discussion about
15 potentially developing another tower or more
16 that one tower on the -- on the campus that
17 would be another way to address the capacity
18 needs of the institution.

19 Q: Okay. In terms of developing that bed need
20 tower are there -- what if any advantages would
21 there be to doing that downtown?

22 A: Well, certainly, it would reduce the need to
23 duplicate administrative and overhead expenses
24 at a new hospital. You know, for example,
25 you're going to have to have administrators;

1 you're going to have to have all of the
2 registration and billing folks and so forth
3 that you -- a lot of that's going to have to be
4 duplicated from downtown. Certainly, having it
5 downtown would be more convenient for the
6 faculty of the Medical University and for the
7 students who are rotating through there and it
8 would provide those patients with access to all
9 the specialized equipment and services on the
10 Medical University Campus.

11 Q: Did you see anything in MUHA Nexton's CON
12 application, Mr. Sullivan, that indicated
13 capacity issues downtown with respect to MRI,
14 CT and other ancillaries?

15 A: I did not.

16 Q: Okay.

17 MR. THOMAS: Let's go to the next slide, page 29.

18 Q: Can you explain to the Court what this is?

19 A: Yeah. This is a -- I guess a Google Earth map
20 of -- of the Medical University campus. And
21 some -- I think you presented this in your
22 opening, but it has some crosshatching on
23 certain sites and my understanding is that the
24 -- at least one of the sites considered is the
25 crosshatched area that says Wellness Center,

1 which is -- I guess I can touch the screen and
2 point to where it is. It's -- it's right there
3 (indicating). And there's -- there's property
4 that the Medical University owns surrounding
5 this that would be a potential location for --
6 for a new patient tower.

7 Q: Okay. Have you had the opportunity to drive
8 around the campus?

9 A: I did. Yeah. I did -- I've done it a couple
10 of times since I first began to think about
11 this and just trying to look at the area and
12 there does seem to be and there would be a
13 logical place to put a new tower if you put it
14 on the Wellness Center because it would sort of
15 line up with the Ped- -- Children's Hospital
16 and with the Ashley River Tower and so forth.

17 Q: Where is your understanding where this
18 Children's Hospital is on this particular
19 Google map? I mean, I know it's -- it may not
20 be there, but what -- what's the site location
21 where it may be about to open?

22 A: It's right here (indicating). This is
23 obviously a -- a picture that was taken at an
24 early stage of construction, but it's -- it's
25 right out near -- right at Calhoun and --

1 Calhoun Street where it begins to turn into
2 Lockwood Drive and it's -- it's in a direct
3 line with the Ashley River Tower and this --
4 the site that I'm talking about would be
5 directly behind that, and so.

6 Q: Okay. Thank you. All right. You have --
7 slide 30. Can you explain to the Court again
8 about the capacity?

9 A: Yeah. I mean the -- one of the arguments is
10 that patients complain about wayfinding and
11 parking. And I mean, that's probably true of
12 every hospital to a certain extent. Academic
13 medical centers, having worked in one, we used
14 to have lines painted of different colors down
15 the -- the hallways and told patients to, you
16 know, if you want to get to this department,
17 follow the blue line; if you want to get to
18 this department, follow the red line. But I
19 mean, it's -- it's kind of a -- you know,
20 something to be expected if you go to a large
21 teaching hospital. The one thing we heard
22 consistently from Medical University witnesses
23 is that they get excellent patient satisfaction
24 scores from the Press Ganey reports, which is
25 a organization that analyzes patient

1 satisfaction surveys. I think there was
2 testimony in some of the depositions about the
3 fact that the Medical University was rated the
4 number one hospital in the State of South
5 Carolina by US News and World Report. So, it's
6 doing a pretty good job with the current set-up
7 that it has right now. And -- and granted, it
8 may need some additional bed capacity, but
9 there's other ways to do it besides building a
10 hospital out at Nexton.

11 Q: Okay. Let's go to the next slide, number 31,
12 TMC 138, and talk again about patient access.
13 What are your opinions with respect to the
14 focus of MUSC's project?

15 A: Well, the -- the application talks primarily
16 about improving patient access as -- as the
17 rationale for developing this project. We saw
18 in some of the -- the documents produced in
19 discussion that MUSC's expansion plans, and
20 this is one of a number of projects that MUSC
21 has proposed in the northern part of the tri-
22 county area. And -- and when we look at some
23 of those documents, we can see that the reason
24 for this project, at least in part, is for
25 strategic objection -- objectives that don't

1 have anything to do with improving patient
2 access. It has to do with expanding the base
3 for capturing tertiary referrals, for being
4 able to leverage higher prices in negotiations
5 with third party payors. Let me explain that
6 just a minute. If you have good geographic
7 coverage, then you can go to a Blue Cross or
8 United Healthcare or what have you and say, you
9 know, you can sign a contract with us and we
10 can give you a network that'll cover this whole
11 geography and you don't have sign contracts
12 with three or four separate hospitals. And in
13 return for that, you might be able to get a --
14 a higher reimbursement rate for the fact that
15 you have greater coverage. And overall
16 enhancing the MUHA brand, which is something
17 that people talk about a lot these days. And
18 then we have an excerpt on the next page from
19 MUHA's ambulatory strategy plan that was done
20 sort of contemporaneous with the time that they
21 were filing this application. And -- and it
22 talks about the reasons why they want to do
23 this ambulatory expansion and it's important to
24 note that the -- the new hospital's going to a
25 significant ambulatory component to it. So,

1 expand geographic reach, enhanced brand, build
2 leverage, enhanced competencies, lower cost per
3 unit and improve access to capital. So -- I
4 mean, these are the same kinds of objectives
5 that many healthcare organizations have. I'm
6 not saying there's anything evil about the
7 Medical University having these objectives.
8 It's just that you don't see a lot of
9 discussion about enhancing geographic access
10 for its patients. It's -- it's about the other
11 broader objectives.

12 Q: And did you see any of these -- did you see
13 anything about building negotiation leverage or
14 enhancing brand reputation in the CON
15 application?

16 A: I did not.

17 Q: Okay. And this particular document that you
18 relied on for your opinion here at the MUHA
19 ambulatory strategy plan, I believe can be
20 found at TMC 30. Exhibit 30. And did you
21 review that document, sir?

22 (Trident Exhibit Number 30 was referenced at this
23 time.)

24 A: I did.

25 Q: Okay. Who do you understand created it?

1 **A: I believe it was done under Sarah Bacik's**
2 **direction. I'm not sure that she created it**
3 **singlehandedly, but I think -- I think she**
4 **testified in her deposition that it was done by**
5 **her folks.**

6 MOTION TO ADMIT:

7 MR. THOMAS: Okay. I'd like to move this MUHA
8 document into evidence, or TMC 30, Your Honor.

9 OBJECTION:

10 MS. CRUM: Your Honor, I'm -- I'm going to object to
11 that on relevance grounds. This has to do with
12 the am- -- with MUSC's strategy ambulatory --
13 out- -- outpatient ambulatory strategy and
14 outpatient strategy. It has nothing to do with
15 the inpatient hospital and the financial range
16 -- long range financial plan is dealing again
17 with the ambulatory strategy. This is not
18 applicable to the MUS- -- well, to the project
19 here. It's a total other strategic initiative
20 by MUSC as opposed to the inpatient hospital.
21 I would also suggest to you, Your Honor, that
22 we've had testimony that inpatient services are
23 different than outpatient services. So, this
24 just -- it flat isn't relevant and I would also
25 suggest it was produced prior to the time the

1 CON application was filed. They took it off
2 the page, but it was produced on December the
3 1st, 2017, which was prior to the application.
4 So, Your Honor, it's just flat not relevant.

5 MR. THOMAS: Let's look at page 9 of the document.
6 Maybe I can show some relevance. Do you see --
7 -

8 Q: Well, first of all, Mr. Sullivan, I think you
9 already testified to this, but what's your
10 understanding of the ambulatory components of
11 MUHA's Nexton hospital?

12 A: Well, it -- it will certainly have outpatient
13 diagnostics, both lab and radiology. It'll
14 have outpatient therapies and will have an
15 emergency department, which is probably the
16 single biggest component of the outpatient
17 services.

18 Q: Okay. And here on -- within this document
19 that's labeled ambulatory strategy and long
20 range plan on page 9 of the document, do you
21 see the hospital that is referenced -- I mean,
22 that's the subject of the CON application here?

23 A: I do. It's items E and F on this page talk
24 about second hospital land and then the second
25 hospital itself. You know, these numbers are

1 **roughly the total project cost of the new**
2 **hospital.**

3 MS. CRUM: Your Honor, first off, the document
4 doesn't say anything about the Nexton project.

5 THE COURT: It speaks for itself.

6 MS. CRUM: Yes, sir, it does.

7 MR. THOMAS: Well, Your Honor, this is in their --
8 their ambulatory strategy and she can cross-
9 examine him whether she knows what other \$300
10 million hospital, you know, that they're
11 developing, but as far as this production idea,
12 this was produced to us in response to our
13 discovery in this case. So, it may have been
14 -- if they didn't think it was relevant, I
15 suppose they would have objected to this
16 document as not being relevant or they just
17 wouldn't have produced it, Your Honor.

18 MS. CRUM: Your Honor, I got to say, it's not up to
19 us to determine what is relevant to them and
20 anytime ---

21 THE COURT: Or admissible.

22 MS. CRUM: --- anytime we produce, I -- we err on
23 the side of caution. In fact, we've gotten
24 fussed at in here because we produced so much.

25 THE COURT: Well, I just don't see the relevance

1 here of this at this point and time. If you
2 want to develop it first, I'm not gonna stop
3 you, but you're asking to introduce this into
4 evidence and there's nothing ---

5 MR. THOMAS: Well, he just -- he just talked about
6 how there's a big ambulatory component of the
7 hospital. Maybe I can ---

8 THE COURT: Well, he -- he can testify to that all
9 he wants.

10 MR. THOMAS: Right.

11 **Q: And do you understand what the revenues are**
12 **that are generated from the outpatient services**
13 **of the hospital, Mr. Sullivan?**

14 MS. CRUM: Your Honor, I'm still going to object.
15 This doesn't have any basis of that. He can
16 testify ---

17 THE COURT: Well, this hasn't been admitted. I -- I
18 told him I'm not admitting this at this point
19 and time.

20 MS. CRUM: All right. All right, sir. Thank you.

21 **A: The -- the outpatient revenues are 35 to 36**
22 **percent of the total revenue of the proposed**
23 **hospital.**

24 MR. THOMAS: Your Honor, I'd like to proffer it
25 then, I guess.

1 THE COURT: That's fine.

2 MR. THOMAS: I think it's -- it's relevant. I

3 mean, they're talking about their ambulatory

4 strategy. That one-third of their revenues

5 from the hospital is coming from ambulatory

6 services, the second hospital is referenced

7 within the document.

8 THE COURT: But ---

9 MR. THOMAS: I guess I'm ---

10 THE COURT: Were you saying -- this is talking about

11 the overall financial strategy of MUHA

12 entirely, correct?

13 MR. THOMAS: No. The ambulatory portion of -- the

14 ambulatory strategy and long range financial

15 plan.

16 THE COURT: Of MUHA?

17 MR. THOMAS: Of MUHA.

18 THE COURT: Yeah. Overall.

19 MR. THOMAS: Right.

20 THE COURT: And ---

21 MR. THOMAS: Well ---

22 THE COURT: This is offered to prove what point?

23 MR. THOMAS: Well ---

24 THE COURT: That's what I'm -- I told you I failed

25 to get ---

1 MR. THOMAS: Well, so ---

2 THE COURT: --- is -- it -- yes, it does address the
3 second hospital, whatever that may be and all
4 that. But what does it -- what point does it
5 make for me to consider?

6 MR. THOMAS: Okay. Because, Your Honor, one of the
7 slides -- I'm glad you asked that. Let's see.
8 If you could go back. If you look at slide --
9 page 6 of TMC Exhibit 30, these are all
10 concepts that are never discussed in the CON
11 application, such as enhanced brand reputation
12 and build negotiation leverage. Now, what is
13 negotiation leverage? Mr. Sullivan just
14 testified that it allows MUSC to get a higher
15 rate of reimbursement from insurers. And what
16 does that mean to the patient, Your Honor?
17 That means that the patient is charged more.
18 That means the patient's co-pay is higher.
19 That means the patients, you know -- if they're
20 under what I'm under, which is a high
21 deductible health plan, that means they're
22 paying more until they reach a level. So, this
23 goes directly to my arguments on cost
24 containment. And they're talking about their
25 long range financial plan. They're talking

1 about expanding geographic reach, enhancing
2 brand reputation, and the last slide, they're
3 talking about a second hospital. Well, they
4 only got one, Your Honor, and the predates
5 their four hospitals that they purchased. So,
6 I -- you know, that second hospital, which is
7 \$300 million, no coincidence, the second
8 hospital they're applying for is 4300 million.
9 This -- this is very relevant to my case.

10 MS. CRUM: Your Honor, I'm not going to make a
11 closing argument, I promise.

12 THE COURT: Okay.

13 MS. CRUM: But the -- this is why scale that --
14 there's a slide they had up there a few minutes
15 ago. It's out of this Exhibit 138, it's page
16 6 of this document. It's the -- the scale of
17 the ambulatory surgery center. It is their
18 development of out -- I'm sorry, not the
19 surgery center; ambulatory services. And we
20 haven't heard any testimony about the co-pays
21 and who pays that and everything else. That --
22 that was just legal argument. This is not --
23 it's not relevant to the project at hand. It
24 is another initiative of MUHA. It's doesn't --
25 it's not relevant ---

1 THE COURT: Okay.

2 MS. CRUM: --- to the hospital.

3 THE COURT: I'm going to take a very short break

4 right outside, so y'all don't go anywhere.

5 I'll be right back.

6 (Off the record from 12:24 p.m. until 12:26 p.m.)

7 THE COURT: All right. After further cogitation, my

8 ruling is he can testify to this document.

9 It's a hearsay document. They did produce it,
10 but I -- this document at this point in time is
11 not sufficient for me to let it in. I'll allow
12 him to take what he gets out of this document
13 as far as his analysis is concerned.

14 MR. THOMAS: Okay. Thank you, Your Honor.

15 **Q: Mr. Sullivan, in terms of the build negotiation**
16 **leverage portion of the scaling -- and by the**
17 **way, what -- what's your understanding of what**
18 **scaling is?**

19 **A: Scaling is increasing the -- the scope of your**
20 **operations.**

21 **Q: The footprint. Is that another way ---**

22 **A: Sure, sure.**

23 **Q: And in terms of building negotiation leverage,**
24 **which you spoke about earlier, what -- what**
25 **effect, if any, would that have on cost**

1 **containment principles in the Certificate of**
2 **Need world?**

3 MS. CRUM: Your Honor, I'm not sure he's laid a
4 foundation if he is directing this to MUHA. If
5 he's just generally talking about it, then
6 maybe so. I didn't know whether he was talking
7 about the leveraging vis-a-vis MUHA or just
8 generally from health planning. I couldn't
9 tell from the question.

10 THE COURT: Sounds general to me, but it sounds like
11 he's working toward MUHA.

12 MR. THOMAS: That's why we're here.

13 **Q: What's your understanding of build negotiation**
14 **leverage in terms of that concept with cost**
15 **containment?**

16 **A: Sure. Well, I mean it -- I guess it depends on**
17 **which seat you sit in if you're on the payor**
18 **side or you're on the provider side, but the --**
19 **the greater the leverage that a provider has,**
20 **the higher the prices that the provider can**
21 **extract from the -- from the third party payor**
22 **and that obviously has cost containment issues**
23 **in the fact that it would raise insurance**
24 **premiums potentially for, you know, companies**
25 **and for individuals by result and patients**

1 having to pay higher portion of the -- of the
2 charges at -- at a particular facility. So, I
3 mean, it's not necessarily a cost -- it doesn't
4 contribute to cost containment. It has the
5 potential to be inflationary if one provider
6 gets a great market leverage over other
7 providers.

8 **Q:** And would this project, the MUHA 128-bed in
9 Berkeley County, would that expand MUHA's
10 geographic reach?

11 **A:** It definitely would. They would have another
12 point of service located, you know, in a
13 different part of the tri-county area and, so
14 it -- yeah. It would definitively expand their
15 -- their reach.

16 MR. THOMAS: Okay. Let's go to the next slide,
17 which is 33.

18 **Q:** What is this slide, Mr. Sullivan?

19 **A:** This was a -- an excerpt from a document that
20 was produced by MUHA. It was called a HUD
21 conversation document and as I recall the
22 context of it from Mr. Pack's deposition, they
23 were presenting this information to MUHA -- I
24 mean to HUD as a -- as a basis for seeking
25 additional funding for the Medical University.

1 Q: Okay. And what concepts do you see in this
2 document, which is MUHA RP29082 production
3 document?

4 A: It's talking about increasing referral. And --
5 and just to put in context, I think this is
6 talking about the purchase of the four CHS
7 hospitals ---

8 Q: Okay.

9 A: --- that we talked about earlier. It's
10 increasing referral volumes, meaning more
11 patients coming to Medical University from
12 outlying areas, cost economies by reducing
13 costs, and then better access to capital. I
14 guess with the theory that you would be
15 operating these other hospitals successfully
16 and then, stronger ---

17 OBJECTION:

18 MS. CRUM: Your Honor, I -- I'm going to object to
19 that testimony. He says -- when he says, I
20 guess, I think that's just speculation.

21 Q: Could -- could you rephrase.

22 A: Sure. Better access to capital through
23 expanding the overall scope of -- of
24 operations, stronger pricing power. The same
25 concept we talked about earlier in terms of

1 negotiation leverage.

2 Q: Okay. Let's go to the next if we could, Mr.
3 Sullivan. All right. You mentioned earlier in
4 your testimony that you had worked on the East
5 Cooper Regional Medical Center replacement
6 hospital. Is that correct?

7 A: It's true.

8 Q: Okay. And that you opposed the Roper?

9 A: I did.

10 Q: Okay. What, if any, opinions do you have re-
11 -- regarding the MUHA Nexton project that
12 relates to your experience in this tri-county
13 market with the MUHA hospital?

14 A: Sure. The concerns that were raised -- well,
15 that I raised in the -- in the review of these
16 two projects was that by putting another
17 hospital out there, East Cooper was already
18 underutilized. This was only going to result
19 in having two underutilized hospitals serving
20 the same market. Roper St. Francis at the time
21 argued that they would largely redirect
22 patients who were traveling from East Cooper
23 area to downtown to the new hospital and it
24 wouldn't have any impact on other providers and
25 -- or any material impact on other providers,

1 and that it's new hospital would be well
2 utilized within three years of opening. And
3 when we look at the actual results because this
4 all happened several years ago, we have some
5 good data. We can see that what I had feared
6 would happen actually did happen.

7 Q: Okay. Let's -- let's turn the page and look at
8 some of that data, if you could summarize it
9 for the Court.

10 A: Sure.

11 Q: First of all, where did this data come from
12 that we're -- you're about to talk about?

13 A: It came from JARs.

14 Q: Okay. TMC 147 through 153?

15 A: It did.

16 Q: Okay. That's in evidence.

17 A: And I -- I took a historical year. So, 2009
18 was -- was before the new development activity
19 started on the Roper Mount Pleasant hospital.
20 And so, the occupancy rate -- I'm sorry, the
21 average daily census at East Cooper at that
22 point was 47, 46 and a half patients. And then
23 when the Mount Pleasant Hospital opened up, the
24 occ- -- the average daily census dropped to
25 38.6. So, it dropped about eight patients and

1 East Cooper's volume was about 10.8. So, much
2 of the loss at East Cooper was due to the
3 patients going to the Mount Pleasant Hospital.
4 And as we look over time, there really -- there
5 has been some part ---

6 THE COURT: Did you say East Cooper was 10.8 or did
7 you mean Mount Pleasant?

8 A: Mount Pleasant. I misspoke if I said that.
9 Yeah. East Cooper is the blue bar and Mount
10 Pleasant is the orange bar.

11 THE COURT: Yeah. I get that.

12 Q: All right. So, what -- what were you saying,
13 Mr. Sullivan?

14 A: I'm saying over time, the Mount Pleasant
15 Hospital has grown a little bit. It's still
16 operating at relatively low utilization levels,
17 which we'll see in a second. And East Cooper
18 really hasn't grown at all. And if we go to
19 the next slide ---

20 Q: Is this slide 36?

21 A: It is. And we put this in the context of
22 occupancy rates. Before Mount Pleasant opened,
23 East Cooper was operating at about 33 percent.
24 I believe East Cooper gave up 10 beds in
25 developing its replacement hospital. But it's

1 occupancy rate dropped and Mount Pleasant
2 operated and continues to operate at very low
3 occupancy rates. And so, now if we look at
4 2018, the most recent year, we have data for --
5 we have one hospital operating at 27.5 percent
6 utilization and the other hospital operating at
7 26.4 percent. So, both these hospitals are
8 only at a little more than a quarter full over
9 their licensed bed capacity. So, approving
10 this new hospital under the theory that it was
11 going to be redirecting patients that were
12 going downtown, didn't really pan out very
13 well. And if we go to the next slide.

14 Q: Slide 37?

15 A: Yeah. Let's skip over than and I'll go to the
16 -- the next slide, slide 38. If we look at
17 what happened in terms of overall market share,
18 Mount Pleasant over the years, has picked up in
19 market share and I -- I took it from 2011
20 through 2016 because this covered, I think the
21 first five years of Mount Pleasant's
22 operations, 14.6 percent market share. Roper
23 St. Francis, which was supposed to be the
24 primary organization impacted by this, dropped
25 by three percent. And the rest of the loss in

1 market share was East Cooper and all other
2 hospitals serving that area. And so, the
3 impact was disproportionately felt on the non
4 Roper St. Francis hospitals. And that's my
5 fear in this case that if you open another
6 hospital four miles away from Roper St. Francis
7 Berkeley, you're going to end up with two
8 underutilized hospitals serving that same
9 general market.

10 Q: Okay. And the basis is your experience in the
11 Mount Pleasant market?

12 A: Yes.

13 Q: Okay.

14 THE COURT: And so -- what I can understand is
15 you've got Mount Pleasant at 14.6 in 2016.
16 Other Roper St. Francis hospitals, what are you
17 referring to there?

18 A: Roper and St. Francis, Bon Secours Hospital.

19 THE COURT: All right. So, that's what you mean by
20 that?

21 A: Yeah. I do.

22 THE COURT: Okay. You could've worded that one
23 better.

24 A: I'm sorry.

25 THE COURT: Then all other hospitals are just the

1 remaining hospitals in the area?

2 A: Yeah. That would be East Cooper and Trident
3 and -- that area was served by a lot of
4 different hospitals in small numbers.

5 THE COURT: Okay. All right.

6 MR. THOMAS: Let's go to the slide 39, please.

7 Q: Tell us about the -- the appendage regarding
8 MUHA's projections and utilization?

9 A: You know, I -- for many of the reasons I've
10 already discussed, I believe that the -- the
11 opening of the Roper St. Francis Hospital is
12 going to, you know, negatively affect the
13 ability of the MUHA hospital to attract
14 patients. And there did not seem to be any
15 consideration given to the opening of the Roper
16 St. Francis Hospital in the -- in the MUHA
17 Nexton application. For example, the
18 projections of utilization just assume that the
19 overall discharges going to MUHA either -- at
20 both hospitals would grow at the same rate as
21 population growth without any consideration to
22 any reduction in -- in volume related to the
23 opening of the Roper St. Francis Hospital,
24 particularly in those zip codes that are
25 closest to the Nexton community. And so the

1 assumption was that MUHA would be totally
2 unaffected by the opening of Roper St. Francis
3 and they would just continue on as they -- as
4 they are currently.

5 Q: Is that related to the redirection analysis?

6 A: It is. What -- but the problem with it is they
7 assume that the number of patients they were
8 drawing from that area wouldn't change. That
9 it would just grow with population, even though
10 a new hospital was opening in a portion of the
11 service area defined.

12 Q: Okay. And so what are your conclusions with
13 respect to that in terms of the -- the MUHA
14 expected shift?

15 A: Well, I think that -- I mean, first of all, I
16 believe they should have assumed a smaller
17 service area because they were too broad in
18 their approach. And I think they should have
19 assumed a lower ability to -- to shift patients
20 to the -- to the new hospital.

21 Q: Okay. Let's go to slide 40, I think you may
22 address that service area ---

23 A: I do.

24 Q: --- to -- tell the Court what you did in terms
25 of redefining that service area?

1 **A:** Well, the application as we saw defined this
2 multi-county service area for 20 -- 128-bed
3 community hospital. Then I said, well let's --
4 let's look at something more reasonable than
5 that. And so I -- I try to be as expansive as
6 possible within the realm of reason. And so I
7 said, let's use 30 minutes driving time as sort
8 of the outer bands of where they're likely to
9 attract patients from. And using drive times
10 and defining services areas is -- is a pretty
11 common methodology. I think there's already
12 been testimony about 15-minute and 20-minute
13 draw areas and so forth around the new
14 hospital. And so I did include some of the zip
15 codes in northern Berkeley County that were
16 more than 30 minutes away from the proposed
17 Nexton Hospital just ---

18 **Q:** Why is that?

19 **A:** Because there were no other hospitals between
20 them and -- and the Nexton hospital. And --
21 and then I reduced the percentage of -- of
22 patients that were expected to shift in
23 recognition that this hospital wouldn't offer
24 the same range of services and that in many
25 cases the patients would be closer to the

1 downtown MUHA hospital then they would be to
2 this hospital. And then I did something that
3 wasn't in the -- the MUHA application and I
4 think Mr. Levitt will likely testify, well, we
5 drew our service area so big, we didn't have to
6 worry about any in-migration of patients from
7 -- unless they were coming from North Carolina
8 or Florida. That -- and so I said, okay, this
9 new service area, it's not going to capture
10 everybody you're going to serve, so I put a 20
11 percent in-migration factor in to cover
12 patients who might come in randomly from other
13 -- other parts of the state.

14 MR. THOMAS: All right. Let's go to the next slide.

15 Q: Is this a worksheet, paper that you developed?

16 A: Yeah. This -- this just shows the zip codes
17 that I included. I believe there are 25 zip
18 codes, which is still a pretty robust service
19 area for a start-up hospital. And this shows
20 the drive times that -- that Mr. Levitt had --
21 had included in the application and it showed
22 which counties these -- these zip codes were
23 in.

24 Q: All right. Is the next slide, which is 42, a
25 visual representation of the zip codes?

1 A: Yeah. It this. And even this I think is
2 probably too extensive, but I -- I wanted to
3 give the applicant the benefit of the doubt,
4 so.

5 Q: Okay. And let's go to slide 43. Tell the
6 Court what this is.

7 A: On Slide 43, I -- I did -- I took the same
8 approach that was taken in the application. I
9 just reduced the ability to shift patients and
10 I assumed that the highest level of shift would
11 be 40 percent for those zip codes closet to the
12 new hospital, and then we'd go down from there
13 to 25, 20 and then all the way down to 5
14 percent when you get to those zip codes that
15 are closest to the downtown area and then to
16 the existing hospitals there, and particularly
17 to MUHA downtown. And -- and overall, my
18 projection is that about 20 percent of the non-
19 tertiary discharges would be shifted and the
20 rest of them would continue to go downtown.
21 And then I added the 20 percent in-migration
22 factor and projected a total number of
23 discharges that would be available from
24 shifting from the existing MUHA facility.

25 Q: And -- and what number is that on this slide

1 **43, Mr. Sullivan?**

2 **A: 1,556.**

3 **Q: Okay. Let's go to ---**

4 THE COURT: And how does that implicate to the size
5 of the hospital?

6 **A: It has a pretty profound effect on it.**

7 THE COURT: And what's the profound effect?

8 **A: Well, we'll see a minute that the occupancy ---**

9 THE COURT: Are you going there?

10 **A: I'm going there.**

11 THE COURT: Oh, okay. All right. I won't stop you.

12 MR. THOMAS: Let's go to the next slide, 44.

13 **A: 44 is just the same calculation for -- for OB**
14 **services because they broke up into non-**
15 **tertiary and OB. And the shift there is a**
16 **little bit higher, 26 percent because MUHA**
17 **actually drew a few more OB patients from the**
18 **zip codes closest to the -- the Nexton**
19 **hospital.**

20 **Q: And so what's the -- the total there?**

21 **A: 596.**

22 MR. THOMAS: Okay. Let's go to the next slide, 45.

23 **Q: And what does this slide show the Court?**

24 **A: Well, if you -- if you believe that MUHA will**
25 **only attract patients from it's existing**

1 hospital, which I don't, I think this is a more
2 realistic expectation of shift. And to answer
3 your question, Your Honor, with an average
4 daily census of 31.3 in the third year, if you
5 see that down towards the bottom of the page --

6 -

7 THE COURT: Yeah.

8 A: --- that would equate to a need for beds
9 somewhere in the, like, 42, 43 range of beds,
10 as opposed to the 128 that are being proposed.
11 So, it's -- it's a significant reduction. I
12 mean, I'm projecting less than half of the
13 utilization level that was projected in the
14 application, if we were to adopt MUHA's belief
15 that only patients who otherwise would have
16 gone to their downtown facility would utilize
17 this facility.

18 Q: Okay. So ---

19 THE COURT: So, to get a 31.3 ADC there or -- how
20 does that also connect, for lack of a better
21 word right now, with the average length of
22 stay?

23 A: Well, this is -- this is using MUHA's length of
24 stay.

25 THE COURT: Okay.

1 **A:** So, I haven't changed that yet. I'll do that
2 on the next page.

3 **Q:** Slide 46. You're anticipating.

4 **A:** If we -- if we drop the length of stay down to
5 the numbers I thought were more reasonable, I
6 testified to earlier, then the overall
7 occupancy rate for the hospital drops to a
8 little over 20 percent. So, the average daily
9 census drops to 26 and so, the bed need would
10 be, you know, in the 33, 34 range, you know, of
11 -- of bed need for -- you know, for the
12 hospital. And so, you know, and it -- and if
13 we think this is unrealistic, look at what
14 happened in East Cooper, you know, where you're
15 running 20 percent occupancy rates in these
16 hospitals. And so I don't believe that they're
17 only gonna serve their own patients. I think
18 they are gonna take market share away from
19 other providers, so I wanted to incorporate
20 that fact in here just to be transparent that,
21 you know, that I think that the utilization of
22 the hospital would be greater than just the
23 patients that would re-direct from the downtown
24 facility.

25 **MR. THOMAS:** Let's go to the next slide.

1 THE COURT: So this -- your percentages now
2 included taking market share?

3 A: No, I'm getting to that now.

4 THE COURT: That's what I thought. Okay.

5 A: Yeah. This is -- this is just the pure ---

6 THE COURT: Based on their ---

7 A: Their shift of patients from their existing
8 hospital.

9 MR. THOMAS: Let's go to slide 47.

10 A: And so this just describes the fact that, you
11 know, the -- basic health planning principles
12 would say that you should expect when you put
13 a new hospital in the area, you're going to
14 attract patients from other facilities. I
15 mean, it just changes the dynamics in the
16 market. And so I made some assumptions about
17 shift in market share in light of the proximity
18 of the zip code to the hospital, the presence
19 of other hospitals in the market, and so if we
20 go to the next page ---

21 Q: This is slide 48?

22 A: Yep. If we can -- the good news is we can skip
23 through these next few pages pretty quickly.
24 This is just population data. It's from the
25 Claritas Nielson Company. I think that was

1 this data source that we talked about earlier.
2 So, if we go down -- let's see. I don't have
3 the document in front me. Keep going. This --
4 all right. Here we go. This just shows what
5 the projected number of discharges would be in
6 the future for each of these zip codes,
7 assuming that each zip code's total -- this is
8 not how many are going to the hospital, just
9 how many total people are going to go to a
10 hospital anywhere from these zip codes. And I
11 grow it by the rate of population growth, so
12 it's growing about one and a half percent a
13 year. And I project out the total discharges
14 in the market. And then if we go to the next
15 page.

16 Q: Which is slide 52?

17 A: I do -- right. I do this -- that was for non-
18 tertiary. I do the same thing for OB. And if
19 we got to the next page. This is where I
20 assume ---

21 Q: Market share.

22 A: --- market share increases and you can see that
23 my maximum increase is nine percent for the zip
24 codes that are closest to the proposed facility
25 and then I -- I scale that back down at six

1 percent and then at three percent and then, one
2 percent. And for those zip codes that are
3 closest to the peninsula, I assume a zero
4 percent increase in market share because I
5 don't think they're going to pick up any market
6 share there. And so, overall, they're going to
7 -- they're going to gain. I think it's like --
8 as I recall, the bottom line number, about four
9 or five percent market share in this broad area
10 as a result of opening the new hospital.

11 Q: All right. Let's go to slide 54. And what
12 does this tell us?

13 A: This tells us how many additional discharges
14 they're going to pick up through this increase
15 in market share for each year. And -- and what
16 -- by the third year, they're going to pick up
17 about 1,280 -- this is my estimate, 1,284
18 additional discharges through increased market
19 share. So you would add that to the base you
20 already had of patients that are shifting from
21 the downtown facility. And if we go to the
22 next slide, this is the same thing for OB.
23 They pick up an additional 317 OB patients.
24 And then the next slide.

25 Q: Which is 56?

1 **A:** **Right. Using MUHA's assumed market shares,**
2 **this is my projection of what their utilization**
3 **would be with shift and increase in market**
4 **share. And it'd be about 40.7 percent**
5 **utilization, average daily census of 52.1, and**
6 **an overall bed need using a 65 percent ratio in**
7 **-- in the range of -- of 63 or 64 beds. So**
8 **about half of what they're proposing. But I --**
9 **as I said, I don't accept these market -- I**
10 **mean, these average lengths of stay. If we go**
11 **to the next page.**

12 **Q:** **Slide 57.**

13 **A:** **And we use my reduced market shares, which I**
14 **think are more realistic, that reduces the**
15 **overall projected utilization level for the**
16 **hospital to 30 -- 33.9 percent, average daily**
17 **census of 43.4, overall bed need at 65 percent**
18 **occupancy in -- in the range of 52 or 53 beds.**
19 **So, this is my best estimate of what the**
20 **utilization would like at that hospital. And**
21 **clearly, even at these low levels, it can only**
22 **be achieved by taking patients away from other**
23 **providers.**

24 **Q:** **Okay. Regardless of what the actual occupancy**
25 **percentage is, is that -- even at that**

1 occupancy percentage, is, in your opinion, a
2 hospital in the Nexton area needed?

3 A: In my opinion, it's not. It -- it doesn't
4 nothing to improve geographic access. It was
5 based on the premise that Berkeley County is
6 under-served and yet the hospital proposes to
7 serve primarily patients from other counties,
8 not Berkeley County. I just don't think
9 there's any justification of a need for a
10 hospital there as it relates to the underlying
11 need that MUHA has for additional capacity.
12 They can certainly address that through adding
13 beds on their existing campus or they could
14 have put a hospital in a different part of the
15 tri-county area. I mean, this is a -- this is
16 a very large geographic area and there's lot of
17 parts of the area that don't have hospitals.
18 And -- and yet they pick a site that's four
19 miles away from a brand new hospital that's
20 opening up. Just -- you know, it -- from a
21 health planning perspective, that would not be
22 the ideal choice in my view.

23 Q: Okay. Did you rely on that analysis that we
24 went through on slides 48 through 57, on
25 summary population data -- the Nielson

1 population data, Mr. Sullivan, found in TMC

2 134?

3 (Trident Exhibit Number 134 was referenced at this
4 time.)

5 A: I did.

6 Q: Okay. Did you rely on RFA data found in TMC
7 Exhibit 128 in terms of your current and
8 projected non-tertiary discharges and OB
9 discharges?

10 (Trident Exhibit Number 128 was referenced at this
11 time.)

12 A: I did.

13 Q: Okay.

14 MOTION TO OFFER:

15 MR. THOMAS: I believe under 1,006, Your Honor, I'm
16 just going to put these into evidence unless
17 there's objection from Ms. Crum. I can put the
18 full TMC 134, but some of these documents are
19 kind of big.

20 MS. CRUM: Your Honor, I -- I don't object. I
21 thought we were going to do them all at once --

22 -

23 THE COURT: Yeah.

24 MS. CRUM: --- at the end, but ---

25 MR. THOMAS: It was -- it was just because these are

1 just summary documents. I just want to go
2 ahead and move -- well, I see what you're
3 saying.

4 THE COURT: Yeah.

5 MR. THOMAS: That's fine. That'll work. Sorry,
6 Your Honor.

7 THE COURT: You've already got her clear that she
8 doesn't object to that, so.

9 MR. THOMAS: That's right. All right. Let's go to
10 the next slide 58.

11 **Q: All right. What -- this slide addresses what?**
12 **Tell the Court about your opinions on flooding.**

13 **A: Sure. One -- one of the arguments, and there**
14 **were several pages in the CON application that**
15 **talked about flooding on the peninsula and --**
16 **and had pictures of flooding and I -- I'm no**
17 **stranger to flooding. My -- my home in**
18 **Charleston has flooded on three occasions. So,**
19 **I mean, flooding is an issue. But I think MUHA**
20 **has a -- has a problem, I think, in arguing**
21 **flooding in this particular instance, because I**
22 **was also involved in a project on behalf of**
23 **Summerville Medical Center to -- to develop a**
24 **small Level III neonatal nursery at six beds at**
25 **Summerville. And one of the factors that we**

1 brought up was well, flooding sometimes makes
2 it difficult for mothers or even for neonatal
3 transport to get patients from the northern
4 part of the service area down to the peninsula.
5 And MUHA took a very strong position saying
6 that flooding was not an issue. And I -- I
7 quote on this particular page a line from a
8 letter they wrote to Ms. Murdock in regard to
9 that project that SMC continues to raise false
10 concern regarding MUHA's ability to provide
11 care during weather emergencies and flooding.
12 So, I mean, this seems to be -- you can't have
13 it both ways. Flooding is either an issue or
14 it's not an issue.

15 Q: Who is SMC in this quote?

16 A: Summerville Medical Center.

17 MR. THOMAS: Okay. Let's go to slide 59.

18 Q: Would you quickly summarize this one?

19 A: Sure. I mean, if flooding was such a concern,
20 would they have spent more than \$500 million to
21 develop two new towers over the last ten years
22 downtown. I mean, it just -- I think that that
23 issue alone is not sufficient to -- to warrant
24 the approval of a new hospital.

25 MR. THOMAS: Okay. Go to slide 60.

1 **Q:** You have some opinions regarding adverse impact
2 in the MUHA Nexton application.

3 **A:** I do. I think the Trident Health facilities
4 are going to be impacted by this. I think Mr.
5 Gallati already testified and Ms. Valentine
6 that the areas that they rely on most heavily
7 for -- for their patients are those zip codes
8 that are proximate to the -- to the MUHA
9 proposed site. It's either 29486 where the
10 hospital is actually proposed to be located and
11 all of the contiguous zip codes represent
12 significant areas where they draw their
13 patients from. And -- and for that reason and
14 they also happen to have the highest market
15 shares in those -- in those zip codes. In some
16 of those zip codes, between Summerville and --
17 and Trident, they might have 70 to 75 percent
18 of all the inpatient discharges from those zip
19 codes coming to those two facilities. So, if
20 MUHA is going to be pulling additional market
21 share as a result of opening a new hospital,
22 the impact is going to be felt directly on --
23 on the Trident facilities. And I think we
24 heard some testimony from Mr. Gallati about
25 what the impact of opening a 50-bed hospital by

1 Roper St. Francis was on -- on his facility
2 even in the first month of potentially 150 --
3 150 discharge -- 55 discharges lost. And we're
4 talking about a situation here with a 128-bed
5 hospital, significantly larger, and if MUHA
6 were to come close to achieving its utilization
7 projections, it would have to take a very high
8 number of discharges out of the market
9 generally and that impact would be borne in
10 large part on -- on the Trident facilities.

11 Q: Okay. Did -- Mr. Gallati also mentioned a
12 number based on the contribution margin, I
13 believe it was \$9 million, just if you were to
14 annualize the ---

15 OBJECTION:

16 MS. CRUM: Your Honor, I'm -- I'm going to object to
17 leading. He can ask him if he remembers what
18 Mr. Gallati said as opposed to putting a number
19 out there.

20 THE COURT: Yeah.

21 Q: Mr. Sullivan, just -- you just mentioned that
22 Mr. Gallati testified about 155 patient loss in
23 October he attributed to Roper Berkeley. Do
24 you recall the -- the number in terms of an
25 annual -- annualized contribution margin loss

1 that he also testified about?

2 A: Yeah. I believe he said almost \$10 million is
3 what my notes say, so.

4 Q: Glad I was able to correct that. And what's
5 your understanding of what the contribution
6 margin is of Trident Health?

7 A: Well, if -- if you look at it blended across OB
8 and non-tertiary services, that -- that
9 contribution margin is somewhere in the range
10 of \$5,000.

11 Q: And so if MUHA were to open up right down from
12 Roper Berkeley and -- would you expect to have
13 a similar effect to Roper Berkeley or ---

14 A: I think it would probably have an even greater
15 effect because, you know, Roper Berkeley did
16 assume that they would have increases in market
17 share in order to fill their hospital.

18 Q: Well, do you recall what that assumption was?

19 A: Well, I think they said 50 percent of the
20 patients would be redirected from -- from Roper
21 Berkeley and then the rest, I think, would come
22 from market share increases.

23 Q: Okay.

24 A: And their ability to grow market share with
25 another hospital basically in their backyard is

1 going to be severely constrained. I think it
2 would have a pretty significant effect. And
3 Roper Berkeley is actually closer to the MUHA
4 Nexton site than the Mount Pleasant hospital
5 was to East Cooper in that -- in that example
6 I provided earlier. I think Mount Pleasant
7 Hospital was seven miles away and this is only
8 about four miles between Roper Berkeley and the
9 -- and the Nexton Hospital. So -- and given
10 that there's not a lot of population to the
11 north, they're all going to be competing in
12 that highly populated area that's in that
13 southeastern portion or southwestern portion of
14 Berkeley County.

15 Q: Okay. And you heard testimony, maybe it was on
16 cross-examination, regarding Trident's
17 financials, but if MUHA were to have a similar
18 effect at Roper Berkeley, would you as a health
19 planner and an expert in healthcare finance, do
20 you have any opinions as to the materiality of
21 such a -- of an impact on Trident Medical
22 Center or Trident Health.

23 MS. CRUM: Your Honor, I haven't heard him lay a
24 basis for that. I mean, he's saying if it had
25 the similar effect that it has on Roper

1 Berkeley. I mean, I haven't heard him lay the
2 foundation. Maybe I just missed it and didn't
3 hear it.

4 MR. THOMAS: He just testified what his thoughts
5 would be -- he said it would have a greater
6 effect than Roper St. Francis Berkeley on
7 Trident. And then he laid out the reasons for
8 that.

9 MS. CRUM: Your Honor, I missed that.

10 THE COURT: Well, you also asked a hypothetical too.
11 So ---

12 MR. THOMAS: Well, I'll ask you again.

13 THE COURT: If you get it, but I overrule it.

14 MR. THOMAS: Okay. I'm going to move -- move
15 forward.

16 **Q: Do you believe that if Roper -- excuse me, if**
17 **MUHA Nexton would have a similar or great**
18 **effect as Roper St. Francis Berkeley as an**
19 **expert in healthcare planning and finance, do**
20 **you believe that would be a material impact on**
21 **Trident Health?**

22 **A: I -- I do. I mean, I -- I think the -- if**
23 **we're talking about the \$10 million as Mr.**
24 **Gallati quantified for the Roper St. Francis**
25 **effect, I think that's a material number to any**

1 organization, \$10 million. And if you're
2 talking about doubling that or more, that would
3 be a significant portion of the -- of the
4 bottom line of -- of the Trident facilities.

5 Q: Okay. You mentioned -- there's some other
6 bullet points in terms of impact. Can you go
7 through those for us ---

8 A: Sure.

9 Q: --- for the Court?

10 A: And other witnesses have testified about that.
11 And, you know, and one point I want to make is
12 that the impact isn't just on inpatient
13 discharges; it's also on -- on outpatient
14 services. And the most direct one, obviously,
15 is going to be on emergency department visits
16 because, you know, if you live in very close
17 proximity to the MUHA Nexton Hospital, even
18 though you weren't going downtown to get your
19 emergency services historically, the likelihood
20 is if you were driving to Trident before and
21 now you've only got a one-mile drive to the
22 MUHA Nexton Hospital and you had a nine-mile
23 drive to Trident, you're going to use the MUHA
24 Nexton project. And similarly, if patients or
25 -- inpatients of the hospital in many cases are

1 going to come back and receive outpatient
2 services at the same facility. So, that --
3 that's one concern. The loss of trained
4 professional staff, I think there's been a lot
5 of testimony about the potential for that. I
6 want try to repeat that. Loss of physicians,
7 you know, I think we're going to hear that MUHA
8 requires that physicians be on the faculty of
9 the -- of the hospital -- of its medical school
10 in order to -- to have staff privileges there.
11 But it doesn't meant that there couldn't be
12 physicians, one, who join the faculty and --
13 and change their allegiance and went to the --
14 to the new hospital. And certainly, as it
15 relates to physician referrals, there's nothing
16 precludes physicians who currently refer
17 patients -- for example, primary care
18 physicians who -- these days, primary care
19 physicians don't take care of patients in
20 hospitals. They refer them to the hospital and
21 a hospital lists a full-time physician who
22 operates inside the hospital takes care of the
23 patients. And so, a primary care physician who
24 historically had been referring to -- to a
25 Trident facility could easily be incentivized

1 to change their referral patterns to -- to the
2 MUHA facility. So -- and then another concern
3 that I -- I don't know has been talked about
4 specifically, and that's the loss of tertiary
5 referrals. And that also relates to the next
6 point, which is the helipad that's being
7 proposed for the site. And that is that
8 Trident is -- is a tertiary facility for that
9 part of the service area and a lot of patients,
10 for example, who are having a heart attack, if
11 they have to be taken to the closest hospital,
12 Trident would be the closest hospital that
13 could perform an interventional procedure. If
14 that patient showed up in the emergency room at
15 -- at MUHA Nexton, they could be transported
16 downtown to the Medical University to get that
17 tertiary level of treatment down there. And
18 similarly, you know, for other types of
19 services where a patient may come in for -- for
20 one type of service, but there's a realization
21 they really need a more specialized treatment,
22 those patients would -- will potentially also
23 be transferred to the downtown facility. So,
24 the impact wouldn't be just the direct loss of
25 the non-tertiary and OB patients, but it could

1 also be on the downstream tertiary referrals,
2 as well.

3 Q: There's one more point on this slide, and --
4 regarding the offset. Why did you include
5 this?

6 A: You know, in the -- in the State Health Plan,
7 and I believe it's also in the review criteria,
8 there is a statement that -- that you -- you
9 know, equal weight has to be given to the
10 improvements and accessibility and the impact
11 on existing providers. You know, I mean, every
12 health plan, and I think Mr. Richardson
13 testified about this, every health planning
14 decision comes down to weighing the benefits
15 that accrue to the community from the approval
16 of a new project versus the adverse effects
17 that it's going to have on existing providers
18 in the -- in the system. In this case, I don't
19 see any significant community benefits. I
20 mean, there might be some institution-specific
21 things that the Medical University wants to
22 accomplish, but I don't see any community
23 benefits of any magnitude resulting from the
24 approval of this project. But I see the
25 potential for significant impacts on -- on the

1 existing providers in the market. So, I think
2 that to the extent that that concept needs to
3 be evaluated, I think the weight overall in
4 that evaluation would be on the adverse impact
5 and because the benefits I think are -- are
6 limited from this project.

7 Q: Okay. Let's do the next slide. I believe it
8 addresses another point of adverse impact.

9 A: Sure. And I think I already touched on this.
10 So, the impact -- the -- it's going to be
11 magnified on -- on Roper t. Francis Berkeley
12 because of its proximity.

13 MR. THOMAS: Okay. Let's go to the next slide, 62.

14 Q: Talk about Colleton Medical Center impact.

15 A: Sure. I mean, I think Colleton, you know,
16 while they are some distance from the proposed
17 site, in the application, MUHA certainly
18 expected that it was going to pull patients out
19 of the eastern part of Dorchester County and
20 the -- and in -- and also from Colleton County.
21 And I think Mr. Hiott testified a lot about
22 this yesterday, about where he draws his
23 patients from. And so I think to the extent
24 that Colleton loses patients from the St.
25 George area, for example, and eastern

1 Dorchester County or from those border county
2 zip codes in Colleton County, that's going to
3 have an adverse impact. And as Mr. Hiott
4 described, and I don't need to repeat all his
5 testimony, that's a rural hospital, got a
6 pretty fragile financial structure now. I mean,
7 they're not making money overall. A loss of
8 any material number, I mean, 50 to 100
9 discharges lost to this new hospital, would be
10 material to Colleton. And so I would be -- I
11 would be concerned about that, as well.

12 Q: Okay. In terms of rural healthcare in South
13 Carolina, what is the state of rural hospital
14 patient care?

15 A: Well, there's been a number of studies and task
16 force that are looking into the issue of trying
17 to preserve access to healthcare in rural
18 areas. I mean, just not very far from
19 Charleston, if you go up to Bamberg and
20 Blacksburg, those hospitals have closed in the
21 last several years. Increasingly difficult to
22 -- to keep these small hospitals open for --
23 for a lot of the reasons Mr. Hiott talked about
24 yesterday. And so doing everything we can to
25 try to protect the -- the fragile nature of

1 these rural hospitals, I think is important.

2 Q: Okay.

3 MR. THOMAS: So, the next slide.

4 Q: What are your opinions -- do you believe that
5 the -- that Nexton is a cost effective
6 alternative?

7 A: Well, I mean at \$325 million, it's pretty
8 pricey. And so -- and you know, one -- one of
9 the considerations is, you know, when you look
10 at the cost of this, even compared to other
11 projects that the Medical University has done,
12 it's -- it's a pretty costly project. And if
13 we can go to the next slide.

14 MR. THOMAS: Which is 64.

15 Q: What is this?

16 A: If we look at the Children's Hospital, Women's
17 Pavilion project, they were building 225 beds,
18 so not quite twice as many beds. It's -- it's
19 more than twice the square footage of the -- of
20 the Nexton Hospital. Construction costs though
21 were only, you know, marginally higher. And
22 when you look at the cost per square foot, it's
23 68 percent higher. The cost per bed, I think
24 is like 86 percent higher. So, this is a --
25 this is a very expensive project. And it's not

1 really explained why it's so much more
2 expensive than building a children's hospital
3 and a women's pavilion. Children's hospitals
4 tend to be fairly expensive facilities to
5 construct. And I don't believe that there's
6 been an ample investigation of other
7 alternatives to constructing a very large
8 hospital, particularly one that's likely to be
9 highly underutilized. So, I think -- as I
10 mentioned earlier, I didn't see any analysis of
11 the ability to backfill additional beds. I
12 didn't see any analysis of alternative
13 locations for the proposed hospital that would
14 be developed off the campus of MUHA. And I
15 think that -- that's a deficiency and was not
16 -- not addressed in the application and not
17 addressed by DHEC in its decision.

18 Q: Okay.

19 MR. THOMAS: Put up on the board TMC 145.

20 (Trident Exhibit Number 145 was referenced at this
21 time.)

22 Q: And this is a page from -- this is TMC 145-10,
23 a page from the Shawn Jenkins Children's
24 Hospital replacement and consolidation of
25 pediatric and perinatal services. Are you

1 familiar with this application?

2 A: I am.

3 Q: Okay. In terms of the services that are going
4 to be offered by the Children's Hospital and
5 Women's Pavilion, can you -- in terms of the
6 services, are they comparable to the type of
7 services that are going to be at -- offered at
8 the community hospital at Nexton, but I -- I
9 understand these are in a pediatric context,
10 but ---

11 A: Sure.

12 Q: In the service type.

13 A: Yeah.

14 Q: For instance, is there an ED in the Children's
15 Hospital?

16 A: There is. There's diagnostic and imaging
17 departments. There's actually going to be
18 services that aren't being offered there, such
19 as cardiac cath services. There's going to be
20 an OR in this proposed hospital. And there's
21 going to be an administrative area that ---

22 THE COURT: In the proposed Children's Hospital?

23 A: Proposed Children's Hospital.

24 THE COURT: Two proposed hospitals for children.

25 A: Yeah.

1 MR. THOMAS: Thank you.

2 A: I guess it's no longer proposed. It's coming
3 out of the ground. It's going to open soon.
4 But -- and they're going to have food service
5 and so forth. So, a lot of the same services
6 that are being provided in this facility are
7 also being provided at the Nexton site, so.

8 Q: Okay. And what was the square footage of the
9 Children's Hospital?

10 A: It was 630,000 square feet roughly.

11 Q: Okay. And -- and what's your understanding of
12 the MUHA Nexton square footage?

13 A: 311,000.

14 Q: Okay. All right. Let's move to slide 65. You
15 have some opinions on financial feasibility of
16 the project.

17 A: I do. And you know, I -- first of all, I don't
18 believe the financial feasibility of the
19 project has been demonstrated. And there's a
20 number of reasons for that. And one relates to
21 MUHA's overall financial condition at the
22 present time. It's -- I think Mr. Johnson
23 talked about this in some length about the fact
24 that MUHA, if you look at various financial
25 ratios related to their income statement, their

1 balance sheet, would -- would generally be
2 considered a junk bond type of credit. And I
3 would concur with that.

4 OBJECTION:

5 MS. CRUM: Your Honor, I'm -- I'm going to -- I
6 objected to Mr. Johnson's testimony and I will
7 again here to any testimony -- the relevance of
8 any testimony regarding bonds to this
9 situation. I'm just preserving my objection,
10 Your Honor. You ruled against me the last time
11 and that's fine. I just want to make sure I
12 preserve my objection for the record.

13 THE COURT: Well, I mean, this is a different
14 witness.

15 MR. THOMAS: Right.

16 THE COURT: But, do you want to respond?

17 MS. CRUM: I just thought it was relying on Mr.
18 Johnson's testimony. That's ---

19 THE COURT: Okay. Well, in that regards, yeah.

20 MR. THOMAS: Now, I think what he says ---

21 THE COURT: I think he said it would be junk bond
22 himself though, this time.

23 MR. THOMAS: Right.

24 MS. CRUM: Okay. I -- I'm sorry. I thought he said
25 Mr. Johnson said that.

1 THE COURT: Okay.

2 MR. THOMAS: I think he said like as Mr. Johnson
3 said. I could be wrong.

4 THE COURT: Yeah. That's -- that's what I said he's
5 ---

6 MR. THOMAS: Okay.

7 A: Yeah.

8 Q: All right. Continue.

9 A: Yeah. And -- and as a consequence of that, and
10 I think -- I think you'll probably hear later
11 in this proceeding from Mr. Stephen Pack, who
12 is the special consultant to Medical University
13 for HUD financing, that the Medical University
14 accesses HUD financing because it has more
15 lenient, if you will, targets in terms of
16 financial measures. And it's -- it's for
17 hospitals who aren't in -- in a financial state
18 that would allow them to go the traditional
19 bond market.

20 OBJECTION:

21 MS. CRUM: Your Honor, I'm -- I'm going to object to
22 the characterization of Mr. Pack's testimony.
23 He can't pre-characterize any testimony that
24 hasn't happened nor can he rely on it. It's
25 hearsay.

1 MR. THOMAS: He's -- I believe he just testified
2 that he was there for -- on the phone. He
3 wasn't there, but he was on the phone, for Mr.
4 Pack's deposition.

5 MS. CRUM: Mr. Pack.

6 THE COURT: He hadn't testified to that just now.

7 A: I -- I can.

8 MR. THOMAS: Okay. I -- I apologize, Your Honor.

9 Q: Were you -- let me lay that foundation. Were
10 -- were you present on the phone for Mr. Pack's
11 deposition when he was deposed in Charleston,
12 South Carolina?

13 A: I was.

14 Q: Okay. Did you also read his deposition
15 testimony?

16 A: I did.

17 Q: Okay. And in terms of Mr. Pack's statements
18 regarding the -- whom HUD lends to, can you --
19 can you discuss what your understanding is as
20 an expert and relying on another expert in the
21 area about what he said?

22 MS. CRUM: Your Honor, the testimony hasn't been
23 admitted, deposition or otherwise. It's still
24 hearsay. And he can't rely on that testimony
25 at this point.

1 MR. THOMAS: Your Honor, Rule 702.

2 THE COURT: 702.

3 MR. THOMAS: If -- pardon me. If -- if of a type
4 reasonably relied upon by experts in a
5 particular field in forming opinions or
6 references upon the subject, facts, or data
7 need not be admissible in evidence. Well, this
8 is the subject area about financial
9 feasibility. He was there for -- or present on
10 the phone for Mr. Pack's deposition; he read
11 the deposition testimony. Mr. Pack ---

12 THE COURT: He can -- we can circumvent all this,
13 but ---

14 MS. CRUM: He ---

15 THE COURT: What relying upon a witness who has not
16 testified is one thing, if -- but he can -- we
17 can deal with this in a hypothetical and move
18 on.

19 MR. THOMAS: Yep.

20 MS. CRUM: And ---

21 MR. THOMAS: Well, Your Honor, I mean, I don't know
22 that he is going to testify.

23 MS. CRUM: Your Honor ---

24 MR. THOMAS: You know, that's the thing.

25 THE COURT: Well, that's why you have to go

1 hypothetical.

2 MS. CRUM: Your Honor, can I also, just for the
3 record, say that Mr. Pack hasn't been qualified
4 as an expert.

5 THE COURT: Yeah.

6 **Q: Well, let me ask you a -- a question. We can**
7 **maybe move on. What is your understanding, Mr.**
8 **Sullivan, of the type of organizations that**
9 **seek HUD financing?**

10 **A: Well ---**

11 MS. CRUM: Your Honor, he -- he hasn't laid a basis
12 for that and that's not a hypothetical.

13 MR. THOMAS: Well, the basis is he -- he has
14 actually worked with a couple of hospitals that
15 sought HUD financing.

16 THE COURT: If you could just add to -- if he has
17 his own knowledge of that.

18 **Q: Do you have your own knowledge, Mr. Sullivan,**
19 **of the type of organizations that seek HUD**
20 **financing?**

21 **A: In -- in my experience, this type of financing**
22 **is generally pursued by organizations that**
23 **would have a difficult time accessing**
24 **traditional credit markets because of financial**
25 **limitations.**

1 **Q: Did MUHA's consultant, Mr. Pack, also express**
2 **that?**

3 **OBJECTION:**

4 **MS. CRUM:** Your Honor, same objection. I mean,
5 we're going back to the hearsay. He can ask --
6 he can ask hypotheticals. I mean, he's ---

7 **MR. THOMAS:** I'll withdraw, Your Honor.

8 **THE COURT:** Okay.

9 **MR. THOMAS:** I'll withdraw it.

10 **Q: In your experience, working with a lot of**
11 **different hospitals and healthcare**
12 **organizations, have financially healthy**
13 **organizations, have those organizations sought**
14 **HUD financing?**

15 **A: In my experience, they have not. I mean,**
16 **typically, hospitals that have strong financial**
17 **position would go to the conventional bond**
18 **market because of the fact that it's -- tends**
19 **to have lower fees, lower complexity in terms**
20 **of obtaining the financing through a**
21 **traditional underwriter. And so, you know, at**
22 **least my experience has been that HUD has not**
23 **been a vehicle used by -- by financially strong**
24 **organizations.**

25 **Q: Okay. Mr. Sullivan, did you do an analysis of**

1 key ratios using Standard & Poors ratings?

2 A: I did.

3 Q: Okay. And what did you rely upon in terms of
4 looking at the different ratings of healthcare
5 debt?

6 A: There's a document that's published by Standard
7 & Poors periodically that sets forth the ratios
8 for -- for healthcare credits and -- and what
9 the various ratios -- and at various ranges of
10 ratios, what type of bond rating would you fall
11 under, you know, so.

12 Q: But why did you do this analysis?

13 OBJECTION:

14 MS. CRUM: Your Honor, I'm again going to object to
15 the relevance of this to MUHA. This is not the
16 type financing they're seeking and whether --
17 however Standard & Poors rates us is not
18 relevant in this context, Your Honor.

19 THE COURT: Well, this is one time I am going to
20 take the bench trial position of I can sort
21 this out because if it -- if you are correct,
22 then it will be ignored. If you're -- if it is
23 relevant, then I'll consider it, so.

24 MS. CRUM: Okay.

25 MR. THOMAS: Thank you, Your Honor.

1 Q: Why did you undertake a key ratio analysis of
2 -- of MUHA using the Standard -- Standard &
3 Poors' data?

4 A: Well, I -- I was concerned by what I was seeing
5 in looking at the financial statements just
6 reviewing them independently with some of the
7 levels of debt, you know, levels of probability
8 and so forth that MUHA had experienced. And I
9 wanted to put in the context of, you know, is
10 this an organization that's well positioned to
11 invest \$325 million in a relatively speculative
12 project from my perspective. And -- and I
13 think in a little while, we'll talk about it in
14 the context of many other projects that MUHA
15 has undertaken, as well. And so I thought that
16 using the Standard & Poors framework would give
17 me a -- a more objective look at how strong --
18 financially strong the organization is. And so
19 that's why I -- I did it.

20 Q: And the Standard & Poors, the U.S. not-for-
21 profit healthcare system, meeting financial
22 ratios 2018 versus 2017, is this the -- is this
23 a market or report or commercial publications
24 that are generally -- that you generally use or
25 rely upon in your occupation?

1 OBJECTION:

2 MS. CRUM: Your Honor, if I could just make a
3 continuing objection ---

4 THE COURT: Okay.

5 MS. CRUM: --- to this line of questioning.

6 **A: Okay. Yeah, it is. In fact, I've -- I've used**
7 **this very same source for -- for many other**
8 **projects.**

9 MOTION TO ADMIT:

10 MR. THOMAS: Okay. Your Honor, I'd like to admit
11 TMC 137, the Standard & Poors document. It has
12 a hearsay exception under 80317, market reports
13 and commercial publications. It's generally
14 used and relied upon by the public or by
15 persons in a particular occupation. I think
16 Standard & Poors is also known as a fairly
17 reputable financial rating agency.

18 OBJECTION:

19 MS. CRUM: Your Honor, I'm simply going to object on
20 relevance.

21 THE COURT: On relevance? I'll deny your objection.
22 I would have considered it on other aspects
23 maybe, but -- I mean, I would have heard --
24 heard her out.

25 MR. THOMAS: Object to the hint, Your Honor.

1 THE COURT: It's admitted. Well ---

2 MS. SHOUN: No objection, Your Honor.

3 MR. WICEVIC: No objection.

4 MR. SHOUN: Thank you.

5 THE COURT: It's admitted.

6 (Trident Exhibit Number 137 was admitted into
7 evidence.)

8 Q: Okay. Let's -- let's turn to slide 66 and tell
9 the Court what you did here.

10 A: Sure.

11 Q: We're going to move through these fairly
12 quickly.

13 A: I will and Mr. Johnson talked about a lot of
14 this already, so I -- I don't want belabor it.
15 The first chart looks at 2017 financials for
16 MUHA and it looks at it in two different capac-
17 -- capacities. One is from the income
18 statement standpoint, that's how much money
19 you're making and how profitable you area and
20 so forth. And then, secondly, from the balance
21 sheet perspective in terms of how much cash do
22 you have on hand, how much debt do you have and
23 -- and so forth. And so, what I've done on
24 here, the far right column is the MUHA metric
25 that I'm comparing to the Standard & Poors'

1 numbers and the -- and the highlighted boxes to
2 the left of that show the range in which the
3 MUHA performance would -- would fit. And in
4 2017, on the income statement, some of the --
5 some of the measures were in the investment
6 grade area in the A and even the A-plus in a
7 couple of cases, but there were also ones that
8 were in the BBB and the speculative grade
9 categories. The balance sheet in 2017, most of
10 the relevant metrics fell into the speculative
11 grade category. So, if we go to the next page,
12 did the same analysis for 2018. There's a few
13 -- you know, a few more in the income statement
14 side that fall on the speculative grade than in
15 '17. The balance sheet ratios were similar.
16 I think there might be one fewer in the
17 speculative grade in 2017 than there was in
18 2018. But I mean, the overall conclusion as
19 Mr. Johnson had said, and I would agree, is
20 that MUHA is a -- is a relatively weak credit,
21 if you will, because of the -- particularly and
22 because of the level of debt -- debt that they
23 have on their books and also because of the
24 level of cash that they have on hand.

25 Q: And their 2017, 2018 data, did you -- what

1 source did you rely upon to get their -- MUHA's
2 actual financials?

3 **A:** **The audit to financial statements of Medical**
4 **University Hospital Authority.**

5 MOTION TO ADMIT:

6 MR. THOMAS: Your Honor, Trident Medical Center's
7 105 is MUHA's 2017 financial statement, TMC --
8 Trident Medical Center Exhibit 1 is the 2018
9 financial statement. And I'd like to move
10 those both into evidence at this time.

11 MS. CRUM: Your Honor, I don't have any objection to
12 that. I think they're already in the DHEC
13 record.

14 MR. THOMAS: If they are, then it should be no
15 problem admitting them.

16 THE COURT: If they're already in, I don't need to
17 have additional ones, so.

18 MR. THOMAS: Okay. If they are, I just don't know,
19 but ---

20 THE COURT: I tell you what. You've offered them.
21 Check and see if they're in the DHEC records.
22 If they're not, later on you can come back and
23 ---

24 MR. THOMAS: Okay.

25 THE COURT: --- I'll admit them.

1 MR. THOMAS: Okay. Thank you, Your Honor. All
2 right. Let's go to the next slide then.

3 Q: What is this?

4 A: This was specific to the proposal in the
5 application that the type of financing to be
6 sought would be HUD financing. We've already
7 talked about that quite a bit in this
8 proceeding. And so, just to try to frame this
9 in my own mind, I pulled the most recent
10 regulations regarding HUD financing and just --
11 just extracted a couple of different points
12 that I wanted to make.

13 Q: Okay. And what are those points?

14 OBJECTION:

15 MS. CRUM: Your Honor, I'm going to object to this
16 testimony. He is giving his legal conclusions
17 based on his interpretation of the regulation.
18 That is simply in this Court's province. It's
19 not in his province as an expert in health
20 planning or financial feasibility.

21 MR. THOMAS: One of the points in this particular
22 regulation -- it's 242. You heard Mr. Sullivan
23 talk about that before and they've done
24 feasibility studies in the past. There's the
25 last sentence here, Your Honor, talks about two

1 -- Section 242, insurance may not -- may
2 support start-up hospitals or major expansions
3 of existing hospital only if existing hospital
4 capacity or services are clearly not adequate
5 to meet the needs of the population in the
6 service area. What I'm asking him to opine
7 about with respect to this is about the needs
8 of the population in the service area and are
9 the healthcare services and hospital capacity
10 in that service area where MUHA wants to go,
11 are they adequate. So, it's not asking for a
12 legal conclusion, but it is a standard here and
13 again, I ---

14 THE COURT: All right. So, where I can be clear,
15 Ms. Crum. I think what he's saying is he's
16 going -- he's going to set forth this is the
17 law, what is your opinion upon the application
18 given that this is the law by factual. I think
19 he can testify to that. He just can't given an
20 opinion as to whether or not his -- his
21 viewpoint of the law itself. Only to the
22 application of this law to the facts of this
23 case.

24 MS. CRUM: So, what you're saying is he can testify
25 as to the application of the law to the facts.

1 THE COURT: Yeah.

2 MS. CRUM: All right, sir.

3 THE COURT: And as long as he stays within those
4 parameters, I'll let him -- I'll let him
5 testify. If he steps out of those parameters,
6 you -- your objection will be sustained.

7 MS. CRUM: All right, sir. And, Your Honor, I'm --
8 I'm just going to note my objection fo the
9 record for this.

10 THE COURT: Well ---

11 MS. CRUM: So -- I understand what you've ruled.

12 THE COURT: I -- I would prefer -- okay. But if I -
13 - I would prefer if he does step out of the
14 parameters of which I've set forth, if you'd
15 let me know.

16 MS. CRUM: I will attempt to ---

17 THE COURT: Okay.

18 MS. CRUM: --- pop up, Your Honor.

19 THE COURT: All right.

20 **Q: Mr. Sullivan, with respect to 240, this --**
21 **section 242 of the HUD financing regs on market**
22 **need, are the services in the area where MUHA**
23 **is proposing to place its Nexton Hospital, in**
24 **your opinion, are there adequate services in**
25 **that -- healthcare services in that area for**

1 that population?

2 A: In my opinion, yes. There are.

3 Q: Okay. And please provide the basis for that.

4 A: Sure. You know, we've talked a lot already
5 about the existing providers in the area, the
6 existing providers having capacity. There's a
7 brand new hospital that just opened up,
8 Summerville Medical Center, which serves a lot
9 of patients coming from that same general area.
10 Just added 30 beds. It just opened, I believe
11 earlier this year. Trident Medical Center, I
12 think Mr. Gallati testified that they still
13 have available capacity at -- at Trident
14 Medical Center. So, there simply hasn't been
15 any demonstration in my view in the application
16 that existing resources in the area aren't
17 adequate to -- to meet the needs.

18 MR. THOMAS: Okay. Let's go to slide 69.

19 Q: And I think Ms. Crum actually referenced this
20 part of the regulation about the State has an
21 official procedure for determining needs for
22 hospitals and in the application -- and that
23 the application document that the need has also
24 been established under that procedure. Do you
25 believe that the need has been established per

1 the -- you know, per the project review
2 criteria for this case or for this project?

3 A: I believe they have not been established for
4 all the reasons I've already stated.

5 Q: Okay.

6 MR. THOMAS: Let's go to the next slide, please.

7 Q: Some more -- do you have some more opinions
8 about financial feasibility?

9 A: Sure. And maybe this is one way to side step
10 the HUD issue.

11 Q: Okay. Let's do that.

12 A: Is to say that, you know, we're not really
13 questioning whether not they can obtain HUD
14 financing. I mean, that's -- I don't think
15 that's necessarily the issue. It's -- but
16 whether it makes sound health planning sense
17 for them to pursue this project from a
18 financial standpoint. If -- if I'm correct and
19 this new hospital is going to not do well
20 financially, and we'll talk a little bit more
21 about that in a minute, I think it's going to
22 be a drain on the resources of the Medical
23 University if it's undertaking a number of
24 other ambitious projects at the same time. And
25 I think it has the potential to hurt their --

1 fulfilling their mission, you know, as an
2 academic, quaternary medical center.

3 MR. THOMAS: Okay. Let's go to slide 71.

4 Q: You have some additional opinions or some bases
5 for the opinions?

6 A: Sure. Well, I mean, the -- the financial
7 condition of the Medical University, as we've
8 already looked at --since the time of the
9 application, the Medical University has
10 undertaken a number of other pretty significant
11 capital projects. We talked a little bit
12 earlier about the -- the decision to purchase
13 four hospitals across the state from community
14 health systems. And I think that -- that
15 figure -- I've seen different numbers, 134,
16 137. And in addition, they borrowed -- on a
17 short-term basis, they borrowed \$120 million
18 using, I believe, revenue anticipation
19 certificates to -- to fund working capital of
20 those new hospitals. So, they've extended even
21 farther out with this \$120 million. And then,
22 another concern I have is that MUHA was --
23 preliminarily applied for a -- a freestanding
24 emergency department one exit south of where
25 the new Nexton Hospital is going to be located,

1 exit 197 versus exit -- I mean, 199 versus exit
2 197. And in the hospital application, they
3 said that their intent was to close that or to
4 relocate that freestanding emergency department
5 to the campus of the new hospital, so they
6 wouldn't be competing with themselves with a
7 freestanding emergency department. But we had
8 a hearing, however long ago that was, four
9 months ago, about that freestanding emergency
10 department application, and the testimony of
11 Dr. Cawley and other witnesses was that Tri- --
12 that MUHA had no intention of closing that
13 emergency department now. And so, as we talked
14 about earlier, a significant component of their
15 overall financial operations is emergency
16 department revenue and they are -- and the
17 freestanding ED said that they were going to
18 redirect patients from downtown to the
19 freestanding ED, and either they're going to
20 redirect those same patients away from the
21 freestanding ED to the hospital or they're
22 going they're going to have find some other way
23 because in the hospital application, they said
24 they were going to redirect those very same
25 patients to the -- to the new hospital. They're

1 -- they're going to compete with themselves.
2 They're going to reduce the overall level of
3 utilization of their emergency department,
4 which is going to put a further financial
5 strain on -- on the operation of the new
6 hospital.

7 MR. THOMAS: Okay. Let's go to the next slide, 72,
8 please.

9 Q: You undertook an exercise, Mr. Sullivan.

10 A: Yeah. They -- in the -- in the discovery
11 documents and I reference the -- it's a -- it's
12 actually in RSF Exhibit 53. They provided an
13 alternative projection of financial performance
14 for the proposed hospital, for -- for MUHA
15 overall for the new hospital and then, the
16 combined operations of the new hospital and
17 MUHA. And they did a version where the
18 outpatient revenue was less than the outpatient
19 revenue number that was included in the -- in
20 the application, the CON application. It was
21 only about 25 percent of the total revenue was
22 outpatient revenue. And under that scenario,
23 the project struggled financially. And then,
24 the application -- the financials that were
25 included in the application assumed that the

1 outpatient revenues would grow instead to 35
2 percent. And I have concerns about the ability
3 of the applicant to achieve that 35 percent, if
4 indeed they keep open that freestanding
5 emergency department in Summerville that's
6 going to draw patients away from the emergency
7 department at the new hospital. So, if we look
8 at the next slide.

9 Q: Right. Is this -- is this a table that you
10 drafted that summarized RSF Exhibit 53?

11 A: Yeah. I mean, I actually cut and pasted it out
12 of that ---

13 Q: Okay.

14 A: --- that document. But what it showed is that
15 the project would lose money in all years and
16 that's even ignoring the high utilization
17 projections. You know, I mean, this is based
18 on the utilization projections that were
19 contained in the application. And also,
20 ignoring the problems that Mr. Johnson talked
21 about about overstating the net revenue for
22 adjusted admission, and the fact that they --
23 they basically double counted the -- the
24 discharges at the Nexton hospital and didn't
25 treat those as shifted patients, but treated

1 that as new business. So, even giving MUHA the
2 benefit of the doubt, if their outpatient
3 revenue is actually less, they're going to lose
4 money in all three years ---

5 Q: Okay.

6 A: --- based on their own projections.

7 Q: And was the scenario set forth on slide 73, was
8 that something you actually found in MUHA's
9 documents?

10 A: It was.

11 MR. THOMAS: Let's go to the next slide please.

12 Q: What is this?

13 A: This is ---

14 Q: Slide 74.

15 A: Slide 74 and this is looking at what the
16 projections in the application were and if we
17 look at the change in the -- in the projections
18 -- so, between the slide we just looked at
19 what's presented in the application, the total
20 revenue changes by about 76 million dollars by
21 the third year. There are other smaller
22 changes. Well certainly the contractual
23 adjustments and revenue reduction change
24 because you have a lot more revenue in there
25 and there are smaller changes in the expenses,

1 but the -- the result is that the operating
2 income increases dramatically between what was
3 presented in that version we just looked at and
4 what's presented in the application.

5 Q: Okay. And the operating income here at the
6 bottom of 74 that's what summarizes it, that's
7 the difference?

8 A: It is.

9 Q: Okay. All right.

10 MR. THOMAS: Let's go to the next slide. Home
11 stretch, Your Honor, for the slides.

12 Q: Slide 75.

13 A: You know, there -- there's significant problems
14 with the model. I -- I think I've outlined all
15 of those and adopted the findings of Mr.
16 Johnson. If we plugged in the revised
17 utilization numbers that I think are the more
18 realistic ones using a reasonable length of
19 stay if we go to the next page.

20 MR. THOMAS: 76, please.

21 Q: Did you create this worksheet?

22 A: I did. This is a -- sort of a summary of the
23 assumptions that went into this. And this
24 shows the revised volumes and lengths of stay
25 and some of the other metrics that -- that flow

1 from that. If we go to the next slide.

2 Q: 77.

3 A: Yeah. This just shows may assumptions about
4 what was going to happen in terms of reduction
5 in revenues, reduction in expenses, and so
6 forth, if you had lower volume at the hospital.

7 Q: And so where did -- where did these assumptions
8 come from on slide 77, the actual like
9 percentages and percent fixed and that type of
10 thing?

11 A: Well, those -- those are based on my estimates.

12 Q: Okay.

13 A: Just from having done financial projections
14 over the years. I tried to, again, be more
15 favorable toward the applicant. Of course, the
16 applicant -- one other assumption that I hadn't
17 mentioned before that I think is also
18 questionable in the financial projections is it
19 appears that the applicant assumes that the
20 expenses of the hospital are 100 percent
21 variable. And so they go up each year in
22 proportion to the increase in utilization in
23 the non-capital expenses, the staffing and the
24 supplies and so forth. And that's not been my
25 experience. You're going to have

1 administrative staff -- you know, you have an
2 administrator, assistant administrator. You're
3 going to have a director of nursing. You're
4 going to have a lot of expensive personnel
5 that's going to fixed regardless of whether you
6 have ten patients or a thousand patients.
7 You're going to have contracts with different
8 types of vendors and with different types of
9 groups to provide services at the hospital.
10 And those aren't going to vary necessarily
11 based on the -- on the volume of the hospital.
12 So ---

13 Q: So, that was just a mistake in planning?

14 A: I think it's a mistake. And -- and so if we go
15 to the next page, based on my assumptions about
16 fixed and variability and the expenses, and
17 with what I think are more reasonable volume
18 projections, but not fixing the problems that
19 Mr. Johnson identified with the overstated net
20 revenue per adjusted admission or the fact that
21 they're -- they're not -- they're treating
22 these as incremental discharges when their
23 assumption is that they're not. The project
24 would lose money in all three years under these
25 assumptions.

1 Q: Hypothetically, if you applied what Mr.
2 Johnson's, I guess, revised net revenue per
3 adjusted case or applied something that was
4 closer to what other community hospitals were
5 doing like Summerville or Trident, what would
6 that do the operating income bottom line?

7 A: it would be a dramatic reduction. You would
8 basically have to reduce the -- the net revenue
9 for adjusted admissions by a third. I think --
10 I think he testified that Roper's experience
11 was around \$12,000 per -- per adjusted
12 admission. I think Mr. Gallati said his
13 experience was \$12,800 per adjusted admission.
14 And what MUHA is projecting is \$18,930 per
15 admission. So, you would have to lop off
16 about 6,000 bucks an admission to come even in
17 the range of reasonable. And even that was
18 probably too high because Summerville's
19 adjusted admission ratio is only about 8,900
20 and that's a community hospital. And so maybe
21 we even have to cut it in half. So, I think
22 the -- the financial feasibility of this
23 project has clearly not been demonstrated.
24 There's so many -- so many problems with the
25 financial projections and I think under any

1 realistic set of assumptions, the project is
2 going to show substantial losses in all three
3 years of operation.

4 THE COURT: Where is that \$18,000 figure? Is it on
5 this?

6 A: It's not on here. You have to calculate it.
7 If you -- and it's a little bit of a
8 complicated -- if you take the net revenue
9 number and divide it by the adjusted
10 admissions, that would give you the \$18,000
11 figure.

12 THE COURT: Okay.

13 Q: Did -- did Mr. Johnson do that in his analysis?

14 A: He did that in his math. And I -- I went back
15 and validated that calculation. I mean, he did
16 -- he did the math right.

17 MR. THOMAS: Okay. Let's go to the next slide, 79.

18 Q: And what are your thoughts about MUSC's ability
19 to complete the project?

20 A: The -- one of the criterion I think that were
21 cited was the ability to complete the project,
22 and -- you know, by -- by DHEC. I don't
23 believe that they've demonstrated it. I mean,
24 one, regardless of what I think about HUD
25 financing, the -- the person they chose to

1 write a letter in the application said there's
2 no guarantee that HUD would ultimately issue a
3 mortgage insurance commitment for the proposed
4 financing. So, you know, there's no guarantee
5 given the significant debt burden that we've
6 seen that the organization carries, either
7 there -- there's a significant concern with the
8 ability of -- of the Medical University to
9 sustain this project in conjunction with all
10 the other things that it's planning to do, as
11 well.

12 MR. THOMAS: Go to slide 80.

13 A: And ---

14 Q: And you have some more opinions regarding ---

15 A: Yeah. Why don't we go to the next slide?

16 Q: Okay.

17 MR. THOMAS: 81, please.

18 A: Yeah. And if we look at all of the things that
19 the Medical University has ongoing, the -- one
20 is the Children's Hospital, three point -- or
21 \$366 million, maybe it will come in a little
22 bit less than that based on some -- some
23 numbers that I've seen. They have a pediatric
24 imaging project. The purchase of the CHS
25 Hospitals, a freestanding ASC. And so, you had

1 \$737 million in projects already committed
2 before Nexton. And then you have Nexton. And
3 then, recently, there was a filing of a CON for
4 a freestanding emergency department on Johns
5 Island, which is another \$15 million. And in
6 addition to that, they -- if you see the
7 footnote there, the Medical University is a
8 joint venture partner in a new hospital down in
9 Beaufort County, which has a total cost of \$36
10 million. And then, on top of that, they
11 announced plans to build two new hospitals
12 related to the purchase of those four CHS
13 hospitals. One I think would be a replacement
14 hospital and one would be a relocation of a
15 hospital. I -- I don't know what the price
16 tags on those are, but it will not inexpensive
17 to build new hospitals in the two different
18 locations. So, the Medical University has
19 bitten off a lot in terms of capital
20 investments that it's proposing to do. Over a
21 billion dollars and probably approaching, if --
22 when you throw everything in that they
23 announced recently, probably approaching \$1.2
24 billion on an organization that already is
25 highly leveraged. And -- and whether or not

1 they can get HUD financing for this and HUD
2 will loan them money even if they have a zero
3 operating margin, is that the wisest thing to
4 do from a -- from a health planning standpoint
5 to -- to sink \$325 million into a project
6 that's likely to lose money in every year, so.

7 MR. THOMAS: Let's go to the last two slides here,
8 82.

9 Q: Talk a little bit about distribution. What are
10 you opinions with respect to this -- this
11 project?

12 A: Yeah. Without repeating myself too much, I
13 mean, there's plenty of bed capacity in the
14 area. You've got a new hospital four miles
15 away. You've got Summerville with 30 new beds.
16 You've got Trident trying to implement a 50-bed
17 hospital in Moncks Corner. If we go to the
18 last slide.

19 MR. THOMAS: 83.

20 A: If we just draw a 10-mile circle around the
21 Nexton location, there are 456 acute care beds
22 within that circle. So, this is not an area
23 that's -- I think -- I can't remember which
24 document said it's staggeringly under-served.
25 It's a area that has excellent access to

1 **inpatient hospital services.**

2 MR. THOMAS: Your Honor, I'm sure everybody's
3 hungry. I myself am not, but ---

4 THE COURT: Well, you're in the minority.

5 MR. THOMAS: That's the -- I'm done with slides.

6 I'll come back -- what I can do is I do have a
7 few more pages in my outline. I think it'll go
8 relatively briskly. And -- and then I will
9 finish up right after lunch.

10 MS. CRUM: Your Honor, I'm just wondering how much
11 longer do we anticipate the direct to go. I'm
12 trying to figure out if we're going to finish
13 today.

14 THE COURT: You said ---

15 MR. THOMAS: I think ---

16 THE COURT: You gave me narrative without any ---

17 MR. THOMAS: Right. I think -- I think I can get --
18 be complete within 30 to 45 minutes coming
19 back. And it may be quicker than that. I
20 don't -- you know. I can't talk to this
21 witness to say okay, have you done this, but I
22 can go through my outline and figure out what
23 I can ---

24 THE COURT: Okay.

25 MR. THOMAS: --- what we've already touched on and -

1 - and I also have to go through the slides so
2 that we can get together on the admissibility
3 of this document.

4 THE COURT: It's one -- about 1:50 now. You want to
5 come back at, what time?

6 MR. THOMAS: 3:00. Whatever time suits -- what'd
7 you say, Melissa?

8 THE COURT: No later than 3:00.

9 MR. THOMAS: I don't know. 2:45.

10 MS. CRUM: Your Honor, it's raining outside and we
11 have -- actually have somebody to come pick us
12 up because we should have brought umbrellas.

13 THE COURT: Well, we'll make it 3:00 then.

14 MR. THOMAS: Okay.

15 THE COURT: All right. Thank you.

16 (Off the record from 1:47 p.m. to 3:00 p.m.)

17 THE COURT: Well, proceed.

18 MR. THOMAS: All right. Welcome back, Mr.

19 Sullivan. Your Honor, we did reach an
20 agreement on Trident's 138 and I think what
21 we'd like to do though is present a clean copy
22 to the Court into evidence, maybe in the -- in
23 the morning, if that would work. But it's --
24 what we've done is we've taken out the
25 narrative portions and then a couple of maps

1 that the other side wasn't to keen on getting
2 into evidence. And ---

3 THE COURT: You've got something against maps? Oh,
4 Ms. Jones does.

5 MS. JONES: Okay.

6 MR. THOMAS: So, anyway. So, we're good with that
7 because I think there are maps in the DHEC
8 record.

9 THE COURT: Okay. Yeah.

10 MR. THOMAS: And we -- we can just utilize those.

11 So, we'll present to TMC 138 in the morning ---

12 THE COURT: Okay.

13 MR. THOMAS: --- as a clean copy of ---

14 THE COURT: Yipee yi yay.

15 MR. THOMAS: All right. Okay.

16 MR. SULLIVAN - CONTINUED DIRECT EXAMINATION BY MR.
17 THOMAS:

18 **Q: Mr. Sullivan ---**

19 MR. THOMAS: Pull up TMC Demo 6.

20 (Trident Exhibit Demo 6 was referenced at this time.)

21 **Q: Are you familiar with this slide?**

22 **A: Yeah. I prepared it.**

23 **Q: Okay. And why did you prepare it? What does**
24 **it show?**

25 **A: I was really wanting to try to depict where the**

1 population concentrations are in Berkeley
2 County. Unfortunately, the U.S. Census Bureau
3 maintains population density by census tract
4 that gives ability to -- to look at this.

5 Q: Okay. And where's this show that -- is that --
6 so, is that an outline, the shaded area, is
7 that Berkeley County?

8 A: It is.

9 Q: Okay. And where does it show the population is
10 located?

11 A: It's highly concentrated, you know, sort of
12 parallel to I-26 along the southwestern border
13 of Berkeley County with another pocket that's
14 down on the very southern tip, which is the
15 Daniel Island area of Berkeley County.

16 Q: Okay. And what -- what does the shading of
17 green represent?

18 A: The darker the green, the higher the population
19 density. So, the areas that are lighter in
20 color tend to be of lower density. And so not
21 surprising given that portions of the area are
22 national forest and rural farmlands, so.
23 You've really got a cluster of population right
24 around the existing hospitals. And then you've
25 got a little bit of population concentration up

1 in the Moncks Corner area where Trident is
2 pursuing a hospital.

3 Q: Okay. And so, where is the -- what's the red
4 star there?

5 A: That's the MUSC proposed hospital in Nexton.

6 Q: Okay. And quickly, with the -- the Roper
7 Berkeley, where is that located?

8 A: It's just a little bit to the southeast of the
9 -- I think about four miles away.

10 Q: Okay. And in your opinion, what, if any,
11 access to the heavily densely area -- densely
12 populated areas have hospital services in this
13 particular area of the tri-county service area?

14 A: They have excellent access, you know, for the
15 population that's in the -- that borders along
16 the I-26 area, they're easily able to access
17 Roper Berkeley, Trident and Summerville. And
18 then on the other southern tip in the Daniel
19 Island area, they can easily go into Mount
20 Pleasant for the Mount Pleasant Hospital or
21 East Cooper.

22 MR. THOMAS: Okay. Let's go to the other slide, TMC
23 Demo 5.

24 (Trident Exhibit Demo 5 was referenced at this time.)

25 Q: Have you seen this slide before?

1 A: Yeah. Another one that I prepared.

2 Q: And why did you prepare it?

3 A: Just to try to show from a travel standpoint
4 how far things are. And so this was just using
5 mapping software, just to get a 15-minute drive
6 time. I think it's based on Google Map drive
7 times. And -- and so that -- that shows you
8 that within 15 minutes drive, most of this area
9 of concentration of population in the
10 southwestern part of Berkeley County is within
11 a 15-minute drive of one or more hospitals.

12 Q: Okay. And is 15 minutes a special number or --
13 -

14 A: No. It's just -- it would, you know, in my
15 mind as a health planner, that would show that
16 you have really good access. I mean, 15
17 minutes is a pretty short travel time.

18 Q: Okay. Let's look at MUHA Exhibit 22, which I
19 believe is the James Island freestanding ED CON
20 application.

21 (MUHA Exhibit Number 22 was referenced at this time.)

22 Q: Are you familiar with this application?

23 A: I am. I -- I helped prepare it.

24 Q: Okay. And has it been contested?

25 A: It has.

1 Q: Okay. Who -- who contested it?

2 A: Roper St. Francis.

3 Q: Okay. And have you reviewed it?

4 A: I have.

5 Q: Okay. Do you -- well, can you explain briefly,
6 Mr. Sullivan, why Trident Medical Center is
7 placing a freestanding ED on James Island?

8 A: Sure. It -- it's definitely not part of
9 Trident's historical service area, but in
10 evaluating the distribution of services in the
11 -- in the Charleston area, the freestanding
12 emergency departments are fairly well
13 concentrated in the northern part of Charleston
14 County and in Berkeley County. And James
15 Island is probably the largest community in --
16 in the Charleston area that really has no
17 significant healthcare services, no hospitals
18 there. There's some urgent care centers there,
19 but no hospital based emergency services are
20 there. And it's become more densely populated.
21 Traffic has gotten worse. And since no one
22 else has stepped up to try to serve that area,
23 I think Trident saw that as a -- as an area in
24 need of a -- of another access point to in --
25 to a hospital level of emergency care.

1 MR. THOMAS: Let's go to page 16 of the application.

2 Q: All right. Are you familiar with the ownership
3 structure of TMC as set forth in the CON
4 application?

5 A: Yes. I mean, I prepared many applications for
6 TMC and have gained familiarity with their
7 ownership structure.

8 Q: Okay. What is the immediate parent to TM --
9 Trident Medical Center, LLC?

10 A: AC Med, LLC.

11 Q: When did AC Med, LLC become the 100 percent
12 owner of Trident Medical Center, LLC?

13 A: December 30th, 2014.

14 MR. THOMAS: Okay. Let's go to MUHA -- I think it
15 was a demonstrative -- it was the Trident
16 Medical Center 6-bed CON application. And --
17 let's see here. I'm not sure of the page
18 number here. Yes. Thank you.

19 Q: So, I'm showing you what's been marked -- this
20 is TMC 6, acute care.

21 (Trident Exhibit Number 6 was referenced at this
22 time.)

23 MOTION TO ADMIT:

24 MR. THOMAS: Actually, what I'd like to do -- I'm
25 sorry, Your Honor. I'd like to move MUHA

1 Exhibit 22, the James Island freestanding ED

2 Con application into evidence.

3 MS. CRUM: No objection, Your Honor.

4 MR. WICEVIC: No objection.

5 MS. SHOUN: None, Your Honor.

6 THE COURT: It's admitted.

7 (MUHA Exhibit Number 22 was admitted into evidence.)

8 Q: Okay. And this is the TMC 6-bed CON
9 application, the demonstrative, and I've got
10 just a couple of questions about the service
11 area here.

12 A: Sure.

13 Q: For the -- first of all, what is this
14 application for, just for the record?

15 A: I -- it's for a renovation project, but also
16 includes the addition of six new acute care
17 beds.

18 Q: Okay. And did you prepare this application,
19 sir?

20 A: I did.

21 Q: Okay. And you have an Exhibit 2 here, a B11 of
22 the need section, Trident Medical Center
23 inpatient service area; is that right?

24 A: That's right.

25 Q: Okay. In terms of the first seven zip codes

1 there, where are those in proximity to Trident
2 Medical Center?

3 A: They're all very close. I mean, they -- most
4 of them adjoin the zip code that Trident is in,
5 which is 29406, and -- and all are with -- well
6 within a 15-minute drive time of Trident, so

7 Q: Okay. And what's the percentage, the
8 cumulative percentage, of inpatient volume for
9 those first seven, up to 29418, for those first
10 seven zip codes.

11 A: 58.6 percent.

12 Q: Okay. And in terms of the -- the service area
13 there, is that a significant portion of
14 Trident's patient population?

15 A: It is. I mean, that -- that clearly is the
16 core of -- what I call the call the core of
17 their service area, where they have the highest
18 draw and also some of the highest market
19 shares.

20 Q: Okay. And then in number 8 -- the number 8 zip
21 code is Walterboro; why is that one number 8?

22 A: It is -- you know, and we heard testimony from
23 Mr. Hiott yesterday and he talked about the
24 fact that they do refer patients to both the
25 Medical University and to Trident for services

1 that they don't provide. And so those patients
2 -- I don't believe that patients coming for
3 routine inpatient services would normally drive
4 from Walterboro to -- to -- to Trident, but --
5 but for more specialized care, they are getting
6 referred to Trident from Walterboro.

7 Q: And what is their overall percentage of the
8 total utilization -- inpatient utilization that
9 comes from 29488?

10 A: It's 2.6 percent.

11 Q: All right. And how about the other zip codes
12 that we see there after the Walterboro zip
13 code, where are those located with respect to
14 Trident Medical Center's service area?

15 A: Hanahan for example is very close to Trident,
16 within -- I would estimate within five or six
17 miles. North Charleston, obviously Trident's
18 in North Charleston or not -- it's not
19 technically in North Charleston, but it's right
20 on the border of North Charleston. And -- and
21 that's the area that's down by Montague Avenue
22 and where they have the Centre Pointe
23 freestanding emergency department. Saint
24 Stephens, a little bit to the north, and
25 Ridgeville, also to the north along the I-26

1 corridor. 405 is another North Charleston zip
2 code that's a little bit farther south, I -- I
3 believe, and closer to the peninsula. Bono is
4 in Berkeley County; it's a little bit more
5 easterly in Berkeley County. Cross is --
6 trying to remember exactly where cross is. I
7 don't recall. St. George is in the -- in the
8 eastern part of Dorchester County.

9 Q: So all of these zip codes in Exhibit 2 that you
10 just went through, what do they comprise?

11 A: That -- that's what I call the primary service
12 area. So that encompasses 78 percent of all
13 the inpatient admissions.

14 MR. THOMAS: Let's go to the next page or the second
15 part of the chart if we could.

16 Q: All right. Now, let's look at this. Is this
17 the chart that contains the secondary service
18 area?

19 A: It is.

20 Q: And why do you do a secondary service area?

21 A: It -- it's just to try to provide some
22 perspective. In this case, you know, to DHEC
23 in terms of where patients are likely to come
24 to receive services at Trident. Certainly, the
25 reliance of folks in these zip codes on Trident

1 is a lot less. And Trident's reliance on those
2 zip codes is a lot less. We see Round 0 made
3 the secondary service area, but, you know,
4 Holly Hill is up I-26. I believe it's in
5 Clarendon County, if I recall. And -- and most
6 of these are -- are more far -- far flung and
7 longer distances, and you know, as I said
8 before, I believe there's a relationship
9 between how close you are to an area and how
10 many patients you draw from that area.

11 Q: Well, how many is -- how many does Trident
12 Medical Center get from 29403, that Charleston
13 zip code that kind of starts down on the lower
14 peninsula and goes up to the neck?

15 A: They got 52 patients.

16 Q: What was the total percentage of their
17 inpatient utilization?

18 A: .3 percent.

19 Q: Okay. So, three-tenths of one percent?

20 A: Right.

21 MR. THOMAS: All right. Let's go to MUHA Exhibit
22 38J.

23 (MUHA Exhibit Number 38J was referenced at this
24 time.)

25 Q: Okay. Are you familiar with this document, Mr.

1 Sullivan?

2 A: I am. I reviewed it. It was -- one of the
3 trial exhibits that was exchanged.

4 Q: And what -- what do you understand the
5 highlighted portions to be?

6 A: Those would be Berkeley County zip codes.

7 Q: Okay. With respect to the -- did -- do you
8 know what the volume is going to come from or
9 what MUSC believes the projected will come from
10 from Berkeley County on this slide?

11 A: Well, if you -- if you total up all of the
12 discharges in -- in those Berkeley County zips
13 and then, again, some of these zips aren't 100
14 percent in Berkeley County. They spill over.
15 I believe that the total number of cases is
16 900-and -- I don't remember the exact number,
17 980 roughly. It represents about 22 percent of
18 the volume would come from Berkeley County
19 based on this exhibit.

20 Q: Okay. And how many do you know from this --
21 from this exhibit coming from the Charleston
22 County area?

23 A: Charleston County represents about 50 percent
24 of the -- of the total volume.

25 Q: Okay. So, would the rest be Dorchester and

1 **then the outlying counties?**

2 **A: That's true.**

3 **Q: Okay.**

4 **MR. THOMAS:** And if we can go -- let's see. Can we
5 go to the second page of this exhibit real
6 quickly? And I -- pull up the -- there we go.
7 Let's go to the peninsula of Charleston right
8 there in the middle. No. The peninsula of
9 Charleston. Yes. That's it.

10 **Q: And -- and how many is MUSC projecting to get?**
11 **How many patients is MUSC projecting to get**
12 **from the 29403 zip code?**

13 **A: They're predicting to get almost 200. 199**
14 **patients.**

15 **Q: Okay. And if -- I believe at the bottom here**
16 **---**

17 **MR. THOMAS:** Go to the bottom.

18 **Q: What's the total number of expected tertiary**
19 **discharges, total all areas?**

20 **A: 4,158.**

21 **Q: So, 199 is roughly what percentage of 4158?**

22 **A: It's roughly 5 percent.**

23 **Q: Okay. Based on your knowledge of Trident**
24 **getting .3 percent or one-third of one percent,**
25 **do you think that's a reasonable expectation**

1 from 29403 for a community hospital that's
2 actually north of Trident?

3 A: I do not. I mean, you would have to travel
4 another approximately ten miles to get to the
5 MUHA Nexton site and I just -- I don't think
6 that's realistic for patients from that area
7 driving that far.

8 Q: Okay. I want to talk to you a little bit about
9 referral relationships. Based on your years of
10 expertise as a health planner, are you familiar
11 with how inpatient referrals and admissions
12 work?

13 A: I am.

14 Q: How -- how does it typically work?

15 A: Well, the -- there's a number of different ways
16 that referrals to hospitals can work. I mean,
17 in one case, a doctor may have a patient and
18 may admit that patient himself or herself
19 directly to the hospital. That's a typical
20 pattern with surgeons. For example, they would
21 see a patient in their office, determine they
22 need surgery and they would admit the patient
23 to the hospital. Primary care physicians, on
24 the other hand, would -- would often times not
25 admit the patient to the hospital, as I

1 mentioned earlier. And they would call the
2 hospital and the hospital would have a referral
3 line. And they would schedule the admission of
4 the patient and the patient would be accepted
5 into the hospital under the care of a
6 hospitalist. In other cases, the patients may
7 on their own decide to go to the emergency
8 department at a hospital. And once they were
9 in the emergency department, be evaluated and
10 then admitted if they needed to be. Or in
11 other cases, a patient may be in a doctor's
12 office and the doctor may call the emergency
13 room at the hospital and say, I've got a
14 patient here that's, for example, having chest
15 pains and I'd like to send them down to you,
16 and would you -- would you evaluate them and --
17 and find a cardiologist who can -- who can care
18 for that patient. And so, you know, there's --
19 - there's a number of different ways that that
20 referral mechanism can occur and it's not
21 simply by doctors who are on the medical staff
22 of the hospital.

23 Q: Okay. And I think that was my next question.
24 What, if any, effect does the fact that the
25 independent physicians in Trident Medical

1 Center, Summerville Medical Center, and
2 Colleton Medical Centers, the fact that they're
3 on their medical staffs, the fact that they
4 don't have privileges at MUHA or an academic
5 appointment affect their ability to send
6 patients to that institution or the proposed
7 MUHA Nexton institution?

8 A: You know, that's not really a major factor in
9 the -- whether they can send patients or not.
10 I mean, you know, I can certainly envision that
11 primary care doctors who -- who refer to
12 Trident now that some portion of those would
13 refer to MUHA if the new hospital opens.

14 Q: All right. Okay. Do -- were you present in
15 the courtroom when Mr. Richardson was
16 questioned by Mr. Wicevic?

17 A: I was.

18 Q: Okay. And I believe that there was a
19 distribution kind of analysis or some
20 worksheets that Mr. Wicevic had Mr. Richardson
21 fill out. Do you recall that?

22 A: I do.

23 Q: Okay. Do you -- do you agree with the premise
24 -- well, first of all, what was the premise of
25 that analysis, if -- as you understood it?

1 **A:** Well, it was to look at the sort of bed to
2 population ratio in the different counties in
3 the tri-county area. And so he was having him
4 fill in a number of beds that were in
5 Charleston County and a number in Berkeley
6 County and Dorchester County, and then also do
7 some population analysis to look at the
8 distribution of population by county and
9 compare the percentage of beds in the counties
10 to the percentage of overall population that
11 county represents.

12 **Q:** Okay. And do you agree with the premise of the
13 analysis?

14 **A:** I don't. As I said earlier, I think that the
15 county line is really, you know, somewhat
16 irrelevant. The question really is is whether
17 the individuals who reside in those counties
18 have appropriate access to care. You know,
19 it's -- in many situations across the country,
20 you may have a hospital located just outside
21 the boundaries of a county and yet, if you were
22 doing a county analysis, you wouldn't count
23 that hospital in -- in the calculation. I
24 think that's exactly what happened here. We
25 have Trident and -- which is just outside the

1 county. And I think -- now, granted, Mr.
2 Wicevic did do an analysis where he allocated
3 the Trident beds to Berkeley County, but that
4 framework of just looking on a county by county
5 basis really doesn't provide useful information
6 in terms of whether there's a community need
7 for another hospital in a particular site.

8 Q: And where did -- I think we saw a slide
9 earlier. Where was -- most of the population
10 of Berkeley County localized?

11 A: It was localized on that -- that southwestern
12 edge of the county, very close to where Trident
13 and Summerville and Roper St. Francis Berkeley
14 are located.

15 Q: Okay. You've heard -- you've heard some of
16 Trident Medical Center's witnesses being
17 questioned about patient choice. My question
18 to you is do patients have a choice of
19 healthcare providers in the tri-county area?

20 A: They definitely do. There -- there's three
21 major systems and then there's another provider
22 at East Cooper that is a little bit smaller in
23 scale. But patients have choices and they
24 apparently exercise those choices because they
25 choose to travel throughout the area to -- to

1 various of the systems.

2 Q: Okay. You heard a little bit about -- were you
3 here for Ms. Valentine's testimony?

4 A: I was.

5 Q: Okay. Are you aware of any significant capital
6 investments made by the Medical University
7 Hospital Authority in Berkeley or Dorchester
8 County prior to the 2017 CON submission for
9 MUHA Nexton?

10 A: I'm not aware of any significant capital
11 investments. They did file a CON prior to
12 filing the application for the hospital for a
13 freestanding emergency department in Berkeley
14 County, which I guess is still the subject of
15 litigation. But the -- before that, I'm not
16 aware of any sizeable investments that they
17 made in the county.

18 Q: Did -- had Trident or Summerville -- had they
19 already applied for a freestanding ED in the
20 Nexton area prior to MUHA?

21 A: They had.

22 Q: Okay. Where did MUHA want to locate its
23 freestanding ED ---

24 A: The ---

25 Q: --- regarding the application you were just

1 talking about?

2 A: Yeah. The application was for a site that was
3 a quarter mile away from the Summerville site.

4 Q: Okay. Did you think that was a good idea?

5 A: I did not.

6 Q: Are you aware of anything that prevented MUHA
7 or MUSC from going out to Berkeley or
8 Dorchester County in the last four decades and
9 making significant capital investments?

10 A: I am not aware of anything.

11 Q: Okay.

12 MR. THOMAS: Let's go -- let's bring up MUHA Exhibit
13 20, I think it's the Berkeley Medical Center
14 application.

15 (MUHA Exhibit Number 20 was referenced at this time.)

16 Q: Are you familiar with this document?

17 A: I am. I -- I didn't prepare it, but I gained
18 familiarity with it over the years.

19 Q: Okay. I just have a couple of questions about
20 this document. Do you know when Trident
21 Medical Center, LLC, actually received the CON
22 -- the actual Certificate of Need with the gold
23 seal on it from DHEC for the Berkeley Medical
24 Center in Moncks Corner?

25 A: Yeah. I -- I believe it was May 26th of 2016.

1 Q: Okay. Do you know if AC Med, LLC was 100
2 percent parent owner of Trident Medical Center,
3 LLC at the time it received the CON for BMC?

4 A: It was.

5 Q: Okay. Do you know if Trident Medical Center,
6 LLC's parent owner has changed since December
7 30th, 2014, when AC Med, LLC became Trident's
8 parent owner?

9 A: Based on my understanding, it has not.

10 Q: Okay. MUHA CON application for the Nexton
11 hospital represents that MUHA is going to close
12 down its freestanding ED and merge it into its
13 hospital when MUHA Nexton opens. Are you aware
14 of this?

15 A: Yes.

16 Q: Okay. I know you testified a little bit about
17 it, but it -- what's your understanding of what
18 MUHA intends to do with the freestanding ED?

19 A: Well, they -- based on the hearing we had a few
20 months ago, they intend to move it about a mile
21 along Highway 17 Alternate in Summerville and
22 keep it open even after the new hospital.

23 Q: Okay. And what's your understanding of where
24 the patients for the MUHA freestanding ED were
25 going to come from?

1 **A:** Well, the application was very similar to this
2 application and it said that all of those
3 patients would be redirected from the emergency
4 department downtown.

5 **Q:** Okay. Will moving it a mile away -- well,
6 what's your understanding of why MUHA decided
7 to move the freestanding ED a mile away from
8 its original location?

9 **A:** That the site that they had chosen initially
10 was not ideal for development of a freestanding
11 emergency department.

12 **Q:** Okay. By keeping that freestanding ED open,
13 what, if any, effect will that have on MUHA's
14 hospital based freestanding ED at Nexton, if
15 it's approved?

16 **A:** I mean, I believe that what it'll do is it'll
17 -- it'll minimize the level of utilization in
18 the ED at -- at the new hospital. The
19 freestanding ED would certainly serve many of
20 the lower acuity patients who otherwise would
21 have gone to that hospital, those patients who
22 would have traveled downtown to -- to MUHA for
23 services. And -- and the same would be true in
24 reverse and that is that opening the hospital
25 was going to reduce the level of utilization of

1 the -- of the freestanding ED because they're
2 located only about -- I guess about four miles
3 apart, and they're drawing from the same pool
4 of patients who were traveling from that area
5 of Berkeley, Dorchester and northern Charleston
6 County down to MUHA in the peninsula.

7 Q: Okay. Have you reviewed MUHA work papers
8 showing the utilization and pro forma models
9 that are related to that freestanding ED?

10 A: I have.

11 Q: Okay.

12 MR. THOMAS: Can we go to MUHA -- no. Excuse me,
13 Trident Exhibit 22.

14 (Trident Exhibit Number 22 was referenced at this
15 time.)

16 Q: Okay. This -- is this the document -- does
17 this look like the document Mr. Sullivan that
18 you would have reviewed, a portion of it?

19 A: Yes.

20 Q: Okay.

21 A: And maybe just clarify one thing. I think ---

22 Q: Yes.

23 A: I think these were projections for the -- for
24 the Nexton hospital.

25 Q: Oh, I'm sorry. Yes. For the next Nexton

1 hospital, the free -- the ED in the Nexton

2 hospital, is that right?

3 A: Correct.

4 MR. THOMAS: Okay. And can we blow up the portion

5 that says emergency department volume?

6 Q: Okay. Can you read that, Mr. Sullivan, because

7 I know it's ---

8 A: I can -- I can see it in the blowed up -- blown

9 up version.

10 Q: Okay. And it states emergency department

11 volumes, it's got an asterisk. What is that --

12 what is that asterisk -- what is after that

13 asterisk?

14 A: It says from free -- FSED CON, freestanding

15 emergency department CON.

16 Q: Okay. So, what is your understanding of that

17 notation?

18 A: Well, what it's showing is the projections that

19 were made for the freestanding ED and I believe

20 this was prepared consistent with the

21 assumption in the application that that -- that

22 volume would be redirected to the Nexton

23 hospital.

24 Q: Okay. And if you could go over to third year

25 of operations there of the Nexton hospital ED.

1 What is the net patient revenue that has been
2 assigned there based on utilization?

3 A: \$8,565,000.

4 Q: Okay. What's going to happen to that net
5 patient revenue if the ED doesn't close down,
6 the freestanding ED?

7 A: Well, I think logically the volume at the
8 hospital would be reduced and so that revenue
9 would be reduced, as well.

10 MR. THOMAS: Okay. Let's go to MUHA Exhibit 26, if
11 we could. Just a couple more questions, Your
12 Honor, then we'll tender the witness.

13 (MUHA Exhibit Number 26 was referenced at this time.)

14 Q: This is a document produced by MUHA. What's
15 the kind of title there underneath the -- I --
16 I think that may be the president's picture,
17 but I'm not 100 percent sure?

18 A: Yeah. It says our -- our mission.

19 Q: Okay. And what do you understand the mission
20 of the Medical University of South Carolina to
21 be?

22 A: Well, it gives me a hint ---

23 Q: Okay.

24 A: A hint on -- on here. It -- it says that it's
25 to "provides an interprofessional environment

1 for learning, discovery, and healing through
2 education of healthcare professionals and
3 biomedical scientists, research in the health
4 sciences and provision of comprehensive
5 healthcare."

6 **Q:** Are you aware of anything -- let me ask you
7 this, what, if any, opinion do you have
8 regarding MUSC's ability to deliver on its
9 mission as stated in MUHA's trial exhibit here
10 if it is unable to build its 128-bed hospital
11 in Nexton?

12 MS. CRUM: Your Honor, I -- I don't think there's
13 been any foundation laid for this. I mean,
14 he's -- he's reading the mission. How does he
15 know how -- first off, that's MUSC's mission.
16 It's not MUHA's mission. And I think the
17 question was MUS- -- MUHA's mission, ability to
18 fulfill its mission.

19 MR. THOMAS: I think I said MUSC because -- I mean,
20 it's their document. It's in their trial
21 exhibit list, Your Honor.

22 MS. CRUM: Yeah.

23 THE COURT: Well, apparently, there's a distinction
24 I'm learning in this case between MUSC and
25 MUHA.

1 MS. CRUM: Yes, sir. MUSC is an academic
2 institution. MUHA is an academic medical
3 facility. It's different.

4 THE COURT: Do ---

5 **Q: Let me ask you this, Mr. Sullivan?**

6 THE COURT: Well, do they put MUHA on all the
7 hospitals out there or do they put MUSC on
8 there?

9 MS. CRUM: Your Honor, it is a brand name.

10 THE COURT: Yeah.

11 MS. CRUM: If they -- if you look at the licensee,
12 it's M-U-H-A is the licensee, MUHA.

13 THE COURT: That's what you call all ---

14 MS. CRUM: And it's a d/b/a.

15 THE COURT: Okay. D/b/a what? MUSC?

16 MS. CRUM: MUSC Healthcare. They do that with all
17 of their facilities.

18 THE COURT: Okay.

19 MS. CRUM: It's a d/b/a.

20 **Q: Okay. What's your understanding, Mr. Sullivan,**
21 **of what MUHA's connection is to MUSC?**

22 **A: Well, I -- I think it -- it is the -- sort of**
23 **the branch of MUSC that's involved in running**
24 **the academic medical center that exists right**
25 **now, the delivering of clinical services.**

1 **Q: Okay. So, MUHA is the healthcare portion of**
2 **the MUSC tri-prong mission?**

3 **OBJECTION:**

4 **MS. CRUM: Object to leading.**

5 **MR. THOMAS: Okay.**

6 **THE COURT: Sustained on that.**

7 **MR. THOMAS: Okay.**

8 **Q: What does MUHA do with respect to MUSC's**
9 **mission?**

10 **A: It -- it provides the clinical setting for the**
11 **other activities that MUSC undertakes. So,**
12 **it's -- it -- it operates the hospital and**
13 **associated outpatient departments and so forth**
14 **in -- in order to -- to provide patient care**
15 **directly, and also to support the other**
16 **activities of MUSC.**

17 **Q: Okay. And MUHA -- if MUHA is not permitted to**
18 **add this 128-bed hospital in Berkeley County,**
19 **do you believe, based on your knowledge of MUSC**
20 **and MUHA, that it will harm MUSC's mission of**
21 **provision of comprehensive healthcare?**

22 **MS. CRUM: Your Honor, he hadn't -- certainly,**
23 **hadn't laid a foundation for that. He has not**
24 **said what knowledge in -- Mr. Sullivan has of**
25 **the foundation other than having him read the**

1 mission statement from the web page.

2 **Q: All right. Let's talk about that first.**

3 MS. CRUM: Or how -- or how he -- how they go about
4 fulfilling their mission.

5 **Q: Mr. Sullivan, what does MUHA -- what type of**
6 **services does it deliver?**

7 **A: Well, it ---**

8 **Q: Start from the beginning. This is going to**
9 **take a while, but we'll do it.**

10 **A: It delivers both inpatient and outpatient**
11 **healthcare services. On the out -- on the**
12 **inpatient side, it delivers what I would**
13 **consider to be secondary level healthcare**
14 **services, the traditional services of a**
15 **community hospital. And then also provides**
16 **what -- what they refer to as tertiary and**
17 **quaternary services, which would be higher**
18 **level acuity services, specialized services.**
19 **And they -- they do it primarily on their**
20 **campus in downtown Charleston, but they do have**
21 **outposts in Mount Pleasant, in West Ashley, and**
22 **-- and in other parts of the service area.**
23 **They -- even into Georgetown County and so**
24 **forth. And so they have -- they have an**
25 **extensive array of services that they provide**

1 in various settings.

2 Q: Okay. Are you familiar with MUHA services?

3 A: I am. I'm -- sat through a few -- few hearings
4 where their witnesses have testified and I've
5 heard a lot about their services.

6 Q: Okay. Has MUHA purchased any other hospitals
7 around the state that you're aware of?

8 A: They have. They purchased four hospitals
9 previously owned by Community Health Systems.

10 Q: Okay. Do you have knowledge about the quality
11 of healthcare of MUHA?

12 A: Certainly they have provided information about
13 that in their application and also through the
14 materials I reviewed in discovery, and I think
15 I am familiar with them.

16 Q: Okay. And what -- what is your understanding
17 of the quality that MUHA offers?

18 A: Well, I mean, the -- they -- they were,
19 according to their press releases, the number
20 one ranked hospital in South Carolina by U.S.
21 News and World Report. They -- they're ranked
22 by Leapfrog. I think they recently got a -- a
23 B score from Leapfrog, which is another
24 organization that measures quality. And so, I
25 mean, they provide a high level of quality amid

1 my experience.

2 Q: As -- as my younger son would say, there's
3 nothing wrong with a B, Mr. Sullivan. Are you
4 aware of anything -- if MUHA's 128-bed hospital
5 in Berkeley County is not constructed, are you
6 aware of anything that is going to harm the
7 patient care delivered by MUHA in its downtown
8 facility and its other facilities throughout
9 the state?

10 A: Not -- not solely based on the -- the denial or
11 decision not to move forward with that project.

12 Q: We can -- they don't -- it's not a licensed
13 hospital now, correct?

14 A: It is not. They -- they don't provide any
15 services there now. They have -- they have bed
16 capacity issues, which, in my view, they can
17 address through other means.

18 Q: Okay. And as you said, they're -- they tout
19 the number one ranking in South Carolina.

20 A: Yes.

21 Q: Are you familiar with the purposes of the South
22 Carolina Health Plan?

23 A: I am.

24 Q: Okay. In terms of cost containment, what are
25 your opinions overall about this project?

1 **A:** I don't believe this project will contribute to
2 cost containment. I believe the -- first of
3 all, it's a very expensive project and as we
4 saw from the some of the analysis I did, it's
5 even more expensive than other projects that
6 MUHA has undertaken. Most importantly though,
7 it's an unneeded project and so it would
8 involve significant capital expenditure, as
9 well as significant operating expenses to be
10 incurred in terms of salaries and supplies and
11 other types of things, without serving any --
12 any true community purpose.

13 **Q:** Okay. Will this project prevent the
14 unnecessary duplication of services?

15 **A:** No. I think this project represents the
16 unnecessary duplication of services.

17 **Q:** In terms of the purpose of the CON Act to guide
18 the establishment of health services which best
19 serve the public need, will that purpose be
20 harmed in any way if the project is not built?

21 **A:** Im my view, not -- it will not. I mean, the --
22 the primary driver of this project is an
23 institution specific desire by MUHA to develop
24 a hospital in this area. The application is
25 devoid of any discussion about other providers

1 in the area or how the other providers would be
2 impacted by this. The only assumption is that
3 we're only going to serve our own patients and
4 nobody is going to affected.

5 Q: And will quality of healthcare services in the
6 area suffer without this project?

7 A: My -- I have no knowledge that there would be
8 any impact on quality.

9 Q: Okay. In terms of Standard 5, could you just
10 summarize -- I know you -- you've testified
11 about this, but what your overall opinion is
12 with respect to the application compliance with
13 Standard 5 in the Health Plan for acute care
14 hospitals?

15 A: My -- my opinion is that the applicant failed
16 to demonstrate compliance with Standard 5 in
17 that they did not show that there was a need
18 for a new hospital at the chosen site and they
19 did not adequately evaluate the adverse impact
20 of the project.

21 Q: Okay. And just -- just real quickly, and we'll
22 be done. The applicable review project --
23 project review criteria considered the most
24 important, could you just quickly summarize
25 those?

1 A: Sure.

2 Q: You can start with community need.

3 A: Yeah.

4 Q: I think you covered ---

5 A: Compliance with the State Health Plan was the
6 first one.

7 Q: Right.

8 A: Community need was the second one. And I spent
9 a fair amount of time testifying about the lack
10 of community need for this particular project.

11 Q: Access.

12 A: In terms of access and distribution, there's
13 excellent access as we've talked about at some
14 length in my testimony. The distribution of
15 beds, I don't think is going to be materially
16 improved by the approval of this project.

17 Q: Okay. I think you talked about the ability to
18 complete the project.

19 A: Right, I have concerns about that given the --
20 the level of commitment -- the commitments that
21 MUHA already has.

22 Q: And in terms of -- we've talked about cost
23 containment. Adverse affects on other
24 facilities, why don't we end with that?

25 A: Okay. I do believe the project is going to

1 adversely affect other facilities for the
2 reasons I've already described. I think the
3 project potentially could adversely affect MUHA
4 itself by developing a needed project that
5 likely is going to underperform and might be a
6 drain on the resources of the system.

7 Q: All right. Mr. Sullivan, please answer any
8 questions on cross-examination the other
9 parties may have.

10 A: Okay.

11 THE COURT: Questions?

12 MS. SHOUN: No questions, Your Honor. Thank you.

13 MR. WICEVIC: No questions.

14 THE COURT: Got a few?

15 MS. CRUM: Your Honor, I need just a minute because
16 I've got to find a notebook that's missing in
17 the courtroom.

18 THE COURT: Okay. We'll take a five minute break.

19 MS. CRUM: Thank you.

20 (Off the record from 3:4 p.m. until 3:49 p.m.)

21 MS. CRUM: Your Honor, thank you for indulging me
22 with my over accumulation of notebooks.

23 THE COURT: That's fine.

24 MS. CRUM: Your Honor, would you mind if I stood
25 here?

1 THE COURT: No.

2 MS. CRUM: Thank you, sir.

3 MR. SULLIVAN - CROSS-EXAMINATION BY MS. CRUM:

4 Q: Mr. Sullivan, good to see you again. I'm Liz
5 Crum. I'm here on behalf of the Medical
6 University Hospital Authority. And I -- I need
7 to ask you just a few questions.

8 A: I'm sure.

9 Q: The average daily census at a hospital is not
10 constant, is it?

11 A: It's not.

12 Q: And typically, a hospital would have a higher
13 census during the weekdays, wouldn't it?

14 A: That is the typical pattern. Yes.

15 Q: And that would be the case of MUSC, wouldn't
16 it?

17 A: I would expect it would be.

18 Q: Do you know?

19 A: I have seen some of their census charts and as
20 I recall, it does seem like they have peak
21 census during the middle of the week.

22 Q: Okay. And generally, hospitals have higher
23 census in the winter months, don't they, as
24 opposed to summer months?

25 A: As -- as a general -- it depends on where you

1 are, you know. But there are some places where
2 you get an influx of people. You know, for
3 example like Hilton Head or whatever, where you
4 actually see the volumes go up in the -- in the
5 summer. But for most hospitals, yeah, the
6 winter months, the flu seasons, and so forth,
7 those are the highest levels of utilization.

8 Q: And the average daily census in the winter
9 months in the tri-county area would be higher,
10 wouldn't it?

11 A: Generally, that's true.

12 Q: I deposed you on October the 15th; do you
13 remember that?

14 A: I do.

15 Q: I don't think my deposition took any longer
16 than Mr. Thomas' direct today, did it?

17 A: I think it was only like four or four and a
18 half hours.

19 Q: Which is less than what you were today. Okay.
20 Let me ask this, when I took your deposition on
21 October the 15th, you did not understand that
22 MUHA was a State agency, did you?

23 A: I -- I did not. You know, I saw that in some
24 other documents subsequent to that, I think.

25 Q: Okay. But you understand now that MUHA is a

1 separately established agency of the State of
2 South Carolina, separate from MUSC, correct?

3 A: Correct.

4 Q: Can you tell me what MUHA's mission is?

5 A: I did see it in a document. I don't know that
6 I can recite it to you, but it's -- part of it
7 I think is to support the Medical University
8 and part of it relates to the provision of
9 clinical care.

10 Q: And part of it relates to education, doesn't
11 it? To teaching the future physicians, nurses,
12 occupational, speech, various therapies,
13 pharmacy and ancillary health professionals in
14 the state, doesn't it?

15 A: Sure. That's one of the ---

16 Q: Okay.

17 A: --- components.

18 Q: That's a rather important component, isn't it?

19 A: Yeah. I think the Medical University serves a
20 very important purpose in South Carolina.

21 Q: Okay. And you understand that as a State
22 agency, the Medical University Hospital
23 Authority has to carry out its statutory
24 mission, doesn't it?

25 A: It does.

1 **Q:** Mr. Gallati talked about charity care. Is that
2 the same as indigent care in the CON
3 regulations?

4 **A:** Yeah. I think there's two different concepts,
5 one is bad debt and one is charity care. And
6 I -- I believe he was referring to charity
7 care. I'm not positive because I didn't -- I
8 didn't see an exhibit, but I know that when
9 I've worked with Trident before, that they
10 recognized charity care and bad debt are two
11 different categories.

12 **Q:** But you would agree with me that his testimony
13 stands for itself?

14 **A:** Whatever he said, uh-huh.

15 **Q:** All right. Thank you. And you would also
16 agree with me that Regulation 61-15 Section
17 202(c)(1), specifically states that indigent
18 care does not include bad debt, contractual
19 adjustments or care reimbursed by government
20 programs, right?

21 **A:** Correct.

22 **Q:** And contractual adjustment, would you explain
23 to the Court what that is?

24 **A:** Sure. Hospitals have charges for things which
25 nobody pays and then third party payers

1 generally, in the case of Medicare and
2 Medicaid, they dictate what they'll pay, which
3 is significantly less than the charges. And
4 third party payers will negotiate rates that
5 are less than charges. So, the difference
6 between charges and what the payer actually
7 pays is a -- that difference is called a
8 contractual adjustment.

9 Q: And you said charges is something nobody pays,
10 right?

11 A: Sure.

12 Q: And that's called -- usually -- it's usually
13 called the usual and customary charge.

14 A: Right.

15 Q: Okay. I want to ask you to look at 2004-05
16 State Health Plan. That's DHEC Exhibit 2 that
17 has already been admitted into evidence.
18 You're -- you're familiar that plan, right?

19 (DHEC Exhibit Number 2 was referenced at this time.)

20 A: I am.

21 Q: And in fact, you helped Mr. Beir, Trident's ex-
22 -- expert in the -- in the trial in 2012,
23 didn't you?

24 A: For the Berkeley hospital?

25 Q: Yes, sir.

1 **A:** Yeah. I -- I didn't have anything to do with
2 application, but I did provide some back-up
3 support for him during the trial.

4 **Q:** Okay. What kind of back-up support did you
5 provide him?

6 **A:** Mainly it was like making maps and getting
7 population data and, you know, maybe pulling
8 some JAR data for him. I mean, things --
9 things like that. I mean, it was, you know,
10 really just trying to prepare exhibits that he
11 could then, you know, utilize.

12 **Q:** You -- you would agree me that there has been
13 significant population growth in the tri-county
14 area since the application -- the Trident
15 Berkeley application was filed under the 2004-
16 2005 Health Plan, wouldn't you?

17 **A:** Yeah. I would. I mean, the population in the
18 tri-county area has been growing somewhere
19 between one and a half and two percent a year
20 over that period of time.

21 **Q:** And for the State of South Carolina, that's
22 significant growth, isn't it?

23 **A:** It is. It's faster than the State overall.

24 **Q:** Now, you would also agree with me, wouldn't
25 you, that Berkeley County's population growth

1 has grown faster than either Charleston's or
2 Dorchester's over that same time period?

3 A: Right. Based on the historical data, I've
4 reviewed, it's -- it's -- it's not dramatically
5 faster, but it's generally within like .3 or .5
6 percent higher on an annual basis.

7 Q: And you would also agree with me, wouldn't you,
8 that the growth in each of the counties that
9 comprise the tri-county area has grown faster
10 than was projected in the 2004-05 plan?

11 A: I've not done that comparison. I mean, it
12 wouldn't surprise me, but I've not done that
13 comparison.

14 Q: Well, let's look at the 2004-05 plan and look
15 on page Roman Numeral II-7.

16 A: Okay.

17 Q: Now, you would agree with me that the State
18 Health Plan has a methodology for calculating
19 bed need?

20 A: It does.

21 Q: Okay. And that methodology uses age cohorts
22 and divides by 365 to obtain a projected
23 average daily census by age cohort, right?

24 A: I would agree with you.

25 Q: And the age cohorts that the plan uses are --

1 I think it's 16-plus -- you can probably tell
2 me better than I can. It's 16-plus.

3 A: I thought it was under 18, maybe if we can pull
4 up the bed need chart.

5 Q: Here we go.

6 A: Yeah.

7 Q: Look on page Roman Numeral X-12.

8 A: Yes. Under 18, 18 to 64, and 65-plus.

9 Q: Okay. So, that was in the 2008 Plan. I'm --
10 '04 -- '04-05. I'm sorry. '04-05 Plan.

11 A: Correct.

12 Q: Okay. And in the 2004-05 Pan, there was a
13 percentage for variable occupancy rates for
14 average daily census, right?

15 A: Correct.

16 Q: In the variable occupancy depended on the size
17 of the hospital, right?

18 A: True.

19 Q: Okay. Now, let's look on over to page Roman
20 Numeral II-17.

21 A: Okay.

22 Q: Okay. And in this Plan, unlike later plans,
23 the service area is at the top. Do you see
24 that? You got Berkeley, Charleston, Dorchester
25 ---

1 **A:** **Right.**

2 **Q:** **--- Counties? Now, under the 2004-05 Plan, how**
3 **many beds did Trident Medical Center need?**

4 **A:** **42.**

5 **Q:** **Okay. And how many beds did Summerville need?**
6 **Summerville Medical Center.**

7 **A:** **20.**

8 **Q:** **Okay. And Charleston Memorial, that -- didn't**
9 **-- you remember old Charleston Memorial?**

10 **A:** **I do.**

11 **Q:** **Sad.**

12 **A:** **It was ---**

13 **Q:** **Is that a good description?**

14 **A:** **It was the charity hospital in the area.**

15 **Q:** **And MUSC bought that -- MUHA bought that,**
16 **didn't they?**

17 **A:** **They did and they operated it for a period of**
18 **time.**

19 **Q:** **And then they consolidated it?**

20 **A:** **They did.**

21 **Q:** **With the system. And they turned that into**
22 **ART. Part of -- part of the beds in ART were**
23 **the beds from the Charleston Memorial Hospital.**

24 **THE COURT:** **Turned in into art?**

25 **MS. CRUM:** **I'm sorry. ART. I'm sorry, Your Honor.**

1 Ashley River Tower.

2 Q: Is that ---

3 THE COURT: Oh, okay.

4 Q: --- sometimes called ART?

5 A: Yes.

6 THE COURT: An acronym.

7 MS. CRUM: Yes, sir. Sorry about that.

8 A: They did.

9 Q: Okay. And so ART was just -- Ashley River
10 Tower was a replacement hospital for the
11 Charleston Memorial Hospital, wasn't it?

12 A: Not exactly, but the -- the beds were consumed
13 in -- in developing that project, and so.

14 Q: All right. Now, let's look on down at the
15 Medical University. How many beds did they
16 need in 2004?

17 A: They had an excess of 68 beds.

18 Q: So, they didn't need any beds, did they?

19 A: Not according to this, no.

20 Q: And what about Roper Hospital?

21 A: An excess of 11.

22 Q: Okay. And Bon Secours had a need of 34, is
23 that right?

24 A: That's right.

25 Q: And East Cooper had a need of one, right?

1 **A:** **Right.**

2 **Q:** **So, in the -- under the 2004-'05 Plan, both**
3 **Summerville and Trident Medical Center had bed**
4 **needs.**

5 **A:** **True.**

6 **Q:** **And MUSC had an excess of 68 beds, right?**

7 **A:** **That's true.**

8 **Q:** **Okay. Come on over and let's look at DHEC**
9 **Exhibit -- I'm sorry. This is MUHA Exhibit.**
10 **Sorry about that. DHEC Exhibit -- I'll get**
11 **this right -- 3. And if you would look on page**
12 **7. Under the bed need for calculating bed**
13 **need. That -- that's the same methodology that**
14 **we used in the 2004-05 Plan, isn't it?**

15 **(DHEC Exhibit Number 3 was referenced at this time.)**

16 **A:** **It is.**

17 **Q:** **Look on page Roman Numeral II-19. Actually, I**
18 **think it starts on II-18.**

19 **A:** **Okay.**

20 **Q:** **At the bottom of the page, Trident Medical**
21 **Center had a bed need of 56, right?**

22 **A:** **Correct.**

23 **Q:** **And Summerville Medical Center had a bed need**
24 **of 24, right?**

25 **A:** **Yes.**

1 Q: And the Medical University had a surplus of 65
2 beds. They didn't need to add any, did they?

3 A: That's true.

4 Q: Okay. And Roper had a surplus of five beds.

5 A: Or six.

6 Q: Oh. And six -- wait, I'm not sure I can read
7 that.

8 A: I am. I'm not going to -- it could be five or
9 could be six.

10 Q: Could be six. But it -- it had a surplus of
11 beds.

12 A: Yes.

13 Q: And Bon Secours had a surplus of 17 beds.

14 A: True.

15 Q: And East Cooper had a surplus of 40 beds.

16 A: Correct.

17 Q: Mr. Sullivan, what State Health Plan did East
18 Cooper file its CON application under for its
19 replacement hospital?

20 A: It may have been under this one. It -- it was
21 not for a new hospital. It was for a
22 replacement hospital.

23 Q: That's what I said, a replacement hospital.

24 A: Yes. Yeah.

25 Q: All right, sir. But it was under this one they

1 had a surplus of beds, didn't they?

2 A: They did and I believe they agreed to give up
3 ten beds in the process.

4 Q: And so they would have still had a surplus of
5 130 beds, right? I mean, of 30 beds, right?

6 A: Yeah. Under -- under this Plan. Yes.

7 Q: And they determined to go forward and build a
8 replacement hospital at a slightly different
9 location, is that right?

10 A: Yeah. I mean, very close to the existing
11 campus.

12 Q: Okay. Now, let's look under the 2010-11 Plan,
13 which would be MUHA Exhibit 10. Do you
14 recognize this Plan, Mr. Sullivan?

15 (MUHA Exhibit Number 10 was referenced at this time.)

16 A: I do.

17 Q: Okay. Is this the South Carolina Department of
18 Health and Environmental Control 2010-2011
19 State Health -- South Carolina Health Plan?

20 A: It is.

21 Q: Effective November 12th?

22 A: 2010.

23 Q: 2010.

24 A: Yes.

25 MOTION TO ADMIT:

1 MS. CRUM: So -- so that I don't forget it, Your
2 Honor, I'm going to go ahead and move this into
3 evidence.

4 MR. THOMAS: No objection.

5 MS. SHOUN: No objection, Your Honor.

6 MR. WICEVIC: No objection.

7 THE COURT: It's admitted.

8 (MUHA Exhibit Number 10 was admitted into evidence.)

9 Q: All right, sir. Would you go on over to page
10 Roman Numeral III-2, starting on 2. And that
11 deals with inventory for acute care beds,
12 doesn't it?

13 A: It does.

14 Q: And look under narrative, general hospital
15 beds. It says acute hospital bed need
16 methodology uses the fo- -- following variable
17 occupancy rate?

18 A: Right.

19 Q: And there, the occupancy rates are one -- 0 to
20 174, 65 percent occupancy rate.

21 A: Right.

22 Q: 175 to 349 is 70 percent.

23 A: Yes.

24 Q: And 350-plus is 75 percent, right?

25 A: Correct.

1 Q: And you would agree with me that the reason the
2 State Health Plan uses these variable occupancy
3 rates is to allow for hospitals to plan for
4 fluctuation in their average daily census?

5 A: That -- that is true. The theory being that
6 you're not going to have constant census. It's
7 going to fluctuate up and down and so by having
8 a target occupancy rate that's below capacity,
9 then you -- you provide some cushion for those
10 fluctuations in demand.

11 Q: And it's also a planning tool that -- occupancy
12 rates is a planning tool to allow hospitals to
13 know when they can start adding or asking to
14 add additional beds, isn't it?

15 A: Yeah. I mean, it's factored into the bed need
16 methodology. So, yes.

17 Q: All right, sir. Let's turn on over to Roman
18 Numeral III-15. Again, this starts at the
19 bottom of the page. Now, Trident Medical
20 Center under this Plan had an excess of 19
21 beds, right?

22 A: Correct.

23 Q: And Summerville had a need for nine beds?

24 A: Correct.

25 Q: And MUSC still had an excess, but this was a

1 need for 15 -- excess of 15, right?

2 A: That's true.

3 Q: Roper had gone -- grown to an excess of 145 --

4 I mean to 45.

5 A: Yes.

6 Q: Bon Secours of minus 44.

7 A: Right.

8 Q: And East Cooper minus 59.

9 A: Correct.

10 Q: Now, let's look at footnote 5 on page III-17.

11 See where it says "bed need combined in new
12 hospital created by transferring bed need from
13 existing hospital appealed"?

14 A: Yes.

15 Q: And the footnote 4 addresses that also, right?

16 A: It does.

17 Q: So, this is where -- but, this is where Trident
18 took its -- the 17-bed need leftover from the
19 2008-09 Plan and transferred those 17 beds from
20 its current location, Trident Medical Center,
21 to the Moncks Corner Berkeley County location
22 and used the State Plan 50-bed economic unit to
23 add a 50-bed hospital, right?

24 A: Correct.

25 Q: Okay. So, having had a bed need of -- I think

1 it was 52 or 56?

2 A: I'm sorry.

3 Q: Trident in the last Health Plan, it had a need
4 for beds. It used all of the beds and got --
5 what's the difference between 56 and ---

6 A: And 17?

7 Q: And 17. Yeah.

8 A: That would be 39.

9 Q: 39. Okay. And it -- it put some additional
10 beds at Trident. But it's bed need excess, did
11 that come from adding the 50-bed compliment?

12 A: If we could look at that ---

13 Q: Sure.

14 A: --- calculation again.

15 Q: You want to go back to ---

16 A: Well, let's look at this one first.

17 Q: Okay. Sure.

18 A: And -- so the total bed compliment here is 346.
19 So, I believe that does include the 50 beds for
20 Berkeley Medical Center.

21 Q: Right.

22 A: Because they had 296 on the prior Plan ---

23 Q: Okay.

24 A: --- as I recall.

25 Q: And of those 50 beds from Berkeley Medical

1 Center, only 17 had been shown as needed in the
2 2008-09 Plan, right?

3 A: Correct.

4 Q: So, they picked up -- they being Trident
5 Medical Center, picked up 33 beds in that --
6 licensed beds when they were approved for the
7 CON, right?

8 A: Correct.

9 Q: Okay. Okay. Let's look at MUHA 9, which is
10 the '12 -- 2012-13 State Health Plan.

11 (MUHA Exhibit Number 9 was referenced at this time.)

12 Q: And look at -- look at page Roman Numeral III
13 -- III-3. Under narrative general hospital,
14 this is the same bed need methodology and the
15 same variable occupancy rates, right?

16 A: Correct.

17 Q: And they used the age cohorts of 0 to 17, 18 to
18 64 and 65 and over, right?

19 A: Correct.

20 Q: Okay. Now, let's go ahead and look over at
21 page Roman Numeral III-16. Berkeley Medical
22 Center -- I'm sorry. Trident Medical Center and
23 Berkeley Medical Center have an excess beds of
24 33, right?

25 A: Correct.

1 Q: Those would be the 33 that they picked up when
2 they got the CON for the hospital in Berkeley
3 County, right?

4 A: Yeah. Probably more of the coincidence in the
5 calculation, but yes. They did pick up 33
6 beds.

7 Q: But that is the difference, isn't it?

8 A: It is.

9 Q: Okay. And Summerville had minus 21.

10 A: Correct.

11 Q: MUSC actually had a need for 52.

12 A: Right.

13 Q: Roper had an excess of 50 -- is that 54?

14 A: I think 84.

15 Q: 84. And Bon Secours had an excess of 56.

16 A: Right. The Summerville number I think went up
17 because they got approved for 30 additional
18 beds in the prior period.

19 Q: Okay. So, they -- that bed need that they had
20 in the last Plan, they went ahead and filled?

21 A: Correct.

22 Q: Okay. Now, are you aware, Mr. Sullivan, that
23 MUSC actually put in an application for a 52-
24 bed hospital? I'm sorry. For a 52-bed addition
25 to MUHA downtown and it was approved under the

1 **2012-13 plan?**

2 **A:** **I am aware that they filed for those beds.**

3 **Yes.**

4 **Q:** **And it was approved, right?**

5 **A:** **Yes.**

6 **MR. THOMAS:** I'm not going to have an objection. I

7 just want to -- because of the prior I think

8 objection, she said MUSC put it in, not ---

9 **MS. CRUM:** And I thought I changed it to MUHA.

10 **MR. THOMAS:** Okay. All right.

11 **Q:** **But MUHA put in an application for 52 beds to**

12 **be located on the downtown campus, right?**

13 **A:** **True.**

14 **Q:** **Okay. And to your knowledge, those 52 beds**

15 **were going to backfill the Shawn Jenkins**

16 **Hospital, the beds that were moved from the**

17 **Children's and University over to Shawn**

18 **Jenkins. Those 52 beds were going to backfill,**

19 **right?**

20 **A:** **To be honest, I don't remember what the**

21 **application said. I mean, I -- we can look at**

22 **it.**

23 **Q:** **So, you don't know whether or not those 52 beds**

24 **are going to backfill space vacated when the**

25 **move occurs to Shawn Jenkins?**

1 **A:** It -- it may well say that. I -- I just don't
2 recall.

3 **Q:** Okay. Do -- you don't remember which Plan the
4 East Cooper and the Mount Pleasant hospitals
5 sought to transfer beds; is that correct?

6 **A:** It don't. It seems like it was in the 2007-
7 2008 time frame. I don't know. I can't
8 remember which Plan was -- was in effect at
9 that time.

10 **Q:** Actually, there was a 2008-2009 plan and a
11 2010-2012 plan.

12 **A:** Yeah. I -- I just -- I just don't remember.
13 That was the time frame we working on the
14 application.

15 **Q:** Okay.

16 **A:** I just don't remember which Plan.

17 MOTION TO ADMIT:

18 MS. CRUM: All right. I would move to admit the
19 2012-2013 South Carolina Health Plan effective
20 November 9th, 2012.

21 MR. THOMAS: No objection.

22 MR. SHOUN: No objection, Your Honor.

23 MR. WICEVIC: No objection.

24 THE COURT: It's admitted.

25 (MUHA Exhibit Number 9 was admitted into evidence.)

1 Q: And let's look at MUHA 8, which is the 2000 --
2 it's the South Carolina Health -- State Health
3 Plan and on the bottom it says enacted 13
4 August 2015. Do you see that one?

5 (MUHA Exhibit Number 8 was referenced at this time.)

6 A: I do.

7 Q: Are you familiar with this Plan?

8 A: Yes.

9 Q: Okay. And let's go ahead and go on over to
10 page Roman Numeral III-2. Again, the variable
11 occupancy rate, it's identical to what it was
12 in the other Plans, correct?

13 A: Correct.

14 Q: And the age cohorts are 0 to 17, etcetera, like
15 they were in the earlier Plans, except for the
16 under 18.

17 A: I think they're the same. I mean ---

18 Q: The same.

19 A: --- it's just a different way of expressing it.

20 Q: All right, sir. Now, let's look on over to
21 page Roman Numeral XIII-9. The -- again, the
22 Berkeley, Charleston, Dorchester County total
23 for in- -- for Trident Medical Center, it shows
24 a need for 20.

25 A: Correct.

1 Q: And that 20 includes the 50 beds for the CON at
2 Roper -- I'm sorry -- at -- in Berkeley County
3 that have not been implemented, correct?

4 A: It does not. I think this is -- at some point,
5 DHEC stopped including those 50 beds with
6 Trident, and I think this might be the first
7 Plan where they stopped doing that, and it's --
8 because the 296 was their actual bed compliment
9 just at Trident.

10 Q: Look under 13, would you for me.

11 A: Okay.

12 Q: So, it says Berkeley Medical Center did not
13 submit 2013 JARs. So, do you know whether or
14 not this includes the additional beds or not?

15 A: I -- I think what it's saying is that they
16 didn't submit a JAR, so they didn't include
17 them in the table. Since they weren't builds,
18 that was the reason that they didn't submit a
19 JAR.

20 Q: But is it your understanding of the State
21 Health Plans, Mr. Sullivan, that the bed need
22 is based on beds -- is an overall number
23 without regard to whether they're licensed beds
24 or CO -- or approved beds?

25 A: Yeah. I mean, in terms of the need

1 calculation, I believe that the correct number
2 to use is the combination of licensed and
3 approved beds.

4 Q: So, then there's still a need for 20 beds?

5 A: At -- at Trident, but that doesn't given any
6 effect of the 50 beds that are approved
7 Berkeley Medical Center.

8 Q: But the 50 beds approved for Berkeley Medical
9 Center are included in the bed compliment for
10 the bed need, right?

11 A: I don't believe they are. They -- if you could
12 show me where they are. I just don't see them
13 included in there.

14 Q: All right. So, let's -- let me go on down
15 here. MUSC has a bed need of 13, right?

16 A: It does.

17 Q: And that 13 is after ---

18 A: I'm -- I'm sorry. They have a bed need of 48.

19 Q: I'm sorry. 13 is Summerville Medical Center.

20 A: Yeah.

21 Q: You're right. I'm sorry about that. And MUSC
22 has a bed need of 48 there, right?

23 A: Correct.

24 Q: And -- and the footnote 16 says that CON SC15-
25 15 was issued June 30th, '15 for the addition

1 of 52 acute hospital beds, right?

2 A: Correct.

3 Q: So, in addition to the 52 hospital beds, MUSC
4 has a need for another 48?

5 A: Correct.

6 Q: Okay. Now, Mount Pleasant has a minus 63. Bon
7 Secours has a minus 37.

8 A: Right.

9 Q: And -- I'm sorry. Roper has a minus 37, Bon
10 Secours has a minus 55, and East Cooper has a
11 minus 56.

12 A: Correct.

13 Q: And at that point -- let's go on to DHEC
14 Exhibit 4, which is the 2017-18 State Health
15 Plan.

16 (DHEC Exhibit Number 4 was referenced at this time.)

17 A: Okay.

18 Q: And looking on page 9, the variable occupancy
19 rate and the need methodology are the same in
20 this Plan as they've been in the previous
21 Plans, right?

22 A: Correct.

23 Q: And the average -- the occupancy rate -- I'm
24 sorry. The age cohorts are used to calculate
25 the average daily census. Same -- same ones,

1 right?

2 A: True.

3 Q: While we're right here, let me just ask you
4 really quickly about Standard 5.

5 A: Okay.

6 Q: Look at that last sentence. Does it say
7 anything about community need or just a need
8 for the new hospital?

9 A: It says the -- a need.

10 Q: And look on -- on page 12 under relative
11 important of project review criteria. Number
12 2 is community need documentation, right?

13 A: It is.

14 Q: Okay. Now, look on over -- on page 27. Now,
15 here we go, Trident Medical Center has a need
16 for 51 beds.

17 A: Correct. 31.

18 Q: I'm sorry. 31. I'm having a hard time reading
19 the difference between the threes and the fives
20 and the sixes. But it has a bed need for 327
21 and it has 290 existing beds -- 96. That's
22 where the 50 beds for Berkeley came in?

23 A: They're not in there.

24 Q: Look on -- on number 13. It's footnote 13.

25 A: That's the Roper facility. I think number 10

1 relates to the Berkeley Medical Center.

2 Q: Number 10. Yeah.

3 A: I think what they did -- what DHEC was doing is
4 they're footnoting the approval of those beds,
5 but they're not including them in the bed need
6 calculation.

7 Q: And that's your understanding?

8 A: That's what it appears looking at ...

9 Q: Okay. Summerville has a negative need there.

10 A: Right.

11 Q: MUHA has a need for 147 beds, right?

12 A: Correct.

13 Q: And all the rest of the hospitals have a need
14 -- have a negative need, right?

15 A: Correct.

16 Q: So, it's Trident Medical Center and MUHA that
17 have bed needs?

18 A: Correct.

19 Q: Okay. Now, the 2018 Plan. Let's go there a
20 minute. That is DHEC Exhibit 5. Look at page
21 9. The variable occupancy rate is the same,
22 right?

23 (DHEC Exhibit Number 5 was referenced at this time.)

24 A: Right.

25 Q: And the method of calculating the average daily

1 census is the same, right?

2 A: Correct.

3 Q: Now, in -- I was going to ask you one thing,
4 too. In the other State Health Plans, in order
5 to calculate the bed need, the State used
6 population, didn't they?

7 A: They did.

8 Q: Okay. And they broke the population down into
9 age cohorts.

10 A: Right. The same age cohorts they did for the
11 utilization data.

12 Q: Right. Okay. Now, look on over on page -- I
13 believe it's 27 again. It is. Here the -- in
14 the 2018-19 Plan, the State broke down the
15 service areas from the tri-county service area
16 to counties, right?

17 A: Yeah. This is the first year that happened.

18 Q: And this is 2018-19 Plan?

19 A: It is.

20 Q: Okay. And you show for -- let's just look at
21 Charleston County. For example, MUSC, ut has
22 a bed need of 157 beds, right?

23 A: That's correct.

24 Q: And the population for Charleston County in
25 2016, was 3,964,884, right?

1 A: Yes.

2 Q: And it projects out to -- it projects out
3 basically seven years, is that right?

4 A: I think that's right.

5 Q: And then the reason they project out seven
6 years is to allow for the planning, filing of
7 applications, getting approvals, going through
8 the appeals process, and allowing a new
9 healthcare facility to get into effect within
10 a seven-year time period, right?

11 A: That's my understanding.

12 Q: Okay. Now, the population, that's not just --
13 I'm sorry. The patient utilization, the number
14 of patient days for the Charleston County for
15 MUHA ---

16 A: Right.

17 Q: --- those aren't just patients from Charleston
18 County, are they?

19 A: Right. They come from all over the State.

20 Q: Okay. Probably about 50 percent of them from
21 the tri-county area and another 50 percent from
22 elsewhere in the State.

23 A: That's the testimony I heard. I ---

24 Q: Okay.

25 A: I haven't verified that, but I've heard that

1 testified to.

2 Q: And do you have any reason to doubt that?

3 A: I don't.

4 Q: Okay. Now, the State uses that inpatient
5 patient days to get the projected average daily
6 census. Would you tell the Court how they
7 calculate the average daily census using the
8 inpatient days?

9 A: Sure. You -- you divide the days by the number
10 of days in the year and that'll give you your
11 average daily census.

12 Q: Okay. Now, look up to Berkeley County for a
13 minute. It shows the two approved 50-bed
14 hospitals, right? Both for Trident Berkeley
15 Medical Center and Roper St. Francis Berkeley.

16 A: Right.

17 Q: How can you calculate whether or not there's a
18 bed need in Berkeley County if you don't have
19 utilization?

20 A: Under this methodology, you can't. You have to
21 wait until the hospitals open up and begin to
22 generate utilization data.

23 Q: Well, you're not suggesting to the Court that
24 MUHA or anyone else for that matter has to wait
25 until Roper Berkeley has established

1 utilization and until Berkeley Medical Center
2 gets built and establishes utilization data
3 before a new hospital or beds can go in there,
4 are you?

5 A: I'm not suggesting that.

6 Q: Okay.

7 A: Because -- you know, I -- I don't know why the
8 Department broke it out in this way because
9 it's not -- not useful from a health planning
10 standpoint, but looking at it from a three-
11 county area is much more useful from a health
12 planning standpoint.

13 Q: Okay. But -- do you have to follow the
14 guidelines of the State Health Plan?

15 A: You do.

16 Q: Okay. You just don't agree with it?

17 A: Well, the need it still determined on an
18 institution specific basis. So, the -- the
19 division into counties only comes into play
20 when you are looking at overall county bed
21 need. And for this particular application,
22 that -- that's not significant because you're
23 -- you've got an institution specific needs
24 that you're proposing to transfer.

25 Q: And you said the need is determined on an

1 institution-specific basis, right?

2 A: Correct.

3 Q: And the population that uses that institution
4 specific need in the case of MUHA covers
5 statewide, right?

6 A: Right. I mean, obviously heavily concentrated
7 in the -- you know, the costal part of the
8 State, but.

9 Q: And people who use the hospital, MUHA, are part
10 of the general public, aren't they?

11 A: Sure.

12 Q: And MUHA fulfills a public need, doesn't it?

13 A: They do.

14 Q: Okay.

15 A: That's a different issue of whether a new
16 hospital fulfills a public need.

17 Q: Even if it's a MUHA hospital?

18 A: Sure.

19 Q: And even if the MUHA hospital has a need for
20 147 beds?

21 A: Sure. You still have to show that a new
22 hospital has to -- is needed at the location in
23 which you're proposing it.

24 Q: Okay. But it's still a public need for those
25 beds, isn't it?

1 **A:** Yeah. I mean, there's an identified need for
2 those beds. I -- I would agree with that, but
3 then that's just the first step in the process.

4 **Q:** And let's look at -- let's see. Trident
5 Medical Center has a need for 37 beds.

6 **A:** Correct.

7 **Q:** And under that, they've already filled six of
8 those, haven't they, with the six-bed neurology
9 renovation project that was just approved that
10 Mr. Gallati talked about?

11 **A:** Yeah. He testified he got the approval letter
12 last week. I haven't seen it yet.

13 **Q:** Yeah.

14 **A:** He testified to that, so.

15 **Q:** Okay. So, but they still have a bed need,
16 right?

17 **A:** Correct.

18 **Q:** And how far is Trident Medical Center from the
19 county line?

20 **A:** It's a mile or so ---

21 **Q:** Okay.

22 **A:** --- from the Berkeley County line.

23 **Q:** And Dorchester County, there's a bed need for
24 two beds in -- at the Summerville Medical
25 Center, right?

1 **A:** Correct.

2 **Q:** Okay. The proposed MUHA Berkeley project, a
3 lot of the -- and we can look at zip codes if
4 you want to. But a lot of the population in
5 north -- in the northern part of Charleston
6 County closer to Trident Medical Center and to
7 Summerville Medical Center is closer to the
8 MUHA Berkeley Medical Center than it is to
9 downtown, isn't it?

10 **A:** The population that's north of Trident is
11 certainly closer to -- to the Nexton hospital
12 than it would be to the downtown hospital.
13 When you get south of Trident, in that North
14 Charleston area, then you get to kind of an
15 equally distant point, and then as you go
16 closer to the city, then obviously, the MUHA
17 downtown is closer.

18 **Q:** And you would agree with me, wouldn't you, that
19 the traffic in downtown Charleston is getting
20 increasingly congested?

21 **A:** Not just in downtown Charleston, but you know,
22 throughout the Charleston area. I would agree
23 with that.

24 **Q:** Okay. But it is more increasingly congested
25 downtown, isn't it?

1 **A:** Well, it's always been bad. So, I -- I mean,
2 I guess to a degree. Certain times of the
3 year. I mean, you know, during the highpoint
4 of the tourist season, it can be particularly
5 congested.

6 **Q:** Gosh. Mr. Sullivan, help me out, but the last
7 time I was down there, I didn't see the tourist
8 season stopping. Does it stop anymore?

9 **A:** Yeah. I was -- a couple of weeks ago, I was
10 there and it was very pleasant. There were
11 hardly any tourists in town. I don't know what
12 happened, but ---

13 **Q:** Was it raining or cold? Okay. But you would
14 agree with me that the -- the -- well, I've
15 asked and answered that. You would also agree
16 with me that from basically -- is that 526 --
17 the -- the not complete ring road yet. Is that
18 526?

19 **A:** Yes.

20 **Q:** Okay. North of 526 going on up to Berkeley
21 County and to the MUHA Nexton location, it's
22 easier to go north then it is to go south down
23 into the peninsula, isn't it? From traffic and
24 time.

25 **A:** I'm not sure that 526 is exactly the dividing

1 line, but I agree with you, somewhere around
2 there is the breakpoint where it would be
3 easier to go north than ---

4 Q: Talking about the State Health Plan, you talked
5 this morning about the State Health Plan and
6 task force?

7 A: Right.

8 Q: You and I served on that together, didn't we?

9 A: We did. You hosted it, as I recall.

10 Q: And we spent a lot of time and it didn't go
11 anywhere, did it?

12 A: No. They sort of got scuttled by certain
13 actions, so.

14 Q: And I -- talking about those certain actions,
15 when was the CON funding vetoed?

16 A: Was it 2013, I believe.

17 Q: And -- and when did the Supreme Court finally
18 say, nah, you can't do that, the program is
19 still in effect and move forward?

20 A: I believe it was in 2014.

21 Q: And in essence, to your knowledge, DHEC
22 wouldn't accept CON applications for new
23 projects during that time period, would they?

24 A: No. We actually sent some to them and they
25 sent them back.

1 **Q:** **Right. Therefore, during that whole time**
2 **period, MUHA couldn't do anything, could they?**
3 **About implementing bed need.**

4 **A:** **I mean, they could have done it at their own**
5 **risk, but most hospitals were unwilling to do**
6 **that.**

7 **Q:** **Surely you would not want MUHA to have risked**
8 **State dollars doing something at their own**
9 **risk?**

10 **A:** **I would not. I'm just saying some hospitals**
11 **did undertake major capital projects, so.**

12 THE COURT: There were some cases that came to me
13 during that time.

14 MS. CRUM: I'm sorry, Your Honor.

15 THE COURT: There were some cases that came to me
16 during that time frame.

17 MS. CRUM: Yes, sir.

18 MR. THOMAS: I'm uniquely aware of that.

19 MS. CRUM: I -- I'm seem to remember reading those.

20 THE COURT: Yeah.

21 MS. SHOUN: As am I, Mr. Thomas?

22 **Q:** **Okay. Let's look MUHA Exhibit 18. You're --**
23 **you're familiar with that application, aren't**
24 **you?**

25 **(MUHA Exhibit Number 18 was referenced at this time.)**

1 **A:** **Right. I actually didn't prepare that one, but**
2 **I am familiar with it.**

3 **Q:** **Yeah.**

4 **A:** **I reviewed it for other purposes.**

5 **Q:** **This was submitted to the Department. Look on**
6 **page 316.**

7 **A:** **Yes.**

8 **Q:** **On August 10th, 2016.**

9 **A:** **Correct.**

10 **Q:** **Okay. And you do recognize this as excerpts**
11 **from the 2016 Women's and Neonatal Services**
12 **Consolidation and Modernization application ?**

13 **A:** **I can only see one page right now, but if you**
14 **tell me an excerpt, I'll take your word for it.**

15 **Q:** **Okay. It is.**

16 **A:** **Okay.**

17 **MOTION TO ADMIT:**

18 **MS. CRUM:** **I would move to introduce this at this**
19 **time as MUHA Exhibit 18.**

20 **MR. THOMAS:** **No objection.**

21 **MS. SHOUN:** **No objection, Your Honor.**

22 **MR. WICEVIC:** **No objection.**

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

24 **(MUHA Exhibit Number 18 was admitted into evidence.)**

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

1 Q: Would you turn on over to MUHA RFP 327? You
2 know, Mr. Sullivan, if you can't see that well,
3 we've got hard copies here.

4 A: This is fine.

5 Q: Okay.

6 A: Mr. Bupp's doing a good job, so.

7 Q: Now, you just testified, if I heard you
8 correctly, that the ownership of Trident
9 Medical Center, LLC, changed in 2014, is that
10 accurate?

11 A: That's -- I -- I spoke with HCA's corporate
12 counsel on the -- as of December 30th, 2014,
13 that was when the transaction supposedly
14 occurred.

15 Q: Okay. Now, this is August 2016. Look under
16 8B. Trident Medical Center, LLC, is the owner,
17 correct?

18 A: Right.

19 Q: And look under 8E on page 328. That still says
20 Health Trust, Inc., the hospital company is 100
21 percent owner, right?

22 A: It does.

23 Q: Okay. Now, have you checked with the annual
24 license renewals at DHEC to see who on the
25 license Trident Medical Center, LLC says is the

1 100 percent owner as of 2017, January 1, 2017?

2 A: I have not.

3 Q: Okay. Okay. Let's look on page 12. I'm
4 sorry. Page 341, paragraph 12. That's the
5 section of the regulation that requires or asks
6 the applicant to discuss alternative facilities
7 and their services considered including the
8 advantages and disadvantages. Application
9 discussed two, didn't it? Maintenance of
10 status quo?

11 A: Right.

12 Q: And consolidation of modernization, and they
13 accepted that one?

14 A: They did.

15 Q: Where'd they give any explanation for the -- or
16 detail discussion of why they chose number 2?

17 A: I -- I didn't prepare this, but I'm not aware
18 that they had any -- I mean, in the need
19 section itself, it discussed all the reasons
20 why they thought it was a good idea to do this.
21 There's not a detailed discussion under this
22 particular question.

23 Q: Okay. Well, MUHA in it's application discussed
24 all the reasons in the need section as to why
25 it thought it was a good idea too, didn't it?

1 A: It did.

2 Q: Okay.

3 A: It just didn't discuss -- I mean, in this case,
4 I think there really were only two
5 alternatives. I mean, either they were going
6 to keep things the way they were or they were
7 going to consolidate. I don't think there was
8 a third alternative. I think in -- in MUHA's
9 case, I think there were other alternatives
10 that could have been considered, so.

11 Q: They didn't do any detailed discussion about
12 why they took the alternative they took, did
13 they?

14 A: Not in this section.

15 Q: All right, sir. Now, let's look on over to
16 454. See that. That's Mr. Gingras is the
17 Chief Financial Officer for Trident Health?

18 A: Yes.

19 Q: Okay. And he says he -- he reviewed the
20 assumptions calculations, etcetera?

21 A: Correct.

22 Q: Look on over on page 458. Are those the
23 assumptions?

24 A: They appear to be.

25 Q: All right, sir. Let's look at MUHA 19. And a

1 look at page -- this was submitted on October
2 10th, 2017, right?

3 (MUHA Exhibit Number 19 was referenced at this time.)

4 A: Correct.

5 Q: Now, you -- look on page 1214. You actually
6 prepared this application, right?

7 A: I did.

8 Q: Okay. What portions of the application did you
9 prepare?

10 A: Primarily B11, which was the need discussion.

11 Q: All right. Who prepared the rest of the
12 application?

13 A: It was information, I think, provided by
14 Trident to Parker Poe.

15 Q: So somebody from Parker Poe prepared the rest
16 of it?

17 A: I believe so.

18 Q: All right, sir. Now, look on page 1225. Under
19 E on page 1225, that's the ownership disclosure
20 form.

21 A: Right.

22 Q: There in 2017, it says AC Med is the 100
23 percent owner of Trident Medical Center, LLC,
24 right?

25 A: Correct.

1 Q: Okay. Look on over to page 1214 -- 41; I'm
2 sorry. Under population, you would agree with
3 me that the service area -- SMC service area is
4 experiencing material population growth and it
5 will over the next five years?

6 A: Yep. I would agree.

7 Q: And the growth in all four counties -- there
8 will be growth in all four counties, but it's
9 going to be faster in Dorchester and Berkeley.

10 A: Right. That's what the data showed. Yes.

11 Q: Okay. And it still shows that, doesn't it?

12 A: I think Dorchester and Charleston -- Charleston
13 might have edged slightly ahead of Dorchester
14 now in the most recent data, but ---

15 Q: But they're still growing, right?

16 A: They are.

17 Q: I ---

18 A: They're still growing. Yeah.

19 Q: And the MUHA Berkeley hospital would be closer
20 to everyone in Berkeley and Dorchester than it
21 would be than -- than any of that population
22 would be through the MUHA downtown center?

23 A: That's true.

24 Q: Okay. Let's look on over to page 1249. This
25 again is a discussion of alternatives.

1 **A:** Correct.

2 **Q:** And the discussion says that they could either
3 not add beds or add beds to meet the demand for
4 the advanced need of neonatal services in a
5 rapidly growing service area.

6 **A:** That's what it says.

7 **Q:** And the app- -- the service area is still
8 rapidly growing, isn't it?

9 **A:** It -- the rate of growth has slowed slightly,
10 but it -- it still is a strong population
11 growth.

12 **Q:** But it hadn't grow -- slowed in Berkeley
13 County, has it?

14 **A:** I think it has. Yes.

15 **Q:** Okay. We'll look at that.

16 **A:** Okay.

17 **Q:** Now, in this application -- in the neonatal
18 application, one of the reasons that, if I
19 remember correctly and you certainly correct me
20 if I'm wrong, that Summerville Medical Center
21 sought the -- put the basinets -- the Level III
22 basinets in Summerville Medical Center ---

23 **A:** Correct.

24 **Q:** --- was because people couldn't get downtown
25 because of the flooding.

1 A: Well, that was only one aspect of it.

2 Q: But it was an aspect, wasn't it?

3 A: It was one aspect. I mean, the main reason was
4 it was -- it's risky to transport critically
5 ill neonates.

6 Q: Now, those are usually -- a lot of times those
7 are transported by -- by a helicopter, aren't
8 they?

9 A: No. Not so much. They -- they have special
10 neonatal ambulances that transport those
11 patients.

12 Q: All right. Tell me the difference between a
13 Level II and a Level III neonatal unit?

14 A: A lot of it has to do with birth weight. And I
15 believe it's 1,500 grams. Level II, the babies
16 have to be above 1,500 grams at least in birth
17 weight. And at a Level III, I think they'd be
18 below 1,500 grams.

19 Q: And a Level III or a Level II NICU is a --
20 that's a specialty service, a highly
21 specialized service, right?

22 A: It is.

23 Q: Okay.

24 A: Let me say this, there's other reasons why
25 patients have to go to Level III. For example,

1 if they had -- they needed cardiac surgery or
2 other kinds of specialized surgery, that would
3 put them at a Level III category.

4 Q: How many cardiac -- pediatric cardiac surgeries
5 does MU- -- has MU- -- did they do last year --
6 MUSC do last year -- MUHA do last year?

7 A: I -- I don't know the number.

8 Q: It's a small number, isn't it?

9 A: It's a relatively small number, yes.

10 Q: Define relatively small?

11 A: Less than 200.

12 Q: Okay. And could be less than 100?

13 A: Could be. I -- I don't know. I can't remember
14 the number, so.

15 Q: Let's see. Let's look at Exhibit 20.

16 (MUHA Exhibit Number 20 was referenced at this time.)

17 MOTION TO ADMIT:

18 MS. CRUM: Let me move the introduction of MUHA
19 Exhibit 19, the Certificate of Need application
20 for the Level IV -- four Level III intensive
21 care basins et al.

22 MR. THOMAS: I will object to the admission of this
23 one, Your Honor. It's not the full
24 application. In this particular case, there is
25 some pretty significant ---

1 THE COURT: Are we talking MUHA 19?

2 MR. THOMAS: MUHA 19, which I believe is the
3 addition of four Level III intensive care
4 basinetts. In fact, there's -- I believe with
5 respect to this application -- I'm just looking
6 at it now, just looking at the portion, they
7 omit a -- a pretty key letter to Maggie
8 Murdock, who I believe is present in the
9 courtroom, where they actually talk about the
10 fact that flooding is not an issue for them in
11 patient care. So, un- -- unless I can
12 supplement this exhibit ---

13 MS. CRUM: Oh --

14 MR. THOMAS: --- I would -- I would ---

15 MS. CRUM: We have no objection, Your Honor. We'll
16 be glad to put the whole thing in. We'll bring
17 it tomorrow.

18 MR. THOMAS: Okay. Then -- then no objection.

19 THE COURT: Well, and you're going to be bringing it
20 tomorrow. Should I wait until tomorrow ---

21 MS. CRUM: Ms. Murdock ---

22 THE COURT: --- and admit it when it's -- when it's
23 complete?

24 MS. CRUM: I can admit it through Ms. Murdock. She
25 will be on the stage tomorrow -- stage. She

1 will be on the witness stand tomorrow. And it
2 was the letter to Ms. Murdock that he was
3 talking about that was submitted.

4 THE COURT: Well, let's just wait until tomorrow and
5 you ---

6 MS. CRUM: I'm sorry.

7 THE COURT: Let's wait. I'll let you move for its
8 admission tomorrow when its complete.

9 MS. CRUM: Yes, sir. That's fine.

10 THE COURT: You -- are y'all good. No objections?

11 MS. SHOUN: The complete application, Your Honor.

12 MS. CRUM: Your Honor ---

13 MR. WICEVIC: No objection.

14 MS. CRUM: Might ---

15 THE COURT: Okay.

16 MS. CRUM: Might I asked a question. Does the
17 complete application include all of the letters
18 of support because I'm happy to put that in
19 another three or four hundred.

20 MR. THOMAS: Yeah. I've already seen the letters of
21 -- well, some letters support. If you want to
22 put the letters of support in, that's fine.
23 This isn't the application that's an issue
24 here, so.

25 THE COURT: Well, apparently the only thing you --

1 I'm not asking for that from the Court's
2 perspective.

3 MR. THOMAS: Okay.

4 THE COURT: You wanted just that one letter?

5 MR. THOMAS: That's right.

6 THE COURT: Let's just do that one letter.

7 MR. THOMAS: I don't think she wants to put the
8 letters of support for Summerville Medical
9 Center's application, Your Honor, but if she
10 does, we don't object.

11 THE COURT: All right.

12 MS. CRUM: All right. Let me also ask you to turn
13 to 1847, page 18 -- I keep saying turn. Would
14 you please put it up on the screen, Mr. Bupp?

15 MR. THOMAS: What exhibit are we in now?

16 MS. CRUM: Same one. It's the same one.

17 MR. THOMAS: I don't have the 1847. Sorry.

18 MS. CRUM: This is from 22. I'm sorry. I needed to
19 move on. Please move to 22. Exhibit 22.

20 (MUHA Exhibit Number 22 was referenced at this time.)

21 **Q: Now, this is 2000 -- April 2019 and you**
22 **prepared this application?**

23 **A: I did.**

24 **Q: And, again, did you just prepare the -- B need**
25 **-- B11 need section?**

1 **A:** That's my recollection.

2 **Q:** Okay. Who prepared the rest of it?

3 **A:** Parker Poe.

4 MS. CRUM: Let's turn on over to 1847, please, sir.

5 **Q:** Now, this was for the construction of the
6 emergency department at James Island?

7 **A:** Correct.

8 **Q:** Okay. And under 12 discussed alterative
9 facilities and -- or services considered,
10 Trident considered one alternative and that was
11 not to develop the emergency center?

12 **A:** Right.

13 **Q:** And the reason Trident rejected this is because
14 it would improve -- they wanted to improve
15 geographic access to the growing demand for
16 emergency services in the rapidly growing area,
17 right?

18 **A:** Right. There -- there are no emergency
19 services currently provided on James Island,
20 Johns Island or any of the Sea Islands.

21 **Q:** It -- is this the one that Roper's contesting?

22 **A:** It is.

23 **Q:** Okay. Yeah. Did you look at any other
24 alternatives of locations to put the
25 freestanding ED?

1 **A:** I mean, I didn't personally, but I believe the
2 Trident did. They looked at other locations on
3 James Island, but they didn't look at other
4 locations beyond that because James Island was
5 an area where -- it was identified as an area
6 of need. There's significant number of
7 freestanding emergency departments available to
8 North Charleston and Berkeley and Dorchester
9 County. There's none to this portion of the
10 tri-county area.

11 **Q:** Mr. Sullivan, Trident -- Summerville, I'm
12 sorry, Medical Center did not tell DHEC about
13 the other areas or locations in James Island
14 that they looked at, did they?

15 **A:** They did not.

16 **Q:** And James Island is, in fact, an island, isn't
17 it?

18 **A:** It is.

19 **Q:** And you've got to go over bridges to get to it?

20 **A:** We do.

21 **Q:** Okay. Look on over on page 1848. You would
22 agree with me that James Island is the gateway
23 for Kiawah, Johns Island and Seabrook Island?

24 **A:** Yeah; it's the most common way that people
25 access those island.

1 Q: Well, you say in your application it's the
2 gateway, right?

3 A: Right.

4 Q: Okay. Now, you also would agree with me that
5 Folly Road is a main thoroughfare and the
6 traffic's awful -- aw- -- try that again. The
7 traffic is almost always horrible on Folly
8 Road, isn't it?

9 A: Folly Road is a very busy road. There's no
10 question about that.

11 Q: Okay. And it bisects James Island and it --
12 doesn't it?

13 A: Not exactly, but, yeah. I mean it's -- it's
14 pretty much toward the center of the island.
15 Yes.

16 Q: Okay. Well, in your application you say it
17 bisects James Island, right?

18 A: Yeah. I mean, I -- I think that's used
19 loosely.

20 Q: The James Island Bridge is the most direct
21 access to downtown, isn't it?

22 A: It is.

23 Q: But it's heavily traveled?

24 A: It is.

25 Q: And if it's got a wreck or anything like that,

1 how do you get downtown?

2 A: You have to work your way through South
3 Windermere and go over to Highway 17 and take
4 the Ashley River Bridge.

5 Q: Is that still a drawbridge?

6 A: No.

7 Q: Okay. When did they do away with the
8 drawbridge?

9 A: That I don't know. I mean, I -- I haven't seen
10 the drawbridge open in recent years, but that's
11 not to say that it never opens. I don't know,
12 so.

13 Q: Okay. The -- okay. The application you stated
14 that as an alternative, residents can travel
15 north to the Ashley River Bridge, which leads
16 to high traffic city streets, as well. That's
17 accurate, isn't it?

18 A: It is.

19 Q: Okay. And those high traffic city streets are
20 the streets in and around Roper and MUHA
21 downtown, which routinely flood, aren't they?

22 A: Those are the streets and portions of those
23 streets do flood.

24 Q: Okay. Let's look at Exhibit 23.

25 (MUHA Exhibit Number 23 was referenced at this time.)

1 Q: This was the addition -- the 30-bed addition
2 for Summerville. We talked about that briefly
3 in our discussion of the State Health Plans,
4 remember?

5 A: I do.

6 Q: Okay. What's a primary service area?

7 A: Typically, that's the area from which a
8 hospital would draw the majority of its
9 patients. Different people use different rules
10 of thumb. I usually use a metric of between 70
11 and 80 percent of the patients coming from that
12 area and I also use sort of a secondary test
13 that -- that the zip code or whatever unit of
14 measure you're using contributes some
15 meaningfully percentage of the -- of the volume
16 to the hospital.

17 Q: What is a meaningful percentage?

18 A: Well, I mean, certainly, if it's less than one
19 percent it's -- it becomes more questionable.
20 In some cases, you -- you can see a clear line
21 of demarcation in the data. There might be --
22 you might be getting ten percent, eight
23 percent, five percent, and all of a sudden it
24 drops off to one or less than one percent. I
25 think you can, you know, sort of draw a line

1 and say that that's where the primary service
2 area ends.

3 Q: All right, sir, thank you. Look over on page
4 30,681. Now, in this situation, y'all discussed
5 three alternatives, right?

6 A: We did.

7 Q: Okay. The first one was to do nothing.

8 A: Right.

9 Q: That's like always an alternative, right?

10 A: It is.

11 Q: Okay. And the second one is to add 50 beds.

12 A: Correct.

13 Q: And you were going to add the 50 beds utilizing
14 the portion of the State Health Plan that said
15 if you had a bed need, you could add up to 50
16 beds.

17 A: Correct.

18 Q: Okay. And the third one was to add one floor
19 to the hospital.

20 A: Right.

21 Q: And that was the alternative selected, right?

22 A: I -- I don't think we -- we accepted --
23 selected that one.

24 Q: Oh, you added the 30 beds. I'm sorry.

25 A: Yeah.

1 Q: I'm sorry. Yeah. The way it was written, I
2 didn't see alternative four.

3 A: Okay.

4 Q: Okay. Now, looking back up on alternative two,
5 you didn't do any analysis that you gave to
6 DHEC to show why it was more economical not to
7 add the 50 beds, did you?

8 A: Not in this section.

9 Q: Okay. You think you did it in another section?

10 A: I think we discussed the fact that
11 architecturally that the addition of the 30
12 beds made the most sense. But I -- I don't
13 recall any specific discussion about why we
14 didn't add 50 beds, and so.

15 Q: In -- in the CON application, you're talking
16 about?

17 A: Right.

18 Q: Okay. And then the alternate three, to add the
19 one floor on the top of the hospital, and after
20 evaluation you said that this alternative would
21 be very expensive and it creates problems in
22 meeting seismic building codes, and would
23 disrupt the operations and systems in the
24 hospital. You didn't tell them how -- you
25 didn't tell DHEC how it would disrupt the

1 operations, did you?

2 A: We didn't go into detail. I can't remember if
3 we had any subsequent discussions with DHEC.
4 I have to just explain them.

5 Q: Did -- you didn't tell them that it was going
6 to be very expensive, did you? Or tell them
7 how -- what the expense was and how you
8 calculated that?

9 A: We didn't give them a specific number in the
10 application.

11 Q: Okay.

12 MS. CRUM: Oh, let me look at Exhibit -- put back
13 Exhibit 22 a second. Let's go on to Exhibit
14 23, maybe it's here. Here we go.

15 (MUHA Exhibit Number 23 was referenced at this time.)

16 Q: Now, look on page 23,663. 23 -- I'm sorry.
17 30,663. Starting down there on the bottom,
18 target population, and going on over to page
19 30,665.

20 A: Okay.

21 Q: You used Summerville Medical Center's historic
22 patient origin data by zip code to define the
23 service area, didn't you?

24 A: I did.

25 Q: And then you used on page 30,663, you used the

1 primary service are of 80%.

2 A: I did.

3 Q: And then you used -- I guess 20% was the ---

4 A: I think it's 14 percent were in the secondary.

5 Q: 14 were in the secondary and then a 5.9 in-
6 migration?

7 A: Right.

8 Q: Okay.

9 MOTION TO ADMIT:

10 MS. CRUM: I would move the admission of MUHA 23.

11 MR. THOMAS: No objection, Your Honor.

12 MS. SHOUN: No objection, Your Honor.

13 MR. WICEVIC: No objection.

14 THE COURT: It's admitted.

15 (MUHA Exhibit Number 23 admitted into evidence.)

16 MS. CRUM: Let's look at MUHA -- we'll come back to
17 that one.

18 Q: Mr. -- Mr. Sullivan, you're not an expert --
19 you're not an architect?

20 A: I am not.

21 Q: And you're not an expert in construction costs,
22 are you?

23 A: I'm -- I'm not involved in estimating
24 construction costs, no.

25 Q: And let me ask you about the -- the Shawn

1 Jenkins Children's Hospital a minute. Do you
2 know whether or not a lot of the square footage
3 in Shawn Jenkins is not clinical space?

4 A: I've not seen anything to that effect and I've
5 reviewed that application, but I -- I don't
6 know specifically.

7 Q: Do you know whether it has a very large atrium?

8 A: I believe it does.

9 Q: Okay. That's not clinical space?

10 A: I wouldn't think so.

11 Q: Okay. Dining rooms aren't clinical space?

12 A: They're not.

13 Q: Parking -- well, no. No. Strike parking. But
14 the -- the laundry, things like that, none of
15 that's clinical space, is it?

16 A: It's not.

17 Q: So, do you have any idea what the percentage of
18 Shawn Jenkins Hospital is actually clinical
19 space as opposed to non-clinical.

20 A: I -- I don't have any knowledge of that.

21 Q: Okay. Let me ask you, you -- I think you
22 testified earlier that you think the MUHA is a
23 highly utilized hospital, right?

24 A: I do.

25 Q: And that the beds are well utilized, right?

1 **A:** Correct.

2 **Q:** You agree that there is a need for 147 beds for
3 MUHA, right?

4 **A:** Well, I mean, I -- I agree that's what the
5 State Health Plan says. I mean, I -- I might
6 calculate it differently, but that's the
7 methodology we -- we have to use.

8 **Q:** Okay. And so you don't disagree that you have
9 to use the State Health Plan, right?

10 **A:** I do not disagree.

11 **Q:** Okay. So, for purposes of this hearing, MUHA
12 has a 147-bed need, right?

13 **A:** Correct.

14 **Q:** Okay. Now, your problem is you just don't
15 think it should be located at Nexton, right?

16 **A:** Correct.

17 **Q:** Okay. Let's look a minute at DHEC Exhibit 1.
18 (DHEC Exhibit Number 1 was referenced at this time.)

19 **Q:** Turn to page 39 of the DHEC record. You see
20 Figure 17 down there?

21 **A:** I do.

22 **Q:** Okay. That -- I think Mr. Thomas asked you
23 about that. The two percent -- well, first
24 off, this -- this figure is just the patient
25 redirection, right?

1 A: It is.

2 Q: And it tells you the percentage of patients
3 that are going to be directed based on drive
4 time, right?

5 A: Right.

6 Q: Have you run any calculation to determine the
7 number of redirected patients based on the
8 drive time with ten percent with 56 to 70 and
9 everything over 71 being at two percent?

10 A: I have not. They ---

11 Q: Okay. All right. Now, you agree with me that
12 MUHA projected its service area based on MUHA's
13 historic zip code analysis, right?

14 A: And drive times.

15 Q: Okay. It projected its service area by zip
16 code, didn't it?

17 A: Right. And tempered that with the evaluation
18 of drive times.

19 Q: But the different -- I'm talking about service
20 area. I'm not talking about how many people
21 come from each area. I'm just talking about
22 the service area.

23 A: Sure.

24 Q: I'm just using the historic zip -- utilization
25 -- historic zip codes, right?

1 A: Sure. But, I mean, obviously drive time is
2 factored into it because MUHA attracts patients
3 from all over the state. They didn't include
4 the entire state in their service area, so they
5 had to make a distinction about how far away
6 the zip code was.

7 Q: And look on page 41. They excluded certain
8 DRGs, right?

9 A: They did.

10 Q: You were in the back of the room when I asked
11 Mr. Richardson about the DRGs, weren't you?

12 A: Right.

13 Q: Okay. And how many DRGs do you think there
14 are?

15 A: Around 1,000.

16 Q: Okay. And this is a whole lot less than 1,000
17 DRGs that are excluded, isn't it?

18 A: Well, these are ranges, so I mean, I haven't
19 counted up how many, but it -- it excludes --
20 I can probably count it at some point, but I
21 mean, it excludes more than a 100 DRG
22 categories.

23 Q: And all you have to do is add up those ranges,
24 right, to figure out how many were excluded?

25 A: Yeah. Just calculate how many are in each

1 range and ---

2 Q: Okay.

3 A: --- then you can add it up.

4 Q: And you would agree with me, wouldn't you, Mr.
5 Sullivan, that MUHA will at the Berkeley County
6 Hospital provide specialized services?

7 A: They didn't describe what I would view as being
8 specialized services at the new hospital, so.

9 Q: Okay. Well, they said they would provide
10 services excluding only these tertiary DRGs and
11 -- tertiary and quaternary DRGs, right?

12 A: Right. But that was also referring to the list
13 of services that were being proposed. For
14 example, they want have a cardiac cath lab.
15 They want have open heart surgery operating
16 rooms. They want have areas to do transplant
17 services. They want have a lot of those types
18 of specialized services.

19 Q: But they're going to have a lot of other
20 specialized services, like spine surgery,
21 right?

22 A: Yeah. I mean, many community hospitals provide
23 spine surgery. Now, I don't consider that --
24 I mean, there's certain types of spine surgery
25 that are very specialized.

1 **Q:** And you don't know if they're going to provide
2 those or not, do you?

3 **A:** I didn't see it described in the application.

4 **Q:** Okay. But they did describe that they were
5 going to provide specialized services?

6 THE COURT: Ms. Crum, just where I'll understand
7 your cross-examination. The DRG sets forth an
8 exclusion of spinal fusion surgery.

9 MS. CRUM: There were all kind ---

10 THE COURT: Cervical spinal fusion surgery.

11 MS. CRUM: Yes, sir. They're different kinds of
12 spine surgery other than the ---

13 THE COURT: I know.

14 MS. CRUM: And I'm not capable of testifying about
15 that, but we have doctors who will. And I was
16 just seeking his ---

17 THE COURT: Okay. I was just trying to understand
18 this.

19 MS. CRUM: Yes, sir.

20 THE COURT: Okay.

21 MS. CRUM: Yes, sir.

22 **Q:** Do you know whether or not spinal fusion
23 surgery, now that Your Honor brought it up, is
24 done at community hospitals?

25 **A:** In some cases. It's -- it's usually done in

1 more specialized facilities.

2 Q: Okay. The medical staff at MUHA Berkeley will
3 be the same medical staff that is MUHA
4 downtown, right?

5 A: I doubt that it will be identical. I assume
6 they'll recruit some additional doctors to go
7 out there. But I mean, they -- they will all
8 be part of a single medical staff as I
9 understand it. Yeah.

10 Q: Do you know what the application says about
11 that?

12 A: You can refresh my recollection. I don't
13 recall.

14 Q: I'm going to come back to that as soon as I
15 find it because I'm going to keep moving on
16 here. But if you look on page 59, under 22,
17 provide the number of existing and proposed
18 medical staff by speciality.

19 A: Right.

20 Q: They're going to have -- let's see. And the
21 response, the following numbers of physicians
22 listed in Figure 33 are currently employed by
23 or have admitted privileges at MUHA Medical
24 Center, which will also have privileges at the
25 community hospital.

1 **A:** **Right. I mean, that's a different issue than**
2 **who's actually going to practice at the**
3 **community hospital.**

4 **Q:** **Do you know what MUSC requires of its**
5 **physicians in regards to where they practice?**

6 **A:** **I assume that's an individual negotiation with**
7 **each doctor.**

8 **Q:** **So, the answer is no?**

9 **A:** **I -- I don't know. I know how it worked at**
10 **Duke. I don't know how it worked at MUSC.**

11 **Q:** **Okay. Now, come on back to page 467. Did you**
12 **study the Berkeley County Comprehensive Health**
13 **Plan when you were reviewing the application?**

14 **A:** **I did.**

15 **Q:** **Okay. Let me ask you Mr. -- Mr. Sullivan, as**
16 **a general rule of health planning, it's**
17 **important to put a new health facility where**
18 **people are, isn't it?**

19 **A:** **As opposed to putting it where they're not,**
20 **yeah. I mean, I ---**

21 **Q:** **Yeah.**

22 **A:** **--- I would agree with that. But also, you**
23 **have to put in it the context of what other**
24 **facilities are already serving that same**
25 **population.**

1 Q: And its also important that a healthcare
2 facility is located so that people have access
3 to it in terms of transportation, right?

4 A: Correct.

5 Q: Okay. Now, you would agree with me that the
6 Charleston Regional -- Area Regional Transit
7 Authority, CARTA actually has a service up to
8 Berkeley County?

9 A: On a very limited basis. Yes.

10 Q: And then within Berkeley County, there's the
11 tri-county -- I think it's call the Tri-County
12 Regional Transit Authority ---

13 A: They're ---

14 Q: --- that connect with CARTA and provide
15 services in Berkeley County, don't they?

16 A: They do. I looked -- I looked at this in some
17 detail the other day when you were talking
18 about it with another witness. And there seems
19 to be something that's -- some sort of link
20 service that has very limited places that it
21 transports people. I mean, the problem with
22 CARTA is it doesn't even transport very many
23 people in Charleston County. There's --
24 there's been a big cutback on the level of bus
25 service in Charleston County.

1 Q: Okay. Well, you have to have an ability to get
2 to the hospital, right?

3 A: You do. I mean, obviously if you're really
4 sick, you'll get there by ambulance, I mean.

5 Q: Right.

6 A: Otherwise, you have to have private
7 transportation or public transportation.

8 Q: Now, let's talk about getting their by
9 ambulance. You were asked a series of
10 questions by Mr. Thomas about, you know, if you
11 went to an emergency center and you needed --
12 or you were in an ER and you needed to
13 transported.

14 A: Right.

15 Q: You can take -- take the person down to MUSC.

16 A: Right.

17 Q: Didn't you hear Mr. Gallati testify yesterday
18 that the patient has a right to say where
19 they're taken in an emergency situation, right?

20 A: They do.

21 Q: And you'd agree with that?

22 A: Right. There are certain protocols, for
23 example, a patient who's having a heart attack,
24 the -- I believe, the protocol requires them to
25 be taken to the closest facility that's capable

1 of treating that patient.

2 Q: Okay. And ult -- but the patient can still
3 overrule that and go to another facility, can't
4 they?

5 A: I suppose they could, in a sense.

6 OBJECTION:

7 MR. THOMAS: I just object to that last one where
8 she's -- she's asking to speculate and -- and
9 she's asking him to determine the condition of
10 the patient. A lot of times patients are not
11 consciousness, Your Honor.

12 MS. CRUM: I didn't ask him to determine the
13 condition of the patient at all. I just asked
14 him if the patient had the right to choose
15 where they wanted to go.

16 THE COURT: I would presume that a patient that is
17 unconscious will not be making such decisions.

18 MR. THOMAS: Thank you, Your Honor.

19 MS. CRUM: As would I, Your Honor.

20 Q: Well, let's take your protocol then. If -- if
21 you say that they have to take them to the
22 closest place with -- as -- it's a STEMI issue
23 or something, that would be to Trident,
24 wouldn't it?

25 A: It could be or they could be put in a

1 helicopter and taken downtown to ---

2 Q: Trident has a helipad, doesn't it?

3 A: It does.

4 Q: Okay. All right. Look on page 497.

5 MS. CRUM: Can you blow the legend up, please?

6 MR. BUPP: Sure.

7 Q: Okay. Now, the colors -- this is the Berkeley
8 County future land use map, right?

9 A: Right.

10 Q: And the colors tell you, like for green is
11 conservation recreation.

12 A: Right.

13 Q: And blue is kind of obvious with lakes and
14 rivers. And the interstates and highways --
15 you don't have the highlight those. I think
16 those are very readable on there. And then the
17 light green is constrained residential growth,
18 right?

19 A: Correct.

20 Q: Okay. A whole lot of Berkeley County is --
21 well, lakes and rivers and conservation and
22 recreation areas, right?

23 A: It is.

24 Q: And you can't build a hospital in there, can
25 you? Or let me put it this way, it would not

1 be good health planning to build a hospital in
2 -- in the Francis-Marion National Forest, would
3 it?

4 A: I would not think so. No.

5 Q: Okay.

6 A: No.

7 Q: And I don't think we're going to break ground
8 and build it in the lake, right?

9 A: Probably not.

10 Q: Okay. So, the major transportation arteries --
11 are you familiar with the road system in
12 Berkeley County?

13 A: Generally, I mean, I've driven through there
14 many times.

15 Q: And there -- there's some back roads.

16 A: There are.

17 Q: And there are some dirt roads that the forest
18 service takes care of in the Francis Marion
19 National Forest, is that correct?

20 A: Sure, there's some small country roads out
21 there as parts of ---

22 Q: And this map shows the major transportation
23 arteries in Berkeley County, doesn't it?

24 A: It does.

25 Q: Okay.

1 MS. CRUM: Flip on over, please sir, to ---

2 THE COURT: I tell you what, I think we should just
3 take a five minute break right now or are you
4 ---

5 MS. CRUM: Yeah. That's fine. That's fine. I'm
6 pretty close to this part, finished with this,
7 and I maybe have another 30 minutes.

8 THE COURT: Okay.

9 MS. CRUM: It could be 45, but no more than that.

10 THE COURT: Okay. Good. Thank you.

11 (Off the record from 5:17 p.m. until 5:30 p.m.)

12 THE COURT: Be seated.

13 MS. CRUM: Your Honor, I'm going to say that was a
14 very worthwhile break.

15 THE COURT: Okay.

16 MOTION TO ADMIT:

17 MS. CRUM: I don't have but a couple questions, but
18 one housekeeping. I would like to move MUHA
19 Exhibit 8, which I believe is one of the State
20 Health -- yes, the 2015 State Health Plan.

21 MR. THOMAS: No ---

22 MS. CRUM: Move that into evidence.

23 MR. THOMAS: No objection.

24 MS. SHOUN: No objection, Your Honor.

25 MR. WICEVIC: No objection.

1 THE COURT: It's admitted.

2 (MUHA Exhibit Number 8 was admitted into evidence.)

3 MS. CRUM: Okay. And if we could go back to or go

4 to 497 in the DHEC record.

5 (DHEC Exhibit Number 1 was referenced at this time.)

6 Q: Now, Mr. Sullivan, the MUHA Nexton Hospital,
7 you see where we've got I-26, 176 and that's
8 176 going through, where is -- where is MUHA
9 located -- or will be located?

10 A: Let me get my bearings here on this map. It's
11 --- where is ---

12 Q: It's right there no the major artery, right?

13 A: Yeah. It's -- it's a little bit to the -- to
14 the west of 176, north of the main Summerville
15 exit. So, it's -- I don't know how to tell you
16 exactly where it is, but it's on Nexton
17 Parkway, right on a curve in the Parkway.

18 Q: But it's on one of the main arteries in
19 Berkeley County, right?

20 A: I guess it's a new artery, but it's -- yeah.

21 Q: And it's a main artery.

22 OBJECTION:

23 MR. THOMAS: Objection, Your Honor.

24 A: It connects. It connects up with -- with other
25 roads in Berkeley County.

1 **Q: Okay.**

2 MR. THOMAS: Withdrawn.

3 THE COURT: Yeah. I think he covered it.

4 **Q: Thank you, Mr. Sullivan. I don't have anything**
5 **else.**

6 **A: Thank you.**

7 MR. THOMAS: Liz must want me to go to this school
8 board thing.

9 MS. CRUM: I'm trying to get -- I'm trying to get
10 you to go to it.

11 MR. SULLIVAN - REDIRECT EXAMINATION BY MR. THOMAS:

12 **Q: Just a couple, Mr. Sullivan.**

13 **A: Okay.**

14 **Q: Okay. Ms. Crum referenced population growth**
15 **and she went over several different CON**
16 **applications. Do you recall that testimony?**

17 **A: I do.**

18 **Q: Does that change your opinion about -- with**
19 **respect to need, access, Standard 5 or any of**
20 **the project review criteria with respect to**
21 **MUHA's Nexton project?**

22 **A: It does not.**

23 **Q: Okay. Why?**

24 **A: Well, the population growth, I mean, I was**
25 **aware of that before she pointed it out to me.**

1 The population growth, as we talked about
2 before, is in a fairly concentrated area in
3 which we just saw on that land use map, as
4 well. And there's hospital beds available to
5 that population.

6 Q: How long has that population growth been
7 occurring in the -- the north area that we've
8 come to talk about, Dorchester, Berkeley, north
9 Charleston?

10 A: It's been going on for quite a while. I mean,
11 I would at least over the last 20 years.

12 Q: Is there any -- anything preventing MUHA from
13 transferring beds from its downtown facility to
14 create a new hospital in the same way Roper
15 Berkeley did that you're aware of over that
16 time period?

17 A: No.

18 Q: Okay. And I believe you said that the South
19 Carolina CON program was suspended and maybe
20 you said that it -- that it was reinstated back
21 in 2014?

22 A: I -- I may have had the dates wrong. I know
23 that the 2015 plan came out after they
24 reinitiated the program and I just -- it was
25 either reinitiated at the end of '14 or

1 beginning of '15.

2 Q: Okay. But still, what -- what's the time
3 period between when the CON program was
4 suspended and when the application was actually
5 submitted by MUHA?

6 A: It's a -- a little over a year, I think.

7 Q: Perhaps two?

8 A: Could have been two.

9 OBJECTION:

10 MS. CRUM: Object to the form of the question. He's
11 leading.

12 A: Okay.

13 THE COURT: Yeah.

14 Q: It's a -- if ---

15 A: I -- I don't recall. I mean, it was some
16 period of time. I remember that it was
17 suspended and then at some point, I -- I
18 thought it was in December of '14 it was
19 resurrected. But it may have been '15.

20 Q: Okay. If it was in '15, then the entire year
21 of 2016 went by, is -- is that right?

22 A: Correct.

23 Q: Without MUHA submitting an application for
24 Nexton?

25 A: Correct.

1 Q: Okay. And then almost a -- another entire
2 year, 2017, went by.

3 A: Correct.

4 Q: Okay. So, it's not like -- is it -- do you
5 believe that MUHA had an application ready to
6 go at the end of the CON suspension time?

7 A: It did not.

8 Q: Okay. You were asked a question of where MUHA
9 gets its patients, 50 percent in the tri-county
10 and I think Ms. Crum said 50 percent outside of
11 the tri-county, do you recall that?

12 A: Yes.

13 Q: Okay. She asked did you have any reason to
14 doubt that?

15 A: I don't.

16 Q: Okay. But wouldn't you let the data speak for
17 itself?

18 A: Sure.

19 MR. THOMAS: Okay. Can we pull up 38c, please?

20 MUHA 38c.

21 (MUHA Exhibit Number 38c was referenced at this
22 time.)

23 Q: Mr. Sullivan, do you rec- -- rec ---

24 OBJECTION:

25 MS. CRUM: Your Honor, I'm going to object to this.

1 This is beyond the scope of anything I asked.

2 I didn't ask about a MUHA 38c exhibit.

3 MR. THOMAS: But she asked about drive times, Your
4 Honor. And this is their own drive time
5 exhibit related to some of the zip codes that
6 she was speaking to directly.

7 MS. CRUM: Your Honor, I asked about the percentages
8 of redirection. Mr. Sullivan responded with
9 drive times.

10 MR. THOMAS: No, no, no. She asked about -- and I
11 can quote it. The 526 corridor -- the ---

12 MS. CRUM: Excuse me. I stand corrected. I did ask
13 about the 526.

14 MR. THOMAS: Okay. All right.

15 Q: Mr. Sullivan, do you recognize this document,
16 MUHA 38c?

17 A: Yeah. It -- it's an update chart. I -- I
18 believe the original was in the application.

19 Q: Okay. And then -- and it's entitled driving
20 distance and time from service area zip code
21 central to proposed MUHA downtown and Berkeley
22 location?

23 A: Yes.

24 Q: Okay. And in looking at the various drive
25 times in the distance/time variance to Berk,

1 how many of those categories are actually
2 closer to MUHA Nexton over MUHA downtown?

3 A: Two.

4 Q: Okay. And how many are there total here,
5 categories, zip codes, are here?

6 A: Nine.

7 Q: Okay. Now, Ms. Crum asked you some questions
8 about, you know, once you get passed 526 going,
9 I guess west on -- on I-26, that things can --
10 traffic can start to lighten up. Do you recall
11 that line of questioning?

12 A: I do.

13 Q: Okay. Doesn't it depend on the time of day as
14 to whether the traffic's light going one way or
15 the other on I-26?

16 A: Sure. I mean, in the mornings coming down I-26
17 towards Charleston is -- is backed up and the
18 afternoons starting about 3:30 or 4:00, it's
19 backed up going northwest on I-26.

20 Q: Okay. And Ms. Crum asked you specifically that
21 -- about MUHA's dollars are State dollars and
22 they shouldn't be put at risk. Do you recall
23 that?

24 A: I do.

25 Q: Do you agree with that?

1 **A: I absolutely agree with that.**

2 MR. THOMAS: Okay. Let's go to MUHA 18, if we can
3 pull that up.

4 (MUHA Exhibit Number 18 was referenced at this time.)

5 **Q: This is the CON application Ms. Crum was asking**
6 **you about, the Women's and Neonatal Services**
7 **consolidation, modernization.**

8 MR. THOMAS: And if we could go to -- I believe we
9 have a -- let's go to MUHA 18-035, if we could.

10 MS. CRUM: I'm sorry. 03?

11 MR. THOMAS: Yeah. Liz, the -- the Bates number
12 would be 457. We -- we have ours paginated for
13 the system.

14 **Q: Ms. Crum asked you some other questions about**
15 **charity and bad debt, correct?**

16 **A: Correct.**

17 **Q: Okay. If we can look at the pro forma here on**
18 **RFP 457 and if you could go down to the**
19 **deductions.**

20 **A: Sure.**

21 **Q: 19 for Trident Medical Center.**

22 **A: Right.**

23 **Q: Trident Health. What is the charity line item**
24 **dollar amount there?**

25 **A: In 2016, it was almost \$73 million. In 2017,**

1 it was projected to go up to about 81.5 million
2 and then grow over that period of time to about
3 114 million over that time frame.

4 Q: Okay. Can you come down to the expense
5 category? Do they have a separate column for
6 bad debt?

7 A: Right. Bad -- bad debts under general accepted
8 accounting principles should not be presented
9 as a contractual allowance or deduction when
10 they're considered an expense.

11 Q: Okay.

12 A: And there's a separate category for that that
13 starts at about \$50 million and grows to about
14 \$79 million.

15 Q: Okay. And Ms. Crum asked you some questions
16 about flooding downtown. Do you recall -- and
17 just -- just for clarity on the record, what
18 MUHA's response was in -- with respect to the
19 Level III NICU application when Summerville
20 Medical Center made the assertions about it
21 could be difficult to get children downtown or
22 neonates downtown during times of flooding?

23 A: Yeah. I mean, their -- their response was that
24 flooding was not an issue in terms of providing
25 access to care for neonates.

1 Q: Okay. Now, Ms. Crum asked you a couple of
2 questions about the Shawn Jenkins Children's
3 Hospital. Do you recall that about the space
4 allocation?

5 A: I do.

6 Q: Okay. She asked you about the atrium. Then
7 she started going into some non-medical items
8 like laundry and dining. Do you recall that?

9 A: I do.

10 Q: Okay. Does -- does MUHA Nexton or do you know,
11 are they going to have dining now?

12 A: They are.

13 Q: Okay. Do -- would expect them to have a
14 laundry center?

15 A: Yeah, of some type. Yes. That's a ---

16 Q: Supply -- supply services?

17 A: Sure.

18 Q: Okay. Environmental areas?

19 A: Absolutely.

20 Q: Okay. In fact, they're going to have a lot of
21 non-clinical space to run that hospital.

22 A: Sure.

23 OBJECTION:

24 MS. CRUM: Your Honor, I'm tired or else I'd get up
25 and object to leading. I wish we would just go

1 -- quit testifying.

2 MR. THOMAS: Okay.

3 Q: What if any ---

4 THE COURT: Was that a perfunctory objection, I
5 guess.

6 (Laughter)

7 Q: What -- what, if any, non-type medical space
8 must MUHA Nexton have in order to run the
9 hospital?

10 A: It needs administrative space for -- you know,
11 for the administration of the hospital. It has
12 to have a loading dock and storage space for
13 supplies and equipment. It has to have an
14 engineering department. It has to have -- we
15 talked about laundry and dietary, kitchen.

16 Q: Let me ask you this, the -- the children's
17 hospital, the new one, do you think it's a
18 300,000 square foot atrium?

19 A: I do not.

20 Q: Ms. Crum asked you about -- a lot about the CON
21 application and the chart of excluded DRGs, and
22 -- but what is -- what's the premise overall of
23 the type of person that MUHA Nexton claims
24 they're going to treat out at the community
25 hospital?

1 **A:** It would be people who didn't require the
2 specialized care of a -- of an academic medical
3 center like MUHA downtown, so it would be --
4 and -- and as she mentioned, a lot of these DRG
5 categories include things that could be more
6 specialized depending on the condition of the
7 patient or it could be less specialized. And
8 -- and my expectation would be the patients who
9 have more specialized needs would be more
10 likely to go downtown and the patients who have
11 -- are on the lower acuity end, would be the
12 type that would go to a community hospital.

13 **Q:** Is that -- is -- is one purpose of the Nexton
14 hospital -- is one purpose of the Nexton
15 hospital to free up space downtown for more
16 complex patients?

17 **A:** That -- that was one of the statements cited in
18 the application as a reason ---

19 **OBJECTION:**

20 **MS. CRUM:** Your Honor, that -- that certainly is
21 beyond the scope of anything I asked on re-
22 cross. I didn't ask anything about the
23 purposes of the Nexton hospital.

24 **MR. THOMAS:** Yeah, but -- well, she made a big deal
25 about asking Mr. Sullivan about the DRGs in

1 tertiary care that's going to be delivered
2 downtown seeming to suggest now that they're
3 going to be doing a much higher level of
4 service at Nexton, but the -- as the
5 application states, I think as Mr. Sullivan
6 just testified, that the entire purpose of it
7 was to clear space from the downtown campus to
8 allow for the higher specialized services.
9 That's -- I think it's right along the same
10 topic line, Your Honor.

11 MS. CRUM: Your Honor, I've sort of forgotten the
12 question that he asked, but I -- I did not ask
13 about what the purposes of doing MUHA was,
14 other than to fill the 147-bed need. I didn't
15 go into anything else about that.

16 MR. THOMAS: I disagree.

17 MS. CRUM: So, that's beyond the scope.

18 MR. THOMAS: I disagree, Your Honor.

19 THE COURT: I think in this instance -- it's close,
20 but I'm going to let him ask the question, so
21 that -- just because it is close.

22 **A: Yeah. I think -- I think the -- you know, one**
23 **stated purpose of opening the Nexton hospital**
24 **was to move lower acuity patients away from the**
25 **downtown campus and free up space for more**

1 complex patients.

2 Q: Okay. And Ms. Crum asked you about Trident
3 having a -- a helipad. Do you know where the
4 next nearest tertiary care hospital from
5 Trident Medical Center is?

6 A: That would MUHA.

7 Q: Okay. And where would the -- and -- and how --
8 do you know how many miles away it is?

9 A: From Trident?

10 Q: Yeah.

11 A: About 18, 19 miles.

12 Q: Okay. And so, MUHA Nexton was also going to
13 have a helipad that's proposed, correct?

14 A: Correct.

15 Q: Okay. And where is that in relation to the
16 Trident Medical Center and tertiary care?

17 A: It's about nine miles to the north.

18 Q: What, if any, concerns do you have about Nexton
19 having a helipad?

20 A: That it may be used to transport complex
21 patients who otherwise would've gone to Trident
22 to MUHA downtown.

23 Q: Okay.

24 MR. THOMAS: That's all the questions I have, Your
25 Honor.

1 MS. CRUM: I have one follow-up on new matter.

2 THE COURT: Okay.

3 MR. SULLIVAN - RECROSS-EXAMINATION BY MS. CRUM:

4 Q: On page -- this is MUHA 18, page 457.

5 (MUHA Exhibit Number 18 was referenced at this time.)

6 A: Okay.

7 Q: Okay. The charity care you were asked about,
8 that's a projected budget, isn't it?

9 A: Right.

10 Q: Thank you.

11 THE COURT: You may step down.

12 A: Thank you very much.

13 MR. THOMAS: I'm not going to release him, Your
14 Honor, because I need him for rebuttal.

15 THE COURT: Okay. What time are we going to start
16 tomorrow?

17 MS. CRUM: Your Honor, if it suits the Court, we
18 would like to start at 9:30 because I
19 anticipate that Ms. Murdock is going to be this
20 long.

21 THE COURT: It's fine with me. Okay. Y'all just
22 want to start earlier, that'd even be fine. I
23 think 9:30.

24 MS. CRUM: Your Honor, we had -- you had asked Mr.
25 Murdock about 9:30, right?

1 MR. WICEVIC: Yeah. She's good with 9:30, Your

2 Honor.

3 THE COURT: Okay. All right. 9:30 it is.

4 MS. SHOUN: Thank you, Your Honor.

5 THE COURT: Y'all be at ease.

6 (The hearing adjourned at 5:48 p.m.)

Transcript of the Testimony of
**ROPER SF, TRIDENT, ET AL. V. DHEC, MUHA,
ET AL.**

Date: November 15, 2019



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STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

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

Petitioners,)18-ALJ-07-0358-CC

v.)

South Carolina Department of Health)
and Environmental Control and Medical)
University Hospital Authority, d/b/a)
MUHA Community Hospital,)

Respondents.)

Walterboro Community Hospital, Inc.,)
d/b/a Colleton Medical Center,)

Petitioners,)18-ALJ-07-0360-CC

v.)

South Carolina Department of Health)
and Environmental Control and Medical)
University Hospital Authority, d/b/a)
MUHA Community Hospital,)

Respondents.)

Walterboro Community Hospital, Inc.,)
d/b/a Colleton Medical Center,)

Petitioners,)18-ALJ-07-0366-CC

v.)

South Carolina Department of Health)
and Environmental Control and Medical)
University Hospital Authority, d/b/a)
MUHA Community Hospital,)

Respondents.)

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HEARING

Friday, November 15, 2019

9:32 a.m. - 7:03 p.m.

Monday, November 18, 2019

10:01 a.m. - 4:58 p.m.

Tuesday, November 19, 2019

9:28 a.m. - 7:00 p.m.

Wednesday, November 20, 2019

10:02 a.m. - 5:41 p.m.

Thursday, November 21, 2019

9:03 a.m. - 1:21 p.m.

The Hearing held before the Honorable Ralph K. Anderson, III, was taken at the Edgar A. Brown Building, 1205 Pendleton Street, Suite 224, Columbia, South Carolina, on the 15th, 18th, 19th, 20th and 21st days of November, 2019 before Travis McLeod, Court Reporter and Notary Public in and for the State of South Carolina.

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21 Also Present:

22 Stephanie Perez, Judicial Law Clerk
23 Katie Buckner, Staff Attorney

24

25

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18	MR. THOMAS CROSS-EXAMINATION	.689
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9	TMC Exhibit 22.	.757,788
10	DHEC Exhibit 1.	.778,795
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11	TMC Exhibit 145	1020
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1	DAY TEN - WEDNESDAY, NOVEMBER 20, 2019	
	CALL TO ORDER	
2	THE COURT.	1025
3	MR. LEVITT:	
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5	RSF Exhibit 119-6	1080
	ADMITTED	1177
6	RSF Exhibit 119-9	1081
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7	RSF Exhibit 119-17.	1082
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8	RSF Exhibit 119-18.	1083
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13	RSF Exhibit 119-26.	1091
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17	RSF Exhibit 119-36.	1094
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18	OBJECTION	1096
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19	RSF Exhibit 119-38.	1097
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20	RSF Exhibit 119-39.	1188
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21	ADMITTED	1189
	RSF Exhibit 119-41.	1100
22	ADMITTED	1189
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23	MUHA Exhibit 38	1102
	ADMITTED	1189
24	MUHA Exhibit 38A.	1104
	ADMITTED	1190
25	OBJECTION	1106

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4	ADMITTED	1193
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6	ADMITTED	1194
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15	MUHA Exhibit 38U.	1132
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2	TMC Exhibit 41.	1245
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5	TMC Exhibit 28.	1270
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1	DAY ELEVEN - THURSDAY, NOVEMBER 21, 2019	
2	CALL TO ORDER.	1335
3	MR. LEVITT:	
	MS. HOLLINGSWORTH CROSS-EXAMINATION.	1335
4	RSF Exhibit 26.	1339
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13	MR. JOHNSON:	
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21	MR. SULLIVAN:	
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24	OBJECTION	1446
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15	OBJECTION	1511
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16	MUHA Exhibit 38Y.	1514
	OBJECTION	1514
17	MS. JONES. CROSS-EXAMINATION	1519
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18	MR. SUMMER REDIRECT EXAMINATION	1532
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19	OBJECTION	1536
20	ADJOURNED	1540
21	Certificate.	1541

EXHIBITS

(DHEC Exhibits 1 through 9; Roper St. Francis Exhibits 1 through 137; Trident, Summerville, Colleton Exhibits 1 through 162 and MUHA Exhibits 1 through 38y were all marked prior to the hearing and provided to the Court. The Court's Exhibit List is incorporated herein by reference. Roper St. Francis Exhibits 135 and 136 were marked during the hearing as referenced in the Index above.)

STIPULATIONS

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

1 (DHEC Exhibits 1 through 9; Roper St. Francis
2 Exhibits 1 through 137; Trident, Summerville,
3 Colleton Exhibits 1 through 162 and MUHA Exhibits 1
4 through 38y were all marked prior to the hearing and
5 provided to the Court. The Court's Exhibit List is
6 incorporated herein by reference. Roper St. Francis
7 Exhibits 135 and 136 were marked during the hearing.)

8 CALL TO ORDER:

9 THE COURT: Okay. So apparently you're about to
10 call somebody?

11 MR. WICEVIC: Yes, sir. The Department calls
12 Margaret Murdock.

13 THE COURT: We were debating who was going to call
14 her.

15 MS. MURDOCK: I'm sorry?

16 THE COURT: We were debating who was going to call
17 you.

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

20 MS. MURDOCK - DIRECT EXAMINATION BY MR. WICEVIC:

21 **Q: Good morning.**

22 **A: Good morning.**

23 **Q: Will you please state your full name for the**
24 **record?**

25 **A: Sure. It's Margaret Parham Murdock.**

1 **Q:** Ms. Murdock, will you please describe your
2 education to the Court beginning with your
3 undergraduate education?

4 **A:** Sure. I did my undergraduate studies at
5 Princeton for two years and Furman for three
6 and got my undergraduate degree from Furman
7 University. After that I attended graduate
8 school at the University of Denver School of
9 International Studies. And then after that --
10 after a period of time I went to -- I attended
11 and graduated from the University of South
12 Carolina School of Law in 2008.

13 **Q:** What was your undergraduate degree in?

14 **A:** I double majored in religion and political
15 science, useful degrees.

16 **Q:** Do you hold any professional licenses or
17 certificates?

18 **A:** Yes. I'm a member of the South Carolina Bar.

19 **Q:** Can you explain your employment history
20 beginning after law school?

21 **A:** Sure. After law school I worked as an
22 associate at Nelson, Mullins, Riley &
23 Scarborough for roughly two years. And then
24 from there I went to -- I was an attorney with
25 the Wyche Law Firm which is based in Greenville

1 but has an office in Columbia. I was in the
2 Columbia office until May of 2015 when I came
3 to DHEC. And I've been at DHEC ever since. I
4 started as a senior consultant in the
5 Certificate of Need program and eventually was
6 -- became director of the Certificate of Need
7 program.

8 Q: Okay. For your senior consultant position,
9 what time frame did you hold that position?

10 A: From May of 2015 until July or August of 2017.

11 Q: And can you explain your duties as a senior
12 consultant, please?

13 A: Yes. My primary duty was Certificate of Need
14 application review analysis and reaching and
15 writing decisions and also assisting with
16 development of the State Health Plan, the South
17 Carolina Health Plan.

18 Q: Okay. And you said your next position at DHEC
19 was the CON director?

20 A: Yes. And my review and State Health Plan
21 duties remained but I took on the additional
22 management of the program itself with the
23 staff. Throughout that time as a senior
24 consultant and as the director I also worked
25 with -- on various other duties. And then we

1 -- my program area is charged with
2 administration of the COPA program, certificate
3 of public advantage. It's a different statute
4 and a different program. But we also
5 administer that program as well.

6 Q: Okay. Can you give a description of, I guess,
7 the organizational structure of the CON
8 program?

9 A: Sure. We have -- I'm the director and then we
10 have two other reviewers that report to me,
11 Vonja Szatkowski and Jennifer Hyman. And we've
12 just had Dave Fiorini join us I'm happy to say.
13 And so ---

14 THE COURT: Apparently that's the guy in the back of
15 the courtroom 'cause he started smiling real
16 big.

17 A: Yes. That's Dave. And he actually has been --
18 has a fair bit of experience with DHEC and we
19 lost him for a little while but now we've
20 gotten him back and are very happy about that.
21 Also we have Arnisha Keitt who works in all the
22 administrative duties and kind of runs all the
23 administrative part of the CON program. And
24 then Lewis Eubank is the bureau chief for the
25 Health Planning and Construction Bureau. I

1 report to him but he also acts as a Certificate
2 of Need reviewer as well. And then we work
3 with Eva Johnson who's the director of the
4 health facilities and -- health facilities
5 services coordination program. It's a
6 different program within our bureau, but she
7 does a lot of work with us in connection with
8 the State Health Plan, especially with
9 communications and coordination with other
10 bureaus and with folks outside of the
11 Department.

12 Q: Who's Nic Gerrald?

13 A: Nic Gerrald was a member of the CON staff. And
14 he was an administrative coordinator who did a
15 lot of what Arnisha does now. He left us, we
16 lost Nick to marriage and he moved to Beaufort.
17 So he was in charge of all the sort of
18 administrative things, and they took care of --
19 did some work with us on the various kind of
20 projects associated with the State Health Plan
21 and other CON matters.

22 Q: Speaking of the State Health Plan, can you --
23 moving into that subject, can you give a
24 general, I guess, description of the process
25 for the development or updating the State

1 **Health Plan?**

2 **A:** **Sure. We are required to update the Plan at**
3 **least every two years. Recently we've begun**
4 **updating the Plan annually or close to**
5 **annually, and the first thing we do is start**
6 **putting together a draft of the Plan and begin**
7 **collecting the members of the State Health**
8 **Planning Committee to plan meetings. And we**
9 **try to get together as early as we can with the**
10 **Committee to discuss the draft that staff has**
11 **developed. Throughout the year we are always**
12 **looking for input and guidance and discussion**
13 **with the regulated community about the State**
14 **Health Plan, but when it comes time to revise**
15 **it we, the staff, the CON staff, creates a**
16 **draft. On the full rewrite years or the full**
17 **revision years we'll create a draft that**
18 **includes updated standards and narrative and**
19 **also updated population charts and need**
20 **analyses and updated utilization data. On the**
21 **off years we will do that very same thing but**
22 **only with the inventory and that data. We just**
23 **update the data that's in the, what we refer to**
24 **as the charts in the Plan. Once we have a**
25 **draft and we discuss it with the State Health**

1 **Planning Committee and if the State Health**
2 **Planning Committee approves it, we will upload**
3 **the draft to our website and announce to the**
4 **regulated community and the public that it's**
5 **available for public comment. And we have a**
6 **public comment period of at least 30 days.**
7 **During that period we'll hold public hearings**
8 **in all four DHEC regions, the Midlands, the**
9 **Upstate, the Pee Dee and the Low Country. And**
10 **at the end of the public comment period the**
11 **staff will collect all of the comments and put**
12 **them together and we will make findings or**
13 **recommendations on each one and then we present**
14 **all of those findings and recommendations to**
15 **the State Health Planning Committee at a**
16 **meeting, you know, publicly called, live**
17 **streamed. And then the State Health Planning**
18 **Committee will vote on whether or not to**
19 **approve our recommended changes to the draft.**
20 **Then we will go back and do whatever**
21 **housekeeping, cleaning up, editing. We'll look**
22 **for -- we'll revise the draft as much as we**
23 **need to to correct mistakes and get the data as**
24 **updated as we can, and once we have a final**
25 **plan together we present it to the DHEC Board**

1 and ask the Board to approve the plan. If the
2 Board approves the plan then that becomes the
3 State Health Plan that's in effect from that
4 time until the Board approves the subsequent
5 plan.

6 **Q:** What's the general contents of the Plan?

7 **A:** The Plan contains projections of needs for
8 health services that actually have standards in
9 the Plan. Not ever health service or facility
10 type has standards in the Plan. But it
11 contains standards for approval of a
12 certificate of need for new facilities, new
13 services or expansion of facilities or services
14 that are covered by the State Health Plan. It
15 also contains projections of need for those
16 services, an inventory of the facilities and
17 services are that currently either operating or
18 are approved to operate, even those that are in
19 various stages of review or appeal. And then
20 each chapter has other elements. We have to
21 have a general statement regarding the project
22 review criteria from the Regulation 61-15 that
23 are considered most important generally for
24 that type of service or facility. And there's
25 some other -- we have some definitions and then

1 some narratives, descriptions, orientation type
2 things ---

3 Q: Uh-huh.

4 A: --- for the State Health Plan.

5 Q: Okay. What was your role in the review of
6 MUHA's application for the 128-bed hospital in
7 Berkeley County?

8 A: I was the primary reviewer on that application
9 and also ultimately the decider; certainly not
10 without discussing it with the team and my
11 supervisor and -- but that was considered my
12 application as far as the assignment of review
13 duties, and I drafted the decision and ...

14 Q: Prior to making the decision do you have an
15 idea of how many applications, CON
16 applications, you've reviewed?

17 A: I don't know exactly but I know it's got to be
18 well over a hundred.

19 Q: Okay. Do you have an idea of how many -- of
20 that many applications, how many you've denied?

21 A: A very small number. We rarely deny CON
22 applications. I think that's in part because
23 the statute and standards and regulations, all
24 those things together, help guide applicants
25 and, you know, an applicant will at least have

1 a reasonable belief that their application will
2 comply with the standards before they even
3 attempt to get approval. Also we work closely
4 with applicants to address problems with the
5 application if possible. During the review
6 period we try to keep the lines of
7 communication open so that if there are any
8 potential problems or things that are missing
9 from the application then we will work with the
10 applicant to see if those problems can be
11 remedied. And also, if it looks like we will
12 not be able to approve an application, we will
13 let the applicant know and give the applicant
14 an opportunity to withdraw the application,
15 which happens almost as often if not more often
16 than a denial. So a denial is rare. I
17 probably have denied fewer than ten. MUSC has
18 been the unfortunate recipient of two of those
19 denials but they are rare.

20 Q: Okay. What involvement do you have with the
21 CON applications for the establishment of new
22 hospitals?

23 A: This is the first, this community hospital case
24 that we're -- for which we're here today, is
25 the first new hospital that I have reviewed in

1 my role at DHEC, any of my roles at DHEC.

2 Q: Can you walk us through the general process as
3 far the Department's review of CON
4 applications?

5 A: Sure. We'll receive an application and it has
6 to be sent to us in hard copy still, and we
7 check a very short list of things to make sure
8 that the application can be accepted. And once
9 we check for those things, then we will receive
10 the application, stamp it as received, and
11 after that it will fairly quickly be assigned
12 to one of the reviewers, either myself or one
13 of the three other that I mentioned before,
14 including Louis. After that we'll do -- each
15 reviewer has their own process, but generally
16 we'll do a preliminary review, sort of orient
17 ourselves with the application and look for any
18 glaring red flags or anything that's missing or
19 anything that's odd or, you know, weird or
20 needs addressing right away, which is rare.
21 And then once we -- and I'm speaking generally
22 -- we're -- this is all of our process. We
23 will routinely notice in the State Register
24 that the application has been accepted for
25 filing. As long as we're able to receive it

1 and it has the short list of things that it
2 needs to be received, we will go ahead and put
3 that notice in the State Register which runs
4 once a month. Then once we have determined
5 that we have enough to sort of get going on a
6 review, enough to really at least get started
7 fairly deep into a review, we will go ahead and
8 put the notice in the State Register that the
9 application has been deemed complete.

10 Sometimes, and again this is somewhat rare or
11 not particularly common, we will not have
12 everything that we know we need to finish the
13 review and actually reach a decision, but
14 because there is a fairly long lead time in
15 between our alerting the publishers of the
16 State Register that we want to put that not- --
17 the deemed complete notice in the Register and
18 the time that the notice actually runs, we try
19 to get a little bit of a head start on that
20 time line so as not to hold up the project.
21 And then meanwhile, we will work with the
22 applicant to collect whatever additional
23 information we need in order to finish the
24 review. There is a process in the regulation
25 and I believe the statute, but certainly the

1 regulation, that allows us to formally ask for
2 additional information and then there's a
3 period of time during which the applicant can
4 respond and we have the ability if the
5 applicant doesn't respond within a certain
6 amount of time to deem the application
7 withdrawn but we rarely -- I can't think of a
8 time that I've ever needed to take advantage of
9 that. We have found that it -- almost all if
10 not all CON applicants know it's in the
11 applicant's best interest to get the Department
12 the information that the Department needs in
13 order to reach a decision. So that's why we
14 don't often make use of that extra process for
15 formally requesting additional information. We
16 will request information that we need
17 throughout the review process until we are --
18 until we are satisfied that we have what we
19 need in order to reach a proper decision.

20 Q: Okay.

21 A: Until we make the decision. Sorry, I just
22 stopped in the middle.

23 Q: Can you tell us a little bit about the relative
24 importance criteria? The waiving of project
25 review criteria?

1 **A:** Yes. Along with the deemed complete notice in
2 the State Register part of that stage in the
3 application review involves sending a letter
4 alerting the applicant -- letting the applicant
5 know what the criteria from the regulation are
6 that the Department has determined are most
7 important for review of that specific project.
8 And that also goes -- that there's an invoice
9 of companies that notice for a fee associated
10 with the total project cost, and then the
11 applicant has 15 days from receipt of that
12 invoice to pay the fee, and then we continue on
13 with the review. Once the deemed complete
14 letter is sent, mailed separately from the
15 State Register notice but they really are part
16 of the same stage, and once the deemed complete
17 notice runs in the State Register, then we wait
18 at least 30 days, we're required to wait at
19 least 30 days to reach a decision, but we have
20 to reach a decision before 120 days after the
21 State Register notice has run, the deemed
22 complete notice has run.

23 **Q:** Can you talk a little bit about the project
24 review meetings and public hearings?

25 **A:** Yes. The public hearing is a option that's

1 available through the regulation. Any one --
2 an affected party or an applicant can request
3 a public hearing to -- in connection with the
4 application. If there is a public hearing --
5 and that's if it's requested -- if a public
6 hearing is requested we have to hold one, and
7 then that can add an extra 30 days to the
8 decision time line if we do that. Public
9 hearings are rare. Often we will instead have
10 an informal meeting -- well, what's referred to
11 as a project review meeting. Typically that's
12 a meeting where the applicant and either other
13 competing applicants or parties opposing the
14 application will come and make a presentation
15 as to whatever their position is with respect
16 to that application. We -- after the -- at the
17 meeting we all agree on a time line for
18 submission of documentation in response to or
19 to supplement issues that are mentioned or
20 brought up or first presented at the project
21 review meeting. And then we will also allow a
22 little time for written responses to the
23 written responses. And then once we receive
24 all that documentation, we'll finish the review
25 and make a decision.

1 Q: Okay. Well let's look at -- let's talk about
2 the MUHA Berkeley application. Mr. Bupp, can
3 you turn to DHEC Exhibit 1?

4 (DHEC Exhibit Number 1 was referenced at this time.)

5 Q: And, Ms. Murdock, there's paper copies of the
6 Exhibits up there as well.

7 A: Okay.

8 Q: Can you identify this for us?

9 A: Yes. This looks like the first page of the
10 application. I believe this is the community
11 hospital application submitted by MUHA.

12 Q: And when we say the DHEC record, what all does
13 the DHEC record contain?

14 A: It contains the application and any
15 correspondence, the deemed complete letter, the
16 -- any invoice associated with the application,
17 the three times or potential times that an
18 applicant will receive an invoice for payment
19 of a fee. Not all applications require all
20 three fees to be paid depending on project
21 cost. It will also include any notice of a
22 public hearing or notice of a project review
23 meeting. We include copies of the State
24 Register notices. We include letters of
25 support. Any documentation submitted in

1 opposition to or in response to opposition to
2 the application will also be part of the
3 record. Any supplementary materials submitted
4 to us by the applicant or any affected person
5 will also be in the DHEC record.

6 Q: And so looking at page 2, who is that applicant
7 for this application?

8 A: The -- well, the organization is the Medical
9 University Hospital Authority and Dr. Patrick
10 Cawley is the human being associated with the
11 -- representative who submitted the
12 application.

13 Q: All right. Let's turn to Attachment G, that's
14 page 168, 167. Go to the next page, please.
15 Now this is -- do you know what attachment G
16 is?

17 A: Yes, but I believe this is a misfiled part of
18 this application. This is MSV which stands for
19 MUSC Strategic Ventures or MUHA Strategic
20 Ventures, which is an entity that's been
21 involved in some other applications; an ASF,
22 ambulatory surgery facility, I think, and I
23 believe also a freestanding ED, although I'm
24 not sure about that. But this is not the Board
25 of Directors of MUHA itself. I think this was

1 just a misfiled Exhibit.

2 Q: What other DHEC staff members, if any, have
3 some type of involvement with this application?

4 A: Well, for all except the most routine and
5 unconcerning or uncontroversial CON
6 applications, we'll -- the whole staff -- it's
7 not a very big staff and we're all in cubicles
8 and we work very closely with each, so we'll
9 all kick it around with the team, every big
10 case. So everyone will have had some part of
11 the discussion. Certainly, with something like
12 this, I did discuss it informally multiple
13 times with my supervisor, Louis Eubank. A lot
14 of that is just me telling him what I think and
15 making -- and then asking him to let me know if
16 there's anything I'm missing or if he thinks
17 that I might be off somewhere or -- so that's
18 how that goes. There's usually at least some
19 discussion, but with this one it would have
20 been a lot of sort of informal, I'll stop his
21 cube or he'll stop by mine and we'll talk about
22 it a little bit.

23 Q: What ---

24 A: I'm sorry. Ultimately he did have to sign off
25 on the decision itself.

1 Q: And what's his signing off mean?

2 A: It means that he's reviewed it and approved it
3 for release.

4 Q: What involvement did Mr. Gerrald have in this
5 matter?

6 A: He would have been involved with the -- some of
7 the correspondence that the -- several of the
8 pieces of correspondence that we send out with
9 an application must be mailed via certified
10 mail, so he will take care of those
11 administrative parts or other -- he would
12 process the application, scan it in. Whenever
13 correspondence came in, he would distribute it
14 to whoever needed it and then add it to the
15 file. He would basically maintain the file.
16 And he also did a good job of anticipating, you
17 know, what was coming next or what might or
18 could happen. If there was anything that he
19 thought was strange or missing or unusual, he
20 would've brought it to my attention generally.
21 That's how he handled all the applications.
22 But he did a lot of file maintenance and upkeep
23 and updating.

24 Q: Let's talk about, I guess, the time frame for
25 MUHA's application. So turning back to page 2,

1 when did the Department receive MUHA's
2 application?

3 A: December 27th, 2017.

4 Q: Okay. And so what Health Plan was the
5 application filed under?

6 A: That would've been the 2017-2018 Health Plan.
7 I think that's the title. We don't always call
8 it the same thing anymore, but, yeah, the 2017-
9 2018 Health Plan.

10 Q: And so, I think you talked about this a little
11 bit earlier, what must an application contain
12 in order for it to be accepted for filing?

13 A: It has to contain the filing fee, \$500 filing
14 fee for each application. It has to be in the
15 proper format. Like I mentioned earlier, we're
16 still unfortunately requiring all hard copy --
17 two hard copies, single sided two hard copies
18 of the application, which hurts my bleeding
19 heart, but that's a conversation for another
20 day. And it also needs to have proof that the
21 public notice has run. The public notice is a
22 requirement before you file an application or
23 before we can accept an application, the
24 applicant has to have run a public notice in a
25 daily newspaper or daily news publication

1 serving the area where the project is to be
2 located or the area to be served, and then --
3 and it has to -- that notice has to run for
4 three consecutive days within 20 days of
5 submission of the application to the
6 Department. So we require proof of that notice
7 before we'll accept an application.

8 Q: All right. Mr. Bupp, can you turn to page 70
9 of Exhibit 1? Okay. Can you identify this,
10 Ms. Murdock?

11 A: Yes. That looks like the public notice for
12 this application in the Post & Courier which
13 serves the Tri-County service area, and it
14 looks like the dates are all within 20 days of
15 the receipt date of December 27th.

16 Q: So what's the next step after deemed -- or
17 you've received all the information to accept
18 it for filing?

19 A: Well, the first thing that happens is that the
20 application will be processed. We maintain an
21 electric file, an electronic file along with
22 our paper file, and so this application would
23 have gone to Nic and Nic would've set the file
24 up, which means putting it in the binder and
25 separating the different folders out, both

1 electronically and in paper, and then he
2 would've brought it to me. I am -- we assign
3 CON application review generally based on
4 region, and I am a Low Country reviewer. And
5 so he would have brought it to me and I would
6 have started -- it would have gone in the
7 hopper of applications for review. And then I
8 would have reviewed it, and Nic would have
9 continued maintaining the file if -- whenever
10 anything came in that needed to go in the file.
11 He'd either look for it in my office or look
12 for it in our filing cabinets and that's kind
13 of how it would work all through the review.
14 And then I would eventually issue a deemed
15 complete letter and then do the analysis and
16 review opposition documents. In this
17 particular case we did not have an in-person
18 project review meeting. We had what -- it's a
19 misnomer, but it's what we refer to as a
20 written project review meeting where we invite
21 the applicants and -- the affected parties and
22 the applicant to submit written documentation
23 either in opposition to or in support of the
24 application. And then, just like after the in-
25 person meeting, we'll have an opportunity --

1 we'll give the people involved, the parties
2 involved an opportunity to respond to each
3 other's submissions. And so we did that with
4 this case and all of those documents went into
5 the file. And after review of all of that, I
6 -- we reached a decision and then I issued the
7 decision letter.

8 Q: Let me back up a little bit. Did the
9 Department make -- or publish notices in the
10 State Register?

11 A: Oh, yes, we did.

12 Q: Mr. Bupp, can you turn to 1018. Can you
13 identify this?

14 A: Yes, that's the January 26, 2018 State Register
15 notice that -- the part that's up there now is
16 the list of applications that have been
17 accepted for filing.

18 Q: Can you go down?

19 A: And the -- this application's on that list.

20 Q: Okay. And then the next ---

21 THE COURT: Is the notice or anything like that in
22 dispute here?

23 MR. WICEVIC: No, Your Honor.

24 Q: Let me ask you this, there was another
25 publication in the State Register, correct?

1 **A:** Yeah. Well, the deemed complete notice goes in
2 -- published in the State Register. And I
3 don't -- sometimes we will publish them in the
4 same Register. I don't know whether or not we
5 did that this time, but sometimes we do.

6 **Q:** Just for clarification, Mr. Bupp, can you go to
7 1023? Excuse me, 1021, please? What State
8 Register is this publication? Can you go down
9 to the very bottom?

10 **A:** It should say at the bottom. March 23rd, 2018.

11 **Q:** All right. And is there where the deemed
12 complete notice is?

13 **A:** Yes, and that would have started the clock
14 running.

15 **Q:** Did you request any kind of additional
16 information before deeming MUHA's application
17 complete?

18 **A:** I don't recall if I requested from -- if I
19 requested information before deeming it
20 complete. I know I eventually requested some
21 information after it -- after deeming it
22 complete, fairly close to the decision issuance
23 date.

24 **Q:** Okay. And so if the application was deemed
25 complete on March 23rd, then when would the

1 deadline be for issuing the decision?

2 A: The window for issuing the decision would have
3 been 30 days after this March date and then the
4 deadline would've been 120 days after this
5 March 23rd date.

6 Q: July 20 ---

7 A: Don't ask me to do calendar math because I'm
8 terrible with that, but yeah.

9 Q: July 21st sound ---

10 A: Yes, that sounds right. I think July 21st was
11 a Saturday, so the deadline was July 23rd.

12 Q: Okay. That'd be a Monday?

13 A: Yes.

14 Q: Okay. And who filed as affected persons in
15 opposition of this project?

16 A: There were quite a few. The three HCA
17 facilities all filed separately. Colleton and
18 then Trident and Summerville, which is a d/b/a
19 of Trident. Both of those hospitals filed
20 separate opposition letters. And then The
21 Regional Medical Center in Orangeburg file as
22 an affected person in opposition. Roper, the
23 Care Alliance entities, specifically Roper, and
24 I believe some of the other Roper entities, but
25 collectively also filed as affected parties and

1 in opposition.

2 Q: Okay. Was a deemed complete letter sent to the
3 affected persons?

4 A: Yes.

5 Q: Okay. Let's go to page 1001, please. Back up
6 one page, please. Okay. Ms. Murdock, can you
7 identify this document?

8 A: Yes, that's the deemed complete letter for this
9 project.

10 Q: Okay. And when's it dated?

11 A: It's dated May 21st, 2018.

12 Q: Do you know when -- did you e-mail the letter
13 to the applicants and affected persons?

14 A: I did eventually. It was much later that -- it
15 was sometime in July I received an e-mail from
16 one of the affected parties. It may be been
17 Will Thomas from Parker Poe asking for the
18 deemed complete letter and alerting me that his
19 clients had not yet received it. I also
20 received either a phone call or an e-mail or
21 some communication from MUHA's attorney asking
22 for a copy of the deemed complete letter, and
23 that's when I -- and also that communication,
24 either voice mail or e-mail, Ms. Crum indicated
25 to me that MUHA had not received the deemed

1 complete letter. So I had this letter, this
2 signed, a copy of it on my desk, and tried to
3 find -- usually we have a trail. We have a
4 certified mail receipt and, you know, a copy of
5 the letter in the file, a copy of the certified
6 mail receipt in the file, and I couldn't find
7 any of those things. And so I began to suspect
8 that only in my own mind had I actually sent
9 the deemed complete letter out on May 21st, and
10 so I immediately e-mailed it to the parties,
11 the affected parties and the applicant, but it
12 was much later than May 21st.

13 Q: Okay.

14 A: So I don't -- I can't say for sure that I
15 didn't sent it out on May 21st, but I really
16 don't believe I did. I couldn't find any
17 evidence that I had.

18 Q: Okay. Let's turn to page 692, please. Can you
19 identify this document?

20 A: Yes. This is an e-mail from me to the affected
21 parties and their attorneys and some of their
22 consultants attaching a copy of the deemed
23 complete letter and ---

24 Q: And was it ---

25 A: --- inviting the -- I don't remember the timing

1 on this, but at some point I had sent out the
2 written project review invitation e-mail with a
3 deadline. And then at some point, once I
4 realized that not everyone, that no one had
5 gotten the deemed complete letter, one of the
6 affected persons asked for an extension on the
7 deadline to submit opposition documentation,
8 and so I, of course, granted it. And I don't
9 remember if this July 18 is the new deadline or
10 if that's the original deadline.

11 Q: Okay. And when was the e-mail sent?

12 A: July 11th.

13 Q: Okay.

14 A: 2018.

15 Q: Mr. Bupp, can we go back to page 1001, please.
16 And what does the relative -- or excuse me,
17 what does the deemed complete letter set forth
18 as the relative importance of the project
19 review criteria?

20 A: Well, the first one is compliance with the need
21 outlined in the plan. That's a requirement for
22 any application that has standards in the plan.
23 And then the other three are community need
24 documentation, distribution, accessibility and
25 ability to complete the project.

1 Q: I'm not sure if you did this when you were just
2 talking generally about your CON review
3 process, but how do you generally select
4 relative importance criteria?

5 A: I will -- my general process is, and this may
6 be different for other reviewers, but my
7 general process is to do a, kind of a once over
8 of the application, read through it, get a
9 sense of what it is. Depending on the project
10 I may look at different things, different
11 exhibits, but I'll generally look at what the
12 applicant is requesting and then look -- and
13 then I go through the regulation and each of
14 the project review criteria and think about the
15 project in light of those project review
16 criteria to see if anything initially stands
17 out as something that needs to be fleshed out
18 or something that either is particularly
19 important to the service area, particularly
20 important to the project type or may be a red
21 flag. Anything that jumps out as important for
22 whatever reason, and that's when I'll start
23 thinking about -- you know, the project review
24 criteria that seem most important kind of
25 bubble to the surface of my mind, and that's

1 the beginning. And then I'll go through the
2 application a little bit more and eventually
3 pick whichever ones end up in the deemed
4 complete letter.

5 Q: Okay. And so for this project why did you
6 select the criteria that you selected?

7 A: Well, the first one is really a given. There's
8 no -- an application has to be consistent with
9 the plan. And then the second one, community
10 need documentation, that is a -- one of the
11 fundamental criteria. It goes to one of the
12 primary purposes of the Certificate of Need
13 statute and program. Same thing with
14 distribution and accessibility. I'd say those
15 are two of the biggest ones. And a lot of the
16 review of the project review criteria
17 necessarily involve these two, and these two
18 have a lot of sub-parts that touch on some of
19 the elements that are included in a lot of the
20 other project review criteria as well. So
21 community need documentation and distribution
22 cover a lot of ground. Ability to complete the
23 project. It's a big project; it's a hospital,
24 and in Berkeley County I think the -- most of
25 the folks here and the people in Berkeley

1 County are acutely aware of how long it can
2 take from approval of a hospital to arrival of
3 a hospital in a county, and so as -- so that
4 was part of the reason why that -- why I
5 included that one. There -- that -- for during
6 that review process and looking at the service
7 area, at the history, at the type project, at
8 this project, that was one of the criteria that
9 bubbled to the surface and came out as
10 important.

11 Q: Okay. It might be easier if you'd look at the
12 paper exhibit. I think it's DHEC Exhibit 4,
13 the 2017-2018 Plan?

14 (DHEC Exhibit Number 4 was referenced at this time.)

15 A: Okay, what color are we? White?

16 Q: I think we're white.

17 A: Yes.

18 Q: Just a second.

19 A: 4?

20 Q: Yes, I believe so.

21 A: Okay.

22 Q: Leave it there. Thank you.

23 A: All right. I'm here.

24 Q: All right. Could we turn to page 12?

25 A: I'm there.

1 Q: And does page 12 contain the -- I guess the
2 list of criteria generally important for these
3 types of projects?

4 A: Yes.

5 Q: And these types of projects being hospitals or
6 hospital beds?

7 A: Yes. General -- or what is often referred to
8 as an acute care hospital. And in this plan
9 and in past plans, the way that we include our
10 general statement is just basically a list ---

11 Q: Uh-huh.

12 A: --- of project review criteria.

13 Q: And so what does the list in the Plan include?

14 A: It includes -- the first three that are in the
15 deemed complete letter for this project,
16 compliance with the need outlined in this
17 section of the Plan, which would be the acute
18 care hospital section, Chapter 3; community
19 need documentation; distribution and
20 acceptability. And then there are additional
21 criteria: acceptability; record of the
22 applicant; cost containment; and adverse
23 effects on other facilities.

24 Q: And so how did this play into your selection of
25 the relevant importance criteria?

1 **A:** Well, these, along with all of the other
2 criteria, you know, I look at every criteria in
3 connection with analyzing the application. And
4 so the ones that I left off, the acceptability
5 part of it, there wasn't anything in that
6 particular criteria that stood out as unique or
7 problematic or particularly enhanced by or
8 important for the purpose of finding -- making
9 findings for this project. Now based on the,
10 you know, the whole application, the service
11 area, some other things, and so I just -- I
12 left that one off or moved that down the list,
13 I guess you would say. None of the project
14 review criteria are left off or ignored or
15 discounted. They just don't remain at the top
16 where the -- you know, where the focus and the
17 findings are in the decision. Record of the
18 applicant, looking at the requirements of that
19 particular criteria, and again there was nothing
20 that stood out, nothing problematic, nothing
21 particularly unique in this case. You know,
22 some of the reasons for that are -- have to do
23 with the number of CON projects that I
24 personally have reviewed and the Department has
25 received and reviewed in connection with this

1 applicant, and so we're generally intimately
2 familiar with MUHA and with the, you know, the
3 Care Alliance -- with every party in this
4 particular case, particularly the Roper
5 entities and the Trident affiliated entities
6 and MUHA. So that one didn't seem like it
7 needed to remain at the top of the list of
8 important criteria.

9 Cost containment, that criteria itself has
10 very specific and somewhat narrow language. I
11 don't believe that that criteria that's listed
12 in the regulation, I think it's number 16, is
13 the entirety of the review that needs to go in
14 to cost containment as a CON purpose.
15 Analyzing a project for cost containment I
16 believe requires more than just what is listed
17 in that particular project review criteria.
18 And so in this case I thought the cost
19 containment review needed to be much broader
20 than that. And like with every CON project,
21 that over-arching CON purpose capital will see
22 cost containment review as part of it. I just
23 didn't -- I thought it would be a little bit
24 redundant, you know, sort of to also do that to
25 -- with this limited language in that

1 particular criteria. It just didn't seem
2 appropriate for this one as a relative
3 importance criteria. Again, I didn't ignore
4 it, it just didn't stand out as something that
5 really needed to be fleshed out based on the
6 language of that criteria.

7 THE COURT: So you found that it's redundant?

8 A: Well, redundant was not the right word.
9 Limited. The language of that project review
10 criteria talks about very specific things, but
11 I don't believe that it -- the language of that
12 criteria requires enough analysis to fulfill
13 our duty to look at a project for the CON goal
14 of cost containment.

15 THE COURT: So you felt the other four that you
16 picked did accomplish that goal?

17 A: I thought the other four in addition to the
18 general analysis that goes into every single
19 project. The four purposes of CON are always
20 at the forefront of our analysis, and so every
21 part of it has to go through the lense of the
22 core purposes of CON. So there are some cost
23 aspects to the community need criteria that
24 actually speak to cost and go to cost. And so
25 the cost containment analysis is necessarily a

1 part of almost all aspects of CON review. And
2 the criteria that's listed in 80- -- it's
3 number 16 in that list of project review
4 criteria, I think it has three sub-parts and
5 they're very limited sub-parts, but those sub-
6 parts didn't -- I don't think were complete for
7 a review of cost containment. I confess I'm
8 not a big fan of the language of that criteria
9 at all. I think it's too limited, and I think
10 it's a little bit confusing because CON -- cost
11 containment is a purpose of CON, and I don't
12 believe that the language in that criteria
13 includes everything that you need to do in
14 order to evaluate a project for cost
15 containment.

16 Q: And then finally, adverse effects on other
17 facilities was left off. Why was that left
18 off?

19 A: In this particular case, again adverse effects
20 on other facilities has specific language. It
21 has two parts. One of them involves staffing
22 and the other one involves kind of a balancing
23 analysis. You have to look at the -- you have
24 to look at the effect on occupancy rates or use
25 rates of existing facilities and balance that

1 against the -- with the benefits of access.

2 I'm paraphrasing, but usually -- may I?

3 Q: You've got the CON regulation?

4 A: I've got the reg right here. I always like to
5 go to the reg. So this criteria, it says, "The
6 impact on the current and projected occupancy
7 rates or use rates of existing facilities and
8 services should be weighed against the
9 increased accessibility offered by the proposed
10 services." And then Section B talks about
11 staffing and looking at whether or not the
12 project will unnecessarily deplete the staff of
13 existing facilities. And both sub-parts of
14 that project review criteria specify that the
15 analysis is existing facilities. This
16 particular project was a hospital in Berkeley
17 County. There were no existing facilities in
18 Berkeley County at the time I did this review.
19 And I believed then and believe now that the --
20 what was a proposed facility at the time and is
21 an existing facility now that could be most
22 affected by this project and the then proposed,
23 now existing facility that I needed to pay the
24 most attention to as far as the impact of the
25 project was Roper Berkeley Hospital. And

1 because this particular criteria only refers to
2 existing facilities and not approved projects,
3 I thought that it was too limited and that
4 findings on this would only allow me to look at
5 facilities like Trident and Summerville which
6 also needed consideration. And so there again
7 are other aspects of the criteria that are on
8 the deemed complete letter, and the overall
9 purposes of CON allow me to look at, sort of
10 holistically at the service area to include CON
11 approved projects. It's logical, it makes
12 health planning sense, and there's language in
13 the other project review criteria that do allow
14 me to look at -- that would have allowed me to
15 look at the potential adverse effects on Roper
16 Berkeley specifically. And I -- so it seemed
17 in- -- inappropriate (sic) to make findings on
18 this and leave Roper Berkeley out of the
19 analysis.

20 Q: Are you aware of other cases in which the
21 Department staff did not select criteria listed
22 in the Plan as a relative importance criteria?

23 A: Yes, that happens often. I know I've done it
24 multiple times as have other reviewers on the
25 staff. And I believe in both the Roper

1 Berkeley Hospital application and in the
2 Berkeley Medical Center project, the staff at
3 the time did not use all of the project review
4 criteria that were on the list of project
5 review criteria in those -- in the plan or
6 plans under which those projects were reviewed.

7 Q: Okay. Mr. Bupp, can you pull up DHEC Exhibit
8 7, please.

9 (DHEC Exhibit Number 7 was referenced at this time.)

10 Q: Can you identify this, Ms. Murdock?

11 A: Yes. This looks like the cover page for the
12 application for the Roper Berkeley.

13 Q: Mr. Bupp, can we turn to page 1107. Can you
14 identify this for the record, please?

15 A: Yes, that looks like the deemed complete letter
16 for this project, the Roper Berkeley project.
17 It's dated March 31st, 2009.

18 Q: Okay. And can we turn to the next page,
19 please? What were the relative importance
20 criteria selected for this application?

21 A: Compliance with the South Carolina Health Plan,
22 community need documentation, distribution with
23 accessibility, which are also the first three
24 on the deemed complete letter in this case.
25 Also financial feasibility, acceptability,

1 adverse effects on other facilities and
2 distribution.

3 **Q:** Okay. Do you know what plan the Roper Berkeley
4 application was filed under?

5 **A:** Whatever was in effect in early 2009. I
6 probably won't get the year span right.

7 **Q:** 2008-2009?

8 **A:** That would make sense, 2008-2009.

9 **Q:** Okay. Mr. Bupp, can we turn -- get DHEC
10 Exhibit 3?.

11 **(DHEC Exhibit Number 3 was referenced at this time.)**

12 **Q:** And can you identify this, Ms. Murdock?

13 **A:** Yes, that's the 2008-2009 South Carolina Health
14 Plan. It went into effect on September 12th,
15 2008.

16 **Q:** Okay. And if you could turn to page II-11.

17 THE COURT: Wait a second, what was that health plan
18 again? 2008-2009?

19 MR. WICEVIC: Yes, Your Honor.

20 THE COURT: Okay.

21 MR. WICEVIC: And it's DHEC Exhibit 3.

22 **Q:** Ms. Murdock, what are the plan listed criteria
23 generally before the hospital proposed?

24 **A:** Compliance with the need outlined in the plan,
25 community need documentation and distribution.

1 Again, the first three that are on the deemed
2 complete letter in this case. Also,
3 acceptability, financial feasibility, cost
4 containment and adverse effects on other
5 facilities.

6 **Q:** Did staff decline to select cost containment
7 which is listed in the Plan as generally
8 important as one of the relative importance
9 criteria?

10 **A:** Yes.

11 **Q:** Do you recall a similar selection for the
12 Berkeley Medical Center application where they
13 left off ...

14 **A:** I believe the Berkeley Medical Center
15 application is the same. They were -- I think
16 the deemed complete letter in that record
17 contains the same project review criteria as
18 the ones listed in the deemed complete letter
19 for Roper Berkeley. I believe they were
20 potentially competing applications so that
21 would necessarily require the project review
22 criteria to be the same. And again, the list
23 that's on the deemed complete letter in the
24 Berkeley Medical Center case is not the same,
25 does not have all the same criteria as the list

1 included in the Plan that was applicable to
2 that application.

3 Q: All right. We won't look at that. And you --
4 I think you mentioned this. In your review of
5 the MUHA application did you review -- or did
6 you ignore any of the project review criteria?

7 A: In the MUHA application?

8 Q: Uh-huh.

9 A: No, I didn't. I look at every project review
10 criteria and -- and I don't make written
11 findings on each one, but I don't ignore any of
12 the project review criteria.

13 Q: Okay. Well moving along in the -- I guess the
14 review of the application, and I think you
15 talked about this briefly, the project review
16 meeting, why didn't you have an in-person
17 project review for this application?

18 A: There were a few reasons and I probably don't
19 recall all of them. I know that scheduling was
20 a big issue. I believe the -- we had just --
21 we are -- we were just days away from adopting
22 a new State Health Plan so we had been in the
23 middle off the planning process and the State
24 Health Planning Committee meetings and things
25 like that during the time leading up to this

1 decision. And ultimately the reason why I was
2 not concerned about that is because the --
3 really the only information that I, as a
4 reviewer, and I believe I can speak for my team
5 as well, all of us, is that we -- when we are
6 relying on information that comes about as a
7 result of the project review meeting, it is
8 always what is included in the written
9 documentation that is submitted during or after
10 the meeting. Now I'm speaking for myself
11 personally, when I -- when we do have those
12 meetings, I am attempting to host and listen
13 and make eye contact and take notes and
14 sometimes I'm able to take some notes, but I am
15 not willing to rely on either my memory or my
16 handwritten notes from what somebody may have
17 said or what somebody may have put up on a
18 slide to rely on something like that in making
19 findings on an application. So we try to
20 accommodate an in-person meeting as often as we
21 can. It's important for many reasons besides
22 just getting information from the applicants
23 and affected parties. We try to maintain a
24 high level of engagement with the regulating
25 community and the public and applicants,

1 opposition, consultants, everyone. And so I'm
2 -- I hate to not have a meeting but when it
3 comes to the actual review of the project
4 itself and the decision, I don't rely on what
5 I'm told at the meeting, I rely on the
6 documentation that comes as a result of, you
7 know, the -- or after the meeting.

8 Q: Okay. Does the CON staff have any kind of
9 policies or procedures, standard operating
10 procedures with regards to project review
11 meetings?

12 A: Yes, we do have a standard operating procedure
13 that we developed not too long after Louis
14 Eubank joined the Department. Prior to that,
15 and especially when I first came to DHEC, there
16 were often situations where scheduling a
17 project review meeting became so cumbersome
18 that it was causing a delay of the decision
19 past the actual decision deadline. There were
20 several pending CON applications that I
21 inherited when I arrived at DHEC that were
22 already past deadline because the parties could
23 not agree on a project review meeting date. So
24 the standard operating procedure was a way for
25 us to give the regulated community a guide for

1 requesting and scheduling project review
2 meetings to kind of hem that process in and
3 make sure that the in-person meeting scheduling
4 wasn't interfering with our duties under the
5 CON Act.

6 Q: Okay. Mr. Bupp, can we turn to Roper Exhibit
7 36, please?

8 (Roper Exhibit Number 36 was referenced at this
9 time.)

10 Q: If you can blow that up I'd appreciate it. Ms.
11 Murdock, do you know what this e-mail is? If
12 you could go down, please.

13 A: Yes, I know what this e-mail is.

14 Q: All right. Can you tell the Court, please?

15 A: It is an e-mail from Ms. Elizabeth Crum who's
16 the attorney for MUHA, and it is -- she's, I
17 guess, giving her opinion on whether not a
18 project review meeting is needed. And she sent
19 that to Louis Eubank and then Ashley Biggers,
20 who's an attorney with DHEC and some other
21 folks.

22 Q: And was it -- Mr. Bupp, if you could scroll up,
23 please.

24 A: And she didn't even send it to me.

25 Q: Was it forwarded to you?

1 **A:** Yes. Louis Eubank forwarded it to me.

2 **Q:** What influence did it have on you, the decision
3 whether or not to have the project review
4 meeting in person?

5 **A:** It did not -- it was not the reason why we
6 didn't have a project review meeting. Our
7 position on project review meetings is -- and
8 we have tried to get the word out -- that a
9 project review meeting is not a requirement.
10 And I believe it's even in the e-mails that we
11 send inviting parties to an in-person project
12 review meeting that attendance at the meeting
13 is not mandatory and that parties are welcome
14 to submit documentation instead of attending
15 the project review meeting and they're not
16 required even to do that. We don't want to --
17 you know, we're in Columbia and although we do
18 try to travel outside of the city to go meet
19 elsewhere in the State we can't always do that,
20 and we don't require any -- certainly not any
21 applicant to drive all the way to Columbia to
22 defend their application because if an
23 application is compliant with the law and the
24 Plan, then it should stand on its own anyway.
25 And so we don't -- we do not view failure to

1 attend a project review meeting with any sort
2 of negative connotations. We actually have had
3 applicants that could not travel to the
4 Department for a project review meeting that
5 respectfully informed us that they would not be
6 there and we had the meeting with opposition
7 only and I don't recall the outcome but
8 certainly we do not view that as any sort of
9 slight or anything other than the complete free
10 choice of the applicant and the opposition.
11 Again, we're relying on the documents really.
12 That's what we need in order to put it in the
13 record and rely on it in order to make a
14 decision and to vet it and analyze whatever the
15 issue is.

16 Q: And you mentioned there was a written project
17 review meeting in this case?

18 A: Yes.

19 Q: Let's turn to page 692 and 693? And the
20 bottom, I guess, e-mail thread carries over to
21 the next page. Can you identify this e-mail?

22 A: Yes. This is the invitation for a written
23 project review meeting. Again, that's a --
24 that's just a misnomer.

25 Q: Okay.

1 **A:** Inviting any affected person to submit
2 documentation in support of or in opposition to
3 the application. That was the original
4 deadline of July 13th.

5 **Q:** Did -- I'm sorry.

6 **A:** No, that's it.

7 **Q:** Did any party request an extension to the
8 deadline?

9 **A:** Yes. I believe it was a representative from
10 Trident at the VAC facilities, Trident,
11 Summerville, Colleton.

12 **Q:** Mr. Bupp, can you go to the next page, page
13 694, please. Can you identify this, Ms.
14 Murdock?

15 **A:** Yes. That's an e-mail from Will Thomas who's
16 the attorney for Summerville, Trident and
17 Colleton requesting additional time.

18 **Q:** And did you grant that extension?

19 **A:** Yes.

20 **Q:** Let's turn back to page 692.

21 **A:** Yes, we extended the deadline until July 18th.
22 And then I believe that there was a little bit
23 of time -- we were limited -- the decision
24 deadline was the 23rd, so the extended deadline
25 was July 18th. And I believe I was still

1 receiving responsive documents up through the
2 moment I issued the decision.

3 Q: Okay. And the parties had submitted written
4 arguments; is that right?

5 A: Yes.

6 Q: Did you have any questions or follow-up with
7 the applicant or affected persons about
8 anything they submitted?

9 A: Yes. I was in the process of drafting the
10 decision and there was a part of the analysis,
11 and I -- of the need analysis in the
12 application where I was having trouble
13 connecting dots. That I could get so far in
14 the, sort of the projections, whatever the --
15 I can't remember exactly what the issue was,
16 but I was -- there was just a step that I
17 couldn't -- I couldn't get from one step to the
18 next step in the need analysis and in the
19 projections to have it make sense and so I
20 asked for -- so I called the consultant for
21 MUHA, in this case David Levitt, and described
22 to him what I couldn't understand, what I was
23 missing, and told him I really needed -- I
24 needed to nail that down before I could approve
25 the project. And so he sent some written

1 documentation in an e-mail to me and copied --
2 because at that point we had requested that all
3 the parties copy each other, he copied everyone
4 else eventually. He may have forgotten the
5 minute, you know, and then he forwarded it to
6 the rest of the folks.

7 Q: Okay. Can we turn to page 977 in DHEC 1,
8 please?

9 (DHEC Exhibit Number 1 was referenced at this time.)

10 Q: Is that the referenced e-mail from Mr. Levitt?

11 A: It is. That's the e-mail that he send to me
12 with his response to my questions. And, yeah,
13 through -- well it looks like two hours and 31
14 minutes he had forgotten to copy everyone else
15 and then he did that that morning. And this is
16 -- it's some historical and projected data by
17 market and the projected admissions at the
18 community hospital. I believe, and I -- I'd
19 have to go back and -- I believe that my
20 question was I needed him to link up some of
21 the shift, the zip code shift, projections with
22 the actual MUHA sub-market from which they
23 would come.

24 Q: Okay. So aside from the application and the
25 various documents in the DHEC record, what

1 other documents did you review as part of your
2 consideration of this application?

3 A: Well, I reviewed documentation that --
4 regarding population, historical and projected
5 population in the Tri-County area. I reviewed
6 utilization data, prior State Health Plans and
7 from joint annual reports of hospitals, the
8 JARS, for multiple years for all of the
9 hospitals in the Tri-County service area. Some
10 I looked at more years than others, but. Also
11 I looked at prior and pending CON applications
12 from -- in particular from some of the
13 facilities, other facilities in the Tri-County
14 service area. There's a lot of information in
15 those applications that can be useful,
16 especially when you're looking at utilization
17 data that might be more recent than what's in
18 the JARS at the time because the JARS are only
19 submitted once a year. Off the top of my head
20 that's all I can think of, but it was primarily
21 JARS, population data and other CON records.

22 Q: All right. Moving on to the actual decision,
23 and looking specifically at the State Health
24 Plan, the 17-18 Health Plan, what was your
25 determination with regards to whether MUHA's

1 application complied with the Plan?

2 A: I determined that it complied with the Plan.
3 It complied with the standards. There were
4 several -- in that chapter there are several
5 avenues to being able to establish a new
6 hospital depending on whether or not there's a
7 surplus of beds or a need for beds in the
8 service area or an institutional need for the
9 -- for particular facilities. And in this
10 case, there was at least one standard with
11 which the project complied along with the other
12 requirements of the chapter.

13 Q: Okay. Mr. Bupp, can you go to 1009? And is
14 this your -- is this your decision in this
15 matter?

16 A: It is.

17 Q: And when did you issue your decision?

18 A: July 23rd, 2018.

19 Q: Okay. And does your decision contain your
20 findings with regards to the Plan's standards?

21 A: Yes. It contains my findings with regards to
22 the standards and with regards to the project
23 review criteria that are listed in the deemed
24 complete letter as most important.

25 Q: Okay. And you talked about the Plan's

1 standards, but with respect to this Plan, what
2 is the service area for MUHA's project?

3 A: The Tri-County service area, Berkeley,
4 Dorchester and Charleston.

5 Q: Why is that?

6 A: That is the service area that is -- that is
7 contained in the chart, in the hospital bed
8 need chart. The -- that chart is both the
9 inventory and the need chart for that
10 particular service type. Some other chapters
11 contain a separate inventory and a separate
12 need chart, but the hospital bed need chart is
13 everything all in one.

14 Q: And can you explain the bed need methodology
15 for 17-18 Plan?

16 A: Yes. The bed need methodology for the 17-18
17 Plan for hospitals is based solely on the
18 utilization -- the historical and current -- or
19 most recent utilization data from the hospitals
20 -- from the existing licensed hospitals in each
21 particular service area. So the methodology
22 takes the -- looks at the existing population
23 and then compares that to the projected
24 population for the particular service area and
25 then looks at the existing -- at the

1 utilization data, the patient days, which is --
2 a patient day is one patient, one bed, one day
3 in a hospital. And it also looks at the number
4 of existing beds in that particular hospital
5 and calculates -- basically takes the projected
6 population growth, whatever the percentage of
7 growth is going to be and then looks at the
8 average daily census of that hospital based on
9 the patient days versus the number of beds in
10 the hospital itself. Was -- you calculate the
11 average daily census for present day, then you
12 grow that by the percentage of projected
13 population growth, and then you get the
14 projected average daily census. Then there's
15 a multiplier. And depending on the size of the
16 hospital, the multiplier is basically a
17 percentage, a target percentage. So for a
18 small -- for the smallest hospitals the goal
19 average daily census is 65 percent full. And
20 then for a medium-sized hospital, and I don't
21 remember what -- exactly how many beds, you
22 know, where the dividing lines are, but the
23 smallest hospital we want -- the target is 65
24 percent full; the medium hospital the target is
25 70 percent full; the largest hospitals the

1 target is 75 percent full. And the reason why
2 we don't want to max out the project- -- the
3 average daily census is because we want
4 hospitals to have some room to absorb the ebb
5 and flow of patients. And since the smaller
6 hospital has fewer beds, then 35 percent of
7 those beds is going to be a smaller number. So
8 if there's a -- you know, a disaster or some
9 sort of event that causes a quick rise in the
10 hospital census, it's going to be felt. Per
11 person it's going to be a -- more of a -- more
12 difficult for a smaller hospital to absorb a
13 certain percentage of patients than for a
14 larger hospital.

15 Q: Mr. Bupp, can you pull up the DHEC Exhibit 4,
16 the 17-18 Plan and turn to the general bed need
17 chart. It's on page 23. It begins on page 23.

18 (DHEC Exhibit Number 4 was referenced at this time.)

19 Q: And, Ms. Murdock, looking at the top I guess
20 titles of the columns, can you explain the
21 charts, listing of existing beds, what does
22 that include?

23 A: Existing beds actually -- and I stopped in the
24 middle of the methodology calculation. Once we
25 get a goal average daily census, a goal of

1 projected average daily census, that's
2 basically the raw bed need for a particular
3 hospital. Then we subtract the number of
4 existing beds, what's in that column, in order
5 to arrive at the actual either bed need or bed
6 surplus. Existing beds includes beds that are
7 already licensed beds at the hospital, but it
8 also includes beds that have been approved but
9 are not yet implemented. You know, the
10 hospital is still being built or it's still in
11 it's renovation and it hasn't yet licensed its
12 beds. And that existing beds category also
13 includes approved beds that are still -- for
14 which the hospital has not yet received a CON
15 if the staff -- if staff has approved those
16 beds but the decision is appealed and in
17 various stages of review or litigation. We'll
18 still include those beds in that list because
19 it wouldn't make sense to keep issuing -- to
20 keep approving beds that we've already approved
21 until we have some finality on whether or not
22 those beds are actually going to be eventually
23 licensed.

24 Q: Are you aware of any errors in the 17-18 Health
25 Plan, that inventory with regards to the Tri-

1 County service area?

2 A: I opined that there may be an error in -- I
3 believe that ---

4 Q: Can you turn to page 27.

5 A: --- that we might have not counted some of the
6 Berkeley Medical Center beds. I confess that
7 I haven't gone back and looked at all the old
8 plans and the drafts and the old licenses to
9 see, but I believe we should have included 50
10 additional beds on -- in the existing beds
11 number for Trident Medical Center and Berkeley
12 Medical Center since we had lumped those two
13 together as the same entry on there. Our
14 normal procedure would have been to include
15 beds that had been approved even if -- even if
16 there was still litigation. I think they may
17 have had a CON already by the time this Plan
18 came out but even if they hadn't, we should
19 have included those 50 beds in that number.
20 And so if we didn't, then that's a mistake.

21 Q: Okay. So what Plan standard allows for the
22 establishment of MUHA's hospital?

23 A: In the Chapter 3, I believe it's Standard 5.

24 Q: And so how is MUHA's application consistent
25 with Standard 5?

1 **A:** Well, MUHA sought to create a new additional
2 hospital at a different site from its downtown
3 site on the peninsula in the Tri-County service
4 area and their -- the project would transfer
5 the projected bed need of MUHA itself to that
6 new proposed facility. So there was a bed need
7 for MUHA or MUSC listed in the Plan and MUSC
8 used some but not all of that bed need.
9 Instead of asking to put all those beds on the
10 peninsula, the request was to put those beds in
11 a new facility in Berkeley County. Sorry, I'm
12 going to sit back. This chair is very deep so
13 I've got to commit if I'm going to either sit
14 back or sit forward.

15 **Q:** Okay.

16 **A:** And then the standard also requires that the
17 applicant must justify through patient origin
18 and other data of the need for the new hospital
19 at the chosen site and the potential adverse
20 impact the new hospital at the chosen site
21 could have on the existing hospitals in the
22 service area. So the need projections in this
23 particular application were based on the
24 prediction that MUSC's existing patient base,
25 the patients that were already traveling from

1 the area approximate to the hospital to the
2 downtown facility, that if MUSC put this
3 facility closer to the area where those
4 patients live, that the patients would travel
5 to that facility and utilize that facility
6 instead of traveling all the way downtown.
7 It's very similar to the analysis that was used
8 in the Berkeley Medical Center and the Roper
9 Berkeley applications. The -- I think Roper
10 referred to them as Roper aligned patients and
11 in this case the -- and so MUSC's -- and I'm
12 sorry, I interchange them a lot, MUSC and MUHA.
13 So this application presented the origin data
14 for MUSC's patients and made some adjustments
15 to not include the higher acuity patients which
16 would need the services of the more -- sort of
17 more robust services of the downtown facility,
18 and there was a high enough number of patients
19 -- a relatively high percentage of patients of
20 MUSC's patient base that actually were coming
21 from the area approximate to the proposed site
22 of the hospital and traveling all the way down
23 to the peninsula to use that facility. And so
24 MUSC included that -- or that patient origin
25 data and did some projections and calculations

1 that included some other elements to project
2 the need for the hospital based on the theory
3 that instead of putting more beds at the
4 facility and having that percentage of patients
5 continue to travel downtown, then instead they
6 would put the beds where the patients are. And
7 then the -- along with that theory the
8 justification for -- the explanation for the
9 impact on existing facilities was that since
10 those patients were already MUSC or MUHA
11 aligned patients and were already traveling
12 downtown to the facility in the peninsula, that
13 the fact that these patients were simply going
14 to go to this facility that was closer to their
15 home would not affect the existing facilities
16 in the service area.

17 Q: Okay. Let me back up a little but. What did
18 -- what does justify mean?

19 A: It means to give a reason for, -- to give a
20 reasonable explanation for something, to me.

21 Q: Okay. What concerns if any did you have about
22 the proximity of the project to -- in relation
23 to other hospitals?

24 A: Well, again, we're talking about existing
25 hospitals in this particular standard that

1 refers to existing hospitals. And under our
2 statute and regulation you cannot be a hospital
3 without a hospital license from the Bureau of
4 Health Facilities Licensing. So I think this
5 standard only required the justification with
6 respect to hospitals that were already licensed
7 -- that were already actually hospitals. So
8 the justification in this particular
9 application was these patients are already MUSC
10 aligned patients. That's -- I'm using that
11 term, that wasn't the term used in the
12 application I don't think. Since they're
13 already MUSC aligned, since they're already
14 part of MUSC's patient base and since they're
15 already not using existing facilities, that
16 whether they use the downtown facility or this
17 new community hospital at the proposed site
18 won't have any effect on the existing hospitals
19 in the service area. Except I suppose the
20 effect would be on the MUSC downtown hospital
21 itself. There would be an effect there that
22 was addressed by the assumed shift and the
23 application went into pretty granular detail
24 and which zip codes would shift and what
25 percentage of them would shift and things like

1 that.

2 **Q:** All right. How would you characterize the
3 distribution of hospital beds in the Tri-County
4 service area?

5 **A:** Well, they are very heavily concentrated in
6 Charleston County. I think I agree with Mr.
7 Richardson who testified that there was
8 maldistribution of beds in the Tri-County
9 service area. There's a lot of beds on the
10 peninsula and there are a lot of beds kind of
11 closer to the coast, but the population is
12 growing extremely rapidly in Berkeley County.
13 And then in the parts of Dorchester and
14 Charleston County, particularly North
15 Charleston, that area right up the sort of 26
16 corridor, that population is growing very, very
17 rapidly in that area. And until Roper Berkeley
18 opened, thank goodness, there were no hospital
19 beds in that area. It has a pretty significant
20 population number already and the growth is
21 just continuing to be very rapid in that
22 particular area where the proposed hospital
23 site's going to be and where the new Roper
24 Hospital is.

25 **Q:** Okay.

1 **A:** So, you know, the distribution of beds, their
2 need -- it makes more sense to have the beds
3 where the people are. And so all of the beds
4 located in Charleston County is now --
5 certainly continuing to put beds in Charleston
6 County instead of where the population is
7 actually growing doesn't make sense from a
8 distribution standpoint.

9 **Q:** Well, how the addition of the MUHA Berkeley
10 Hospital affect that distribution of beds in
11 the Tri-County service area?

12 **A:** Well, it will -- it will put more beds where
13 the population is growing the most rapidly.
14 Charleston -- the Charleston peninsula which is
15 where the current MUHA facility is is -- well,
16 it's a peninsula. So it's hemmed in on three
17 sides. It's very -- it's already very well
18 developed. It's built out. There's not a lot
19 of room to grow, certainly not into the ocean
20 or the marsh on any of the, you know, the water
21 -- the water sides. And so the population has
22 nowhere else to grow but up towards the
23 northwest which is basically the direction in
24 which the -- in which 26 goes and that
25 population is sort of flowing upstream if you

1 will and spreading out of that area of North
2 Charleston and Berkeley County close to 26 and
3 then on the other side in the Summerville area,
4 Dorchester County. So the -- I can't stress
5 enough, and I know we've already gone through
6 some testimony with other folks regarding how
7 -- how much faster the population's growing in
8 that area as opposed to the rest of the Tri-
9 County area.

10 Q: On that I think you just testified about some
11 of your review of the Roper Berkeley and
12 Berkeley Medical Center applications. What did
13 Roper Berkeley -- what did their application
14 provide regarding adverse impact on existing
15 providers?

16 A: It was -- it was similar to what MUSC MUHA's
17 application says, although Roper's application
18 did not predict a 100 percent shift of Roper
19 aligned patients. It did not -- its
20 projections were that I believe -- I believe it
21 was 60 percent of the projected volume would
22 come from redirected patients and the rest
23 would come from new market share in the area.
24 And the application itself even back in 2008,
25 2009, the population was growing very rapidly

1 and the application talks about the rapid
2 population growth in that area. And so the
3 theory was that in addition to the redirected
4 patients the rest of the market share would
5 come from population growth which was and still
6 is explosive. In fact the application itself,
7 you know, made predictions of future population
8 and the reality has just completely blown
9 through the roof of all those populate- -- of
10 those projections with respect to population in
11 that area.

12 Q: Mr. Bupp, can we turn to page 31 of DHEC
13 Exhibit 7, The Roper Berkeley application.
14 (DHEC Exhibit Number 7 was referenced at this time.)

15 Q: Bottom of the page, is that what you were
16 referring to, Ms. Murdock?

17 A: Yes. Repositioning of Roper St. Francis
18 Berkeley County residents.

19 Q: All right. And what does it provide about the
20 adverse impact -- expected adverse impact?

21 A: It says there'll be no material adverse impact
22 on any other existing healthcare provider. And
23 then it notes that population growth alone and
24 the resulting increase in the market size is
25 anticipated to offset any hospital patient

1 volume reductions. And how right they were in
2 that prediction because the population growth,
3 the market growth has exceeded every projection
4 that I've seen either in the State Health Plan
5 or from the State demographer or in CON
6 applications submitted projecting population
7 growth in that area. Every time, the reality
8 of it exceeded the projections.

9 Q: Okay.

10 A: It's worth noting -- well, I'll probably have
11 a chance to say all that later.

12 Q: Okay.

13 A: Okay.

14 Q: What did Berkeley Medical Center, did their
15 application provide with regards to the adverse
16 impact?

17 A: It was very similar that there would be -- that
18 the only adverse impact would be on the other
19 -- the other HCA facilities or the other
20 Trident facilities. I say HCA, there are some
21 other HCA facilities that aren't in the service
22 area that aren't part of that so that's
23 shorthand for Trident and some of the ...

24 Q: Mr. Bupp, can we get DHEC Exhibit 8, please.

25 Turn to page 37.

1 (DHEC Exhibit Number 8 was referenced at this time.)

2 Q: And the top two paragraphs, Ms. Murdock, is
3 that what you were referring about the no
4 adverse impact on the HCA facilities?

5 A: Yes. The Trident system. That's a better way
6 to put it. They'll be no adverse impact on any
7 existing provider outside of the Trident
8 System.

9 Q: And what do they say about the adverse impact
10 about those HCA or Trident Health System
11 facilities?

12 A: That it'll be insignificant.

13 Q: How can you characterize, I guess, the general
14 acute care utilization of Trident Health System
15 facilities?

16 A: It is a very highly utilized -- Trident itself
17 is a very highly utilized facility and
18 Summerville is more and more -- both facilities
19 are showing increased utilization when looking
20 at it as a percentage of their available beds.
21 Trident in particular is very highly utilized.
22 I think the last time I looked at the JARS
23 versus the available beds, the utilization was
24 in the mid to possibly high 80 percent which is
25 above the target range for any State Health

1 Plan category. Summerville is, I think, very
2 close to 60 percent utilized now. Those --
3 both of those facilities' utilization grew --
4 there was a five year period sometime between
5 roughly 2012 and 2016 or 2017 and each one of
6 those facilities grew by 15 to 16 percent and
7 are now -- Trident Medical Center is close to
8 capacity currently. That's inpatient, patient
9 day utilization. There are also other aspects
10 of the hospital that we heard some testimony
11 about that. The emergency departments of the
12 hospitals are also growing very, very rapidly.
13 There have been several projects that both
14 Trident and Summerville have either completed
15 or are in the process of implementing to try
16 and catch up to the growth and ED utilization.
17 They have several -- they have a couple of
18 freestanding emergency departments.
19 Centerpointe and then one pretty far up north
20 in Berkeley County near Moncks Corner. The
21 last time I looked at the Centerpointe
22 utilization it was well above capacity if you
23 use the 1,500 visits per bay capacity number
24 that is generally accepted as the capacity for
25 an ED bay and also it has been mentioned and

1 used by Trident in some of its emergency
2 department applications. I know Summerville --
3 I think Trident has just completed an ED
4 expansion and already they are -- their ED --
5 number of ED visits is significantly higher
6 than their projections in that CON application
7 for years later. They're already now higher
8 than they expected to be in 2022 or
9 thereabouts. They're also, again if you use
10 that 1,500 visits per bay utilization figure,
11 Trident's ED is well, well over capacity. Very
12 much more than 1,500 visits per bay. The same
13 is true for Summerville. Summerville's ED
14 utilization grew extremely rapidly,+ again over
15 the same kind of four or five year period
16 between 2012 and 2016 or 2012 and 2017. I
17 think both those hospitals' ED visit number
18 grew by 50 percent or close to 50 percent, and
19 so Summerville is in the process of adding ED
20 bays in its facility. I don't know that they
21 have implemented that project yet but even --
22 even if you count them as already having those
23 new ED bays they are significantly above
24 capacity already. So -- and Centerpointe, the
25 freestanding ED that's kind of closest to that

1 area, is over that 1,500 per -- 1,500 visits
2 per bay capacity. So Trident has been working
3 very hard just to catch up with the explosive
4 growth that's already happened in its own
5 facilities and it's already, even with these
6 projects that it's implementing or implemented,
7 the Trident system already -- the Trident ED
8 system is already over capacity right now.
9 Significantly.

10 Q: Can you explain to me how sometimes the
11 occupancy rates listed in the Plan can be kind
12 of artificially low?

13 A: Yes. If you have beds that are approved but
14 aren't implemented, then the calculation makes
15 it appear as though there's -- the effect is
16 that it would seem as though there are a bunch
17 of beds sitting empty in a facility. You can't
18 use a bed if the bed's not licensed yet. And
19 so the facility sort of gives credit for having
20 those beds even when it doesn't, in reality,
21 have those beds. So if a facility has a large
22 number of beds that aren't yet licensed, then
23 even if it is practically full, it will not
24 show that in its utilization figure until it
25 can implement those beds and actually use those

1 beds.

2 Q: You were talking about Summerville Medical
3 Center's utilization occupancy.

4 A: Yes.

5 Q: Do you know when the 30-bed addition became
6 licensed and operational?

7 A: I don't know exactly when, but it was fairly
8 recent. And I think it may have even been --
9 I don't know the exact date. I know that the
10 CON itself -- Summerville had that project
11 ongoing for a while. It was the subject of
12 litigation. Then the CON program shut down so
13 the project kind of hung around and finally
14 they received the CON I believe in 2015. Then
15 the project itself, certainly due to the
16 passage of time, they had to kind of go back to
17 the drawing board a little bit and revise the
18 project to catch up with, you know, new
19 pricing, new everything that had transpired in
20 the intervening time between the original
21 application and issuance of the CON. And then
22 the project itself changed a couple of times
23 since then. So I think it may have been just
24 recently finished.

25 Q: All right. And this idea of, I guess,

1 artificially low utilization, let's turn to
2 page 38 of DHEC Exhibit 1, please.

3 (DHEC Exhibit Number 1 was referenced at this time.)

4 Q: And, Ms. Murdock, I'll let you catch up.

5 A: Okay. I'm there.

6 Q: Is that something that MUHA points out? The
7 top of page ---

8 A: 38?

9 Q: --- 38? Bates labeled 38.

10 A: Let's see. Well, yeah, MUHA itself has beds
11 that are approved but not yet operational. It
12 received a CON for an increase of 52 beds. It
13 has brought some of those beds online, but it
14 -- a large -- I think 33 of those beds are not
15 yet licensed because they are going to go into
16 the children's -- the current children's
17 hospital as soon as it's vacated. But those
18 beds are counted as existing beds for the
19 purposes of the State Health Plan calculation.
20 So it makes it look like there are more beds
21 sitting idle for MUSC than there really are.

22 Q: Let's turn to DHEC Exhibit 6, please.

23 (DHEC Exhibit Number 6 was referenced at this time.)

24 A: You said 6?

25 Q: Correct.

1 **A: Exhibit 6?**

2 **Q: Exhibit 6.**

3 **OBJECTION:**

4 **MS. HOLLINGSWORTH:** Your Honor, not to interrupt.

5 **MR. WICEVIC:** Yeah, that's fine.

6 **MS. HOLLINGSWORTH:** This is obviously an Exhibit
7 that was subject to -- well, everything was
8 supposed to be subject to those pre-hearing
9 objections to evidence, as the draft of the
10 health plan. I did want to bring that to the
11 Court's attention. We have briefed that, so
12 you do have some information about that
13 already, but this would be the document subject
14 to those written objections.

15 **MR. SUMMER:** Yeah, obviously we'd join in that
16 motion, Your Honor. They've just started the
17 planning process. The public hearings on it
18 are next week. And while the law allows the
19 Court ---

20 **THE COURT:** Okay. Right now I agree with y'all, so
21 I don't really need to hear. I don't think
22 this is admissible.

23 **MR. WICEVIC:** Well, I think it's certainly relevant,
24 and I'm not sure if you're referring to the
25 statute that says, you know, the Department,

1 the ALC and Court of Appeals shall consider the
2 Plan in place and then may consider the Plan --
3 the current Plan. I think it's relevant in
4 multiple respects and it contains updated
5 population data, updated utilization data, and
6 those are all issues in dispute in this case.
7 Whether there's a need for the hospital,
8 whether the distribution of hospital is -- the
9 beds in the Tri-County service area is
10 appropriate. I think it's appropriate,
11 relevant. And you know, I think something else
12 that's noteworthy is that actually in the
13 Berkeley Medical Center application, and I
14 don't -- Mr. Bupp, if you could pull this up.
15 This is DHEC Exhibit 8, page 29, the bottom
16 paragraph.

17 (DHEC Exhibit Number 8 was referenced at this time.)

18 MR. WICEVIC: Trident said it's important to note
19 that in this context the utilization growth at
20 Trident Medical Center has been such that in
21 the draft 2008-2009 Plan, the State rejects the
22 2013 56 acute care beds at Trident Medical
23 Center beyond the 296 acute bed inventory that
24 resulted in the conversion of above-referenced
25 25 skilled nursing beds. While the draft Plan

1 has no legal force as yet, bed need forecast
2 clearly indicates substantial incremental need
3 within the Trident Health System. So it was
4 relevant to them back then, and I think it's
5 certainly relevant here. And I think the Court
6 can certainly, you know, apply the Plan that it
7 feels is appropriate in accordance with the
8 statute. You know that statutory provision
9 also doesn't say it's excluded from evidence.

10 THE COURT: Agreed. A draft plan though is
11 something that is subject to change. It's
12 almost like you seeking to introduce
13 legislation that's proposed. So what? I mean,
14 it's proposed. It's a draft. So what? It may
15 change. Now if there's ---

16 MR. WICEVIC: And I think it can ---

17 THE COURT: --- if there's -- you've pointed out one
18 thing that I do think is probative is if there
19 were new population data or information like
20 that, that information could be introduced if
21 it's verified, you know.

22 MR. SUMMER: I would point you, Your Honor, I've got
23 clients who've already called me that there are
24 errors in this draft Plan ---

25 THE COURT: Well ---

1 MR. SUMMER: --- so I would want that to come from
2 primary source from ---

3 THE COURT: I can't verify it, you know, so. But
4 I'll hear you out but I really -- y'all are
5 shooting way up hill on this one.

6 MS. CRUM: All right, sir. We certainly agree that
7 the draft Plan is not enforceable because it's
8 not enforceable until it's adopted by the DHEC
9 Board. That's under the same Plan. That's not
10 -- that's not contested.

11 THE COURT: Well, no. The issue's not ---

12 MS. CRUM: Yes, sir.

13 THE COURT: --- enforceable is not what I really
14 even care about. It's whether it's probative.

15 MS. CRUM: Yes, sir, I'm trying to get there.

16 THE COURT: Okay.

17 MS. CRUM: All right, sir. Now under -- it's public
18 record. There's no question about that under
19 Rule 803(A). This is a public record. The
20 draft Plan is required by law, specifically 44-
21 7-180, to be published and to be circulated.
22 So it's public record.

23 Second, it has great relevance to this case.
24 South Carolina Rules of Evidence 401 define
25 relevant evidence as evidence that has any

1 "tendency to make the existence of any fact
2 that is of consequence to the determination of
3 the action more probable or less probable than
4 it would be without the evidence." One of the
5 major issues in this case is whether or not the
6 need -- there's need for additional beds in
7 Berkeley County. The location, Berkeley
8 County, has been, certainly from the
9 plaintiffs' -- the Petitioners' standpoint, a
10 focus in this case. This case is also, Your
11 Honor, about projection of future need in the
12 Tri-County area and specifically in the
13 Berkeley County. And Trident listed the 2018-
14 19 State Health Plan as an Exhibit. And I
15 believe it was both Mr. Richardson and Mr.
16 Sullivan that testified the 2018-19 Plan was a
17 deviation from all the previous plans that had
18 counted the Tri-County as the service area for
19 MUHA, HCA and Roper St. Francis. And in the
20 2018-19 Plan they -- DHEC shifted to a county
21 basis. You heard testimony, Your Honor, that
22 Berkeley County showed a zero need. And why
23 did it show a zero need? Because they had no
24 historic utilization. You heard Ms. Murdock
25 testify about how bed need is calculated. So

1 this fills in an issue, albeit draft, it tends
2 to show that there is a need in Berkeley County
3 for additional beds. 'Cause the only thing
4 that the 2018-19 Plan has is that there are --
5 one hospital that is admittedly now open. The
6 other that was approved and the CON issued in
7 May of 2016 that hadn't even begun to be
8 constructed yet.

9 So, Your Honor, Mr. Richardson in the 2018 --
10 I'm sorry, in the 2012 CON case for Roper
11 Berkeley and Trident Berkeley, Mr. Richardson
12 testified, and that's in Judge, Judge McLeod's
13 Order, that there was a need for 286 beds in
14 Roper County -- in Berkeley County. So, Your
15 Honor, -- and that was for non-tertiary. I
16 think -- and as Mr. Wicevic has said, in the
17 case in 2012, Trident specifically relied on
18 the draft Plan while admitting, just like we
19 have, that there is no legal force yet. It
20 clearly indicates substantial incremental need
21 within the Berkeley County area. The
22 population figures I don't think are
23 unverified. Nobody said the population figures
24 weren't right. That's from the U.S. Census
25 Bureau. The Exhibit that it's in with the --

1 it has been admitted with the population data
2 says that's from the U.S. Census Bureau through
3 RFA, Revenue and Fiscal Affairs. So I think
4 it's pretty disingenuous for the Petitioners to
5 rely on a draft plan in their cases, in 2012
6 and say now we can't rely on the draft Plan
7 now. And, Your Honor, I'm quite confident
8 you're not going to be unduly prejudiced or
9 confused by the bed need methodology and the
10 projections contained in the 2020 State Health
11 Plan. I do think that it goes to make more
12 probable that there is a bed need. Maybe the
13 exact number might be disputed, but the fact
14 that there is a bed need, additional bed need
15 above and beyond 228 in Berkeley County and
16 that's assuming that the Trident Berkeley
17 Hospital actually gets built.

18 THE COURT: What is to prohibit you, DHEC, from
19 presenting all the evidence that is in the 2020
20 draft Plan here so that it will be subject to

21 ---

22 MR. SUMMER: Objection.

23 MS. CRUM: So that it'd be what? I'm sorry.

24 THE COURT: --- subject to objection and

25 consideration as to whether or not the data

1 that you wish me to consider is reliable.
2 'Cause that's -- I think everything that's in
3 that plan that you've just referenced, even
4 including the bed methodology indicating that a
5 greater bed need, can certainly be presented to
6 me. This is a de novo hearing. But I don't
7 know if I want to have that considered through
8 a public document that carries with it
9 supposedly a veracity that should not be
10 attributed to it because it's a draft.

11 MS. CRUM: Your Honor, I'm not -- I'm not sure that
12 -- we are not producing it to say that it is
13 anything but a draft.

14 THE COURT: Well, then what ---

15 MS. CRUM: Now ---

16 THE COURT: --- what probative value does a draft
17 carry, because that was my point.

18 MS. CRUM: Your Honor ---

19 THE COURT: The draft carries no probative value ---

20 MS. CRUM: Your Honor, I think is subject to FOIA.
21 It is a public document. It is equally subject
22 to their ability to come in and try to attack
23 it. But if Your Honor wants us to put it in
24 through evidence we can certainly do that.

25 THE COURT: Well, I don't I want to; I just think

1 you have a right to.

2 MS. CRUM: All right, sir. We can ---

3 THE COURT: And that way it would be something that
4 I could properly consider. Now, y'all may not
5 -- y'all may not ---

6 MR. SUMMER: I'd like to respond if I might, Your
7 Honor.

8 THE COURT: all right.

9 MR. SUMMER: First of all, they're citing something
10 from the certificate of need application 11
11 years ago, okay. That was not evidence in the
12 court, that was a proposal submitted to DHEC.

13 THE COURT: I get all that.

14 MR. SUMMER: That's number one. Number two is, I
15 want to point out to the Court that there are
16 some radical changes in this draft Plan, and I
17 have multiple clients that are writing public
18 comments next week and submitting those, and I
19 suspect this is going to be debated. So I
20 would agree that it creates more prejudice than
21 it does anything else and leaves a lot of
22 unanswered questions in the record. So I don't
23 have an objection if they want to present and
24 have introduced updated population information,
25 that's one thing. But to be espousing

1 methodologies that have not gone through the
2 statutorily prescribed processes that have
3 already been testified to would be highly
4 prejudicial.

5 THE COURT: Okay.

6 MS. HOLLINGSWORTH: And, Your Honor, I'd even step
7 this way back to the beginning. This document
8 that was shown on the screen a moment ago,
9 that's not the draft anymore, Your Honor. As
10 of November 1st there's even a different draft.
11 That's how fluid this document is. So I would
12 submit you can't even consider what was
13 identified and designated as a potential
14 Exhibit, which we objected to, as the draft
15 Plan because -- and as we've already noted, Ms.
16 Lipham has done a lot of work evaluating, it
17 looks nothing really like the draft Plan. And
18 when it has statements that say the Department
19 finds, the Department concludes, it's not been
20 approved by the Department. So I would submit
21 that ---

22 THE COURT: Yeah.

23 MS. HOLLINGSWORTH: --- everything in here, it
24 really has no value, but October 25th is no
25 longer the draft Plan, Your Honor, so it truly

1 isn't a document that I think should even be
2 presented to the Court in any fashion.

3 THE COURT: I sustain the objection.

4 MR. WICEVIC: Okay. May I use it as a demonstrative
5 to have Ms. Murdock testify to the population
6 and utilization data?

7 THE COURT: I don't have a -- as long as --
8 demonstrative is if we're not referencing the
9 Department finds, the Department concludes and
10 things like that because there is no Department
11 conclusion yet, there's no finding, it's a
12 draft.

13 MR. WICEVIC: Sure.

14 THE COURT: Okay.

15 MS. HOLLINGSWORTH: And, Your Honor, I don't know
16 how the witness could do that even on the
17 population data. I mean, if what was presented
18 was the underlying population data and she was
19 asked that, but this document, I mean, as my
20 colleagues would say, there's just nothing but
21 hearsay in this document. So to put it on the
22 screen and ask her parrot information to the
23 Court would be improper. We've learned that
24 repeatedly the last two weeks.

25 MR. WICEVIC: Well I think first of all the

1 population data, and Ms. Murdock can testify
2 about it, comes from the Revenue and Fiscal
3 Affairs. And there is MUHA Number 2 I believe
4 is ---

5 THE COURT: I don't have a problem with population
6 data so if you're going to be putting up, as
7 Ms. Hollingsworth stated, hearsay statements
8 and having her parrot them into the record, I
9 don't think that's proper. Like I said, again,
10 I don't mind you using all the information if
11 it can be verified. I'm up for hearing all of
12 that.

13 **Q: Ms. Murdock, are you familiar with the updated**
14 **projections, population projections from the**
15 **Revenue and Fiscal ---**

16 THE COURT: Hold on one moment. We'll take a short
17 break.

18 MR. WICEVIC: Thank you.

19 (Off the Record)

20 **Q: All right. Ms. Murdock, so we're talking about**
21 **the 2020 draft Plan, and let's talk about the**
22 **population in the plan?**

23 **A: Sure.**

24 MS. HOLLINGSWORTH: Your Honor ---

25 THE COURT: And I want to -- why -- I discussed with

1 my staff when I went out and they explained
2 that maybe I didn't explain my position well
3 enough 'cause we were all in agreement it's
4 just a -- and that is, the data that is in the
5 Plan. I don't think just because there's data
6 in the Plan means -- you just reference the
7 data. I said data that is in the Plan that is
8 verifiable. So ---

9 MR. WICEVIC: Okay.

10 THE COURT: --- when you reference whatever data is
11 in the Plan it has to be something that is --
12 I don't know what phrase we're using, but y'all
13 know what data's out there that is -- that is
14 public record.

15 MR. SUMMER: Your Honor, there are source documents
16 from ---

17 THE COURT: Yeah, the source documents.

18 MR. SUMMER: --- from research and statistics. If
19 they want to go to a source document, I
20 understand that, but referring to a page in the
21 draft Plan is not ---

22 THE COURT: Well, if it's a page in the draft Plan
23 that relies on a source document and none of
24 it's disputed then ---

25 MR. SUMMER: Again I prefer to go to the source

1 document. The reason being is that we already
2 know that there are changes that have been made
3 to the draft Plan that's been submitted to the
4 Court and that those numbers are out to be
5 verified. In other words the public's
6 commenting on them. There are errors in that.

7 THE COURT: Okay.

8 MR. SUMMER: And so I just think it's safer to take
9 the numbers from Budget Control Board.

10 MR. WICEVIC: Your Honor, that's fine. We can go
11 straight to the source document.

12 THE COURT: Okay.

13 MR. WICEVIC: and before I move on ---

14 THE COURT: Okay.

15 MR. WICEVIC: --- I was going to proffer the draft
16 2020 Plan.

17 THE COURT: Oh, okay, good.

18 (DHEC Exhibit Number 6 was proffered at this time.)

19 MR. WICEVIC: Let's move to the source document.

20 And it's -- let's go to MUHA ---

21 THE COURT: Hold up a minute. I want the record to
22 be clear so I'm going to cover you.

23 MR. WICEVIC: The draft Plan ---

24 THE COURT: You've proffered the draft Plan. It's
25 marked as?

1 MR. WICEVIC: It's marked as DHEC Exhibit 6 I
2 believe. Yes.

3 THE COURT: Okay. It's accepted as a proffer.

4 MS. HOLLINGSWORTH: And, Your Honor, we would just
5 ask the record reflect that it's actually an
6 earlier draft. It is no longer the draft as of
7 this hearing.

8 THE COURT: Yeah.

9 MS. HOLLINGSWORTH: Thank you, Your Honor.

10 MS. MURDOCK - CONTINUED EXAMINATION BY MR. WICEVIC:

11 **Q: Okay. Let's turn to MUHA 2.**

12 **(MUHA Exhibit Number 2 was referenced at this time.)**

13 **Q: Are you familiar with this document, Ms.**
14 **Murdock? Maybe turning to the last page.**

15 **A: Yes. Yes, this is the -- well, this is the**
16 **description that accompanies the spreadsheet**
17 **that the State demographer sent to the CON**
18 **staff for the purpose of updating the State**
19 **Health Plan population and population**
20 **projections.**

21 **Q: Okay. And, Mr. Bupp, can you just scroll to**
22 **the very top.**

23 MR. WICEVIC: And, Your Honor, for the Court's
24 reference, this is simply an Excel version on
25 the screen now, and the only reason why I

1 suggest putting it up is because the PDF
2 version that MUHA has labeled doesn't have all
3 the columns across the top.

4 THE COURT: This is a lot easier to read.

5 MR. WICEVIC: Yes, Your Honor.

6 THE COURT: I'm all in favor of that.

7 Q: So if we could, Ms. Murdock, what is the
8 Berkeley County projected 2024 population?

9 A: The total Berkeley County 2024 population
10 projection is 255,510 people.

11 Q: Okay. And what's the estimate for 2018 for
12 Berkeley County?

13 A: The estimate for 2018 is 221,091 people.

14 Q: What about the estimated 2018 for Charleston
15 County for 2018?

16 A: Estimated 2018 for Charleston County the total
17 population is 405,905.

18 Q: And for Charleston County what's the projected
19 2024 population?

20 A: 444,730.

21 Q: And then finally, for Dorchester County, what's
22 the estimated 2018 total population?

23 A: 2018 it's 160,647.

24 Q: And for Dorchester County the projected 2024
25 total population?

1 **A:** **179,110.**

2 **Q:** **All right. So getting back to the Plan -- so**
3 **what have the projects for Trident, out of the**
4 **projects that they've applied for and receive**
5 **CONs for, along with their utilization, speak**
6 **to, I guess the future of the north area, the**
7 **Tri-County service area?**

8 **A:** **Well, Trident and Summerville -- Trident**
9 **Medical Center and Summerville Medical Center,**
10 **which I'll refer to as the Trident System, are**
11 **the existing facilities or existing hospitals**
12 **that are -- and Roper Berkeley is -- those**
13 **three are now the existing hospitals closest to**
14 **the proposed location of this MUSC MUHA**
15 **project. The -- if you're looking at the**
16 **trends in utilization of both ED and inpatient**
17 **utilization for both of those hospitals they**
18 **have -- the utilization's been increasing at a**
19 **pretty good clip. And Trident Medical Center**
20 **itself, as far as it's -- it is over capacity**
21 **in its ED right now by a fairly large number,**
22 **and that includes recent expansion of ED bays.**
23 **It's still well over its projections and well**
24 **over capacity right now. Trident inpatient**
25 **utilization has been increasing over the last**

1 several years as indicated in the last several
2 Plans. Based on Trident's 2018 Joint Annual
3 Report which is, you know, Trident's document
4 that it submitted to -- pursuant to the
5 requirements of the regulation. It's -- if you
6 look at that number of patient days and compare
7 it to Trident's available beds, Trident's most
8 recent utilization estimate is now 80 --
9 somewhere around 85 percent, which for a
10 hospital of that size is well over the target.
11 I think for Trident the target would be either
12 70 or 75, at least 70 percent. So already as
13 we sit here today Trident is over the target
14 occupancy for State Health Plan purposes. And
15 its ED is far over the target capacity for ED
16 services. And that is after Trident has
17 already implemented expansion projects.
18 Trident does -- has just received approval for
19 an addition of six beds which will have some
20 affect on utilization, but it's a \$22 million
21 dollar project that will involve renovation of
22 an entire floor. I believe -- and based on
23 memory and I'm not certain of this -- but I
24 think the timeline is two or three years on
25 that project so it'll be a while even before

1 those additional six beds are implemented. So
2 Trident has diligently worked -- Trident has
3 had a number of other products that have been
4 approved and implemented in an effort to catch
5 up with all the population and utilization
6 explosion in that area, but it's still already
7 behind, you know, as far as the current status
8 right now as we sit here today, even after
9 having implemented all these projects.

10 Summerville Medical Center is working on an
11 ED expansion but, again, its capacity is -- it
12 is far over capacity. I think -- I want to say
13 maybe 15,000 visits over the target annual
14 capacity of 1,500 visits per bay as of 2018.
15 So -- and that -- that's if you count the
16 additional ED bays that it will have, but
17 doesn't currently have yet, pursuant to the
18 project that it has recently been approved for.
19 I think that's a \$20-something million dollar
20 project, I can't recall exactly what the cost
21 of that project is. But again, and in
22 Summerville, according to its 2018 Joint Annual
23 Report compared to the number -- its number of
24 beds that it's approved for and licensed for,
25 its utilization is either at or close to 60

1 percent which is not far from the 65 percent
2 target.

3 THE COURT: What was that again? 'Cause I'm trying
4 to keep up with it.

5 A: The Summerville's utilization, based on its
6 2018 Joint Annual Report.

7 THE COURT: You're talking about the ED?

8 A: No, not the ED. Now inpatients.

9 THE COURT: Oh, so no. I missed that.

10 A: Oh, I'm sorry, I didn't link that up. Thank
11 you for catching that. But the ED is far over
12 capacity.

13 THE COURT: I caught that.

14 A: The inpatient utilization is right at -- I
15 think it's at 59 point something or maybe 58
16 point something at -- looking back on 2018, its
17 inpatient utilization is approaching 60
18 percent. That is based on all of the beds that
19 Summerville is approved for, and Summerville
20 has only recently implemented a 30 bed
21 addition. So that utilization occurred without
22 Summerville having access to those 30 beds that
23 it's been approved for. Again the approved
24 beds seem like they're just sitting there empty
25 when they're actually just not implemented yet.

1 So even if you count those 30 beds, Trident is
2 still -- I mean, Summerville is still, as of
3 2018, the end of 2018, right at 60 percent
4 utilization.

5 THE COURT: If you -- so you count the beds that are
6 approved but not licensed, they're still right
7 at 60 percent?

8 A: Yes.

9 THE COURT: All right.

10 A: And we have count those beds so that we don't
11 keep issuing more and more and more beds
12 because if we don't count them a facility that
13 needs beds is going to show a need. And so
14 then if we approve the beds, we don't add those
15 to the existing bed count, that facility's
16 still going to show the same need and then we
17 could end up in a illogical cycle of -- you
18 have kind of a false need. So we count those
19 when we look at utilization, at least when
20 we're looking at the occupancy rate for the
21 purpose of using that data to predict need in
22 the State Health Plan.

23 Q: Going along with that, let me ask you this.
24 Are you aware of any kind of change in licensed
25 bed compliment at Trident Medical Center?

1 **A:** I believe their bed count went down from 296 to
2 280-something. I think it went down by 14.

3 **Q:** When you say the bed count, are you referring
4 to the general occupied ---

5 **A:** Yeah, the acute care beds. The hospital beds
6 that would be in a chapter 3 chart.

7 **Q:** Was there a conversion of some sort?

8 **A:** I believe that those beds were part of a
9 project to -- I think those were converted to
10 inpatient rehab, comprehensive rehabilitation
11 beds. I didn't review that application of
12 Trident's before -- for the rehabilitation beds
13 and so I don't recall directly that it was a
14 conversion of current beds to rehab beds, but
15 the numbers match up, so it would make sense
16 that that right about the time that 14 bed
17 rehab project was implemented the acute care
18 bed count at Trident went down by 14 beds.

19 MR. WICEVIC: And, Your Honor, before I move on I
20 would going to introduce MUHA 2 into evidence.
21 I don't want to forget.

22 THE COURT: Well, Ms. Crum?

23 MS. CRUM: No objection, Your Honor.

24 MS. HOLLINGSWORTH: It's our understanding it's
25 already in evidence which is what I thought she

1 was commenting on, but if not that's fine.

2 MR. SUMMER: No objection, Your Honor.

3 THE COURT: Well it's either admitted or recognized
4 that it is admitted.

5 MR. WICEVIC: Okay.

6 (MUHA Exhibit Number 2 was admitted into evidence at
7 this time.)

8 **A: I'm sorry, before -- I forgot to mention that**
9 **Summerville has also recently been approved for**
10 **a freestanding ED. Summerville and MUHA have**
11 **similar projects before the Department for**
12 **freestanding emergency departments. I think**
13 **that there's been testimony on that, that they**
14 **are close together and how we reviewed them at**
15 **the same time and staff approved both. One is**
16 **under appeal; the other -- Summerville's has a**
17 **Certificate of Need and that is a -- that is a**
18 **ten bed ED project I believe. And the premise**
19 **of that project was to help to alleviate ED**
20 **capacity at Summerville Medical Center which it**
21 **will help, but as Summerville recognized in its**
22 **subsequent ED expansion application that FSED**
23 **will help but it certainly will not fully**
24 **alleviate the capacity constraints. And that**
25 **was as of -- I think it was November 2017 when**

1 we received the Summerville ED expansion
2 project. Interestingly several months prior
3 the submission of that Summerville project,
4 Trident claimed that the MUSC FSED project was
5 not needed because there was plenty of capacity
6 in the area and then a couple months later it
7 filed an application to expand it's own ED
8 based on significant capacity constraints which
9 were -- which are current and exist currently.
10 It is a exploding ED reality there.

11 Q: Okay.

12 A: In that area, not just Berkeley.

13 Q: Do you have anything else to add as far as
14 Standard 5 of the Health Plan?

15 A: To the extent -- I thought that MUSC's
16 application did enough to justify the project,
17 to comply with that Standard. I also believed
18 then, and believe even more now, that based on
19 the population in the area, based on all the
20 other growth in utilization, even if there was
21 a market share shift and the MUSC project, the
22 community hospital, actually did absorb some
23 market share, particularly from the Trident
24 system, I don't believe that that would be an
25 adverse impact that would run afoul of the

1 purposes of CON. In fact, I believe that it
2 would be a beneficial impact to both the people
3 of North Charleston, Dorchester and Berkeley
4 County and even the Trident System itself.
5 Trident has spent a significant amount of
6 capital and has worked very hard to expand to
7 try and meet the need but it is a heavy burden,
8 and thank goodness we now have a new 50 bed
9 hospital in that area, but I don't believe it's
10 going to be enough. So even if there was --
11 even if MUSC's Standard 5 analysis is not
12 completely accurate regarding whether or not
13 there will be an affect on existing facilities,
14 not only do I believe that affect would not be
15 harmful, I hope there is an affect because
16 right now there's -- Trident is overfull and
17 it's already struggling to implement the
18 projects that it has currently pending with the
19 Department. There are some projects that its
20 had to delay based on its own admission that it
21 has so many CON projects, because the Trident
22 System has so many CON projects that it's
23 already trying to implement and it's devoting
24 so many resources to those projects that it has
25 had to delay projects that it already has

1 approval for.

2 Q: Mr. Bupp, can we turn to DHEC Exhibit 4, pages
3 11 and 12.

4 (DHEC Exhibit Number 4 was referenced at this time.)

5 Q: Ms. Murdock, what were your findings with
6 regards to the remainder of hospital plan
7 standards?

8 A: Standard 6 has some kind of general
9 requirements that MUHA either has already
10 satisfied or appropriately indicated that it
11 would satisfy just regarding things that a
12 hospital needs to have and do basically.

13 And the rest of the Standards, Standard 7 has
14 to do with other bed types, so that's not
15 applicable to this particular project.

16 Standard 8 has to do with tourists. MUHA
17 didn't rely on that, on a tourist, influx of
18 tourist in order to justify its projections.

19 Standard 9 is not applicable; it has to do
20 with federal facilities and a deletion of
21 services at federal facilities.

22 Standard 10 talks about the transfer of beds
23 between affiliated hospitals. The proposed
24 project is not a hospital yet so that's not
25 applicable.

1 And Standard 11 has to do with modernization
2 of facilities. This will be a new facility so
3 it's not applicable here.

4 Same with twelve.

5 Q: Okay. Then on page 13 of the Plan there's a
6 statement, general hospital beds are typically
7 located within approximately 30 minutes travel
8 time for the majority of the residents of the
9 State. And it says, the benefits of improved
10 accessibility will be equally weighed with the
11 adverse effects of duplication in evaluating
12 the CON applications for these beds. How does
13 that play into your review and, I guess,
14 ultimate decision for this project?

15 A: Well, the first part is kind of just a
16 statement. I think of it as kind of a minimum
17 target, in at least 30 minutes or less. The
18 second part of that paragraph is what I refer
19 to as the balancing test. Each State Health
20 Plan chapter has to include a statement as to
21 whether the benefits of improved accessibility
22 will be equally weighed with the adverse
23 effects of duplication, or more heavily weighed
24 or less heavily weighed with the adverse
25 effects of duplication in evaluating

1 Certificate of Need applications for these
2 beds. So this balancing test kind of sets the
3 stage for how we look at the project and review
4 the project against the State Healths Plan
5 standards and the criteria. I think about this
6 balancing test in terms of whether or not I'm
7 supposed to put my thumb on the scale on one
8 side or the other. And so if I'm required to
9 more heavily weigh one aspect of this or the
10 other, then each time I look at the project
11 review criteria or the plain standards or other
12 aspects of the project that I'm reviewing, I
13 look at it through the lens of, you know, how
14 each aspect of the project does these two
15 things, either improves accessibility or
16 represents an adverse effect of duplication.
17 And then the balancing test tells me how I need
18 to look at each one and how much weight I need
19 to give each one. And the accessibility and
20 adverse effects are concepts that apply in the
21 context of several review criteria. They're
22 kind of fundamental concepts that go to the
23 purposes of CON really. And so this balancing
24 test just kind of tells me which lens to look
25 through. And in this case the benefits of

1 improved accessibility are equally weighed with
2 the adverse effects of duplication. So I don't
3 need to give one more import than the other;
4 it's just an equal analysis.

5 In this particular case, I'm -- there are
6 benefits of improved accessibility that have
7 been demonstrated by MUHA, not the least of
8 which is putting the beds that are demonstrated
9 as needed, that are clearly needed by MUHA
10 itself, putting those beds where they have
11 demonstrated that they have a pretty -- a
12 fairly large patient base in Berkeley County
13 and then in some northern parts of Charleston
14 County and the Summerville area.

15 As far as the adverse effects of duplication
16 there is duplication, which to me just means
17 two of the same thing near each other. But an
18 adverse effect involves more than just the
19 similarity of facilities next to each other.
20 The adverse effect has to be something that
21 happens as a result of there being more than
22 one or multiples of the same kinds of facility
23 that run afoul of the fundamental purposes of
24 CON or other parts of the criteria for the
25 State Health Plan. And in this case I don't

1 think that that's the case. In fact I think
2 that there are beneficial effects of
3 duplication in this case.

4 Q: Okay. Well, we talked about 8021, right?
5 Compliance with the need outlined in the Plan.
6 Let's move on to the next criterion. What was
7 your finding with regards to compliance with
8 the community need documentation criteria?

9 A: I found that the project would lag with the
10 community need documentation.

11 Q: All right.

12 A: For some of the reasons that I've already
13 talked about in response to some of your other
14 questions. In addition to just kind of the
15 general reasonableness of the utilization
16 projections, MUHA -- this criteria will require
17 MUHA to identify its target population, which
18 it did quite extensively. It started with a
19 kind of a general service area, a map with a
20 border around it saying this is our service
21 area. But, more importantly, it went into more
22 granular detail about how many patients were
23 coming from what parts of that service area.
24 And that's really what I look at when I review
25 the reasonableness of the projections. That it

1 -- not necessarily what area falls within or
2 without the black like around the service area
3 map. It's what patients and what percentage
4 are going to be utilized in the proposed
5 facility. And MUSC went into great detail
6 about that with predicted population shifts
7 based on zip code, and so it clearly identified
8 its target population.

9 Then some of the other requirements of that,
10 the projections of the anticipated population
11 changes were reasonable. They were based on --
12 I think MUSC relies on Claritas data which has
13 population information broken down into -- in
14 different ways than the State demographer data
15 does. We see the Claritas data all the time
16 and consider it reliable and in keeping with
17 the methodologies used by our State
18 demographer. They're consistent with the State
19 demographer's projections.

20 The project has to provide services that meet
21 an identified need of the target population.
22 MUSC showed that it, among other things, by
23 noting that the number of the people from that
24 target population who are actually traveling
25 already to the downtown facility to use the

1 MUSC Hospital. MUSC also discounted some of
2 its higher acuity patients and based a lot of
3 this on its own data. And then its consultant
4 predicted a shift based on a number of factors
5 including proximity, ease of access to highways
6 and other things to project utilization of the
7 proposed project. The -- and so I had no
8 reason to doubt the reasonableness of those
9 projections for the most part.

10 I even, myself, wondered if -- how many
11 people were really gonna drive to the tip of
12 the peninsula all the way up to the community
13 hospital. So I did some kind of what if
14 analysis as I was looking at this data. You
15 know, well what if none of those people drive
16 up to the facility? And what if these other
17 folks from far away, what if anything, what if
18 -- so I did play around with the margins of the
19 predictions, but because of the market itself
20 and the growth in the market, and not only the
21 lack of harm but the actual benefits to this
22 proposed facility actually kind of carrying
23 some of the load of this population growth and
24 utilization growth, even if there were some
25 assumptions that didn't come to fruition as far

1 as percentage shift, I thought that the market
2 itself and the growth itself, which wasn't a
3 big part of the projections in the application,
4 that that would be enough to mitigate any
5 inaccuracies in the percent shift predictions
6 in the application.

7 So all that, you know, so the utilization,
8 the projected utilization and in concert with
9 the current utilization at MUSC itself, at the
10 downtown facility, through the -- kind of
11 through the mechanisms of the need analysis,
12 need projections were sufficient to justify the
13 project.

14 Q: According to MUHA's application, are they
15 experiencing any kind of operational issues as
16 a result of the capacity restraints or
17 constraints?

18 A: Well, I mean, any hospital would experience
19 operational difficulties, not just MUHA. And
20 they have documented these constraints and
21 difficulties and -- the same way that other
22 applicants tried it. For example, in its
23 recent six bed addition, has noted the effects
24 of capacity constraints. And that involves
25 longer wait times for admission or staffing

1 inefficiencies, ED overcrowding. A lot of ill
2 effects of the capacity constraints that are
3 borne most heavily by the patients and the
4 public.

5 Q: The opposition made some arguments about
6 Berkeley County not being -- not being under
7 served. What was your thoughts -- what's it
8 mean to be under served?

9 A: Under served means that the population needs
10 more resources than are available. And that
11 can manifest itself in a number of ways. It
12 can manifest itself in an absence of a certain
13 type of health facility or service. It can
14 manifest itself in the -- a greater distance
15 between the population, the members of the
16 public and the needed health service. I could
17 manifest itself through capacity constraints by
18 the wait times or kind of languishing and
19 waiting for a hospital bed or languishing in an
20 ED waiting for service. ED overcrowding is not
21 new to many of the folks in the Low Country.
22 And again, Trident has worked mightily to
23 alleviate those capacity constraints, and MUSC
24 has -- is also attempting to work mightily to
25 alleviate its capacity constraints. Again the

1 population growth, even in MUSC's own patient
2 base, is happening up where an area close to
3 where the proposed project is supposed to be,
4 so.

5 **Q:** What concerns if any did you have about the 5.2
6 day average length of stay for the med-surg
7 patients and then also the 2.9 days for OB
8 patients for the project?

9 **A:** Those average length of stay numbers, that's
10 based on clinical data that I don't typically
11 review unless I have a reason to seek out and
12 evaluate. I did hear testimony that other
13 facilities don't have the same length of stay
14 and -- but I did not -- I don't have any reason
15 to dispute any -- MUHA's analysis of its own
16 internal data and its own predictions about its
17 own patients. Those are clinical realities
18 that really are outside of the scope of what I
19 would look at unless I really had to. And in
20 this case I didn't feel like I had to.

21 **Q:** This ---

22 **A:** Again, if there are -- if they're
23 miscalculations as to the average length of
24 stay, the market itself is prepared to absorb
25 -- to mitigate any of those miscalculations

1 that might occur, if they occur, based on, you
2 know, an average length of stay that turns out
3 to be shorter than MUHA predicted.

4 **Q:** There's been some comparisons and analogies of
5 kind of the Mt. Pleasant hospital landscape
6 with the Roper Mt. Pleasant and East Cooper
7 Medical Center struggling with lower
8 utilization. What distinctions, if any, are
9 there with the addition of MUHA Berkeley to the
10 north area?

11 **OBJECTION:**

12 **MS. HOLLINGSWORTH:** And, Your Honor, I would just
13 object on foundation. This witness is not an
14 expert, so I would ask first that he establish
15 how she would know anything about those
16 applications from prior to her time at the
17 Department.

18 **THE COURT:** Sure. Any response?

19 **MR. WICEVIC:** I'll lay the foundation.

20 **THE COURT:** Okay.

21 **Q:** Ms. Murdock, are you familiar with the Mt.
22 Pleasant Hospitals?

23 **A:** I am familiar with the Mt. Pleasant Hospital.
24 I have access to the -- well to prior State
25 Health Plans to other CON records and also the

1 Joint Annual Report data that is available
2 going back all the way, I think, to 2006 or
3 2007, and I have reviewed that data. I've
4 reviewed the Joint Annual Reports of the Mt.
5 Pleasant Hospital, of the East Cooper Medical
6 Center, of all the hospitals in the Tri-County
7 area. In particular the Mt. Pleasant
8 Hospital's JAR data in relation to the JAR data
9 of Roper Hospital itself.

10 Q: Okay. Did you see the arguments in opposition
11 material about this analogy?

12 A: I -- not -- yes. Yes, I did.

13 Q: Okay. What distinctions, if any, are there
14 with the addition of MUHA Berkeley Hospital?

15 A: Well, the most significant distinction that I
16 noticed is that the utilization of -- the Mt.
17 Pleasant Hospital was a transfer of beds from
18 Roper Hospital out to the Mt. Pleasant
19 location, much like the plan for the Roper
20 Berkeley Hospital. And in the case of the Mt.
21 Pleasant Hospital, Roper Hospital, the mother
22 hospital, I don't want to say parent because
23 that has all sorts of other connotations, but
24 the main hospital from which the beds were
25 going to be transferred to Mt. Pleasant

1 experienced a decline in utilization every year
2 from whichever year I started with, 2006 or
3 2007, it experienced a decline every single
4 year all the way to -- I think there was one,
5 2011 maybe or 2012, where the utilization
6 bumped up and then it fell back down again. So
7 Roper's utilization was declining at the time
8 it was transferring those beds to the Mt.
9 Pleasant area. So what's different in the case
10 of this project is that MUHA's utilization has
11 been increasing, and, you know, MUHA, rather
12 than seeking out patients to increase its
13 utilization, you know, it's needing to -- its
14 word is decant, patients from its already
15 arguably over utilized downtown hospital by
16 putting the beds out in the community. I
17 believe that this population and utilization
18 growth is also more rapid and explosive than it
19 was over in Mt. Pleasant. I did not study the
20 causes of the differences in the population
21 growth but certainly it makes sense that,
22 again, Mt. Pleasant is over near the coast and
23 it doesn't have as many places to grow as the
24 Highway 26 corridor where the population is in
25 -- resulting ED and inpatient hospital

1 utilization is growing explosively. So it's
2 really not a similar comparison. You had a
3 hospital that was -- that had -- you know, that
4 was declining in utilization seeking to put
5 resources where maybe the patients -- where it
6 might hope the patients would utilize it more
7 as opposed to this scenario where there's
8 already a strong patients base and increasing
9 utilization at MUSC.

10 Q: Do you have anything else to add about
11 community need documentation?

12 A: No.

13 Q: Okay. Let's move on ---

14 A: You'll all be relieved to know the answer is
15 no.

16 Q: Let's move on to distribution accessibility.
17 What was your finding with regards to
18 distribution accessibility?

19 A: That the project complied with that criteria as
20 well.

21 Q: Okay. And what was the basis for that finding?

22 A: Well, this criteria has several sub-parts, some
23 of which are more applicable than others. But
24 basically this criteria deals with the
25 distribution of healthcare resources and this

1 is where the analysis into whether or not
2 duplication is unnecessary is really done in
3 connection with this project or, you know, any
4 project with this criteria. There is
5 duplication. This project is going to be
6 located, I think, between four and six miles
7 from the Roper Berkeley Hospital, so that is
8 duplication. And so the question is, is that
9 duplication unnecessary? And based on a lot of
10 the factors that I've already discussed I found
11 that the duplication was not -- was justified
12 and not unnecessary.

13 As far as serving medically under served
14 areas, we talked a little bit about whether or
15 not Berkeley County was under served. It's --
16 now that Roper Berkeley is there, it is less
17 under served than it was but the need is
18 greater than just that new 50 bed hospital
19 based on all the data and all the trends. So,
20 again, it's -- the area of the proposed project
21 is less under served than it was, but it's
22 still under served.

23 The location is right -- it's not far off of
24 Highway 26 so it should be relatively easy to
25 access. One concern in that area is flooding,

1 weather events and things like that. And so it
2 being -- it's located in an area that I think,
3 based on what -- on some research that I did,
4 would be a fair amount more protected from
5 flooding and other weather events than the
6 downtown campus. And that, you know, as far as
7 necessary support services and things like
8 that, it makes -- that helps with compliance
9 with that part of the criteria. The
10 application document, you know, the proposed
11 facility was -- is not gonna restrict
12 admissions. You know, that's pretty standard
13 for a facility of that type.

14 The applicant documented the means of access.
15 And going down to the negative impact of the
16 proposed project upon the ability and/or
17 resources of existing providers to serve
18 medically underserved areas. Again there's
19 that -- the existing provider's language. At
20 least it doesn't say existing hospitals. But,
21 you know, in this case there may be, and
22 hopefully will be, at least some element of a
23 market share shift that I, based on the data
24 and everything that I've already discussed, I
25 didn't think that that impact would affect the

1 ability of existing providers to fulfill that
2 part of their duty.

3 Q: Moving back to 3A where it's talking about
4 duplication of services, is this an area where
5 you would consider CON approved but not yet
6 operational ---

7 A: Yes.

8 Q: --- hospitals?

9 A: Yes. And this is the -- this is the criteria
10 that allows me to focus on Roper Berkeley,
11 which I really considered the entity that
12 needed the most intense analysis as to whether
13 or not this project would adversely effect that
14 soon to be hospital. And so I did go back and
15 did an in-depth review of the Roper Berkeley
16 application. I looked at the need projections,
17 the analysis that went into how that applicant
18 came up with its own projections, its own
19 utilization projections. I looked at, in
20 particular, the population trends, and based on
21 everything that I saw in that application, what
22 I wanted to do was to verify that that
23 applicant and that -- well that entity, would
24 be able to do what it set out to do in its
25 initial application even in light of this new

1 approved project. And so there are a lot of
2 things that went into that analysis. We've
3 talked about the explosive population. Due to
4 the passage of time in between the submission
5 of that Roper Berkeley application and the
6 review of this MUHA project, the population had
7 just blown through the roof with all the
8 intervening -- or projections starting from the
9 time of that application all the way up to day.
10 And so my determination was that there are
11 enough -- there's enough market there to
12 preserve the goals of that Roper Berkeley
13 project. And that this MUHA project is, you
14 know, after the passage of time, is based on a
15 recognition that there's a new reality and more
16 need now than there was then.

17 Q: Anything else with regard to distribution
18 accessibility?

19 A: No.

20 Q: Okay. Moving on to the next criteria, ability
21 to complete the project, what were your
22 findings with regards MUHA's compliance with
23 14A?

24 A: I found that MUHA complied with 14A. The
25 timeline was reasonable. You know, the

1 financial schedules, which are kind of the pro
2 forma. You know, how much is it gonna cost,
3 what's the money being spent on? Looking at
4 that in light of the projected utilization of
5 the facility. All of that was consistent with
6 other similar projects. And I did look at
7 other projects to see what the timelines were
8 and what the cost versus -- in light of the
9 project just to see if there are any red flags
10 or outliers in this particular application that
11 struck me, and none did.

12 In addition, based on the history of the
13 other projects in that area and the ability to
14 complete the project, I think just thinking of
15 it in light of what a resident of that area
16 might be thinking about, if there's been a
17 significant delay in implementation of the
18 projects there. Roper has fought tooth and
19 nail to finally get this hospital up and
20 running and, thank goodness, it did. And then
21 there's another approved hospital in Berkeley
22 County that that applicant has had some trouble
23 -- Trident has had some trouble getting that
24 project off the ground. As far as I know it's
25 still not near -- they haven't broken ground on

1 that. And based on some testimony about a
2 possible change of ownership and the timing of
3 that, that -- the whole CON itself might be
4 void. We don't know yet and we'll need to look
5 into that some more, but there are some
6 significant concerns about that Berkeley
7 Medical Center project right now as we sit here
8 today.

9 MUHA, on the other hand, has applied for,
10 received approval for, moved forward with and
11 completed multiple recent large scale projects.
12 They've built a, kind of a comprehensive
13 ambulatory facility, a pediatric facility in
14 North Charleston. They have -- they are near
15 completion of the Shawn Jenkins to replace the
16 Children's Hospital. They're replacing the
17 hospital. They have several other projects
18 that they've received approval for and built.
19 There are some that are still experiencing
20 delays. One ambulatory surgery facility in
21 particular, but the reason for that is because
22 MUSC is waiting for another facility to finish
23 their own CON project and move out of that
24 space so that MUHA can move in. But MUHA has
25 a good track record of moving forward and

1 completing projects, even big projects that
2 we've approved.

3 Q: When, if ever, have you ever looked at the bond
4 rating of a CON applicant?

5 A: I have not.

6 Q: You mentioned some other hospitals'
7 applications and schedules, timelines you've
8 looked at. Can you -- do you recall which
9 ones?

10 A: I recall a few. Probably not all of them. I
11 looked at several other CON records for several
12 things looking at time frames, looking at cost
13 and looking at per bed cost trying to get a
14 sense of this project in terms of the sort of
15 the over-arching cost containment analysis.
16 It's an expensive -- it's a high price tag.
17 And so in looking at cost containment, we have
18 to look at the capital expenditure going into
19 the project in light of the results and the
20 effect of that cost on, in particular, the
21 public among other things. And so I looked at
22 Roper Medical Center and Roper Berkeley of
23 course. And I looked at the Summerville 30 bed
24 addition. I looked at the Lexington Medical
25 Center 71 bed addition. It wasn't a new

1 hospital but it was a 400-plus million dollar
2 expansion project that did several things,
3 including adding 71 beds. And then the most
4 recent was Trident's six bed addition. That's
5 a 22 million dollar six bed addition. And in
6 addition to finding that this project was sort
7 of in line with what's typical regarding time
8 frame, I also found that it was in line with
9 what's typical in terms of the per bed cost of
10 the project. In fact the per bed cost was
11 certainly lower than the Lexington project and
12 lower than, I believe, both Berkeley Medical
13 Center and Roper Berkeley when you look at --
14 when you compare -- do an apples to apples
15 comparison of the construction and equipment
16 cost compared to the number of beds associated
17 with the project.

18 Q: Was that one of the questions you had for Mr.
19 Levitt?

20 A: I don't know if I asked him that directly but
21 he did provide me with some of that
22 information. I think I may have asked him if
23 he knew off the top of his head or even if he
24 had a copy of the -- that part of the Roper
25 Berkeley application, but as it turned out I

1 found my copy of it, it was in my office.

2 Q: Ms. Mur- ---

3 A: But -- I'm sorry. Yeah, yeah. So some of that
4 was sent to me by Mr. Levitt, but I did go and
5 kind of verify some of those numbers and looked
6 at some other projects independently of that.

7 Q: Mr. Bupp, can you pull up page 975 of DHEC 1.
8 (DHEC Exhibit Number 1 was referenced at this time.)

9 Q: Is this the referenced comparison of various
10 hospitals in Berkeley County?

11 A: Yes. That's for those three, for those three
12 projects. And you can see there's a total
13 project cost and then there's a construction
14 and equipment cost. And in the CON application
15 there's a -- in Part A of the application,
16 there's an area where you -- where the
17 applicant completes information about per bed
18 cost and the per square foot cost and
19 oftentimes it is -- that cost is -- those
20 numbers are generated based on the construction
21 and equipment cost of the project. There's
22 another cost associated with, you know, fees
23 and financing and things like that that might
24 not go into the construction and equipment
25 number. So in an attempt to compare apples to

1 apples, I went with the data that was most
2 readily available and most frequently available
3 which was the construction and equipment per
4 bed cost.

5 Q: Let me ask you this, what requirements are
6 there concerning a CON applicant needing to
7 have a guaranty for funding?

8 A: There's no requirement that there be a
9 guaranty. Everything about a CON application
10 is a prediction or a projection. And there's
11 certainly no guarantee that any applicant is
12 going to receive approval for any CON project.
13 So, it would not be in keeping with cost
14 containment principles to expect applicants to
15 make moves. And I'm not saying that this would
16 necessarily be, you know, an issue in securing
17 your guaranteed funding, but as far as the
18 executed lease agreements, other third-party
19 relationships, things like that, we don't
20 require, unless we absolutely have to, we don't
21 require an applicant to go so far down a road
22 regarding financing or land or anything else
23 without knowing whether or not it's even gonna
24 have approval to do that project. So we're
25 looking for a reasonable prediction. Something

1 that is reliable as much as a prediction can be
2 reliable.

3 Q: Okay. One of the main opposing arguments was
4 consideration of a project review criteria, 23,
5 adverse effects. How did you consider that?

6 A: Well, I didn't include it on the deemed
7 complete letter, but it is an oft raised
8 opposition argument. We have a lot of CON
9 cases that adverse effects on other facilities
10 should have been included in the deemed
11 complete letter. And I always or -- unless
12 there -- unless there's really no reason to,
13 and usually there is, do that analysis
14 regardless, but I do it in light of the whole
15 kind of the landscape of existing and approved
16 facilities. The criteria itself is limited if
17 it requires considering the impact on the use
18 rates and balancing that against the increased
19 accessibility offered by the proposed services.
20 The language of the criteria really only
21 requires weighing one against the other. It
22 doesn't prescribe a result. And so part of any
23 CON analysis, part of the analysis into whether
24 or not there is unnecessary duplication
25 necessarily involves looking at what the effect

1 might be on other facilities. And for other
2 facilities, most of the time, the current --
3 their currency is what's -- what is their
4 occupancy rate, what is their use rate? And so
5 you can do the -- you can only look at the
6 current occupancy and use rates of facilities
7 that actually have patients. And so it's hard
8 to do that with a proposed facility that
9 doesn't have any utilization data. You can
10 look at projected occupancy rates, but again it
11 has to be an existing facility. So I do this
12 analysis, but I do this analysis as part of the
13 duplication, unnecessary duplication analysis,
14 both in the criteria of distribution and
15 accessibility and through the lens of the core
16 purposes of CON, which are always the
17 fundamental, you know, sieve through which all
18 the analysis goes, all this data goes through
19 those core purposes.

20 The staffing, again talks about existing
21 facilities, but staffing is another part of
22 this adverse effects criteria. It's also --
23 it's important and, you know, I did review this
24 application in light of the nationwide and also
25 statewide staffing shortage, particularly

1 nursing staff. So I looked again at the
2 applicant's plan, at the applicant's history.
3 Then I looked at the existing facilities and,
4 you know, how those existing facilities, in
5 particular the Trident Health System staffs its
6 facilities. What sort of staffing resources it
7 has and if you -- most, if not all, of the
8 Trident System CON applications talk about its
9 relationship to HCA, it's a nationwide or --
10 maybe not nationwide -- but it's a very large
11 scale entity that involves a lot of hospitals,
12 a lot of facilities. And so based on the
13 Trident Health System's own touting of its
14 staffing reality, I was less concerned about
15 the effects of staff in that system than I
16 might be on a smaller community hospital or
17 some other type of facility. I also looked at
18 the staffing plan of the Roper Berkeley
19 project. That's a transfer of beds so, you
20 know, there would -- there will be some element
21 of transfer of corresponding staff and
22 resources. It's certainly not -- it wouldn't
23 be a neat and tidy, you know, one to one
24 transfer, but that at least was part of what I
25 looked at and alleviated a little the concerns

1 about the effect that this might have on
2 staffing the new hospital, the new Roper
3 Berkeley hospital. So I did a lot of that
4 analysis but didn't make findings on it because
5 of the limitations of the project review
6 criteria itself, the language of the project
7 review criteria itself.

8 Q: Okay. Home stretch. Section 501, Findings.
9 Are these applicable to this project?

10 A: Yes.

11 Q: And why is that?

12 A: Because the -- they're applicable to a new
13 institutional health service, which is a
14 defined term. I don't recall off the top of my
15 head what the definition actually is, but I can
16 find it real quick.

17 Q: That's page 4 of the regulation.

18 A: An institutional health service --
19 "Institutional health services means health
20 services provided in or through health care
21 facilities and includes the entities in or
22 through which such services are provided." And
23 so 501, itself, says, "In the case of any
24 proposed new institutional health service,"
25 which this would be, "for the provision of

1 health services to inpatients," which this
2 would do, "the Department shall not grant a
3 Certificate of Need ... unless" -- "or
4 otherwise make a finding that such proposed new
5 institutional health service is needed,
6 unless:" and then it has a list of
7 requirements.

8 Q: Okay.

9 A: And so some of these -- some of this analysis
10 I already did by virtue of other criteria, but
11 the capital and operating costs of the proposal
12 and their potential impact on patient charges
13 are reasonable. I already had done a fair
14 amount of that analysis looking at the
15 community need documentation and then just the
16 cost containment aspect of the review that
17 always accompanies CON review. The superior
18 alternatives to such services, in terms costs
19 efficiency or appropriateness, regarding the
20 alternatives that -- MUHA did present a couple
21 of alternatives in its application. Off the
22 top of my head I can't repeat them, but I
23 believe it was something like either do nothing
24 or add beds in the downtown facility or
25 implement the project.

1 Q: Mr. Bupp, can we go to page 54, 55 of DHEC
2 Exhibit 1, please. 54, please. Ms. Murdock --

3 -

4 A: Yes.

5 Q: --- (B)(12) explained the alternatives.

6 A: Wrong exhibit, sorry. Oh, I'll just look at
7 this. Yeah. Okay, yes. That's a -- this is
8 a response to a question in the application and
9 the alternatives included here are maintain the
10 status quo, which -- and then MUHA explained
11 why that wouldn't work. And then further
12 expand MUHA's existing hospital base service.
13 And, you know, why it wouldn't work there's a
14 need, there are capacity constraints, things
15 we've already discussed. Further expand MUHA's
16 existing hospital based inpatient services.
17 And that was not a superior alternative because
18 the -- and this is based on the application and
19 my findings as a reviewer that the addition of
20 the beds at the facility would not address the
21 fact that there are so many patients that are
22 actually in the -- proximate to the proposed
23 location of this -- of this new hospital. And
24 since the patients are there, it made sense to
25 put the services there. Also there are a lot

1 of issue already with the age and state of the
2 buildings on the current MUHA campus. It is
3 remarkably costly to renovate down there on the
4 peninsula. It's certainly in their guaranty
5 that renovation of existing facilities will be
6 less costly than building new. I think we're
7 -- Trident is acutely aware of that, in having
8 to spend \$22 million dollars to renovate a
9 floor of its existing hospital that currently
10 has existing patient rooms and patient beds in
11 it. And so that -- those are among the reasons
12 why putting the beds on the peninsula didn't
13 make sense. Also, that's not where the
14 populations is growing as rapidly. The growth
15 is up where the proposed location of the
16 project is. The peninsula is hemmed in.
17 Certainly we're not gaining land as a result of
18 climate change so that the area's not getting
19 any bigger. There really isn't any room for
20 growth, population growth or developmental
21 growth down there. So those are all reasons
22 why it made more sense to put the beds
23 elsewhere.

24 Q: What alternatives did Roper Berkeley and
25 Berkeley Medical Center consider in their

1 applications?

2 A: I believe they were similar alternatives but
3 I'd have to go back and check.

4 Q: Mr. Bupp, DHEC Exhibit 8, please. It's 129,
5 130, please.

6 (DHEC Exhibit Number 8 was referenced at this time.)

7 A: All right. This is the Berkeley Medical Center
8 alternatives response in this application.
9 Alternative one, do nothing. The justification
10 for rejecting that alternative is very similar
11 to what we have here, in that there is a bed
12 need, but the citizens are -- it doesn't make
13 sense to make them travel all the way from
14 where they are to the Trident facility instead
15 of putting the beds where the patients actually
16 are.

17 Oh, I'm sorry. Do nothing, yeah, was just to
18 ignore the fact that there's a need altogether.
19 And, you know, the result of that would be
20 traveling long distances to a highly utilized
21 facility, which if it's an over -- a facility
22 experiencing capacity constraints is gonna have
23 longer wait times, you know, ED overcrowding,
24 things like that.

25 Alternative number two is to add beds to the

1 existing campus. And this response looks at
2 where the population growth is and kind of
3 discusses, you know, why it makes sense to put
4 the beds where the patients already are.

5 Q: Is there anything on the following page, Mr.
6 Bupp.

7 A: And this is the alternative three, is to
8 construct a community hospital.

9 Q: All right. Let's look at the Roper Berkeley
10 quickly. And that's DHEC Exhibit 7, page 39,
11 please.

12 (DHEC Exhibit Number 7 was referenced at this time.)

13 Q: All right. And what were their alternatives?

14 A: Maintain the status quo, and that would mean
15 that the Berkeley County residents would remain
16 without a hospital. And so again, the patients
17 living in Berkeley County are forced to travel
18 to receive care. That was rejected, thank
19 goodness.

20 Repositioning and developing a larger
21 hospital. I think some of it's cut off because
22 I don't think that it was an alternative to
23 establish a hospital in a goose. I think they
24 mean Goose Creek. And I think that was
25 rejected based on, you know, the projections of

1 population growth and size and what would be
2 the appropriate sized hospital. And then the
3 last alterative is to develop this -- the
4 project that they ended up developing.

5 Q: Okay.

6 A: The Roper Berkeley Hospital.

7 Q: All right. The final finding or the final
8 applicable finding is regarding whether the
9 patients will experience serious problems in
10 terms of costs, availability or accessibility.
11 What was your finding and the basis for that
12 finding?

13 A: That -- well, the project complies with that.
14 The serious problems in terms of costs, some of
15 the things we've already touched on. And even
16 if there is geographic proximity to a facility
17 doesn't automatically mean there's access. If
18 that facility is full, then you might be near
19 it but you're gonna experience delays and
20 barriers to care. So that's part of, when you
21 look at the kind of booming utilization and
22 population growth that's putting so much
23 pressure on the Trident system, even though
24 there may be patients that are near those
25 facilities, if they are full or overcrowded or

1 any of those things, then there could be access
2 issues even the patient's right near it. And
3 so -- and then the geographic distance the
4 patients were already traveling, choosing to
5 travel for whatever reason all the way down to
6 the peninsula from up in the area proximate to
7 the proposed location. So those are examples
8 of some of the serious problems that would be
9 experienced without the project.

10 Q: Okay. And then the fifth finding of 501,
11 that's not applicable?

12 A: Yes, this is not a proposal for nursing care
13 services.

14 Q: Okay. Last question. How does MUHA's project
15 further the purposes of the CON Act and
16 regulation?

17 A: Well, the purposes of the Act -- of the -- are
18 the -- and it's the health facility --
19 something like the certification and licensing
20 act, and it comes as more than just Certificate
21 of Need. But the purposes of that Act are to
22 -- are cost containment, preventing unnecessary
23 duplication of facilities and services, guiding
24 the establishment of health facilities and
25 services to best serve the public need, and

1 ensuring access to high quality services by the
2 public.

3 Cost containment we talked about that. Yes,
4 it is an expensive project, but not necessarily
5 unreasonably so. And the advantages of access
6 and some of the other elements of building new
7 in Berkeley County versus attempting to add
8 additional beds and space and floors at the
9 downtown facility, in light of all the other
10 things that we've discussed, the -- I think it
11 does further the cost containment goal of CON.
12 There was no evidence in the application or in
13 the -- in any part of the record that the
14 project itself would increase the financial
15 burden on the patients or the payer. There was
16 nothing that led me to believe that. There was
17 no evidence of that, and that's -- that would
18 definitely be a red flag if it was gonna result
19 in a higher cost to the patient or to the
20 public.

21 Unnecessary duplication, we already talked
22 about that. There needs to be more duplication
23 out there in that area. It makes sense,
24 looking at the Tri-County as a whole, it makes
25 the most sense to add services in that general

1 area. Guiding the establishment of facilities
2 and health services that best certainly meet
3 public need. There's a need for the beds and
4 we've established that the growth and the
5 utilization is happening in the area of the
6 proposed project. So that's that purpose.

7 And then ensuring access to quality services.
8 I think that that purpose is fulfilled by all
9 three of the entities in that area, along with
10 MUSC. I mean there's no question that Roper's
11 -- the Roper system's services with the quality
12 of care is outstanding. Same thing with the
13 Trident system. It is impressive and they have
14 faithfully served, from over the border, have
15 faithfully served the people of Berkeley County
16 for many, many years and they've expended a lot
17 of resources and energy trying to, you know,
18 maintain that faithfulness to meeting the needs
19 of the folks in that area. Like I said, Roper
20 fought tooth and nail to finally get that
21 hospital up and running. And so, you know,
22 thank goodness for the people of Berkeley
23 County that they provided that resource there.
24 And so this particular project, I think, will
25 add to the provision of quality, high quality

1 service to those folks. I think it's a
2 situation where, you know, MUSC has -- is now
3 stepping up to help carry the load that
4 Trident, the Trident system has been carrying
5 for so long and that the Roper folks have
6 fought to join in that, you know, burden
7 sharing and now MUSC is stepping up to the
8 plate too with this project. So all of those
9 facilities are, really as a whole, I think,
10 will work together to further that final
11 purpose of the CON.

12 Q: That's all the questions I have. Thank you.

13 THE COURT: Well that means we're going to break for
14 lunch. 2:15? Thank y'all.

15 (A break was taken from 1:00 p.m. until 2:17 p.m.)

16 COURT REPORTER: All rise.

17 THE COURT: Y'all be seated. Thank you. Ms. Crum?

18 MS. CRUM: Yes, sir.

19 THE COURT: This is going to be a fairly friendly
20 cross-examination.

21 MS. CRUM: And, Your Honorable, I certainly hope
22 it's going to be fairly short.

23 THE COURT: Oh, that's even better.

24 MS. CRUM: I'll tell you what, I'm going to move
25 over here so that when you're looking at me the

1 Judge can hear you.

2 MS. MURDOCK: Okay.

3 MS. MURDOCK - CROSS-EXAMINATION BY MS. CRUM:

4 Q: Ms. Murdock, I'm Liz Crum, and I represent
5 Medical University Hospital -- the Medical
6 University Hospital Authority. And if I ask a
7 question that you don't understand, please let
8 me know so that I can ask it more clearly,
9 okay?

10 A: Okay.

11 Q: Would you get DHEC Exhibit 4, please, ma'am.
12 It's the 2017-18 State Health Plan.

13 A: I have it right here.

14 Q: Mr. Bupp, would you pull up page 27. Would
15 you, please, ma'am, look at the medical -- MUSC
16 Medical Center. It has 602 projected average
17 daily census, correct?

18 A: Yes.

19 Q: And it has a bed need for a 147 beds under the
20 2017-18 plan, right?

21 A: Yes.

22 Q: There is not another hospital -- strike that.
23 MUSC Medical Center has the highest average
24 daily census of any hospital in the 2017-18
25 Plan, doesn't it?

1 MS. HOLLINGSWORTH: Your Honor, I apologize for
2 interrupting. I would object and ask that
3 counsel not ask leading questions of this
4 witness. This is friendly witness and so the
5 use of leading questions are limited.

6 MS. CRUM: I'll be glad to rephrase it.

7 THE COURT: Okay.

8 Q: Ms. Murdock, does the Medical University, MUSC
9 Medical Center, have the highest daily census
10 in the State Health Plan in 2017-18?

11 A: Certainly in the Low Country Region 4. I
12 believe in the whole state. I'm just looking
13 at some of the upstate hospitals.

14 Q: I would direct you to page 24. What is the
15 average daily census for Palmetto Health
16 Richland?

17 A: 521.

18 Q: And was MUSC Medical Center 604?

19 A: Yes.

20 Q: And look at Greenville Memorial Medical Center
21 on page 22?

22 A: Greenville Memorial Medical Center is 546.

23 Q: And how many beds did Greenville Memorial
24 Medical Center need?

25 A: Greenville Memorial Medical Center has a

1 surplus of 18 beds.

2 Q: Okay. And Palmetto Health Richland on 24?

3 A: Palmetto Health Richland has -- let's see, has
4 a bed need of 117.

5 Q: Is it correct that the Medical University
6 Medical Center has both the highest projected
7 average daily census and the highest bed need
8 of any hospital in South Carolina in the 2017-
9 18 Plan?

10 A: Yes.

11 Q: Okay. Ms. Murdock, would you, and Mr. Bupp,
12 would you please pull up the DHEC Exhibit 1
13 starting on page 703?

14 (DHEC Exhibit Number 1 was referenced at this time.)

15 Q: Do you recognize this from the CON DHEC file?

16 A: Yes, this looks like some opposition
17 documentation from Dan Sullivan who was the
18 consultant for the Trident system facilities.

19 Q: Is that -- when you say the Trident system?

20 A: I mean Trident Medical Center, Summerville
21 Medical Center and I believe Colleton, but I'm
22 not sure.

23 Q: Okay.

24 A: On this it just has Trident and Summerville on
25 this letter.

1 Q: And this opposition goes through page 21; is
2 that correct? Well, I'm sorry, Bates -- 723 is
3 the Bates page.

4 A: Yes. The document itself is 21 pages.

5 Q: Look under adverse impact on page 722.

6 A: Okay.

7 Q: Are you aware, under the adverse impact -- is
8 there any quantification of the Trident Health
9 System or CMC that's included of the adverse
10 impact that MUHA would cause?

11 A: I don't recall there being a -- an actual
12 quantification of the adverse impact, just a
13 general allegation of adverse impact.

14 Q: And look, if you would please, ma'am, under the
15 ability to complete the project starting on
16 page 718 and going through 719. I'm sorry it
17 goes through -- it stops at 721. Other than
18 the actual listing of the major capital project
19 that MUHA has, is there any kind of
20 quantification or reason why MUHA doesn't have
21 the ability to complete the project?

22 A: Other than a summary of the capital commitments
23 and then implication that that would inhibit
24 MUHA's ability to complete the project, I --
25 and then a statement about the equivocal nature

1 of the funding commitment, there isn't
2 anything, anything else. It just talks about
3 the kind of Standard & Poor rating and the non-
4 guaranteed nature of the funding and then the
5 kind of general financial state of MUHA.

6 Q: If you'll look on page 718 under 6, financial
7 feasibility?

8 A: Yes.

9 Q: Is there anything that you see that either
10 quantifies or gives reasons why the project is
11 not financially feasible, other than saying
12 it's flawed?

13 A: The -- there's a statement that MUHA is highly
14 leveraged and then a conclusion that the shift
15 analysis is flawed and that because -- and then
16 that would affect the financial projections in
17 the application. But there's no detail or
18 modification just the conclusion that the
19 analysis is flawed.

20 Q: Ms. Murdock, look on page 714, please.
21 Berkeley County is not an under served county.
22 You were here for Mr. Sullivan's testimony
23 yesterday?

24 A: For most of it.

25 Q: Okay. The need analysis, the financial

1 feasibility analysis, the -- his testimony on
2 under served markets, any of that that he
3 testified to yesterday, is any of that
4 presented in this application?

5 A: In this opposition?

6 Q: Yes, sir -- yes, ma'am, in this opposition
7 letter.

8 A: No, certainly not the detail that was presented
9 yesterday.

10 Q: And on pages 712 and 713, there was some
11 discussions on the -- about the East Cooper
12 Medical Center and the Mt. Pleasant Hospital
13 average daily census. Do you see that?

14 A: Yes.

15 Q: This morning Mr. Wicevic asked you about with
16 the move from Roper downtown to Mt. Pleasant,
17 and I think you testified that the -- there was
18 not a need. They were over-bedded in downtown
19 Mt. Pleasant, right? Is that correct?

20 A: I think my testimony was that the -- that
21 Roper's utilization had been declining ---

22 Q: All right.

23 A: --- and had before, during and after the
24 development of the Mt. Pleasant Hospital and
25 the transfer of the beds to Mt. Pleasant.

1 Q: Had Mt. Pleasant at East Cooper bed need -- bed
2 utilization been declining also?

3 A: I don't recall the trend. I think it had
4 either been relatively flat or -- I don't
5 recall that it necessarily had been declining,
6 and it depends on what year span you use. But
7 the utilization percentage of East Cooper was
8 never particularly high.

9 Q: Did East Cooper have a bed need when it applied
10 to do the replacement hospital?

11 A: I don't know. I don't know the answer to that.

12 Q: But we could look in the applicable State
13 Health Plan for that, couldn't we?

14 A: Sure.

15 Q: Okay. All right. Would you look at DHEC 1,
16 Exhibit -- page 967.

17 A: Okay.

18 Q: And on 967 this is a map that Trident's counsel
19 provided to you for the record; is that
20 correct?

21 A: I believe so.

22 Q: Let's look at the legend over here. You've got
23 the HCA facilities at the top, and in the
24 middle you've got the Roper St. Francis, and at
25 the end you've got the other facilities?

1 **A:** Yes.

2 **Q:** And if you look at page 966 in the middle, the
3 e-mail to you, it says, I have attached a map
4 for your ease -- for you to easily discern
5 where the existing and proposed healthcare
6 resources are located in the Tri-County area.

7 **A:** Yes.

8 **Q:** Okay. Look at MUHA -- it says MUSC Medical
9 Center, but it's got an existing hospital on
10 the peninsula; is that correct?

11 **A:** Yes.

12 **Q:** The only other facility on this map, if I'm
13 correct, is the proposed facility; is that
14 correct?

15 **A:** The only other MUSC or MUHA affiliated
16 facility, yes.

17 **Q:** Yeah, okay. Now at Roper St. Francis
18 Healthcare, you see Roper Bon Secours over in
19 West Ashley?

20 **A:** Yes.

21 **Q:** Do you see the Roper Hospital right downtown
22 next door to the MUS -- the MUHA Hospital?

23 **A:** Yes.

24 **Q:** Do you see the Roper St. Francis Hospital,
25 Roper Moncks Corner up 17? Roper St. Francis

1 **Moncks Corner?**

2 **A:** **Yes, yes.**

3 **Q:** **Do you see East Cooper down 17?**

4 **A:** **Yes.**

5 **Q:** **And do you see the Roper Berkeley Hospital up**
6 **on -- up there by MUHA -- up there on ---**

7 **A:** **Yes.**

8 **Q:** **The road, I can't see what the road is.**

9 **A:** **Yes.**

10 **Q:** **Now, with HCA, you see the CenterPointe**
11 **emergency room?**

12 **A:** **Yes.**

13 **Q:** **And do you see the Moncks Corner Medical**
14 **Center?**

15 **A:** **Yes.**

16 **Q:** **And do you see the Summerville Medical Center**
17 **existing hospital?**

18 **A:** **Yes.**

19 **Q:** **And do you see the Summerville -- I'm sorry, do**
20 **you see the Trident Medical Center existing**
21 **hospital?**

22 **A:** **Yes.**

23 **Q:** **Is the proposed Roper -- the proposed Trident**
24 **Berkeley Medical Center as a proposed**
25 **healthcare resource on this map?**

1 **A:** **No.**

2 **Q:** **Looking at this map is the Mt. Pleasant -- I'm**
3 **sorry the MUSC -- MUHA downtown hospital ringed**
4 **by all of the other hospitals?**

5 **A:** **It is surrounded on all the sides that aren't**
6 **water by the other hospitals.**

7 **Q:** **Okay. Thank you, sir. Thank you, ma'am.**
8 **Yeah, it'd be hard to put one out in the ocean.**

9 **A:** **So far, yes, it would.**

10 **Q:** **Okay. Let's go to 741 in DHEC Exhibit 1. Do**
11 **you recognize this letter?**

12 **A:** **Yes.**

13 **Q:** **What is it?**

14 **A:** **It is the -- it is some documentation related**
15 **to opposition of the project, of the MUHA**
16 **project by the Care Alliance entities which are**
17 **the Roper and Roper St. Francis, Bon Secours-**
18 **St. Francis -- the hospitals, all the Roper**
19 **affiliated hospitals.**

20 **Q:** **And the letter submitted by Mr. Richardson on**
21 **behalf of the Roper St. Francis Hospitals, is**
22 **there any quantification of adverse impact that**
23 **MUHA -- the 128-bed hospital would have on the**
24 **facilities?**

25 **A:** **I don't recall there being any quantification;**

1 I'm just looking to confirm that. I don't
2 recall there being any and I don't think there
3 -- no, there's not a quantification there.
4 There's some language about adverse impact and
5 some conclusions but not an actual
6 quantification of what the impact would be.

7 Q: Thank you, ma'am. Would you look at DHEC
8 Exhibit 1, the CON application page 9?

9 A: Okay.

10 Q: And under project review overview, does that
11 say that MUHA is committed to building an
12 integrated healthcare system?

13 MS. HOLLINGSWORTH: Your Honor, I ask that the
14 leading questions -- I object to these leading
15 questions,

16 MS. CRUM: Okay. I'm not sure that was a leading
17 question. I just said does it say that. She
18 could say yes or no. I didn't ask her if it's
19 true.

20 THE COURT: That's correct. I'll overrule that one.

21 Q: Ms. Murdock?

22 A: Yeah, it -- yes, it says MUHA is committed to
23 building an integrated healthcare system.

24 Q: And does it say that the MUHA, that MUHA
25 Berkeley Hospital would establish a natural

1 complimentary component to MUSC's
2 tertiary/quaternary hospital facility that's on
3 the peninsula?

4 A: Yes.

5 Q: Does it also say that a new community hospital
6 in Nexton will provide a range of specialized
7 inpatient and outpatient services?

8 A: Yes.

9 Q: Okay. Flip on over on page 10, under the
10 second paragraph beginning the second. As part
11 of your review of this application did you
12 review the Roper County comprehensive plan that
13 was included in the application?

14 A: Yes, I did.

15 Q: Did the Roper County comprehensive plan, based
16 on your reading, indicate a lack of healthcare
17 facilities providing services for the general
18 population in the county?

19 MS. HOLLINGSWORTH: Your Honor, I just ask that it's
20 not Roper County ---

21 MS. CRUM: I'm sorry.

22 MS. HOLLINGSWORTH: --- for the record if we could
23 just ...

24 Q: Berkeley County.

25 A: It's been a while since I've looked -- since

1 I've reviewed it, but yes, I do believe that it
2 mentioned or set forth a lack of healthcare
3 resources.

4 Q: Look on page 11. I think you've talked about,
5 in response to some of Mr. Wicevic's questions,
6 about the fact that MUHA is heavily utilized;
7 is that correct?

8 A: Yes.

9 Q: And under third and about a third of the way
10 down, it says, the midnight census in the acute
11 care units at MUHA has risen significantly over
12 the past three years with all units averaging
13 90 percent capacity in 2017. Did I read that
14 correctly?

15 A: Yes.

16 Q: Harkening back to the State Health Plan, the
17 2017-18 State Health Plan?

18 A: Yes.

19 Q: I think you testified that there were some beds
20 that weren't -- that were approved but not
21 licensed yet therefore our occupancy was
22 understated, the occupancy rate; is that
23 correct?

24 A: For MUSC, yes.

25 Q: Yes. I'm sorry, when I say our I mean MUSC.

1 **Sorry about that.**

2 **A: I understand. I understand.**

3 **Q: Okay. If you would look, please, ma'am, on**
4 **page 16 and then to 17?**

5 **A: Okay.**

6 **Q: Ownership disclosure form? Under 8B who is the**
7 **licensee of this project?**

8 **A: Medical University Hospital Authority.**

9 MS. CRUM: Your Honor, I would ask that the Court
10 take judicial notice that the Board members of
11 the Medical University Hospital Authority.
12 It's on the website, it's easily attainable,
13 and that the members of the MUHA Hospital
14 Authority Board of Trustee are not the MSCV
15 Board of Trustees.

16 THE COURT: Capable of and ready, but not subject to
17 reasonable dispute because it's commonly known
18 in the territorial jurisdiction of the trial
19 courts, so it wouldn't be that. Or capable of
20 accurate and ready determination by resort to
21 sources whose accuracy cannot be reasonably
22 questioned. So, which one is it?

23 MS. CRUM: I'm sorry, I just couldn't hear you, Your
24 Honor.

25 THE COURT: I was going through the judicial notice

1 provisions of the evidence law.

2 MS. CRUM: I think it is easily verifiable, Your
3 Honor, by looking at the DHEC -- I'm sorry, the
4 MUHA website. They list the Board members on
5 there.

6 THE COURT: Okay. What's your position?

7 MS. HOLLINGSWORTH: And I understand counsel to say
8 she wanted judicial notice that they're
9 different Board members?

10 MS. CRUM: No. That they are not the MSV Board
11 members.

12 THE COURT: I don't think anybody would argue about
13 ---

14 MS. HOLLINGSWORTH: Well, actually, Your Honor, the
15 Board members that serve as the Board -- I
16 mean, they might be the same, right?

17 MS. CRUM: They're not.

18 MS. HOLLINGSWORTH: Well it's not capable of ---

19 MR. SUMMER: I think ---

20 MS. HOLLINGSWORTH: --- determination on the site.

21 MR. SUMMER: I think there might be a distinction
22 here. Are you referring to the MUSC Board or
23 a different Board?

24 MS. CRUM: The MUHA Board ---

25 MR. SUMMER: Right.

1 MS. CRUM: --- which by statute is the MUSC Board.

2 MR. SUMMER: Correct.

3 MS. HOLLINGSWORTH: Right.

4 MS. CRUM: When they declare themselves to the MUHA
5 Board.

6 MS. HOLLINGSWORTH: Right.

7 MR. SUMMER: So are you trying to say that they're
8 not the same people?

9 MS. CRUM: No, the question was asked about the MSV
10 Board of Trustees being incorrectly -- the
11 members being incorrectly put into the
12 application, and I was asking him to take
13 notice of the fact that Ms. Parham was right,
14 that that was incorrectly put in the
15 application, and those are not the members of
16 the Board.

17 THE COURT: I was asking, number one, is that even
18 something that y'all truly dispute. And then
19 we can go into the, take number one, accurate
20 and ready determination by resort to sources
21 whose ---

22 MR. SUMMER: Do you want us just to stipulate that
23 there's an error in the application? I mean,
24 I don't mind stipulating that there's an error
25 in the application.