

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 MS. HOLLINGSWORTH: And I think Dr. Cawley will be
2 clearing it up on Monday. I think that'd be
3 fine and if it can be substituted or something.

4 MS. CRUM: And that's fine. As long as we don't
5 have a -- a argument that this is an incorrect
6 Board and a different licensee. That's what
7 I'm trying to make sure we have clear.

8 MS. HOLLINGSWORTH: Okay.

9 THE COURT: I don't see that as an issue.

10 MR. SUMMER: I don't see that as an issue.

11 MS. CRUM: All right.

12 THE COURT: Mr. Wicevic?

13 MS. CRUM: I'm sorry?

14 MR. WICEVIC: No objection to that issue.

15 THE COURT: You don't see that as an issue as far as
16 ...

17 MR. WICEVIC: No, no.

18 THE COURT: Okay. All right. It's unanimous, Ms.
19 Crum.

20 **Q: Would you look on over to page 39 of the DHEC**
21 **record, Exhibit 1?**

22 **A: Okay.**

23 **Q: Do you see the Figure 17?**

24 **A: Yes.**

25 **Q: New direction? Did you rely on that figure**

1 when you were making a decision to approve the
2 CON application?

3 A: Yes, in part.

4 Q: Okay. And with the -- you were asked about the
5 52 bed hospital this morning. Am I accurate
6 that four, only four of those beds have been
7 implemented?

8 A: Of the CON that was issued in ---

9 Q: '16.

10 A: --- 2015 or 2016?

11 Q: Yes, ma'am.

12 A: For 52 beds?

13 Q: Yes, ma'am.

14 A: I know that four have been implemented and then
15 I'm not certain -- for some reason I have the
16 number 33 stuck in my head as the beds that are
17 left, but I don't know -- I think that may be
18 based on some testimony that I heard earlier in
19 this case.

20 Q: Okay.

21 A: I only recall prior to the trial knowing for
22 sure that four were implemented, but that's
23 just based on memory. I really can't say.

24 Q: And four from 52 is how many?

25 THE COURT: I can take judicial notice of math.

1 **A:** **I guess 48.**

2 **Q:** **Okay.**

3 **A:** **All right.**

4 **Q:** **The plan shows a bed need for MUHA of a 147**
5 **beds, doesn't it?**

6 **A:** **Yes.**

7 **Q:** **And if we put 128 beds in place anywhere in the**
8 **Tri-County area there would have to be staff;**
9 **do you agree with that?**

10 **A:** **If you're licensed and use the beds, yes. You**
11 **set them up, yes.**

12 **Q:** **Let me ask you to look at Exhibit -- DHEC**
13 **Exhibit 7 and page 471.**

14 **(DHEC Exhibit Number 7 was referenced at this time.)**

15 **A:** **Between the chair and these notebooks I'm**
16 **getting a workout over here. All right, what**
17 **page?**

18 **Q:** **471.**

19 **A:** **All right. Okay.**

20 **Q:** **Do you recognize that as the financial --**
21 **financing letter that Wachovia submitted on**
22 **behalf of Roper Berkeley in 2008?**

23 **A:** **Bear with me, it's been a while. Yes.**

24 **Q:** **Look on down to the second paragraph, please?**

25 **A:** **Okay.**

1 Q: If you'd just highlight please, Mr. Bupp, and
2 pan out. Is that a guarantee that the project
3 will be financed by Wachovia?

4 A: I don't believe so. There's some contingencies
5 that have to happen first before there will be
6 any funding.

7 Q: Is one of those contingencies subject to
8 satisfactory completion of a security package?

9 A: Yes.

10 Q: And is there anywhere in the CON Act, the CON
11 regs or the State Health Plan that says what
12 form the DHEC approval letter or denial letter
13 has to take?

14 A: No, not specifically.

15 Q: Is there anything that requires a specific
16 level of detail in the decision letter?

17 A: No, not specifically.

18 Q: Do you have to address all of the project
19 review criteria that were listed in the
20 completeness letter?

21 A: Well, I mean, we have to make findings, but I
22 don't think it says in so many words that we
23 have to make -- have to list all the project
24 review criteria in the deemed complete letter.

25 Q: Thank you very much.

1 **A:** **Thank you.**

2 **THE COURT:** Who's up?

3 **MS. HOLLINGSWORTH:** Me, Your Honor.

4 **THE COURT:** All right.

5 **MS. MURDOCK - CROSS-EXAMINATION BY MS. HOLLINGSWORTH:**

6 **Q:** **Ms. Murdock, it's nice to see you again.**

7 **A:** **Good to see you.**

8 **Q:** **All right, it's my turn. I appreciate you**
9 **being here, and I will be as diligent as I can**
10 **so that I can save a little bit of your**
11 **excitement for one last attorney. But I**
12 **appreciate your time, and I appreciate your**
13 **testimony. So you've been the Department since**
14 **2015, right?**

15 **A:** **Yes.**

16 **Q:** **Okay. And you have reviewed applications for**
17 **CONs during that entire time, correct?**

18 **A:** **Yes.**

19 **Q:** **Okay. So since day one when you came into the**
20 **Department you were reviewing applications,**
21 **right?**

22 **A:** **Maybe like day seven, but, yes.**

23 **Q:** **Okay. And when you started there was a prior**
24 **Director of the program, right?**

25 **A:** **Yes.**

1 Q: Okay. And what training or how did you go
2 about getting training for the review and
3 decision making process for CONs?

4 A: It was all on the job after I came to DHEC, and
5 so there was a lot of research on my own and
6 then some training with Sam Phillips, Robert
7 Phillips, the Director, but most of it was my
8 own research into the law, regs, history, other
9 applications and then some guidance from Sam.

10 Q: And you'd been a member of the Bar and a
11 practicing attorney for several years, right?

12 A: Yes.

13 Q: And when you came the Department, prior to that
14 you'd just worked in private practice as an
15 attorney, right?

16 A: Right.

17 Q: Okay. But would it be fair to say you, from
18 the beginning, familiarized yourself with the
19 Certificate of Need Act?

20 A: Yes.

21 Q: And the regulations as well?

22 A: Yes.

23 Q: Which regulations are the Certificate of Need
24 regulations?

25 A: Regulation 61-15.

1 Q: Okay. And same with the Health Plan, you right
2 away became familiar with that document, right?

3 A: Yes.

4 Q: Okay. And you mentioned, I think, in your
5 direct that throughout the time that you've
6 been with the program that you have a lot of
7 familiarity -- you've gotten familiar with a
8 lot of the parties that are in the courtroom
9 today, right?

10 A: Yes, I'd say so.

11 Q: In terms of the healthcare systems that are
12 here?

13 A: Yes, the systems and the people,
14 representatives, consultants, attorneys.

15 Q: Yeah, okay. And I just want to -- and we'll go
16 through it very quickly and we can stop at any
17 time if we want to look more specifically at
18 documents -- but I'm just going to see what you
19 -- if these are generally your recollection.
20 You're familiar with the, what we call Shawn
21 Jenkins, the replacement children's hospital
22 application for -- I'll try to say Medical
23 University just to keep it clear.

24 A: Okay. Yes.

25 Q: You're familiar with that application?

1 A: I am.

2 Q: But that was slightly before your time, right?

3 A: Yes.

4 Q: In terms of the approval of that application?

5 A: Yes. Yes, it was.

6 Q: And similarly that 52 bed, sort of the backfill
7 application, was that just before your time in
8 2015 that that was approved?

9 A: I believe so, yes.

10 Q: But you're familiar with those projects even
11 just as they've been kind of implemented over
12 time, right?

13 A: Yes, I'm the one that receives the
14 implementation reports and other information.
15 Extension requests, things like that.

16 Q: And good point here to make, you actually, in
17 addition to reviewing applications in the
18 approval/denial process, it's your office that
19 issues the actual certificates at the
20 appropriate time, right?

21 A: Right.

22 Q: And then with regard to sort of the updates
23 that are provided to the Department, and I
24 think at various times the names may change,
25 but who generally gets those like sort of

1 quarterly updates or progress updates on
2 projects?

3 A: It really depends. It's either the reviewer or
4 the -- or myself as the Director, or whoever
5 the person mailing the letter thinks is the
6 Director.

7 Q: Okay.

8 A: Or reviewing.

9 Q: Would it be fair to say that even after sort of
10 the point of decision, your program, the CON
11 program, kind of still continues to touch
12 projects as they go through to the point of
13 being sort of implemented and operational?

14 A: Yes.

15 Q: Okay. So we talked about the replacement
16 hospital and the 52 bed. Now you participated
17 in actually the review of Medical University's
18 pediatric outpatient imaging center, right?

19 A: Somewhat. I -- for lack of a better word, I
20 had -- I inherited some of that. That was --
21 the imaging center was part of a two CON
22 project that also involved a medical office
23 building, so it was a three part project with
24 two Certificate of Need applications, and I
25 became involved in that, in those. More of the

1 ambulatory surgery facility part of it than the
2 imaging center part of it.

3 Q: Okay. So there was an application for an
4 outpatient imaging center and then a separate
5 application for an ambulatory surgery center in
6 the same general location; is that right?

7 A: I believe -- yes.

8 Q: Okay. And the decisions, both, issued, I
9 think, on December 4, 2015. That would have
10 been a few months after you'd gotten to the
11 Department, right?

12 A: That date is, and I believe the decisions were
13 issued around that. I don't recall, but that
14 sounds right.

15 Q: Okay. But are you familiar with those two
16 projects?

17 A: Yes.

18 Q: Okay.

19 A: Yes.

20 Q: And then are you familiar with Trident's ED and
21 OR renovation that would have been right around
22 that same time period, late 2015?

23 A: Yes.

24 Q: Okay. And then there was a -- I never say this
25 right -- musculoskeletal institute project that

1 Medical University had; are you familiar with
2 that project?

3 A: Somewhat, and congratulations on the perfect
4 pronunciation.

5 Q: It's a big font.

6 A: I didn't review that project myself ---

7 Q: Okay.

8 A: --- but I'm familiar with it.

9 Q: All right. And then there were some -- a
10 series of home health applications that Medical
11 University did with Bayada; are you familiar
12 with those applications?

13 A: Yes.

14 Q: Okay. And did you assist with the review of
15 those?

16 A: I believe I was the primary reviewer on all of
17 those or most of those.

18 Q: Okay. And those projects, they were actually
19 beyond the Tri-County, right? They actually
20 set up home health -- they were proposed home
21 health outside the Tri-County area; do you
22 recall that?

23 A: They had to be because there were more than
24 three.

25 Q: Yeah, okay. All right. And then -- and I

1 think you testified this morning you were
2 involved in the review of the freestanding
3 emergency department proposals by both
4 Summerville and Medical University, right?

5 A: Right.

6 Q: Yeah, and I think you testified this morning
7 you approved both those applications?

8 A: Yes.

9 Q: Okay. And then I think maybe Mr. Eubank has
10 also had a few Low Country applications during
11 the times that you've been there. Are you
12 familiar with like Roper St. Francis's
13 replacement and relocation of our freestanding
14 emergency department in North Charleston?

15 A: The Northwoods?

16 Q: In Northwoods?

17 A: Yes.

18 Q: Okay.

19 A: Again, that wasn't mine but I'm familiar with
20 the project.

21 Q: Okay. And then, too, I guess we have an
22 ambulatory surgery center in Mt. Pleasant that
23 Medical University sought; are you familiar
24 with that one?

25 A: Yes, that was actually two different

1 applications. They were -- we denied the first
2 one and then granted the second one.

3 Q: And the Mt. Pleasant ASC for short, is that the
4 one that you were mentioning has been delayed
5 because sort of another applicant is needing to
6 fulfill a project of their own or were you
7 referring to ---

8 A: That's what I was referring to. It's been some
9 time but the last time I checked the
10 Southeastern Spine Institute was going to
11 vacate the location that that project was going
12 to use as its location. And so Southeastern
13 Spine Institute is building a facility on East
14 Cooper Campus and that -- so one had wait for
15 the other to finish.

16 Q: Okay. And then I think Medical University had
17 some linear accelerator projects, right?

18 A: Yes.

19 Q: And are you familiar with those projects?

20 A: Yes. They were -- there were several.

21 Q: Okay. What -- did you ultimately approve a
22 proposal for linear accelerator services in
23 Berkeley County by Medical University?

24 A: Yes, that was the final one and we approved
25 that one.

1 Q: Okay. And earlier you mentioned that Medical
2 University, I think, was the recipient of a
3 couple of your denials. Was that -- were some
4 of the lin-ac projects what you were speaking
5 to?

6 A: One of them was a lin-ac project and the other
7 one was that ASC.

8 Q: Okay. All right. And then at that same,
9 around that same time with the linear
10 accelerator project for Berkeley County, did
11 you also review an application that Roper St.
12 Francis filed for linear accelerator services
13 in Berkeley County?

14 A: Yes.

15 Q: And then there were some projects for
16 conversion of NICU bassinets; do you remember
17 those?

18 A: Yes.

19 Q: All right. And did you review those?

20 A: Yes.

21 Q: All right. And I think we have some, you know,
22 sort of an equipment project here and there,
23 but would that -- does that sort of generally
24 summarize that familiarity you were referencing
25 in terms of your familiarity with the parties,

1 the providers in this case?

2 A: Well those are certainly examples of
3 opportunities I had to become familiar with the
4 entities and those health systems in that area.

5 Q: Okay.

6 A: Just through review of quite a few of their
7 projects.

8 Q: Okay. But did I miss any sort significant ones
9 that jump out to your mind in terms of, you
10 know, you remember well or you remember detail
11 about the parties or their positions or
12 anything?

13 A: I can't say for sure. We have a lot of cases
14 and so -- that sounds -- it sounds like you've
15 got most of them. There were several robotic
16 arms for the Trident system facilities and the
17 radio surgery technology package for one of the
18 Roper St. Francis entities. And then there was
19 a -- the Low Country Rehab rehabilitation
20 hospital that was a Roper project. That's all
21 I can think of.

22 Q: Okay. All right. And I think during the time
23 period up to the point of your decision, I
24 think there was also Trident had submitted a
25 proposal for establishing a freestanding

1 psychiatric hospital and behavioral health
2 unit. And I think may Mr. Eubank reviewed that
3 one; are you familiar with that project?

4 A: Yes. And there was also like a -- there's an
5 interventional radiology project, an EP lab.
6 The more I think, I mean, I could do this for
7 a while, but I'm pretty sure you hit the
8 highlights, but I'm not sure that's a full
9 list.

10 Q: Okay. Any other, though, hospital projects
11 involving these parties in terms of
12 construction of a hospital, a new hospital or
13 even a hospital tower?

14 A: Well I've only done one new hospital, so.

15 Q: And that would be this application, right?

16 A: Yes.

17 Q: Okay.

18 A: So, no, I don't think so.

19 Q: Okay. So in terms of the sort of project
20 expense or cost of a project, did any of those
21 ones that we've just talked through, are any of
22 them comparable in expense to the proposal of
23 Medical University in this case?

24 A: No. As far as the total project cost?

25 Q: Right. The 325 million dollars?

1 A: No, none of those in the Low Country.

2 Q: Okay. All right. And so this application, if
3 we could take a look at DHEC 1, I think it's
4 CON 1018. And you might want to -- I always
5 think it's easier to have the paper in front of
6 you. Do you have that? Okay.

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

8 Q: So we're in the record for this application.
9 Now as -- once it was sort of assigned to you
10 after it kind of came in in that very initial
11 processing that was done, where does the
12 physical file live?

13 A: Well, its primary home is in a file cabinet,
14 the paper file.

15 Q: Okay.

16 A: It's in a blue binder in a file cabinet in our
17 program areas files.

18 Q: Okay. So when you have an application that
19 sort of is being reviewed by you, and I don't
20 want to say under review because I know that
21 sort of ---

22 A: Right.

23 Q: --- technically is a specific time. But say
24 from the time of receipt until you issue a
25 decision, the hard copy, the three ring binder

1 that I've learned a lot about with the red
2 pages and the tabs, the ones that you're
3 reviewing, you keep them in the file cabinet?

4 A: It depends on -- it'll be in my office or in
5 the file cabinet ---

6 Q: Okay.

7 A: --- usually.

8 Q: But there's typically only sort of only one
9 master hard file, right?

10 A: Yes.

11 Q: All right. And so what we have up here on the
12 screen, and I know you briefly touched on this
13 with Mr. Wicevic, but this is the State
14 Register in which the Berkeley County hospital
15 proposed by Medical University was published as
16 accepted for filing, right?

17 A: Yes, I believe so.

18 Q: And we can scroll down ---

19 A: Yeah, I just don't see the ---

20 Q: --- a little bit.

21 A: --- yeah, there it is.

22 Q: Yep, right there. Okay. So is that correct?

23 A: Yes.

24 Q: And now -- and you mentioned this a little bit
25 too, but there's, I think you called it a lag

1 time, right, between when you have to tell the
2 State Register what information you want to
3 publish in the register and when it actually is
4 out into the -- provided to the public, right?

5 A: Right.

6 Q: Okay. And I think we have -- we might have
7 just a demonstrative because I think it's
8 sufficient to be in the -- demonstrative ...
9 But I have -- this actually is the March 23rd,
10 2018 State Register, but really the point is
11 just to the bottom there. 2018 Publication
12 Schedule. Can you explain to the Court what
13 that is or what those dates mean to you in the
14 State Register.

15 A: It looks like what it says it is, a publication
16 schedule for the State Register.

17 Q: Right. So for the January 26th, 2018 State
18 Register that we saw this application was
19 accepted for filing, you had to submit that
20 information to the State Register on or before
21 January 12th; is that right?

22 A: As I know it, it has to be the Thursday -- I'm
23 sorry, the Thursday before the second Friday of
24 the month. So if that's that, that's our
25 deadline.

1 Q: Okay.

2 A: That's ...

3 Q: Thursday before the second Friday?

4 A: Yes.

5 Q: All right. And so then similarly, for the
6 March 23rd, 2018 State Register that would have
7 been on or before March 9th of that -- in that
8 month, right?

9 A: Yes.

10 Q: And I think -- and it might be at DHEC you
11 might even have a couple days before that that
12 you might follow internally to get the
13 information circulated?

14 A: That would make sense.

15 Q: Okay.

16 A: Yes.

17 Q: All right. And so this State Register is in
18 the application at DHEC 1 CON 1020. So is it
19 your recollection that this application was
20 published deemed complete March 23rd, 2018?

21 A: I believe so.

22 Q: Sure.

23 A: Yes, according to this.

24 Q: It's dated at CON 1021?

25 A: Yes.

1 Q: Okay. And so that information, at least two
2 weeks before and as we look at that State
3 Register page that would be March 9th, of 2018,
4 that's when you had to provide the information
5 in order to say that you wanted this project,
6 this application, to be published in the State
7 Register; is that right?

8 A: Right. The Thursday before the second Friday.

9 Q: Okay.

10 A: And this is the fourth Friday, the 23rd.

11 Q: Right. The State Register comes out the last
12 Friday of the month.

13 A: The fourth Friday of the month.

14 Q: The fourth Friday?

15 A: Yeah.

16 Q: Okay. And in terms of, just to kind of orient
17 ourselves again, the application came in the
18 door December 27th, right?

19 A: I think so, yes.

20 Q: Okay. And so as of March 23rd, you'll agree
21 with me that the public was notified that the
22 Department had deemed the application complete,
23 right?

24 A: Right.

25 Q: And I think if you look at page 1021 just where

1 that State Register language is, you would
2 agree with me that it says, affected persons
3 are hereby notified that the following
4 projects' applications have been deemed
5 complete and the review cycle has begun, right?

6 A: Right.

7 Q: And this starts your clock that we talked
8 about. That you have to wait at least 30 days
9 but then no later than 120 days you have to
10 issue a decision on the application, right?

11 A: That's right.

12 Q: Okay. Take a look at DHEC 1 CON page 1000.
13 All right. We talked about this a little bit
14 this morning, I mean, into the afternoon. I do
15 lose track of time.

16 A: That's all right.

17 Q: This is your deemed complete letter, right?

18 A: Yes.

19 Q: And you touch on some of this this morning. We
20 know that it's dated May 21, 2018. And this is
21 the letter that notifies the applicant of the
22 review criteria that you consider most
23 important for your review of the project,
24 right?

25 A: Right.

1 Q: And I think you might have a copy up there. Do
2 you have the regulation with you?

3 A: Yes. I do.

4 Q: You're one step ahead of me.

5 A: I'm never far from Regulation 61-15.

6 Q: Yeah, 61-15. Take a look, and I think it
7 starts at 303. So -- and I think you have a
8 different version than our fancy one on the
9 screen. But looking at Section 303, and this
10 is within the CON regulation, right?

11 A: Right.

12 Q: Okay. And the title is payment of filing and
13 application fees.

14 A: Yes.

15 Q: What is the process here that the Department --
16 the Department's regulation provides with
17 regard to this deemed complete letter?

18 A: Well, the app- -- when the application is
19 determined to be complete, the Department shall
20 invoice the applicant by certified mail for the
21 Certificate of Need application fee. Then the
22 applicant has 15 calendar days from the date of
23 receipt of the invoice to pay the fee. And
24 then if the fee's not received within 15
25 calendar days from receipt of the Department's

1 invoice by the applicant, the application will
2 be considered withdrawn.

3 Q: Okay. And your deemed complete letter, it
4 included an invoice, right?

5 A: Yes, it should have.

6 Q: And you mentioned three fees this morning but
7 sometime two are only applicable. Which --
8 tell me where this application fee falls in
9 those three you described?

10 A: The application fee is based on the total
11 project cost.

12 Q: Okay.

13 A: It's one half of one percent or .5 percent of
14 the total project cost and it's capped at
15 \$7,000, I think.

16 Q: Okay. And so is that separate than that \$500
17 fee that comes in the door ---

18 A: Yes.

19 Q: --- in order to be accepted for filing?

20 A: Yes, it's a separate fee.

21 Q: All right. And so we've got the deemed
22 complete letter is dated May 21st, 2018. And
23 you discussed this morning that there was sort
24 of a point in time when you realized that -- I
25 think what you said was you couldn't determine

1 whether or not the letter, the deemed complete
2 letter went out on this date; is that what you
3 said?

4 A: That's correct.

5 Q: Okay. Take a look at -- just go forward a
6 couple pages actually in the application. So
7 I think it's actually on 1002.

8 A: Okay.

9 Q: So towards the middle of the page -- I mean,
10 that's the invoice we were just talking about,
11 right?

12 A: Right.

13 Q: And what's the date of the invoice?

14 A: Let's see, July 10th, 2018.

15 Q: Okay. So, was the letter recreated when it
16 went out in July or what happened?

17 A: The letter was not recreated. I found the
18 letter itself, a copy of it. I think it was a
19 copy of it, it may have even been the original,
20 which would explain a lot, but I found it on my
21 desk.

22 Q: Okay.

23 A: And under some things, so when I found it and
24 noticed that there wasn't -- they -- the little
25 article number at the top which is what we --

1 how we track the certified mailing, I wondered
2 what was going on. I don't recall the sequence
3 either both Mr. Thomas and Ms. Crum or one or
4 the other, they both eventually alerted me that
5 they had not received copies of the deemed
6 complete letter, but I don't remember if that
7 was before or after I found the actual letter
8 itself on my desk without an article number at
9 the top.

10 Q: Okay. Take a look at Roper St. Francis Exhibit
11 37. If we could pull that up.

12 (Roper Exhibit Number 37 was referenced at this
13 time.)

14 Q: And if please get it on -- you can do the whole
15 screen, but this is a document that was
16 produced in discovery by the Department and I
17 think we talked about it earlier, but who's Nic
18 Gerrald?

19 A: Nic was a member of the CON staff; he's not
20 longer on the staff. He was our administrative
21 professional who covered all things ---

22 Q: Is he the one that you lost to marriage ---

23 A: Yes.

24 Q: --- is that rat?

25 A: Well, good grief, this is even smaller.

1 Q: When you were preparing for this case and
2 preparing even for trial, did you discover that
3 the payment fee wasn't paid by the MUHA Medical
4 University until July of 2018, July 13th; were
5 you aware of that?

6 A: Are you asking me when I was aware of that, or?

7 Q: Yeah, were you aware of it before now?

8 A: I knew that this was -- I became aware of this
9 e-mail in the ramp up to this case.

10 Q: Right. This case or was it the hearing? Do
11 you recall? Do you recall if you read this
12 before coming for testimony or did you realize
13 it during discovery itself?

14 A: I didn't realize it. It was pointed out to me.

15 Q: Okay. And what, if anything, do you recall
16 about not getting payment from Medical
17 University shortly after the May 21st date?
18 Did that -- did you realize at the time that
19 you didn't get the invoice payment on the
20 application fee?

21 A: That wasn't even a -- no, I didn't realize
22 anything about the invoice. Clearly, I didn't
23 even realize anything about the deemed complete
24 letter itself, so, no, the invoice and the
25 payment of invoice was never an issue, and I

1 had not seen this e-mail, and nor was I aware
2 of this communication between Nic and Jessica
3 Gage before the end of the kind of -- close to
4 the close of the discovery period in this case.

5 Q: Okay. Take a look back at the regulation if
6 you would at 305, Section 305 of Regulation 61-
7 15.

8 A: Yes.

9 Q: Looking at 305, Section 1, do you agree with me
10 that the Regulation states, upon determination
11 by the Department that the application is
12 complete and receipt of the application fee,
13 the Department shall publish in the State
14 Register a notice that the review cycle for the
15 project has begun?

16 A: Yes.

17 Q: And so the -- in this case, though, you
18 published it as deemed complete on March 23rd,
19 right?

20 A: Right.

21 Q: So why is it that the application was published
22 and deemed complete in March but the
23 application fee wasn't paid until July?

24 A: I believe it was because in error I had
25 neglected to see to it that the deemed complete

1 letter got mailed out timely.

2 Q: Okay. Well, your deemed complete letter's
3 dated May 21st, right?

4 A: Right.

5 Q: But March 23rd is still before that, isn't it?

6 A: I should say that, again, in error, I didn't
7 even see to it that the deemed complete letter
8 was even written before the deemed complete
9 notice went in the State Register.

10 Q: Okay. 'Cause you'll agree with me once you
11 publish it in the State Register you're on the
12 clock, right?

13 A: Right.

14 Q: And so in this case the Regulation is setting
15 up that the clock's not starting until you've
16 informed the applicant of the review criteria
17 and you've gotten the application fee back,
18 right?

19 A: Well the Regulation says that the clock starts
20 when the deemed complete notice goes out.

21 Q: And you've received payment on the invoice,
22 right?

23 A: And the Regulation sets forth that the timing,
24 the Department puts that notice in the deemed
25 complete -- I mean, in the State Register upon

1 determination that it's complete and receipt of
2 the application fee.

3 **Q:** Right. So the Department has to receive the
4 application fee back before it's published and
5 the clock begins, right?

6 **A:** Yeah, the -- upon determination that the
7 application is complete and receipt of the
8 application fee the Department publishes the
9 notice.

10 **Q:** And that's what you lost track of.

11 **A:** Yeah, that's supposed to be the sequence.

12 **Q:** Okay.

13 **A:** Yes.

14 **Q:** All right. And so here, if we look back at the
15 incomplete letter which is DHEC 1 ---

16 MS. CRUM: Your Honor, I'm going to object to this
17 line of questioning. The CON Act is crystal
18 clear that the only issues that can be heard by
19 this Court are issues that were raised before
20 the staff during staff review. This is not an
21 issue that was raised during staff review, nor
22 is it an issue that was put in even one of the
23 pre-hearing statements, Your Honor.

24 MS. HOLLINGSWORTH: Your Honor, this entire -- the
25 deemed complete letter, the issue of the

1 timing, and all that stuff was entirely raised
2 by -- on direct. So all I'm doing is just
3 walking through a time line. I haven't made
4 any -- taken any position about it at all.
5 Just -- this is in the record.

6 MS. CRUM: Well, then it's irrelevant, Your Honor.

7 THE COURT: Well she's cross-examining that which
8 you presented in your direct, so.

9 MS. CRUM: I didn't, Your Honor. The Department
10 did.

11 THE COURT: Oh, the Department did, so.

12 MS. HOLLINGSWORTH: And I'd point out, Your Honor,
13 of course this is the Department's witness, so.

14 THE COURT: Okay.

15 Q: Well, and if we could, let's take a look at the
16 deemed complete letter, DHEC 1, 1002.

17 A: Okay.

18 Q: And actually you mentioned this morning that it
19 wasn't clear to you when or whether or how the
20 letter went out, but the article numbers on the
21 letter, they give the information about the
22 tracking of when the letters went out, right?

23 A: Right.

24 Q: And so when you found the letter, you sent them
25 out by certified mail in July, right?

1 A: Well Nic did, but, yes.

2 Q: Okay.

3 A: In July. That -- those -- all of those article
4 numbers were -- all of that mailing and the
5 article numbers were generate in July after I
6 discovered that I probably hadn't sent out the
7 letter.

8 Q: Okay. And why didn't you change the date of
9 the letter to reflect the date that it went
10 out?

11 A: Well, at that point in time I wasn't sure
12 whether or not I had sent it out, so I just
13 thought I would err on the side caution, rather
14 than change the letter, that I would send it
15 out either again or just send it out with the
16 -- you know. And I thought I was clear that I
17 -- it came to my attention ---

18 Q: Right.

19 A: --- that folks had not received that letter,
20 and so I didn't want to change the document, so
21 instead I just sent the document out as it was
22 already -- 'cause it was written and completed
23 and signed and I didn't feel right about
24 changing the document. I, instead, decided to
25 send it out and then explain what I knew about

1 the status and the timing. So it's not --
2 there was no secret that I was concerned that
3 I had not -- that it had never left my desk.

4 Q: Well ---

5 A: And at the same time I just -- I didn't want to
6 change the document.

7 Q: Right. But as I understood it the applicant
8 contacted you and said we don't have the deemed
9 complete letter, right?

10 A: Right.

11 Q: And at least one affected person reached out?

12 A: Right.

13 Q: Okay. So at least the applicant and at least
14 one affected person at the point of July 6th,
15 didn't know what review criteria you were
16 considering most important for review of the
17 project, right?

18 A: Well they had not received the deemed complete
19 letter, and that's what I knew, and so, right,
20 rather than change the date, the timing of the
21 letter is -- and the import of the timing of
22 the letter, is the receipt of the letter by the
23 applicant. So I knew when we sent it either
24 again or for the first time, and so, again,
25 rather than change the document -- I just

1 didn't want to change the document. I couldn't
2 -- I didn't want to spend more time trying to
3 figure out whether it had gone anywhere or
4 where it had gone, and instead very quickly
5 just put it together and sent it out either
6 again or for the first time with a mea culpa in
7 writing and the e-mail so that it would be
8 clear that I was aware that there may have been
9 some mistake on my part.

10 Q: Are you saying in the e-mail that you looked at
11 earlier when you provided a copy of the letter?

12 A: I thought I sent an e-mail that said something
13 to the effect of it's been brought to my
14 attention that not everyone has received this
15 letter. Maybe I'm wrong -- I might be thinking
16 of something else, but.

17 Q: Okay.

18 A: Certainly, the e-mail date would indicate when
19 the letter was actually transmitted to
20 everyone.

21 Q: And why didn't you republish the project then
22 in the State Register as deemed complete so
23 that the clock would start over and you'd have
24 the 120 days to review?

25 A: I didn't see that that was what the Regulation

1 either required or allowed.

2 Q: Okay. Because I mean the Department has
3 republished projects where there have been
4 issues in an initial publication, right?

5 A: Yes, we feel a duty to correct information
6 that's incorrect, but we try very hard not to
7 adjust the statutory timelines. We do that for
8 the purpose of notice and then we work to
9 inform and do whatever we need to do to
10 minimize any sort of disruption to the
11 statutory timelines or deadlines.

12 Q: Okay. But the applicant on July 6th said we
13 still don't have the project review criteria so
14 this would have affected them as well, right?

15 A: I believe that it was July 6th, I don't -- I'm
16 sure the e-mail says, or, you know -- and the
17 applicant wanted the letter clearly which is
18 why they asked for it.

19 Q: All right. And we looked -- you looked at an
20 e-mail this morning on your direct because you
21 did not hold a project review in this
22 application, right?

23 A: Not in person.

24 Q: Right. All right.

25 A: We received documents in lieu of an in-person

1 meeting.

2 Q: And let's see, let's go to DHEC 1 at -- all
3 right -- if you'll go to DHEC 676?

4 A: Okay.

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

6 Q: All right. And you -- this is in the DHEC
7 record and this is a letter from Nexsen Pruet
8 on behalf of the Roper St. Francis entities,
9 right?

10 A: Right.

11 Q: And you're familiar with Mr. Barbier?

12 A: Yes.

13 Q: Okay. And do you agree with me that this is
14 the affected person in opposition notice to
15 DHEC for this project?

16 A: Yes.

17 Q: All right. And what's the date of that?

18 A: March 22nd ---

19 Q: Okay.

20 A: --- 2018.

21 Q: All right. And then it's about two pages long.
22 If you'd look right before the conclusion of
23 the letter, so DHEC CON 677, Roper St. Francis
24 respectfully requests that the Department staff
25 conduct a project review meeting on this

1 application, right?

2 A: Right.

3 Q: And so on March 22nd, 2018 at least Roper St.
4 Francis had made the request that there be a
5 project review meeting, right?

6 A: Yes.

7 Q: Okay. And then look at DHEC CON 678? Is this
8 the affected person opposition letter on behalf
9 of the Trident Summerville entities?

10 A: Yes.

11 Q: And what's the date of that letter?

12 A: April 19th, 2018.

13 Q: Okay. And it's the bottom of that very first
14 paragraph, but is your recollection that
15 Trident also requested a project review meeting
16 be held by the Department prior to the
17 Department making a decision on the
18 application?

19 A: Yes.

20 Q: All right. Now there was an e-mail that, you
21 know, you guys touched on this morning briefly,
22 Mr. Wicevic. Turn to Roper St. Francis 36,
23 please?

24 (Roper Exhibit Number 36 was referenced at this
25 time.)

1 Q: And actually you can just do the bottom half of
2 the e-mail. You testified this morning you
3 received this e-mail, right?

4 A: It was forwarded to me, yes.

5 Q: And you were aware of it, right?

6 A: Yes.

7 Q: Is the reason you didn't hold a project review
8 because Medical University asked DHEC not to
9 hold one?

10 A: That is not the reason.

11 Q: Okay. Well what, if any, influence did this
12 letter from Medical University's attorney to
13 the Department have your decision not to hold
14 a project review?

15 A: I noted the position of MUSC's attorney but it
16 did not -- it was not in any way the reason why
17 we didn't hold a project review meeting. If an
18 applicant does not want a project review
19 meeting, then we have before and we will
20 continue to assure the applicant that it is not
21 required to attend a project review meeting.
22 And we usually go on to explain that a CON
23 application that's strong enough to be approved
24 should be able to stand on its own and not
25 require someone to show up and argue for it at

1 a project review meeting. And so we invite
2 applicants not to attend and assure applicants
3 and affected parties that their choice not to
4 attend an in-person meeting will not in any way
5 negatively affect their position either in
6 support of or in opposition to a project.

7 Q: Okay. Well what, if any, weight did you give
8 to Medical University's statement that these
9 parties are as familiar with each other's
10 operations as any healthcare systems in the
11 state?

12 A: I noted it, but, again, that's not why we
13 didn't hold a project review meeting.

14 Q: Okay. What about the position that it was a
15 complete and thorough application?

16 A: Again, I -- my position on that is and was, if
17 -- that if it is a complete and thorough
18 application then it's true that a project
19 review meeting, at least attendance at a
20 project review meeting by the applicant would
21 not be necessary.

22 Q: Okay. All right. Were you here for any of the
23 testimony last week?

24 A: I was here for some of Mr. Richardson's
25 testimony and some of Mr. Sullivan's testimony

1 this week and that's it.

2 Q: Okay. Are you aware that any of the other
3 testimony like Mr. Johnson stating that the
4 volume assumptions that are used to support the
5 pro formas were not included in the CON
6 application?

7 A: I didn't hear that testimony so now that you
8 said so, yes, I own it.

9 Q: Okay. And I think we might have talked about
10 it even at your deposition but the pro formas
11 or footnote to volume assumptions and the
12 volumes schedules and those volume schedules
13 weren't with the pro formas; do you recall
14 that?

15 A: That rings a bell. I believe that there was
16 something called volume -- what was it called,
17 volume -- whatever that term was, it said
18 please see those and I remember that they
19 weren't actually there. There wasn't something
20 called that included with the application.

21 Q: Okay. And you'll agree with me that the
22 framework for the Certificate of Need
23 application actually requires that those pro
24 formas include information as to how proposed
25 charges, proposed costs of service,

1 utilization, all those good things are
2 calculated, right?

3 A: Right. They're specific requirements that are
4 -- that are set beautifully by the application,
5 and then I think there's a project review
6 criteria may speak to it, I'm not sure, but I
7 think that's a question of Section 16 of the B
8 Section.

9 Q: Right, right. 'Cause you'd agree with me that
10 assumptions made in the application are
11 supposed to be specifically noted and shown,
12 right?

13 A: Any assumptions made in the application must be
14 specifically noted, noted/shown.

15 Q: Okay. And I think maybe when you mentioned the
16 project review criteria that might be 802(6),
17 right?

18 A: It could be. Well, 6 talks about the proposed
19 charges, how the proposed charges are
20 calculated.

21 Q: Okay. All right. And then, sort of -- it's
22 spoken to in that e-mail from Medical
23 University, but then I think your deposition
24 too I recall sort of a belief that these
25 parties are involved in a lot of projects

1 together and a lot of oppositions, right?

2 A: Right. Oh, yes, that's -- that is certainly
3 true.

4 Q: So that's your belief that these folks, these
5 hospital systems, are getting in disputes over
6 projects a lot?

7 A: My belief is that when there's opposition to
8 these particular parties' projects it's usually
9 by one of the other of the three parties. The
10 parties being Roper St. Francis, the Trident
11 Health System and MUHA.

12 Q: Okay. Well, we rolled through a number of
13 applications involving these parties in the Low
14 Country, right?

15 A: The ones that you listed, yes.

16 Q: Right. And tell me what is it that Roper St.
17 Francis has opposed other than the freestanding
18 emergency department and the community hospital
19 that were proposed a few miles away from our
20 Berkeley hospital?

21 A: Oh, I'd have to look, I'd have to look and see.

22 Q: 'Cause it might be none, right?

23 A: I'd be surprised, but maybe.

24 Q: Okay.

25 A: I really would have to look and see.

1 Q: All right. Because even the cancer center that
2 was proposed for Berkeley County, Roper St.
3 Francis didn't oppose the cancer center by
4 Medical University; they simply filed an
5 application to be batched in the review, right?

6 A: Well, there was -- during the review period
7 there's documentation from Roper's consultant
8 kind of opposing the MUSC project, but I don't
9 recall -- I think it may have been in -- only
10 if there had to be one and not the other. So
11 I think it was more of a if you -- we oppose it
12 to the extent that the Department feels it has
13 to choose one ---

14 Q: Okay.

15 A: --- and not the other.

16 Q: And is ---

17 A: Which is typical for competing applicant -- I
18 mean that -- it's -- yeah.

19 Q: Right. But other than that, I mean, to your
20 knowledge Roper St. Francis didn't oppose the
21 ambulatory surgery centers in Mt. Pleasant nor
22 in North Charleston did they?

23 A: I don't think so.

24 Q: Or the musculoskeletal institute?

25 A: I don't know for sure, but it wouldn't surprise

1 me if Roper didn't oppose that.

2 Q: Okay. All right. Now you had not traveled to
3 the area where these -- and I say these, the
4 Berkeley County hospital either being pursued
5 by be it Trident, Roper St. Francis or Medical
6 University, you had not traveled to the area to
7 view any of those proposed locations at any
8 time during your review prior to making a
9 decision, right?

10 A: Right.

11 Q: So when was the first time that you drove out
12 to these areas of southern Berkeley County?

13 A: The -- my team and I drove down there -- now,
14 I don't remember the date, but I think it was
15 -- it was not long before my deposition in the
16 FSED case.

17 Q: Okay. So May of 2019 maybe?

18 A: That sounds right.

19 Q: Okay. All right. But at any time during your
20 review of either the freestanding EDs or this
21 community hospital application, you had not
22 driven out there to see what the distance was
23 between where Medical University was proposing
24 to put their hospital and where Roper's
25 Berkeley hospital was nearly complete, right?

1 **A:** No, I had not.

2 **Q:** All right. And instead of the project review
3 meeting, you informed the parties that you
4 would receive written comments, right?

5 **A:** Right.

6 **Q:** Okay. But, and I think we looked at this, that
7 notice that you were not going to hold project
8 review, that was an e-mail from July 6th,
9 right?

10 **A:** That sounds right.

11 **Q:** Let's see that.

12 **A:** I know we looked at it before, but I don't
13 recall the date exactly.

14 **Q:** Is it DHEC Exhibit 1, page 692?

15 **A:** 692.

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

17 **Q:** The e-mail at the bottom is sort of that first
18 e-mail, Friday, July 6th, is your e-mail, in
19 lieu of an in-person private review meeting you
20 invited written argument and/or documentation
21 by July 13th, right?

22 **A:** Right.

23 **Q:** And then on July 11th is this where you provide
24 a copy of the deemed complete letter that we
25 were talking about?

1 A: Yes.

2 Q: And I think you had gave them a few more days,
3 you gave that extension ---

4 A: Yes.

5 Q: --- Trident asked for, that July 4th holiday
6 week request; is that the extra days you gave?

7 A: Those are the extra days I gave.

8 Q: Okay. But when was your decision due then from
9 that deemed complete notice that you published?

10 A: Are you talking about the deemed complete
11 notice in the State Register that the State
12 Register published?

13 Q: The clock. Yeah, when was the clock running?

14 A: The clock had been running the 120 days prior
15 to July 21st. That was -- everyone was aware
16 of that deadline.

17 Q: Right. So everyone was aware of the 120 days
18 from the deemed complete, but it wasn't until
19 July 11th that the information, in terms of
20 project review, that you considered most
21 important were provided to the affected person?
22 To -- we know at least one affected person and
23 the applicant, right?

24 A: Right. That's right.

25 Q: And we know from the certificates on the

1 mailing that those mailings that went to the
2 affected person and the applicant didn't go
3 until mid-July, right?

4 A: Right.

5 Q: Okay. And then you received -- and you --
6 we've looked -- you looked at some of it
7 earlier, I think I counted about 40 pages of
8 health planning sort of opinion and argument on
9 behalf of the petitioners, right?

10 A: I don't know the exact page count, but it was
11 hefty, yes.

12 Q: Okay. Well, I think you did the page count
13 maybe on Mr. Sullivan's, about 21 pages just of
14 his narrative, right?

15 A: His letter was 21 pages, yes.

16 Q: Okay. And then Mr. Richardson, I think, had
17 similar -- let me see -- where's Mr.
18 Richardson's letter? And then would you agree
19 with me that these letters also had a number of
20 attachments to them?

21 A: If I recall correctly, yes, they had either a
22 number of attachments or some lengthy
23 attachments.

24 Q: Mr. Richardson's letter is 19 pages in length.

25 A: That sounds right.

1 Q: So you received this information on July 18th.
2 I mean, that was a lot of information to digest
3 and rely on before you made your decision,
4 right?

5 A: It sure was.

6 Q: Okay. And so the -- you don't think that the
7 kind of mix up over the deemed complete letter
8 wasn't a reason to republish and start the
9 clock over?

10 A: No, I did not.

11 Q: Okay. All right. You testified earlier that
12 the concept behind the written project review
13 is both to receive information from folks and
14 then there'd be a period of time for reply to
15 the positions of others, right?

16 A: That's the -- that is the most useful part of
17 the project review meetings for the Department
18 is the written documentation that we receive as
19 a result. The purpose of the review period
20 after the notice is published in the State
21 Register is to give affected parties time to
22 prepare and submit documentation to the
23 Department. So I would prefer if -- it'd be
24 easier just to more leisurely to review that
25 documentation earlier rather than later, but I

1 don't believe that the regulation and statute
2 gave me the authority to republish the notice
3 and restart the clock.

4 Q: Well, you'll agree with me that the regulation
5 actually says that not until you've sent out
6 the deemed complete letter and received the
7 application fee, then you publish it in the
8 State Register and start the clock, right?

9 A: That's the sequence outlined in the regulation,
10 yes.

11 Q: Okay. And so that sequence in the regulation
12 then, folks would actually have the project
13 review criteria considered most important in
14 their possession at the time of it being
15 published and the review cycle beginning,
16 right?

17 A: If they had notified the Department that they
18 were affected parties prior to that notice.
19 Oftentimes the deemed complete notice is what
20 causes the parties to decide to notify the
21 Department that they are affect parties, and we
22 only sent -- we are only required to send the
23 notice -- the required notices that -- to
24 affected parties that we produce once we know
25 that the party is an affect party. So after

1 the deemed complete letter has already gone
2 out, unless a party requests it, then we will
3 move forward in time and send whatever else is
4 required by the regulation, which will be the
5 decision or a notice of public hearing.

6 Q: Right.

7 A: So if the deemed complete had already been sent
8 prior to the deemed complete notice being
9 published in the State Register, and then a
10 party notified the Department that it was an
11 affected party, it would not be sent the deemed
12 complete letter unless it specifically
13 requested that letter.

14 Q: Like a FOIA request?

15 A: Yes.

16 Q: Which is something you typically see when folks
17 decide or are trying to decide whether they're
18 going to notify that they have opposition or
19 are affected in a project, right?

20 A: That is very often how they make that decision,
21 yes.

22 Q: Okay. All right. Now you testified this
23 morning a good bit about reviewing both the
24 Trident and the Roper St. Francis Berkeley
25 Hospital CON application, right?

1 **A: Right.**

2 **Q: All right. Let's look at DHEC 7, please.**

3 MS. HOLLINGSWORTH: Oh, and I'm remiss, Your Honor.

4 I would like to move into evidence Roper St.

5 Francis 36, the e-mail that was discussed on

6 direct and again here on cross.

7 MR. WICEVIC: No objection.

8 MS. CRUM: No objection.

9 THE COURT: Admitted.

10 MS. HOLLINGSWORTH: Thank you, Your Honor.

11 (Roper Exhibit Number 36 was admitted into evidence
12 at this time.)

13 **Q: Okay. And, Ms. Murdock, this is the CON**
14 **application for Roper St. Francis, right?**

15 **(DHEC Exhibit Number 7 was referenced at this time.)**

16 **A: Yes.**

17 **Q: And I will give you a minute to reorient**
18 **yourself.**

19 **A: Thank you. All right. Okay.**

20 **Q: All right. And if we go to page, I think, 15,**
21 **hopefully, of the application, yes. Are you**
22 **with me?**

23 **A: Yes.**

24 **Q: Okay.**

25 **A: Sorry.**

1 Q: You're fine. And you recognize this don't you
2 as the (B)(11) portion of the application?

3 A: Yes.

4 Q: All right. And what do you consider -- what is
5 the importance of this section of an
6 application to you as the reviewer?

7 A: (B)(11) section is kind of the shorthand that
8 we use to refer to the need analysis.

9 Q: Okay.

10 A: The projections of need and the demonstration
11 that the projected is needed.

12 Q: All right. And if you -- and you can flip
13 through on your end, you don't have to review
14 it, but it seems to me, it looks like it goes
15 through about 38 of that application, so from
16 page 15 to 38?

17 A: Yes.

18 Q: Is that right? So would you agree with me that
19 Roper St. Francis did a detailed discussion and
20 analysis in response to (B)(11)?

21 A: Yes.

22 Q: Okay. If you would turn to page 31.

23 A: Okay.

24 Q: Mr. Wicevic directed you to this portion of the
25 application this morning.

1 A: Yes.

2 Q: The bottom where adverse impact on existing
3 providers. Do you recall talking with him
4 about that?

5 A: Yes.

6 Q: Okay. And y'all looked at this bottom
7 paragraph, but if you would, turn over a page.
8 There's actually a whole additional page, isn't
9 there, of narrative from Roper St. Francis
10 discussing adverse impact in this CON
11 application, right?

12 A: Right.

13 Q: And I think -- I'm not sure, I might have
14 misunderstood you or maybe there's been a
15 misunderstanding of our project, but would you
16 agree with me or are you aware that Roper St.
17 Francis, in the Berkeley Hospital application,
18 did project and assume that there would be a
19 shift in market share?

20 A: Yes.

21 Q: Are you aware of that?

22 A: Yes, yes.

23 Q: Okay. So ---

24 A: And if I didn't testify clearly to that then I
25 meant to.

1 Q: Okay.

2 A: Yeah, it was not a full shift.

3 Q: Okay.

4 A: It was not a hundred percent shift for the
5 Roper project.

6 Q: And so there is actually an analysis of the
7 impact on other providers as to those patient
8 days that we were projecting would be captured
9 from non-aligned patients, right?

10 A: Yes.

11 Q: Okay. So it -- and in fact I think it says in
12 the third paragraph towards the bottom, in
13 other words while a provider's market share may
14 decline slightly, the expansion of the total
15 market will offset any market capture loss with
16 future volumes at or above current volume
17 levels, right?

18 A: Right.

19 Q: Okay. I just want to make clear you agree with
20 me Roper St. Francis did not propose a hundred
21 percent redirection as it's been called here in
22 the hearing, right?

23 A: No, it did not.

24 Q: Okay. And in fact Roper St. Francis only
25 proposed 50 percent redirection; do you recall

1 that? And you can look.

2 A: Well, there's a 60 percent number in the
3 application.

4 Q: Right. But is it your understanding that kind
5 of the overall proposal of the Roper St.
6 Francis Berkeley application was that 50
7 percent of Roper aligned patients in Berkeley
8 County would redirect to the proposed hospital?

9 A: Yeah, I think -- okay, yes, I'm understanding
10 that.

11 Q: Okay.

12 A: Sixty percent of the total volume of the new
13 project would be redirected patients, but 50
14 percent of the patients in that area would be
15 redirect, yeah.

16 Q: Right. And to be clear, in that area is
17 Berkeley County, right?

18 A: Right, yeah, I believe so.

19 Q: Okay. Because Roper St. Francis did not
20 propose redirection of patients that were
21 outside of Berkeley County such as Mt. Pleasant
22 or the peninsula, right?

23 A: No, I don't think so. I think it was much
24 localized.

25 Q: Okay. All right. And we can just turn in the

1 book, if you could look at, it's still in DHEC
2 7, but page 987?. I think you touch on this
3 briefly this morning. 987.

4 A: All right. Okay.

5 Q: Or 981. I might just can't read my own
6 handwriting. Can you tell us what this
7 document is, when you get a chance to get there
8 too?

9 A: Okay. This appears to be a request for
10 information from the Department.

11 Q: Okay. And you mentioned it briefly this
12 morning but there's a mechanism in your
13 regulation, isn't there, where the Department
14 can ask an applicant for greater detail or more
15 information about a proposed project, right?

16 A: Yes.

17 Q: And there's like a timing where so many days to
18 respond with your additional information and --
19 -

20 A: Yes.

21 Q: --- all that good stuff, right?

22 A: Yes.

23 Q: Okay. And you'll agree with me that back in
24 2009 that Roper St. Francis was asked a number
25 of questions for more details about our

1 proposed project, right?

2 A: Yes. On this letter there are four questions
3 with the -- one of them has some subparts.

4 Q: Okay.

5 A: So they're -- if you count the subparts, it's
6 seven questions.

7 Q: Okay. And then I think it's page 1089. This
8 is what happens when I use someone else's
9 exhibit. So this is DHEC's version and there
10 might be a post-it note apparently on the front
11 of it, but this is another request for
12 additional information and that's allowed in
13 the reg, right? There can be multiple rounds
14 or it's provided there can be multiple rounds
15 of request for additional information, right?

16 A: Yes, and I'm not ---

17 Q: Sure. I think it's 1089. Oh, 1082 maybe.
18 Yeah.

19 A: Here we go. Oh, and the post-it note, yes.

20 Q: Okay.

21 A: Yes.

22 Q: And you'll agree with me this is another round
23 of additional information that the Department
24 was asking of Roper St. Francis about our
25 proposed hospital, right?

1 **A:** I'm going to go out on a limb and try to go
2 under that post-it note and say, yes, I think
3 that's what this is. That is what this is.

4 **Q:** So, for example, it looks that question (1) is
5 delineate the inpatient and outpatient surgery
6 volume projections for Roper Berkeley ASC and
7 Roper Hospital, right?

8 **A:** Right.

9 **Q:** And patient volume shift data for Roper and our
10 Mt. Pleasant hospital, right?

11 **A:** Right.

12 **Q:** So it was a number of questions and details
13 that were asked during that review; is that
14 fair?

15 **A:** Yes.

16 **Q:** Okay. All right. It's my understanding that
17 you reviewed this application, or certainly our
18 application, to determine whether the hospital
19 proposed by the Medical University was
20 approvable; is that right?

21 **A:** That was part of my analysis, yes.

22 **Q:** Okay. Well you understand, right, that what
23 was being sought by Roper St. Francis and
24 Trident were 50 bed hospitals in Berkeley
25 County, right?

1 A: Yes.

2 Q: And those are both still approved, one of which
3 is operational today, right?

4 A: Yes.

5 Q: And Berkeley Medical Center they still have
6 their CON, don't they?

7 A: I'm not a hundred percent sure of that as of
8 recently.

9 Q: Okay. So has your office taken some move to
10 revoke the Certificate of Need issued to
11 Berkeley Medical Center?

12 A: No. We are researching some ownership history
13 to determine whether or not there was a
14 transaction that would have caused the
15 Certificate of become void.

16 Q: And how did that information come to your
17 attention?

18 A: I believe it was the testimony of Todd Gallati,
19 but I was not here. I heard about the
20 testimony.

21 Q: Who told you about the testimony?

22 A: I don't recall.

23 Q: Is it ---

24 A: And it may ---

25 Q: Yeah, I'm certainly not asking if you had a

1 conversation with your attorney, but did
2 someone other than your attorney give you that
3 information?

4 A: I will say I believe the answer to that is
5 covered by attorney client privilege.

6 Q: Okay.

7 A: I believe that, but I ---

8 Q: Okay.

9 A: --- I think that's right.

10 Q: Okay. So did the information about the
11 testimony that came from Mr. Gallati come from
12 one of the attorneys at the Department?

13 A: I believe so, but I'm -- again, I'm not sure.

14 Q: Okay.

15 A: It was either one of the attorneys at the
16 Department or it was my supervisor who might
17 have been here.

18 Q: Okay. All right. How -- what did you do to
19 prepare for your trial testimony?

20 A: I looked over some of the record. I reviewed
21 the decision and some of the notes, some of the
22 opposition documents. I looked at some other
23 applications. I looked at some deposition
24 testimony. We're in the middle of the state
25 health planning process so didn't have the

1 luxury of as much time as I wish I had, but I
2 tried to review as much of the record as I
3 could, and I had some meetings with an
4 attorney, one of DHEC's attorneys, Mr. Wicevic.

5 Q: All right. Did you have any meetings or
6 discussions with Medical University or any of
7 their attorneys?

8 A: To prepare for today or for this trial?

9 Q: Sure, yeah.

10 A: No.

11 Q: Okay. Have you met with them since your
12 deposition? Or had conversations with them
13 since your deposition?

14 A: Probably.

15 Q: All right. And was it about this application?

16 A: Which one? The ---

17 Q: The one we're here for today.

18 A: I'm sure we've discussed it. I've seen the
19 MUHA's attorney on a number of occasions and we
20 have discussed it almost certainly in passing.

21 Q: Okay. But have you had any meetings or
22 specific discussions in advance of trial about
23 the hearing and your participation at the
24 hearing?

25 A: We have had -- I know that Mr. Wicevic and I

1 met with Ms. Crum at some point, and I don't
2 recall this -- whether it was before my
3 deposition or after my deposition. And during
4 that meeting we talked about the opposition
5 letters, and I, basically I told Ms. Crum what
6 I thought about some of the things in the
7 opposition letters.

8 Q: Okay. Now I think -- it's my understanding
9 you've reviewed Judge McLeod's Order during
10 your review of this application, right?

11 A: I did back before the decision. I have not had
12 a chance to review it in much detail at all
13 before this trial.

14 Q: Okay. Did you review that Order actually
15 before you had the Medical University's
16 application or was it as part of your review of
17 this project that you decided to review his
18 Order?

19 A: I've read that Order more than once.

20 Q: Okay.

21 A: So -- and I believe I actually had it as part
22 of the legal research in connection with
23 something completely different.

24 Q: Okay.

25 A: So I've read it several times including in

1 preparation for making the decision in this
2 case.

3 Q: Okay. And 'cause -- and if I recall, the Court
4 of Appeals decision probably came down right
5 around the time that you were getting started
6 at the Department, right?

7 A: Probably. I don't know what the date is, but
8 if it was anywhere close to May 2015 then the
9 answer is yes.

10 Q: Okay. All right. Let's look at DHEC Exhibit
11 9.

12 A: Oh, there it is.

13 (DHEC Exhibit Number 9 was referenced at this time.)

14 Q: All right. When you were reviewing Judge
15 McLeod's Order and reviewing some of that
16 backdrop to the Berkeley Hospital application.
17 Sorry, let me give you a chance to grab that.

18 A: I'm sorry for all the noise in this chair over
19 here. Sorry. Okay.

20 Q: I think it's at 9, DHEC 9.

21 A: Okay. I'm there.

22 Q: And I think maybe page 11 might be one of the
23 findings I wanted to ask you about.

24 A: Okay. All right.

25 Q: All right. There's been a lot of discussion

1 about, of course, that prior proceeding and the
2 outcome of that proceeding. If you look at
3 finding of fact 25 in his Order, were you aware
4 that sort of the conclusion in that case was
5 that both of the applicants had established and
6 projected non-tertiary patient base of Berkeley
7 County admissions that would be more than
8 sufficient needed for their project to be at
9 target occupancy? It's right there, that first
10 finding, the first sentence of finding 25.

11 A: Yes.

12 Q: Okay. And what is a non-tertiary patient bed?

13 A: It's one patient, one bed, one day for a
14 patient that's -- a rough translation would be
15 a lower acuity patient, one that doesn't need
16 the tertiary services that only -- that not
17 every hospital can provide.

18 Q: And what is your understanding of what Medical
19 University is proposing to provide at their
20 community hospital?

21 A: Non-tertiary services.

22 Q: Okay. And you were discussing this morning
23 analysis that you had done. Did you analyze
24 patient days?

25 A: In reviewing the project?

1 Q: Yeah.

2 A: Yes. I mean, that's the currency of projected
3 utilization is patient days, so a lot of my
4 analysis involved analyzing patient days.

5 Q: Okay. And you were looking at non-tertiary
6 patient days, right?

7 A: Yes.

8 Q: Or were you?

9 A: Well, I mean, that -- yes, where I could. In
10 some parts of the review, looking at other
11 facilities, it's not always possible to break
12 down the difference between tertiary and non-
13 tertiary patients. So when I could, I did.

14 Q: And you would agree with me that non-tertiary
15 patients is the population at issue here,
16 right?

17 A: For the project, yes, that's the target
18 population.

19 Q: Okay. Let's look at Roper St. Francis Exhibit
20 39.

21 (Roper Exhibit Number 39 was referenced at this
22 time.)

23 Q: We had a very good time with this at your
24 deposition.

25 A: Yes, we did.

1 Q: I had clever jokes in my outline, but folks
2 took offense. Nope, nope, one of them's still
3 here.

4 A: Okay.

5 Q: So can you tell the Court what this is?

6 A: It is not in fact a chisel and stone tablet,
7 but it is a page of notes that I took -- that
8 I started jotting down while I was looking at
9 the Roper Berkeley CON application. But
10 there's some other things on there including
11 some mathematical ---

12 Q: And ---

13 A: --- and then some population data, and then
14 some other -- I was crunching some other
15 numbers from some other -- I think from JARS
16 for, you know, certain facilities.

17 Q: Okay. This is -- is it all of your handwriting
18 that's on here?

19 A: Everything except the Exhibit 3, the 3.

20 Q: The sticker?

21 A: Yes.

22 Q: Okay. And did you give this to the attorneys
23 in the case during the deposition, your
24 deposition in this case; do you recall that?

25 A: Yes.

1 **Q:** All right. It would be -- would it be fair to
2 say this is your work paper from review of the
3 Medical University's hospital project?

4 **A:** Yes.

5 **Q:** Okay.

6 MS. HOLLINGSWORTH: Your Honor, I would move to
7 admit Roper St. Francis Exhibit 39.

8 MR. WICEVIC: No objection, Your Honor.

9 MS. CRUM: No object.

10 MR. SUMMER: No objection, Your Honor.

11 THE COURT: It's admitted.

12 MS. HOLLINGSWORTH: Thank you, Your Honor.

13 (Roper Exhibit Number 39 was admitted into evidence
14 at this time.)

15 **Q:** Just so the record knows, in case no one flips
16 through it later, there is very impressive long
17 division that takes place at the top of the
18 page, and we did discuss at your deposition how
19 you could not possibly have had a calculator
20 anywhere.

21 **A:** I still don't know but apparently I didn't.

22 **Q:** Because you calculated a multi-million dollar
23 cost per bed in long division on this page,
24 didn't you?

25 **A:** I think that's what that is.

1 Q: I think you were very close to Mr. Levitt's
2 calculation, right? And he uses a calculator.

3 A: Then I hope I was very close to that.

4 Q: All right. Now I'm not aware of any other work
5 papers from your review, so -- and I know at
6 your deposition you had, a number of times,
7 thought that you'd have notes or would've
8 written something down, or -- to my knowledge,
9 and I think through discovery and counsel,
10 there are no other papers, right?

11 A: I looked. I thought that I had taken some
12 other notes too. And did try mightily to find
13 them, but it could be -- sometimes I do take
14 notes on post-it note, and so I don't know. I
15 thought I had more of -- not a lot more.
16 Certainly not pages and pages, but I thought
17 that I had jotted down some similar things when
18 I looked at the Berkeley Medical Center
19 application, but I cannot find -- I cannot find
20 those notes.

21 Q: Okay. And from this work paper, would you
22 agree, sort of that top section is where you
23 are looking at that sort of cost calculation
24 that you were wondering the price per bed for
25 our project? Is that what that calculation is?

1 A: That's what it looks like, yes.

2 Q: All right. And then it looks as though you
3 have sort of written out sort of summary or
4 important points that you took from the need
5 analysis that's found in the Roper St. Francis
6 Berkeley application, right?

7 A: Yes.

8 Q: Okay. Because it appears to me that all of
9 this information on this page really is related
10 to, or certainly primarily related to things
11 that were either in the Roper St. Francis
12 Berkeley application or calculations related to
13 the Roper St. Francis Berkeley application,
14 right?

15 A: Yes, it is primarily that. I think I went off
16 on kind of a -- just a general look down there
17 at the population trends and growth in the
18 three counties. But this -- all the
19 information that pertains to one particular
20 project, it would be the Roper Berkeley
21 project. I think I did, I was looking at
22 something else and jotting down some JAR data
23 for Trident and MUSC and Summerville up in this
24 sort of wider writing, and then I did some
25 other math looking things at the top. But the

1 -- everything that is project specific on this
2 page refers to Roper Berkeley.

3 Q: Okay. And it looks like we have a calculation
4 here towards the middle of the page, you have
5 ALS which I've -- my guess is sort of your
6 shorthand for average length of stay, right?

7 A: I think so.

8 Q: And 4.25 was what was in Roper St. Francis's
9 Berkeley application back in 2008?

10 A: I believe that's why I wrote it there, yes.

11 Q: Okay.

12 A: That wasn't a number that I calculated. I
13 think I got that from the application.

14 Q: Okay. And then you've got notes here about the
15 50 percent redirection from service area Roper
16 aligned volume, non-tertiary, non-specialty,
17 right?

18 A: Yes. But it just went away, but -- oh, yes,
19 yes.

20 Q: Okay. And you've got these calculations here,
21 you've got 3,550 patients and you divide that
22 by two to get the 50 percent redirection
23 volume, right?

24 A: Yes.

25 Q: Okay. But looking back and recalling what

1 Judge McLeod said about the sort of existing
2 volume or the projected volume that Roper St.
3 Francis had in that area being sufficient to
4 support the project, is all of this data data
5 that would have been in the application
6 underlying those findings?

7 A: I can't speak to what Judge McLeod based his
8 findings on. I would assume that it would be
9 information from the application and then
10 whatever was in the record throughout the
11 course of the appeal and the hearing.

12 Q: Did you do any different calculations with this
13 data? Did you calculate anything differently
14 or separate from what's set forth in the
15 application?

16 A: I'm not sure how you mean. Can you be more
17 specific?

18 Q: Sure, I'm just trying to understand. You said
19 you reviewed this and you did this analysis to
20 determine if Medical University's project was
21 approvable, and I'm trying to understand.
22 You've got data here, is any of this data that
23 -- did you do any of these calculations to make
24 some sort of determination that the project --
25 that the Medical University's project was

1 approvable?

2 A: Well, these -- I mean, these are just notes
3 that I took while I was reviewing the
4 application so that I didn't have to open it
5 back up to, you know, things that I might have
6 wanted to refer to later. It's not -- I didn't
7 do a -- an analysis with a conclusion here.
8 And a lot of what I did when I was looking at
9 the approvability of the MUHA application was
10 to stay as close to the proposed calculations
11 in the application as possible and just kind of
12 do some quick what if this, what if that, what
13 if you take this variable out, what if you move
14 this around, and I would have just jotted down
15 numbers, but I didn't substitute a different
16 analysis for either the Roper project or the
17 MUHA project to determine approvability. I
18 just wanted to see what Roper proposed to do,
19 what Roper Berkeley proposed to do, and
20 specifically what patient -- what the target
21 population was and where Roper Berkeley was
22 planning on drawing those patients.

23 Q: Okay. and that was Berkeley County, right?

24 A: It was whatever was in the application. I'd
25 have to go back and look again. Like I said,

1 I looked at it in review, but I have no reason
2 to doubt that it was Berkeley County.

3 Q: Okay.

4 A: I don't recall one way or the other whether
5 there was some analysis about anything -- any
6 draw from across the county line, but I
7 generally recall it to be Berkeley County
8 focused.

9 Q: Okay. And it had -- and certainly it had some
10 other elements to it in terms of a secondary
11 area population growth, all of those things
12 that you would typically see in a need
13 analysis?

14 A: Sure.

15 Q: Okay. So where's the what if analysis? Where
16 is the analysis that you did when you were
17 evaluating impact to determine that the what if
18 scenarios, after you did them, that the project
19 was still approvable?

20 A: Those would have been just one off calculations
21 and I would -- I mean, at most I would have
22 jotted down a number to remember it while I
23 employed the calculator to crunch some other
24 numbers just to see how things changed. But,
25 again, my purpose was not to substitute my own

1 analysis; it was to see what would happen if I
2 changed some variables and then go back and use
3 the analysis in the application to see if I
4 change this number or change that number or
5 change this percentage and ran it through Mr.
6 Levitt or MUHA's kind of need analysis hopper,
7 what that would do to the projected volumes.
8 And -- but there wasn't a, you know, a written
9 -- I didn't set out to kind of create a
10 document that would demonstrate a different
11 analysis or alternative need projection.

12 Q: Okay. Let's look at Roper St. Francis 14, page
13 13. And this notebook, I hope that we'll be
14 able to see.

15 (Roper Exhibit Number 14 was referenced at this
16 time.)

17 Q: And you mentioned you were here for some of Mr.
18 Richardson's testimony. Did you do any
19 calculations to test whether the Medical
20 University's project was supported in the same
21 way Judge McLeod found in terms of the Berkeley
22 County non-tertiary discharge as supporting
23 their project volume assumptions? Did you do
24 that calculation?

25 A: I did not set out specifically to try and

1 recreate any calculation that was done by the
2 Judge in that Order. Maybe I'm not
3 understanding your question.

4 Q: I think you're doing fine. I'm trying to get
5 behind, you testified this morning and when we
6 spoke before at your deposition, that Roper
7 Berkeley's CON application was significant in
8 your review, right?

9 A: Right.

10 Q: And I think you mentioned even this morning
11 that you thought the proposal by the Medical
12 University was very similar to what Roper St.
13 Francis proposed, right?

14 A: There were a lot of similarities.

15 Q: Okay. And so in terms of sort of testing the
16 information, similar to how it was tested in
17 the first Berkeley hospital dispute, did you
18 test any of this data in terms of what Medical
19 University's Berkeley County discharges volume
20 numbers were? Did you do any sort of analysis
21 of that?

22 A: When you say this data, to what data are you
23 referring?

24 Q: Well, what's on the screen here, Roper St.
25 Francis 14-13 is Medical University's non-

1 tertiary Berkeley County resident volume and it
2 gives you the information about Berkeley County
3 volumes for Medical University and it converts
4 them to patient days. So this is data of the
5 Medical University. Did you look at any data
6 like this when you were reviewing before you
7 approved the project?

8 A: I looked at the data that was included with the
9 application.

10 Q: Okay. All right. And in terms of -- let's
11 look at Judge McLeod's Order again real quick.
12 DHEC 9, page 13.

13 (DHEC Exhibit Number 9 was referenced at this time.)

14 Q: I think it's at finding 29. You're aware,
15 aren't you, that in that case the finding was
16 that based on the substantial population growth
17 in the 2010 census and the historical growth
18 since 1970, that the finding was Berkeley
19 County's -- Berkeley's population side is well
20 able to support two 50 bed hospitals, right?

21 A: Right.

22 Q: Okay. There's been a lot of discussion about
23 hospitals and hospital size. Do you agree with
24 me at issue in that case was two 50 bed
25 hospitals, right?

1 **A:** At issue in that case was two 50 bed hospitals,
2 yes.

3 **Q:** And he approved both of them, right?

4 **A:** Yes.

5 **Q:** He affirmed the Department's approval of both
6 of them, right?

7 **A:** Yes.

8 **Q:** And so, in terms of the locations, do you know
9 where those hospitals are located?

10 **A:** I know where Roper Berkeley is, and I know
11 where the proposed site for the Berkeley
12 Medical Center project is.

13 **Q:** Where are they?

14 **A:** The Roper Berkeley Hospital is in the Carnes
15 Crossroads area. It's right where -- I mean,
16 the roads actually make an X on the map. It's
17 north of Highway 26. I can't remember the --
18 which of the two; I just know it as Carnes
19 Crossroads.

20 **Q:** 76 and 176 maybe?

21 **A:** That sounds right, something like that. And
22 then the proposed site for the Berkeley
23 Medical Center project is up much further north
24 towards Moncks Corner.

25 **Q:** Okay.

1 **A:** Near Moncks Corner on the outskirts of Moncks
2 Corner, but it's up in the northern part of
3 Berkeley County.

4 **Q:** And do you recall that Judge McLeod's Order
5 found that Moncks Corner and Goose Creek were
6 separate communities, separate and distinct
7 from the other?

8 **A:** That rings a bell, but, again, I haven't
9 reviewed the Order too recently, but that
10 sounds right.

11 **Q:** Okay. And his finding -- it's in paragraph 31
12 of the Order, for the record, his Order notes
13 that the communities are approximately 20
14 minutes apart; does that sound familiar to you?

15 **A:** Yes.

16 **Q:** Okay. Now, as I understood it, you reviewed
17 his Order during review but you've reviewed it
18 before as well, right? Before you ---

19 **A:** Yes, I've read it before a different purpose,
20 yes.

21 **Q:** Okay. Let's go back to your deemed complete
22 letter. It's at DHEC 1 CON 1000. Actually,
23 let me ...

24 MR. SUMMER: Your Honor, might this be a good time
25 for a break?

1 THE COURT: That would be fine with me.

2 MS. HOLLINGSWORTH: We can, Your Honor, sure.

3 THE COURT: Okay.

4 MR. SUMMER: Thank you.

5 (Off the Record)

6 THE COURT: Have we had a sufficient break?

7 MS. HOLLINGSWORTH: Yes, sir, I think so.

8 THE COURT: Have at it.

9 **Q: Back at it, all right.**

10 **A: All right.**

11 MS. HOLLINGSWORTH: I would say I used the time to
12 cut off a whole lot of my outline, but I'm not
13 going to fool you.

14 **Q: Ms. Murdock, have you handled an application --**
15 **reviewed an application that used HUD-backed**
16 **financing as the proposed source of financing?**

17 **A: I don't recall. I'm not sure that I have**
18 **reviewed one from beginning end, but I believe**
19 **there was HUD financing involved with the Shawn**
20 **Jenkins Hospital.**

21 **Q: Okay. But in terms -- I'm so sorry ---**

22 **A: Yeah, that wasn't my application to review, but**
23 **I, you know, kind of inherited it after the**
24 **decision.**

25 **Q: After it was approved?**

1 **A:** Yeah.

2 **Q:** Okay. But for this application, as part of
3 your review, did you familiarize yourself at
4 all with the National Housing Act or the
5 framework around HUD and HUD-backed financing?

6 **A:** Not any more so -- I mean, no I didn't go do
7 extra research.

8 **Q:** Okay.

9 **A:** I was somewhat familiar with it based on the
10 Shawn Jenkins experience, but I didn't go do
11 extra research on that, no.

12 **Q:** Okay. Did you -- did your research -- did you
13 review information to evaluate the sort of --
14 the National Housing Act's purpose as to assist
15 with the provision of urgently needed
16 hospitals? Had you reviewed that language ---

17 **A:** No.

18 **Q:** --- in the law? Did you make a determination
19 that the Medical University's community
20 hospital in southern Berkeley County was
21 urgently needed?

22 MS. CRUM: Your Honor, I'm going to object to the
23 form. There's been no foundation laid of
24 whether it's urgently needed or not.

25 THE COURT: Did you make a review about whether it

1 was urgently needed, I thought was the
2 question.

3 MS. HOLLINGSWORTH: I asked if she made a
4 determination whether that proposed hospital in
5 southern Berkeley County was urgently needed.

6 THE COURT: Yeah, was urgently needed. So she's
7 asking if it was.

8 MS. CRUM: No, sir. That's a provision out of the
9 HUD regulations, and she's asking her to
10 interpret the HUD regulations. So that's
11 something in your province.

12 THE COURT: No, I disagree with that, respectfully.

13 MS. CRUM: All right, sir.

14 THE COURT: I think it's a legitimate question. I
15 overrule your objection.

16 **A: Okay. So you're asking if I made a**
17 **determination whether this project was urgently**
18 **needed?**

19 **Q: Did you make a determination that Medical**
20 **University's community hospital in southern**
21 **Berkeley County was urgently needed?**

22 **A: I made a determination that the project was**
23 **needed, and I don't know that I focused**
24 **specifically on the term urgently or not**
25 **urgently. CON being my program area and my**

1 daily work, if a project is needed then it sort
2 of is inherently urgent, I suppose, but I
3 didn't make a specific determination as to
4 whether there was a degree of need that was
5 more urgent than any other project that I
6 determined was needed.

7 Q: Okay. All right. Let's look at your decision
8 letter, please. It's in the DHEC record.
9 Exhibit 1, DHEC Exhibit 1 and I think it's at
10 1009.

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

12 MS. CRUM: What was the number?

13 MS. HOLLINGSWORTH: 1009.

14 MS. CRUM: All right, thank you.

15 Q: Okay. You there?

16 A: Go ahead. I've got the electronic version at
17 least.

18 Q: And so this is your decision letter approving
19 the Certificate of Need application for Medical
20 University Hospital Authority's community
21 hospital in Berkeley County, right?

22 A: Right.

23 Q: And it's dated July 23rd, 2018, right?

24 A: Right.

25 Q: All right. And what health plan did you review

1 it under?

2 A: The 2017-2018 South Carolina Health Plan.

3 Q: Okay. Let's go to the next page. And as I
4 understood your testimony that it was Standard
5 5 that you reviewed in evaluating whether the
6 project could be approved; is that right?

7 A: That's the standard that's the most appropriate
8 for MUSC to have complied with this part of the
9 plan. I didn't say that very well but that's
10 the vehicle, Standard 5.

11 Q: I mean, is that the standard identified by the
12 applicant in the application that they were
13 proposing the project?

14 A: I believe -- yeah, I believe so.

15 Q: And we don't have to jump back and forth, but
16 what is your finding -- well, let's see before
17 we do that. Standard 5 -- I hate to make you
18 have two records in front of you. I'm sorry.
19 But at DHEC 4 is the 2017-2018 Health Plan.

20 A: Okay.

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

22 Q: And while we're familiarizing ourselves, I
23 think it's at page 10 and then it goes to the
24 top of page 11. And so you'd agree with me,
25 Medical University was applying to create -- or

1 is applying to create a new additional hospital
2 at a different site, right?

3 A: Right.

4 Q: And they're proposing it within the same
5 service area which under this Health Plan is
6 the Tri-County area, right?

7 A: Right.

8 Q: 'Cause the facility generating the bed need is
9 the campus on the downtown peninsula, right?

10 A: Right.

11 Q: And that's Charleston County?

12 A: Right.

13 Q: Okay. So -- and under Standard 5, Medical
14 University can use projected bed need to
15 create this new additional hospital, right?

16 A: Right.

17 Q: Okay. And remind us, just read for us, what
18 does that last sentence of Standard 5 that
19 starts at the bottom of page 10?

20 A: The applicant must justify through patient
21 origin and other data the need for a new
22 hospital at the chosen site and the potential
23 adverse impact a new hospital at the chosen
24 site would have on the existing hospitals in
25 the service area.

1 Q: Okay. And you agree with me that that is --
2 those are two elements of Standard 5 that the
3 applicant must justify, right? What you just
4 read?

5 A: Need and potential adverse impact.

6 Q: Sure.

7 A: Those are the two elements that you mean? Yes.

8 Q: Right.

9 A: Yes.

10 Q: The need at the chosen site, right?

11 A: Right.

12 Q: And the potential adverse impact at the chosen
13 site, right?

14 A: Right.

15 Q: Okay. And take a look at the inventory in that
16 same Plan, it's on page 27 is where we'll find
17 the Tri-County area.

18 A: Okay.

19 Q: Identify for us where the -- where's the bed
20 need in the Tri-County that's being used for
21 this project? Who has it?

22 A: MUSC.

23 Q: Okay. There's been a lot of back and forth in
24 the hearing about that this is Medical
25 University Hospital Authority. You'll agree

1 with me that the Health Plan identifies bed
2 need for MUSC Medical Center, right?

3 A: Right.

4 Q: Okay. And that's the bed need at issue in this
5 application, right?

6 A: Right. The inventory is of each individually
7 licensed hospital or proposed/approved
8 hospital. That it's -- the institutes listed
9 in the Health Plan are actual facilities or
10 proposed facilities.

11 Q: And here it's MUSC Medical Center, right?

12 A: Yes.

13 Q: Okay. And under the Plan how many existing
14 beds does MUSC Medical Center have?

15 A: 656.

16 Q: Okay. And what is the service area need? What
17 is the need for beds in the service area under
18 the 2017-2018 Health Plan?

19 A: Well, the total for all the facilities in the
20 Tri-County area, the raw bed need is 1,798
21 beds. Then you subtract the existing and
22 approved beds and so you get a surplus of 13.

23 Q: Right. So there's no need for additional beds
24 in the Tri-County service area under the 2017-
25 2018 Health Plan, right?

1 **A:** Well, that statement is problematic. I mean,
2 the total of the bed need for all the hospitals
3 in the area shows a surplus of beds.

4 **Q:** Right.

5 **A:** But we don't interpret that to mean that there
6 is no need for one of these hospitals that
7 might actually show a need.

8 **Q:** Right. But you'll agree with me that there's
9 facility specific need and then there's service
10 area need, right? That those calculations get
11 summed up in the Plan, right?

12 **A:** Yes, there's a sum in the Plan.

13 **Q:** So ---

14 **A:** And so that would be something that would be
15 applicable to a new player. Somebody new to
16 the system that are new to the service area
17 that did not have its own institution specific
18 need.

19 **Q:** Right. So you'll agree with me that the way
20 the Health Plan is set up, it sums a total to
21 provide a service area surplus for need, right?

22 **A:** Yes. It shows the total, you know, whether as
23 a -- if you look at the whole service area and
24 basically tallied up all of the needs ---

25 **Q:** Right.

1 **A:** --- it's either a positive number or a negative
2 number.

3 **Q:** Okay. And looking at the variable occupancy
4 rate formula -- it's on I think page 9.

5 **A:** Okay.

6 **Q:** The -- am I correct that the Health Plan says,
7 where the term, quote, hospital bed need is
8 used, these figures are based upon utilization
9 data for the hospitals; is that right? Is
10 that what that says?

11 **A:** Yes.

12 **Q:** Okay. Would you agree with me that the Health
13 Plan says this term does not suggest that
14 facilities cannot operate at higher occupancy
15 rates than used in the calculations without
16 adding additional beds?

17 **A:** Yes, it does say that.

18 **Q:** Okay. And so the use of the word hospital bed
19 need, that is just the phrase used for outcome
20 of the bed need formula, correct?

21 **A:** Yes.

22 **Q:** All right. And looking back at the number of
23 beds in the 2017-2018 Plan, I think you gave me
24 the numbers, how many beds are there in -- in
25 this Health Plan, how many existing beds are in

1 the service area?

2 A: The total existing beds which includes improved
3 but not licensed beds is 1,811.

4 Q: Okay. And is this -- this is the Health Plan
5 where there might be 50 beds that should be
6 included for Trident's Berkeley Medical Center
7 that might be missing?

8 A: Yes.

9 Q: All right. Now going back to Standard 5, the
10 proposal to transfer 128 beds, and you'll agree
11 with me, and we just looked at it again, but
12 that's an institution specific bed need for
13 MUSC, right?

14 A: The 147?

15 Q: Right. So the 128 beds they were using comes
16 from that 147, doesn't it?

17 A: That's correct.

18 Q: Okay. And it's an institution specific need,
19 correct?

20 A: That's a term that is often used. I'm not sure
21 if that's a State Health Plan term ---

22 Q: Okay.

23 A: --- but that is a facility specific.

24 Q: Facility specific?

25 A: Yeah.

1 Q: Okay. Well we'll use that word. It's a
2 facility specific need for MUSC Medical Center,
3 right?

4 A: Right.

5 Q: Okay. And the looking back at Standard 5 and
6 the 2017 Plan, you'll agree with me that the
7 standard has two separate requirements that the
8 applicant must establish to comply with the
9 standard. One being to justify through patient
10 origin and other data the need for a hospital
11 at the chosen site, and the other being the
12 potential adverse impact a new hospital at the
13 chosen site could have on the existing
14 hospitals in the service area, right?

15 A: Right. Those are two requirements of that
16 standard. There's also kind of the general
17 requirement that there needs to be some sort of
18 bed need to transfer or something else, but in
19 that last sentence there are two components
20 that are required ---

21 Q: Right.

22 A: --- for compliance with ---

23 Q: And you would agree with me that if the
24 applicant does not meet both elements of proof,
25 the CON application cannot comply with this

1 standard, right?

2 A: Well, the applicant specifically must justify -
3 - I don't want to change words and say approve
4 or anything like that, I'm not trying to be
5 troublesome, but the applicant must justify
6 through the required data, the need and then
7 the potential adverse effect on existing
8 hospitals.

9 Q: Okay. And you agree with me that those are
10 standards that the applicant must justify,
11 right?

12 A: Those are two requirements of a standard that
13 -- with which the applicant must comply.

14 Q: Right. But I'm asking and want to make very
15 clear, the -- if the application doesn't
16 comply with both of those components that we
17 just read, then the application would not be
18 compliant with the standard, right?

19 A: Well, the application has to be consistent with
20 the State Health Plan. And part of being
21 consistent with the State Health Plan means
22 being consistent with the standards. And in
23 order to be consistent with that standard, the
24 applicant has to justify two things pursuant to
25 that sentence. One of them's the adverse

1 **impact of the new hospital at the chosen site,**
2 **potential adverse impact on existing hospital,**
3 **and the other is that the applicant must**
4 **justify the need for the new hospital at the**
5 **chosen site.**

6 **Q: So the applicant has to satisfy both of those**
7 **elements in order to be compliant with the**
8 **standard?**

9 MS. CRUM: Your Honor, that question has been asked
10 and answered and beat to death.

11 THE COURT: Yeah, I've got it now.

12 MS. HOLLINGSWORTH: That's fine, Your Honor. I'm
13 not one to try to impeach a witness unless I
14 ask the question directly, and the witness
15 actually wasn't giving me the answer, but I'm
16 happy to move on, Your Honor. That was based
17 on her prior testimony. But that's fine.

18 **Q: So let's look back then again at your decision**
19 **letter, page 1010 of DHEC 1.**

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

21 **A: Okay.**

22 **Q: And what are your findings with regard to**
23 **Standard 5?**

24 **A: That MUSC justified, through patient origin and**
25 **other data, the need for the new hospital at**

1 the chosen site and the potential adverse
2 impact of the new hospital at the chose site on
3 existing hospitals in the service area.

4 Q: Okay. So where is -- where is your analysis or
5 evaluation of either of those two elements that
6 we just talked about?

7 A: Well the evaluation was done during the review.
8 That's part of the review of the record and the
9 analysis of the methodology. The decision
10 contains findings ---

11 Q: Okay.

12 A: --- that come about as a result of that review
13 and analysis.

14 Q: So how do we know and how does the Court know
15 where MUSC justified, through patient origin
16 and other data, the need for a new hospital at
17 the chosen site? Where will we find the
18 information that satisfied your inquiry as to
19 that element?

20 A: Well, I believe that I've testified earlier
21 about what I saw as the justification and the
22 requirements of the standard.

23 Q: Okay. And so that's with regard to the
24 redirection analysis and the drive times?

25 A: The need analysis, the patient origin data,

1 that the -- that MUSC provided of it's target
2 population. Other data includes a great many
3 things including population changes, things
4 like that. The -- and then, you know, the site
5 specific redirections, and then the -- MUSC's
6 justification of the potential adverse impact
7 was based on it's premise that the shift of its
8 own patients would -- is where the volume would
9 come from. And so its justification or its --
10 the justification I guess means to provide a
11 reasonable basis for it, provide a reason for,
12 to provide a reason why was its -- the part of
13 its analysis that said basically the
14 redirection of our own patients will not
15 adversely impact existing hospitals in the
16 service area. That was MUSC's justification of
17 those two things.

18 Q: Okay.

19 A: That's a summary of it.

20 Q: Okay. And so is it your testimony that that
21 information is all found within the DHEC record
22 that you just described as supporting your
23 analysis? That's all within the DHEC record?

24 A: Well, the -- I mean, my analysis in general is
25 based on things that are in the record or

1 other, you know, information or data that I'm
2 allow to use as a reviewer -- that we're
3 allowed to use. But as far as MUSC's
4 justification ---

5 Q: Right.

6 A: --- which is specifically, MUSC has to provide
7 the Department with its reason for this or
8 that, or it's basis for this or that. MUSC's
9 conclusion was that the -- was that there
10 would be no adverse impact on existing
11 hospitals in the service area because the
12 patients would come to the facility as a result
13 of this redirection. All of that was based on
14 the origin and other data that MUSC provided in
15 its application, and that part is in the record
16 in the application.

17 Q: The assumption that that redirection means that
18 there won't be adverse impact ---

19 A: Yeah, I ---

20 Q: --- is that what you mean?

21 A: I think the language is something like that.
22 I'm paraphrasing but I believe it states
23 something like there will be no adverse impact
24 on existing hospitals or something similar.

25 Q: Okay. All right. You would agree with me that

1 location is generally acknowledged as one of
2 several considerations that go into a patient's
3 selection of a hospital, right?

4 A: I'm sorry, ask me that one more time?

5 Q: Sure. Would you agree with me that location is
6 generally acknowledged as one of several
7 considerations that goes into a patient's
8 selection of a hospital?

9 A: So you're not asking me if I believe that
10 location is important to a patient's choice;
11 you're asking me if I believe that other people
12 generally agree that location is an important
13 choice, an important component?

14 Q: Yes.

15 A: Yes.

16 Q: Yes. What you do in considering and planning
17 for health services ---

18 A: Yes.

19 Q: --- would you agree that geographic location of
20 a hospital is a consideration to a patient?

21 A: Yes.

22 Q: Okay. Would you agree that geographic location
23 of the hospital is a consideration to an
24 insurer?

25 A: It could be.

1 Q: Okay. And so where in the CON application or
2 anywhere in the record is there reasonable
3 support from MUHA for the notion that it can
4 shift its existing patient volume to a new
5 location without impacting volumes of other
6 service area providers?

7 A: The data and application and the analysis in
8 the application is what it is. I think I've
9 summarized in MUHA's, you know, theory and
10 analysis, and so I have to say the application
11 and the data, supporting data, speaks for
12 itself.

13 Q: Okay. So other than the data with numerical
14 numbers and percentages and maps -- what I'm
15 asking you is, where is there reasonable
16 support for the idea that Medical University
17 can shift existing patients to a different
18 location?

19 A: I'm still not sure what you're asking. It's a
20 prediction. MUSC predicts that the patients
21 will go to this location closer to their home
22 instead of going to the location that's on the
23 peninsula.

24 Q: Okay. Let's pull up Roper 137. Right now it's
25 a demonstrative mark-up.

1 (Roper Exhibit Number 137 was referenced at this
2 time.)

3 Q: Ms. Murdock, please feel free to take a minute
4 to orient yourself. This was back in the days
5 of the online filings for CON applications.
6 And you testified, I think, a couple times
7 today about reviewing projects by Medical
8 University for a pediatric ambulatory surgery
9 facility in North Charleston; do you remember
10 that?

11 A: Yeah, I wasn't the initial reviewer on either
12 one and I wasn't the reviewer at all one of
13 them, and I became involved in the ambulatory
14 surgery facility application review at some
15 point either close to the decision on that
16 review. Honestly, I don't recall whether I
17 wrote the decision or Sam Phillips wrote the
18 decision; I think he did.

19 Q: It was during the time, though, that Sam was
20 still the director?

21 A: It was very close to the end of his time as the
22 Director.

23 Q: Okay. But you are familiar with the project,
24 right?

25 A: I am.

1 Q: Okay. And you do recall, don't you, having
2 worked on it to some extent at the time of the
3 review, right?

4 A: I mean, I knew about it and discussed it, but
5 as far as the actual review of the project for
6 compliance, that wasn't necessarily me.

7 Q: Okay. Well, do you recall having a work file?
8 It was about 240 pages long of -- or MCM
9 working file for this project?

10 A: What's MCM?

11 Q: It's a -- that was the discovery notation of a
12 working file. Do you recall there being a
13 working file?

14 A: My working file?

15 Q: I -- well, DHEC -- the production doesn't tell
16 me whose working file it is.

17 A: Well, I mean, my initials are MPM, so if it's
18 possible that it's a P, then maybe that was my
19 working file. I know that I worked on the post
20 decision, some of the staff response and things
21 like that.

22 Q: Right. Take a look ---

23 A: So I don't know, I mean, it could be working
24 file of mine as a result of that, I just don't
25 know.

1 Q: Okay. Take a look if you would at the decision
2 letter. It's the very last few pages.

3 A: Okay.

4 Q: Before I hand it to you. And at the top, just
5 for the record, the numbers on it are RSF137-
6 046.

7 A: Okay.

8 Q: And do you recognize this?

9 A: This looks like a decision in this pediatric
10 ambulatory surgery facility matter.

11 Q: And the application was denied by the
12 Department, right?

13 A: Initially, yes, it was.

14 Q: Okay. And do you recall reviewing -- do you
15 recall from your review of this application
16 that the proposal from the Medical University
17 was a redirection of existing patient volume
18 from downtown campus to a proposed ambulatory
19 surgery facility in North Charleston?

20 A: This was a pediatric only facility, right?
21 Yes.

22 Q: This is ---

23 A: I recall that it was a pediatric only facility,
24 but I really don't recall the details of the
25 analysis. It's just -- I just don't remember.

1 Q: Okay. You -- let's see. Take a look at -- I
2 beg the Court's indulgence.

3 Okay. Well, would you agree with me that the
4 Department has found that detrimentally
5 shifting volumes away from service area
6 providers is adverse impact?

7 A: I -- it's possible. I mean, I -- without any
8 specifics if it's -- I mean, it's possible.

9 Q: Okay.

10 A: I can't say one way or the other.

11 Q: Okay. Would you agree with me that it's
12 unrealistic to believe that building a brand
13 new state of the art 128 bed hospital won't
14 affect patient referrals or utilization
15 patterns in a service area?

16 A: I believe that building a 128 bed state of the
17 art hospital will impact those patterns.

18 Q: Okay.

19 A: And a service area.

20 Q: Did the Medical University offer you any
21 analysis or information about that potential
22 impact on market share and referral patterns
23 and utilization?

24 A: Well, yes. And its conclusion was that there
25 would be minimal or no impact on -- adverse

1 impact on existing facilities. I can't say for
2 sure that it spoke specifically to -- I mean,
3 I know that its conclusion was that the adverse
4 impact would be minimal, but I can't say
5 without looking at the language. I don't want
6 to just blanket agree with that statement until
7 I can see it.

8 Q: Okay. Looking at -- looking at this decision,
9 of course this decision involved an ambulatory
10 surgery facility, right?

11 A: Right.

12 Q: And you're familiar with the standards for an
13 ambulatory surgery facilities?

14 A: I am.

15 Q: Okay. And you did work on the staff response
16 to a request for final review that Medical
17 University filed, didn't you?

18 A: I believe so.

19 Q: So you recall, don't you, that the Department
20 concluded that the Medical University failed to
21 document a community need for this ambulatory
22 surgery facility?

23 A: That sounds familiar. Again, it was a long
24 time ago, but that sounds familiar.

25 Q: Sure. And feel free to take a minute to

1 familiarize yourself with the decision.

2 A: It looks like the -- like we found that -- yes,
3 the applicant has failed to offer sufficient
4 documentation of a community need to justify
5 the relocation of its existing ASF pursuant to
6 802 of 61-15.

7 Q: Okay. And do you recall there being an
8 evaluation of both existing providers of
9 similar services in North Charleston as well as
10 a discussion of projects that had been approved
11 by the Department but were not yet implemented
12 at the time of review?

13 A: At the time of review of what?

14 Q: Of this application, of this denial.

15 A: I don't recall.

16 Q: Okay. Do you recall being concerned that some
17 of the statements made in the pediatric ASF
18 application were inconsistent with the
19 children's hospital replacement application?

20 A: Yes.

21 Q: Okay. And do you recall finding it
22 inconsistent that an application was based
23 fully on redirection but also proposed to
24 enhance care -- access to care for persons or
25 patients in the area?

1 A: I can't say that I recall that conclusion
2 specifically ---

3 Q: Okay.

4 A: --- one way or the other.

5 Q: Okay. And do you recall that the project, one
6 of the justifications was it was a means to
7 eliminate challenges that were currently placed
8 within the downtown facility?

9 A: That sounds like something that was in -- that
10 was in the application.

11 Q: Okay.

12 A: Yes.

13 Q: And do you recall concluding that those
14 constraints or problems downtown were not a
15 demonstration of community need for the
16 project?

17 A: I don't recall specifically one way or the
18 other making that conclusion.

19 Q: And thinking through to kind of familiarize
20 yourself or remind yourself of this project,
21 would you agree with me that there are some
22 striking similarities between the analysis and
23 the justification for the pediatric ASF in
24 North Charleston as this Berkeley County
25 community hospital project?

1 **A:** I don't know. I would have to go back and look
2 at the analysis. I really don't know.

3 **Q:** Well, you'd agree with me that both
4 applications propose that the projects will be
5 fully supported by redirected volume, right?

6 **A:** I can't recall for this pediatric ASF. I don't
7 recall.

8 **Q:** I thought you just recalled a moment ago in
9 your testimony that it was based on
10 redirection.

11 **A:** I may have said that sounds familiar, but I
12 don't recall specifically the analysis that was
13 given.

14 **Q:** Okay. All right. Do you recall, were you
15 involved in a project review meeting for this
16 application?

17 **A:** I believe so.

18 **Q:** Okay. Do you recall there being opposition by
19 several providers in the area?

20 **A:** Yes.

21 **Q:** Okay. That's what I get for not using yellow
22 paper.

23 **A:** Why don't you hand me some of that orange
24 paper, that's what I have.

25 **Q:** Couldn't find something that was in a bright

1 yellow folder -- orange folder. Ms. Murdock,
2 take a look at what I've handed you and we've
3 put a note on the top RSF DM 9 and flip through
4 that if you would.

5 (Roper St. Francis DM 9 was referenced at this time.)

6 A: Okay.

7 Q: Okay. Do you recall this document?

8 A: It looks like a draft of a staff response.

9 Q: Well, it's a signed staff response, right?

10 A: Well, it's signed by one. It's signed by me,
11 but not by Jennifer, the chief counsel, and
12 that usually means that it's still a draft.

13 Q: Okay. And I'll represent to you we've put on
14 the bottom 'cause the Department doesn't --
15 didn't use Bates numbering, but it was produced
16 in DHEC's files as DHEC 20028 Signed Staff
17 Response 15-RFR-80; do you see that?

18 A: Okay, yes.

19 Q: Does that sound like a way that it would be
20 found in your files in terms of how you would
21 describe this particular document?

22 MS. CRUM: Your Honor, I think I understood, and
23 correct me if I'm wrong, Ms. Hollingsworth, but
24 I thought that you said that -- or somebody
25 said this was a draft document?

1 MS. HOLLINGSWORTH: I didn't say that.

2 THE COURT: I think they're exploring about whether

3 ---

4 **A: It is a draft.**

5 THE COURT: --- it is or is not right now.

6 MS. CRUM: All right, sir. Because if it's a draft,
7 I'm going to object to it coming in, just like
8 they objected to the 2020 State Health Plan
9 coming in.

10 THE COURT: Well, I think ---

11 MS. CRUM: Or to her questioning.

12 THE COURT: --- seems like to me the path they're
13 going right now is to figure out whether it is
14 or is not.

15 MS. CRUM: Okay. I just ---

16 THE COURT: Okay.

17 MS. CRUM: --- want to object if it is.

18 MS. HOLLINGSWORTH: I haven't offer it, Your Honor,
19 up right now.

20 THE COURT: Okay.

21 MS. HOLLINGSWORTH: I'm just trying to authenticate
22 it and determine whether it's this witness's
23 document.

24 **Q: Ms. Murdock, is this your signature on the last**
25 **page of the document?**

1 **A:** It is my signature.

2 **Q:** And I believe you testified a few moments ago
3 that you do recall being involved in a staff
4 response to a request for final review, right?

5 **A:** Yes. I feel like I should say that my
6 involvement in the staff responses usually
7 involves a lot of back and forth with our
8 office of general counsel, so. And this, with
9 one signature on it, is part of that.

10 **Q:** Okay. Who would have drafted the summary of
11 staff decision portion of this document?

12 **A:** If this -- again, it often was just kind of a
13 joint project, especially at this point in time
14 so soon after the restart.

15 **Q:** Okay. So is it your testimony that the summary
16 of staff decision information would be provided
17 by someone other than you, the reviewer?

18 **A:** I can tell you that more than one person was
19 working in authorship of this document. It
20 would have been me and one of our attorneys.

21 **Q:** Okay.

22 **A:** And so I can't recall which -- exactly which
23 parts of this would have been provided by me
24 and which parts would have been provided by
25 someone else.

1 Q: Sure. And I'm not -- and setting aside the
2 relevant law, what I'm trying to determine who
3 would have provided information that would be
4 a summary of staff's decision?

5 A: Again, at this point this was -- there's no
6 date on here, so at this point early in the
7 game back in 2015, it -- later down the road
8 the role in drafting these -- the roles in
9 drafting these staff responses became more
10 clearly delineated, but this soon after
11 restart, there were multiple people working on
12 the staff responses and collecting information
13 which would have been available in the record.
14 And so staff would have made some contributions
15 and Office of General Counsel would have made
16 some contributions.

17 Q: Okay. Go back to the decision letter that's at
18 the back of the first document I handed you,
19 RSF 137.

20 (Roper Exhibit Number 137 was referenced at this
21 time.)

22 A: Okay.

23 Q: All right. And if you could turn to page 3 of
24 -- it says page 3 at the top of the -- it's
25 page 3 of the letter, so RSF 137-048. And at

1 the bottom of that sort of -- well, you'll
2 agree with me that first kind of main
3 paragraph, it says, Certificate of Need
4 Standard 3? Do you see that language, that
5 section?

6 A: I see it.

7 Q: Okay.

8 A: Yes.

9 Q: And at the bottom of that main paragraph, sort
10 of nearly the bottom, there's a sentence that
11 says, the Department finds that the applicant
12 has failed to adequately consider the impact of
13 the proposed project on patient volumes and
14 existing ASFs in the PSA and whether the
15 proposed project will shift patient volumes at
16 the existing facilities in a manner that will
17 cause them economic harm. Do you see that?

18 A: Yes.

19 Q: Okay. And it goes on to say adequate
20 consideration of a project's effect on the
21 patient volumes of existing facilities is not
22 only required by the 2012-13 SHP, it is
23 especially important with regard to this
24 application, as Charleston County has the most
25 extensive and diverse inventory of ambulatory

1 and outpatient surgery facilities in the entire
2 state. Do you see that?

3 A: Yes.

4 Q: Would you agree with me that Standard 5 in the
5 Health Plan applicable to the community
6 hospital application considers important the
7 potential adverse impact on existing facilities
8 in the proposed service area?

9 A: I think the standard speaks for itself. It
10 requires the patient to provide some
11 justification in connection with potential
12 adverse impact, and I don't want to read -- I
13 don't want to substitute my own words for the
14 standard's words.

15 Q: Okay. But I'm asking you to consider the
16 language here used in this decision letter.
17 I'm asking if similarly Standard 5 in the
18 Health Plan for general hospital beds also
19 finds important the impact, potential impact,
20 on existing facilities?

21 MS. CRUM: Your Honor, first off it's been asked and
22 answered and she's being argumentative with the
23 witness.

24 THE COURT: I don't think it's been answered in the
25 way she's asked.

1 MS. CRUM: Okay. I don't think she's got an answer
2 she wanted ---

3 THE COURT: Well ---

4 MS. CRUM: --- but I think it was asked.

5 THE COURT: --- well, go ahead. One more time.

6 MS. HOLLINGSWORTH: Okay, Your Honor.

7 Q: Ms. Murdock, will you agree -- do you agree
8 with me that, similar to what we just read for
9 Standard 3 as applied to ambulatory surgery
10 facilities, that Standard 5 in the 2017 Health
11 Plan for the proposed hospital project that
12 we're here for, that it similarly considers
13 important the impact a proposed project may
14 have on the volumes of other existing
15 facilities in the service area?

16 A: Well, I -- you're asking me to agree with
17 something that makes a supposition about
18 something else that I've just talked about and
19 said that I don't want to substitute my words
20 for the standard's in -- in Standard 5 language
21 in the State Health Plan. That is a
22 requirement specifically to that standard that
23 an applicant provide justification for this and
24 that thing. And so you're asking me to agree
25 that this standard does something that I never

1 did agree that the other standard does. So I
2 can say Standard 5 requires an applicant to
3 justify, through patient origin and other data,
4 the need for the proposed hospital. It also
5 requires the applicant to justify -- and again
6 I'd like to go back to the language and read
7 exactly what it requires the applicant to do to
8 justify this and that. You're asking me to
9 make a supposition that that means something
10 that the standard doesn't say and then apply
11 that to this language that comes from a
12 different year's health plan about a different
13 service. And so I can't -- I'm not comfortable
14 with agreeing with that statement the way that
15 you've said it. So, no.

16 Q: So you will agree with me, won't you, that
17 Standard 5 in the 2017 Health Plan requires the
18 applicant justify the potential adverse impact
19 a new hospital at the chosen site could have on
20 the existing hospitals in the service area?

21 A: Yes ---

22 Q: Do you agree with that?

23 A: --- I will agree with that. I have already
24 agreed that it says that.

25 Q: Okay. And do you agree with me that the Tri-

1 County service area has the most -- the highest
2 volume or the most in number of acute care bed
3 as compared to any other service area in the
4 state?

5 A: That wouldn't surprise me, but I haven't gone
6 back to look and count all the beds. We looked
7 at MUSC's beds and it has the most. It
8 wouldn't surprise me to know that Charleston
9 County has the most, but I'd have to go back
10 and check.

11 Q: Okay. So you're not familiar with whether or
12 not, I think it's the 18, little over 1,800
13 beds in the Tri-County service area, is the
14 most acute care hospital beds in a service area
15 in the state?

16 A: Again, it would not surprise me to know that
17 that's true, but I haven't specifically
18 verified that for myself.

19 Q: Okay.

20 A: So if you'd like to count them, we can, but I
21 don't know that for a fact without looking.

22 Q: Okay. Take a look at the next page of the
23 decision.

24 A: Uh-oh, I lost my place. Hold on.

25 THE COURT: You can look on the screen.

1 A: I got it. I'm sorry.

2 Q: Pull out that middle paragraph.

3 A: I'm having a hard time reading what's on the
4 screen with or without my glasses.

5 Q: Can you pull it out? It's the last couple of
6 pages of the document.

7 A: I'm here though. I found it.

8 Q: You got it? Okay.

9 A: I'm here.

10 Q: And I will read into the record if that'll
11 help. This letter, the decision letter,
12 December 4, 2015 to Dr. Cawley says, location
13 is generally acknowledged as one of several
14 considerations that goes into a patient's
15 selection of a surgical facility. Applicant's
16 assertion that the shift if its patients from
17 an existing facility to another part of the PSA
18 will have no affect on the patient volumes of
19 other surgical facilities is contrary to this
20 understanding and essentially asks the
21 Department to find that the geographic location
22 of a surgery center is of no importance to a
23 patient, insurer or healthcare provider in
24 selecting a surgical facility. Would you agree
25 with me that similarly, here, that the

1 assertion by the Medical University that it
2 will only redirect its own patients and will
3 have no effect on the volumes of other
4 providers of similar services is contrary to
5 the understanding that location is an important
6 consideration for patients of the hospital that
7 they choose?

8 A: I apologize. I need you to ask me that
9 question again. I got a little lost.

10 Q: Sure. I'm just trying to confirm whether you
11 agree similar to this finding here that the
12 Department made in the pediatric ASF
13 application, would you agree with me that
14 similarly, the proposal that the Medical
15 University makes in this case, that they are
16 going to only redirect their own patients. You
17 agree with m that that's their proposal, right?

18 A: That is -- that's a reasonable summary of their
19 proposal, yes. Not unlike Berkeley Medical
20 Center and, in part, the Roper Berkeley
21 project.

22 Q: Okay. Well, Roper Berkeley's project assumed
23 a change in market share, right?

24 A: Forty percent of its patients would come from
25 a change in market share, which would make

1 sense since Roper already had a lagging
2 utilization at its own facility that it would
3 need to generate market shares some other way.
4 That's part of that analysis. I don't ---

5 Q: Sure.

6 A: --- I mean that is a factor there, so it's not
7 an apples to apples comparison.

8 Q: Right. Medical University did not do that
9 analysis in the application that's at issue
10 here, did they?

11 A: Are you talking about the ASF or the ---

12 Q: At issue here in this case?

13 A: In this case? What analysis?

14 Q: They did not do an analysis of any change of
15 market share, did they?

16 A: They did not assume that 40 percent of their
17 patients would come from the market. New
18 patients from new market share.

19 Q: You'd agree with me that they ---

20 THE COURT: Okay. Could you answer her question so
21 we can keep this moving along?

22 Q: Would you agree with me that they assumed zero
23 percent of their patients would come from
24 anyone other than their own patients?

25 A: Yes.

1 Q: They did not assume any change in market share,
2 right?

3 A: That's correct. They did not.

4 Q: Would you agree with me that this assertion
5 that there will be no shift in market share is
6 not reasonable in light of how location is an
7 important consideration for patients obtaining
8 care?

9 A: I wouldn't necessarily say that it's not
10 reasonable. I think that, however, that it's
11 quite possible that there will be a shift, some
12 shift in market share based in part on
13 location. But I'm not going to say that that
14 analysis is unreasonable regardless of what Sam
15 Phillips said in connection with this
16 ambulatory surgery facility, which is an
17 ambulatory service which is a different type of
18 service and has -- you know, location is
19 certainly important with an ambulatory service,
20 even more so I would believe, than an inpatient
21 facility. But -- maybe I can help us move
22 along -- I think that the location of a
23 hospital is important, and I believe that it's
24 reasonable to assume that there may actually
25 be, in fact, some shift in market share as a

1 result of the MUHA project. That doesn't mean

2 I believe that their premise is unreasonable.

3 Q: Okay.

4 A: It's a prediction and so it's possible that
5 there could be other results other than what
6 MUHA's predicted, and I don't think it's
7 unreasonable to assume that there will be a
8 shift of some kind in market share based on the
9 location.

10 Q: I understand that, Ms. Murdock, but what I'm
11 asking you is what's in the application and
12 what the applicant proposed.

13 A: You're asking me about what's in this other
14 decision that has to do with a different
15 facility type and trying to make me match that
16 up, and I'm having a little trouble following
17 you there.

18 Q: I am asking you about a prior decision that
19 involved the same applicant and involved the
20 same analogy in terms of how the project, where
21 the patients would come from, right? A hundred
22 percent redirection.

23 A: I don't recall that analysis. I need to back
24 and look at the application to make sure that
25 it is in fact the same because I don't know

1 **that.**

2 MS. CRUM: Your Honor, at this point, counsel is
3 just arguing with the witness. She has said
4 what she knows. And she's trying to get her to
5 say something and she said what she knows.
6 She's simply arguing with her at this point.

7 THE COURT: I think that cross-examination consists
8 of presenting questions that may be difficult
9 at times. So, if she gets to the point of
10 harassing her or becoming argumentative in her
11 approach, I will agree with you, but I don't
12 see that at this point.

13 MS. CRUM: Well I think it's right on the borderline
14 of being argumentative, Your Honor.

15 THE COURT: Overruled.

16 MS. HOLLINGSWORTH: Thank you, Your Honor.

17 **Q: Ms. Murdock, in -- let me just lay a little bit**
18 **more of a connection here so that we can move**
19 **on because I do think and I agree that the**
20 **document speaks for itself. To your knowledge**
21 **-- and let me ask it this way. Mr. Phillips**
22 **was gone by the time you worked on this staff**
23 **response to the request for final review,**
24 **right?**

25 **A: I think so. I'd have to look at the date.**

1 Again, the draft isn't dated and I can't really
2 remember. It wouldn't surprise me if he was
3 gone. And this case was complicated because
4 ultimately we actually were -- we approved the
5 project, so there was kind of a lot going on,
6 and so I really am not trying to be difficult
7 with the time line. I don't know whether or
8 not he was gone. Based on the RFR number here,
9 even, I can't tell when in the year this
10 decision was -- when the request for final
11 review was submitted, so I really don't know.
12 I know he left kind of during all of this but
13 I don't remember exactly when. And then even
14 when he did leave he sort of stayed on in a
15 temporary capacity and then ended up doing some
16 work on contractual basis with the Department.
17 So unfortunately there's not a clear finite
18 leaving date for Sam Phillips.

19 Q: Okay. Let me ask you this, that request for
20 final review that we're looking at, that does
21 have your signature on the last page, right?

22 A: Yes.

23 Q: Okay. And is it your practice to sign
24 documents before you've determined that they're
25 ready for your signature?

1 **A:** Typically, no. This was a unique type of
2 document though.

3 **Q:** Are requests for final review responses are
4 unique?

5 **A:** Our way that we prepared staff responses and
6 the way that I communicated with our Office of
7 General Counsel in connection with preparing
8 the staff response was unique.

9 **Q:** Okay.

10 **A:** There was a lot of back and forth and so we
11 would try to facilitate completion of the
12 document and sometimes that involved me signing
13 a document and sending it subject approval from
14 someone else.

15 **Q:** Okay.

16 **A:** So I might've at the time thought it was
17 signable. That is a reasonable assumption that
18 I would not have signed it absent that.

19 **Q:** Ms. Murdock, I've handed you a document. This
20 is the document that I described in the DHEC
21 discovery and I thought it said MCM working
22 file. I do think that's how it was labeled.
23 I don't know where that came from, but would
24 you flip through this and tell me if this
25 appears to be your handwriting or might it be

1 someone else's?

2 A: No, this is my handwriting. Yes.

3 Q: So would you agree with me that this is your
4 work file related to your review of that
5 application, that pediatric ASF application?

6 A: I'm now believing that that C is really a P and
7 this it was MPM work file.

8 Q: Okay. And so taking a look through this, I
9 mean, does this refresh your recollection that
10 you did work, whether it was at the response to
11 request for review or leading up to the
12 decision, that you assisted in DHEC's review of
13 this application?

14 A: Oh, I assisted in the preparation of the staff
15 response, I have no doubt about that; I know I
16 was involved in that. But when I came on board
17 and at what point Sam left I don't know and a
18 lot of this was, you know, I was working on
19 kind of -- at the direction of Sam Phillips at
20 least while he was there to look at this or
21 that and find evidence of this or that and come
22 up with a staff response.

23 Q: And ---

24 A: But this is definitely my work. I remember
25 working on it.

1 Q: Okay. And will you agree with me that your
2 work in reviewing the request for final review
3 and preparing the staff response, that your
4 work was in support of the decision that the
5 Department made denying the application?

6 A: Yes, at this point it was. This was before we
7 ended up approving it, so this -- at this point
8 in time I was working on the support for the
9 denial, yes.

10 MS. HOLLINGSWORTH: Your Honor, I would move to
11 admit what I have marked as Roper St. Francis
12 137, which is excerpts from the pediatric ASF
13 application. This is an application that was
14 filed online, so it's sort of in a number of
15 parts. So, for the record, the parts that we
16 have are sort of the introductory download
17 pages, then it's the need section, and I think
18 the deemed complete letter and the decision
19 letter or what we have marked as Roper St.
20 Francis 137.

21 MR. WICEVIC: Ms. Hollingsworth, is this what you
22 just handed me?

23 MS. HOLLINGSWORTH: No, the one -- the first one
24 that walked through ---

25 MR. WICEVIC: Okay.

1 MS. HOLLINGSWORTH: --- that we planned ahead

2 enough to have a sticker superimposed on.

3 MR. WICEVIC: And you said it's not the complete

4 record?

5 MS. HOLLINGSWORTH: It's excerpts like we've done

6 the excerpts of applications. So it's an

7 excerpt from the online application produced in

8 discovery by the Department.

9 MR. WICEVIC: No objection subject to perhaps giving

10 us an opportunity to review ---

11 THE COURT: And supplement it?

12 MS. HOLLINGSWORTH: Sure.

13 THE COURT: Yeah, no problems.

14 MS. HOLLINGSWORTH: If you want to put more pages

15 in, of course.

16 MR. WICEVIC: Sure.

17 MS. HOLLINGSWORTH: Yes, we'd be happy to add those

18 to the exhibit.

19 MS. CRUM: Your Honor, I would say also that it is

20 in incomplete and it doesn't even have the

21 decision where the application was finally

22 approved as Ms. Murdock has testified.

23 THE COURT: Testified.

24 MS. CRUM: And so I think it needs to have that.

25 And it was approved -- it was disapproved by a

1 different director 'cause it had to have been
2 approved by a new director because she's
3 already testified that Mr. Phillips was gone.
4 So, you know, I -- it doesn't even have the
5 final approval letter of the project so it's
6 totally incomplete and until we have that in
7 there, then I would object. But subject to
8 getting the complete file, including the
9 approval letter.

10 THE COURT: Your response?

11 MS. HOLLINGSWORTH: There's ---

12 MR. SUMMER: Your Honor, I'm looking at it. There
13 were plenty of applications that have been
14 dealt with and come in regarding our clients
15 and we've agreed to accept excepts of them, so
16 for me it's goose and gander.

17 THE COURT: Yeah, I just ---

18 MS. CRUM: Your Honor, may I respond to the goose
19 and gander because they specifically ---

20 THE COURT: You don't need to respond ---

21 MS. CRUM: --- wanted me to put a letter in ---

22 THE COURT: Here's my ruling, is Mr. Wicevic asked
23 for the opportunity to supplement it if need
24 be, and I'll certainly allow you to do that.
25 When you say it's not -- something's not in,

1 fine. Find what you want in and put it in, but
2 right now I'm going to admit this Exhibit and
3 allow you to either supplement this Exhibit or
4 present your own exhibit that results in a
5 supplementation of said exhibit.

6 MS. CRUM: Your Honor, we would just -- we would
7 like to supplement it just with this exhibit.

8 THE COURT: Okay.

9 MS. CRUM: Just like Trident wanted to supplement
10 our Exhibit 22.

11 THE COURT: I get it. That or was giving you the
12 option.

13 MS. CRUM: Thank you, sir.

14 THE COURT: Okay.

15 (Roper 137 was admitted into the record at this
16 time.)

17 MS. HOLLINGSWORTH: And just to assist with the
18 record, Your Honor, there is no other letter
19 approving it. There is no other documentation
20 of the Department changing this decision.
21 There was a contested case that was filed --
22 and, Ms. Murdock, correct me, of course, if I'm
23 wrong. There was a contested case that was
24 filed.

25 **A: Yes.**

1 MS. HOLLINGSWORTH: And that contested case was
2 settled and as part of the settlement, which is
3 just a couple paragraph sentence Order, the
4 Department's decision was reversed and a CON
5 issued, correct?

6 **A: That's correct, there was a new decision**
7 **letter.**

8 MS. HOLLINGSWORTH: There is no other analysis or
9 writing that changes the Department's findings.

10 MS. CRUM: Yes, Your Honor, I would just say that
11 it's very important to have a complete record,
12 to have the Order that reversed the DHEC
13 decision and issued this -- and required the
14 CON to be issued.

15 THE COURT: And I am sure that you are more than
16 capable of finding that Order and supplementing
17 it in there.

18 MS. CRUM: Thank you, sir. We will do that.

19 THE COURT: All right.

20 MS. HOLLINGSWORTH: And, Your Honor, we -- I don't
21 have it right now, it says RSF DM9, but I would
22 also move to have the staff response to request
23 for final review that is signed by Ms. Murdock.
24 I offer that into evidence. If accepted we
25 would provide a copy that's marked Roper St.

1 Francis 138.

2 THE COURT: You may have a little more rough
3 sledding on this one, but we can ...

4 MS. HOLLINGSWORTH: I figured I'd get them all done
5 at once, Your Honor.

6 THE COURT: Okay.

7 MR. WICEVIC: And, Your Honor, I think she testified
8 she wasn't sure if this was the final copy.

9 THE COURT: Yeah.

10 MR. WICEVIC: So as far as the reliability of it,
11 it's in question.

12 THE COURT: Okay.

13 MS. CRUM: I agree with him.

14 THE COURT: Okay. Any response?

15 MR. SUMMER: It's my understanding that it was
16 produced by the Department in discovery which
17 to me means we ought to be able to use it.

18 THE COURT: This does -- you probably produced it in
19 discovery, it does authenticate it as a
20 document that the Department -- was in the
21 Department's files, but it doesn't authenticate
22 it as the final determination.

23 MS. HOLLINGSWORTH: And that's fine, Your Honor. I
24 would of course point out, it's the witness on
25 the stand that signed the document, so it does

1 bear her signature. And I'm happy for the
2 Court to give it whatever, if any, weight, but
3 I think in terms of its admissibility it's a --
4 I think the foundation's been laid. It's a
5 record of the Department, and there is no ---

6 THE COURT: Okay.

7 MS. HOLLINGSWORTH: --- there is no other version, I
8 guess I would say, Your Honor. They didn't
9 provide any other signed response, so this is
10 the last word that the Department has.

11 THE COURT: Well that's the last word they produced.

12 MS. HOLLINGSWORTH: Well that's true, Your Honor.

13 THE COURT: For what purpose are you offering the
14 exhibit? To impeach her regarding what?

15 MS. HOLLINGSWORTH: No, Your Honor, I think this
16 goes to the similar analysis that this same
17 witness and this -- the Department's analysis
18 of issues that I believe are relevant and
19 similar here. For example, a project that
20 relied entirely on patient redirection. A
21 project where the applicant did not address or
22 document any adverse effect. So I think it's
23 relevant to this Court's inquiry. Those are
24 issues in dispute and so I think this is sort
25 of prior precedent in interpretation of the

1 Department of similar issues.

2 THE COURT: Where I can understand, Ms. Murdock,
3 you're telling me that this document -- or
4 you're not sure if this document was the final
5 decision or not?

6 **A: Well the staff response is ---**

7 THE COURT: Or the final staff response or not?

8 **A: Right. It's usually not the final response**
9 **until both of the -- the attorney and the staff**
10 **person signed it and then it's submitted as the**
11 **staff response.**

12 THE COURT: Well, where would there be another one?

13 **A: I would have expected it to be part of the RFR**
14 **file wherever the -- but once the request for**
15 **final review is submitted to DHEC, that request**
16 **is submitted to the Clerk of the Board and not**
17 **the CON staff. So those documents are a part**
18 **of the CON staff files. So I can't answer**
19 **where the final one would be. I would have**
20 **expected it to be part of the RFR file that**
21 **would be ---**

22 THE COURT: Well here, let me ask you this where I
23 could -- what you signed, could it have changed
24 after you signed it or -- let's just go with
25 that. Or would you have known if it had

1 changed after you signed it? I know that's a
2 compound question.

3 A: Well, the answer, it could have changed, yes.
4 What I know based on looking at this one, no.
5 But I would have known if our staff response
6 had been changed because there were occasions
7 when I would complete my portion of it and
8 then, because we're in different buildings, I
9 would e-mail it over to our counsel and she
10 might have found something that she wanted to
11 change or make some suggestions and then had --
12 have sent me back another version to sign again
13 and give to her so that she could sign it and
14 give it to the Board. So my -- what I would
15 typically do is send a signed copy if I thought
16 I was done, but also send the Word version so
17 that she, and then later he, could make
18 comments and revisions. The reason why --
19 sometimes, not all the times, but the reason
20 why I would go ahead and send a signed version
21 is so that if it met with approval, then either
22 Ms. Biggers or Mr. Wicevic would not have to
23 seek me out again for my signature.

24 THE COURT: All right.

25 A: So it's here -- here's -- I think I'm done,

1 **here it is. If you think we're done you sign**
2 **it and go and then it goes to the Board, the**
3 **clerk of the Board.**

4 MS. CRUM: Your Honor, I'd just point out again that
5 ultimately this decision was reversed by the
6 Administrative Law Court.

7 THE COURT: Well, it really is taking -- all of this
8 is taken care of in the other exhibit by and
9 large anyway, so ---

10 MS. CRUM: Yes, sir.

11 THE COURT: So I'm just going to sustain the
12 objection on this exhibit from what I've heard.

13 MS. HOLLINGSWORTH: Okay. Thank you, Your Honor.

14 **Q: If we could take a look at the 2017 Health**
15 **Plan, it's DHEC 4. If you could, Ms. Murdock,**
16 **could you take a look at the red inventory?**
17 **And as I've heard used, we're in the home**
18 **stretch, I promise.**

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

20 **A: That's okay. I'm here 'til we're done.**

21 THE COURT: I have a tendency -- I have in the past,
22 unlike staying with Judge Bagel (ph) until
23 11:00 o'clock at night. Do you want -- you
24 gonna commit to that?

25 **A: I would. I wouldn't ask everyone else here to**

1 do that, but this is a big deal. It's a big
2 case, and it's important ---

3 THE COURT: Well good.

4 A: -- so I'm here until we get what we need from
5 me.

6 THE COURT: Okay.

7 A: So.

8 Q: All right. It's page 27 of the Plan. On the
9 screen it's right.

10 A: Okay.

11 Q: And, Ms. Murdock, we're taking a look at the
12 inventory of acute care beds in the 2017-2018
13 Health Plan. We talked about this briefly but
14 we didn't have this document in front of us.
15 Would you agree with me that in this plan there
16 are 1,811 existing beds in the Berkeley,
17 Charleston, Dorchester service area?

18 A: Yes.

19 Q: Okay. And that this is the Health Plan that
20 the 50 beds for Berkeley Medical Center are not
21 reflected in the Trident Medical Center and
22 Berkeley Medical Center line item at the top of
23 the page?

24 A: I am 95 ---

25 Q: Yeah.

1 A: --- percent sure that that's the case.

2 Q: Okay.

3 A: So, yes.

4 Q: And so if that were the case, then it's the --
5 the number would be 1,861; is that right?

6 A: Yes, that's right.

7 Q: Okay. And you can flip through, and I think
8 when you were talking with Ms. Crum you had
9 identified the likely sources, but do you see
10 any other service areas that have an existing
11 bed count that is as high as what we have in
12 the Tri-County service area?

13 A: Give me one second. I'll do this as fast as I
14 can. Okay. No, I do not see any other service
15 area that has a higher number of existing beds
16 ---

17 Q: Okay.

18 A: --- than the Tri-County service area.

19 Q: And the closest I saw, Greenville I believe was
20 around 1,262 and Richland was around 1,274.
21 Those were about as high a count as I saw.

22 A: Those were where I went to look for higher bed
23 counts, so, yeah, that sounds right.
24 Greenville's 1,179 and Richland is 1,274.

25 Q: Okay. And ---

1 A: I said Greenville wrong. It's 1,262.

2 Q: Okay.

3 A: Sorry.

4 Q: 1,262. I -- it seems I had it written down
5 wrong so you're good. Thank you for fixing
6 that. Now there was a lot of this and even on
7 -- in your direct and maybe some cross you were
8 asked about distribution, and I think you
9 volunteered that you agree with Mr.

10 Richardson's testimony in the earlier case that
11 there was a mal-distribution of beds within the
12 service area; do you recall that?

13 A: Yes.

14 Q: Okay. And do you recall the time of his
15 testimony was there was a mal-distribution of
16 beds and there were no beds in Berkeley County,
17 right?

18 A: Yes.

19 Q: At the time of his prior testimony?

20 A: Yes.

21 Q: Okay. And looking at the Health Plan and the
22 distribution of where the beds are located, so
23 of the -- and this is math, I'm not going to
24 lie, I have math, and I wrote it all down so I
25 don't ---

1 A: I can't do it without a pencil or something,
2 so, okay.

3 Q: I do have a calculator if you need to test me.

4 A: I think I saw one up here.

5 Q: Is there one up there?

6 A: Well there's one up there. I've also got my
7 phone if I can use my phone.

8 Q: No long division at all.

9 A: Okay.

10 Q: Just adding. I promise. Some dividing.

11 A: All right.

12 Q: All right. So if you will assume with me that
13 it is 1,861 'cause that -- credit those 50 beds
14 ---

15 A: Okay.

16 Q: --- to Berkeley Medical Center.

17 A: All right, sure.

18 Q: If you could, how many of the beds are beds
19 within the Roper St. Francis system?

20 A: That would be -- I'm getting 605; does that
21 sound right?

22 Q: Okay. Did you get that by looking at the 316
23 beds at Roper Hospital, 204 beds at Bon
24 Secours-St. Francis, and 85 at Roper Mt.
25 Pleasant Hospital?

1 A: Yes.

2 Q: Okay. So 605 of the beds are with Roper St.
3 Francis. How many of the service area beds are
4 with the Trident Health System?

5 A: Would you like me to include the 50 beds?

6 Q: Yes, ma'am.

7 A: Okay.

8 Q: Please.

9 A: That's 470 beds.

10 Q: Okay. Yep, that's what I've got. 296 at
11 Trident Medical Center, right?

12 A: Right.

13 Q: And 124 at Summerville Medical Center?

14 A: Yes.

15 Q: And then the 50 beds for Berkeley Medical
16 Center, right?

17 A: That's right.

18 Q: And then we have East Cooper here that has 130
19 beds; is that right?

20 A: That's right.

21 Q: Okay. So I -- when I tallied those up, I got
22 1,205 when I added the 605 beds, I hope that's
23 what I got, the 605 beds that Roper had, the
24 470 beds with Trident and 130 beds at East
25 Cooper.

1 A: 1,205.

2 Q: Did you get that as well?

3 A: That's what I got.

4 Q: All right. And so would you agree with me that

5 those beds account for 65 percent of the

6 service area beds in the Health Plan; is that

7 right?

8 A: Give me one second and I will answer that.

9 Wait, how many?

10 Q: So 1,205 of the beds ---

11 A: Okay.

12 Q: --- of the 1,861.

13 A: I did the wrong math. Sorry about that. Hold

14 on.

15 Q: I did 1,205 divided by 1,861 and I've got ---

16 A: Yeah, I forgot to ---

17 Q: 65 percent.

18 A: --- I forgot to do 61. I did 11 instead --

19 okay, yeah, 65 percent.

20 Q: Okay.

21 A: Yes.

22 Q: So would you agree with me that there's only

23 one provider in the service area that has the

24 other 35 percent of the service area beds?

25 A: Yes.

1 Q: Okay. And that's ---

2 A: MUSC.

3 Q: --- the Medical University, right?

4 A: Yes.

5 Q: And so the Medical University, which has 35
6 percent of the service area beds, has placed
7 all 656 of those beds on the Charleston
8 peninsula, right?

9 A: Right.

10 Q: Okay. And would you agree with me that over
11 the past number of plans, I can't -- I'm not so
12 long that I know all of them, but you would
13 agree with me that for the last decade plus
14 that that bed need formula, for purposes of
15 this service area, used the Tri-County
16 population data?

17 A: Yes.

18 Q: Okay. So the beds that have been amassed by
19 the Medical University has been based on the
20 Tri-County population data, right?

21 A: Yes.

22 Q: Okay. But the Medical University elected to
23 put them all on the peninsula downtown, right?

24 A: Yes. All of those, yes. All of the 656 beds.

25 Q: Okay. And so would we -- is it still your

1 personal belief that it's unfair that MUHA is
2 buttoned in on the peninsula?

3 A: Well, I mean, it depends on why. If MUSC chose
4 to be buttoned in on the peninsula then, no.
5 But if -- but if the -- if they're otherwise
6 buttoned in on the peninsula if they would like
7 to place beds somewhere else, I guess all the
8 other things being equal, it really depends on
9 why they're buttoned in on the peninsula.

10 Q: Okay. Well, would you agree with me that at
11 least the last time we spoke that it was your
12 personal belief that it was unfair that MUHA
13 was buttoned in on the peninsula, right?

14 A: I think -- I'd be surprised if I said that just
15 in a vacuum. It was probably -- I would have
16 -- I do believe that it would be unfair to
17 assume that because MUHA has not yet ever moved
18 off the peninsula that it is now -- should not
19 be allowed to move off the peninsula because --
20 for whatever reason. It's late to the party,
21 or, you know, other systems have claimed
22 territory or planted flags or what have you.
23 If that was the reason, I don't -- I don't see
24 that as a valid goal of CON. And so if the
25 purpose is just to keep MUSC out of anybody

1 else's sandbox, then I don't believe that, in
2 and of itself, is necessarily a fair scenario
3 or a laudable goal of health planning.

4 **Q:** Well, as I understood it, it was your thought
5 that every time MUHA attempts to develop
6 something off the peninsula, they're challenged
7 on every front by other hospitals that have
8 multiple hospitals, right?

9 **A:** Something like that. I wouldn't say one
10 hundred percent of the times, but more often
11 than not when -- certainly whenever MUHA has
12 ever tried to do a CON project in Berkeley
13 County or in North Charleston or anywhere other
14 than the peninsula and then I think maybe West
15 Ashley or somewhere close to the coast, then it
16 is challenged by the other systems in the area.

17 **Q:** Okay. Well, let me ask you this. Since 2008
18 you're aware, aren't you, that the Medical
19 University has spent hundreds of millions of
20 dollars to build two new hospitals on the
21 peninsula?

22 **A:** There are no new hospitals on the peninsula.
23 There is a building that is the new children's
24 -- it's not a hospital by itself; it's part of
25 MUSC's license. So I want to be careful

1 calling it a new hospital. It's a kind of
2 shorthand referred to as a replacement
3 hospital. It's a replacement building for what
4 MUSC refers to as MUSC Children's Hospital.
5 But like the Palmetto Health Children's
6 Hospital, it's actually not a separate
7 hospital. It's just a separate building that's
8 for pediatrics but it's still under the same
9 license.

10 Q: Okay. But setting aside sort of the
11 technicality and the word hospital, you'll
12 agree with me that the Medical University spent
13 nearly 300 million dollars to build a four
14 story 600,000 square foot facility called the
15 -- today it's called the Ashley River Tower,
16 and it has a 156 beds in it, right?

17 A: That sounds right. I'm not familiar with the
18 exact cost of that project but the cost numbers
19 you mentioned don't surprise me, and I'm sure
20 it'd be easy for me to verify that, so no, that
21 doesn't surprise me.

22 Q: And you know it has its own emergency
23 department, right?

24 A: It has a -- again, the emergency department is
25 all one -- a part of one license, and so it has

1 an area that serves ED patients but it is not
2 a separate department.

3 Q: Okay. You'll agree with me that the Medical
4 University describes them as three emergency
5 departments that are downtown that they kind of
6 consider separately but they're one emergency
7 department from a licensing perspective, I
8 understand is what you're saying, right?

9 A: Yes. And if we don't worry so much about the
10 semantics ---

11 Q: Right.

12 A: --- then three different locations, different
13 EDs. One's pediatrics, one -- and they're in
14 separate places, so ---

15 Q: Generally.

16 A: --- generally, yes. Yeah.

17 Q: And they call it the Chest Pain Center.

18 A: Yes.

19 Q: And you recall that from the freestanding
20 emergency department ---

21 A: Yes.

22 Q: --- matter, right?

23 A: Yes.

24 Q: And, I mean, you're aware, aren't you, that
25 DHEC approved that as Phase One of the Medical

1 University's hospital consolidation and
2 replacement plan, right?

3 A: I'm -- I don't recall whether -- what phase it
4 was of what plan. I may have known that at
5 some point in time, but I don't specifically
6 recall that detail.

7 Q: Well, you'll agree with me the application says
8 what it says, right?

9 A: Yes. Yes, it does.

10 Q: And then separately -- to make sure I cover
11 both of them -- you are very familiar with the
12 11 story replacement children's hospital that's
13 now known as Shawn Jenkins, right?

14 A: Well, I -- having not reviewed the application
15 itself -- I'm familiar with it, you know, post
16 review and certainly in the implementation. I
17 mean, I've been there a few times and been
18 inside of it, so I'm -- I am familiar with it,
19 yes.

20 Q: And you'll agree with me those are two brand
21 new beautiful facilities on the ---

22 A: Yes.

23 Q: --- downtown peninsula, right?

24 A: I would agree with that, yes.

25 Q: I mean, they are -- they were very costly and

1 they are very well done, right?

2 A: I believe so.

3 Q: Okay. And you would agree with me that those
4 facilities and those plans, it was the choice
5 of the Medical University to place them on the
6 peninsula downtown, right?

7 A: Right.

8 Q: Okay. And you're aware in that same time
9 period, within the last ten years, Roper St.
10 Francis has developed two community hospital in
11 other areas of the service area, right?

12 A: Right. Mt. Pleasant and Roper Berkeley.

13 Q: Right. So during the time period that the
14 Medical University established two very large
15 facilities downtown, Roper St. Francis
16 transferred beds and created a community
17 hospital in Mt. Pleasant and a community
18 hospital in Berkeley County, right?

19 A: Right.

20 Q: Okay. And so, you know, isn't it fair to say
21 that MUHA has had the opportunity to develop
22 facilities off the Charleston peninsula in the
23 last decade?

24 A: It depends on how you view that. I mean, by
25 opportunity if it means could they have

1 attempted to file an application for a CON to
2 build a hospital elsewhere? Yes, they could
3 have done that. I'm not sure how realistic it
4 is to say that they had an opportunity to
5 finish that project. I do believe that that
6 choice would have been actively opposed by
7 other hospitals in the service area.

8 Q: And you agree with me, Roper St. Francis is
9 pretty familiar with being actively composed --
10 opposed in order to pursue a satellite
11 hospital, right?

12 A: Yes, I do.

13 Q: Okay. And you would agree with me that even
14 during the years when the Medical University
15 didn't have a bed need they would have had the
16 opportunity, like Roper St. Francis, to propose
17 a transfer of existing beds ---

18 A: Yes.

19 Q: --- to create a satellite facility, right?

20 A: Yes, they could have attempted that.
21 Absolutely.

22 Q: Okay. Are you aware that at the time of
23 developing what is now the Ashley River Tower
24 that going off the peninsula was considered but
25 the Medical University was committed to the

1 local community? Were you aware of that?

2 A: I don't know. No, I'm not aware of that.

3 Q: Okay. But you do know that Roper St. Francis

4 has not opposed any of the Medical

5 University's projects that have been in Mt.

6 Pleasant or North Charleston, right?

7 A: I don't think so.

8 Q: Okay. And so this -- is it fair to say that

9 when you were reviewing some of the materials

10 of opposition in this case that you thought to

11 some extent you'd heard it all before from

12 these same affected parties?

13 A: I would never assume that I had heard it all

14 before, especially not for a new hospital.

15 There was some familiar elements, some very

16 familiar elements. But, no, I would never

17 have deigned to assume that I had heard it all

18 before, especially in opposition to a new

19 hospital, and especially for an entity that had

20 not developed a second hospital yet.

21 Q: Okay. And you'll agree with me that none of

22 those projects that we had walked through

23 involving any of these parties involved a

24 project cost as substantial as the one that

25 we're here about now, 325 million dollars,

1 right?

2 A: The Low Country projects that we've discussed
3 before, no, none of them did.

4 Q: Okay. And so certainly there hadn't been any
5 -- in any of these proceedings or prior
6 disputes has there been discussion of financial
7 feasibility or financial issues tied to a
8 project of that cost base, right?

9 A: The arguments have been raised but in
10 connection with projects that had a lower price
11 tag.

12 Q: Okay. So is it -- what project are you
13 thinking of when you think financial
14 feasibility or the cost of the project was an
15 issue like was in this case?

16 A: Well, the financial feasibility and cost was
17 challenged in the FED case.

18 Q: Is that your recollection?

19 A: Yeah, I believe so.

20 Q: Okay. Are you aware of any empirical analysis
21 underlying the Medical University's allegation
22 that it can -- that it will only redirect its
23 existing patient volume?

24 A: Ask me that one more time, I'm sorry.

25 Q: Are you aware of any empirical analysis

1 underlying the Medical University's allegation
2 that it will only redirect it's existing
3 patient volume to the new hospital?

4 A: Empirical analysis separate from whatever else
5 I've reviewed in the record? I mean -- I'm not
6 sure to what you're referring.

7 Q: I'm just asking you if you're aware of any
8 empirical analysis underlying the assumptions
9 that the Medical University offered for the
10 redirection of existing patients?

11 A: Other than what I've already mentioned as the
12 evidence that I reviewed in connection with
13 this case, then no, I'm not aware of any
14 additional analysis.

15 Q: Okay. And really quickly, you testified this
16 morning that you sort of towards the end of
17 your analysis there was -- you had time to
18 connect the dots and some of the data; do you
19 recall talking about that?

20 A: Yes.

21 Q: Okay. And so you reached out for some
22 information from Medical University's
23 consultant on the -- sort of the utilization
24 and need analysis; is that fair?

25 A: Yes.

1 Q: Okay. If we could turn to DHEC 1? To point
2 this out for the record. If you will go to --
3 it's CON 977 in DHEC 1.

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

5 A: Okay.

6 Q: Are you there?

7 A: I'm there.

8 Q: And just so we're clear in the record, we're at
9 an e-mail that's at DHEC's Exhibit 1, the CON
10 record, page 977, and it looks like the e-mail
11 to you is sent Monday, July 23rd, 2018 at 9:00
12 a.m., right?

13 A: Right.

14 Q: And you are provided -- the subject is
15 projections, and you are provided historical
16 and projected total MUHA admissions by market
17 and the projected admissions at the proposed
18 MUHA Berkeley community hospital, right?

19 A: Right.

20 Q: And it goes on to say the sub-markets include
21 a number of zip codes. Certain zip codes
22 within each sub-market are more accessible to
23 the proposed MUHA Berkeley Hospital, right?

24 A: Yes.

25 Q: And then there's a chart at the top of the next

1 page that is providing by sub-market actual FY-
2 2017 information for Medical University
3 projected 2025, and then presumably some
4 portion of that third column is what would be
5 redirected to the community hospital; is that
6 right?

7 A: Right.

8 Q: So if I'm reading that correctly then, the
9 5,700 volume -- and that number ties to earlier
10 in the application, right? 5,700 is the ---

11 A: I believe so, yes.

12 Q: And then if I'm reading this correctly then
13 what you were provided is that of the 5,700,
14 252 would be from the Moncks Corner area; is
15 that right?

16 A: Yes.

17 Q: 252 of the total proposed patient volume is
18 from Moncks Corner, right?

19 A: That -- yes, I believe that's what this is
20 saying. Yes.

21 Q: But more than Moncks Corner there were 321
22 being proposed to come from outside the Tri-
23 County; is that right?

24 A: Right.

25 Q: And more than that, 354 were proposed to come

1 from the peninsula Charleston?

2 A: Uh-huh. Yes.

3 Q: And 500 from the sea islands?

4 A: Yes.

5 Q: What do you understand the sea islands to be?

6 A: The -- well, these particular markets, I think,
7 were kind of broken out and fleshed out in the
8 application itself. And so that the
9 corresponding zip codes that match up with
10 these. I think MUSC referred to it as their
11 sub-markets.

12 Q: Okay.

13 A: So the sea islands is a collection of zip codes
14 that were that collectively grouped together in
15 that market.

16 Q: But how would you describe them? To you, when
17 you see that, where generally are those area?

18 A: When I think of the sea islands I think of the
19 kind of islands dotting the coast, kind of
20 mixed up on the coast of the Low Country.

21 Q: Okay. And then it looks like 522 were proposed
22 to come from East Cooper?

23 A: Yes.

24 Q: And 616 from West Ashley?

25 A: Yes.

1 Q: Okay. And it looks like the largest volume is
2 coming from North Charleston; is that right?

3 A: Right.

4 Q: And so the North Charleston, those would be
5 folks that would be sort of further east of the
6 proposed site going towards downtown
7 Charleston?

8 A: Kind of south, southeast.

9 Q: I guess east on the interstate?

10 A: Yes.

11 Q: Yes.

12 A: Like 26 East. Yes, that's right.

13 Q: Okay. All right. And so this was the
14 information that you needed in order to close
15 the gap and get from point A to point B in the
16 analysis; is that right?

17 A: Yes.

18 Q: Okay. And so for you as the reviewer, which of
19 these zip codes, or which of these sub-markets
20 are the -- is reflective of the need at the
21 chosen site in what I understand that's
22 described as the Nexton Development in Berkeley
23 County?

24 A: Well, I would need to go and look at their sub-
25 market break out because these should

1 correspond to various collections of zip codes.
2 And so the zip codes, you know, some of them
3 were much closer to the proposed location than
4 the -- than on the peninsula. I mean, that was
5 the basic premise.

6 Q: Okay.

7 A: But I'd need to go back and kind of look at the
8 sub-markets and then look at the zip codes and
9 then look at the map to figure out -- to
10 remember exactly where they were 'cause I did
11 sit there with a magnifying glass trying to
12 paint this picture and see if I could follow
13 the methodology in the application. And I got
14 -- and this was a result of me getting to a
15 point where I really -- where I wasn't
16 comfortable getting all the way across this
17 expanse. This helped. I would have preferred
18 more detail, but this was enough for me to find
19 the analysis credible and reasonable.

20 Q: And, but you felt that this, with this
21 information, that MUSC had justified, through
22 patient origin, need at the chosen sight?

23 A: That in connection with the rest of the data
24 and figures and other contents of the
25 application, yes.

1 **Q:** Would you agree with me that East Cooper and
2 the sea islands are not proximate to the chosen
3 site?

4 **A:** Not nearly -- and again I want to be careful
5 because some of these sub-markets might have
6 zip codes that reach up and are weirdly shaped
7 and so -- but generally, with that caveat, that
8 each one of these sub-markets was actually
9 fleshed out by MUSC in the application as
10 containing certain zip codes, so, you know, we
11 could look in the map and figure out where they
12 all are. But when I think about East Cooper,
13 I'm not thinking about Berkeley County and the
14 exit where the proposed site is going to be.

15 **Q:** And you would agree with me ---

16 **A:** I generally agree with you, yeah.

17 **Q:** You would agree with me outside the Tri-County
18 is not proximate to the chosen site, is it?

19 **A:** No.

20 **Q:** And can we agree that the peninsula of
21 Charleston is not proximate to the chosen site?

22 **A:** Not the lower part of it, it really -- again,
23 it's a sliding scale, but it's not what I would
24 consider proximate as opposed to Summerville
25 and other parts of Berkeley County.

1 Q: Moncks Corner?

2 A: Right.

3 Q: Right? Okay. And you got this at 9:00 a.m. on
4 Monday the 23rd, right?

5 A: Yes.

6 Q: And it was provided -- as you noted, it was
7 provided at 11:30 to the affected persons'
8 attorneys?

9 A: Yes.

10 Q: And this is the day you made your decision,
11 right?

12 A: Yeah. Well, it was the day that issued the
13 decision. I had done a fair amount of the
14 analysis and had got -- and was still
15 struggling with that last piece of the puzzle,
16 and I finally felt -- I just wasn't comfortable
17 moving forward with the decision until I got a
18 little bit more information about that.

19 Q: Okay. And let's turn to DHEC CON 988.

20 A: Okay.

21 Q: And would you agree with me that counsel for
22 Roper St. Francis responded the same day with
23 commentary on behalf of Roper St. Francis
24 trying to address this information that was
25 provide to Roper St. Francis at 11:30?

1 **A:** Yes, that's what this is.

2 **Q:** Is it fair to say that your decision was
3 already signed and on it's way out at 4:59 that
4 day?

5 **A:** I certainly hope so. It should have been. So,
6 yes, it's fair to say that.

7 **Q:** So you'd agree with me that Roper St. Francis
8 and the Trident parties didn't have a -- a
9 meaningful opportunity to respond to that new
10 information, right?

11 **A:** Well, I mean, it would have required -- it
12 would have had to be a same day response and it
13 would've had to have been earlier than it was,
14 so I think there was very little opportunity to
15 respond to that the day of.

16 **Q:** And you would agree with me you didn't have
17 time to give this information any sort of
18 meaningful review ---

19 **A:** No.

20 **Q:** --- before you made your decision?

21 **A:** I did not, no.

22 MS. HOLLINGSWORTH: Your Honor, if I could take two
23 minutes, I think I'm probably done.

24 THE COURT: All right.

25 MS. HOLLINGSWORTH: I'm trying to really ruin Mr.

1 Summers' dinner plans and I think I'm very
2 close.

3 MR. SUMMERS: That's all right. I just kicked them
4 down.

5 MS. HOLLINGSWORTH: So close.

6 MS. MURDOCK: If you'll excuse me, I've got to do
7 the same thing.

8 MS. HOLLINGSWORTH: Two minutes. I'll confer and
9 I'll be ---

10 THE COURT: Okay.

11 MS. HOLLINGSWORTH: --- wrapped up.

12 (Off the Record)

13 THE COURT: Ms. Hollingsworth?

14 MS. HOLLINGSWORTH: Just an hour or so, Your Honor,
15 and my kids are still out and about and so I'm
16 trying to avoid that, like bedtime, and ---

17 (Laughter.)

18 MS. HOLLINGSWORTH: --- so. No, Your Honor, I am
19 done. I do have -- this is one copy, but I'd
20 be happy to give it to counsel, either response
21 counsel. But it's the consent order of
22 dismissal in the contested case involving the
23 pediatric ASF, so instead of having to go look
24 for it, I'd be happy to just hand it to you and
25 ---

1 MS. CRUM: Let me look at it real quick 'cause I've
2 got a copy, I just didn't bring it with me.

3 MS. HOLLINGSWORTH: Sure and we ---

4 MS. CRUM: Yeah, sure.

5 MS. HOLLINGSWORTH: But we can use that to make
6 copies and add that to -- and if you'd like, I
7 can use that -- put the sticker on it and then
8 tomorrow add those pages into that Exhibit.

9 MS. CRUM: Not tomorrow.

10 MS. HOLLINGSWORTH: Well, that's true. And I can
11 get that from you later.

12 THE COURT: I'd come in tomorrow. My staff might
13 kill me.

14 MS. HOLLINGSWORTH: I have no further questions for
15 the witness. Ms. Murdock, thank you very much.

16 **A: Thank you.**

17 THE COURT: Mr. Summers?

18 MR. SUMMERS: Thank you, Your Honor.

19 MS. MURDOCK - CROSS-EXAMINATION BY MR. SUMMER:

20 **Q: Ms. Murdock, how are you?**

21 **A: I'm fine. How are you?**

22 **Q: Doing fine.**

23 **A: Good.**

24 **Q: I did not have the privilege of being at your**
25 **deposition, but I don't think there's much left**

1 to ask. Can we pull up -- I just want clarify
2 a few things for the record.

3 A: Sure.

4 Q: First, I want to go to something that MUHA
5 counsel was using earlier in the week that has
6 the word demon on it. I think that's for
7 demonstrative; isn't that what's that for?

8 MS. CRUM: That's actually what I said. I'm not
9 sure you were in the court room.

10 MR. SUMMER: Uh-huh.

11 THE COURT: And she asserted it that she doesn't
12 know how that N got on there.

13 Q: So the demon exhibit is a demonstrative exhibit
14 and it's entitled second floor renovations and
15 the addition of six acute care beds. You're
16 familiar with this application, are you not?

17 A: Yes, I am.

18 Q: Okay. Let's turn over first to page 5 of that
19 application. If we could just look at total
20 project cost down on G, and blow that up so
21 that everybody can be in agreement what that
22 is, what's the total project cost?

23 A: It's 22,656,000 dollars.

24 Q: Great. And if you'll turn to page -- and in
25 fact I am committing the same sin that I've

1 criticized other people for. Sorry.

2 A: Which reminds me, I owe y'all a certificate.

3 Q: All right. If you'll turn over to page 6 of
4 that and go to the bottom of that page, that's
5 the Part B questionnaire, number 2, describe
6 the project, right?

7 A: Right.

8 Q: Okay. If you'll look at that last paragraph,
9 you remember, do you not, that Summerville
10 Medical Center and Trident made a decision to
11 combine all of the OB over at Summerville ---

12 A: Right.

13 Q: --- do you remember that?

14 A: Yes.

15 Q: And so that left a whole floor vacated at
16 Trident, did it not?

17 A: Yes.

18 Q: Okay. And this application is actually for the
19 completion demolition of that floor and a build
20 out; fair statement?

21 A: Yes.

22 Q: Okay. So let's look at the middle of that
23 paragraph. If we see where it begins
24 therefore. Therefore Trident proposes to
25 renovate the space on the second floor vacated

1 by the OB consolidation to create a second IC
2 unit containing ten beds, right?

3 A: Right.

4 Q: A med-surg unit containing 34 beds, okay?
5 Trident proposes to achieve this by utilizing
6 38 beds from its current acute care and adding
7 six. So if you add those up, what we're really
8 ending up with is the ten plus the 34 plus the
9 six is 50; is it not?

10 A: Beds that will end up on that floor after the
11 renovation.

12 Q: Right?

13 A: Right.

14 Q: Okay. So we take the 50 beds, but go back to
15 the prior page and you've still got that
16 wonderful calculator in front of you?

17 A: I've got it right here. No, I'm just kidding.
18 Yes. I have it.

19 Q: Divide the 50 beds into the 22,656,000 dollar
20 project cost. What number do you get?

21 A: It's 50 beds right?

22 Q: Right.

23 A: I get 453,120.

24 Q: Okay. So the per bed cost for them after the
25 demolition would be 453,000 dollars per bed,

1 right?

2 A: Yeah, if you're counting all the beds, the beds
3 that will remain on that floor and then the
4 beds that will be added to the floor, yes.

5 Q: But you do understand that was a complete gut
6 of that floor and a rebuild ---

7 A: Yes.

8 Q: --- you understand that, right?

9 A: Yes, absolutely.

10 Q: All right.

11 A: I want to be clear, I, by no means, mean to
12 imply that this is an unreasonable project. In
13 fact I've checked on this and so it's -- it
14 absolutely makes sense. In fact, I owe your
15 client a certificate in this.

16 Q: We'd love to get one.

17 A: Yeah.

18 Q: When you can.

19 A: I'll get right on it.

20 Q: All right. Let's go back and, first of all in
21 fairness to you, when we sit here today some
22 year and a few months later, is there more
23 information available in this room for this
24 Court to look at than you had to look at in the
25 summer of 2018?

1 A: Yes.

2 Q: I mean, we can just look at the binders and
3 figure that out, right?

4 A: Yes.

5 Q: All right. So in fairness to you, what really
6 you were looking at was the DHEC record which
7 is DHEC 1. I want to talk a little bit about
8 the redirection that was discussed. And you
9 understood that their argument was -- and I'm
10 going to try to make this as concise as I can.
11 Their argument is we are taking patients that
12 would have come downtown to see us, but we're
13 going to see them in the new hospital. That
14 was their position, correct?

15 A: Correct.

16 Q: And because they're only going to patients that
17 were already theirs, there would be no adverse
18 affect on others; fair statement?

19 A: Yes, fair sign.

20 Q: Okay. That -- and that was their analysis, if
21 you will, in terms of is there any patient
22 redirection, and that was their analysis about
23 why there's no adverse impact; fair statement?

24 A: Yes.

25 Q: All right. Let's look -- and I know we didn't

1 have a lot of volume information for this
2 because the application didn't have -- it
3 didn't have outpatient volume numbers. But I'd
4 like to take a look at the budgets and just
5 look at a little bit and see what was there in
6 the budgets and whether or not it's consistent
7 with the notion that they won't take anyone
8 else's patients, okay?

9 A: Okay.

10 Q: All right. So let's look first in the plan at
11 page 596. When I say the plan I mean the
12 application which is DHEC Exhibit 1 and that's
13 page 596. Pull that up.

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

15 Q: Okay. Here's what I'd like to do is we're
16 going to toggle among three pages, and the
17 pages that we're going to toggle among would be
18 596, 597 and 598. So what I'd like to do first
19 is identify for the Court what each one of
20 those are. Would you agree with me that what's
21 on 597, if you look at the top, is MUHA, that's
22 the Medical University Hospital Authority, and
23 that's their budget, and it's a pro forma that
24 also includes the community hospital; is that
25 correct?

1 A: On 597.

2 Q: No, we're starting on 596.

3 A: Okay. I thought you said 597 that's why I was
4 looking -- that's what 596 says, yes.

5 Q: At 596 would be the entire system, including
6 the new hospital, right?

7 A: Right.

8 Q: Then if you go over to 597, that is the system
9 if it wasn't built. That would be the whole
10 system without the new proposed hospital in
11 Nexton, correct?

12 A: Correct.

13 Q: And if you turn the page and go over to 598,
14 that is only the community hospital at Nexton,
15 correct?

16 A: Correct.

17 Q: All right. So under their scenario, if they're
18 only seeing their patients, okay, shouldn't the
19 revenue numbers on 596 and 597 be the same,
20 because those patients are simply being
21 relocated; fair statement?

22 A: I think that's one way to look at it, sure.

23 Q: All right. So now let's take a year in
24 particular.

25 A: Okay.

1 Q: Let's look -- and here's how -- what we need to
2 do because we want to look at revenue that's
3 only attributable to patient charges. So if we
4 look at the top three lines, these would be
5 gross charges, correct?

6 A: Yes.

7 Q: Inpatient revenue ---

8 A: Uh-huh.

9 Q: --- outpatient revenue, total revenue.

10 A: That's right.

11 Q: So if we're pulling off the charge master,
12 that's what it looks like, right?

13 A: Right.

14 Q: Okay. So let's go and look at what total
15 revenue is. And this, again, is expressed in
16 thousands. But the total revenue that is for
17 the two hospitals together, the total revenue
18 in 2023 is 6,536,988,000 dollars; is that
19 correct?

20 A: Yes.

21 Q: 2023, total revenue, gross revenue; fair
22 statement?

23 A: Yes.

24 Q: Okay. But let's compare that to if the
25 hospital wasn't built. If we go over to the

1 next page which is 597, we take that same year,
2 2-23, and that number is actually lower. It's
3 6,214,021,000 dollars, right?

4 A: Without the hospital, without the community
5 hospital.

6 Q: Without building it. So would you do me a
7 favor? Subject -- subtract the number on page
8 597 for 2023 total revenue from the total
9 patient revenue of 2023 on page 596, which
10 would be the two hospitals and tell me what
11 number you get?

12 A: Oh my gosh, it's in thousands, so, 322,967,000
13 dollars?

14 Q: Correct. Turn the page. Look at 2023 for the
15 new hospital only, and what is that number? Is
16 it the number you just read me.

17 A: Yes.

18 Q: Okay. That's new revenue. That's revenue from
19 new patients.

20 A: Right.

21 Q: So take that number down while we're there and
22 look, do you see where you come down to net
23 revenue? You have net operating revenue?

24 A: Which chart are you on? I'm ---

25 Q: I'm still on 598.

1 A: Okay.

2 Q: Where you just read that number.

3 A: Uh-huh.

4 Q: Drag your finger down from 2023 and look at
5 what is the total net operating revenue?

6 A: Okay.

7 Q: And what is that number?

8 A: It's 94,755,000 dollars.

9 Q: That includes other income, so that would be
10 non-patient income, right?

11 A: Right.

12 Q: You understand that other income is non-
13 patient?

14 A: Right.

15 Q: So let's back out the other income and tell me
16 what number you come up with?

17 A: What number I come up with for -- oh, subtract
18 other income from the net operating revenue?

19 Q: There we go. Tell me what you get.

20 A: I get 92,896,000.

21 Q: Okay. Do you understand that net revenue is
22 money, cash in the door. That's actually what
23 they get. It's the actual cash they receive,
24 right?

25 A: Right. Generally, yes. I mean, that's ---

1 Q: Yes.

2 A: --- that's a fair characterization I guess.

3 Q: Okay. So that 92,000,000 dollars has got to
4 come from somebody else. It's got to come from
5 Trident. It's got to come from Roper. It's
6 got to come from Orangeburg. It's got to come
7 from Colleton. But that 92,000,000 dollars is
8 not money they would have had on the peninsula.
9 That 92,000,000 dollars is new money; is it
10 not?

11 A: Well, the new hospital has additional beds, and
12 so they expect to grow -- you know, they expect
13 the utilization to grow with the new hospital
14 and you would expect there to be -- I mean,
15 there could be a number of reasons beside a
16 patient doesn't go to Trident.

17 Q: 92,000,000 dollars.

18 A: Now that's a lot to assume that it's because
19 patients are going to the hospital more often
20 because it's closer or because there are fewer
21 capacity constraints, not as long as of a wait
22 time for beds because they were able to add new
23 beds. Those could all be factors that would
24 affect that number and it would be just be raw
25 market redirection from Trident. I'm not

1 comfortable saying it's all coming from someone
2 else.

3 Q: You would agree with me that the way these
4 budgets are presented completely contradicts
5 the notion that they're going to see the same
6 patients in a different location, does it not?

7 A: I would have to spend more time looking at the
8 numbers and considering some of the factors
9 before I could agree with that conclusion
10 wholeheartedly.

11 Q: Let's take a look at -- see if you can find
12 this, do you know where that is? I'm skipping
13 a lot of stuff in my outline so I'm trying to
14 get -- let's go down to -- back up, it's right
15 there. There we go. Were you here when Mr.
16 Johnson testified?

17 A: No.

18 Q: Okay. Well, what Mr. Johnson did, and what he
19 testified to, was he computed, okay, the net
20 revenue per adjusted discharge at the new MUHA
21 hospital. If you look on the bottom right-hand
22 corner, net revenue per adjusted discharge for
23 St. Francis Hospital for 2018 is 9,904 dollars.
24 For Roper Berkeley Hospital, the new hospital,
25 it's projected to be 9,857 dollar. But he

1 projected, based upon those financials he was
2 able to deduce that they're going to have net
3 revenue per discharge at the new MUHA hospital
4 of 18,931 dollars. That's double what these
5 others are. And you testified on your direct
6 that it's your understanding from your review
7 of the application that MUHA had adjusted its
8 application, it's projections and it's budget
9 for acuity. They're not planning to do
10 transplants out there, right?

11 A: I don't believe so, no.

12 Q: Okay. And it's your understanding that their
13 projections were adjusted for acuity to be
14 appropriate for a community hospital, correct?

15 A: Correct.

16 Q: Okay. You also testified that if this resulted
17 in increased charges or cost to patients, that
18 that would be a red flag for you, wouldn't it?

19 A: If it was a material increase, yes.

20 Q: Do you believe that twice the net revenue per
21 adjusted discharge for community hospitals
22 currently operating in the community is
23 substantial?

24 A: I believe a net revenue that's double -- from
25 one hospital that's double the net revenue of

1 another hospital of similar size and scope is
2 a significant disparity.

3 Q: And you understand that in order to show that
4 this was financially feasible, they have to
5 show enough revenue to make that happen, right?

6 A: That's certainly part of the analysis.

7 Q: Okay. Let me just take you now -- I'd like to
8 go and take a look at 61-15, and if we could,
9 go to section 307. Now earlier you testified
10 about the process of how we get a State Health
11 Plan; do you remember that?

12 A: Yes.

13 Q: That there's a lot of hard work that goes into
14 it, but there's also a long due process that
15 must be gone through by statute and regulation,
16 correct?

17 A: Yes.

18 Q: First your staff has to draft a plan, correct?

19 A: Correct.

20 Q: Second they must submit it to the Health
21 Planning Committee for its consideration,
22 correct?

23 A: Yes, generally. I mean, we work with the
24 oversight of the Health Planning Committee and
25 that usually involves that staff drafting, then

1 presenting it to the Committee. But we could
2 do it more collaboratively. Someday, hopefully
3 we will, but that's the way it works now.

4 Q: And then the Planning Committee votes to put
5 the plan out for publication, correct?

6 A: Correct.

7 Q: And then the plan goes out for publication and
8 there has to be a 30 day comment period,
9 correct?

10 A: Yes.

11 Q: And you hold four public hearings across the
12 state, one in the Pee Dee, one in the Upstate,
13 one in the Midlands and one in the Low Country,
14 correct?

15 A: The first one's tomorrow, yes.

16 Q: Okay.

17 A: I mean Monday.

18 Q: Okay. And then you take public comments during
19 the comment period. You also take them at the
20 public hearings that are conducted, correct?

21 A: Correct.

22 Q: Then you come back and then meet with the
23 Planning Committee to decide what other changes
24 may be made to the plan based upon those
25 comments, correct?

1 **A:** Correct.

2 **Q:** Then ultimately the Planning Committee will
3 submit that plan to the big DHEC Board for its
4 review and consideration?

5 **A:** Correct.

6 **Q:** And then the plan becomes effective the day
7 after it accepts that plan for the next year?

8 **A:** Well, we've had plans that became effective at
9 the moment of the Board vote and then we've
10 also had plans that the motion that carried was
11 that it would become effective the next day,
12 but other than that, yes.

13 **Q:** Within 24 hours?

14 **A:** Yes.

15 **Q:** Okay. So you would agree with me that the
16 State Plan is, in a sense, your roadmap,
17 correct?

18 **A:** Sure.

19 **Q:** Okay. So let's look at the language in 407,
20 and if we could just blow up the first sentence
21 of 307, section 1 and let's just take a look at
22 what that says.

23 **A:** Okay, 307 or 407? I think you said both.

24 **Q:** 307 is what I meant.

25 **A:** Okay.

1 Q: The Department may not issue a certificate of
2 need unless an application is in compliance
3 with the South Carolina Health Plan; is that
4 your understanding?

5 A: Yes.

6 Q: Okay. So let's do a for instance. If there
7 were no beds in a Plan region and there were no
8 institutional need and there's no need within
9 the region, someone wants to add a new
10 hospital, if they submitted an application
11 where there's a negative bed need, you would
12 not accept that application for review, would
13 you?

14 A: Okay. Can we break that off a little bit,
15 piece by piece? If there was a service area
16 and it was a section of the Plan that -- for
17 which there was a projected bed need typically,
18 and that bed need was zero?

19 Q: No, I said ---

20 A: --- let's ---

21 Q: --- I wanted you to assume for me that there
22 was no bed need, either institutional or within
23 the region. Zeros across the board.

24 A: Okay. Are we talking about for the hospital.

25 Q: Let's take general acute care hospitals.

1 **A:** **Okay.**

2 **Q:** **Can you approve it if there's no bed need?**

3 **A:** **No.**

4 **Q:** **Okay. In other words, what appears in the Plan**
5 **is what you have to follow; fair statement?**

6 **A:** **If it -- if it's one of the things in the Plan**
7 **that we are required to follow.**

8 **Q:** **Okay.**

9 **A:** **And the need cap would be one of those things.**

10 **Q:** **Let's take a look at the Plan that was in**
11 **effect at the time that you made your decision.**
12 **And that would be the 2017-2018 State Health**
13 **Plan. And let's start, let's start on page 12.**

14 **A:** **Okay.**

15 **Q:** **And if we could just blow up where it starts**
16 **relative importance of project review criteria**
17 **at the bottom. Let's just blow up that part of**
18 **it so we can all look at it. This is the Plan**
19 **that went through the process we've previously**
20 **discussed, correct?**

21 **A:** **Correct.**

22 **Q:** **Your staff wrote this Plan, correct?**

23 **A:** **Correct.**

24 **Q:** **The Health Planning Committee approved this**
25 **Plan, correct?**

1 **A:** Correct.

2 **Q:** It went out for public comment with this
3 language in it, correct?

4 **A:** Correct.

5 **Q:** And the Board adopted it that way, correct?

6 **A:** Correct.

7 **Q:** Okay. The following project review criteria
8 are considered to be the most important in
9 evaluating certificate of need applications for
10 this service. The service we're in is general
11 acute care hospital beds, correct?

12 **A:** Correct.

13 **Q:** And you see there are seven criteria?

14 **A:** Yes.

15 **Q:** Okay. Now I realize that the end of the review
16 period here was a bit of a fire drill. On July
17 the 11th you sent out the letter that for the
18 first time told the parties what the relative
19 criteria would be that you would evaluate this
20 project on, correct?

21 **A:** Correct.

22 **Q:** Let's jump over and take a look at that. I
23 think that's at page 1000 in the application if
24 I'm not mistaken. On page 1000 and 1001 out of
25 the DHEC record 1, please. Okay. Go to the

1 second page, please, sir. And let's just blow
2 up the text from the top of the page all the
3 way to above the signature. There we go. This
4 is the letter that everybody got on July the
5 11th, correct?

6 A: Yes.

7 Q: Okay. Now let's just count days so I can get
8 the days right here. For the first time the
9 adverse parties saw the ordered criteria and
10 that was on July the 11th, right?

11 A: I believe that that was the first time they saw
12 that.

13 Q: And you had to make a decision by July 23rd,
14 correct?

15 A: Correct.

16 Q: As a practical matter, there's no way you could
17 have had a project review under that time
18 table, is there?

19 A: To have a project review meeting?

20 Q: Yeah.

21 A: I would not have attempted to schedule one
22 between July 11th and July 23rd, no.

23 Q: Not enough time, is it?

24 A: No, not enough notice.

25 Q: Ordinarily, however, you would've had a minimum

1 of 30 days had the letter gone out when it was
2 supposed to, which would've been prior to the
3 date it was published on March the 23rd.

4 A: Right.

5 Q: It should have gone out prior to that because
6 you would have gotten a check by then.

7 A: That's right.

8 Q: So you're some three months later and you've
9 got ten days to make a decision, 12?

10 A: Well, it -- yeah, it was about that amount of
11 time between July 11th and the decision date,
12 yes.

13 Q: And all this material comes in to you from the
14 opposing parties, Blitzkrieg, on the 18th of
15 July, correct?

16 A: I think it all came in and then some trickled
17 in later.

18 Q: Okay. And so between the 18th of July when you
19 received that information and the 23rd, you had
20 to make a decision?

21 A: Well, I was -- yeah, I had to make a decision
22 by the 23rd, but I didn't have to do the entire
23 review between the 18th and the 23rd. I did
24 review the material I got from the -- the July
25 18th, you know, flurry of e-mails, but so, yes,

1 **I had between July 18th and the 23rd to review**
2 **the rest of documentation and then consider**
3 **that in light of the decision.**

4 **Q: Okay. But Mr. Levitt helped you out. You**
5 **called him on the phone, you needed help, he**
6 **sent you information, you got the letter out on**
7 **the 23rd, correct?**

8 MS. CRUM: Your Honor, I'm just going to object to
9 his testimony on that. If it's a question,
10 it's a question as opposed to making all of
11 this commentary.

12 THE COURT: But he's allowed to ask leading
13 questions.

14 MS. CRUM: I'm objecting to his testifying actually,
15 Your Honor.

16 THE COURT: Well, that's kind of what leading
17 questions are. I overrule that.

18 **A: I needed the applicant's consultant to**
19 **supplement and clarify something that I**
20 **couldn't find in the application itself. And**
21 **so I called the consultant, which is my normal**
22 **practice if I run into that.**

23 **Q: But July 11th you knew you had to approve this**
24 **application. You didn't have time to do**
25 **anything else but approve it because that's the**

1 only information you had in front of you.

2 A: I don't agree with that statement.

3 Q: Take a look at the criteria.

4 A: If I hadn't been satisfied by Mr. Levitt's
5 supplementary information I would have denied
6 the application.

7 Q: Take a look at the criteria you selected. You
8 will agree with me that the State Health Plan
9 states that cost containment is to be
10 considered as a criteria, does it not?

11 A: The State Health Plan says the following
12 project review criteria are considered to be
13 the most important in evaluating certification
14 of need applications for this service. Cost
15 containment is one of the criteria on that
16 list.

17 Q: You would agree with me that adverse effects of
18 other facilities is one of the criteria on that
19 list, correct?

20 A: Yes.

21 Q: Yes?

22 A: Yes, yes. I'm sorry. I said yes.

23 Q: And then acceptability is also on that list.
24 None of those three were included in your list
25 of criteria, was it not?

1 **A:** None of those three were included on that -- on
2 my deemed complete letter.

3 **Q:** Now, there -- I'm sorry. There a lot of
4 criteria, there are 33 of them, isn't it?

5 **A:** I think that's the exact number, yes.

6 **Q:** And that -- it's sad that I know that. And if
7 you look at Regulation 61-15, Section 802, it
8 gives the comprehensive list of those 33
9 criteria, correct?

10 **A:** Yes.

11 **Q:** And your staff and your leadership -- let's go
12 back to page 12 if we can -- your staff, under
13 your leadership selected these seven criteria
14 to be considered when approving or considering
15 an application for a new hospital, correct?

16 **A:** As part of the general statement they were
17 required to make in every health plan chapter,
18 those were the ones -- those were the project
19 review criteria that we included on that list.

20 **Q:** And those are the ones that were approved by
21 the State Health Planning Committee, were they
22 not?

23 **A:** This Plan was approved by the State Health
24 Planning Committee.

25 **Q:** And those criteria for general hospital beds

1 were approved by the Health Planning Committee
2 when it approved this Plan, correct?

3 A: Yes, it was part of the Plan that was approved
4 by the Health Planning Committee.

5 Q: And it went out for public comment with those
6 seven criteria, did it not?

7 A: It did.

8 Q: To the regulated public, correct?

9 A: To the public. To the general public, yes.

10 Q: And your Board approved this language and those
11 criteria, did it not?

12 A: Yes.

13 Q: Okay. But you believe that you have the
14 ability to unilaterally ignore those three
15 criteria. Is that your testimony to this
16 Court?

17 A: No.

18 Q: Is it your testimony to this Court that you
19 have the ability to delete them from the most
20 important criteria to be considered?

21 A: I believe everyone knows that's not my
22 testimony. I have authority from the statute
23 to reorder the criteria as is appropriate for
24 each individual project. 44-7-190(B) ---

25 Q: So ---

1 **A:** --- gives staff that authority.

2 **Q:** So you believe that that statute gives you the
3 authority to ignore this directive and pick
4 others if you so desire.

5 **A:** I did not ignore any project review criteria,
6 and I have never testified that I did or would
7 ignore project review criteria in connection
8 with review of any case. I simply reordered
9 the project review criteria and placed others
10 on top of the list. And the ones at the top of
11 the list are the ones that get findings in the
12 decision letter. But I do not ignore or delete
13 project review criteria.

14 **Q:** You will agree with me that you testified in
15 your deposition you did not make any specific
16 findings regarding adverse impact regarding
17 this project, correct?

18 **A:** I did not make any specific findings on project
19 review criteria number 23 in the reg and number
20 5 -- or number 7 on this list on page 12 of the
21 2017-2018 Plan.

22 **Q:** You also have testified in our deposition that
23 you made no specific findings regarding the
24 record of the applicant, correct?

25 **A:** Correct.

1 Q: You also testified you made no specific
2 findings regarding cost containment, correct?

3 A: Regarding the cost containment listed as
4 described in project review criteria number 16
5 in the regulations and number 6 on this page 12
6 of the ---

7 Q: And you also made no specific findings
8 regarding acceptability, did you?

9 A: Correct.

10 Q: Okay. Let's go back to the State Health Plan
11 if you will. And look at first -- let's look
12 at Standard 5. All right. Let's just look at
13 the last sentence. The applicant must justify
14 through patient origin and other data the need
15 for a new hospital at the chosen site and the
16 potential adverse impact a new hospital at the
17 chosen site could have on the existing
18 hospitals in the service area. Do you see that
19 language?

20 A: I do.

21 Q: And your testimony is you were satisfied when
22 the applicant said we're simply redirecting
23 patients, we're not going to take anybody
24 else's, correct?

25 A: I determined that that was sufficient for me to

1 find that they had justified through patient
2 origin and other data the need for a new
3 hospital at the chose site and the potential
4 adverse impact a new hospital at the chosen
5 site could have on the existing hospitals in
6 the service area.

7 Q: Even though they're going to get 92,000,000
8 dollars from somewhere?

9 A: As I said, that 92,000,000 dollars could be a
10 result of the fact that they're able to add
11 additional beds and the growth and population
12 of their own patient base and the ease of
13 access and the fewer constraints. Those are
14 other factors that could contribute to that
15 92,000,000 dollars. I can't be certain that
16 that 92,000,000 dollars is coming from other
17 providers. It's possible and reasonable to
18 assume that some of it will.

19 Q: As we sit here today, you have no idea what
20 incremental growth in that market could be
21 attributable to that 92,000,000 dollars; you
22 just don't know, do you?

23 A: Well all of it would have to be a prediction.
24 It's a future event, so the best that I could
25 ever do would be to attempt to predict it, but

1 **I can't know for sure until it happens.**

2 THE COURT: I mean, I can understand if you said
3 that it could from them growing their patient
4 base?

5 **A: Well, the population ---**

6 THE COURT: That patient base is going to grow from
7 where?

8 **A: The population growth of the patients, the**
9 **percentage of the patients from that area that**
10 **are a part of -- already part of MUHA's market**
11 **share because the population itself will get**
12 **bigger. Now the future projections in the pro**
13 **forma with the downtown hospital without the**
14 **community hospital would also assume that there**
15 **would be some growth in the population, but**
16 **without the new beds, even if the population**
17 **that typically goes to MUHA grows, if there's**
18 **no more room in the inn, then it can't -- they**
19 **can't continue to access at a higher rate.**

20 THE COURT: Right.

21 **A: The facilities, there aren't any new beds for**
22 **them to be in, so.**

23 THE COURT: Okay. Well then if they've got a
24 certain base already, some of that's going to
25 be moved to the community hospital.

1 **A: Right.**

2 THE COURT: If the population is growing at less
3 than two percent, then the only base that could
4 grow -- if it was a component of their base,
5 would be that -- if it's based on the
6 population growth, would be no more than two
7 percent per year, right?

8 **A: Well it ---**

9 THE COURT: That's what I'm trying to figure out.
10 He's -- if you're saying it's growing from
11 their base, then I don't -- and I haven't done
12 the math and all the revenue stuff ---

13 **A: Neither have I.**

14 THE COURT: --- but they would only have to -- could
15 only go up two percent per year at the most to
16 translate to the growth of the population base.

17 **A: If the two percent growth is the growth of the**
18 **population in each zip code that already had**
19 **patients traveling to MUHA, if that growth is**
20 **two percent, then that would be, you know, the**
21 **limitation on how much population growth would**
22 **contribute to additional patient days. What**
23 **I'm saying here is, the reason that I can't**
24 **agree to that 92,000,000 dollars as coming from**
25 **no other source than redirection of patients**

1 from other health systems is that if MUHA stays
2 status quo and doesn't implement any beds at
3 its current facility, then the patients that
4 are going down there will arguably still go
5 down there. But when there are capacity
6 constraints, patients that would be seen at a
7 MUHA hospital either can't be seen at all or
8 have to wait longer to get service. Whereas if
9 there are beds implemented in the community
10 hospital, whether it be at that site or even
11 downtown, when there are new beds implemented,
12 there's somewhere for those patients who are
13 naturally going to MUHA, they're going to still
14 be able to continue to grow as the population
15 grows. If they don't implement any additional
16 beds then because of the capacity constraints
17 they get stuck. The growth gets stuck. So I
18 don't believe that all of that 92,000,000
19 dollars is just going to come from population
20 growth. I actually believe -- I don't
21 necessarily agree with the premise that there
22 isn't going to be an impact, that there isn't
23 going to be a market share shift. That's not
24 to say that because MUSC's theory is what is is
25 that that makes them non-complaint and that

1 they were unable or did not, with their own
2 theory, justify what they believe to be true.
3 I might not agree with it, but that doesn't
4 mean that its not enough justification from
5 them to have satisfied that criteria.

6 THE COURT: Right.

7 A: I believe the market share would be -- the
8 market adjustment will actually be beneficial
9 to the system.

10 THE COURT: You've gone way beyond what I even
11 asked.

12 A: I'm sorry. I can do this all day.

13 THE COURT: And that's one speech.

14 A: Sorry.

15 MR. SUMMERS: Thank you, Your Honor.

16 Q: All right. So we know we just went over the
17 adverse effects language in Standard 5.
18 There's also the relative criteria that you
19 deleted at the bottom of page 12 of the Plan.
20 Adverse effects on other facilities. Do you
21 see that language?

22 A: I didn't delete any project review criteria.
23 So I do see the -- I see the project review
24 criteria that you just referred to on the page,
25 but I disagree that I deleted them from

1 anywhere.

2 Q: It was not included in your deemed complete
3 letter as a relative criteria for
4 consideration, was it?

5 A: That is true.

6 Q: Right. And you've already testified under oath
7 that you made no specific finding regarding
8 adverse impacts on other facilities, correct?

9 A: Specifically with regard to that particular
10 project review criteria, yes, correct.

11 Q: And you've already testified under oath that
12 you simply accepted the redirection theory as
13 sufficient to satisfy Standard 5, correct?

14 A: To satisfy what I see as the requirements that
15 MUSC needed to fulfill in order to move forward
16 from Standard 5, yes.

17 Q: Look on page 13, if you would, the last breath.
18 The very, very top, that paragraph at the top,
19 and blow that up please. This is the last
20 statement in this section of the Plan. General
21 hospital beds are typically located within
22 approximately 30 minutes travel time for the
23 majority of the residents of the State. And
24 this sentence, the benefits of improved
25 accessibility will be equally weighed with the

1 adverse effects of duplication in evaluating
2 certificate of need applications for these
3 beds, correct?

4 A: Yes.

5 Q: Okay. Again, you made no specific finding
6 regard adverse impact, correct?

7 A: This is a different section. It's a different
8 requirement and it speaks to different things.
9 This refers to the balancing test and the
10 adverse effects of duplication. It does not
11 say adverse effects on other facilities or
12 existing facilities. It simply says adverse
13 effects. There are more potential adverse
14 effects of duplication than just a decrease in
15 market share or occupancy rates of other
16 existing facilities. So, although I did not
17 label a specific part of the decision with this
18 language and make a finding there, as I
19 testified before, everything about certificate
20 of need review requires me to look at
21 duplication and whether or not there is
22 unnecessary duplication of services. I believe
23 that unnecessary duplication is the same things
24 as the duplication that has an adverse effect,
25 and so although I didn't title part of the

1 decision with this language and then quote it
2 and make a finding, my findings regarding
3 accessibility and the distribution or, you
4 know, unnecessary duplication part of the
5 analysis of the project review criteria, those
6 are findings that speak to this.

7 Q: So practical matter, you had three days to
8 digest what the opposing parties sent to you
9 before you made a decision, did you not?

10 A: It was more than three days.

11 Q: Got it on the 18th of July, five days?

12 A: Five days.

13 Q: Okay. You frequently meet with folks from
14 MUSC, planners and other people like that,
15 right?

16 A: I frequently meet with anyone from the
17 regulated community that wants to meet with us,
18 including MUSC. Yes, I do meet with them and
19 their representatives, I'd say fairly often.

20 Q: Okay.

21 MR. SUMMER: I beg the Court's indulgence. That's
22 all I have, Your Honor.

23 MR. WICEVIC: I have no re-direct, so.

24 THE COURT: Okay. I want to understand things a
25 little bit better, but I'll leave it where I

1 am. You may step down and we'll start again
2 Monday.

3 MR. WICEVIC: And, Your Honor, can Ms. Murdock be
4 excused?

5 THE COURT: You can be excused.

6 PROFFER OF 2020 DRAFT HEALTH PLAN BY MS. CRUM:

7 MS. CRUM: Your Honor, I do have one proffer.

8 THE COURT: Okay.

9 MS. CRUM: It -- and I've given the authority to --
10 this is the draft 2020 South Carolina Heath
11 Plan prepared for public comment current as of
12 November 1st, 2019. This morning they were
13 pointing out that the 2000 -- October 25th was
14 not the most recent, so I would like to proffer
15 the most recent 2020 draft Health Plan.

16 MR. SUMMER: It's fine by me, Your Honor, because it
17 shows the date of this change. It's still just
18 a proffer. They're just going to have two
19 plans as evidence instead of one, so that's
20 fine by me.

21 THE COURT: Well, the problem is proffering it when
22 there's no witness in -- I mean.

23 MS. CRUM: I was going to proffer it through Ms. --
24 but that's okay.

25 THE COURT: Well, I mean, I'll let you proffer it.

1 I'm just telling you what my concern is.

2 MS. CRUM: Well, and Ms. Murdock has testified all
3 day ---

4 THE COURT: Yeah.

5 MS. CRUM: --- that she was the drafter of the plan.

6 THE COURT: Well, you can proffer it. I'm not --
7 I'm will never keep a lawyer from proffering
8 something. Matter of fact, I try to help y'all
9 to proffer things. So, I mean, how are we
10 going to have this marked? Proffer Number 2?

11 MR. SUMMER: Two.

12 THE COURT: All right.

13 (Proffer Number 2 was marked for identification
14 purposes.)

15 THE COURT: Got it marked. Thank you. All right.
16 Monday, not tomorrow. What time?

17 MS. HOLLINGSWORTH: We can do 10:00, Your Honor.

18 THE COURT: Will we get through whoever we're
19 planning on ---

20 MS. JONES: It'll be a long day Monday.

21 MS. CRUM: Your Honor, these are ---

22 MS. JONES: Monday, Tuesday, Wednesday and Thursday,
23 I think.

24 MS. CRUM: These are the witnesses from MUSC ---

25 THE COURT: We're off on Thursday here, so.

1 MS. JONES: Do what?

2 THE COURT: I think the Court's off on Thursday.

3 MS. JONES: Thursday and Friday?

4 THE COURT: Wait a minute, I'm think of -- oh,
5 that's not Thanksgiving, okay.

6 MS. JONES: Well, and hopefully we'll finish next
7 week.

8 THE COURT: Okay.

9 MS. CRUM: These are the witnesses coming up from
10 Charleston on Monday morning.

11 THE COURT: Does that mean we need to start earlier?

12 MR. SUMMER: We'll start whenever it's convenient
13 for the people putting witnesses up.

14 MS. CRUM: Your Honor, I don't know. We're not sure
15 we can get -- this is -- Dr. Cawley is the
16 first witness, and he's scheduled for 10:00
17 o'clock, so. And it's kind of hard to get him
18 up earlier than that.

19 THE COURT: Well, I've never met the man, so I'll
20 say 10:00 and I'll find out why when he gets
21 here he can't get up earlier.

22 MS. CRUM: Well, he gets up very early. I shouldn't
23 say that.

24 THE COURT: Okay.

25 MS. JONES: Your Honor, he'll be here whenever you

1 want to start.

2 THE COURT: No, that's fine.

3 (DAY SEVEN of the hearing adjourned at 7:03 p.m.)

4 (DAY EIGHT - MONDAY, NOVEMBER 18, 2019. The hearing
5 reconvened at 10:01 a.m.)

6 CALL TO ORDER:

7 THE COURT: Be seated. Thank you. Are you calling
8 somebody?

9 MS. JONES: I am, Your Honor. If you are ready?

10 THE COURT: First chair, you're ready to go.

11 MS. JONES: All right; I'm ready.

12 THE COURT: I'm ready, too.

13 MS. JONES: May it please the Court, Your Honor.

14 The Medical University would call Dr. Patrick
15 Cawley.

16 THE COURT: Okay.

17 DR. PATRICK CAWLEY, being first duly sworn, testifies
18 as follows:

19 DR. CAWLEY - DIRECT EXAMINATION BY MS. JONES:

20 **Q: Dr. Cawley, if you would, please, I'd like to**
21 **start out your direct examination and get you**
22 **to briefly, but thoroughly, go through your**
23 **educational background for Judge Anderson.**

24 **A: Sure. My education started in undergrad, I**
25 **attended the University of Scranton where I was**

1 a biology and a business major. Then I went to
2 Georgetown University for medical school in
3 Washington, D.C. Graduated from there with a
4 degree -- with an M.D. degree. Then I went to
5 Duke University Medical Center where I did an
6 internal medicine residency and I completed
7 that after approximately three years. I then
8 practiced hospital medicine, which is a sub
9 branch of internal medicine, for many years.
10 In the early 2000s, I then attended business
11 school at the University of Amherst --
12 University of Massachusetts at Amherst, and
13 completed an MBA there, and that completed my
14 formal education.

15 Q: When you were at Duke, did you -- or in between
16 your finishing your residency at Duke and going
17 to the University of Massachusetts for your
18 MBA, did you work in multiple different
19 programs?

20 A: Yes, I initially started -- after I finished
21 residency at Duke, I stayed there as a faculty
22 member for several years, then I moved to the
23 Myrtle Beach area, actually in Conway, South
24 Carolina, and worked there as a hospitalist,
25 once again, which is a doctor that focuses on

1 inpatient internal medicine work. And I did
2 that as well as did some consulting around the
3 country for at the time hospital medicine was
4 a growing specialty and helped a lot of
5 hospitals around the country get hospital
6 medicine programs started, and did that until
7 2003, at which point I came to the Medical
8 University of South Carolina.

9 **Q:** Would you tell the Court a little bit about the
10 transition from the old way to the hospitalist
11 way of treating patients in a hospital?

12 **A:** Historically, when you -- when you went to see
13 your primary care physician and you needed to
14 be put in the hospital, your primary care
15 doctor put you in the hospital. And so your
16 primary care doctor would go see patients in
17 the office and then when they were done with
18 the office or before they went to the office,
19 they would come to the hospital and see you in
20 the hospital. That all began to change in the
21 mid 80s as more and more physicians simply
22 wanted to do outpatient work and not even come
23 to the hospital at all. The other reason was
24 that patients were starting to get sicker and
25 needed more full-time physician presence in the

1 hospital. And so in the late 80s, the
2 specialty of what's called hospitalist or
3 hospital medicine slowly grew. You know, when
4 I first started, there was probably just a
5 couple hundred hospitals in the entire nation;
6 I think there's almost 60,000 at this point, so
7 it's grown heavily over the last 25 years.

8 Q: And the hospitalist system allows for there to
9 be a physician in the hospital 24/7?

10 A: Right. A typical hospitalist program these
11 days has a dedicated physician in the hospital
12 24 hours a day, seven days a week, and even the
13 smallest hospitals these days have 24/7
14 hospital medicine programs.

15 Q: Dr. Cawley, when you came to the Medical
16 University in 2003, is that right?

17 A: That is correct.

18 Q: What position did you assume when you came to
19 the Medical University?

20 A: I came to MUSC to have two positions, one was
21 the director of the hospitalist program to
22 start their program, and then the other one was
23 to be the Associate Chief Medical Officer of
24 the hospital.

25 Q: And how long did you work in those two roles?

1 **A:** I worked -- I came in 2003 and worked to 2006
2 in both of those roles, until I became the
3 Chief Medical officer in 2006.

4 **Q:** When you started as the Chief Medical Officer
5 in 2006, what were the projects that were
6 underway and your primary responsibilities
7 during that time period?

8 **A:** As Chief Medical Officer, my role was to mainly
9 work with the medical staff, oversee quality,
10 be involved in really anything that the medical
11 staff needed to be involved in. I was the
12 major liaison to the medical staff. When I got
13 to -- when I got to MUSC in 2003, we were right
14 in the middle of -- probably the biggest
15 project under discussion was the building of
16 Ashley River Tower.

17 **Q:** And what is Ashley River Tower? We call it
18 ART.

19 **A:** Right. Ashley River Tower is -- is actually
20 phase one of a hospital replacement project
21 that was planned around -- I think around 2000.
22 The current hospital we're in, which is over on
23 Ashley Avenue, was built in 1950s and it's
24 become hard to deliver more modern day care in
25 that building. It can be done; it just -- it

1 just becomes difficult. Rooms are not as big
2 and you can't have as much electronics in the
3 building. So it became evident that we were
4 gonna need to replace that building and it
5 would have to be done over time. And so there
6 was a plan to do this over 30 -- 30 years, and
7 we'd do it in phases. We'd break it down to
8 phase one, two, and three. And Ashley River
9 Tower was the first phase. So when I got there
10 in 2003, it was heavy in the planning stage.
11 It eventually opened in 2008.

12 MS. JONES: Your Honor, at this point in time, I'd
13 like the Court to take judicial notice of
14 Section 59-123-60, which was the ---

15 THE COURT: 59 ---

16 MS. JONES: 123-60, which is the statute that
17 actually formed the Medical University of South
18 -- I mean, the Medical University Hospital
19 Authority in 2000. Did I give you a copy? Do
20 you want one?

21 MS. HOLLINGSWORTH: If you don't mind.

22 MS. JONES: Okay. All right. And ---

23 THE COURT: Well, I assume nobody objects to me
24 taking notice of a statute.

25 MR. SUMMER: I don't think we can object to what the

1 General Assembly has passed and Your Honor
2 signed.

3 **Q: And, actually, the Hospital Authority was**
4 **formed in 2000. Prior to 2000, how ---**

5 THE COURT: Was it -- I didn't -- I got lost in my
6 notes.

7 MS. JONES: Okay.

8 THE COURT: Ashley Tower was completed when?

9 **A: 2008.**

10 THE COURT: Okay. Thank you.

11 **Q: And in -- I'm trying to back up and kind of put**
12 **that a little bit in perspective because in**
13 **2000 is when the Hospital Authority was formed.**
14 **And the statute actually provides that the --**
15 **as shall be provided in an implementing**
16 **resolution by the Board of Trustees of the**
17 **Medical University of South Carolina, the Board**
18 **of Trustees of the Medical University of South**
19 **Carolina becomes the governing body of the**
20 **Medical University hospitals, clinics, and**
21 **other healthcare and related facilities,**
22 **hereinafter hospital, and shall be determined**
23 **from time to time by resolution of the Board.**
24 **And before then, the academic medical center,**
25 **where the patient care and the teaching**

1 functions of MUSC went up was in the Charleston
2 Memorial Hospital and what were -- and the
3 other clinics.

4 A: Right. Prior to the establishment of the
5 Hospital Authority, clinical care was
6 predominantly done either in the University
7 Hospital, which was directly subdivision of the
8 Medical University of South Carolina, was not
9 -- it was not a separate authority prior to
10 2000. And then the other place was over at the
11 Charleston Memorial Hospital, which was a
12 county hospital about two blocks down the
13 street. So those two places was where the
14 majority of care was provided for the mission
15 of MUSC.

16 Q: And Charleston County didn't want to be in the
17 healthcare running the hospital business any
18 more?

19 A: That is correct. And around that time, then
20 MUSC took over Charleston Memorial Hospital.

21 Q: And as part of that, the beds that were in the
22 Charleston Memorial Hospital and the age of
23 that facility was what?

24 A: Oh, yeah, that -- that was built in the '40s,
25 I believe.

1 Q: Those beds were actually transferred to where?

2 A: They were transferred to -- eventually to the
3 Hospital Authority.

4 Q: And then they -- they actually went to the
5 Ashley River Tower, is that right?

6 A: Right. And then eventually we held those beds
7 and we built Ashley River Tower with those
8 beds.

9 Q: And that's what you were talking about a minute
10 ago as phase one of this three-phase plan ---

11 A: Correct.

12 Q: --- that was put together by the Board of
13 Trustees back in around 2000?

14 A: Right. Not too long after the Hospital
15 Authority came into fruition, the Board then
16 decided their -- we'd have to upgrade the plans
17 and have to work on this over a number of
18 years.

19 Q: Okay. And that's -- that was a long term
20 strategic plan that was put in place by the
21 Board of Trustees?

22 A: Yes, it was anticipated that approximately
23 every ten years we would open up a new phase.

24 Q: All right. What facilities are located in the
25 Ashley River Tower?

1 **A:** Ashley River Tower is -- is about 150, 160-bed
2 hospital. It has a bed tower. It also has
3 what's called a diagnostic and treatment
4 center, which is operating rooms, radiology,
5 anything needed to treat the 150-some patients
6 in that -- in that building. The services are
7 predominantly heart and vascular, digestive
8 disease, adult oncology. In fact, I should say
9 Ashley River Tower is almost 100 percent adult.
10 And those are the three main services. There's
11 a smattering of other services there, as well.

12 **Q:** So, from the time that you came to the Medical
13 University until now, has there ever been a
14 time period when the hospitals down there, the
15 Medical University hospitals, didn't have bed
16 constraints on their capacity?

17 **A:** Since -- since I arrived in 2003, and I was the
18 Associate Chief Medical Officer, I had to deal
19 with bed constraints from day one. That was
20 one of the major projects that I had to deal
21 with on a -- just about on a regular basis.
22 Now, the only time that it's never been full
23 was for about a two-year period after Ashley
24 River Tower was opened up.

25 **Q:** And that time period was what years,

1 approximately?

2 A: It was about 2008 to 2010.

3 Q: Since the opening of the Ashley River Tower,
4 what was the second phase of the long-term plan
5 by the Medical University Board of Trustees?

6 A: The second phase is the -- what we call now the
7 Shawn Jenkins Children's Hospital. And that is
8 to open probably in the next month.

9 Q: And what is the -- what was the impetus behind
10 that second phase?

11 A: Well, the main thing was about a quarter of
12 MUSC's overall business is pediatric and
13 increasingly it's sicker kids, more complicated
14 illnesses, you know, higher -- what we call
15 higher acuity of care, and it was just getting
16 difficult to deliver that in the current -- in
17 the current hospital, which was built -- and
18 the current children's hospital was even
19 younger than the adult current hospital. That
20 was built in the 1980s, but it was just getting
21 difficult to do that, and so we felt the second
22 phase would be replacing the children's
23 hospital. It's the children's hospital and
24 what we call women's services.

25 Q: Since the 1980 -- the new children's hospital,

1 the Shawn Jenkins Hospital, is it state-of-the-
2 art?

3 A: Yes.

4 Q: And can you give us some examples of the
5 improvements that the children will have, the
6 patients in the new children's hospital?

7 A: Yeah, when it opens in the next month, it will
8 be the most technologically, as well as patient
9 family center hospital in the nation. And it's
10 -- first of all, the rooms are big. The rooms
11 allow for families to actually stay in the
12 room, which is these days key. We can't do
13 that in the old room. Often we have to put
14 children in each room. But in this new
15 building, families can stay right there. And
16 just all the technology that's needed in the
17 room to be able to take care of the patient is
18 what we're able to do.

19 Q: Like the oxygen and the ---

20 A: I mean just ---

21 Q: --- telemetry?

22 A: Just about -- just about everything. All kinds
23 of -- all kinds of information technology, all
24 type of stuff. You know, probably the biggest
25 change is gonna be our neonatal intensive care

1 unit, which, today, is a big open unit with
2 about 60 babies in it, but it's big and open.
3 But in the new building, each baby and family
4 will have their own room. So it gets out of
5 that paradigm of a big open unit to
6 individualized rooms.

7 Q: And what effect does that have on the quality
8 and the experience and all of the metrics that
9 you followed as a Chief Medical Officer?

10 A: Well, it gets -- I mean, it certainly helps the
11 quality to be much, much easier because imagine
12 just taking care of the children in a big open
13 room. And the team does great things with what
14 they do, but this will make it a lot easier.
15 It'll also just be better for families.
16 They'll be able to be there; they're be able to
17 stay in the room. It'll be a much, much better
18 experience.

19 MS. JONES: And I'd also, Your Honor, at this
20 point, ask the Court to take judicial notice of
21 Section 59-123-60, entitled Organization of
22 Powers of the Board Designated as Medical
23 University Hospital Authority. Likewise, it
24 was passed by the General Assembly when the
25 Hospital Authority was formed in 2000. And

1 subsection (e) states, it shall be provided in
2 -- well, I already did that one. I already did
3 that one. Sorry; I'm repeating myself, Judge.
4 It's 59-123-40, Composition of the Board of
5 Trustees. The management and control of the
6 University shall be vested in a Board of
7 Trustees to be composed as follows. The
8 Governor or its designee ex officio, 14 members
9 to be elected by the General Assembly in Joint
10 Assembly and one member to be appointed by the
11 Governor. Because a question had come up about
12 the composition of the board for the Medical
13 University and the Medical University Hospital
14 Authority.

15 **Q: How long did you work as the Chief Medical**
16 **Officer for the Medical University Hospital**
17 **Authority?**

18 **A: I did that from 2006 until 2013.**

19 **Q: And, if you would, please explain when you came**
20 **on as the Associate Chief Medical Officer and**
21 **from that point forward, did you also take on**
22 **a role with the faculty of the Medical**
23 **University?**

24 **A: Yes. At the same time I was a faculty member.**

25 **Q: What are the -- how does that work at the**

1 Medical University, when you become an employee
2 of the Hospital Authority or the Medical
3 University from a physician's standpoint?

4 A: Well, from a physician's standpoint, there are
5 no physicians, except for one now, that has any
6 employment in the Medical University Hospital
7 Authority. I'm the only one and that's because
8 I'm the CEO. All other physicians, including
9 during my time as Chief Medical Officer, my
10 primary employment is with the Medical
11 University of South Carolina and I'm contracted
12 over to the Medical University Hospital
13 Authority for any duties that they need over
14 there. In doing that, it keeps us very
15 connected on things.

16 Q: And are you a member of the faculty?

17 A: I am.

18 Q: Okay. And the faculty appointments are
19 pursuant to the final authority of appointment
20 vested in the Board of Trustees, is that right?

21 A: Yes.

22 Q: Okay. Are there any physicians practicing at
23 any Medical University Hospital Authority
24 hospital that are not members of the faculty of
25 the Medical University of South Carolina?

1 **A: No.**

2 **Q: Okay.**

3 **THE COURT: Are there any members practicing that -**

4 **--**

5 **MS. JONES: At the hospital that are not on the**

6 **faculty.**

7 **THE COURT: Oh, that would be a simpler way of**

8 **saying it. Thank you.**

9 **A: All members -- all medical staff of any**

10 **Hospital Authority need to be members of the**

11 **faculty.**

12 **THE COURT: I got it.**

13 **Q: And as a member of the faculty and of being on**

14 **staff at the Medical University, do the**

15 **physicians engage in activities other than**

16 **patient care?**

17 **A: Yes.**

18 **Q: What do you do?**

19 **A: Yes, I mean, there's an expectation that**

20 **everyone is judged -- every faculty member is**

21 **judged by three things, clinical care,**

22 **teaching, and research or some kind of academic**

23 **productivity. The teaching could be -- for a**

24 **physician is predominantly medical students or**

25 **residents or fellows, but it could also be**

1 nurses, physical therapy students, anything.

2 Q: Can you tell the Court generally, and I'm
3 confident we might leave some out, what medical
4 professionals are trained at the Medical
5 University?

6 A: We train just about the entire gamut of medical
7 specialties. I mean, there may be some rare
8 sub, sub, sub specialties that are don't train,
9 but I would say for the most part we train just
10 about everything. Even sub, sub specialties.

11 Q: And not just physicians?

12 A: Oh, oh, not at all. Physicians, I was
13 referring to physicians mainly, but nursing,
14 pharmacists, physical therapy, occupational
15 therapy, nurses, you know, etcetera, keep going
16 on and on.

17 Q: The role of Chief Medical Officer, how long did
18 you stay in that role?

19 A: I was in that role almost seven years.

20 Q: Until -- when did you -- where did you go next
21 or what role did you take on after that?

22 A: Well, I stayed there. I just moved into the
23 CEO of the hospital role.

24 Q: So there was a period of time when you were the
25 Chief Operating Officer and the Chief Medical

1 **Officer?**

2 **A:** Well, what happened was when I was Chief
3 Medical Officer, I began to take on bigger
4 roles and became what is known as the
5 functional Chief Operating Officer. I oversaw
6 all clinical service lines in the hospital. We
7 had eleven service lines at that time, which
8 constituted the bulk of the employees in the
9 Hospital Authority and all of those came under
10 my oversight.

11 **Q:** Can you give the Court a few examples of the
12 different service lines?

13 **A:** Sure. The transplant center, so that's the
14 center that involves the clinical care in
15 taking care of patients that are transplanted.
16 Heart and vascular center, you know, that's the
17 center that deals with all things heart-
18 related. You know, the children's hospital, so
19 that involves all pediatric care and
20 subspecialty care. And there were -- there
21 were eleven of them, so all eleven reported up
22 to me.

23 **Q:** How long did you remain the Chief Medical
24 Officer and also serving in this other capacity
25 as the Chief Operating Officer?

1 **A:** Until -- until the end of 2012, then I became
2 the CEO designate on -- in January of 2013.

3 **Q:** So that was about six years ago? Six and a
4 half ---

5 **A:** Correct.

6 **Q:** --- close to seven years ago, I guess? And how
7 did your job responsibilities change when you
8 became the CEO of the Hospital Authority?

9 **A:** Well, in that role, I have complete
10 responsibility for the Hospital Authority. And
11 so anything that involves, you know, clinical
12 care, finance, building, anything, anything
13 that involves the day-to-day operation, as well
14 as future planning for the Hospital Authority
15 comes under my purview.

16 **Q:** Dr. Cawley, do you still engage in patient care
17 and teaching?

18 **A:** I do.

19 **Q:** What do you do in regards to patient care? Do
20 you actually work in one of the clinics or what
21 do you do?

22 **A:** I -- I work as a hospitalist on occasion,
23 mainly covering, not as much any more, but
24 mainly covering and helping out.

25 **Q:** And what do you do in your teaching role?

1 **A:** Well, when I do that, I will teach students and
2 residents, but predominantly most of my
3 teaching these days is with hospital
4 administration students.

5 **Q:** Did your role as CEO of the Hospital Authority
6 change in 2016?

7 **A:** Yes, I took on a broader role for the -- what
8 we call the health system at MUSC.

9 **Q:** And I want you to go into a little bit of
10 detail and explain to the Court what the MUSC
11 health system encompasses.

12 **A:** Right. So at MUSC, predominantly historically
13 most of the clinical care is done through the
14 Hospital Authority, but increasingly, there
15 were other things happening in terms of
16 clinical care. For instance, the physician
17 practice group was doing more clinical work;
18 the College of Nursing was doing clinical work;
19 the College of Health Professions was out doing
20 clinical work, so as it became easier to do
21 clinical work in different kind of settings,
22 more of the colleges got involved in their own
23 clinical work. And then the problem that that
24 -- you know, just coordinate that then. So we
25 didn't want the College of Health Professions

1 off doing something that wasn't fully
2 coordinated with everything else. So around
3 that time, we developed the concept of the MUSC
4 Health, which is an envelope, more of a way of
5 doing business that says that all of these
6 things, all of these clinical aspects of MUSC,
7 will be coordinated by someone and that someone
8 would be me. So yes, predominantly, I've
9 continued to do work in the Hospital Authority,
10 but then I had purview to coordinate all
11 clinical care across the entire gamut of MUSC.

12 Q: And the concept of MUSC Health, was that
13 presented to or was that a decision by the
14 Board of Trustees of the Medical University of
15 South Carolina and the Medical University
16 Hospital Authority?

17 A: Yes.

18 Q: And it was so that there would be an oversight
19 and coordination among all of the different
20 facets of the University, the hospital, and the
21 clinics?

22 A: Right, and the physician practice groups.

23 Q: And the physician practice ---

24 A: Yeah, I mean, those would be the big three.

25 The University, the Hospital Authority, and the

1 physician practice -- practice collab would be
2 the big three in terms of who's providing
3 clinical care.

4 Q: What facilities does the Medical University
5 Hospital Authority provide here in South
6 Carolina that no one else provides?

7 A: That would -- that would be a long list, but
8 some of them, just to highlight, we have a
9 transplant center, so no one else in South
10 Carolina's doing solid organ transplant. We
11 have a comprehensive NICU. There are other
12 Level IV NICUs across South Carolina, but we
13 have a status even above that called a
14 comprehensive neonatal unit.

15 Q: When you say you have a status above that, how
16 are you recognized as a status above that?

17 A: Yeah, we applied for a formal Certificate of
18 Need for that and received that.

19 Q: If you would, please, what is the designation
20 for the Hollings Cancer Center at MUSC, MUHA?

21 A: Sure, so that's another example of something
22 that no one else is doing. We have a National
23 Cancer Center designation, which is given to
24 cancer centers that are combining not just the
25 clinical care, but they're adding the teaching

1 component and the research component to it.
2 There's an expectation to do all of those three
3 and link them together in a way that moves
4 cancer treatment forward.

5 Q: And is part of the Medical University, also a
6 part of it is the Storm Eye Institute?

7 A: Yes, so the Storm Eye Institute is a
8 comprehensive eye center that treats just about
9 anything eye related. There's nothing we don't
10 treat when it comes to the eye, including we
11 end up being a major, major referral center for
12 any ocular trauma or eye trauma throughout the
13 entire State.

14 Q: For all of those, you know, subspecialties, do
15 you -- are you called on daily for transfers of
16 patients for those subspecialties?

17 A: Yes.

18 Q: At present, how -- approximately how many
19 transfer requests are you having to decline
20 every month because you don't have the
21 capacity?

22 A: That's easily in the 50 to 60 range that we can
23 determine. Now, at the same time, I know in
24 talking with other physicians that sometimes
25 they don't want to call us because they know

1 we're so jammed, so there could be more. So a
2 minimum, that's the number, but it could be --
3 could be greater.

4 THE COURT: And that was -- give me that number
5 again.

6 A: 50 to 60 a month that we're aware of. You
7 know, we get calls. We have something called
8 an admit transfer center, we get calls and then
9 we look to match them into a bed or a place and
10 we just can't do it. So we keep track of that
11 and some of those are turned down.

12 MS. JONES: Mr. Bupp, would you put on the screen
13 MUHA Exhibit 26, the mission statement for the
14 MUSC?

15 (MUHA Exhibit Number 26 was introduced into the
16 record at this time.)

17 Q: If you would, please, Dr. Cawley, would you
18 explain to the Court how the mission statement
19 -- first of all, what is the mission statement
20 for MUSC?

21 A: So the mission statement there is in that
22 second -- it's that second sentence -- second
23 and third sentence, purpose is to preserve and
24 optimize human life in South Carolina beyond
25 and to do that through learning, discovery,

1 healing, which means education, research, and
2 provision of clinical care. That's the mission
3 statement. That comes straight from -- I think
4 it's actually written in the -- in the Higher
5 Ed Act for MUSC and it's also part of the
6 mission for the Hospital Authority. It's the
7 same exact mission statement.

8 MS. JONES: And, Your Honor, at this point in time,
9 I'd ask the Court to take judicial notice of
10 Section 59-103-15, the statute, the Commission
11 on Higher Education Statute, that requires the
12 institutes of higher education in the State,
13 particularly in this regard, the Medical
14 University is a -- is a ---

15 THE COURT: All right. I'm at 59-103-15. What am
16 I ---

17 MS. JONES: Is the Commission on Higher Education
18 statute that delineates and provides for the
19 different levels of higher education in South
20 Carolina.

21 Q: And in that regard, Dr. Cawley, the Medical
22 University is a research university, is that
23 correct?

24 A: That is correct.

25 MS. JONES: And, particularly, Your Honor, the

1 statute requires that the -- and actually, it's
2 in 59-103-30 that the research university be
3 mission focused and adopt an approval and
4 submit it to the higher education a mission
5 statement and that the mission then -- that the
6 university then approve the expenditure of
7 funds to achieve the institutional mission,
8 provide for curriculum offered to achieve the
9 mission, the approval of the mission statement,
10 the adoption of a strategic plan to support the
11 mission statement, and attainment of goals of
12 the strategic plan. And that is ---

13 THE COURT: That was 59-103-30(b)?

14 MS. JONES: (b), that's correct.

15 THE COURT: (1)(A) through (E)?

16 MS. JONES: Yes, sir. That's it.

17 **Q:** And so in that regard, is the Medical
18 University and the Hospital Authority
19 accountable to the Commission on Higher
20 Education for those -- for those requirements?

21 **A:** Yes.

22 **Q:** And this mission statement is the one that has
23 been submitted to the Commission on Higher
24 Education and approved for the Medical
25 University, is that right?

1 **A:** Yes.

2 **Q:** So the three pillars that you talked about, the
3 clinical care, the teaching, and the research,
4 is that -- those are the three metrics that
5 everybody who's working down there is focused
6 on, is that right?

7 **A:** Yes. I mean, we talk about that constantly.
8 We talk about how to -- how each one is
9 important and plays off each other.

10 **Q:** At present, Dr. Cawley, how many employees does
11 MUHA have?

12 **A:** The Hospital Authority has almost 13,000
13 employees at this point.

14 **Q:** And approximately how many of those employees
15 are actual physicians or other allied
16 healthcare professionals?

17 **A:** Approximately 1,200.

18 **Q:** And currently, the Medical University Hospital
19 Authority on the peninsula in Charleston
20 operates which inpatient facilities? Inpatient
21 hospital facilities?

22 **A:** We operate five facilities. One on the
23 peninsula in Charleston. That's -- all those
24 buildings are considered one inpatient
25 hospital. And then we operate four others

1 outside of Charleston.

2 Q: Okay. Well, let's talk about the ones that are
3 on the peninsula in Charleston because there's
4 been some characterizations of the main
5 hospital and then the Shawn Jenkins Children
6 Hospital, and the Ashley River Tower.

7 A: Yeah, that is all technically one inpatient
8 hospital. Now it's separated into there's a
9 children's hospital; there's a psych hospital;
10 there's University Hospital; there's Ashley
11 River Tower. So those are the four you can
12 call them ---

13 Q: The four.

14 A: --- four big sub units of the big hospital
15 downtown, but that is all technically the
16 Charleston Medical University Hospital
17 Authority.

18 Q: And the psych hospital, what is -- the name of
19 the psychiatric hospital is the ---

20 A: It's called the Institute of Psychiatry.

21 Q: Okay.

22 A: IOP. It's a 100-bed psychiatric inpatient
23 facility. I think 105 to be exact.

24 Q: And let me ask you this, on an annual basis,
25 how many patients does the Medical University

1 treat, the Hospital Authority?

2 A: On an inpatient basis, we see about 40,000 and
3 then on a total basis, inpatient plus
4 outpatient, it's almost a million.

5 Q: Per year?

6 A: Per year.

7 Q: 40,000 is that adults or does that include
8 children?

9 A: That's adults and children.

10 Q: Okay.

11 A: And about a quarter of that is children.

12 Q: And then when you include all the clinics and
13 all the outpatient services, it's a million --
14 -

15 A: Yes.

16 Q: --- people a year?

17 A: Yes.

18 Q: Why does the Medical University Hospital
19 Authority need this new hospital?

20 A: Well, I mean, we continue to grow and the
21 patients want to come see us and, you know, we
22 remain jammed and have to turn patients away
23 and, you know, we feel that our mission is
24 exactly as was stated before that we need to
25 expand and take care of the patients that want

1 to come to us.

2 Q: Where does the Medical University receive
3 patients from?

4 A: We receive from every county in South Carolina.
5 About half of them come from outside the tri-
6 county and half come from inside the tri-
7 county. By tri-county, I mean, Charleston,
8 Berkeley, and Dorchester counties.

9 Q: And so half of the patients that are coming
10 down to Charleston to be seen by your care
11 teams are coming from outside the tri-county
12 area?

13 A: That is correct.

14 Q: And that's true today?

15 A: Correct.

16 Q: And it's been true for a number of years?

17 A: It's been like that for -- as long as I've been
18 there.

19 Q: And the patients that come to you from outside
20 the tri-county area, 50 percent of your patient
21 load, do they come through the patient just
22 calling you up or referrals or how does that
23 generally happen?

24 A: Well, it's both. I mean, there are patients
25 that call us and schedule time and

1 appointments. And then there are patients that
2 are referred from physicians and they could be
3 coming on an inpatient side; they could be
4 coming on an outpatient side. There's any
5 number of ways they could be coming to see us.

6 **Q:** And, Dr. Cawley, these patients that are coming
7 to see you, when they call and ask for a
8 referral and you can't accommodate it, is that
9 information that is communicated to the Board
10 of Trustees?

11 **A:** Yes. Yes.

12 **Q:** And is that why the Board of Trustees
13 authorized the Medical University to file for
14 the CON application?

15 **A:** Yes, the Board is well aware of our ---

16 MS. HOLLINGSWORTH: Your Honor ---

17 THE COURT: Hold on.

18 MS. JONES: Sorry.

19 THE COURT: Do you object?

20 MS. HOLLINGSWORTH: Your Honor, I object to that
21 last question it's leading.

22 THE COURT: Is that why the Board authorized you to
23 ---

24 MS. HOLLINGSWORTH: It's also asking him to
25 speculate. I mean, if she'd ask it a little

1 bit differently to get the same information.

2 MS. JONES: I can lay a foundation and ask it
3 differently.

4 THE COURT: Proceed ahead, then.

5 Q: Dr. Cawley, who do you report to?

6 A: I report to the Board of Trustees and Dr. David
7 Cole, the President.

8 Q: Do you attend every Board of Trustee meeting?

9 A: I do.

10 Q: How often is it discussed with the Board of
11 Trustees or what information is imparted to the
12 Board of Trustees to review in regards to the
13 capacity at the Medical University and the
14 constraints?

15 A: I do a report to the Board every single Board
16 meeting and capacity constraints is most of the
17 time part of that discussion and report.

18 Q: Is information reported to them regarding the
19 transfer requests that you are not able to
20 accommodate?

21 A: It is.

22 Q: And what has been their response and
23 instruction to you and President Cole?

24 A: The Board persistently over the last five years
25 has instructed us to find ways to deal with

1 those capacity constraints.

2 **Q:** Okay. How often is the bed need discussed at
3 the Medical University?

4 **A:** On an operational level, it is discussed every
5 single day, multiple times a day, and we have
6 -- we start with -- starts very early in the
7 morning, you know, 6:00, 7:00 o'clock, and we
8 talk about how to move patients through the
9 system quicker. There's a series of meetings
10 throughout the day. Our doctors get involved.
11 Dr. Phillip Warr, who's our current Chief
12 Medical officer, leads much of that. So it's
13 a constant -- constant.

14 **Q:** What are your most significant areas of
15 overcrowding?

16 **A:** Probably the biggest one at any time is the
17 emergency room, that is typically -- we have I
18 would say on average 15 to 20 patients boarding
19 in the emergency room at any one time. And
20 it's not uncommon to be 20 to 30 boarding.

21 **Q:** What exactly does that mean, a patient boarding
22 in the emergency department?

23 **A:** That means a patient is in the emergency room,
24 you know, basically hanging out there because
25 they can't go home. They're too sick to go

1 home.

2 Q: They need to be admitted?

3 A: They need to be admitted somewhere and they
4 can't be admitted, so we call that boarding.
5 That they're hanging out in the emergency room
6 because they have simply no other place to get
7 the kind of care that they need. So that's one
8 area and that includes both the adult emergency
9 room and the pediatric emergency room. The
10 second area of crowding increasingly is just
11 regular beds. So regular beds particularly for
12 patients coming out of procedure or coming out
13 of the operating room. It's not uncommon for
14 us to have a situation which we have to stop
15 the operating room and not bring any more
16 patients into it because we don't have any
17 patient -- we don't have any beds for the
18 patients that are coming out of the operating
19 room to go into. It's not uncommon for us to
20 stop certain kind of procedures because we
21 don't have patients coming out of those
22 procedure units to have beds. And then the
23 third area of overcrowding, I would just say,
24 to me, is the patients that don't come in. You
25 know, so that's a different kind of crowd, but

1 it's crowding outside our system.

2 Q: It's just patients that you just don't have the
3 capacity to receive?

4 A: We -- we can't take and they want -- these are
5 -- these are not just patient requests. These
6 are also other doctors and other institutions
7 who want to get a patient to us.

8 Q: In the new Nexton hospital, what is the plan to
9 address those issues that you just described?

10 A: Well, I think having that hospital will address
11 all of those things. I think it will help us
12 and every single one of those. We would hope
13 that we could move patients who don't have as
14 high acute an illness to Nexton or begin to
15 bring them into Nexton first and then keep the
16 higher acute, real sick patients, down in the
17 peninsula in Charleston. So it'll help us
18 manage the whole situation a lot better. And
19 I think it'll end up helping every single one
20 of those areas.

21 Q: How much is this hospital needed? I mean ---

22 A: Oh, it's -- I can tell you personally it's
23 needed because we deal with it every single day
24 and how crowded we are. But I think if you
25 look at other criteria, whether it's the bed

1 need that the State puts out or if you look at
2 the population, how it's growing particularly
3 in the low country, I think those are all other
4 kinds of evidence that this is needed.

5 Q: Now, there's been a lot of discussion in the
6 courtroom about the purported impact for or
7 some effect that this Nexton hospital would be
8 taking patients from Trident or Roper. Is that
9 your intention in any way?

10 A: Absolutely not. We are building this hospital
11 to take care of the patients that want to see
12 us. I think also -- I think having this
13 hospital would actually help those facilities
14 because they're big referrers particularly for
15 subspecialty care at MUSC. It would be a lot
16 easier for them to get patients in. So I don't
17 see this as hurting those hospitals at all.

18 Q: Do you -- are you aware that referrals come in
19 routinely from the Roper and Trident hospitals
20 with those facilities attempting to have
21 patients there transferred to the Medical
22 University?

23 A: Yes, happens all the time and, you know,
24 because I'm in the tri-county and I know many
25 of the -- I know many of the physicians and

1 many administrators of many of those hospitals,
2 I get calls from them to try to some how, you
3 know, grease the wheels to get those patients
4 in the hospital faster.

5 Q: And if you would, please, because this is
6 something that -- this is something that we
7 need to have the facts on, what is it about
8 those subspecialty areas that many of these
9 other hospitals, that Roper and Trident, have
10 subspecialists working there, why do those
11 people contact the Medical University to
12 transfer patients if they've got subspecialists
13 in their facilities?

14 MS. HOLLINGSWORTH: Your Honor, I object; calls for
15 speculation about the reasons in particular our
16 clients would have transfers to another
17 institution.

18 THE COURT: Any response?

19 MS. JONES: This is not speculation. Dr. Cawley is
20 running that system down there. He knows that
21 they get 50 or 60 transfer requests every month
22 that they can't accommodate. He knows that
23 they come from Trident and Roper and he knows
24 ---

25 THE COURT: Well, you're asking ---

1 MS. JONES: --- the subspecialty areas that I --

2 I'm sorry.

3 THE COURT: I didn't mean to cut you off, but what
4 I want to understand is you're asking why they,
5 the other doctors, in their mind are doing --
6 taking a certain action. Would that not be
7 speculation?

8 MS. JONES: I'm trying to ask him -- if I've asked
9 it inartfully, I'll re-state it. I'm trying to
10 ask him to delineate to the Court the factual
11 information about the subspecialty areas that -
12 - and how those subspecialty areas reach into
13 a sub subspecialty area at the Medical
14 University. And I can do it specifically with
15 various lines, service lines.

16 THE COURT: If you can ask it through the
17 information that's his knowledge rather than
18 the knowledge or the thought processes of
19 others ---

20 MS. JONES: Okay.

21 THE COURT: --- that would probably alleviate the
22 objection.

23 **Q: Okay. What subspecialty lines does the Medical**
24 **University provide for patients in the tri-**
25 **county area and the other 50 percent of all**

1 your patients that come outside the tri-county
2 area that are not available in the Trident and
3 Roper facilities?

4 A: I mean, I think across just about every single
5 specialty MUSC has deeper what we call
6 subspecialty or sub subspecialty expertise.
7 I'll give you an example. So, take head and
8 neck surgery. That is available at both of
9 those hospitals. We have subspecialties in
10 head and neck surgery. So we have surgeons
11 that just do cancer; we have surgeons -- heck
12 and neck surgeons that just do sinus surgery;
13 we have -- you know, and so on. I can give you
14 each and every one of them. You know, we have
15 head and neck surgeons that just do ear work.
16 That's all they do. And it is very typical to
17 get a referral for -- from a more generalist
18 say head and neck surgeon to a more specialty.
19 So if you're taking care of an ear problem as
20 a head and neck surgeon, and you're running
21 into a situation you need more help on or you
22 want more deep knowledge, then you may send to
23 the ear specialist at MUSC. Now, that's just
24 one example. But I could do that across
25 cardiology, pediatrics ---

1 Q: Neurosurgery?

2 A: I'm sorry?

3 Q: Neurosurgery?

4 A: Neurosurgery, every specialty is that way. And
5 not only do we have just, you know, it's not
6 typical to have one physician in an area. We
7 usually have at least three because we want to
8 take 24/7 call for that kind of specialty. So
9 it's -- so I'm trying to think the concept is
10 deep sub subspecialty experience, and that is
11 the reason for many of the referrals.

12 Q: And Dr. Cawley, just to use the example you
13 just gave, a head and neck surgeon that is a --
14 admittedly a subspecialty to be a head and neck
15 surgery, but who at MUSC just does head and
16 neck cancer surgery?

17 A: Sure, so Dr. Terry Day is one example. He does
18 just -- just head and neck cancer treatment.
19 He doesn't do any other work. He doesn't do
20 ears; he doesn't do sinuses. He just does --
21 he does that.

22 Q: And Dr. Day, does he have a dedicated team that
23 only do the head and neck cancer surgery and
24 treatment with him?

25 A: Yes.

1 Q: And what kind of people are on that dedicated
2 team?

3 A: You know, it's all kinds. I mean, hospitalists
4 are actually on that team, social workers, case
5 managers, nurses, anesthesia. And typically, a
6 lot of them are practicing in that
7 subspecialty, as well, but in their area. So
8 anesthesia doctors who just do head and neck --
9 head and neck work, but there's a whole team.

10 Q: And is that the level of subspecialty that
11 patients can find at the other hospitals in the
12 area?

13 A: Not comprehensively, you know. On occasion,
14 they may find some deep -- or sub subspecialty
15 in a particular area, but not as comprehensive
16 as say what MUSC has.

17 Q: So what is the plan for the Nexton hospital?
18 How will it become -- what is the plan that the
19 Board of Trustees envision for it to become a
20 part of the Hospital Authority?

21 A: Right. So it will be a part of the Hospital
22 Authority. It will take on all the
23 characteristics of the Hospital Authority. We
24 would hope to put less acute patients there so
25 that the more acute patients that really need

1 that kind of care can come down to Charleston,
2 down to the peninsula. But that's the plan.
3 The -- and not just clinical care, so -- but
4 also the education and it is our intent to
5 also, you know, do research studies, as well,
6 in that hospital.

7 Q: What is the general patient acuity for the
8 Medical University Hospital Authority patients?

9 A: Overall, it is very high acuity. And that can
10 be measured in different ways, but it's -- but
11 that is -- it's high acuity.

12 Q: Is it the Medical University's intent to treat
13 the patients at the Berkeley hospital that you
14 can't accommodate downtown presently?

15 A: Yes.

16 Q: Do you intend to solicit patients from Trident
17 or Roper?

18 A: We do not.

19 Q: Do you solicit them now?

20 A: No.

21 Q: At the new hospital in Nexton, how many IC- --
22 do you remember how many ICU beds is planned
23 for?

24 A: I can't recall exactly.

25 Q: I'll come back to that.

1 MS. JONES: If you could, please, Mr. Bupp, would
2 you pull up the CON application? And I just
3 want to run through this real quickly, Your
4 Honor. I know the Court can read, but I just
5 want to point it out to you. Go to page 8,
6 DHEC 8.

7 Q: And in the introduction in that first
8 paragraph, does the CON application anticipate
9 that or state there that centrally located in
10 downtown Charleston MUHA has achieved
11 international recognition and national acclaim
12 as a premier biomedical research, educational
13 and clinical institution?

14 A: I think that's factually true.

15 Q: And then sets forth MUHA's mission statement.
16 And in the second paragraph, does it also
17 provide that MUHA serves as an academic
18 training facility for the numerous residency
19 programs with 49 different medical specialty
20 resident training programs and the hospital
21 serves as a valuable resource for educating and
22 preparing future physicians. Is that part of
23 the plan for the Nexton hospital, as well?

24 A: Yes, absolutely.

25 Q: Okay. Do you further discuss the -- on page

1 11, DHEC 11, in the first full paragraph that
2 begins, third, the Medical University has
3 experienced an increased demand for inpatient
4 services, and then about halfway down, you say
5 that MUHA is unable to accept patient transfer
6 requests from Roper Tri-County and affiliate
7 hospitals on a daily basis due to the lack of
8 available beds?

9 A: That is correct.

10 Q: And that continues to today?

11 A: It does.

12 Q: And on DHEC 21, under the project review --
13 wait a minute. I'm sorry, page 22. Page 22 in
14 the first paragraph, about the third sentence
15 down it states that the State's largest
16 academic medical center MUHA has achieved
17 international recognition and national acclaim
18 as a premier biomedical research, educational,
19 and clinical institution, and then in the
20 bottom paragraph it speaks to the community
21 health needs assessment in 2016, and the next
22 to the last sentence, the top health issue
23 identified as a priority in CHMA was access to
24 health services. Is it your intention to offer
25 better access in the Nexton community?

1 **A:** Yes.

2 MS. JONES: On DHEC 43, Mr. Bupp.

3 **Q:** There is a figure there, figure 23, actually
4 delineates in detail when this was submitted to
5 DHEC, the transfer request by the hospitals
6 that make the most requests as of fiscal year
7 2017, do you see that chart?

8 **A:** Yes.

9 **Q:** To your knowledge is that still an accurate
10 depiction of the transfer database request
11 coming from those facilities?

12 **A:** Yes, I don't believe that has changed at all.

13 **Q:** Okay. And it's depicted on there and is it
14 accurate that there are significant transfer
15 requests from Trident, Summerville, Roper St.
16 Francis, and Colleton Medical Center?

17 **A:** Yes.

18 **Q:** As well as the others?

19 **A:** Yes.

20 **Q:** Okay. And DHEC 60, in response to question 25
21 or criteria 25, the response delineates or sets
22 forth the fact that the Medical University was
23 founded in 1824 and that MUHA educates and
24 trains more than 3,000 students and residents
25 annually and has nearly 10,000 employees, I

1 think you updated that and it's now at ---

2 A: Yes.

3 Q: --- 13,000?

4 A: Today it's closer to 13,000.

5 Q: Is the number of students that MUHA educates
6 and trains still approximately or more than
7 3,000 students and residents annually?

8 A: Well, it's about 3,000 students and it's now
9 about 800 residents.

10 Q: Okay.

11 A: Residents and fellows.

12 Q: And the faculty members, is that still about
13 the same?

14 A: That's roughly about the same.

15 Q: Okay. Also delineated in this section is some
16 of the designations that the hospital that MUHA
17 has achieved in the heart and vascular center
18 and the children's hospital area and that the
19 neonatal -- the NICU is one of the country's
20 top ten, is that still correct?

21 A: Yes.

22 Q: And then on the next page, DHEC 61, in response
23 to criteria 26, it sets forth that the Medical
24 University has extensive clinical training
25 programs, which involve the rotation of

1 students and it includes medical students,
2 nursing students, radiology technicians, and
3 that the training programs will continue and be
4 enhanced through the project will foster and
5 improved learning environment or the students.

6 And can you explain that a little bit, Dr.
7 Cawley, in regards to what the plan is in
8 Nexton and the -- you know, the level of the
9 facilities, the state-of-the-art nature of it?

10 A: Sure, and I'll just focus on the student
11 component for -- and the learner component for
12 a minute. You know, we've talked about how
13 tight we are on beds. We're also very, very
14 tight on clinical rotations for all kinds of
15 students. So we need to have more sites that
16 can take more students. That was one of the
17 major reasons that MUHA bought those four
18 hospitals earlier in the year. We need to have
19 more clinical sites. Having this Nexton
20 facility site will actually help with that and
21 so we fully expect we're gonna have residents
22 there and students of all kinds, so medical
23 students, nursing students, physical therapy
24 students, all kinds, radiology students. So we
25 think having that availability will be -- would

1 be good to have.

2 Q: I want to ask you one more question about
3 what's going on down in the main hospital in
4 Charleston today. What is EP3 status?

5 A: EP3 is when we get so locked up that we -- we
6 have to call an overhead of urgency in order to
7 move patients out of the emergency room
8 quickly. And when we call EP3 status, that's
9 notice to everybody, all the docs, all the
10 nurses, that you must halt what you're doing
11 and do whatever you can to get patients
12 discharged from the hospital faster.

13 Q: And, Dr. Cawley, how often are you having to go
14 to EP3 status?

15 A: You know, I can't give you exact numbers. I
16 think Dr. Phillip Warr would be the person who
17 can tell you about the exact numbers, but it is
18 being called with increasing frequency. This
19 used to be something that when I was chief
20 medical officer, you know, we called, you know,
21 maybe once a month, but it's definitely
22 happening much more often these days.

23 Q: And what happens to the patients that when you
24 move them out of the emergency room where
25 you've been holding them into EP3 status? What

1 happens to some of them?

2 A: So -- so we move the patients out of the
3 emergency room and we put them, at least
4 temporarily, up on the unit and then the unit
5 itself has to be -- has to be sort of
6 prioritizing getting other patients out of that
7 unit. So it's a large scramble in order to
8 move patients through the system quickly, but
9 it's -- it's one of the few ways -- we hate to
10 call it, we really do, because everybody gets
11 on edge about it, but sometimes it's the only
12 way to move patients through the system.

13 Q: When the Board of Trustees and when the senior
14 management at MUHA were considering this
15 project, did you consider alternative sites?

16 A: Yes, we looked at all kinds of ways to do this.
17 And in the end the best alternative was the
18 site we chose.

19 Q: Okay. There's been a suggestion that there is
20 a superior alternative to the Nexton site and
21 that would be to try to build a 128-bed
22 hospital downtown. Do you consider that a
23 superior alternative?

24 A: Ab- -- absolutely not.

25 Q: And why is that?

1 **A:** For a variety of reasons. I think, you know,
2 that could have been part of the plan 30 years
3 ago, but things have changed on the peninsula.
4 We have flooding issues; the number of cars
5 trying to get into the peninsula is a problem.
6 I used to never worry about traffic; now I
7 worry about traffic and traffic alternatives
8 all the time. And just the traffic in
9 Charleston is now an increasing problem. So if
10 we're gonna take care of the patients we're
11 gonna take care of, I think we've gotta be
12 closer to where the patients are.

13 MS. JONES: Mr. Bupp, would you put up MUHA Exhibit
14 21?

15 (MUHA Exhibit Number 21 was referenced at this time.)

16 **Q:** Dr. Cawley, can you -- do you recognize this?

17 **A:** That's MUSC and right there in the middle is
18 the Roper campus. VA's in the background.
19 It's basically the medical district in
20 Charleston.

21 **Q:** That's downtown on the peninsula?

22 **A:** Yeah.

23 **Q:** Is there any place down there that's available
24 for any construction?

25 **A:** Not at present. I don't think there's a

1 superior alternative down here at all.

2 Q: What's the situation with parking?

3 A: Parking's tough. Parking is probably the other
4 thing that continues to be a problem is -- on
5 MUSC campus is not enough parking. Not enough
6 patient beds; not enough parking.

7 Q: And the reason that you chose the site that you
8 chose is why?

9 A: It's for all those reasons. It's because it's
10 easier to access; there's flooding down on the
11 peninsula. You know, healthcare is becoming
12 more distributed, meaning it's coming closer to
13 where patients are so patients don't have to
14 travel as much. And then the fourth reason is
15 we think there's an opportunity here to better
16 distribute our patients, so have the high, high
17 acuity downtown and the less highly sick, you
18 know, patients that are probably only gonna be
19 in the hospital for maybe a few days less than
20 would be down in the peninsula, we think
21 there's an opportunity to distribute patients
22 differently. So for all those reasons, we
23 think the Nexton site is the superior
24 alternative.

25 Q: Is that site more or less accessible for the 50

1 percent of your whole patient population that's
2 coming from outside the tri-county area?

3 A: I think that's -- I think it's very accessible.

4 Q: And, of course, for the patients in Berkeley
5 County and Dorchester and North Charleston,
6 what's the more accessible location?

7 A: Yeah, I think it's highly accessible for them,
8 as well.

9 Q: Dr. Cawley, has the Medical University ever
10 failed to complete a CON project that it
11 applied for?

12 A: Not that I'm aware of.

13 Q: Has the Medical University ever failed to pay
14 its debts and its financing charges?

15 A: We have not.

16 Q: Okay. What's the current general financial
17 condition of the Medical University Hospital
18 Authority?

19 A: I think -- you know, I can speak to the
20 generalities of that. I think Lisa Goodlett,
21 who's our chief financial officer, can speak to
22 more of the details, but in general, the
23 financial situation is very solid. We're in
24 much better stead than we were about six, seven
25 years ago.

1 **Q:** Okay. Do you know of any impediment from a
2 financial standpoint, from a manpower
3 standpoint, from a nursing shortage standpoint
4 that would impair MUHA's ability to complete
5 the construction of this hospital and utilize
6 it fully for the care of your patients?

7 **A:** I don't see any impediment and I don't see any
8 impediment to operationalizing and opening this
9 hospital and having it be a successful
10 facility.

11 **Q:** And I want you to speak a few minutes, if you
12 would, please, sir, to the risks. Are there
13 any appropriated state dollars being used for
14 this project?

15 **A:** No.

16 **Q:** Okay. So there are no state dollars, no
17 appropriated funds involved at all?

18 **A:** Not -- not for this project.

19 **Q:** Okay. And this project -- well, let me ask you
20 this, over the course of the years that you've
21 been there when the Medical University builds
22 a new facility like the Ashley River Tower, the
23 revenue that is generated from those
24 operations, what happens to that revenue?

25 **A:** That revenue is put right back into the system

1 at MUSC, you know, for the -- for the
2 improvement of services either at MUSC or, you
3 know, you could say the improvement of health
4 for all of South Carolinians, because that's
5 our -- that's our mission statement. That's
6 what it all stays in. Anything we do complete
7 stays in -- in the system.

8 Q: And when the Board of Trustees considers
9 revenues from the patient care, and it comes
10 from patient care, right?

11 A: Yes.

12 Q: You don't -- there is no revenue from tuition,
13 is there?

14 A: Not to do anything on the clinical side.

15 Q: Well, that's what I meant, to do anything on
16 the clinical side. There's no revenue for ---

17 A: No, we have to -- 100 percent of the revenues
18 on the clinical side have to be generated from
19 clinical revenues in order to do anything. We
20 don't use any -- any tuition dollars. We don't
21 use any grants from research or anything like
22 that. 100 percent of the dollars must come out
23 of the clinical revenue.

24 Q: Okay. And the -- I want to talk to you a
25 minute about charity care. What different

1 aspects of charity care does the Medical
2 University and MUHA deliver to citizens in
3 South Carolina?

4 A: You know, we really don't even consider that
5 when we're taking care of patients. You know,
6 we just take them and, you know, deal with that
7 on the -- on the other end. So we will take
8 anybody that needs to be -- needs to be seen
9 and just deal with it.

10 Q: Okay. Let's just walk through that a little
11 bit because I want the Court to understand it.
12 When a patient with no insurance and no
13 resources comes into the emergency room,
14 there's a federal law that requires any
15 hospital to stabilize and treat that patient.

16 A: That is correct.

17 Q: And it's called EMTALA, E-M-T-A-L-A, right?

18 A: That is correct.

19 Q: All right. So everybody does that charity
20 care?

21 A: Yes.

22 Q: Because the federal law requires it now.

23 A: Yes.

24 Q: Over and above that, what does the Medical
25 University do?

1 **A:** Well, I mean, even -- even abo- -- so that's
2 baseline, but then when you start looking at
3 our referral base and being able to take
4 patients from other parts of South Carolina,
5 once again, we take anybody at any time.

6 **Q:** All comers?

7 **A:** All comers, that is correct.

8 **Q:** How about to a walk-in clinic?

9 **A:** Same thing.

10 **Q:** How about for outpatient services?

11 **A:** Same thing. If -- if we can take them. I
12 mean, that's -- you know, our problem is not --
13 is not what payer status they have or whether
14 they have insurance or not, it's whether we
15 have the capacity to take them is our major
16 determining issue and we don't -- we don't say
17 that, you know, has to be this percent of
18 Medicaid or this percent, it's first come,
19 first serve.

20 **Q:** And in that regard, those numbers on that
21 charity care, does the hospital -- are you
22 required to track it and report it to the state
23 and federal authorities?

24 **A:** Yes.

25 **Q:** And in regards to that, do state and federal

1 authorities recognize the level of charity care
2 that the Medical University provides?

3 A: Yes.

4 Q: And is there a component of reimbursement that
5 you receive as a result of that?

6 A: Yes.

7 Q: And what is that called?

8 A: Yeah, it's called disproportionate share.

9 Q: Or DSH?

10 A: Or DSH.

11 Q: D-S-H.

12 A: Right. That's the acronym, yes. So for
13 hospitals which are considered safety net
14 hospitals, and we're definitely a safety net
15 facility, the other word that's used commonly
16 -- safety net has I think become a little bit
17 of a pejorative term in the last 20 years, so
18 the more common term is essential hospitals.
19 And the word essential comes from these are
20 essential to the community and provide
21 services. And so essential hospitals or safety
22 net hospitals do get some reimbursement. It
23 doesn't cover everything, but it does attempt
24 to cover some of the costs of taking care of
25 those patients through the DSH program.

1 Q: Will the services provided at the Nexton
2 hospital cost the patients anything more to go
3 to Nexton than it would to go anywhere else?

4 A: No.

5 Q: Is location -- does location affect
6 reimbursement from payers?

7 A: No.

8 Q: It doesn't matter at all. For Medicare, you'd
9 get the same amount of money for a designated
10 services at any hospital around?

11 A: That is correct.

12 Q: It doesn't change based on location?

13 A: If you travel far, you may end up in a
14 completely separate area that -- if you went to
15 New York City versus -- versus Charleston,
16 there may be a difference there.

17 Q: But there would be no difference in the
18 reimbursement ---

19 A: Not in South Carolina. There's no -- there
20 would be no difference in South Carolina.

21 Q: Or between the peninsula and ---

22 A: No.

23 Q: --- Berkeley County?

24 A: No.

25 Q: So there's no extra cost on the public?

1 **A: No.**

2 **Q: All right. The ---**

3 MS. JONES: Would you go to, Mr. Bupp, to DHEC page
4 28?

5 THE COURT: DHEC page 28?

6 MS. JONES: Exhibit 1 ---

7 THE COURT: Okay. There you go.

8 MS. JONES: It's DHEC Bates number 28 in Exhibit 1.

9 THE COURT: I was needing the exhibit number.

10 MS. JONES: I'm sorry.

11 **Q: Dr. Cawley, what is the MUHA's track three**
12 **accountable care organization that is discussed**
13 **in the application?**

14 **A: An ACO is an accountable care organization.**
15 **It's a newer way to try to deliver healthcare**
16 **that has greater value. Meaning it's higher**
17 **quality at a lower cost. So we are part of**
18 **what's called a -- there's different kinds of**
19 **ACOs or accountable care organizations. The**
20 **one that has the most risk attached to it is**
21 **what's called a track three. So what you see**
22 **on that picture there is where all of our**
23 **patients are for our track three ACO. So you**
24 **can see, it's just -- you know, it's heavily in**
25 **the Charleston tri-county area, but it also**

1 spans out to other parts of the state, as well.
2 And I think what that points out, because an
3 ACO patient is attached to a primary care
4 doctor, and I think what that points out is
5 that there are patients who are getting their
6 primary care in another part of the state --
7 I'm sorry, there are patients in other parts of
8 the state that are choosing to get their
9 primary care at MUSC and I think that just
10 demonstrates that we don't just treat patients
11 coming out of the tri-county area.

12 Q: Let me ask you that, it says in here that the
13 -- in 2017, when this track three ACO began,
14 you became responsible for the healthcare of
15 about 13,277 patients. And approximately how
16 many ACO patients does MUHA's track three ACO
17 cover today?

18 A: It's closer to 20,000.

19 Q: All right. Dr. Cawley, I'm about to cover
20 everything here. I want to ask you a few
21 questions about the length of stay at the
22 Medical University Hospital Authority. What is
23 length of stay?

24 A: Length of stay is how long someone stays in the
25 hospital. That's from the day they are

1 discharged -- the day that they are admitted to
2 the day they are discharged.

3 Q: Okay. And how is length of discharge (sic)
4 different at an academic medical center?

5 A: The length of stay at an academic medical
6 center is typically longer. It's usually -- I
7 think it's a little over six days on average
8 or, for a typical academic medical center.

9 Q: And the length of stay that is anticipated at
10 the Nexton hospital for this MUHA project is
11 5.2 days based on the DRGs that -- which is the
12 type of patients that are gonna be treated
13 there?

14 A: Right. So we think that -- and the reason we
15 chose 5.2 versus the normal I think we're up a
16 little over six, like 6.1 or something, we
17 chose 5.2 because we don't think there's gonna
18 be as many acutely ill patients or high acuity
19 patients in the Berkeley hospital. At the same
20 time, that 5.2 is still higher than a typical
21 community hospital, which would be probably in
22 the three to four range. So that's recognition
23 of the fact that we're gonna see -- compared to
24 MUSC normally, we're gonna see less acutely --
25 less acuity, but we're still gonna be higher

1 than the typical community hospital.

2 Q: But in calculating the length of stay and
3 admittedly it's longer for an academic medical
4 center ---

5 A: Yes.

6 Q: --- right?

7 A: Yes.

8 Q: Because you're teaching and there are other
9 things going on?

10 A: Yeah, it's predominantly, though, it's a little
11 bit of teaching, but it's predominantly related
12 to how sick the patients are. You know, 30, 40
13 years ago, teaching was a bigger component, but
14 we don't hold patients in the hospital any more
15 just to teach. This is really a factor of how
16 sick the patients are.

17 Q: In -- since this application was filed, between
18 then and now, the Medical University Hospital
19 Authority purchased four community hospitals,
20 two in the Florence area and two in the
21 Lancaster area, right?

22 A: Yes.

23 Q: What effect, if any, has the purchase of those
24 hospitals had on the demands for the services
25 and the sub subspecialty services in

1 Charleston?

2 A: Well, it's actually increased the services
3 needed in Charleston mainly because what has
4 happened in those -- in those communities is
5 that patients with high acuity needs were going
6 up into North Carolina, so they were going up
7 to Duke, to Chapel Hill, up to Charlotte, and
8 -- and they're now coming to Charleston rather
9 than to go up. So it's actually put further
10 burden on the hospital in Charleston.

11 Q: Do you know of any advantages to the patients
12 or the payers to have those patients coming to
13 Charleston now as opposed to going out of
14 state?

15 A: Well, yeah. Many of those -- particularly, if
16 they're commercial insurance, they're going out
17 of network for the most part.

18 Q: Dr. Cawley, from your perspective as the CEO of
19 the system, is the construction of this
20 facility in Nexton the best way to serve the
21 public's need for the care that you intend to
22 provide up there?

23 A: Yes. I think that is definitely the case.
24 We've had a long hard discussion about this
25 between senior leadership and our Board and

1 that's what -- that's what we've determined.

2 Q: And the Board approved it?

3 A: Yes.

4 Q: And -- and they did that after becoming aware
5 of the need that this was gonna serve, is that
6 accurate?

7 A: Yes.

8 Q: Do they -- does the Board of Trustees, do they
9 consider this hospital important to South
10 Carolina and the community and the Medical
11 University?

12 A: They do.

13 Q: Will this hospital in Nexton help to ensure
14 access to, you know, quality care for not only
15 patients in the tri-county area, but for all
16 the others coming from outside the tri-county
17 area?

18 A: It definitely will.

19 Q: And will it have any -- let me ask you about
20 this, will this hospital have any unnecessary
21 duplication of any services that are gonna go
22 to waste?

23 MR. SUMMER: Your Honor, I am gonna object now.

24 I've given this counsel wide latitude, but now
25 what we're doing is taking a fact witness,

1 who's not qualified in healthcare planning, and
2 asking a specific term from the statute. I
3 think that's inappropriate.

4 THE COURT: Will this hospital have any unnecessary
5 duplication of services?

6 MS. JONES: Yeah, that'll go to waste.

7 MR. SUMMER: He's not a health planner. He can't
8 testify as to that.

9 **Q: Let me ask you this, has any MUHA or MUSC**
10 **health project ever gone unused by the patients**
11 **and the citizens of South Carolina?**

12 **A: Not that I'm aware of.**

13 **Q: Do you anticipate any of them going to waste at**
14 **Nexton?**

15 **A: I do not.**

16 **Q: All right. Let me ask you this, the new Nexton**
17 **facility, are the facilities there going to be**
18 **used, among other things, to help the other**
19 **hospitals in the area?**

20 **A: Absolutely.**

21 **Q: Do you know of any way that the Nexton facility**
22 **is going to, you know, harm those hospitals?**

23 **A: I don't think that's the case at all.**

24 MS. JONES: Would you give me just a second, Your
25 Honor? Your Honor, I would offer the mission

1 statement, which is MUHA Exhibit 26 -- yeah,
2 MUHA 26 into evidence.

3 THE COURT: Any objection?

4 MS. HOLLINGSWORTH: No objection.

5 MR. SUMMER: No objection, Your Honor.

6 MR. WICEVIC: No objection.

7 THE COURT: It's admitted.

8 (MUHA Exhibit Number 26 was admitted into evidence.)

9 **Q: Last question, Dr. Cawley, while we are**
10 **awaiting the outcome of this litigation, who is**
11 **bearing most heavily the constraints that y'all**
12 **are facing down at the Medical University on**
13 **the peninsula right now?**

14 **A: I think the patients and their families.**

15 MS. JONES: That's all I have, Your Honor.

16 THE COURT: We will take a -- hopefully, just five
17 minutes.

18 MS. JONES: Five minutes, that'd be good.

19 (Off the record.)

20 MS. HOLLINGSWORTH: Your Honor, I did jump to the
21 podium, but Mr. Wicevic ---

22 MR. WICEVIC: No questions.

23 THE COURT: Okay.

24 MS. HOLLINGSWORTH: I offered to step back. May it
25 please the Court.

1 DR. CAWLEY - CROSS-EXAMINATION BY MS. HOLLINGSWORTH:

2 Q: Good morning, Dr. Cawley.

3 A: Good morning.

4 Q: Almost. We have a little more time left. Nice
5 to see you.

6 A: Good to see you, too.

7 Q: All right. So I appreciate your time this
8 morning and we'll use it diligently. So you
9 serve as the CEO of MUSC Health, is that right?

10 A: That is correct.

11 Q: Okay. And then the vice president of health
12 affairs for the Medical University, is that
13 right?

14 A: That is -- that is correct.

15 Q: All right. And just in your words, can you
16 explain to us the significance of the
17 distinction here between using MUHA and MUSC or
18 is there any from your seat?

19 A: Yes, so MUHA is a legal entity; it's an
20 authority of the State of which I am the
21 executive director of it, but then it's part of
22 a larger puzzle, which is called MUSC and all
23 its affiliates. So yes, and that is a -- it is
24 a big piece, but it's not the only component of
25 which I need to coordinate care around MUSC.

1 Q: Okay. In terms of these clinical facilities
2 that are operated by MUHA, explain the
3 significance, if any, to the sort of use and
4 branding of MUSC on those buildings.

5 A: Well, on those buildings, I mean, you'll see
6 the -- you'll see that it says MUSC -- it'll
7 say Hospital Authority if it's a Hospital
8 Authority building. But you'll also see MUSC
9 Health, meaning it's part of a larger almost --
10 it's a DBA or more of a marketing term.

11 Q: Okay. All right. And so when we're talking
12 about branding, though, is that sort of having
13 that -- the MUSC Health, is that the brand so
14 to speak that ---

15 A: Yes.

16 Q: --- operate under ---

17 A: Yes, you could say that and that is the -- the
18 clinical enterprise at MUSC.

19 Q: Okay. And do you still also serve as CEO of
20 MUSC's strategic ventures?

21 A: I do.

22 Q: Okay. And -- but that is a separate 501(c)(3)
23 not for profit, is that right?

24 A: That is correct.

25 Q: All right. And actually, you cleared something

1 up well on your direct, so the statutory
2 mission we've heard spoken of so far in this
3 contested case hearing, that is pulled from the
4 Commission on Higher Education's statutes, is
5 that right?

6 A: That is correct.

7 Q: So separately set forth in the enabling
8 statutes for the Medical University, there's
9 not any other mission set out there, is there?

10 A: That is correct, I believe.

11 Q: Okay. And then -- and so that mission that you
12 speak to is a mission and an obligation that
13 the Commission on Higher Education puts on
14 institutions of higher education throughout the
15 state, is that right?

16 A: Yes, and the connection is that, in fact, any
17 related entity to MUSC assumes the -- assumes
18 a similar mission and that's how we stay
19 connected is that we all have the same or
20 similar mission.

21 Q: Okay. And this morning, we were directed to
22 this Section 59-103-30 in the Commission on
23 Higher Education's legislative enactments and
24 this (b)(1)(3), I just wanted to ask you
25 specifically, it talks about these elements of

1 a mission focus and it included adoption of a
2 strategic plan to support the mission statement
3 and attainment of goals of the strategic plan
4 and you were asked whether you -- or you as in
5 the Medical University was accountable to the
6 Higher Education Commission, and you are --
7 your answer was that you were. Is that right?
8 Did I understand that right?

9 A: Yes, particularly in my role as the vice
10 president over health affairs on the University
11 side. That's directly accountable. And, you
12 know, not directly out of MUHA, but definitely
13 in my University role.

14 Q: Okay. Does the Medical University provide a
15 strategic plan to the Commission on Higher
16 Education, in terms of being accountable, do
17 you provide to them, the Commission, what your
18 strategic plan is or how goals are being
19 attained in furtherance of the plan?

20 A: I -- I don't know if we actually submit a
21 strategic plan. We have strategic plans that
22 we put together and update regularly, but
23 whether we submit it, I don't know the answer
24 to that.

25 Q: Okay. So in what way are you held accountable

1 to the Commission?

2 A: I can't -- I can't answer specifically on that.

3 Q: Okay. Certainly those directives set out in
4 that legislation are what inform your planning
5 process, is that ---

6 A: Yes.

7 Q: Okay. All right. Now, you've been CEO since
8 2013, is that right?

9 A: That is correct.

10 Q: Okay. And you testified this morning, you're
11 very familiar with the major strategic projects
12 for the Medical University?

13 A: Yes.

14 Q: All right. And we talked about several
15 important endeavors this morning generally and
16 I wanted to -- really for the assistance of the
17 record, I have a few applications I'd like to
18 show you and then if acceptable to everyone
19 offer them into the record. Let's look first
20 at Roper St. Francis Exhibit 31, please.

21 (Roper Exhibit Number 31 was introduced into the
22 record at this time.)

23 Q: And while we pull that up, you're familiar,
24 aren't you, Dr. Cawley, with the -- what we now
25 call the Shawn Jenkins' Children's Hospital and

1 Pearl Tourville Women's Pavilion?

2 A: Yes.

3 Q: And that's a replacement of the current
4 children's hospital, is that right?

5 A: Yes.

6 Q: And the children's hospital sort of
7 structurally -- structurally, they -- well, let
8 me ask this. There's currently the children's
9 hospital is still performing its services
10 today, is that right?

11 A: Yes. The current children's hospital which is
12 right next to the University Hospital on Ashley
13 River is still there and will be there for
14 another four or five weeks.

15 Q: Okay. But the structure that we call the
16 children's hospital, as you point out, there
17 are several sort of hospital facilities, but
18 it's one hospital because it's licensed as one
19 entity, right?

20 A: Correct.

21 Q: With the children's hospital being one of them,
22 that physically adjoins in some way with what's
23 called the University Hospital, is that right?

24 A: Correct.

25 Q: Okay.

1 A: Today.

2 Q: All right. And so this application that was
3 submitted in 2014 on behalf of the Medical
4 University Hospital Authority, is that project
5 that is sort of relocating those women and
6 pediatric services to a new structure on the
7 peninsula, right?

8 A: Correct.

9 Q: Okay. And let's go to page three in this Roper
10 St. Francis 31 and just have you confirm, if
11 you would, Dr. Cawley, is this your information
12 here on the first page of the application under
13 proposal presented by?

14 A: It is.

15 Q: Okay. And did you sign this application?

16 A: I did.

17 Q: All right. And if we could turn to page six of
18 the application.

19 MS. HOLLINGSWORTH: If you could blow up that
20 chart, that bottom chart.

21 Q: And as I understand it, Dr. Cawley, currently
22 in the children's hospital today, there are --
23 I tried to do some math, but we have -- is it
24 correct, 159 sort of general acute care beds,
25 98 med/surg, 36 obstetrics, and 25 ICU/CCU?

1 A: Yes.

2 Q: Is that right? Okay. And in addition, there
3 are 66 NICU bassinets units, is that right?

4 A: Yes.

5 Q: Okay. So there are sort of 22 -- 225, I'm
6 sorry, sort of treatment spaces, rooms, beds
7 between bassinets and acute care beds, is that
8 right?

9 A: Yes.

10 Q: And then on page seven we have the total
11 project costs for the submission was about \$367
12 million, is that right?

13 A: Ye- -- yes. Yes.

14 Q: Okay. There's no new beds being sought in this
15 application, in this project, the children's
16 replacement hospital, right?

17 A: Yes, I think in this application, correct.

18 Q: All right. And so -- but as I understood it
19 and I think it talks about, if you go to page
20 ten of this application, the project was an
21 unbundling, is that phrase familiar to you, an
22 unbundling of pediatric and perinatal services?

23 A: Yes.

24 Q: Okay. And so in 2014, you were officially in
25 the CEO role for the Authority, right?

1 A: Yes.

2 Q: Okay. And so if you could, were you part or
3 tell us what role you had in the strategic
4 discussions about the unbundling for selecting
5 these two areas to unbundle from the University
6 Hospital and put into this replacement
7 facility?

8 A: You know, I think -- you know, I don't recall
9 all the details on it, but I think at the time
10 we just felt it would serve us better to -- to
11 disconnect those because it would allow us a
12 little more flexibility. But other than that,
13 I can't say it was a huge topic of discussion.

14 Q: Okay. Well, let's go to page -- let's see, I
15 think it's in that page 10, 11, but it's
16 probably under the project overview. Towards
17 the bottom of the page. Do you recall that the
18 project was intended to create capacity within
19 the existing hospital envelope?

20 A: I'm sorry; did you want me to look at
21 something?

22 Q: It should be on the screen. It's right -- see
23 all that right there (indicating).

24 A: Okay.

25 Q: That very bottom paragraph.

1 **A:** Yes, I think that's accurate.

2 **Q:** Okay. And it might go on to the top of the
3 next page, okay, and then it says -- it sort
4 of discusses that unbundling concept and it
5 says this strategy will address needs in
6 pediatric and women's services and continue the
7 long-term expansion envisioned in the
8 hospital's master plan, what was the hospital's
9 master plan that's identified here in this 2014
10 application?

11 **A:** You know, this was probably referring to the --
12 the replacement project -- the hospital
13 replacement project master plan.

14 **Q:** Okay. Is that what you were talking this
15 morning about and I think you called it a 30
16 year ---

17 **A:** Yes.

18 **Q:** --- plan? Okay. All right. And if we could
19 turn to -- well, let me ask you this, so the
20 replacement hospital, what we call Shawn
21 Jenkins, that will have a full emergency
22 department, is that right?

23 **A:** It will have -- it will relocate our current
24 peds emergency department over to this
25 hospital.

1 Q: Okay. And full complement of tertiary and
2 quaternary services that you provide for
3 pediatric and women's perinatal services,
4 right?

5 A: Yes. Pretty much all the services we have
6 today will be in this new building in four or
7 five weeks.

8 Q: Okay. And if you'd turn to page 17 in Exhibit
9 31. And there -- yeah, so pull up that bottom
10 paragraph. That last sentence, there are no
11 other immediate plans to backfill the vacated
12 inpatient space, additional feasibility
13 settings will be conducted in the future to
14 determine appropriate use of the space and, if
15 necessary, appropriate approvals will be
16 requested. Have there been additional
17 feasibility studies on backfill of the
18 children's hospital?

19 A: At the time -- you mean, you're talking about
20 the time this was written or since then?

21 Q: Yeah, since this was written.

22 A: Yes. So we've done other analyses to try to
23 figure out how we would backfill that vacant
24 space.

25 Q: Okay. And have you done any feasibility

1 studies similar to like the feasibility study
2 that was done for this project or the
3 feasibility study that was done for the CHS
4 acquisition?

5 A: I -- all the feasibility studies for the
6 backfill space were done internally.

7 Q: Okay. All right. Okay. And now in this was --
8 this is called phase two, is that right?

9 A: Yes.

10 Q: The phase two plan. And at the time -- Okay.
11 That's great.

12 MS. HOLLINGSWORTH: If we could, Your Honor, we
13 would offer Roper St. Francis 31 into evidence.

14 MS. JONES: We have no objection.

15 MR. WICEVIC: No objection.

16 MR. SUMMER: No objection.

17 THE COURT: It's admitted.

18 (Roper Exhibit Number 31 was admitted into evidence.)

19 Q: So let's talk briefly about phase one and if it
20 suits you, we'll just call the Ashley River
21 Tower project. Would that be a correct
22 description today of what ---

23 A: Yes.

24 Q: --- back then was phase one? And I think you
25 said -- well, if you could, when you came to

1 the Medical University, where was that project
2 in the time line? Was it still in planning or
3 what do you recall?

4 A: When I -- when I got there, it was in active
5 planning.

6 Q: Okay. And I think when we talked at your
7 deposition you called that facility a satellite
8 hospital, is that right?

9 A: I don't recall whether I used that term or not,
10 but -- but it's a hospital about a block down
11 the street from the current hospital.

12 Q: So the current hospital is in the ---

13 A: University Hospital, yes.

14 Q: Yes, sir. Okay. And in terms of the planning
15 for Ashley River Tower and Shawn Jenkins, do
16 they connect? Are they sort of coordinated in
17 any way, those facilities?

18 A: They are connected, yes. There are walkways on
19 several levels -- will be several walkways on
20 several levels.

21 Q: Okay. All right. We ---

22 MS. HOLLINGSWORTH: Your Honor, we handed it
23 around, some copies are still printing back at
24 the office, but we have Roper St. Francis 138
25 that we will hopefully be able to address. I

1 have given a copy to Ms. Jones.

2 (Roper Exhibit Number 138 was introduced into the
3 record at this time.)

4 **Q:** And if I could, Dr. Cawley, just have you look
5 through that. We can put it up on the screen.
6 And really just to identify, Dr. Cawley, what
7 I've handed you, is that document familiar to
8 you as the excerpt, not the entire very lengthy
9 DHEC record, but is this familiar to you as
10 documents from the DHEC record for the phase
11 one project, what's now Ashley River Tower?

12 **A:** I mean, it's vaguely familiar. I probably
13 haven't looked at this in 15 years. But it's
14 -- I'm vaguely familiar with it, yes.

15 **Q:** Okay. And are you aware that the project was
16 a replacement and consolidation of existing
17 facilities?

18 **A:** Once again, I can only tell you from what I've
19 heard; whether it actually says this in here,
20 I can't tell you.

21 **Q:** Okay. Well ---

22 **A:** But, in general, I'd say yes to your question.

23 **Q:** Okay. Is that your understanding of what that
24 project was?

25 **A:** Yes.

1 Q: Okay. And I thin you said that that's been
2 operational since 2008, is that right?

3 A: Correct.

4 Q: Did you have any role or involvement in the
5 discussions about where to put this Ashley
6 River Tower?

7 A: I did not. That was already planned by the
8 time I got to MUSC.

9 Q: Okay. And so let's talk a few minutes about
10 the proposed community hospital in Berkeley
11 County. As I understood it, kind of break it
12 into two parts in terms of its purpose, and
13 you'd agree with me, though, one is to expand
14 your inpatient bed capacity, is that right?

15 A: Yes.

16 Q: Okay. And by your, I should be more specific,
17 would it be fair to say expanding the inpatient
18 bed capacity at the downtown campus for MUHA?

19 A: I -- I think it's -- in general, I think it
20 will have that desired effect, yes.

21 Q: Okay. And at the time that this application
22 was submitted, there were not other hospital
23 facilities outside of the tri-county, right?

24 A: I'm sorry, at the time ---

25 Q: MUHA hospitals, I'm sorry.

1 A: At the time which this --

2 Q: The Nexton application.

3 A: The Nexton, that is correct.

4 Q: Okay. Because when you were testifying on your
5 direct -- when you were testifying on your
6 direct, you mentioned there are now I guess
7 five hospital facilities, right, for MUHA?

8 A: Yes.

9 Q: We talked about the four ---

10 A: Yes, we have five inpatient facilities. One
11 here in the -- one in Charleston, and then four
12 outside of Charleston.

13 Q: Okay. So, those are reasons for me to try to
14 be a little bit more clear with that change
15 since the application that the expansion of the
16 inpatient bed capacity is -- is directed to
17 concerns with the downtown inpatient capacity
18 issues ---

19 A: Yes.

20 Q: --- in Charleston, is that fair?

21 A: Yes.

22 Q: All right. And then I think the other reason
23 that we've talked about is you want to be
24 closer to where your patients can more easily
25 access the facility, is that right?

1 A: Yes.

2 Q: But -- and the numbers we heard this morning
3 about half or more of your inpatient volume
4 comes from outside the tri-county?

5 A: Yes, about.

6 Q: I'm sorry?

7 A: About.

8 Q: Okay.

9 A: Yeah.

10 Q: With the acquisition of the four hospitals, you
11 -- do you think that that needle's gonna move
12 slightly to more than whatever number it is
13 now, slightly over 50 percent? Do you
14 anticipate that ---

15 A: You know, I think it may actually start to
16 increase a little bit. You know, we didn't
17 anticipate that the number of patients come
18 from those hospitals. We never actually
19 thought there'd be a lot because it's still
20 pretty far to come. But that has proven --
21 proving not to be the case. We're actually
22 getting more referrals and I think it's largely
23 because our doctors are talking to doctors up
24 there and developing those relationships and
25 those doctors up in the Florence area and

1 Lancaster area are feeling comfortable to send
2 patients down -- down to Charleston.

3 Q: Okay. And so you'd agree with me that those
4 patients that are coming from those four newly
5 acquired facilities, they will be patients
6 originating from outside the tri-county area,
7 right?

8 A: Yes.

9 Q: So as that impacts sort of this percentage of
10 your patient origin being outside the tri-
11 county area, that sort of occurrence of those
12 four hospitals would likely increase that
13 percentage, would that be fair?

14 A: I mean, it could, but, at the same time, the
15 population in Charleston's growing, the total
16 numbers are growing, so I -- you know, you can
17 envision any one of three scenarios. Yeah, it
18 could -- it could increase the percentage from
19 the outside. It could be that Charleston's
20 overall population just maintains it. And
21 actually, you could say the Charleston
22 population may even -- may even cause more from
23 the tri-county, so ---

24 Q: Okay.

25 A: --- you know, comparatively speaking. So I'm

1 not really sure which one it'll be.

2 Q: Okay. All right. You'll agree with me that a
3 significant percentage of your inpatient
4 patient volumes are the higher acuity tertiary,
5 quaternary services, is that right?

6 A: You know, yes, overall, and from outside the
7 tri-county, I would say yes.

8 Q: Okay. Because, as you talked about this
9 morning, MUHA's clinical enterprise is very
10 unique, isn't it?

11 A: Yes.

12 Q: And you have designations that no other
13 inpatient facility in the lowcountry has and
14 some designations no where else in the state,
15 is that fair?

16 A: That is correct.

17 Q: Okay. And MUHA downtown is the only Level I
18 trauma center in the lowcountry, right?

19 A: That is correct.

20 Q: And the only Level I pediatric trauma center in
21 the state, is that right?

22 A: Correct.

23 Q: Okay. And you mentioned this morning that you
24 had recently gotten a different designation,
25 Level IV or above Level IV, but that was

1 related to -- specifically to your NICU ---

2 A: Correct.

3 Q: --- patients? Okay. All right. And I think
4 you mentioned, only solid organ transplants, is
5 that in the state or just the lowcountry that
6 you were ---

7 A: Within the state.

8 Q: Okay. All right. And you'll agree with me --
9 well, let's put DHEC 1 up on the screen please,
10 and we can go to page 23 of the application.
11 Would you like to have it in hard copy so that
12 you don't have ---

13 A: No, that's okay.

14 Q: Okay. So page 23 of the application, all
15 right, it's towards the bottom of that
16 paragraph that starts with -- it's towards
17 maybe the bottom half of the paragraph, but the
18 proposal in the CON application says by
19 shifting lower acuity patients away from the
20 downtown campus and providing primary,
21 secondary care in the community, MUHA will be
22 able to focus on the tertiary and quaternary
23 care downtown. Is that still a fair statement
24 of what the proposal is?

25 A: Yes.

1 Q: Okay. And so -- and it's your understanding,
2 because I think you talked about it on direct,
3 that the DRG codes that were used to sort of
4 identify the patient populations for this
5 facility were non-tertiary DRGs, is that right?

6 A: Yeah, less -- less acutely -- less acute ones.

7 Q: Okay. Did you have input into the DRGs that
8 were identified in the application?

9 A: You know, in general, not down to the specific
10 DRG level.

11 Q: Okay. But would it be sort of -- the
12 application and the identification of those
13 codes are what the proposal was to the
14 Department?

15 A: Yes, yes.

16 Q: Okay. All right. And pediatric patients will
17 still be served downtown, is that right?

18 A: Yes.

19 Q: Okay. And what about with regard to the
20 women's services that -- the Pearl Tourville
21 Pavilion, is it the intention that those
22 services should still be provided downtown?

23 A: You know, I don't recall exactly, but -- but
24 typically the acutely ones or the ones high
25 acuity, absolutely.

1 Q: All right. Now, I think what we discussed is
2 your understanding that over half of your
3 patient volume -- MUHA's downtown patient
4 volume from the tri-county area comes from what
5 you described this morning as the northern
6 area, which would be sort of Berkeley County,
7 Dorchester County, North Charleston, is that
8 still your understanding?

9 A: Yes.

10 Q: All right. What is that percentage? I mean,
11 what is your -- what is your understanding of
12 kind of generally what that number is?

13 A: Numbers in terms of what?

14 Q: What percentage of your tri-county patient
15 population is from that north or north or
16 northern area?

17 A: Oh, it's a -- it's a growing area and I think
18 it's up to two-thirds and getting -- and
19 getting bigger ---

20 Q: Okay.

21 A: --- over time.

22 Q: And how -- how do you -- do you have any
23 further definition of what that is or is it
24 just -- like, how do you describe
25 geographically ---

1 **A:** I mean, we typically say, you know, North
2 Charleston and then everything north of that,
3 which includes Berkeley County, Dorchester
4 County, so that northern part of Charleston
5 County and then going into Berkeley and
6 Dorchester, that's kind of the north -- you
7 know, quote-unquote, the north area.

8 **Q:** Okay. And so when you're thinking about the
9 patients that are -- that you intend to be
10 served at this community hospital, is there
11 sort of a radius that that falls into, miles or
12 minutes, or do you have any sort of description
13 for that that gives us an idea of that range?

14 **A:** You know, not -- not that I recall specifically
15 or if it's in the application I don't recall
16 it, but, you know, I would just say in general
17 that it would be an easier place for those in
18 those northern areas to go to, particularly if
19 they, you know, don't need high acuity care
20 that would only be provided down in the
21 peninsula.

22 **Q:** Okay. All right. Let's look at -- in DHEC 1
23 at page 977 of the record. This is the record
24 for the community hospital application. If you
25 could flip to the next page; I'm sorry, 978.

1 And to orient you, Dr. Cawley, this is an e-
2 mail that's in the DHEC record for the project
3 where MUHA's consultant, at the request of the
4 Department, provided some additional detail
5 about the proposed project. Are you familiar
6 with what it was that MUHA provided to the
7 Department?

8 A: I am not.

9 Q: Okay. In looking at this chart, and this is
10 from July 26 of 2018, this is information sort
11 of broken down on this left column, are these
12 -- I think they were referred to as markets or
13 submarkets, are those familiar to you?

14 A: You know, in general, yes.

15 Q: Okay. Is that something that you typically
16 when you're looking at data or information
17 about your clinical enterprise downtown that
18 you look at information broken out by a
19 geographical area such as these markets?

20 A: Yeah, it's not something we look at regularly,
21 but something we do -- are aware of, you know,
22 on an infrequent basis, maybe once or twice a
23 year.

24 Q: Okay. And who would pull that information or
25 how would you obtain that information?

1 **A:** Typically, our strategic planning department
2 keeps an eye on the data.

3 **Q:** Okay. And would that be sort of the department
4 under the sort of province of Sarah Bacik?

5 **A:** Yes. Sarah's our chief strategist, yes.

6 **Q:** Okay. Now, in looking at this chart and
7 looking at the projected FY 2025 community
8 hospital admissions, would you agree with me
9 that you don't believe that your patients that
10 live downtown near the main campus will travel
11 to southern Berkeley County for hospital
12 services?

13 **A:** I would say in general, I reviewed that, but
14 I'm never surprised where sometimes patients go
15 to get care.

16 **Q:** Okay. Do you think that 30 percent of those
17 patients are gonna drive up to southern
18 Berkeley County for lower acuity care, hospital
19 care?

20 **A:** You know, once again, you know, it's hard to --
21 hard to say. I mean, is that question in
22 relation to this data? I guess I'm more -- a
23 little unclear on what the question is.

24 **Q:** Sure. So I'm asking you whether or not you
25 believe that your patients that live downtown

1 near the main campus will travel to southern
2 Berkeley County for hospital services.

3 A: I would say in general I wouldn't think so, but
4 once again I think patients travel pretty far
5 sometimes, that's unexplained.

6 Q: Okay. In looking at this chart in the Sea
7 Islands, from your perspective -- well, first
8 let me -- where generally do you live in the
9 Charleston area?

10 A: Where do I personally live? I live in Mount
11 Pleasant.

12 Q: Mount Pleasant.

13 A: Which is East Cooper.

14 Q: So if someone refers to the Sea Islands, what
15 does that mean just to you? What are the Sea
16 Islands?

17 A: That would be down in John's Island, Kiawah,
18 Seabrook.

19 Q: Okay. And do you think that 500 of your
20 downtown patients that traditionally went to
21 the downtown hospital for lower acuity services
22 are going to travel to the community hospital
23 in southern Berkeley County?

24 A: Once again, I would say the same thing. I
25 would say in general, no. However, I have been

1 surprised how patients will travel,
2 particularly to another area. And I'll give
3 you an example. When we opened up our Mount
4 Pleasant East Cooper office, one of the biggest
5 areas of growth was actually from the Sea
6 Islands. So you'd have to travel over
7 peninsula and into Mount Pleasant to do that.
8 So I'm never surprised that that occurs.

9 Q: Okay. Let's turn to -- we're still in the DHEC
10 record Exhibit 1 at CON 27. And, Dr. Cawley,
11 this application, the community hospital
12 application, that is one of the applications
13 that you signed and submitted to the
14 Department, is that right?

15 A: Yes.

16 Q: Okay. And you would have reviewed it before
17 you signed it, right?

18 A: Yes.

19 Q: Do you -- are you familiar with the drive time
20 analysis that is in the application?

21 A: You know, vaguely. I've looked at it at the
22 time; we talked about it at the time. I
23 haven't looked at it recently.

24 Q: Okay. So it sounds like you did have some
25 input into what or how this analysis was

1 structured?

2 A: Yes.

3 Q: So let's look at James Island 29412, about
4 midway down the chart. It appears, if I'm
5 reading the chart correctly, that James Island
6 is about 7.8 miles from the downtown campus, is
7 that -- does that seem accurate to your ---

8 A: Yes.

9 Q: Okay. And then -- and it looks like it's
10 nearly 32 miles, 31.6 miles away from the
11 proposed community hospital site, is that
12 right?

13 A: Yes.

14 Q: And so -- and, again, just your belief and your
15 sort of knowledge of your patient population
16 downtown, do you think that 30 percent of your
17 lower acuity non-tertiary patients are going to
18 drive the 32 miles to the community hospital as
19 opposed to your downtown facility?

20 A: Once again, it doesn't make sense that somebody
21 would do that, but, you know, we have found
22 that, you know, we talk to the patients that
23 going to those places, like I said before, is
24 not -- is not a surprise. So they'll do that.
25 And I think there will be some percentage of

1 patients that that will occur. And I think
2 there's good reasons for it. Maybe it's just
3 easier to get there in some ways and park and
4 all those things. They may have family out in
5 that area. So, I mean, there could be other
6 things at play. I don't know the answer to
7 that.

8 Q: Okay.

9 A: But we do know that patients from other areas
10 will move to other parts of Charleston.

11 Q: And I guess similarly there are probably
12 patients that live in the northern area that
13 come to downtown Charleston for reasons other
14 than just the downtown campus; maybe they work
15 in downtown Charleston, is that right?

16 A: Sure.

17 Q: So, in terms of the additional capacity that
18 MUHA needs downtown, you'll agree with me that
19 since this application was filed and approved,
20 that MUHA has doubled its bed capacity through
21 the purchase of the four CHS hospitals, is that
22 right?

23 A: That is correct.

24 Q: Okay. So -- because I think there were about
25 800 acute care beds?

1 **A:** Yes.

2 **Q:** Right. And as a result of that acquisition,
3 there's now a MUHA hospital facility in
4 Florence, Marion, Chester and Lancaster
5 Counties?

6 **A:** Correct.

7 **Q:** With one facility in each of those four
8 locations, is that right?

9 **A:** Correct.

10 **Q:** All right. Would you expect that with those
11 four locations and the doubling of that bed
12 capacity that MUHA can sort of decant some of
13 these non-tertiary volumes to one of those
14 locations?

15 **A:** No, I don't think we'll decant to them and the
16 reason would be because I think that's really
17 far away. The closest facility there would be
18 two hours away and the farthest facility's
19 almost three hours. I do think it may help,
20 though, prevent lower acuity patients in those
21 facilities from coming to Charleston.

22 **Q:** Okay. So what about -- so, for example,
23 actually in this drive time analysis, Florence
24 County is actually one of the counties
25 identified as proposed redirection to the

1 community hospital, is that right?

2 A: This -- this application was at the time before
3 we had a Florence facility.

4 Q: Right.

5 A: So I think that changes a little bit, that
6 assessment.

7 Q: So would it be fair to sort of hazard a guess
8 that actually the patients that would have been
9 coming from Florence certainly for non-tertiary
10 services might hopefully stay in their home
11 county and be treated at the MUHA Florence
12 hospital instead?

13 A: I think for lower acuity patients, that is --
14 that is the case.

15 Q: Okay. Have you reviewed any updated either
16 sort of need projections or financial analysis
17 for the community hospital in light of the
18 acquisition of those four community hospitals?

19 A: We -- we have not.

20 Q: You're familiar, aren't you, with the CON
21 application to develop a freestanding emergency
22 department in Berkeley County, is that right?

23 A: Yes.

24 Q: And you're aware that in this application for
25 the community hospital that MUHA's plan was to

1 co-locate that emergency -- freestanding
2 emergency department into the community
3 hospital, is that right? Do you recall that?

4 A: Yes.

5 Q: Okay. And that's no longer the plan, right?

6 A: Yes.

7 Q: Has there been any updated analysis or
8 financials for the community hospital given
9 that change that the freestanding emergency
10 department now will not be co-located?

11 A: There may be, but I'm not -- I'm not aware.

12 Q: Okay. All right. Let's look at Exhibit Roper
13 St. Francis 26.

14 (Roper Exhibit Number 26 was introduced into the
15 record at this time.)

16 Q: If you'll go to the first page, please. And,
17 Dr. Cawley, can you identify what this document
18 is at Roper St. Francis 26?

19 A: It looks like the freestanding ER CON
20 application for that project.

21 Q: Just go to the very beginning.

22 A: Looks like the front page.

23 Q: And is that your -- is that your signature, Dr.
24 Cawley?

25 A: It is.

1 Q: You have a physician's signature, so you are in
2 the right field.

3 A: Unfortunately, yes.

4 Q: And what is the date that you signed this
5 proposal?

6 A: 5/27/2017.

7 Q: Okay. And you're familiar with this
8 application, right?

9 A: Yes.

10 Q: Okay.

11 MS. HOLLINGSWORTH: And I don't think it's been
12 admitted yet, so we take this opportunity, Your
13 Honor, to offer Roper St. Francis 26 in
14 evidence.

15 MS. JONES: No objection.

16 MR. WICEVIC: No objection.

17 MR. SUMMER: No objection.

18 THE COURT: It's admitted.

19 (Roper Exhibit Number 26 was admitted into evidence.)

20 MS. HOLLINGSWORTH: Thank you, Your Honor.

21 Q: Would you turn to page 25? And I think it's
22 sort of that figure 7 and that bottom
23 paragraph. And, Dr. Cawley, you're familiar
24 with these volumes, aren't you, for your ED --
25 historical ED volume downtown?

1 A: Yes.

2 Q: And it's your understanding, isn't it, that
3 this application, the freestanding ED for
4 Berkeley County was premised on an expectation
5 that a portion of your downtown ED volume would
6 shift to the freestanding ED for services,
7 right?

8 A: Yes.

9 Q: Okay. And if we go to page 26 and sort of that
10 -- yeah, that kind of top couple paragraphs,
11 number 8. All right. And would you agree with
12 me that those assumptions set forth again the
13 Berkeley County freestanding ED application was
14 that -- that kind of current patient origin
15 patterns would remain the same, but that
16 greater volumes would shift to the proposed
17 freestanding ED from zip codes in Berkeley and
18 Dorchester and some of North Charleston?

19 A: Yes.

20 Q: Do you recall that?

21 A: I do.

22 Q: Okay. So now, what, if any, consideration or
23 analysis have you done to evaluate the overlap
24 between the patients that are shifting to the
25 freestanding ED in Berkeley County versus

1 patients that would be the lower acuity
2 patients for the community hospital?

3 A: Well, I think -- so a couple things there. The
4 first thing I would say is the patients that
5 are gonna come into the freestanding ER and
6 gonna come into the hospital, I don't think are
7 gonna completely overlap. That -- and I think
8 there was one point in time that I think we
9 felt that one ER is one ER and it doesn't
10 matter where the patients -- patients will go
11 to either one. But we've done some fairly deep
12 analysis looking at freestanding ERs versus
13 hospital ERs and other places in the country
14 and it turns out that you can have these things
15 not too far from each other and they both
16 actually -- they sort of serve different
17 patient populations. And so we have assumed
18 that both ERs will remain the same -- I mean,
19 will remain. We'll have both ERs and we'll
20 just see those populations across both of those
21 ERs, not -- they're really, you know, take one
22 from the other. We're just -- patients will
23 sort of choose where to go.

24 Q: But you'll agree with me, won't you, that both
25 the community hospital project and the Berkeley

1 freestanding ED project assumed redirection of
2 patients that were otherwise choosing to go
3 downtown for their services, right?

4 A: Yes.

5 Q: And so you'd agree with me, we can't redirect
6 the same patient twice, right?

7 A: That's -- that's correct, yes.

8 Q: So then the expectation must be that there are
9 going to be patients that weren't going
10 downtown and are now choosing to come to either
11 the freestanding ED and/or the community
12 hospital?

13 A: That is correct. Once again, I think if
14 patients wanted to come to see -- want to come
15 to an MUSC facility, they'll have -- they'll
16 have choices.

17 Q: All right. So well ...

18 MS. HOLLINGSWORTH: I think a little further down
19 on that page, 26, if you could pull up more of
20 that paragraph. Sorry. Below the map.
21 There's a reference here and I just want to
22 make sure that Dr. Cawley can see it on the
23 screen. Okay. Move that. Yeah.

24 Q: You'll agree with me, though, that certainly in
25 the application what the Department -- the

1 position of MUHA took before the Department was
2 that given that it was a volume shift from MUSC
3 only other providers in the service area would
4 not be impacted, right?

5 A: Correct. I think that's still the case.

6 Q: Okay. All right. So would it be fair to say
7 that MUHA's patient satisfaction scores are
8 still very good?

9 A: Yes, for the most part. Yes.

10 Q: And that's information that you follow, right?

11 A: Yes.

12 Q: Has there been any significant decline or
13 change in those scores in the last say five
14 years?

15 A: No.

16 Q: Okay. And you talked on your direct about this
17 EP3 status ---

18 A: Yes.

19 Q: --- is that right? That's different than
20 diversion status, right?

21 A: Yes, it has nothing to do with diversion
22 status.

23 Q: Tell the Court, what is it if you have to go on
24 diversion?

25 A: Diversion is when you actually shut your

1 hospital down to receiving certain kinds of
2 patients.

3 Q: Okay. And is that something that happens
4 often, as well, downtown?

5 A: We -- we do not divert because, typically, we
6 find that -- diversion usually is a very
7 specific. It means that you can't provide
8 those services any more. That typically means
9 emergency services or something like that. So
10 we rarely do that because we find that we just
11 have to get the patients in and then that may
12 require us to call an EP3 status to -- in order
13 to move patients through the hospital a little
14 bit quicker.

15 Q: Okay. Well, how is the EP3 status as we're
16 focused on -- I assume when you go on this EP3
17 status and there's discharges taking place,
18 they're still appropriate medical discharges,
19 right?

20 A: Yes. It just happens faster.

21 Q: Okay.

22 A: And there's more focus on it by the entire team
23 in the hospital.

24 Q: Okay. And is that not something that you would
25 sort of expect to be everyday or how is it

1 different than what you expect your clinicians
2 to be focused on all the time in terms of
3 having -- maximizing your throughput?

4 A: Well, I think our clinicians are focused on it.
5 They're focused on it every single day. This
6 is an even more heightened awareness that
7 everybody needs to try to work on resolving the
8 issues that are keeping somebody in the
9 hospital. For instance, you know, if a
10 patient's staying in the hospital waiting to
11 get an x-ray and all of a sudden that patient
12 gets -- gets their x-ray -- that's the only
13 thing holding them in the hospital, they'll get
14 that x-ray quicker. Or, you know, if they're
15 waiting on a family member to pick them up,
16 there's an effort made to try to get that
17 family member to come earlier. Everybody just
18 -- when we call EP3, everybody has to focus on
19 getting patients discharged.

20 Q: Okay. And is that a process or a mechanism
21 that has been around since you came to the
22 Medical University or is it something that
23 developed during your tenure?

24 A: No, it's developed. We've called it different
25 things over the years. But it's a common

1 mechanism particularly in academic medical
2 centers and in order to get patients through
3 the hospital quicker.

4 Q: All right. But in terms of a diversion status,
5 or sort of shutting down your ED or -- you
6 haven't had to do that?

7 A: No, we don't. In fact, because what we find is
8 -- so, for instance, you can only call a
9 diversion for emergency services, because
10 that's the only thing you could prevent to
11 come. Say like trauma, you know, those
12 patients have to come. There is no other, you
13 know, Level I trauma in Charleston and they
14 have to be taken care of.

15 Q: Okay.

16 A: And if there's a patient that needs an
17 emergency something else, you know, we have to
18 be able to accommodate them, so what we find is
19 we accommodate them and we'll just work our
20 hardest to -- to deal with it and that has
21 resulted in us calling EP3 more frequently.

22 Q: Okay. And you mentioned how the capacity
23 constraints have impacted the transfer requests
24 that you receive, but in terms of patients --
25 potential patients showing up at the door, I

1 mean, MUHA's not turning away patients saying
2 we're full, you can't come in, right?

3 A: No.

4 Q: Okay. All right. So as I understand it, in
5 the planning for the community hospital, you
6 were very involved in the planning, is that
7 right?

8 A: Yes.

9 Q: And were you sort of accountable and
10 responsible for conveying information or
11 overseeing information that was conveyed to
12 your Board that you talked so much about this
13 morning?

14 A: Yes.

15 Q: Okay. And as I understood it, in planning for
16 the hospital, MUHA wasn't as focused on where
17 to locate the hospital so much as we need to
18 get off the peninsula, is that -- is that fair?

19 A: I think we -- we considered many options and
20 then I think in the end we felt that a Berkeley
21 County facility would be the best -- best
22 option. So I wouldn't say it was just get off
23 the peninsula; it was, you know, find something
24 that works the best.

25 Q: Well, would you agree with me that it was an

1 important component of the planning to whatever
2 -- whatever was going to be established be off
3 the peninsula, that was important?

4 A: Yes. Yeah, but once again, you know, it was
5 not the primary criteria, but that was a --
6 that was a -- that was a significant criteria,
7 yes.

8 Q: Okay. But you'll agree with me in the last 10
9 to 15 years, MUHA has had opportunities to
10 pursue hospital projects off the peninsula,
11 right?

12 A: We -- we have not considered -- well, I would
13 say prior to me getting there, I do know they
14 considered the hospital replacement project to
15 go off the peninsula and I don't know the whole
16 story behind that, but that was the last time
17 that I'm aware that there was a plan to put
18 anything off the peninsula. And then the
19 decision was made, this was prior to when I got
20 there, that the hospital replacement project
21 would stay on the peninsula.

22 Q: Okay. And -- but same with the children's
23 replacement hospital, I mean, understanding the
24 location that was chosen, but, I mean, was
25 there any reason that MUHA couldn't have

1 considered somewhere off the peninsula for that
2 major strategic project?

3 A: That is -- that is correct. But I think that
4 goes back to at least the first two phases kind
5 of go back to that decision to remain on the
6 peninsula.

7 Q: Okay. And those two phases, I mean, is it fair
8 to say there are elements of those phases that
9 sort of contemplated this ongoing plan, this
10 sort of master plan? I think maybe three
11 phases is what I've seen in a feasibility
12 study.

13 A: Yes, I think the plan around 2000 -- sometime
14 between 2000 and 2001 roughly, there was this
15 plan, three phases, about one every year -- I'm
16 sorry, about one every ten years, would be
17 planned and then, you know, would take about
18 ten years. And so if you figure the one --
19 this plan came out 2001, Ashley River Tower got
20 planned and opened in 2008, and then shortly --
21 about 18 months after Ashley River Tower was
22 opened, the planning for the second phase was
23 begun, and here we are opening up in 2019. So,
24 about every ten years, plus or minus.

25 Q: In the infrastructure for those first two

1 phases, did they contemplate the longer range
2 plan with the third phase in terms of how the
3 structures were laid out?

4 A: Well, you know, only -- only generally that
5 they would be lined up next to each other, but
6 not any more than that.

7 Q: Okay. And because there are -- there's a
8 physical connection between -- or there will
9 be, I think, between Ashley River Tower and
10 Shawn Jenkins, right?

11 A: That is correct.

12 Q: I think several floors connect some how?

13 A: Yes, two or three floors do.

14 Q: Okay. All right. Now, in terms of the
15 capacity constraints you talked a little bit
16 about on your direct and supporting the need
17 for the hospital, you'll agree with me, won't
18 you, that capacity constraints that are related
19 to sort of the bedded outpatient and the
20 observation patients that that's been a
21 constant problem since you've been at the
22 Medical University?

23 A: You know, bedded out patients and observation,
24 I would say that kind of comes and goes. Some
25 years it's a problem that we have to deal with

1 and some -- some years we -- we actually don't
2 have an issue. It largely is -- is largely
3 depending on what insurance companies call an
4 inpatient and what they call an outpatient or
5 bedded outpatient.

6 Q: Okay. And just -- just to make sure we're
7 clear on the record, if you could, kind of give
8 the -- give the Court sort of a definition or
9 description, what is, first, a bedded
10 outpatient?

11 A: That is a patient who actually doesn't meet the
12 criteria for inpatient or there's three --
13 there are three types of patients in a
14 hospital. There's inpatient, observation, or
15 bedded outpatient. And in terms of inpatients,
16 the most -- the most acutely sick and a bedded
17 outpatient is someone that is not that sick.
18 An example would be a bedded outpatient may be
19 just in the hospital to get some -- get a
20 transfusion of blood and as soon as they get
21 that transfusion, they can go home. And an
22 inpatient is somebody, you know, who needs to
23 be there because they may -- they may get sick
24 or potentially may even die if they're not
25 treated in the hospital. And then you've got

1 this category in the middle called observation.
2 These are people that typically stay in the
3 hospital less than 24 hours, you need to
4 monitor them to see are they gonna get sick and
5 be closer to inpatient or are they gonna get
6 better and be more outpatient. So those are
7 the three types of patients that tend to be in
8 the hospital.

9 Q: Okay. And in terms of capacity constraints
10 that arise from sort of a non-inpatient
11 classified patient being in an inpatient bed,
12 that that's been, since you came to the
13 University in 2003, a focus and an issue
14 throughout that time, is that fair?

15 A: I mean, I would say yes, but, you know, it's
16 not -- it's not consistent. I mean, some years
17 it's a -- it's a problem. Some years it's not
18 a problem. Once again, a lot of this has to
19 do, too, with how insurance companies classify
20 patients. That's not always a clinical
21 classification. That is often depending on
22 what the insurance company almost pushes the
23 patient to.

24 Q: Okay. Let's take a look at Roper St. Francis
25 Exhibit 30.

1 (Roper Exhibit Number 30 was introduced into the
2 record at this time.)

3 Q: And I apologize in advance. This is an
4 application that was during the brief time in
5 which the Department was testing out online CON
6 submissions. So -- and we can flip through --
7 maybe kind of scroll through it just a little
8 bit and you'll see this is an application for
9 additional beds, keep going down, submitted by
10 Mr. Levitt. You know who Mr. Levitt is, right,
11 Dr. Cawley?

12 A: Yes.

13 Q: And has he been your -- MUHA's health planner
14 since you've been CEO?

15 A: Yes.

16 Q: Or I guess outside consultant health planner?

17 A: Outside consultant's a better term.

18 Q: Yes. Okay. And then if we go and I wish I had
19 a -- let's see if I can find -- go to -- I'll
20 ruin the surprise to tell you this is the 52-
21 bed application. Are you familiar with the 52-
22 bed application?

23 A: I am. Not the online version, but, yes.

24 Q: I can find the page and we can scroll to it.
25 Let's go to page 18 of that exhibit. So the

1 RSF 30-18. Go up just a little bit and this
2 will show you that it's the addition of general
3 hospital beds. There was an existing count of
4 604 and added 52. Is that how MUHA has gotten
5 to the number we have seen a lot, 656 beds?

6 A: Yes.

7 Q: And those are your normal acute care beds,
8 right?

9 A: Yes.

10 Q: And I think you gave us a number this morning,
11 there's 105 psychiatric beds?

12 A: Yes.

13 Q: Is that right?

14 A: Uh-huh.

15 Q: In this application, were you part of the
16 process in planning to do this 50-bed addition?

17 A: Yes.

18 Q: All right.

19 MS. HOLLINGSWORTH: If we go to -- go to page 44,
20 please. So that first paragraph in that --
21 that's perfect. Yes. Thank you.

22 Q: All right. And, Dr. Cawley, is it consistent
23 with your memory that for the 52 beds, they
24 were gonna be divided between Ashley River
25 Tower, the children's hospital, and University

1 **Hospital?**

2 **A:** **Yes.**

3 **Q:** **Now, the four beds that were going to Ashley**
4 **River Tower, have those been implemented?**

5 **A:** **You know, I can't tell you whether they've been**
6 **exactly implemented or not.**

7 **Q:** **Okay. Now, the 15 beds for Shawn Jenkins, I**
8 **assume those have not been since you're not yet**
9 **in the new space?**

10 **A:** **Correct.**

11 **Q:** **All right. But the remainder was 33 beds for**
12 **University Hospital, is that right?**

13 **A:** **Correct.**

14 **Q:** **And it was to backfill space once existing in**
15 **MUSC Children's Hospital, is that right?**

16 **A:** **Correct.**

17 **Q:** **All right. And then down in that bottom**
18 **paragraph where it talks about the bed addition**
19 **and then the total beds, it says the proposed**
20 **bed addition will relieve existing capacity**
21 **constraints for inpatient services while**
22 **promoting a long-term expansion envisioned in**
23 **the Hospital's master plan in a cost effective**
24 **manner. Is that still your understanding of**
25 **the reasoning behind that application?**

1 **A:** Yes.

2 **Q:** And do you still believe that those 33 beds
3 will alleviate or will relieve existing
4 capacity constraints?

5 **A:** Some of it.

6 **Q:** All right. Now, the 33 beds that are in this
7 application, where are those going to be placed
8 or, generally, if you could describe where are
9 they going?

10 **A:** Well, we -- just as that's saying, we would
11 take the current children's hospital, which in
12 about four to six weeks will become the old
13 children's hospital and we're gonna call it
14 University Hospital Annex, and so those 33 beds
15 will be in the University Hospital Annex.

16 **Q:** Will there be other beds in what will be called
17 the University Hospital Annex?

18 **A:** Those ---

19 **Q:** Like acute care beds?

20 **A:** Those 33 beds would be the beds in that annex.
21 There is not -- there is no other beds there.
22 When the children's hospital moves out, they're
23 out. They're gone. It's empty.

24 **Q:** They're taking the furniture with them?

25 **A:** They're taking everything with them. And then

1 so everything will be gone and then we'll --
2 we'll put the 33 back in there.

3 **Q: Okay. All right.**

4 MS. HOLLINGSWORTH: Your Honor, I'd offer Roper St.
5 Francis 30 into evidence which represents
6 excerpts from the certificate and the
7 application for the 52-bed addition.

8 MS. JONES: Your Honor, we don't have an objection.
9 We may need to add some information into it
10 since it's an excerpt. I don't know exactly
11 what the ---

12 THE COURT: That's fine.

13 MS. JONES: Okay. Thank you.

14 MR. WICEVIC: No objection.

15 MR. SUMMER: No objection.

16 THE COURT: It's admitted with leave to substitute
17 additional pages from the application.

18 (Roper Exhibit Number 30 was admitted into evidence.)

19 MS. HOLLINGSWORTH: Okay. Thank you, Your Honor.

20 **Q: And, if we could, let's look at Roper St.**
21 **Francis 23.**

22 **(Roper Exhibit Number 23 was introduced into the**
23 **record at this time.)**

24 **Q: All right. And Dr. Cawley, you're familiar,**
25 **aren't you, with what we'll call the 29-bed**

1 application?

2 A: Yes.

3 Q: And the date on this, it was received by DHEC
4 July 1 of 2019, so this is an application that
5 would have been filed by MUHA after the
6 application that we're here for today for the
7 community hospital, is that right?

8 A: Yes.

9 Q: All right. And this application ---

10 MS. HOLLINGSWORTH: And if you can just scroll to
11 the second page so we can allow Dr. Cawley to
12 see his signature and confirm that.

13 Q: And Dr. Cawley, is that your signature there on
14 page two of ---

15 A: Yes.

16 Q: --- Exhibit 23? Let's take a look at page 10
17 of this exhibit, so it'll be RSF 23-10. And
18 sort of again orienting ourselves to the
19 timeline, this is July of 2019. Try to find
20 myself in my notes here. On the project
21 overview for the 29-bed application, is it
22 consistent with your understanding that this
23 application is part of the long-term strategic
24 plan envisioned in the hospital's master plan?

25 A: Yes.

1 Q: Okay. Has the master plan changed since the
2 references to it that we talked about in some
3 of these earlier applications?

4 A: In terms of which part of the master plan are
5 you asking changed? The three -- the three
6 phases?

7 Q: Yes, so if we look down in this last paragraph
8 and it says the proposed bed addition in
9 conjunction with 128-bed MUSC Health Berkeley
10 Hospital will relieve existing capacity
11 constraints for inpatient services while
12 promoting the long-term strategic plan
13 envisioned in the hospital's master plan in a
14 cost effective manner. This reference to the
15 long-term strategic plan envisioned in the
16 hospital's master plan, is that still the three
17 phase plan that we talked about in the -- for
18 example, the women and children's hospital
19 application?

20 A: Well, I mean, I would say that's one component
21 of the master plan and we haven't rolled out
22 even the third phase yet. So -- and that
23 hasn't even been into the planning stage yet.

24 Q: Okay. But I really am just trying to
25 understand when this is what we have in the

1 application, the information to the Department
2 is -- where it says promoting the long-term
3 strategic plan envisioned in the hospital's
4 master plan, is that still the same ---

5 A: Yeah, I mean, to me, what that says is long-
6 term strategic plan, which means to expand bed
7 capacity to deal with the patients, and we were
8 gonna do that over time is what that statement
9 means to me. That's simply, you know, this --
10 this proposed addition is part of the plan to
11 add beds over time.

12 Q: Okay. Let's take a look at page 13. And this
13 is just one of the answers to part of the
14 regulation that speaks an application, the very
15 back -- bottom paragraph says, renovation was
16 the most feasible alternative as the space is
17 existing making the project cost effective.
18 And then the proposed project enhances access
19 to inpatient services while also alleviating
20 capacity constraints currently being
21 experienced at MUSC. In evaluating this, do
22 you still agree that the addition of these 29
23 beds is the most feasible alternative for this
24 -- the additional beds?

25 A: For this particular project, yes.

1 Q: Okay. And is it still cost effective because
2 you're renovating existing space?

3 A: For this project, yes.

4 Q: What analysis have you done to determine
5 whether there's any other existing space that
6 you could renovate and add beds to?

7 A: I don't think we need to do any other analysis
8 because there is no other space available to
9 put beds into or even potential beds into.

10 Q: Okay. And so that's sort of as of July 2019
11 that the analysis was maxed out at these 29
12 beds plus the 33 that are on hold, for lack of
13 a better word?

14 A: Yes.

15 Q: Okay. All right. And earlier I asked you
16 about the feasibility study and I think you
17 explained that the studies that have been done
18 on this backfill have been internal
19 evaluations, not an outside feasibility study
20 like the examples we've seen for the CHS
21 acquisition and the Shawn Jenkins project, is
22 that right?

23 A: Correct.

24 Q: Who would be the folks that were performing
25 those with internal analyses?

1 **A: I think our finance team.**

2 **Q: The finance team?**

3 **A: Uh-huh. Yes.**

4 **Q: Okay. And would that be a team that's lead by**
5 **Ms. Goodlett?**

6 **A: Yes.**

7 **Q: Let's take a look at Roper St. Francis 68.**

8 **(Roper Exhibit Number 68 was introduced into the**
9 **record at this time.)**

10 MS. HOLLINGSWORTH: Did I -- I did not. Your
11 Honor, I would offer Roper St. Francis Exhibit
12 23, which is excerpts of the 29-bed
13 application.

14 THE COURT: I thought that was already entered.

15 MS. JONES: I think it is, but no objection.

16 MR. SUMMER: No objection.

17 MR. WICEVIC: No objection.

18 THE COURT: All right. It's either admitted or
19 readmitted.

20 **(Roper Exhibit Number 23 was admitted into evidence.)**

21 MS. HOLLINGSWORTH: Thank you, Your Honor. My
22 apologies if I missed that.

23 **Q: Roper St. Francis 68, Dr. Cawley, you're**
24 **involved, aren't you, in the process through**
25 **which MUHA is seeking HUD backing for various**

1 major strategic projects of the Medical
2 University over the last few years?

3 A: Yes.

4 Q: Okay. And sort of particularly with regard to
5 the children's hospital project, you've been
6 very involved in pursuing the HUD backed
7 financing to that project?

8 A: Yes.

9 Q: And do you work with Mr. Pack on that? Stephen
10 Pack?

11 A: I mean, he's one of the consultants we use and
12 I -- you know, I've worked with him a little
13 bit. Lisa Goodlett, who's our chief financial
14 officer, works with him much more closely.

15 Q: Okay. Well, in terms of documents that might
16 be acquired on behalf of the Medical
17 University, such as this document, the
18 appraisal report, that was submitted to
19 Armadale Capital, Inc., are you familiar with
20 Armadale Capital, Inc.? Do you know who that
21 is?

22 A: Yes, that is who Steve Pack, who's our
23 consultant, works for.

24 Q: Okay. And are you provided either with these
25 documents or kept aware as CEO when documents

1 like this appraisal report for MUHA come out?

2 A: Yes. Roughly. Yes.

3 Q: Okay. And this report is -- I think might need
4 to go to the next page. Again, we're in Roper
5 St. Francis 68. And the date of this report is
6 April 24, 2019. Are you aware of the appraisal
7 report that was obtained by Mr. Pack for MUHA
8 in April of this year?

9 A: Once again, roughly, yes.

10 Q: Okay. Well, let's turn to page 74 in Roper St.
11 Francis 68. And I should say in April of 2019,
12 would this have been work being performed
13 related to the financing for the CHS hospital
14 acquisition?

15 A: Yes.

16 Q: Is that right? Okay. And this page, 74, yeah,
17 kind of blow that out a little bit, was it
18 discussed with you that the replacement cost
19 estimate for the children's hospital component
20 of the downtown structure had a total
21 replacement cost of \$122,645,349?

22 A: You know, not specifically. Vaguely aware,
23 though, of -- of this.

24 Q: Have you had other -- any other studies or
25 analyses done in terms of replacement costs or

1 renovation costs for the children's hospital
2 structure?

3 A: Not that I'm aware of.

4 Q: Okay. All right. Let's look at Roper St.
5 Francis 67.

6 (Roper Exhibit Number 67 was introduced into the
7 record at this time.)

8 Q: So would it be fair to say you're also
9 generally familiar with a similar report that
10 would have been obtained on MUHA's behalf for
11 the Shawn Jenkins project's financing?

12 A: Once again, roughly.

13 Q: Okay. And this report is dated April 9th of
14 2018. If we turn to page 76, the total
15 replacement cost new for -- again, this is the
16 children's hospital component of the downtown
17 structures, was \$119,424,350, would that also
18 have been sort of within your general
19 understanding around that time period?

20 A: You know, not specific to the number, but I do
21 know this was done, yes.

22 Q: Okay. So these replacement cost estimates over
23 the last couple years and again were specific
24 to the children's hospital component of the
25 downtown campus, do they impact your analysis

1 at all of the possibility of renovation of the
2 soon to be vacated children's hospital compared
3 to the \$325 million new community hospital?

4 A: You know, I think these are unrelated from my
5 perspective. I think that the need is still
6 there for the community hospital. Some of the
7 areas in what'll become the University Hospital
8 Annex would make good adult care space, not all
9 of it. And we're gonna use, hopefully, some of
10 that for some backfill and -- but I don't think
11 it relates to the community hospital project.

12 Q: Okay. All right. Now, the proposed location
13 for the community hospital, you know, don't
14 you, that it's just three or four miles away
15 from Roper St. Francis' Berkeley Hospital,
16 right?

17 A: Yes.

18 Q: But as I understood when we've talked before,
19 you weren't concerned about that proximity
20 because you were inundated with patients, is
21 that right?

22 A: Yes.

23 Q: And because there were so many patients, you
24 didn't think it would be an issue being so
25 close to Roper's Berkeley hospital, is that

1 right?

2 A: Correct.

3 Q: All right. So you'll agree with me that there
4 hasn't been an analysis of the potential impact
5 that the community hospital would have on Roper
6 St. Francis that you've had performed, have you?

7 A: No, no, we have not had anyone perform that.
8 I'm aware of it and I don't think it will have
9 impact. Just like I don't think it impacts,
10 you know, Roper's only a couple hundred feet
11 away from us on the peninsula. I don't think
12 it's impacted there either.

13 Q: Okay.

14 A: I think we both have different patient
15 populations we service.

16 Q: Okay. And the patient population that you
17 service downtown is I think you described a
18 higher acuity tertiary, quaternary for the
19 sickest patients of the state, is that fair?

20 A: Yes.

21 Q: And ---

22 A: Once again, not all of them, but many of them,
23 yes.

24 Q: And, certainly, you would agree with me that,
25 and you've described, that there is a

1 significant patient population that's coming to
2 you downtown seeking services that Roper's
3 hospital across the street doesn't offer,
4 right?

5 A: Correct.

6 Q: Okay. Are you familiar with the services that
7 Roper St. Francis' Berkeley hospital is going
8 to provide?

9 A: You know, roughly. Roughly.

10 Q: Okay. I mean, would you consider it sort of a
11 community hospital in terms of the general
12 acute care services you'd expect to see?

13 A: Yes.

14 Q: And you know that that's a 50-bed hospital
15 project, right?

16 A: Yes.

17 Q: All right. Let's look at Trident's Exhibit 24.
18 (TMC Exhibit Number 24 was introduced into the record
19 at this time.)

20 Q: Dr. Cawley, you're familiar with the
21 presentation that MUSC or MUHA made to DHEC
22 just before the submission of the application,
23 right?

24 A: Once again, roughly. I think you're about to
25 show it to me, but, yes.

1 Q: And you've seen this before, at least at a
2 deposition, right?

3 A: Yes, yes.

4 Q: And I think you called them a slide deck, which
5 is something I hadn't heard before, but in
6 terms of how this is set up, this slide deck is
7 familiar to you and what y'all do for ---

8 A: You're making me date myself. So, all right.

9 Q: I did not mean to. My apologies. I thought it
10 was actually a fancy term. So Trident's
11 Exhibit 24, would it be consistent with your
12 understanding that this was a presentation that
13 would have been made to DHEC personnel sort of
14 in advance and kind of describing the proposed
15 community hospital?

16 A: Yes.

17 Q: And that's common, isn't it ---

18 A: Yes.

19 Q: --- to meet with the Department and talk about
20 plans in your community, right?

21 A: It is.

22 Q: Okay. And in looking at this presentation, if
23 we could look at -- so, for the record, the
24 date is December 14, 2017. The application was
25 submitted at the end of December 2017, right?

1 Is that your recollection?

2 A: Yes.

3 Q: Okay. Take a look at slide 3. And this slide
4 presents key objectives of a community hospital
5 and it reiterates, doesn't it, that the
6 proposed project is directed to serve MUHA's
7 existing patient base, right?

8 A: Yes.

9 Q: And that there are capacity constraints and
10 prolonged boarding hours downtown that are
11 supporting the need for this additional
12 capacity?

13 A: Yes.

14 Q: And that information, that's consistent with
15 what you still think would be key objectives of
16 the community hospital, right?

17 A: Yes.

18 Q: Let's go to the next slide. And you recall,
19 don't you, again at this time period, that the
20 intention and certainly what was identified to
21 the Department was that the FSED proposed will
22 be relocated to the site to avoid duplication
23 of services?

24 A: Yes, at that time, that was what we thought.

25 Q: And that was true through the time of the

1 submission and that changed at some point in
2 time after you submitted the CON application,
3 right?

4 A: That is correct.

5 Q: And it changed after the Department issued
6 their decision, right?

7 A: That is correct.

8 Q: Okay. All right. And look at slide five.
9 This slide has been titled project review
10 criteria and it's still consistent with your
11 intentions and testimony that the patient need
12 for this project is based on utilization of
13 MUHA downtown, right?

14 A: Yes.

15 Q: That would be MUHA downtown as opposed to ---

16 A: Yes.

17 Q: --- any other hospitals, right?

18 A: Yes.

19 Q: And the patients that would be redirected to
20 the community hospital?

21 A: Correct.

22 Q: And it talks in sort of number two that it's to
23 relieve pressure at MUHA and free up ED space
24 for trauma and the more acutely ill tertiary
25 quaternary patients, right?

1 **A:** Yes.

2 **Q:** And it says there in the fifth point that it's
3 a lower acuity community hospital, right?

4 **A:** Correct.

5 **Q:** I mean, certainly, it wasn't the intention and
6 it wasn't described to DHEC that this was going
7 to be a tertiary quaternary care facility,
8 right?

9 **A:** Yes, but if you're making the assumption that
10 that means it's a lower acuity hospital, like
11 Roper, I don't think that's correct. I think
12 that means compared to MUSC. So it'll be lower
13 acuity -- it'll be lower acuity than MUSC
14 typically is.

15 **Q:** Okay. And you're not aware of any plans at the
16 moment to make it any sort of trauma
17 designation at this time, right?

18 **A:** No.

19 **Q:** The community hospital?

20 **A:** No.

21 **Q:** Okay. Let's take a look ---

22 MS. HOLLINGSWORTH: Your Honor, I'd offer and I
23 don't know if it's in, Trident's Exhibit 24.
24 It may be in through the designations, but I
25 don't have that list yet.

1 THE COURT: I don't ---

2 MS. JONES: No objection.

3 THE COURT: Okay.

4 MR. WICEVIC: No objection.

5 MR. SUMMER: No objection.

6 THE COURT: It's admitted. Yeah, you're not gonna
7 object to your own exhibit.

8 (TMC Exhibit Number 24 was admitted into evidence.)

9 MS. HOLLINGSWORTH: You're welcome, Mr. Summer.

10 Q: If we could look at Trident's Exhibit 50,
11 please.

12 (TMC Exhibit Number 50 was introduced into the record
13 at this time.)

14 Q: You discussed on your direct that there were
15 evaluations of potential land options
16 throughout the review process for the proposed
17 community hospital, is that right?

18 A: Yes.

19 Q: And what was your role in those discussions or
20 the planning for the ultimate site chosen?

21 A: The -- the site -- potential sites were studied
22 by our strategic planning office and they put
23 together a variety of options and I presented
24 those options to the Board.

25 Q: Okay. And do you recall that there was some

1 discussion of after the application was filed,
2 that there was some discussion that potentially
3 there were some other locations that popped up
4 and were being reviewed to see if you wanted to
5 move the proposed site?

6 A: Yes.

7 MS. HOLLINGSWORTH: And this presentation Berkeley
8 County land evaluation and we can flip through
9 a couple pages to orient Dr. Cawley.

10 Q: Is this information or this slide that would be
11 familiar to you?

12 A: Yes.

13 Q: Okay. Let's -- if we could just -- I wanna ask
14 you about slide nine. Yeah, that one. If we
15 could pull that out. And so this would have
16 been during the time period when the
17 application had been submitted, but there were
18 maybe some potential sites that were being
19 evaluated.

20 A: Yes.

21 Q: And looking at slide nine, and specifically
22 thinking about Roper St. Francis Berkeley, why
23 was it important that the second bullet point,
24 the current location protects MUSC as provider
25 of closest proximity to Nexton/Cane Bay? Why

1 was that important? Who was it that MUHA was
2 concerned would be closer than your community
3 hospital to Nexton/Cane Bay?

4 A: You know, this was the Board asked us for a
5 presentation on other locations and, you know,
6 this was put together, pluses or minuses, and,
7 you know, I think that bullet simply states the
8 fact and I think the other provider would be --
9 would be Roper.

10 Q: I mean, you know, don't you, that Roper's --
11 Roper St. Francis Berkeley Hospital is
12 immediately adjacent to Nexton and Cane Bay
13 communities, is that fair?

14 A: I think it's next to Cane Bay. I think it's a
15 little further from Nexton, but ---

16 Q: Isn't Cane Bay across the street from Nexton?

17 A: Yeah, it's a big -- it's a big area, though.
18 I mean, so -- and yes, technically, yes, but I
19 think the hospital that MUSC is proposing is
20 right in the middle of Nexton.

21 Q: It's in that neighborhood, the Nexton ---

22 A: Yes.

23 Q: --- neighborhood development, right?

24 A: Yes.

25 Q: And Cane Bay is a neighborhood development

1 across the ---

2 A: Across the road, yeah.

3 Q: And then Carnes Crossroad is a neighborhood
4 development sort of one over from that ---

5 A: Correct.

6 Q: --- right?

7 A: Correct.

8 Q: And, I mean, you know, I know you've been with
9 -- in this area a good long time, too, and you
10 know, don't you, that Carnes Crossroad was sort
11 of one of the first sort of named developments
12 to start getting off the ground, right? I
13 think Carnes Crossroad and Cane Bay were a
14 couple of the first in that southern Berkeley
15 County area?

16 A: Yeah; I don't know if they were the first or
17 not, but they were early as far as I'm aware.

18 Q: Okay. And the Nexton development, ten years
19 ago, there was no planned Nexton development,
20 at least it was kind of known out in the
21 public, right?

22 A: Yeah. Once again, I -- you know, I couldn't
23 tell you the exact dates, but, yes, Nexton has
24 been -- has come online seems in the last ten
25 years.

1 **Q:** Okay. And you're aware, aren't you, that
2 actually in the sort of Nexton neighborhood
3 promotional materials that are in the community
4 hospital CON application, that they -- they
5 identify the Roper St. Francis Berkeley
6 Hospital in their own marketing, right? Are
7 you familiar with that?

8 **A:** No, I'm not familiar with that.

9 MS. HOLLINGSWORTH: Okay. Let's pull up DHEC 1,
10 CON 407. And while we pull that up, Your
11 Honor, I would offer Trident 50 in evidence.

12 MS. JONES: No objection.

13 MR. WICEVIC: No objection.

14 MR. SUMMER: No objection.

15 THE COURT: It's admitted.

16 MS. HOLLINGSWORTH: Thank you, Your Honor.

17 (TMC Exhibit Number 50 was admitted into evidence.)

18 **Q:** And Dr. Cawley, we're pulling up the CON
19 application marked as DHEC Exhibit 1. Go back
20 one page. I'm sorry, early in the application.
21 This is a brochure about Nexton that's in the
22 CON application for the community hospital and
23 if you go down the map that we were just on,
24 sorry. Do you see right there there's Nexton
25 sort of in the middle and you've got Carnes

1 Crossroads next door and then the Roper St.
2 Francis Berkeley Hospital is shown there where
3 176 and 17A connect?

4 A: Yes, I see it.

5 Q: Let's look at -- I just want to pull up a map
6 and this was from -- and I don't know if we --
7 it was from Mr. Sullivan's slides, I don't
8 think that they are -- I don't think they're in
9 evidence and I just want to have the map
10 available. I think it's probably got 13 on it.
11 Demonstrative 13. And really just to give us
12 our geographic bearings. And so, Dr. Cawley,
13 this is just a map, a geographic representation
14 that Mr. Sullivan has prepared and the only
15 reason I show this to you is, again, just to
16 sort of orient ourselves geographically, it's
17 consistent with your understanding, isn't it,
18 that Roper St. Francis' Berkeley Hospital and
19 I think we talked about three or four miles
20 away from your planned hospital, right?

21 A: Yeah, something like that.

22 Q: Okay. So this radius, which is a ten-mile
23 radius, around MUHA's proposed community
24 hospital, I mean, you'd agree with me, wouldn't
25 you, that the Roper St. Francis Berkeley

1 Hospital is accessible and available to all of
2 the same sort of resident population that is
3 within that ten mile and greater radius of the
4 proposed MUHA location, right?

5 A: I'm sorry, repeat your question.

6 Q: Sure. Would you agree with me that Roper St.
7 Francis Berkeley Hospital is open and
8 available -- accessible to these residents of
9 Berkeley County that are also proximate to your
10 proposed hospital ---

11 A: Sure.

12 Q: --- location?

13 A: Yes.

14 Q: Okay. And so would it be fair to say there are
15 residents in this geographic area that lack
16 access to inpatient or outpatient acute care
17 hospital services, right?

18 A: If they want access at MUSC, that would be --
19 they wouldn't have access. If they wanted
20 access at Roper St. Francis, they would have
21 access.

22 Q: Okay. But if we made it more generic, if they
23 wanted access to emergency services or
24 inpatient/outpatient community hospital
25 services, they would have that access, right?

1 **A:** Yeah, I agree with that statement, but that's
2 not typically what patients do. Patients
3 choose where they want to go. But, yes, that
4 is correct; they would have access to ER and
5 inpatient, but when it comes to choice, they
6 would not have choice.

7 **Q:** If they -- if they wanted to choose Medical
8 University or Summerville Medical Center or
9 somewhere else, they would travel to go to that
10 choice to do -- if that was the decision they
11 wanted to make, right?

12 **A:** Correct.

13 **Q:** Would you agree with me, though, location is an
14 important consideration in making the choice
15 for where to go for say hospital services?

16 **A:** I think it's a factor. It's not the only
17 factor.

18 **Q:** Okay. Let's talk a minute about staffing. We
19 touched on it briefly this morning, you did.
20 But in terms of staffing, the Court's heard a
21 good bit about staffing and particularly
22 nursing staff and traveler -- traveling nurses.
23 Can you just describe for the Court what that
24 is and how those operate in your institution?

25 **A:** A traveling nurse is a temporary nurse or

1 someone who comes -- they're not -- they're not
2 a permanent employee of your organization, but
3 they come for a period of time, usually because
4 you need nurses and can't find them locally.

5 Q: Okay. And you, and, specifically, of course,
6 MUHA downtown, you've had to increasingly turn
7 to traveling nurses to fulfill your staffing
8 needs, right?

9 A: I mean, it kind of goes up and down over the
10 years. Some years we need to go to travelers
11 and some years we don't. Just depends.

12 Q: Are you still using 30 to 40 traveling nurses
13 today?

14 A: Yes, that's probably about accurate. Yes.

15 Q: Okay. Is it any higher from your deposition a
16 few months ago or lower or about the same?

17 A: I think once again it's -- depends on the
18 weeks, but I would say that's about the right
19 average.

20 Q: Okay. And as the sort of the chief executive
21 for that clinical enterprise, is it something
22 that's important to you to try to reduce the
23 use of travelers as your staffing resource?

24 A: Yes, we always try to reduce the number of
25 travelers.

1 **Q:** Okay. And you'll agree with me, won't you,
2 that the nursing shortage is a real problem in
3 your market?

4 **A:** I -- I think that's a little bit of an
5 overstatement. For us, or at MUSC, the nursing
6 shortage problem is in specialty areas, not all
7 nurses. So getting what we call typical
8 med/surg nurses is not hard at MUSC. Getting
9 subspecialty nurses, pediatric subspecialties,
10 transplant nurses, cardiac ICU nurses, those
11 tend to be our problem, not more general
12 nurses.

13 **Q:** Okay. Well, what about say nurses that you
14 would have in your intensive care or critical
15 care units?

16 **A:** Once again, for straightforward intensive care
17 units, not specialty ICUs, we don't tend to
18 have that problem. It's the specialty ICUs
19 where we have the issue.

20 **Q:** Okay. What about OB nurses?

21 **A:** Doesn't tend to be a problem.

22 **Q:** Okay. So the 30 or 40 travelers that you're
23 using today are isolated to those kind of
24 subspecialty areas?

25 **A:** I would say overwhelmingly in the subspecialty

1 areas, OR nurses, subspecialty nurses,
2 pediatric nurses, things like that.

3 Q: Okay. Was that first one OR nurses?

4 A: Operating room; I'm sorry.

5 Q: Okay. I wasn't sure I heard you.

6 A: Yes.

7 Q: Well, so, what, if any, understanding do you
8 have about whether any of your four new
9 community hospitals in other areas have similar
10 nursing staffing issues in terms of the use of
11 travelers?

12 A: Well, in the other community hospitals that we
13 now own, so they -- we found them very, very
14 understaffed when we got in there and so we are
15 actually putting more nurses in and, you know,
16 it will be more typical of what -- how MUSC
17 would staff. And it's -- it's taken time, yes.

18 Q: So you had some struggles trying to get those
19 satellite hospitals to the staffing level that
20 you want your brand to have?

21 A: Yes. And remember, we're only in there six
22 months, so it'll take a year to two years to
23 fully staff up to the -- in those hospitals to
24 the level that we would prefer.

25 Q: And are you relocating staffing and --

1 particularly nursing staffing from your
2 downtown campus out to some of those areas as
3 part of ---

4 A: Not really. There's a little bit of movement,
5 but I would say, you know, you could probably
6 count them on one hand. You know, people that
7 are maybe in -- maybe in Charleston that want
8 to go back to Florence because that's their
9 hometown, I would say we probably have the same
10 number, so it's probably -- same number coming
11 from those areas down to Charleston, so it's a
12 -- probably a net-net, zero.

13 Q: Okay. But you will agree with me that you have
14 a goal of decreasing the number of travelers in
15 your system, right?

16 A: Yes.

17 Q: It is a more expensive means of having to staff
18 your facilities, right?

19 A: Yes.

20 Q: Do you have vacancies at your downtown facility
21 even with the travelers you're using today?

22 A: Well, you can consider every one of those
23 travelers a vacancy, so if we're using 30
24 travelers, that probably means we have at least
25 30 vacancies not filled.

1 **Q: Okay. Is it like when you have vacancies in**
2 **addition to that?**

3 **A: Sure. Yeah.**

4 **Q: Let's look at Roper St. Francis Exhibit 101.**
5 **(Roper Exhibit Number 101 was introduced into the**
6 **record at this time.)**

7 **THE COURT: How much longer do you think you'll be?**
8 **Just trying to decide what ---**

9 **MS. HOLLINGSWORTH: Only a few hours, Your Honor.**
10 **I -- three pages -- less than three pages, so**
11 **maybe 30 minutes, if that.**

12 **THE COURT: Okay.**

13 **MS. HOLLINGSWORTH: Do you wanna take a break, Your**
14 **Honor?**

15 **THE COURT: No, let's stick it out. How are y'all**
16 **doing down there? All right?**

17 **Q: Dr. Cawley, are you okay?**

18 **A: I'm fine; thank you.**

19 **Q: Roper St. Francis 101, and Dr. Cawley, you and**
20 **I have looked at this before, who is the McNair**
21 **Group?**

22 **A: They're an external consulting group that we**
23 **use on occasion to help us with particularly**
24 **communication issues.**

25 **Q: Okay. And by communication issues, are you at**

1 times using the sort of public relations or
2 conduit in discussing things with your
3 communities?

4 A: Yeah. And whatever -- or sometimes we're
5 trying to get out and have big group meetings
6 where we're trying to get a -- something
7 communicated. So, yes, in a sense like public
8 relations.

9 Q: Okay. And did you use the resources of the
10 McNair Group in reaching out to your community
11 about the proposed hospital in southern
12 Berkeley County?

13 A: We did. We had multiple listening sessions,
14 some of which leadership at MUSC did; I did
15 some of it, but I couldn't do all of it, so we
16 asked the McNair Group to help us. And David
17 McNair, who's part of the McNair Group, did
18 some of the listening sessions.

19 Q: Okay. And this document that was produced in
20 discovery is listening sessions at MUSC
21 Community Hospital, Nexton Elementary School,
22 March 20, 2018. Is presentation at the
23 elementary school in the Nexton area the type
24 of community event that you or your
25 subordinates would have attended to talk about

1 the proposed hospital?

2 A: Yes.

3 Q: All right. And I do want to ask you about
4 point 4 on the document, which is -- would it
5 be fair, this is sort of a summary back to MUHA
6 of what transpired; it was provided by the
7 McNair Group? Is that your understanding?

8 A: Yes.

9 Q: And specifically the point, what would you like
10 to express to the leadership of MUSC about the
11 plans to make healthcare more accessible to
12 your area and there are sort of three comments
13 noted, what discussion, if any, have you had
14 internally about point B, which is how will you
15 staff with the nursing shortage?

16 A: We haven't had any additional discussion that
17 I'm aware of. You know, maybe there's been
18 some -- our chief nursing officer has had a
19 discussion, but we haven't identified it as a
20 particular operational challenge.

21 Q: Okay. All right. Are you aware or were you
22 made aware that at least one member of the
23 community perceives that there's a nursing
24 shortage in the area?

25 A: Sure. I saw this document and I think we

1 reviewed it at my deposition, but, you know, I
2 would say the overall staffing or I'm sorry the
3 nursing shortage problem in Charleston is not
4 that bad. There are areas of the state which
5 are much, much worse. And we just don't see
6 that this is gonna be a significant challenge.

7 Q: Okay.

8 MS. HOLLINGSWORTH: Your Honor, I would offer Roper
9 Exhibit 101.

10 MS. JONES: No objection.

11 MR. WICEVIC: No objection.

12 MR. SUMMER: No objection

13 THE COURT: It's admitted.

14 MS. HOLLINGSWORTH: Thank you, Your Honor.

15 (Roper Exhibit Number 101 was admitted into
16 evidence.)

17 Q: All right. Dr. Cawley ---

18 MS. HOLLINGSWORTH: And you can take that down.

19 Thank you.

20 Q: We talked about the acquisition of the four
21 hospitals and that occurred after the filing of
22 this application. I want to ask you about a
23 few other projects that MUHA has pursued and
24 announced since then. Let's look at Trident
25 158.

1 (TMC Exhibit Number 158 was introduced into the
2 record at this time.)

3 Q: This is dated October 2019 and this appears to
4 be the main application for the development of
5 a freestanding emergency department. Can you
6 go over to the second page? You actually
7 mentioned the Sea Islands earlier when we were
8 discussing access to services. Are you
9 familiar with this application?

10 A: Yes.

11 Q: All right. And if you could, just describe to
12 the Court what is this application that MUHA
13 has filed in October of 2019?

14 A: This is an application for a freestanding
15 emergency room down in the Seabrook-Kiawah
16 region.

17 Q: Okay. And is this application in part to
18 address ED patient volumes that are originating
19 from that sort of Sea Islands area?

20 A: Yes.

21 Q: Okay. And you're familiar with this project,
22 right?

23 A: Yes.

24 Q: Let's go to page 29 of the exhibit, please.
25 And are you -- is it consistent with your

1 understanding of the application that it's
2 intended to alleviate capacity constraints and
3 enhance access for -- and it focuses on a
4 single zip code on John's Island, did you --
5 are you aware of that?

6 A: Yes.

7 Q: 29455?

8 A: Yes.

9 Q: And it proposes a redirection of patients that
10 are currently traveling to your downtown ED
11 from 29455, is that right?

12 A: Yes.

13 Q: And so -- and we discussed this earlier, but
14 you'll agree with me, won't you, that John's
15 Island was also one of the areas that the
16 community hospital application proposed would
17 be served at the -- up in southern Berkeley
18 County, right?

19 A: Yes.

20 Q: And have you -- was that part of your analysis
21 for this freestanding ED application to
22 consider whether or not the community hospital
23 was already gonna increase access for them?

24 A: You know, I don't know if we've done an
25 additional analysis, but, you know, I can't --

1 can't comment on if we have.

2 **Q:** **Okay. What -- what ongoing ---**

3 MS. HOLLINGSWORTH: I think Trident 158 is in
4 evidence. No. Your Honor, I would offer
5 Trident's 158.

6 MS. JONES: No objection.

7 MR. WICEVIC: No objection.

8 MR. SUMMER: No objection.

9 THE COURT: It's admitted.

10 MS. HOLLINGSWORTH: Thank you, Your Honor.

11 (TMC Exhibit Number 158 was admitted into evidence.)

12 **Q:** **Dr. Cawley, what is your level of involvement**
13 **and how frequently in terms of the debt**
14 **capacity or the -- that's being taken on by**
15 **MUHA in the last five, ten years?**

16 **A:** **I'm well aware of it.**

17 **Q:** **Okay. And what is your sort of general**
18 **understanding of what the level of debt**
19 **commitment is for MUHA as we sit here today?**

20 **A:** **Yeah, I -- you know, Lisa Goodlett, when she**
21 **comes to testify, can give you more details,**
22 **but we are not at all maximizing our debt**
23 **capacity.**

24 **Q:** **Okay. Well, what is your debt capacity? I**
25 **mean, you talked this morning about sort of**

1 what your general understanding on financial
2 matters is. I mean, do you ---

3 A: Well, I -- I would say, you know, debt capacity
4 depends upon, you know, a lot of different
5 things, the size of your assets and what you're
6 already paying for debt, but I would say, and
7 Lisa can give you more details, but we're less
8 than 50 percent of our debt capacity is being
9 used to fund projects. And that actually
10 includes planned projects.

11 Q: So you're less than 50 percent with the \$325
12 million community hospital?

13 A: I believe that's correct. You'll have to get
14 -- ask Lisa specifically, but I think that is
15 correct.

16 Q: Is it your understanding that in terms of
17 commitments today that MUHA is over a 1 billion
18 dollars in debt commitments?

19 A: Well, you know, these things happen over time.
20 You know, I think there's a -- I think there's
21 -- sounds like what you're doing is adding up
22 all these projects. These projects don't all
23 come online at the same time.

24 Q: Sure.

25 A: So some projects come on; others go off. What

1 our total debt capacity is at any one time does
2 need to be added up, and I -- what I just told
3 you was that's looking at all our planned
4 projects.

5 Q: Okay. But what is your understanding, if any,
6 and, certainly ---

7 A: The total -- the total number, I do not know.

8 Q: Okay. And let me see if I ask the same
9 question you thought I would. With regard to
10 your current balance sheet, what is your
11 understanding, if you have one, of what your
12 current debt obligations amount to? So not
13 planned projects, but on your balance sheet
14 today, how much debt is it your understanding
15 that MUHA's carrying?

16 A: In terms of what, debt capacity?

17 Q: No, debt. How much debt do you have? Dollar
18 amount.

19 A: I couldn't tell you the exact amount.

20 Q: Okay.

21 A: I think that's a better way to look at that
22 from my perspective as the CO is to look at
23 debt capacity, debt service capacity, those
24 things, which is kind of like, you know, how
25 much house can you afford based upon your

1 payments. And we're well within appropriate --
2 and actually conservative metrics there.

3 Q: Okay. And now you are familiar, aren't you,
4 with the recent project announcements that the
5 Board approved, I think just last month,
6 related to -- several of them related to the
7 CHS -- the newly acquired hospitals? Are you
8 familiar with those?

9 A: Well, I think four of the five all relate to
10 the new hospitals.

11 Q: Okay.

12 MS. HOLLINGSWORTH: And if we could put
13 Demonstrative 11 up.

14 (Demonstrative Exhibit Number 11 was referenced at
15 this time.)

16 Q: October 2019, so would there have been a
17 meeting of your Board of Trustees in October?

18 A: Yes.

19 Q: And you're aware, aren't you, of several
20 projects that were approved by your Board to
21 pursue that required Certificates of Need?

22 A: Well, the projects weren't approved. The --
23 the -- we were granted permission to submit
24 Certificate of Need applications. That does
25 not mean the projects were approved.

1 Q: Okay. So and I think you kind of talked me
2 through this before. There's several different
3 approvals that you typically will do piecemeal
4 with your Board, right?

5 A: Correct.

6 Q: Filing the application is a first step?

7 A: Correct.

8 Q: Subsequent to that would be approval to seek,
9 for example if it's a debt obligation, you
10 would get that permission at a separate time,
11 right?

12 A: Correct.

13 Q: And then I think, too, there may be a third
14 step in terms of approving a budget ---

15 A: Well, approving the project itself at that
16 time, yes.

17 Q: All right. But certainly your Board approved
18 the filing of applications and asking the State
19 for regulatory approval for certain CON covered
20 projects, right?

21 A: That is correct.

22 Q: And one of them is a satellite hospital, is
23 that right?

24 A: That is correct.

25 Q: And, of course, we don't have a number on that,

1 but there was also I think another project for
2 Lancaster's cardio cath program and a
3 freestanding ED in Florence County, is that
4 right?

5 A: Yes.

6 Q: Now, when we met at your deposition just a
7 couple months ago, those projects were not on
8 your planning horizon, were they?

9 A: I mean, they're -- at that stage very early, no
10 decision's made at that point.

11 Q: Okay. Well, when we -- when we talked at your
12 deposition there were no plans, capital
13 commitments. I think what we talked about was
14 over \$5 million in the next twelve months, so
15 did these plans sort of materialize after your
16 deposition?

17 A: Yes.

18 Q: Okay. And then MUHA -- you've also recently
19 entered an affiliation agreement with Doctors'
20 Care, is that right?

21 A: Correct.

22 Q: So the Doctors' Care I think that's a regional
23 affiliation, so it's not Doctors' Care offices
24 throughout the state, is that right?

25 A: Correct.

1 Q: But there's a number of locations in the tri-
2 county area?

3 A: And Florence and Horry County, yeah.

4 Q: Where -- do you have any ideas generally where
5 some of the Doctors' Cares are located in the
6 tri-county area?

7 A: You know, roughly.

8 Q: About how many are there, do you know?

9 A: I think there's three or four.

10 Q: Okay. And so the reasoning for that
11 affiliation -- well, and let me back up a step,
12 so Doctors' Care, that's an urgent care
13 setting, is that right?

14 A: That is correct.

15 Q: So would you agree with me that's sort of a --
16 it's a step below what you anticipate
17 freestanding ED population and then going up
18 from there, is that right?

19 A: That is correct.

20 Q: Okay. And an urgent care center does not have
21 to be affiliated with a hospital; it can just
22 be -- it's just a physician's office for
23 purposes of CON regulation, right?

24 A: That is correct.

25 Q: And, I mean, do you have any idea of how many

1 doctors are covered and sort of coming into
2 this affiliation agreement that now exists
3 between the Doctors' Care and MUSC Health?

4 A: You're asking how many doctors are in Doctors'
5 Care, is that ---

6 Q: Well, in terms of these offices that you've now
7 affiliated with your institution, do you know
8 roughly how many physicians would be with those
9 Doctors' Care locations?

10 A: I couldn't even tell you; I don't know how many
11 doctors are at each Doctors' Care. There's
12 usually one to two staff, but how many does
13 that equate to over the course of a year, I
14 don't know.

15 Q: Okay. But is it fair to say that kind of the
16 reason for the affiliation is to provide
17 increased access to MUHA's primary and
18 secondary services for these folks that are
19 showing up for an urgent care encounter at
20 Doctors' Care?

21 A: The Doctors' Care relationship developed
22 because Doctors' Care came to us because they
23 were having trouble getting their patients who
24 they needed follow-up care for in to various
25 physician offices. So we agreed to help them

1 on that and we would make special effort to
2 make sure those patients could get seen.

3 Q: Okay. And, Dr. Cawley, I don't know -- I know
4 you haven't been here; I don't know if you've
5 seen some of the transcript from the hearing,
6 but Brett Johnson, do you know who Brett
7 Johnson is?

8 A: Yes.

9 Q: Are you familiar with Roper St. Francis? And
10 he testified earlier in the hearing that it was
11 important for there to be connectivity between
12 an organization's strategic planning and
13 financial planning. Do you agree with that?

14 MS. JONES: Objection, Your Honor. It's improper
15 to pit the witnesses. That's an improper
16 question.

17 MS. HOLLINGSWORTH: I don't think I was pitting,
18 Your Honor. I just wondered his thoughts on
19 the concept. I didn't ask if he was right or
20 wrong.

21 MS. JONES: She's seeking an opinion about
22 testimony of another witness and that is
23 improper under the Rules.

24 THE COURT: Do you want to rephrase your question
25 or ...

1 MS. HOLLINGSWORTH: I can, Your Honor. That's
2 fine. I don't think that it's -- that's fine.

3 Q: Dr. Cawley, do you think it's important as CEO
4 of MUHA that your strategic planning for the
5 system and your financial planning be connected
6 and inline with each other?

7 A: Yes.

8 Q: Okay. And do you agree that your projections
9 of future financial performance should be
10 commensurate with how aggressive your strategic
11 planning process is in terms of new -- new
12 projects?

13 A: Yes.

14 Q: Okay. And do you still believe that -- or has
15 it been your belief that MUHA's mission is best
16 served through a strategic philosophy that
17 favors being deliberate and incremental?

18 A: Yes, and I think that's what we've been.

19 Q: Okay. And phase one and phase two of the long-
20 term master plan, you agree with me, that's a
21 deliberate and incremental plan that furthered
22 MUHA's mission, is that right?

23 A: Yes.

24 Q: And those were both significant capital
25 projects, weren't they?

1 A: Yes.

2 Q: I think something like nearly \$700 million in
3 debt obligations, right?

4 A: Yes.

5 Q: And the CHS -- I'm sorry, the children's
6 hospital project, that -- there are going to be
7 additional debt obligations coming on once it
8 becomes operational, right?

9 A: Yes.

10 Q: And do you believe that an organization or that
11 MUHA can damage itself if it moves faster than
12 the volatility of its situation requires?

13 A: I think you can move as fast as you feel your
14 obligations can carry you.

15 Q: Okay.

16 A: And whether that's fast or whether it's slow,
17 I think it could be either.

18 Q: Okay. And we're just about two years out from
19 the filing of the community hospital
20 application. And you'd agree with me that this
21 application is a \$325 million project, right?

22 A: Yes.

23 Q: And since then, MUHA has acquired four
24 hospitals and that has amounted to nearly 300
25 million dollars in debt, is that right?

1 A: For buying the new hospitals?

2 Q: Yes, buying the new hospitals and then the
3 capital operating cost loan that was obtained,
4 120 million dollar?

5 A: No, I mean, it didn't cost 300 -- the purchase
6 price was -- was in the hundred millions, not
7 the 300 millions.

8 Q: Right. I was adding up -- is it fair to say
9 that there was 120 million dollar debt that was
10 incurred sort of to assist with the operating
11 revenue ---

12 A: Yes.

13 Q: --- that -- sort of the operating expenses?

14 A: Yes.

15 Q: Right. Okay.

16 A: You said 300, that's why I was ...

17 Q: Sure.

18 A: Yeah.

19 Q: 120 million for that and then the purchase
20 price of the hospitals themselves, is that
21 right?

22 A: Yeah, you're mixing up, though, two different
23 issues there. One of those issues it was
24 dollars borrowed too for working capital.

25 Q: Right.

1 **A:** **Right. That is something that's paid back**
2 **fairly quickly.**

3 **Q:** **Okay.**

4 **A:** **It's paid back in 18 months and you can talk to**
5 **Lisa Goodlett when she gets on the stand for**
6 **specifics. And then there's the purchase price**
7 **for the CHS hospitals, which is paid over time.**

8 **Q:** **Right.**

9 **A:** **So I think it's an apples and oranges**
10 **comparison.**

11 **Q:** **Sure. And I was inartful, I'm sure, in my**
12 **question. What I'm asking is since the**
13 **submission of the application for the community**
14 **hospital, those two significant expenditures**
15 **have taken place, the purchase of the CHS**
16 **hospitals and attaining the loan to assist with**
17 **sort of initial ---**

18 **A:** **Yes, that ---**

19 **Q:** **--- operating expenses?**

20 **A:** **That is correct. However, I would say that --**
21 **and we've talked about this at our Board level,**
22 **what's possible, and we've gone through our**
23 **long-term financial planning, because these**
24 **things don't come on online. There's a**
25 **tendency to think, you know, if we have a**

1 billion dollars, that it's a billion dollars
2 I'll want. That is not the case. So we have
3 been paying off Ashley River Tower for almost
4 ten years and it's not gonna continue to be at
5 that level. So we've looked at that and felt
6 that we can handle the debt capacity while
7 remaining in a very conservative financial
8 situation.

9 Q: Okay. And so do you think that the acquisition
10 of the four CHS hospitals sort of so closely in
11 time with pursuit of the community hospital
12 project was consistent with sort of a
13 deliberate incremental strategic plan?

14 A: Yes.

15 Q: Okay. You don't consider the purchase of those
16 hospitals to have been a bold move on MUHA's
17 part?

18 A: Bold in terms of maybe strategic, yes, because
19 we hadn't -- hadn't bought hospitals outside
20 Charleston before. Was it bold in terms of
21 financial? I would say not.

22 Q: Okay. And I promise we are at the end of my
23 outline, so I appreciate your patience with me.
24 You would agree with me, though, that you can't
25 control your patients' choices in terms of

1 where they travel to obtain their hospital
2 services, right?

3 A: Correct. Patient choice always rules.

4 Q: Okay. And so -- and you would agree with me
5 that that's why location for where you place
6 your services is important because of location
7 and proximity are important to your patients,
8 is that right?

9 A: Yes.

10 Q: Okay. And so -- and we looked at some of your
11 internal documents when evaluating your
12 location, it was important to be near where you
13 believe your patients are, is that right?

14 A: Yes.

15 Q: So when you locate services or a hospital in
16 very close proximity to another provider, you
17 would agree with me that you have no control
18 over whether a patient would have chosen to go
19 to the, say, Roper St. Francis Berkeley
20 Hospital chooses, instead, to go to your
21 community hospital, right?

22 A: Yes. Patients will choose where they want to
23 go.

24 Q: Okay. And you'll agree with me that in terms
25 of the re-direction of your patients from even

1 say North Charleston or downtown Charleston,
2 you would have to rely on your patients
3 choosing to travel to that alternate location,
4 right? You're not going to bus patients from
5 your downtown campus and direct them to ---

6 A: Correct.

7 Q: --- Berkeley County, right? There is ---

8 A: Correct.

9 Q: --- no need for that? And so you would agree
10 with me that a new hospital in southern
11 Berkeley County, you would expect it to shift
12 volumes from other providers in the service
13 area, right?

14 A: You know, that may occur, but that is not --
15 not something that we're planning on.

16 Q: Okay. So it's still your position that the
17 community hospital will be 100 percent re-
18 direction of patients who have been choosing to
19 travel to the downtown campus?

20 A: I -- no, no, I think you're putting words in my
21 mouth. What I think that will fill is patients
22 that want to come to MUSC will come to that
23 hospital. Now, whether they choose to go down
24 to the peninsula or maybe they never went to
25 the peninsula, but they live in Summerville and

1 they decided to go there where in the past they
2 would have gone down. So I think it's -- that
3 hospital's being built for the patients that
4 want to come see us.

5 Q: Okay. But without regard for whether or not
6 they were otherwise choosing to go to a
7 different provider in the community, right?

8 A: You know, once again, I -- you know, I hear
9 what you're saying, but patients choose to go
10 to the health system they want to go to. Just
11 like Roper downtown, patients choose to go to
12 Roper or they choose to go to MUSC. They're
13 200 feet apart. And Roper does fine; we do
14 fine. I think it would be the same issue in
15 Berkeley County.

16 Q: Okay. And you have not -- and you're familiar,
17 of course, with MUHA's capacity constraints
18 downtown, right?

19 A: Yes.

20 Q: But you haven't analyzed or evaluated the
21 capacity or utilization of other providers in
22 the service area, have you?

23 A: We have some knowledge -- I have some knowledge
24 of the capacity, availability in some of these
25 other facilities, yes.

1 Q: And so did you provide that information in the
2 CON application?

3 A: No. Now, you asked me whether I was aware and
4 I'm aware of some of the capacity availability.

5 Q: Okay. In terms of operationally when you -- is
6 that how you -- in the context that you're
7 speaking to?

8 A: We have been -- we have talked with just about
9 every hospital in the tri-county over the last
10 several years in order to find other means to
11 put our patients in other beds, so that's how
12 I became aware of that there's capacity for
13 inpatients at most of the other hospitals.

14 Q: They have capacity to ---

15 A: Yes.

16 Q: --- receive inpatients?

17 A: Yes.

18 Q: Okay. And you believe, don't you, that Roper
19 St. Francis offers high quality care?

20 A: Yes.

21 Q: And do you have any reason to believe that
22 Roper St. Francis doesn't make its services
23 available to any patient regardless of their
24 ability to pay, just like MUHA does?

25 A: I don't know anything about their services.

1 Q: And, in fact ---

2 A: In terms of financial.

3 Q: Sure. And you agree with me that MUHA has
4 worked with Roper St. Francis in terms of
5 caring for patients that don't have sufficient
6 resources, right?

7 A: Yes, yes.

8 Q: All right. I'm just about done.

9 MS. HOLLINGSWORTH: If I could have one minute.

10 Q: Thank you, Dr. Cawley, I appreciate your time.

11 MS. HOLLINGSWORTH: Thank you, Your Honor.

12 THE COURT: We're going to take a lunch break now.

13 It's 2:45, a good time to be back.

14 MS. JONES: We're done. Y'all pass?

15 MR. SUMMER: We're going to lunch. What the Judge
16 just said.

17 MS. JONES: Oh, no, no, I want to finish Dr.
18 Cawley.

19 MR. THOMAS: I want to eat, Your Honor.

20 THE COURT: Well, I want to take a lunch break.

21 MS. JONES: Okay.

22 THE COURT: All right. 2:45, is that a good time
23 to go back?

24 MS. JONES: I beg your pardon?

25 THE COURT: 2:45, is that ---

1 MS. JONES: Well, we've got one more witness today.

2 THE COURT: Well, we'll get him. We've got to eat
3 some time. I want to eat.

4 MS. JONES: Okay.

5 THE COURT: And since I make the rules of when we
6 go ---

7 MS. JONES: I get it. I get that. I thought he
8 passed.

9 THE COURT: Okay.

10 (Off the record.)

11 THE COURT: Y'all can be seated.

12 MR. SUMMER: Thank you, Your Honor.

13 THE COURT: I didn't say anything.

14 MR. SUMMER: For letting me stand there and letting
15 me asking questions. I can always say thank
16 you.

17 THE COURT: Okay.

18 DR. CAWLEY - CROSS-EXAMINATION BY MR. SUMMER:

19 **Q: Dr. Cawley, a pleasure to see you again.**

20 **A: Good to see you again.**

21 **Q: Nice of you to say so. Let's start with the**
22 **stuff that you and I can probably agree on and**
23 **that's the stuff that y'all do so well at MUSC.**
24 **You would agree with me that you've got a**
25 **special team of clinicians in that institution,**

1 wouldn't you?

2 A: Yes.

3 Q: Okay. And I heard you talking about different
4 types of specialists and then the teams that
5 work around them, because it's not all just
6 about the physician, it's also about the nurses
7 and the techs and the people who make that
8 patient better, correct?

9 A: Yes.

10 Q: You also have these subspecialists that aren't
11 in other places because you're able to get the
12 critical mass necessary at your teaching
13 institution to keep them busy, correct?

14 A: Correct.

15 Q: And they get better through redundancy, would
16 you agree with me on that?

17 A: Yes, in general.

18 Q: In general, redundancy begets quality, does it
19 not?

20 A: In general, yes.

21 Q: The more you do it, the better you should get
22 at it?

23 A: Most of the time, yes.

24 Q: Most of the time.

25 A: Yes.

1 Q: Okay. There are a few exceptions we can think
2 of in baseball players, but at the end of the
3 day, that's an important tenet of medical care,
4 would you agree with me?

5 A: Yes.

6 Q: And if we look at some of the things that you
7 do well there, would you agree with me that
8 your neurosciences programs are pretty awesome?

9 A: Yes.

10 Q: Okay. That you have the only neuro intensive
11 care unit in the region?

12 A: Yes, that is true.

13 Q: Okay. That you're the state's only
14 comprehensive movement disorder program in
15 South Carolina, right?

16 A: I don't know exactly, but I wouldn't be
17 surprised.

18 Q: And you're a leader in Parkinson's care, are
19 you not?

20 A: Yes.

21 Q: Okay. You're also the only Level IV epilepsy
22 center in South Carolina, correct?

23 A: Yes.

24 Q: And that's the highest designation you can have
25 for treating epilepsy, correct?

1 A: Yes.

2 Q: Again, that's a disorder that you draw from all
3 throughout South Carolina and beyond, correct?

4 A: Yes.

5 Q: You've got the only gamma knife in the region,
6 is that correct?

7 A: In the -- in the low country, tri-county, yes.

8 Q: Correct. You probably have one of the largest
9 aneurysm programs in the United States, don't
10 you?

11 A: I don't know.

12 Q: Don't know about that? I'm just -- I'm going
13 off your website.

14 A: Well, I mean, you know, I don't know -- I don't
15 know all the details, you know.

16 Q: Okay. You would agree with me that you have a
17 comprehensive aneurysm program?

18 A: We do.

19 Q: Okay. Again, that's not something I would find
20 in a community hospital, for example?

21 A: Not -- no, not all community hospitals. But,
22 occasionally, you do find in some community
23 hospitals that if you get a bunch specialists
24 to come together, then something unique like
25 that could happen, yeah.

1 Q: But, as a general rule, you've got the best
2 aneurysm program in South Carolina?

3 A: I'll take your word for that, yes.

4 Q: Okay. You have the only neuro ICU that's
5 staffed by a neuro intensivist, correct, in
6 South Carolina?

7 A: Yes.

8 Q: You also have a comprehensive MS clinic, do you
9 not?

10 A: We do.

11 Q: Okay. You have the state's largest academic
12 based cancer research program, correct?

13 A: Yes.

14 Q: You also have the state's only National Cancer
15 Institute designated cancer center, correct?

16 A: Yes.

17 Q: Okay. You're the only center in South Carolina
18 offering all four types of prostatectomies,
19 correct?

20 A: That I don't know the answer to.

21 Q: Okay. You've also got the Jenny Sullivan
22 Sanford Melanoma and Skin Cancer Program,
23 correct?

24 A: Yes.

25 Q: And that's the only program in South Carolina

1 dedicated to melanoma care, correct?

2 A: Once again, I'll take your word for it. I
3 don't know specifically.

4 Q: So we've got -- you would agree with me that
5 you've got really the most comprehensive cancer
6 center in the state, correct?

7 A: Yes.

8 Q: You've got the most comprehensive neuroscience
9 program in the state, correct?

10 A: Yes.

11 Q: Okay. And we haven't even gotten into the
12 heart and vascular care, which is also one of
13 your preeminent programs, correct?

14 A: Yes.

15 Q: Okay. You treat more heart patients than any
16 other facility in the State of South Carolina,
17 isn't that correct?

18 A: You know, that I don't know the answer to.

19 Q: Okay. You're the only transplant program that
20 we have in South Carolina, correct?

21 A: Yes.

22 Q: Do you do heart transplants?

23 A: We do.

24 Q: Do you do pancreatic transplants?

25 A: We do.

1 Q: You do kidney and pancreas transplants?

2 A: Yes.

3 Q: You do kidney transplants?

4 A: Yes.

5 Q: Do you do small bowel transplants?

6 A: I think we have done a small bowel. It's not
7 something we do regularly.

8 Q: And you do liver transplants?

9 A: We do live transplants, yes.

10 Q: You also have the state's -- as far as cardiac
11 care is concerned, the only arrhythmia
12 treatment center in South Carolina is on your
13 campus, correct?

14 A: You know, once again, that one I'm not sure
15 about.

16 Q: Okay. You also have a number of devices
17 available through your partnerships with
18 vendors that aren't available at other sites in
19 South Carolina, is that a fair statement?

20 A: Maybe.

21 Q: Okay.

22 A: Maybe.

23 Q: For instance, you're the only medical center to
24 offer the watchman device for arrhythmia in
25 South Carolina?

1 **A:** Yeah, I don't know the details on that.

2 **Q:** Okay. How about the lariat device?

3 **A:** Don't know the details.

4 **Q:** Do you know anything about that?

5 **A:** No.

6 **Q:** Okay. Your cardiologists are the only ones in
7 South Carolina with expertise to perform
8 epicardial ablations, isn't that correct?

9 **A:** I don't know.

10 **Q:** Don't know. Okay. You offer more treatment
11 options for heart valve disease than any other
12 center in the state, isn't that correct?

13 **A:** Yes, I think that one's correct.

14 **Q:** Okay. I think you've touched on some of our
15 specialties regarding the children's hospital
16 and children's health, but you would agree that
17 MUSC has the most comprehensive children's
18 hospital in the State of South Carolina,
19 correct?

20 **A:** Yes.

21 **Q:** Okay. I'm not gonna go through everything that
22 I've got on here, but you would agree with me
23 that if we look at musculoskeletal and ortho,
24 you have subspecialists there that are not
25 elsewhere in South Carolina, fair statement?

1 A: Yes.

2 Q: Okay. And you do a really good job, don't you?

3 A: I think we do fairly well, yes.

4 Q: Press Ganey is a national ratings company that
5 rates patient satisfaction for hospitals,
6 correct?

7 A: Yes.

8 Q: You participate in Press Ganey, do you not?

9 A: Yes.

10 Q: You have very good Press Ganey scores, don't
11 you?

12 A: Yes.

13 Q: Which means that your patients like you, don't
14 they?

15 A: Yes, in general, yes.

16 Q: And you do a good job for those patients,
17 correct?

18 A: I think so.

19 Q: US News and World Report says you are the
20 number one hospital in South Carolina, is that
21 correct?

22 A: That is correct.

23 Q: Okay. Let's shift gears a little bit and talk
24 a little bit about -- I'm not gonna pull the
25 org chart out again, but suffice it to say if

1 we look at -- and I'm gonna pull the statute
2 real quick, it is basically -- it's South
3 Carolina Code 59-121-10, et. seq., it creates
4 basically two co-equal bodies; there's MUHA as
5 a state of authority and the University, is
6 that a fair statement?

7 A: Yes.

8 Q: Okay. And while they each have separate
9 boards, the membership of those boards is the
10 same, correct?

11 A: Correct.

12 Q: Okay. And the powers of each of those
13 entities, in other words, the powers of the
14 University Board and the separate powers of the
15 MUHA Board, are enumerated in the statute that
16 I just referred to, correct?

17 A: I believe that's correct.

18 Q: Okay. Let's start walking through just a
19 couple of exhibits. I did not get to take your
20 deposition, so if I have some questions that
21 are open-ended, it's because I don't know the
22 answer. But let's start with Trident Number
23 73, please, if we could pull that up.

24 (TMC Exhibit Number 73 was introduced into the record
25 at this time.)

1 Q: This is a PowerPoint that you commented on in
2 your deposition as the Nexton land purchase and
3 consolidated service center financing plan, are
4 you familiar with that?

5 A: In general, yes.

6 Q: Okay. If you would, turn over to -- let me
7 make sure we're on the same thing. Let's start
8 with page 05, if we look at the top of these
9 pages, it's 005. If we could just blow that up
10 a little bit. This is basically MUSC's impact
11 in the community. Would you agree with that?

12 A: Yes.

13 Q: Okay. So 27,000-plus employees, is that
14 correct?

15 A: No, that's not our employees. That's the
16 impact, economic impact.

17 Q: Impact to the community?

18 A: Correct.

19 Q: As a result of your presence there?

20 A: Correct.

21 Q: Okay. And then in total labor market, it's 1.8
22 billion dollars of impact?

23 A: Correct.

24 Q: Okay. The total economic impact is nearly 4
25 billion dollars a year, is that a fair

1 statement?

2 A: Correct.

3 Q: Okay. If we could, turn over to the next page,
4 page 6, just go over one. I'm not really sure
5 why it's in the financing piece, but imagine
6 2020 is kind of a strategic business plan for
7 your organization, is that a fair statement?

8 A: Yes.

9 Q: Okay. And if we go to the next page, please.
10 That just outlines the areas that you're
11 focusing on in your Imagine 2020 strategic
12 goals, correct?

13 A: Correct.

14 Q: Okay. Is this a plan that you're committed to?

15 A: Yes.

16 Q: Okay. And is it a plan that is currently
17 ongoing?

18 A: Yes.

19 Q: Okay. All right. Let's take a look at -- go
20 to page 12 in that, please, same Exhibit, 73.
21 Now, the original date of this was July 10 of
22 2018, so this is before the CHS acquisition,
23 correct?

24 A: Yes.

25 Q: Okay. But even before the CHS acquisition, you

1 had a lot of good outreach stuff going on in
2 South Carolina, did you not?

3 A: Yes.

4 Q: Okay. And this details the presence and the
5 type of presence you might have be it primary
6 care, specialty care, affiliations, that's all
7 captured on this slide, correct?

8 A: Yes, at that time, yes.

9 Q: Okay. Is it fair to say that that's part of
10 your networking that you draw from that for
11 admissions and treatments at your hospital?

12 A: Yeah, some of that. Some of that's also
13 research partners who may not say clinical, but
14 that's a combo of clinical and research.

15 Q: Okay. Let's go over to page 21 if we could.
16 We're still in the same presentation, but then
17 it begins with a discussion of the consolidated
18 service center. Could you explain to the Court
19 what the consolidated service center is?

20 A: The CSC or what we call -- use the acronym is
21 a building that we built up in -- up in an area
22 just north of the Charleston airport up in --
23 up in North Charleston that is meant to be a
24 place in which we consolidate all our supplies,
25 do all our sterile processing, and then deliver

1 out to our various inpatient and ambulatory
2 areas.

3 Q: Okay. So part of this presentation was
4 discussing about how to do an RFP to get
5 financing for that project, is that a fair
6 statement?

7 A: Yes.

8 MS. JONES: Your Honor, I do have an objection to
9 that because this is a draft and it's clearly
10 marked draft and there has been no testimony
11 about this being included in a presentation.

12 MR. SUMMER: I'll rephrase the question and simply
13 ask what it refers to.

14 Q: How much was this gonna cost you to finance
15 this?

16 A: Almost 30 million, 28, 29 million.

17 Q: Okay. Let's go over to page 28 of the
18 presentation, please. If we could, there's a
19 bullet point down there that refers to no
20 revenue pledge from MUHA available. Do you see
21 that in the middle of the page right there?

22 A: Yes.

23 Q: That's a result of the covenant that you have
24 regarding your HUD financing, correct?

25 A: Yes, I assume so.

1 Q: Okay. Because the way HUD financing works is
2 once you're in that facility, you have to get
3 permission from HUD to do anything that would
4 encumber your revenue strain, correct?

5 A: That is correct.

6 Q: So basically you've got to get their permission
7 to finance anything off of your revenue, fair
8 statement?

9 A: Correct.

10 Q: Okay. So when you were going out to get
11 financing for Nexton and for this consolidated
12 service center, you could only basically
13 utilize the value of the real estate as
14 collateral, correct?

15 A: Correct.

16 Q: Okay. Go over to page 30, please, of this
17 presentation. So when you went out to market,
18 these are the lenders that declined to lend to
19 you for this \$30 million project, correct?

20 A: Yes, I assume so, yes.

21 Q: So Bank of America would not finance this
22 project, would they?

23 A: It appears not.

24 Q: Okay. Neither would BB&T?

25 A: Correct.

1 Q: Neither would JP Morgan?

2 A: Correct.

3 Q: Not even South State Bank?

4 A: Correct.

5 MR. SUMMER: Jump over to -- jump over to Exhibit

6 48, Trident Exhibit 48.

7 (TMC Exhibit Number 48 was introduced into the record

8 at this time.)

9 Q: Do you recognize this presentation?

10 A: I think this was the presentation presented
11 earlier.

12 Q: It says MUSC Health Community Hospital
13 September 19, 2018. Let's look -- and this is
14 regarding the community hospital in Nexton,
15 Berkeley County Community Hospital, correct?

16 A: Yes.

17 Q: Okay. Look over on -- go on to page 3 for me,
18 please. Actually, let's start on page 4.
19 Start on page 4 of this document. I just want
20 to confirm ---

21 MR. SUMMER: Can you blow that up just a little bit
22 there?

23 Q: All right. That star is the Nexton land where
24 you anticipate putting the hospital if you're
25 ultimately approved, correct?

1 **A:** Yes.

2 **Q:** And you can see all the development below it,
3 but where it's projected for right now, there
4 is no development at that site as we sit here
5 today, right?

6 **A:** Not on that site, no.

7 **Q:** Okay. Then let's take a look then at page 3 of
8 this presentation. There we go. You were at
9 some point in time, I guess this was September
10 of 2018, a little more than a year ago,
11 thinking about changing the site, were you not?
12 You were looking at alternate sites?

13 **A:** Well, our Board of Trustees asked us to do an
14 assessment of alternative land and so this is
15 something we put together for that.

16 **Q:** All right. Will we be able to capture patients
17 as effectively not being on the highway, so you
18 were looking at comparing property that was on
19 I-26 as opposed to the map that we just looked
20 at, correct?

21 **A:** Yes.

22 **Q:** Okay. So the notion of capturing patients,
23 you're obviously trying to place this facility
24 where you have the ability to attract more
25 market share as opposed to where you're looking

1 at on page 4, is that what you're wanting?

2 Where you can get the most market share?

3 A: Well, what we mean by capture patients is
4 capture the patients that want to come see us.

5 Q: Okay. And the second piece of that, the bullet
6 right below it, 15 minute drive time from the
7 current site will draw a higher patient capture
8 rate in 20 minutes from the alternative site,
9 correct?

10 A: Well, I don't know that that -- that actually
11 got some discussion at our Board of Trustees
12 and I'm not sure everybody believes that
13 statement, so.

14 Q: So you're saying you're not sure you agree with
15 it?

16 A: Well, I mean, this was a presentation that was
17 put together by our strategic planning
18 department and given to our Board for decision
19 and, you know, typically, some things are fully
20 accepted and some things are debated.

21 Q: Turn with me, if you will, over to -- I think
22 that's all we need to do with that one. Let's
23 take a look at -- look at TMC 50, Trident 50.
24 This is a PowerPoint regarding Berkeley County
25 land evaluation. Let's take a look first at

1 **page 7.**

2 MR. SUMMER: Will you blow that up, please?

3 **Q:** It's my understanding you're still
4 contemplating whether or not to move the site.
5 The first bullet point is DHEC staff will look
6 unfavorable, it's just the way it's written, to
7 changes made to any CON project at this time.
8 Therefore, a site relocation could jeopardize
9 the entire project. Do you see that?

10 **A:** Yes.

11 **Q:** And then the Dustoff LLC, that's another site,
12 correct?

13 **A:** That's the site next to I-26 ---

14 **Q:** Okay.

15 **A:** --- on that previous map that you showed.

16 **Q:** It's permitted for light industrial use by the
17 Army Corps of Engineers and so re-designation
18 would be required. So is it your understanding
19 that you ended up sitting pat with the site
20 that you had your CON application?

21 **A:** Our Board asked for some details and a
22 presentation. We presented it and no action
23 was taken.

24 **Q:** Okay. So this was actually presented to your
25 Board for its consideration?

1 **A:** **Yes, at the Board's request.**

2 **MR. SUMMER:** Okay. While we're still in this one,
3 let's take a look over at page 13, please, of
4 this presentation. If you could just blow up
5 the text is what I'm most interested in.

6 **Q:** **So, again, this is a Board presentation. It**
7 **says currently there are more than 465,000**
8 **residents who live within the 30-minute drive**
9 **time of the proposed MUHA location in Nexton.**
10 **Is that correct?**

11 **A:** **Yes, I assume so.**

12 **Q:** **And so one of the things you're evaluating is**
13 **30-minute drive time to your new facility,**
14 **correct?**

15 **A:** **Well, I don't know if we're evaluating or we're**
16 **just -- it's part of a presentation that our**
17 **Board asked about. You know, our Board comes**
18 **from around the entire state. There's only a**
19 **couple members that are from the low country.**
20 **So we tend to give them more information about**
21 **the tri-county and the area and things like**
22 **that.**

23 **Q:** **Okay. Do you agree with me it's kind of like**
24 **the Field of Dreams, you build it and they will**
25 **come, fair statement?**

1 **A:** I'm not sure I would agree with that. I think
2 you have to -- when you build something, you
3 have to do it high quality; you have to follow
4 through. You know, the reason I'm just not
5 immediately agreeing with that is because
6 sometimes our physicians think just build it
7 and people are gonna come. That is not always
8 the case.

9 **Q:** If you were to spend \$325 million, you hope
10 they're gonna come, don't you?

11 **A:** Well, I mean, we'll work it and make sure that
12 everything's appropriate to make sure that it's
13 a successful project, but just building it
14 doesn't necessarily mean they're just gonna
15 show up. And if we think that, it's not gonna
16 be successful.

17 **Q:** You would agree with me that your catchment
18 area is probably about a 30 minute drive time
19 from your new facility, correct statement?

20 **A:** You know, our catchment area is about half the
21 tri-county and half outside the tri-county. I
22 do think this area up in North Charleston where
23 increasing more and more people are living is
24 a better location for patients that want to be
25 able to come to us.

1 **Q:** Let's take a look -- so at the beginning, this
2 was all presented to your Board. If you could,
3 let's start over -- go over to page 18 of this
4 document, so, in addition to noting the 465,000
5 residents within a 30-minute drive time of your
6 new facility, the last line -- blow up the last
7 line here and just highlight that and expand
8 that very last line. The location protects
9 MUSC as provider of closest proximity for
10 Nexton and Cane Bay, correct?

11 **A:** That's what that says, yes.

12 **Q:** Yeah. Go over to 19 and let's take a look at
13 19. Again, presenting this to your Board,
14 evaluate whether or not to move it ---

15 MR. SUMMER: Let's try to blow that up as much as
16 we can, please.

17 **Q:** So you're telling your Board studies have shown
18 that distance appears to be one of the main
19 influences on a patient's choice of hospital
20 rather than statistics available on the
21 internet. Is that what that says?

22 **A:** That's what that says, yes.

23 **Q:** That's a shame because y'all got really good on
24 that site. Look at the next one. Patients
25 admit they are more likely to choose a hospital

1 **based on convenient location and amount of co-**
2 **pay than on quality outcome data, that's what**
3 **you told your Board, correct?**

4 **A: Yeah, that is correct.**

5 MR. SUMMER: Your Honor, I move to admit Trident
6 Exhibit 50, please.

7 MS. JONES: No objection.

8 MS. CRUM: I think it's already admitted.

9 MS. JONES: I think it is too. I think that's with
10 the other -- I think that Roper put it in, as
11 well, so it's just a duplicate.

12 MR. SUMMER: Good deal. Just want to make sure.
13 Thank you very much.

14 THE COURT: Well, do you want it admitted or not?

15 MR. SUMMER: I will accept my co-counsel's
16 representation.

17 THE COURT: Okay. It's admitted.

18 **Q: Let's look at -- next, let's go to Trident**
19 **Number 71, please. This is a report to the**
20 **MUSC Board of Trustees proposed purchase of CHS**
21 **Health System, correct?**

22 **A: Yes, appears so.**

23 **Q: So this would have been a presentation that you**
24 **gave to your Board about whether or not to buy**
25 **the CHS hospitals?**

1 **A:** **Could be. I just -- I don't know the exact**
2 **document here.**

3 **Q:** **Okay.**

4 **A:** **So I'll hold that until I see the rest of it.**

5 **Q:** **All right. Well, we'll start flipping through**
6 **it. Let's talk a little bit about CHS and how**
7 **that came to be.**

8 **MS. JONES:** **Dr. Cawley, their exhibits are in those**
9 **notebooks right there if you want to see the**
10 **whole exhibit.**

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

12 **MS. JONES:** **I think they're green.**

13 **MR. SUMMER:** **They are green and I'm gonna grab it**
14 **for him right now.**

15 **MS. JONES:** **That might be easier.**

16 **MR. SUMMER:** **That would be great.**

17 **Q:** **That's 71, so if you can find TMC 71, that's**
18 **where you'll find it. Tab 71. And if you want**
19 **to take a minute and take a look at it, make**
20 **sure you recognize the document.**

21 **A:** **Yeah, this appears to be a report, some of --**
22 **I would say we didn't present all this to our**
23 **Board, but gave it to them to review in detail.**
24 **And then when we actually present it to the**
25 **Board, parts of it were presented. This was**

1 more of a report rather than a presentation
2 that was made. But it was given to the Board
3 as a report.

4 Q: Okay. So the entire document was given as a
5 report to the Board?

6 A: Correct.

7 Q: Okay. Let's talk a little bit about timing
8 because the application for the Nexton
9 Community Hospital was filed in December of
10 2017, is that your recollection?

11 A: That is correct.

12 Q: And this opportunity to purchase the CHS
13 hospitals didn't materialize until later in
14 2018, correct?

15 A: Correct.

16 Q: And you didn't close on those properties until
17 the first quarter of this year, correct?

18 A: Correct.

19 Q: All right. So it's fair to say that when you
20 submitted your Certificate of Need application
21 for the Nexton hospital, you didn't know you
22 were gonna be buying four new hospitals in the
23 Upstate, did you?

24 A: Correct.

25 Q: Okay. Let's take a look at page 8 of this

1 document, go over to page 8. Called financial
2 overview. If we could blow that up, please.

3 THE COURT: You said four new hospitals in the
4 Upstate?

5 MS. JONES: It's two in Florence ...

6 MR. SUMMER: Well, two in the Pee Dee, Your Honor.
7 Two in the Pee Dee.

8 THE COURT: Florence ain't the Upstate, Greg.

9 MR. SUMMER: It depends; if you live in Charleston,
10 that's the Upstate. But I understand, Your
11 Honor.

12 Q: So two in the Pee Dee and then two in the
13 Upstate, fair statement?

14 A: Yeah. If you consider Charlotte the Upstate,
15 yes.

16 Q: So the financial overview, there's some
17 interesting things here. The MUSC, that second
18 line, MUSC conversion and not for profit
19 creates addition over the first year of nine
20 million instant dollars, right?

21 A: Yes.

22 Q: And that's because you don't pay taxes, so that
23 money's gonna drop directly to the bottom line,
24 correct?

25 A: You know, for the details on that, you'd have

1 to talk with Lisa Goodlett. Some of that is
2 not paying taxes; some of it's at -- there are
3 other dollars that not for profits are -- have
4 available to them that for profits do not. So
5 I think some of it's taxes, but not all of it.

6 Q: It's a 9 million dollar pick-up, anyway you
7 look at it, correct?

8 A: It is a 9 million dollar pick-up, but it's not
9 all taxes is, I think, the point I would make.

10 Q: All right. And then you've got on here the
11 second lien under the MUSC enhanced operational
12 performance second and third year, you believe
13 you got a 5.6 million dollar pick-up if you can
14 get it into your system, is that right?

15 A: That is correct.

16 Q: Okay. And some of those things are things like
17 governmental reimbursement. As a teaching
18 hospital, you get a little bit more because
19 you're an educational facility, right?

20 A: I mean, that's based on -- that's one thing,
21 but there are other things like, for instance,
22 all of these hospitals are on different
23 electronic health records. Even within their
24 system, they run one inpatient and a different
25 outpatient, so that leads to optimizing

1 operational performance, etcetera. So there
2 were a series of things that we felt that we
3 could do and apply to these hospitals that
4 would actually make them bring additional
5 profit.

6 Q: Okay. Look at the potential market share
7 impact and it says marquis services captured
8 for MUHA 7 million dollars and if I go down and
9 look at -- it's got an asterisk under it, if I
10 look at what it says in the notes, based on 50
11 percent of market opportunity not currently
12 captured and conservative. So are you looking
13 to basically get a greater market share because
14 of your marquis name of MUSC?

15 A: No, those are -- marquis services are those
16 complex services that only we typically can
17 provide. And what we determined was that many
18 of those services were going up into North
19 Carolina, to different systems up there, and we
20 felt that if we can develop the relationships
21 with the physicians, that they would begin to
22 send some of those to Charleston.

23 Q: So when we were earlier you and I going over
24 those tertiary/quaternary services that you
25 provide that are unique, you're saying that you

1 believe you can capture some of that by these
2 new acquisitions?

3 A: Correct. Some would come to Charleston and
4 some would stay in the market.

5 Q: Okay. Look over on page 10 of this exhibit.
6 Again this is CHS report to the Board. Let's
7 go to number three, if we could blow it up.
8 This is benefits of acquisition. Look at
9 number three, leverage. Size and location
10 matter to insurers. Helps maintain favorable
11 reimbursement rates for MUSCP, that's the old
12 UMA, right?

13 A: That's the physician practice plan.

14 Q: Those are your physician practices, what used
15 to be called M -- UMA, and for the Authority.
16 So talk to me about is this just simply the
17 more insured lives you've got, the better
18 reimbursement rates you can demand for -- from
19 insurers?

20 A: Well, increasingly, insurers want to work with
21 one organization. If you can bring to them
22 patients in multiple areas and have a certain
23 size, they are more likely to work with you
24 than not work with you.

25 Q: But you can get higher rates of reimbursement

1 with the more lives you have in your system,
2 fair statement?

3 A: That is correct.

4 Q: Okay. Jump over to page 16 for me, if you
5 don't mind. Let's look at that second bullet
6 point that begins with acquisitions, let's blow
7 that one up. Potential benefits to MUSC and it
8 says that acquisition of the four CHS hospitals
9 allows MUSC to expand beyond the Charleston
10 market. MUSC has existing affiliation,
11 clinical and otherwise ---

12 MR. SUMMER: And highlight -- just highlight --
13 it's very distracting. You're done. Stop.
14 Okay.

15 Q: Has plans to build new hospitals and has just
16 completed the Beaufort transaction. However,
17 this proposed acquisition moves MUSC's steer of
18 direct influence well beyond the Charleston
19 market area for the first time. That expansion
20 of MUSC service footprint into the community
21 served by the CHS hospitals presents a unique
22 opportunity to add new services to those
23 communities and to submit referral patterns for
24 tertiary/quaternary services at MUSC, correct?

25 A: That's what that says, yes.

1 Q: And it's actually working because you've now
2 shifted migration to some extent from Lancaster
3 into Charlotte and shifted it from Lancaster
4 down to Charleston, correct?

5 A: Yes, for some services, yes.

6 Q: Okay. Let's go over to 16 -- let's go to 18.
7 This is just the executive summary for Project
8 Game. I assume that Project Game was your code
9 name for the CHS acquisitions, correct?

10 A: Yes.

11 THE COURT: I'm sorry, what was that last page we
12 were on?

13 MR. SUMMER: We were on page 16.

14 THE COURT: Okay.

15 MR. SUMMER: Trident Exhibit 16 of 71.

16 Q: Why the name Project Game?

17 A: I really don't recall. It sort of caught on
18 and we kept it.

19 Q: Okay. Let's look first at the very first
20 bullet point. It says page two, blow that one
21 up for me, please. Summary of baseline
22 assumptions. That is that MUHA has identified
23 approximately \$16 million in improvements to
24 Project Game baseline operations. \$9 million of
25 which is estimated due to MUHA's non-profit

1 governmental status, property taxes,
2 malpractice insurance cap. MUHA also has
3 opportunity due to debt set-off program for bad
4 debts. Do you want to explain to the Court
5 what that is?

6 A: You know, I don't know the details of the
7 program, but allows not-for-profit institutions
8 to apply bad debts for patients to have them
9 paid back.

10 Q: It's actually limited to governmental entities,
11 is it not?

12 A: Correct. That is correct.

13 Q: Okay. And what it allows you to do is to file
14 with the South Carolina Department of Revenue
15 each December a list of those people who owe
16 you money and are state residents, correct?

17 A: I don't know the details of the program.

18 Q: And then to the extent that any of them ---

19 MS. JONES: Objection, Your Honor, he just stated
20 he doesn't know the details of the program.

21 MR. SUMMER: And I accepted that answer. Now, I'm
22 moving to another premise.

23 THE COURT: Okay.

24 Q: And to the extent that any of those individuals
25 have a tax refund coming, it is garnished by

1 the South Carolina Department of Revenue and
2 paid to you, correct?

3 **A:** You know, I don't know the details of the
4 program. I think Lisa Goodlett would be the
5 best person to talk to about that.

6 **Q:** Okay. But that's not something that's
7 available to private hospitals; it's only
8 available to governmental hospitals, fair
9 statement?

10 **A:** That is my understanding.

11 **Q:** Okay. Take a look under the third bullet point
12 where it says marquis market opportunities, do
13 you see that?

14 MR. SUMMER: Will you blow that one up? Come on
15 down. There you go. Marquis, right there.
16 Let's blow that one up, please, so we can read
17 it. Lost it in cyberspace.

18 **Q:** Okay. Marquis market opportunity is 1053 cases
19 as of 2017 at an estimated contribution margin
20 of 7 million of MUHA Charleston is able to
21 capture 50 percent of the identified cases.
22 These are new cases that you're seeking to
23 capture for those tertiary and quaternary
24 referrals, correct?

25 **A:** That is correct.

1 Q: Okay. And that would be new cases to you and,
2 therefore, new revenue to your system, correct?

3 A: Yes.

4 Q: Okay. And so based upon that report to your
5 Board, I assume they authorized you to move
6 forward and purchase those CHS facilities?

7 A: They did.

8 Q: Let's go over to Trident Exhibit 68, please.
9 (TMC Exhibit Number 68 was introduced into the record
10 at this time.)

11 Q: As a practical matter, you were able to
12 purchase those facilities, but in order to keep
13 the purchase price low, you did not purchase
14 their accounts receivable, did you?

15 A: I don't know if that was the reason, but we
16 felt we didn't want their accounts receivable,
17 that we would borrow the money for work capital
18 and proceed from there.

19 Q: Okay. So in order to run what you just bought,
20 you had to do what we refer to as a revenue
21 anticipation note, correct?

22 A: Correct.

23 Q: And you had to go to the State to get
24 permission to do this, did you not?

25 A: Correct.

1 Q: Okay. And the State then authorized you to do
2 a revenue anticipation note, based upon the
3 State's guarantee Wells Fargo did loan you this
4 money, correct?

5 A: Correct.

6 Q: Okay. Do you know what the status of your
7 payback is on those notes?

8 A: I think we paid over half of it back at this
9 point.

10 Q: Okay.

11 A: But I think you need to ask Lisa Goodlett for
12 the details.

13 Q: But, as a practical matter, you did not have
14 cash on hand, you had to go and borrow the
15 money to operate these facilities, correct?

16 A: No, we had cash on hand, but I think you always
17 -- you always weigh these things out, depends
18 on timing and what the interest rate will be
19 and how to do it. And we felt that the RAN was
20 the best way to finance this.

21 Q: All right.

22 MR. SUMMER: I don't believe Number 68 is in, so
23 I'll go ahead and move that into evidence, Your
24 Honor, Trident 68.

25 MS. JONES: No objection.

1 MR. WICEVIC: No objection.

2 MS. HOLLINGSWORTH: No objection, Your Honor.

3 THE COURT: It's admitted.

4 (TMC Exhibit Number 68 was admitted into evidence.)

5 Q: Let's go over to Trident 63, please. This is

6 a document produced during discovery.

7 (TMC Exhibit Number 63 was introduced into the record
8 at this time.)

9 MR. SUMMER: If you could blow that up.

10 Q: MUSC Health major projects list, have you ever
11 seen this before?

12 A: I have not seen this particular document, no.

13 Q: Okay.

14 A: Not that I recall.

15 Q: All right. Well, let's talk about what some of
16 these major projects are and what debt is
17 associated with them because it's a lot. Are
18 you familiar with the power plant project?

19 A: Yes.

20 Q: Okay. And that is 36 million and still
21 outstanding indebtedness on the power plant
22 project?

23 A: You know, I haven't seen this before and I
24 don't know the numbers exactly, so I'm not sure
25 -- I'm not sure what that means. Whether that

1 means 36 still remaining.

2 Q: Okay. It was produced to us as a list of debt
3 on major projects. It's dated June 30 of 2019.
4 Do you have any reason to doubt that these
5 numbers are accurate?

6 A: No, I just haven't seen the document before and
7 I don't know those numbers off the top of my
8 head. I don't look at the -- the total debt
9 numbers on a regular basis.

10 Q: Well, let's look at, and just by way of
11 example, ART would be the Ashley River Tower,
12 right?

13 A: Yes.

14 Q: Okay. And here it's reflecting that it's got
15 over \$269 million of debt on it, correct?

16 A: You know, once again, I'm assuming that's what
17 it is. I don't know ---

18 MS. JONES: And I'm gonna object, Your Honor. He
19 said multiple times he's not familiar with this
20 document and trying to cross-examine him on it
21 is improper, so I object ---

22 THE COURT: It's not been probative ---

23 MS. JONES: --- and move to strike it.

24 THE COURT: I don't know how probative it is to
25 cross somebody on something they don't

1 recognize.

2 MR. SUMMER: All right.

3 Q: Well, let's do it this way. Let's just talk
4 about how much some of the stuff cost because
5 that you should know. What do you think your
6 all-in cost is gonna be for the children's
7 hospital, Shawn Jenkins?

8 A: About 390 million.

9 Q: 390, okay. What do you think your all-in costs
10 are for the Consolidated Service Center?

11 A: About 28 million.

12 Q: 28 million even though it says 38 here, you
13 think it's 28, okay. All right. And the CHS
14 acquisition that you just did was about 137 is
15 what I remember. Do you remember that number?

16 A: It was about -- about 130, 135, yes.

17 Q: 135 million. Okay. And you've got other
18 projects which would include some of these
19 internal things here, but you've got a 52-bed
20 project. How much do you think that project
21 is? Of course, we can pull the CON, but what's
22 your recollection?

23 A: You know, that number's probably not far off.

24 Q: Okay. You're building multiple -- or
25 attempting to build multiple freestanding EDs.

1 You want to build one in Summerville, correct?

2 A: Correct.

3 Q: And you also want to build one -- it's really
4 out by Seabrook Island, isn't it, at the
5 Bohicket Marina?

6 A: That is correct.

7 Q: Okay. So you've got two freestanding EDs going
8 on. Okay. The radiation project, what is
9 that?

10 A: I'm assuming that's our radiation treatment
11 center that we're trying to do. I think it's
12 held up by CON right now.

13 Q: Okay. So that would have been Linak is that
14 what you're thinking that is, the Berkeley
15 County Linak case?

16 A: Potentially, yes.

17 Q: Okay. What's the Level IV project, I don't
18 know that one?

19 A: I don't know what that is.

20 Q: Okay. Other entity funded down here, what's
21 CAC?

22 A: That's probably the Children's Ambulatory
23 Center, I'm assuming.

24 Q: That's your freestanding ASC for children,
25 right?

1 **A:** Correct.

2 **Q:** And that's ---

3 **A:** And other things, yes.

4 **Q:** North area. Let's talk a little bit the
5 difference between freestanding and free
6 leaning, do you understand those concepts?

7 **A:** Yes.

8 **Q:** Okay. The way I understand it is, and you've
9 not gone through this in prior testimony, Shawn
10 Jenkins is not a freestanding facility, it's a
11 free leaning facility, is that a fair
12 statement?

13 **A:** That is correct.

14 **Q:** Okay. So it's its own separate building, but
15 it's within the infrastructure, you know,
16 you've got your own physical plan; you've got
17 all the other logistics on your downtown campus
18 that support Shawn Jenkins, which makes it free
19 leaning as opposed to freestanding, fair
20 statement?

21 **A:** Correct.

22 **Q:** And a freestanding -- a good example of
23 freestanding would be the Nexton Community
24 Hospital?

25 **A:** That is correct.

1 **Q:** That would be a freestanding facility because
2 it's not part of your campus infrastructure
3 downtown and doesn't lean on the resources of
4 that, correct?

5 **A:** Correct.

6 **Q:** And so the ambulatory surgery center's a
7 freestanding ambulatory surgery center and what
8 imaging center is that for 40 million bucks?

9 **A:** I'm not sure what that means by imaging center.

10 **Q:** Me neither.

11 MS. JONES: Your Honor, I'm gonna renew my
12 objection about his continuing questions about
13 a document that he clearly is not familiar with
14 and he's asking the witness to speculate and
15 guess and I move to strike all of it.

16 THE COURT: Well, I'm not gonna strike all of it,
17 but as far as that question.

18 MS. JONES: Yeah, move to strike that question.

19 MR. SUMMER: Well, I think I'm entitled to ask him
20 if he knows what the imaging center is. He's
21 answered he doesn't know, so I don't know that
22 we need to move any further.

23 MS. JONES: Your Honor ---

24 THE COURT: You're asking him about a document that
25 he says he's not familiar with.

1 MS. JONES: That's what I object to.

2 THE COURT: I mean, an imaging center that he
3 doesn't know what it's talking about, so.

4 MR. SUMMER: All right. So I'll withdraw that one.

5 THE COURT: If there was an imaging center that you
6 could identify, then it would be a proper
7 question.

8 MR. SUMMER: I was hoping that since it's 40
9 million dollars and he's the CEO, he could
10 identify it.

11 THE COURT: Okay.

12 MR. SUMMER: If he can't, he can't.

13 OBJECTION:

14 MS. JONES: I object to that and move to strike
15 that because it's a mischaracterization of the
16 whole thing. I mean, it's one thing to ask a
17 witness about something that they've identified
18 that they're familiar with, but to pull a
19 document out and have a witness say, I'm not
20 familiar with that document. I don't know if
21 it's a draft; I don't know who prepared it; I
22 don't know where it came from ---

23 THE COURT: I sustain your objection.

24 MS. JONES: Thank you, Your Honor.

25 **Q: Let me ask you another question, is there a**

1 pediatric imaging center in North Charleston?

2 A: There is.

3 Q: Okay. All right. Then let's talk about some
4 other things ---

5 A: And just to be clear, that wouldn't match that.
6 Because we don't have a pediatric imaging
7 center that cost 40 million dollars, so there's
8 something wrong with that line.

9 Q: All right. Let's talk about the RAN, the RAN
10 was 120 million dollars, correct?

11 A: Yes.

12 Q: Then the other projects that you're committed
13 to in addition to Seabrook and what's been
14 announced would be 100 bed hospital in northern
15 Lancaster County, correct?

16 A: Well, I wouldn't say we're committed to it yet.
17 I mean, we have begun the CON application
18 process.

19 Q: You are seeking approval for that project, are
20 you not?

21 A: Yes. We're seeking a CON for that, yes.

22 Q: And then you're also seeking approval for a new
23 hospital in Williamsburg, correct?

24 A: Yes.

25 Q: And that's a 50 million dollars project, is it

1 not?

2 A: That amount hasn't been determined yet, but
3 it's probably not gonna be 50; it's probably
4 gonna be closer to 30 or 35.

5 Q: Okay. Are you partnering with anybody? Do you
6 have somebody who's gonna build to suit? What
7 are you doing there?

8 A: No, no, that hasn't been fully determined
9 exactly how we're gonna build it.

10 Q: Would you expect your per bed cost for the
11 Lancaster project to be similar to your per bed
12 cost for your Nexton project?

13 A: Roughly.

14 MR. SUMMER: I'm not gonna try to move Number 63
15 into evidence.

16 Q: Let's look over at -- we discussed the concept
17 between free leaning and freestanding. Let's
18 take a look at Trident Number 2 if we could put
19 that on the board. This is a map -- this is a
20 map of your campus according to Google and if
21 we look, we can see the Ashley River Tower
22 which it's got right there with the hospital on
23 it, do you see it?

24 (TMC Exhibit Number 2 was introduced into the record
25 at this time.)

1 **A:** **Yes.**

2 **Q:** **Okay. Directly ---**

3 **THE COURT:** You can actually go over to this
4 monitor -- you can go over to this monitor and
5 mark things.

6 **Q:** **Okay. So there's -- there's the Ashley River**
7 **Tower, that's what we call ART, correct?**

8 **A:** **Yes.**

9 **Q:** **And then directly below that is where Shawn**
10 **Jenkins is being constructed as we speak,**
11 **correct?**

12 **A:** **Correct.**

13 **Q:** **Do you expect that to be open in the coming**
14 **weeks?**

15 **A:** **Yes.**

16 **Q:** **Okay. Looking at the land -- if you look at**
17 **what's hashtagged in yellow around, those are**
18 **parcels that are either in MUSC or MUHA's or**
19 **the Foundation's name. You would agree that**
20 **those parcels are owned by one of your**
21 **affiliates?**

22 **A:** **Yes. I would say yes.**

23 **Q:** **Okay. So there are places like where the**
24 **Wellness Center is that you could build**
25 **downtown if you chose to do so, correct?**

1 **A:** If we -- if we chose so and that was a good --
2 good idea. So we've looked at these and
3 decided at this time that's not the best --
4 that's not the best place for the reasons
5 stated earlier.

6 **Q:** I've done a little bit of research on the
7 internet and you've actually got -- do you
8 remember talking in your prior testimony that
9 phase one was ART; phase two of your master
10 plan was Shawn Jenkins Children's Hospital,
11 correct?

12 **A:** Correct.

13 **Q:** And phase three is actually on the internet.
14 Are you aware of that?

15 **A:** Yes.

16 **Q:** Okay.

17 **A:** Yeah.

18 MR. SUMMER: And so let's go ahead and pull up --
19 old school doesn't work as well as it used to.
20 If we could pull up that demo -- is that Demo
21 7? And let's pull up Demo 7 and take a look at
22 that.

23 (Demonstrative Exhibit Number 7 was referenced at
24 this time.)

25 **Q:** This is the master facilities plan, is it not?

1 **A:** This was a facility plan that was put together
2 in the early 2000s.

3 **Q:** Okay. Well, I'm looking at -- is this from the
4 architect firm Ayers Saint Gross.

5 MR. SUMMER: Can we blow up that text, please?

6 **Q:** Hard copy might be easier for you to read.

7 MR. SUMMER: Can we blow that text up?

8 **Q:** Let's just look at what it says. And it says
9 Medical University of South Carolina, MUSC
10 facilities master plan is a culmination of many
11 ideas generated through a rigorous planning
12 process. This plan greatly expands on the
13 pedestrian focus, greenway improvements by
14 offering more green space and better connecting
15 the campus through improved streetscapes. The
16 master plan effort builds on MUSC's strategic
17 plan, Imagine 2020, which I think you
18 previously testified is in full force and
19 effect today. Through the construction of and
20 reinvestment in some building and the
21 divestment of others, MUSC can better integrate
22 its tri part type mission by creating physical
23 connections between buildings and modern
24 interdisciplinary innovative and collaborative
25 environments. The master plan also helps MUSC

1 improve patient experience and establish a
2 culture of health and wellness, correct?

3 A: Yes. That's out of our -- that is out of our
4 facilities plan drawn together, yeah.

5 Q: Okay. And so when I look at this ---

6 MR. SUMMER: If we can pull just this piece up,
7 please.

8 Q: But when I look at this, at the bottom it's
9 Shawn Jenkins that's getting ready to be
10 completed, correct?

11 A: Correct.

12 Q: And then that's ART in the middle?

13 A: Correct.

14 Q: And then here looks to be two twin bed towers,
15 probably got three or four hundred beds in
16 them, that would be a replacement of the main
17 hospital, correct?

18 A: Yes, once again ---

19 THE COURT: Could you draw a circle around that so
20 I'll ...

21 MR. SUMMER: The one that would be the phase three
22 is right here (indicating).

23 THE COURT: Who was doing the circle drawing?

24 MR. SUMMER: I was trying to get her to -- there we
25 go. That building right there.

1 THE COURT: I thought y'all were using the
2 annotations on the screen.

3 MR. SUMMER: There we go.

4 **Q: So that would be twin bed towers.**

5 MS. JONES: That's ART.

6 MR. SUMMER: No, actually ART is ---

7 MS. JONES: That's ART.

8 MR. SUMMER: Huh-uh. ART is right here
9 (indicating).

10 MR. THOMAS: ART, it's already built.

11 MS. JONES: Where is the river?

12 MR. SUMMER: ART is already built.

13 **Q: There's also great parking proposals here, as**
14 **well. The things that are in pink would be**
15 **parking decks, correct? So there are two**
16 **proposed parking decks on that property, right?**

17 **A: Yeah, once again -- so, as I said before, that**
18 **-- that line there which has Shawn Jenkins,**
19 **ART, and future hospitals was part of the**
20 **hospital replacement project that was put**
21 **together in the early 2000s. The update of the**
22 **facility master plan, which was updated around**
23 **that time -- I'm sorry, just a few years ago,**
24 **took all the different pieces and parts that**
25 **have been proposed across campus and put them**

1 all in one document. But that is still an old
2 plan and it didn't re-look at the plan; it
3 didn't reassess whether the hospital
4 replacement project is appropriate or not. It
5 just pulled all the different pieces and parts
6 across the campus that there have been thoughts
7 about replacing or doing something different
8 with in the future.

9 Q: This master ---

10 A: So the planning for that phase three has never
11 -- has never started.

12 Q: It says right here this master plan effort
13 builds on MUSC's strategic plan Imagine 2020.

14 A: Once again ---

15 MS. JONES: Is there a question, Your Honor? I
16 object to the statement.

17 A: Once again, that master plan was ---

18 THE COURT: Hold one second. Was it a question.

19 Q: So you would agree with me that this is a
20 current plan?

21 A: This is a -- you know, you're intimating that
22 the tri -- the three piece hospital replacement
23 plan is a definite go and I would say that is
24 not the fact. That is not true.

25 Q: Why would we have not gotten this in discovery?

1 Why did it have to find it on the internet, do
2 you know?

3 A: I don't know the answer to that. This is a
4 part of a 100-page document that sits on our
5 web.

6 Q: Yep. Just a couple of follow-ups. You'd agree
7 with me that CON stands for Certificate of
8 Need, correct?

9 A: Usually, yes.

10 Q: And we don't have a Certificate of Convenience
11 program in South Carolina, do we?

12 A: I'm not aware of one.

13 Q: And the Certificate of Need program is governed
14 by statutes, regulations, and the State Health
15 Plan, is that your understanding?

16 A: Yes.

17 Q: And in order to construct, you've got to follow
18 those rules, do you not?

19 A: Yes.

20 MR. SUMMER: Beg the Court's indulgence. I've only
21 got one copy of this. This does clear
22 everything up and he signed it, so I'd like to
23 at least ask him about it. This is a
24 Certificate of Need for pediatric outpatient
25 imaging center with a price tag on it. Oh,

1 you've got copies, good. That solves my
2 problem.

3 **Q:** If you would, Dr. Cawley, take a minute and
4 just take a look at this document I handed you
5 and ask -- and let me know if that refreshes
6 your recollection in any way.

7 **A:** Yes, I would agree that I think the words -- if
8 I'm looking on page 7, a better
9 characterization of this would be pediatric
10 outpatient clinic and imaging center. The
11 words imaging center sort of does not describe
12 what this project is.

13 **Q:** It's 39 million, right?

14 **A:** That is correct. On page 7, yes, that is
15 correct.

16 **Q:** And on page 5, that's your signature, correct?

17 **A:** That is correct. So if that was termed -- if
18 that had said pediatric outpatient clinic and
19 imaging center, then I would recognize that.

20 **Q:** Okay.

21 MR. SUMMER: Your Honor, this is ...

22 **Q:** Dr. Cawley, thank you very much. Answer any
23 questions your counsel may have.

24 MS. JONES: Nothing further from us, Your Honor.

25 THE COURT: You may step down.

1 DR. CAWLEY: Thank you.

2 MS. JONES: Dr. Cawley's gonna be excused, please,
3 Your Honor.

4 THE COURT: I assume there's no objection.

5 MS. HOLLINGSWORTH: No objection.

6 MR. SUMMER: No objection.

7 THE COURT: He's excused.

8 MS. JONES: Your Honor, we would call Dr. Warr.

9 Dr. Phillip Warr. Wait a minute; he stepped
10 out.

11 THE COURT: Well, then we'll take a five minute
12 break.

13 MS. JONES: Okay. Thank you.

14 (Off the record.)

15 THE COURT: When are we gonna finish tonight?

16 MS. JONES: I'm gonna finish -- we're gonna -- what
17 time is it, you know?

18 THE COURT: That was a ---

19 MS. JONES: Depends on what time it is right now.

20 THE COURT: She is ready to be a witness.

21 MS. JONES: I think my direct examination of Dr.
22 Warr will take about 45 minutes.

23 THE COURT: Okay.

24 MS. JONES: So, how about your cross?

25 MS. LIPHAM: Well, ours will take less than that.

1 THE COURT: Okay.

2 MR. SUMMER: It's not gonna take long ---

3 THE COURT: Okay.

4 MR. SUMMER: --- I don't think. I'll be concise.

5 MS. JONES: Are we ready?

6 THE COURT: Yeah. He's gotta be sworn in.

7 MS. JONES: Your Honor, we would call Dr. Phillip
8 D. Warr.

9 DR. PHILLIP D. WARR, being first duly sworn,
10 testifies as follows:

11 THE COURT: Spell that last name.

12 MS. JONES: W-A-R-R.

13 DR. WARR - DIRECT EXAMINATION BY MS. JONES:

14 Q: Did I pronounce your last name ---

15 A: You did. That's right.

16 Q: --- properly? Thank you.

17 A: Correct.

18 Q: Dr. Warr, if you would, please, would you
19 briefly but completely tell the Court your
20 educational background?

21 A: Sure. So I graduated from the University of
22 Georgia undergrad with a B.S. in microbiology;
23 attended Medical College of Georgia for medical
24 school; trained at MUSC in internal medicine
25 and pediatrics, a four-year program, from 2004

1 to 2008. That's the completion of my training.

2 Q: And after you completed your training, in what
3 capacities have you worked and where before
4 coming to the Medical University Hospital
5 Authority?

6 A: I was an adult hospitalist with Roper Hospital
7 for eight years. So 2008 to 2016. And then
8 came back to MUSC in July of 2016.

9 Q: When you came to the Medical University in
10 2016, what position did you assume?

11 A: The associate chief medical officer.

12 Q: And what did you do? What were your
13 responsibilities as the associate chief medical
14 officer?

15 A: My primary role and focus was inpatient
16 throughput and efficiency of the system, and
17 then transitions of care after the acute
18 setting.

19 Q: And did you in February of 2018 become the
20 chief medical officer ---

21 A: I did.

22 Q: --- for MUHA?

23 A: I did.

24 Q: And in that role, your responsibilities -- do
25 you have responsibilities in regard to patient

1 assessments?

2 A: Yes.

3 Q: And what are patient assessments?

4 A: Patient assessments are evaluations of what
5 medical care the patient needs.

6 Q: And do you have a responsibility in regards to
7 care transitions?

8 A: I do.

9 Q: And what is a care transition?

10 A: The easiest way to describe a care transition
11 is a transition of care from one phase of the
12 healthcare system to another. And so an
13 example may be a hospitalization in an acute
14 care hospital and then transitioning to home,
15 or a transition to a rehab center.

16 Q: And do you also have responsibilities for
17 utilization management?

18 A: I do.

19 Q: And what does utilization management encompass?

20 A: Utilization management really focuses on the
21 right level of care at the right time and
22 appropriate use of resources in a cost strained
23 environment.

24 Q: And at MUHA, do you have committees set up to
25 evaluate and monitor those methods?

1 **A:** We do.

2 **Q:** Do you serve on the Performance Excellence
3 Committee?

4 **A:** I do.

5 **Q:** And what is the Performance Excellence
6 Committee?

7 **A:** The Performance Excellence Committee is a
8 weekly meeting that really comprises multiple
9 areas of MUSC and it focuses on reviewing key
10 performance indicators and how those areas
11 might improve to serve our patients better.

12 **Q:** Who else serves on the Performance Excellence
13 Committee?

14 **A:** Dr. Cawley, Lisa Goodlett, the C suite, if you
15 will, and then there's representation from
16 multiple department chairs and what we call
17 ICCE chiefs, so integrated clinical centers of
18 excellence.

19 **Q:** So it's I-C-C?

20 **A:** E.

21 **Q:** ICCE -- I-C-C-E ---

22 **A:** I-C-C-E.

23 **Q:** --- chairs?

24 **A:** Integrated Clinical Centers of Excellent,
25 correct.

1 **Q:** Okay. And does the Medical University also
2 have a CMO Throughput Committee?

3 **A:** We do.

4 **Q:** And what does the Throughput Committee -- what
5 does it do?

6 **A:** That is a monthly meeting where we look at
7 metrics and how efficiently we are caring for
8 patients in our system. So we look at length
9 of stay; we look at time from discharge to bed
10 cleans; we look at boarding hours -- so
11 emergency department boarding hours, boarding
12 hours in our OR and PACU, so the metrics that
13 really affect, again, how efficiently patients
14 are moving through our system.

15 **Q:** And do you also serve on the Utilization
16 Management Committee?

17 **A:** I do.

18 **Q:** And what is the Utilization Management
19 Committee?

20 **A:** So Utilization Management Committee likewise
21 looks at how we're utilizing resources within
22 the hospital. That is really focused on
23 observation rates, bedded outpatient rates, and
24 then how we can bolster documentation to assert
25 the care that we're giving to patients.

1 Q: Dr. Warr, in those committees and in your role
2 as the chief medical officer, how often do you
3 -- how familiar are you with the bed shortage
4 or bed constraints at MUHA?

5 A: Very familiar, daily basis.

6 Q: How familiar are you with patient throughput
7 metrics, how are they tracked at the Medical
8 University Hospital Authority?

9 A: So the reporting metrics are within EPIC, which
10 is our electronic medical record. Those
11 metrics are reported from that medical record
12 to what we call Tableau which effectively
13 synthesizes information in a viewable format in
14 the form of dashboards that people can easily
15 interpret for improvement.

16 Q: Do those -- and how often do you look at that?

17 A: Daily.

18 Q: Okay. Do they reflect the daily border volume
19 ---

20 A: Yes.

21 Q: --- at the Medical University?

22 A: Yes.

23 Q: And when I say border volume, I think the Court
24 knows this, but just, you know, for accuracy,
25 what do you mean by border volume?

1 **A:** So, a border -- I'll give the example in the
2 emergency department, so once the patient has
3 been assessed in the emergency department and
4 found to be appropriate for admission to the
5 hospital, the time that decision is made until
6 the time that the patient actually physically
7 gets into a bed, they will be considered a
8 border. So the time that they are waiting,
9 again, to physically be in a bed, they would be
10 considered border status. So we have borders
11 in our emergency department, borders in our
12 PACU, which is the post anesthesia recovery
13 unit after they come out of the operating room.

14 **Q:** And do you track the length of stay?

15 **A:** Yes.

16 **Q:** And is that also tracked through the electronic
17 medical record system, EPIC, and in the
18 Tableau database?

19 **A:** It is.

20 **Q:** And how often do you review the length of stay
21 metrics at MUHA?

22 **A:** Almost daily.

23 **Q:** Okay. Are those delineated by -- how are they
24 delineated? By service?

25 **A:** So they are -- you can actually with our

1 Tableau dashboard, you can actually slice and
2 dice multiple ways, so by ICCE, so Integrated
3 Clinical Centers of Excellence, had a very high
4 level. Then you can actually do it by
5 provider, by unit, and then other kind of
6 outlier categories.

7 Q: Do you track the CMI?

8 A: Yes.

9 Q: And what is CMI?

10 A: CMI is Case Mix Index and it is a reflection of
11 the acuity of the patient and the assumption of
12 the needed resources to provide care to that
13 patient. So the higher CMI would reflect a
14 higher acuity of the patients.

15 Q: Okay. And what is the trend at the -- at MUHA
16 regarding the CMI index?

17 A: It's increasing.

18 Q: What was it last year?

19 A: We ended the year at 1.99, just shy of 2.0.

20 Q: I want to talk to you a little bit about the
21 specifics of some of these metrics that are
22 currently in play at MUHA. What is the current
23 boarding hours that you're seeing with patients
24 coming in through the emergency department?

25 A: So we track this again on a daily, weekly,

1 monthly basis, but an aggregate in the
2 emergency department, we have four to five
3 thousand hours boarding hours of patients in
4 our emergency room. That represents about 1200
5 patients with an average or, excuse me, a
6 median boarding time of about two hours. The
7 reason why median is important, there are many
8 patients who have to stay 20-plus hours. The
9 example that is not infrequent is a decision is
10 made to admit a patient at 9:00 p.m. There are
11 no physical beds available and that patient
12 actually has to stay in the emergency
13 department overnight, does not get into a
14 physical bed sometimes the next day until the
15 following afternoon.

16 Q: And what goal are you trying to reach there?
17 What is the standard that you're trying to meet
18 in regard to patient boarding hours through the
19 emergency department?

20 A: The ideal scenario, I think, from a quality
21 standpoint, from a patient experience
22 standpoint would be zero boarding hours. So
23 when that decision is made that you would have
24 a ready bed, clean room, ready bed for that
25 patient to move up seamlessly.

1 Q: And what are the boarding hours that you're
2 seeing through the PACU?

3 A: So, again, the PACU is -- the way we calculate
4 those hours is after the patient comes out of
5 the operating room, once they're fully
6 recovered, the time stamp starts there, and
7 those hours are from the time they fully
8 recover from surgery to the time that they
9 physically get in a bed. And so our PACU hours
10 monthly are about two to three thousand.
11 Again, approximates 1,000 patients in our PACU.
12 The median time there is about half an hour.
13 But, again, some have to stay in the PACU
14 overnight, not an ideal situation.

15 Q: Okay. And do you also monitor the -- in
16 addition to the boarder volume, the patient
17 transfer requests?

18 A: I do.

19 Q: Okay. And what is the current situation in
20 regards to the patient transfer requests coming
21 into the Medical University Hospital Authority?

22 A: So over a period of time, the last three years,
23 those -- the calls into our ATC or Admit
24 Transfer Center has been steadily increasing,
25 and so the number has gone from about 10,000 a

1 year to -- we're on pace to have about 12,000
2 incoming calls this year. 40 to 45 percent of
3 those are what we call consult only. So those
4 are through our telehealth outreach and so
5 those primarily, we want to really reach
6 patients with stroke, other neurological
7 diagnosis, peds critical care, infectious
8 disease, and psychiatry. And so when we -- we
9 look at the patients, the total call volume, we
10 look at those that were coming in as consult
11 only, so again, the outside facilities are
12 reaching out to us to render an opinion and
13 hopefully continue care in that facility, but
14 to render an expert opinion. And there's a
15 majority of those patients who actually the
16 calls come in to physically transfer the
17 patients to our facility. There are 50 to 60
18 patients every month that we're not able to
19 physically bring into our facility. I think
20 it's important to note in addition to those 50
21 or 60 that we cannot physically bring into our
22 facility, that there are many that wait days to
23 come into our facility. So, again, that's not
24 an immediate time frame. I've also had
25 discussions with our surgical chair, who, as

1 similarly shared by Dr. Cawley, said that
2 surgeons have told him that they're no longer
3 calling because they know that our bed capacity
4 and bed constraints won't enable transfers of
5 their patients.

6 **Q:** Dr. Warr, do you work with the telemedicine
7 unit at the Medical University Hospital
8 Authority?

9 **A:** I'm very familiar with those who staff it, but
10 not -- I don't intimately work with them.

11 **Q:** What interaction do you have in your job
12 responsibilities with the telehealth facilities
13 at the Medical University?

14 **A:** It's certainly -- given our matrix environment,
15 there are two very capable leaders in
16 telehealth and we work together sometimes in
17 the capacity as medical directorships for
18 telehealth to, again, expand new services to
19 patients in South Carolina.

20 **Q:** And are you ---

21 MS. JONES: Your Honor, at this point in time, I'd
22 ask the Court to take judicial notice of
23 Proviso 117.126 of the Appropriations Bill for
24 the last several years in which the General
25 Assembly has designated the Medical University

1 Hospital Authority as the regional support hub
2 for telemedicine to collaborate with the
3 Department of Health and Human Services to
4 provide telehealth services through the
5 participating entity in South Carolina that
6 wishes to participate with telehealth.

7 MS. LIPHAM: We just want to clarify what year this
8 is for?

9 MS. JONES: This is last year. I mean, but it's
10 the same proviso. It's 117.126 in -- since the
11 telehealth was approved by the General Assembly
12 and appropriated.

13 THE COURT: Which was when?

14 MS. JONES: I will have to get ---

15 THE COURT: Well, we'll just go with last year
16 then.

17 MS. JONES: Okay. Yeah, but this was from last
18 year, but telehealth's been going on for a
19 number of years now and I don't have that
20 information right here, but I'll get it.

21 THE COURT: What's your position?

22 MS. LIPHAM: I have no objection.

23 MR. SUMMER: Well, I mean, she's not offering it into
24 evidence. She's asked you to take judicial
25 notice of it.

1 THE COURT: Yes.

2 MR. SUMMER: We're all gonna file proposed orders and
3 she's free to put it in there, so I don't have
4 any objection to you looking at any law of the
5 State of South Carolina.

6 THE COURT: Okay.

7 MR. WICEVIC: No objection.

8 THE COURT: All right.

9 Q: Dr. Warr, since you came to the Medical
10 University Hospital Authority in June of 2016,
11 has there been a bed shortage?

12 A: Yes.

13 Q: And how -- and I think you already testified to
14 this, but how often do you track it?

15 A: Daily.

16 Q: Is the bed capacity at MUHA ever over 100
17 percent?

18 A: Yes.

19 Q: How frequently?

20 A: So usually on a Tuesday, Wednesday, Thursday it
21 is over 100 percent.

22 Q: And on those days each week, usually on
23 Tuesday, Wednesdays, and Thursdays, when other
24 patients are coming into the emergency
25 department or coming out of surgery or you're

1 getting a transfer call and you are over 100
2 percent capacity, what happens to those
3 patients?

4 A: Unfortunately, they sit where they are. So in
5 the emergency department, in the PACU, or in an
6 outside hospital we're not able to physically
7 bring them into an appropriate bed.

8 Q: Okay. And over the past year, have you had to
9 go on EP3 status?

10 A: Yes.

11 Q: What is EP3 status?

12 A: It stands for Emergency Patient Placement
13 Protocol. Effectively, we will call it when
14 there are more than 25 percent of our emergency
15 department's beds are taken up by boarders and
16 approximately 85 percent of their entire
17 capacity is used. And so when we call EP3, the
18 patients who are boarding either in the PACU or
19 in the emergency department are physically
20 brought up to a unit, but they don't have a
21 bed, so they are in the hallway, usually with
22 curtains around them to try to give them, you
23 know, some semblance of privacy. So they're
24 without a private bathroom. So, again, just
25 describing a non-ideal situation that again

1 impacts quality inpatient experience.

2 Q: And this happens every week?

3 A: Almost every week. So within the past calendar
4 year, we've called EP3 just over 100 times and
5 so. Last week, as an example, we had to call
6 it at Ashley River Tower three times.

7 Q: And when you as the chief medical officer are
8 trying to manage all of this, what -- what is
9 the goal or the metrics that you're trying to
10 achieve as far as maximum efficient capacity?

11 A: I think when we really talk about what do we
12 want to deliver in healthcare, it's high
13 quality, reliable care at a lower cost with a
14 great patient experience. I think those are
15 what we're really trying to deliver on. I
16 think that there -- there is expert opinion
17 that really says a hospital -- to operate at
18 maximum efficiency really should be around 80
19 to 85 percent capacity, so that -- when I say
20 expert opinion, there is the Institute for
21 Healthcare Improvement. Some of you have heard
22 of healthcare's triple aims, so they talk about
23 health and populations, individual patient
24 experience at a lower cost, so that was the IHI
25 or the Institute for Healthcare Improvement,

1 that they've really done a number of studies
2 and, again, they speak to once a hospital's
3 capacity is over 85 percent, they describe
4 crowding, which, again, has negative effects on
5 all those things I mentioned before, quality
6 patient experience, reliability, and cost.

7 **Q:** Either by number or percentage-wise, how many
8 patients -- less patients in the facilities
9 downtown at the hospitals on the main campus
10 that you currently have would you have to
11 discharge or transfer to get to that 80 to 85
12 percent metric for maximum efficiency?

13 **A:** So if you look at our numbers, especially mid-
14 week, Tuesday, Wednesday, Thursday, we're well
15 over 100 percent occupancy with up to 20 to 30
16 boarders at time -- at times. And so you're
17 really talking about 75 to 100 additional
18 patients that would have to be either
19 discharged or more efficiently moved through
20 the system to get to that 80 to 85 percent
21 occupancy.

22 **Q:** And Dr. Warr, how do those numbers relate in
23 regards to adult med/surg beds and patients at
24 MUHA downtown?

25 **A:** In general, the adult medical/surgical units

1 are even at a higher capacity than our
2 pediatric side. So they typically run 90 to
3 again well over 100 percent occupancy.

4 Q: How many adult med/surg beds are there in the
5 main hospital?

6 A: So right -- 304.

7 Q: Okay. And that's in the -- in the main
8 hospital, not Ashley River Tower?

9 A: Correct.

10 Q: Okay. And how many are in Ashley River Tower?

11 A: 202. That's including ICUs.

12 Q: And which units of the hospitals or the
13 different facilities downtown run are by far
14 the most full?

15 A: I can speak for my work as a hospitalist, again
16 internal medicine and hospitalist, that we have
17 -- at the main hospital we have six services
18 roughly caring for 90 patients and there are 45
19 -- only 45 allocated beds for our service. And
20 so what happens to the remainder of the
21 patients on our service, they are placed on
22 other floors whenever there's a bed available.
23 So you lose the ability to cohort patients and,
24 again, loses -- you lose efficiency, which,
25 again, negatively impacts ---

1 Q: Well, Dr. Warr, explain that a little more.
2 When you -- when you can't cohort patients,
3 what do you mean by cohort them? Is that
4 grouping them together?

5 A: Grouping them together ideally on one unit, so
6 when you -- when you round, you can round
7 efficiently and you're not going between five
8 and six floors, especially if you need to do
9 follow-up rounds and have discussions with
10 patients and families.

11 Q: And what additional stress or difficulties
12 arise as a result of the current situation that
13 you have where you don't have the ability to
14 have the similarly ill patients in the same
15 units being cared for by the -- by common
16 caregivers, nurses and physicians?

17 A: Sure. I think it absolutely presents a
18 challenge to coordination of care, so in your
19 -- in these multiple district nursing units,
20 there's multiple other staff members and
21 providers that you're interacting, so, again,
22 different charge nurses, different bedside
23 nurses, different physical therapists at times,
24 different respiratory therapists at times, and
25 so as complex as the internal hospital

1 environment is, it's made even more complex
2 when you're having to round on your patients
3 on multiple units.

4 Q: And the example you gave a minute ago about the
5 general medicine patients, in the main hospital
6 I think you said there are about 45 beds for
7 general medicine patients.

8 A: Correct.

9 Q: Okay. But the average daily census for general
10 medicine patients is about 90.

11 A: Correct.

12 Q: So it's double the number of beds that you
13 actually have available with the treatment
14 teams to care for?

15 A: Correct.

16 Q: And so you have to spread them all over the
17 place?

18 A: Yes.

19 Q: I want to ask you a few questions about the
20 average length of stay. The -- what metrics or
21 goals are you trying to achieve or do you
22 measure yourself against in regards to average
23 length of stay?

24 A: So, we're a part of an academic medical center
25 consortium called Visiant that helps with data;

1 it helps with efficiency and some various other
2 things, but we utilize them primarily for data
3 as referenced in the Tableau dashboard and so
4 we send our data DRG based on how long these
5 patients are staying in our hospital. We
6 compare ourselves to our peers, to our other
7 academic peers and so we get an index, so it's
8 called length of stay index, which is, again,
9 essentially how long you observe your patients
10 being in the hospital compared to how long are
11 they expected to stay in the hospital. And so
12 our goal is really a length of stay index of
13 1.0 and patients staying as long as they're
14 expected to stay.

15 Q: And when you say 1.0, that's comparing the MUHA
16 average length of stay to the Visiant academic
17 benchmarks for academic medical centers?

18 A: Correct.

19 Q: Okay. And currently what is the average length
20 of stay aggregate for academic medical centers
21 similar to the Medical University Hospital
22 Authority?

23 A: It's about 6.4 days.

24 Q: And these other academic medical centers that
25 MUHA's being compared to, do they have similar

1 metrics in regards to the acuity of the
2 patients and the level of care that the
3 patients need?

4 A: They do.

5 THE COURT: It's 6. what?

6 MS. JONES: 6.4.

7 A: 6.4.

8 Q: What is the ACT ICCE?

9 A: The ACT ICCE is acute critical care and trauma.
10 Historically, service line -- people would say
11 service line so that is the Integrated Clinical
12 Centers of Excellence that encompasses the
13 acute care patients which the hospitalists take
14 care of, the critical cares, medical ICUs, and
15 our trauma patients.

16 Q: And is that where you're seeing the average
17 length of stay with the other academic medical
18 centers at 6.4 days?

19 A: Correct.

20 Q: And in this particular situation for the
21 hospital to be built up in Nexton, MUHA has
22 estimated an average length of stay at 5.1 or
23 5.2 days. Is that in line with the Visiant
24 data that you monitor on a day-to-day basis?

25 A: I think that the assumption would be that there

1 are patients currently in our system that can
2 be appropriately cared for -- cared for in this
3 new setting that would not be to the highest
4 acuity level and so, yes, I think the reduction
5 of approximately one day or roughly almost 20
6 percent is appropriate.

7 Q: And one other point I want you to explain is
8 that since you've been at the Medical
9 University, the length of stay -- the average
10 length of stay has slightly improved, is that
11 right?

12 A: Correct.

13 Q: But your census has not?

14 A: Correct.

15 Q: Can you explain that a little bit to the Court
16 how that's occurring?

17 A: So -- so length of stay is a metric that every
18 system follows. It has a significant impact on
19 patient experience and, again, resource
20 utilization. We have decreased our aggregate
21 length of stay, our observed length of stay
22 about a third of a day, and if you kept
23 everything else the same, you may see some
24 additional beds being opened up because of
25 improved throughput. We have seen our average

1 daily census remain constant this year despite
2 decreasing by a full third of a day.

3 **Q:** The last thing I want to ask you about, Dr.
4 Warr, is the transfers, patient transfers
5 coming into the Medical University, because
6 you've talked about the boarding of the
7 patients through the emergency department and
8 coming out of the PACU, do you -- do you
9 monitor the transfer requests coming into the
10 Medical University?

11 **A:** Yes.

12 **Q:** And how has the capacity constraints at MUHA
13 over the last three years affected the transfer
14 requests that you're receiving at MUHA?

15 **A:** So the number of calls has steadily increased.
16 Again, at this time there are at least 50 to 60
17 patients per month that we're not able to bring
18 into our facility. These are calls from
19 usually outside emergency departments, outside
20 hospitals, trying to transfer their patients to
21 us for -- for appropriate care. We, obviously,
22 want to do that and that's our mission to do
23 that, but we're not able to because of volume
24 and capacity constraints.

25 **Q:** And that's 50 to 60 a month that you cannot

1 take right now because of these capacity
2 constraints?

3 **A:** Correct.

4 **Q:** I think those are all the questions I have, Dr.
5 Warr.

6 MR. WICEVIC: No questions from the Department.

7 MS. JONES: On time and under budget.

8 THE COURT: All right.

9 MR. SUMMER: I would agree with you on the on time
10 part, but Dr. Cawley's not here for me to ask
11 about under budget.

12 DR. WARR - CROSS-EXAMINATION BY MR. SUMMER:

13 **Q:** Dr. Warr, how are you doing today?

14 **A:** I'm well. Hope you are.

15 **Q:** I am. And I'm pleased that you're here because
16 it's nice to actually talk to a physician who's
17 on the floor and understands what's going on in
18 your facility. I am confused and I was hoping
19 you could help me out a little bit. You talked
20 about there are only 45 general medicine
21 patient beds in your facility and you'd be
22 better off with 90, fair statement?

23 **A:** In that aspect, I was speaking to the --
24 specifically to the hospitalist patients, so we
25 only have two units that are truly allocated

1 for hospitalist patients.

2 Q: But you're talking about basically medicine
3 patients, not surgical, correct?

4 A: Correct.

5 Q: And you're just talking about general medicine
6 patients, there's 45 beds out of the 771 that
7 you have, are dedicated to that patient
8 population?

9 A: And -- and just to clarify, that's in main --
10 in main hospital.

11 Q: In main hospital. And I know you don't do much
12 with planning because in your deposition you
13 said you had minimal ---

14 A: Correct.

15 Q: --- exposure, correct?

16 A: Correct.

17 Q: Have you seen this plan before?

18 A: I have not.

19 Q: Okay. So that's Shawn Jenkins right there
20 (indicating), this is what Dr. Cawley testified
21 to is the main replacement with two bed towers
22 -- not Shawn Jenkins, excuse me, ART, did you
23 say there are 202 beds at ART?

24 A: Correct.

25 Q: So that would be 404 beds in that phase three

1 for replacing main. But for the 45 beds for
2 adult general medicine, did I hear you right
3 that you really need 90?

4 A: Correct.

5 Q: Okay. Were you here for the testimony about
6 the purchase of the CHS hospitals?

7 A: I heard some of the testimony today, Dr.
8 Cawley's testimony.

9 Q: Okay. And Dr. Cawley testified it was about
10 \$135 million purchase price, \$120 million
11 borrowing money to run them for about \$255
12 million, I want to compare that -- in your
13 deposition you explained that the children's
14 hospital, which has got about, if you count OB,
15 NICU, and everything else, about 150 beds in
16 there right now, fair statement?

17 A: If you count all the NICU bassinets, yes.

18 Q: Okay. So well, it's got 150 beds now. Those
19 eight floors will be vacated when those folks
20 move into this pretty new Shawn Jenkins, right?

21 A: Yes.

22 Q: All right.

23 MR. SUMMER: So if we could put up, this is Trident
24 160.

25 (TMC Exhibit Number 160 was referenced at this time.)

1 **Q:** I think you testified in your deposition you
2 were generally familiar with the fact that MUSC
3 is trying to get a Certificate of Need for
4 adding 29 beds in what is the old children's
5 hospital.

6 **A:** I believe in my deposition I said I was
7 familiar with the request for 33 in the CON,
8 but otherwise I'm not intimately familiar with
9 this document.

10 **Q:** Okay. The 33 approved and these 29 would be
11 new, so it would be 62 total, right?

12 **A:** Correct. But I'm not familiar with the -- the
13 request for the additional 29.

14 MR. SUMMER: If we could go to the very last page.
15 Go to page 59.

16 **Q:** So what's proposed in this 29-bed application
17 ---

18 MS. JONES: Your Honor, I'm gonna object; the
19 witness has said he's not familiar with the 29-
20 bed application and asking him questions about
21 it is improper. And I object.

22 MR. SUMMER: I don't think so, Your Honor. He's
23 talking about space constraints. This is one
24 of the things they're doing to address that.
25 This is cross-examination. I think I'm

1 entitled to ask him about it.

2 THE COURT: Well, if he can identify the diagram
3 you're talking about as far as space.

4 MR. SUMMER: Can you blow up the footer on that.

5 Q: It says fifth floor University Hospital
6 Building 300. That's the children's hospital,
7 correct?

8 A: It says University.

9 Q: So old main hospital?

10 A: Yes.

11 Q: Okay. And so that's a one-floor renovation is
12 what your understanding is for this project,
13 right?

14 A: I -- I'm honestly not familiar with the
15 details.

16 Q: Okay. Let's go back to page 2 of this exhibit.
17 Okay. Looks like it's signed on 5/29/2019, is
18 it not? That's this year. And if we go to
19 page 5 of that exhibit, please. This would be
20 for the addition of -- it says gain or loss 21
21 adult med/surg beds and an ICU with eight, and
22 you're not familiar with this project?

23 A: This -- this proposal for the 29 additional
24 beds, the CON, I'm not.

25 Q: So you're here to testify about space

1 constraints, but you didn't even know they were
2 gonna add 29 beds?

3 A: I've not reviewed that document in detail.

4 Q: Okay. Well, they're gonna add 29 beds for \$7
5 million, 7.3. You would agree with me that
6 there's room to backfill in the children's
7 hospital for the eight floors being vacated for
8 Shawn Jenkins, correct?

9 A: I am familiar with the plan to backfill the 33
10 beds once that space is vacated, yes.

11 Q: So between this project, the 29 beds, and the
12 33 that you are aware of, that's 62 beds they
13 would just for med -- the general medicine
14 patients, that'd give you 107 beds, correct?

15 A: So 107, so break that math down again.

16 Q: You have 45 ---

17 A: What are you adding to the prior number?

18 Q: You have 45 existing.

19 A: On the eighth floor.

20 Q: General medicine beds.

21 A: Correct.

22 Q: And you are aware of 62 new beds to come
23 online, correct? The 29 and the 33?

24 A: So, again, I'm aware of the 33 and the plans to
25 enact those, not intimately familiar with the

1 additional request for 29.

2 Q: But you're aware that that project is out
3 there?

4 A: Yes. Currently.

5 Q: So that would be 62 new beds, correct?

6 A: Correct.

7 Q: And if you add that to your 45, that's 107,
8 okay. These beds are supposed to be online by
9 January of 2021. That would help you greatly,
10 wouldn't it?

11 A: It would. So the discussions that I've been
12 part of, you know, the 33 additional beds,
13 would be discussed and referenced to transplant
14 organ procurement, additional neuroscience
15 beds, so, again, those tertiary/quaternary
16 patients.

17 Q: Okay. We still have eight floors available in
18 the old children's hospital that will now be
19 empty, correct?

20 A: So, again, I don't -- I can't speak to the
21 first few floors. I know there's lab equipment
22 and materials, so I don't know if there's a
23 plan, Dr. Cawley and our COO to maybe maintain
24 some of those.

25 Q: I understand ---

1 **A:** Meaning it's not all gonna be vacated for
2 patients.

3 **Q:** So you're here talking about problems with
4 throughput, but you don't know how multiple
5 stories of that building will be utilized to
6 ease throughput, you just don't know?

7 **A:** Correct.

8 **Q:** Let's talk about transfers. You would agree
9 with me, based on what I read in your
10 deposition, that the transfer situation has now
11 gotten worse because you have those old CHS
12 hospitals in your system now, fair statement?

13 **A:** I do think that has increased the requests to
14 come to downtown MUSC, yes.

15 **Q:** So, expending the \$255 million to get those
16 facilities has actually made things worse in
17 terms of having space for transfers, fair
18 statement?

19 **A:** I think if we're speaking to the tertiary and
20 quaternary needs of the community, yes.

21 **Q:** Okay. And you would agree with me that, you
22 know, a core piece of your mission is taking
23 care of the sickest and most complex patients
24 in South Carolina, isn't it?

25 **A:** Absolutely.

1 Q: In fact, most of your transfers are coming from
2 community hospitals, fair statement?

3 A: That's a fair statement.

4 Q: Okay. Because community hospitals do not have
5 the ability to take care of the types of
6 patients that you do, correct?

7 A: Correct.

8 Q: Did you hear the testimony of Dr. Cawley when
9 I was asking him about all of the
10 subspecialties that you have that are unique at
11 MUSC?

12 A: Yes.

13 Q: Okay. And would you agree with him those exist
14 at your facility?

15 A: Yes.

16 Q: Okay. And that's why the community hospitals
17 need to have access to your programs is to get
18 the sickest people to the peninsula, correct?

19 A: Yes.

20 Q: Okay. You also have no idea what services are
21 gonna be offered at the Nexton hospital, do
22 you?

23 A: Current state, I don't know that's been
24 determined.

25 Q: Correct. Don't know that it's been determined.

1 You mean that y'all are still planning what you
2 may or may not put out there?

3 A: To my knowledge, correct.

4 Q: Okay. Also being vacated would be at least two
5 pods in your ED when the ED moves over -- the
6 children's ED moves over into the new system,
7 correct?

8 A: Correct.

9 Q: That would be into the new Shawn Jenkins,
10 correct?

11 A: Correct.

12 Q: Do you know who Dr. Greg Hall is?

13 A: I do.

14 Q: Okay. Dr. Hall has explained that there's been
15 on the drawing boards a \$30 million renovation
16 for the ED for years that would basically fix
17 that fragmented system. Are you aware of those
18 plans?

19 A: In -- in -- in general. In generality, yes.

20 Q: Okay. But MUSC has not moved forward with
21 those plans, has it?

22 A: Correct. The space has not been vacated yet.

23 Q: Okay. And to your knowledge, there are no
24 plans to renovate the ED at this time, are
25 there?

1 **A:** When you -- when you say ED, you mean the main
2 ---

3 **Q:** Main ED.

4 **A:** --- ED? The current space that we're currently
5 seeing patients?

6 **Q:** Correct.

7 **A:** It would be very difficult to do so is my
8 understanding.

9 **Q:** Okay.

10 THE COURT: Why is that?

11 **A:** Just because of the infrastructure, height of
12 the ceilings, walls, load-bearing walls, the
13 expense to do so would be significant.

14 **Q:** Since you don't participate in planning, you
15 don't know where a new ED would be in this
16 phase three, do you?

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

18 **Q:** Okay. Since you do not know what service lines
19 might be at Nexton, it would be very difficult
20 for you to estimate where you would get relief
21 downtown from the new hospital as we sit here
22 today?

23 **A:** So, again, don't think those decisions have
24 been made, I think there are certainly
25 hospitalist patients, a few diagnoses that I

1 can think of, that would be appropriate for
2 this hospital, so I think sickle cell patients,
3 cystic fibrosis patients it absolutely could be
4 utilized at this new facility that would help
5 appropriately free up beds for more tertiary --

6 -

7 Q: But you don't know what the plans are to treat
8 those patients right now, do you?

9 A: Specific plans, no.

10 Q: Okay. Would you agree with me that patients by
11 and large are gonna be treated where they're
12 presented -- where they present?

13 A: By and large if they present to an emergency
14 room and need to be admitted?

15 Q: Yes.

16 A: If -- if that facility has the appropriate care
17 available, yes.

18 Q: So let's use your new Nexton hospital as an
19 example. If someone with sickle cell anemia
20 presents on the peninsula, if Nexton is open,
21 are you gonna take that patient and transport
22 them out or are you gonna treat that patient
23 where they presented downtown?

24 A: I think it's never ideal to have a significant
25 transport of a patient. However, I would say

1 if we're in a situation where there are 20
2 other boarders in the emergency department, the
3 patient could be informed of that to say it's
4 likely if you stay here, you would remain in
5 the emergency department for -- until tomorrow
6 overnight, or we can accommodate you an
7 appropriate transfer and there's a bed
8 available at another facility. So, again, that
9 would be a patient ---

10 Q: Would be patient choice?

11 A: --- inform the patient choice. Correct.

12 Q: You wouldn't be able to just transfer that
13 patient without their consent, correct?

14 A: Correct.

15 Q: Far as you know, are there any plans to build
16 a hospital on John's Island that you're aware
17 of?

18 A: Not that I'm aware of.

19 Q: Are you -- have you been involved at all in the
20 planning of the ED out at Seabrook?

21 A: No.

22 MR. SUMMER: Beg the Court's indulgence.

23 Q: And you say that your understanding is that the
24 ED would be expensive to renovate, is it gonna
25 be more than the \$30 million described by Dr.

1 **Hall?**

2 **A:** **I don't know.**

3 **Q:** **All right.**

4 MR. SUMMER: No further questions, Your Honor.

5 THE COURT: Questions?

6 MS. LIPHAM: May it please the Court.

7 DR. WARR - CROSS-EXAMINATION BY MS. LIPHAM:

8 **Q:** **Good afternoon, Dr. Warr.**

9 **A:** **Hi.**

10 **Q:** **We met at your deposition. I'm Shannon Lipham**
11 **and I have only a few questions. I think David**
12 **hit almost everything.**

13 **A:** **Sure.**

14 **Q:** **You've been -- you talked earlier about you've**
15 **been on several committees since you've been at**
16 **the Medical University, right?**

17 **A:** **Correct.**

18 **Q:** **And one of those is the Executive Leadership**
19 **Committee?**

20 **A:** **Yes.**

21 **Q:** **I think you described for us that's where the**
22 **high level things are discussed, is that right?**

23 **A:** **That's fair. I think that was in response to**
24 **maybe a specific strategic plan and my response**
25 **was I'm not intimately familiar with that, but**

1 there are things discussed at ELC at a very
2 high level, yes.

3 Q: So, in general, at Executive Leadership
4 Committee meetings, you can kind of get a high
5 overview of what's going on, is that right?

6 A: That's fair.

7 Q: But you don't remember any specific meetings
8 with regard to this 128-bed hospital?

9 A: So specific meetings ---

10 Q: Are you ---

11 A: --- separate -- separately?

12 Q: Yes, that's correct.

13 A: Correct.

14 Q: Okay. And just a few minutes ago you were
15 talking about some of the challenges with
16 putting -- with renovating the children's
17 hospital and part of that is some of the
18 ceilings are too low?

19 A: I believe my response was that's when I was
20 speaking in the emergency department other than
21 children's.

22 Q: Okay.

23 A: Yeah.

24 Q: So that would be costly to renovate because
25 you'd have to raise the ceilings, is that

1 right?

2 A: That would be my assumption, yes.

3 Q: But doctors fit in there now, right, not just
4 children?

5 A: In our -- in our adult ED? Yes.

6 Q: Yes.

7 A: Yes.

8 Q: So people do fit in there?

9 A: Sure, they fit in the space.

10 Q: And you review average length of stay on a
11 daily basis, right?

12 A: Yes.

13 Q: When does -- when does a patient's length of
14 stay, when do you start tracking that?

15 A: From the time that the decision is made to
16 admit, so when the admission order is signed.

17 Q: Okay. And you just told us earlier that 80 to
18 85 percent would be maximal efficiency, would
19 be kind of the best for efficiency at the
20 hospital, is that right?

21 A: Correct. So crowding -- there's been a
22 description by the IHI that crowding really
23 happens above 85 percent capacity and yet has
24 a negative impact on quality patient
25 experience.

1 Q: Okay. And then you actually identified some
2 concerns for us at your deposition if a
3 capacity at a hospital were too low. Say, 50
4 to 55 percent, you talked -- you said that
5 there might be some problems with managing
6 staffing and supplies, is that right?

7 A: As I recall, I think the question was what
8 happens if it's too low, and I think my
9 response was I think that's a very different
10 scenario I think you would have to manage it
11 very differently.

12 Q: A different problem?

13 A: Correct.

14 Q: But a problem nonetheless?

15 A: I think it would have to be managed
16 effectively, yes.

17 Q: Okay. You agreed at your deposition that
18 probably ballpark 20 percent of emergency
19 department patients are eventually admitted
20 into the hospital.

21 A: Right. Since that time, so our MUSC numbers
22 are about 25 percent.

23 Q: Okay. So it's fair to say that those patients
24 no matter which emergency department they go
25 to, they would eventually need to be admitted

1 into some hospital?

2 A: So, 25 percent of patients who present to the
3 emergency department ultimately need admission
4 to the hospital. That's our current state.

5 Q: So at a new community hospital, there'd be some
6 percentage of patients that also need to be
7 admitted?

8 A: That's a fair assumption, yes.

9 Q: And at -- it's probably also fair to say if a
10 lot of the same patients or all the same
11 patients are going to the -- the new 128-bed
12 community hospital, some percentage of those
13 patients would need to be transferred downtown?

14 A: Correct. I think that would be, again, a
15 decision by the emergency department physician
16 who's assessing them based on what each
17 facility could provide. And so, yes, there
18 would be a subset of patients who would need a
19 higher level of care, tertiary/quaternary care,
20 who would need to come to the peninsula,
21 correct.

22 Q: So tertiary/quaternary, those patients that
23 need to be admitted for those services would be
24 transferred downtown?

25 A: So, again, I think it would -- so my example

1 would be a hospitalist patient, I think there
2 are a great percentage of hospitalist patients
3 that could be appropriately treated there, but
4 there would be some, depending on their
5 comorbid conditions and how they're presenting
6 that day, that, yes, the decision would be made
7 to transfer them downtown.

8 **Q: Okay.**

9 MS. LIPHAM: One moment.

10 **Q: That's all I have. Thank you, Dr. Warr.**

11 **A: Thank you.**

12 THE COURT: Re-direct?

13 MS. JONES: That's all, Your Honor. Thank you.

14 THE COURT: You may step down.

15 DR. WARR: Thank you.

16 THE COURT: Well, what time tomorrow? If it's
17 gonna be long, we vote to start early.

18 MS. JONES: 9:30 it is.

19 THE COURT: Okay. You can step down. So I can
20 understand where we're going on this case ---

21 MS. JONES: Yes.

22 THE COURT: --- I'm gonna be making the decision
23 about Berkeley, but I'm not gonna find out what
24 the service lines will be at Berkeley? Isn't
25 that -- Nexton/Berkeley is what I should say.

1 Is that correct?

2 MS. JONES: The service lines that are -- the
3 figure that was in the CON application that we
4 talked about ---

5 THE COURT: I mean, what services are gonna be
6 offered at Nexton?

7 MS. JONES: They're in the CON application.

8 THE COURT: Okay.

9 MS. JONES: The list of them. Dr. Cawley talked
10 about them. Ms. Goodlett is gonna talk about
11 them some more.

12 THE COURT: Okay.

13 MS. JONES: The DRG numbers.

14 THE COURT: Okay. I just wanted to ask. Thank
15 y'all.

16 MS. JONES: Thank you.

17 MR. SUMMER: Thank you, Your Honor.

18 (DAY EIGHT of the hearing adjourned at 4:58 p.m.)

19 (DAY NINE - TUESDAY, NOVEMBER 19, 2019. The hearing
20 reconvened at 9:28 a.m.)

21 CALL TO ORDER:

22 THE COURT: Y'all be seated.

23 MS. JONES: Thank you, Your Honor. The Medical
24 University would call Lisa Goodlett. Come over
25 here, Lisa, and the court reporter will swear

1 you in.

2 LISA GOODLETT, having been duly sworn, testifies as
3 follows:

4 THE COURT: Y'all got less of an entourage today.

5 MS. JONES: I know. They're back at the office
6 working on stuff.

7 THE COURT: Well that's good.

8 MS. JONES: That is good, you know.

9 THE COURT: Yeah.

10 MS. JONES: Hopefully it'll make things go quicker
11 and smoother.

12 MR. SUMMER: It never works out like that.

13 MS. JONES: Well, yeah, there's some truth to that,
14 so. But you know, we hope.

15 THE COURT: Yeah.

16 MS. JONES: Hope springs eternal.

17 THE COURT: That's true. All right. Can you spell
18 your name for me?

19 MR. GOODLETT: G-O-O-D-L-E, two Ts.

20 THE COURT: That's easy. Thank you.

21 MR. GOODLETT: Thank you.

22 MS. GOODLETT - DIRECT EXAMINATION BY MS. JONES:

23 **Q: Ms. Goodlett, good morning. I would like for**
24 **you to begin your testimony with first of all**
25 **what is your position at the Medical University**

1 **Hospital Authority?**

2 **A: I have three titles. I'm the CFO of MUSC**
3 **Health, the CFO of MUHA, or the Medical**
4 **University Hospital Authority, and the CFO of**
5 **MSV.**

6 **THE COURT: What was the last one?**

7 **A: MSV.**

8 **THE COURT: Okay.**

9 **Q: And then I want to back up sort of to the**
10 **beginning. Where did you get our undergraduate**
11 **degree?**

12 **A: At Clemson.**

13 **Q: And what did you major in at Clemson?**

14 **A: Accounting.**

15 **Q: After you finished your accounting degree at**
16 **Clemson what post-graduate work did you do?**

17 **A: I received my MBA from USC.**

18 **THE COURT: All good.**

19 **A: South Carolina. That's my schizophrenic**
20 **degree.**

21 **THE COURT: It redeems the latter on your resume.**

22 **Q: All right. After you got your MBA degree did**
23 **you begin working in healthcare related fields?**

24 **A: Yes. I worked for Pride Thomas and Welch, a**
25 **firm here in Charleston, and about 50 percent**

1 of the package was healthcare. And then I was
2 recruited to what was then DSH Health to be the
3 Director of Finance for Home Health and
4 Hospice. During that time they were starting
5 to merge with Richland which became Palmetto.
6 I was the CFO down in Bamberg was I was 26,
7 stayed there for about five years and then was
8 recruited to Kershaw County Medical Center for
9 about five years and then got recruited to
10 Children's Healthcare of Atlanta, then came
11 back to Charleston to -- I've got kids and
12 wanted to come back home to the family, and was
13 the CFO down in Orangeburg Regional Medical
14 Center. Then got recruited to UAB. I managed
15 an entity over in Alabama, Baptist Health, and
16 then got recruited to the University of
17 Maryland Medical System to be a health system
18 CFO for dementia and so it was a three hospital
19 system we were bringing into a 13 hospital
20 system, so mergers and acquisitions and turn
21 arounds are my specialty. And then I've been
22 with Medview for about two and a half years.

23 Q: Ms. Goodlett, I want to back up a little bit
24 more. You are -- what professional license do
25 you hold?

1 **A:** **A CPA.**

2 **Q:** **Okay. And when did you -- are you licensed in**
3 **South Carolina, and how long have you been**
4 **licensed?**

5 **A:** **I am, and I've been licensed since 1999 I**
6 **believe.**

7 **Q:** **Okay. In all of those different roles, and I**
8 **want to go back through a couple of them a**
9 **little bit. So you were working for the**
10 **Baptist Hospital System here in Columbia when**
11 **Palmetto Health was formed?**

12 **A:** **I was down with the Bamberg facility so I was**
13 **a Baptist employee down at Bamberg when the**
14 **merger was going on.**

15 **Q:** **And then you moved from there to Kershaw**
16 **Medical Center over in Kershaw County?**

17 **A:** **Camden, yeah.**

18 **Q:** **In Camden. And then to the Children's**
19 **Healthcare of Atlanta?**

20 **A:** **Uh-huh.**

21 **Q:** **And what was your position there?**

22 **A:** **Vice President of Finance.**

23 **Q:** **Okay. And then when you came back to South**
24 **Carolina and went to work at the Regional**
25 **Medical Center in Orangeburg what was your**

1 position, what position did you take then?

2 A: When I arrived I was the Chief Financial
3 Officer for there years and then was promoted
4 to be the Chief Operating Officer for three
5 years.

6 Q: So you moved from basically a management to the
7 Vice President of Finance to the CFO position
8 in Orangeburg to the Chief Operating Officer in
9 Orangeburg?

10 A: Correct.

11 Q: And then when you went to the -- to UAB. And
12 what is UAB?

13 A: University of Alabama. Birmingham is there
14 Health Sciences and their equivalent of MUSC in
15 Alabama. Sterling State's Health System. And
16 so they were managing a three health system in
17 Montgomery called Baptist Health.

18 Q: Right. And they work as the academic medical
19 center in the State of Alabama?

20 A: Correct, yes.

21 Q: And you are the Chief Financial Officer there?

22 A: Of Baptist Health, yes.

23 Q: And then you moved up to the University of
24 Maryland Medical System?

25 A: Uh-huh. The Dimension System was the system

1 within University of Maryland Medical System.

2 Q: Okay. And you were the Chief Financial Officer
3 there?

4 A: Correct.

5 Q: All right. And when you came to the Medical
6 University in June of 2017 what position did
7 you take?

8 A: It was the Chief Financial Officer of MUHA.

9 Q: Uh-huh.

10 A: And the Chief Financial Officer of the health
11 system.

12 Q: And if you would please, tell the Court, tell
13 the Judge a little bit about how MUHA and
14 Health System interact and work together?

15 A: I think it's important to understand MUSC
16 Health is a brand of many different entities
17 within it, and so MUHA typically represents the
18 hospitals and traditionally it was one campus
19 down in Charleston which has four hospitals
20 within that one campus. There's MUSCP which
21 may formally be known as UMA which houses the
22 physicians and that has about five to six
23 entities within itself. And then there's two
24 entities, MSB, Inc. and MSB which are our
25 strategic venture for when we need to joint

1 venture with certain people. So they all their
2 own entities and structures but we roll them up
3 and so we when we use the brand MUSC Health in
4 our vernacular when we say MUSC we're
5 traditionally including the University as a
6 part of that enterprise as well.

7 Q: Okay. Thank you for that. And in your role as
8 CFO how many people work within the finance
9 division that you oversee?

10 A: Slightly over a thousand.

11 Q: Okay. And the thousand or so people that
12 you're responsible for their work, what
13 different areas does that encompass? And just
14 give us generally. I know that we would be
15 here half the day if you went through all of
16 it, so.

17 A: It falls really in six quadrants. So the
18 supply chain, the revenue cycle, the finance
19 which is your AP payroll, putting the financing
20 statements together, FP&A which is where we do
21 our financial planning and analysis
22 reimbursement, and then we have innovation
23 engagement training vertical. So within the --
24 those are the top six that I manage.

25 Q: And in that role can you tell the Court what

1 annual reports that you prepare for the Board
2 of Trustees of MUSC and MUHA?

3 A: Sure. Roughly we produce financial statements
4 and we'll do the sensitivities and analysis.
5 On an annual basis we perform the audit that is
6 then shared with the Controller General, shared
7 with all our lenders, and ultimately approved
8 by the Board at the December meeting. We're
9 audited by KPMG. We've been audited for
10 several years by them.

11 Q: The -- and if you would please, would you
12 explain to the Judge how you -- how the monthly
13 financials are put together, what your process
14 is?

15 A: Sure. We're a learning institution so I'm also
16 a professor and teach for MUSC, and so we do it
17 very publicly, a little different than most
18 people do, and we put everything up on big
19 screens, all the financial statements, and
20 drill into the accounts and then look at the
21 journal entries. And we're doing that so that
22 the accountants who perform the work, you know,
23 get the opportunity to show what they've done
24 and also learning lessons, and it's an
25 efficient way to mitigate risk as we tie

1 everything down to make sure that it's buttoned
2 up and makes sense. And we have about 20
3 people in the room when we do that. So that's
4 a clear ---

5 Q: And that's for the monthly financials?

6 A: That's for the monthly financials. We have all
7 our entities under MUSC Health go through that
8 process. So they'll come in and show all their
9 information and we make sure it's all related
10 and connected.

11 Q: And the Medical University of course is a
12 public entity and subject to FOIA and so that
13 information is available to the public?

14 A: Yes. Uh-huh.

15 Q: Okay. Now on an annual basis when you are
16 preparing the -- what becomes the audited
17 financial reports, the CAPA, what is your
18 process for that?

19 A: Oh we use the same process. It's -- normally
20 we are closed by the tenth working day of the
21 month, the following month. When we do the
22 audit we allow additional -- about ten extra
23 days -- just to make sure that we have all of
24 the trailing information that comes in and we
25 publish it by September 30th.

1 Q: And -- right, but well what is the fiscal year
2 for the Medical University and MUHA?

3 A: June 30th for both entities.

4 Q: Okay. For both entities. And the -- once the
5 financial statements are prepared -- the annual
6 financial statements are prepared by you and
7 your team -- are they audited by an outside
8 auditor?

9 A: Yes, KPMG is with us throughout the year doing
10 inspections randomly and then we go into an
11 official process that starts in June. They do
12 the pre-audit work and they're heavily embedded
13 with us all the month of August and September.

14 Q: Okay. Mr. Bupp, if you could put up MUHA
15 Exhibit 29, please?

16 (MUHA Exhibit Number 29 was introduced into the
17 record at this time.)

18 Q: And if you would when this comes up on the
19 screen or if you need the hard copies easier
20 I'll hand it to you. Okay, here we go. Okay,
21 now I see the blue one. All right. Now we're
22 -- there we go. Could you identify that
23 document for the Court, please?

24 A: Yes, this is MUHA's audited financial statement
25 for June 30, '19.

1 **Q:** And this is one that has -- where KPMG has
2 completed its audit and this document has
3 actually already been submitted to the
4 Controller General for the State of South
5 Carolina; is that right?

6 **A:** That's correct.

7 **Q:** Okay. And that -- and you do that on an annual
8 basis?

9 **A:** Yes.

10 **Q:** And you're required to submit that information
11 to the Controller General?

12 **A:** Yes, we are. It rolls -- it becomes a part of
13 the State's income statements.

14 **Q:** Okay. All right. Your Honor, we would move to
15 admit MUHA 29.

16 MR. THOMAS: No objection.

17 MR. WICEVIC: No objection.

18 THE COURT: It's admitted.

19 (MUHA Exhibit Number 29 is admitted into the record
20 at this time.)

21 **Q:** Ms. Goodlett, if you could in the audited -- in
22 the financial statement in Exhibit 29, what is
23 the size of the Medical University Hospital
24 Authority in terms of revenue, volume and
25 assets?

1 **A:** It's about a 1.7 billion dollar corporation in
2 size of revenue. As far as asset the portion
3 is about 2 million -- 2 billion, sorry.

4 **Q:** And how does that compare to, you know, other
5 businesses located in South Carolina or in the
6 Charleston area?

7 **A:** As far as healthcare providers?

8 **Q:** Yes, healthcare providers, yes.

9 **A:** Okay. 'Cause we're less than Boeing.
10 Comparable to Roper would be the largest one I
11 knew. HCA gets a little complex, you know,
12 because they do have a foothold in Summerville
13 with it's intent is over in East Cooper so
14 smaller than those big for-profit corporations.

15 **Q:** In addition to the annual audited financial
16 statement do you also prepare the budgets for
17 the Medical University that are submitted and
18 reviewed by the Board of Trustees.

19 **A:** For MUHA, yes we do.

20 **Q:** For MUHA. And how often do you prepare those
21 budgets?

22 **A:** Typically it's a once a year. Occasionally if
23 we are seeing change in our environment such as
24 maybe a uncertainty around DSH or we're
25 launching, you know, new facilities at

1 different times we may do a mid-year budget
2 adjustment.

3 Q: Can you tell the Court what the audited
4 financials as of June the 30th, 2019, what is
5 the financial condition of MUHA at year end
6 6/30/2019?

7 A: Very strong. We had an operating profit of
8 about \$55 million dollars. The cash stage on
9 hand were up to about 81. So very strong, very
10 favorable.

11 Q: And today has it changed since June the 30th?

12 A: Not materially, no.

13 Q: And does it reflect the financial condition
14 since this application that we're here in this
15 litigation? It was filed in December of 2017,
16 so over the past two years what is the big
17 picture changes if any to the MUHA financial
18 outlook?

19 A: Well there's been a lot over the past two
20 years. Going into chronologically, Children's
21 was starting to be built. That's our big Shawn
22 Jenkins platform. That would be about \$390
23 million dollar in cost; the debt on that is
24 about 330 million because we've had a lot of
25 philanthropy and donations and stuff like that.

1 We hope to open that in the January-February
2 time frame. But we've been building that.
3 We've also opened various locations throughout
4 Charleston. The Kenny Summey Medical Pavilion
5 up in North Charleston where we're trying
6 really decamp the main campus to make room for
7 quaternary tertiary care and put services for
8 the pediatric population, physicians mainly in
9 the imaging center so they can go up and be
10 seen outside of the peninsula. The largest
11 probably -- although it wasn't large from a
12 dollar magnitude -- was the acquisition of the
13 four new hospitals from CHS that commenced, or
14 completed or March 1st.

15 Q: March 1st of 2019?

16 A: Correct, yes.

17 Q: So you began operating those four hospitals,
18 the two in the Florence area and the two in the
19 York Lancaster area April the 1st, 2019.

20 A: March 1st.

21 Q: I mean March 1st, 2019. Excuse me.

22 A: Yeah.

23 Q: The other thing I want to ask you about is do
24 you monitor and track the debt capacity of
25 MUHA.

1 A: Yes, we do.

2 Q: Okay. Would you put up Demonstrative 1 for Ms.
3 Goodlett, please? All right. Ms. Goodlett.
4 (MUHA Demonstrative Exhibit Number 1 was referenced
5 at this time.)

6 Q: Okay. So, Ms. Goodlett, did you prepare this
7 MUHA debt capacity analysis?

8 A: Some of them my team did, yes.

9 Q: All right. And if you would please would you
10 explain to the Court what information was used
11 to prepare this debt capacity analysis and what
12 it reflects?

13 A: Certainly. To preface it, when you determine
14 that capacity there's two way you look at it.
15 One is the number of assets that you own or
16 what's called book value, and then the amount
17 of debt that carries, i.e., like your mortgage.
18 What's the appraisal and what's the mortgage on
19 your house. The other way is the income
20 statement approach is what this denotes. And
21 it says typically how many times over can you
22 make a mortgage payment. So it takes some
23 assumption in there, and this part relates more
24 to your own personal finances. What's your
25 income and how much debt could you buy as you

1 attributed new towards the house. So the green
2 is debt issuance that are committed or planned
3 from our long range financial plan. The white
4 means we have additional capacity that we're
5 not touching or tapped into, and then the red
6 line is really our safety line that even
7 though, hey, we could go off and borrow all
8 this money, we have safeguards in place and say
9 we really wouldn't want to go above that red
10 line unless there was some really, really good
11 strategic business reason.

12 Q: All right. Can you -- if you would please can
13 you go through Demonstrative Number 2 and
14 explain to the Judge what this is, Ms.
15 Goodlett?

16 (MUHA Demonstrative Exhibit Number 2 was referenced
17 at this time.)

18 A: Sure. MUHA is changing as is MUSC Health, but
19 going back to it's historical roots in 1999
20 MUHA was almost sold to HCA I believe.

21 Q: That's right.

22 A: And at that time it had reserves of \$120
23 million dollars that were shipped over to the
24 University. And though we ask annually they
25 haven't sent the money back, but basically MUHA

1 came out of the ground with no cash stays on
2 hand, just a line of credit, or what we call a
3 revenue anticipation note. And so cash has
4 always been a big focus of MUHA. The blue dots
5 denote the cash stays on hand we have at the
6 end of each month during this time frame. And
7 we've determined some different safety zones
8 and ability to invest. So the red line
9 indicates HUD wants us to have 21 days cash on
10 hand. So that's what our main lenders says,
11 just stay above the red line. Internally we've
12 developed a safety zone to say we don't want to
13 go, you know, for a protracted period below 60
14 or 50 days cash on hand. Things would be
15 cumbersome in those type matters. And then
16 anything above it -- and it's an interesting
17 and it really goes back to our authority status
18 -- we're here to improve the healthcare status
19 of South Carolinians and all patients who use
20 our services. We don't have stockholder
21 demands. We want to invest the resources we
22 create back into the healthcare delivery system
23 here. So we deem those anything above that to
24 be -- anything to be above the 60 in this
25 particular model -- to be strategic reserves,

1 meaning we want to go and build a new clinic or
2 build a new free standing ED, whatever we can
3 do to improve access in the health status in
4 patients.

5 Q: And what does this reflect in regards to the
6 cash position of the hospital authority at
7 present?

8 A: Strengthening. Over this point in time its
9 increased about 628 percent from when it
10 started out without 13 days cash on hand in
11 2013. And a lot of that equates to we now have
12 physician -- we're a physician led organization
13 and so really having the ability to get into
14 the business and thought process behind that
15 and to just take off. I mean, we've been at
16 super capacity for five years down on the main
17 campus just people can't get in to see us. And
18 so that's a good problem to have. We're
19 probably overextended meaning we're not running
20 in the safety zone we'd like to be there, but
21 it's a favorable problem to have.

22 Q: If you would please go to Demonstrative Number
23 3?

24 (MUHA Demonstrative Exhibit Number 3 was referenced
25 at this time.)

1 **Q:** Ms. Goodlett, could you please -- let's start
2 with the -- with this debt structure and
3 financial projection chart. Does this reflect
4 the debt structure and financial projections of
5 MUHA?

6 **A:** Yes.

7 **Q:** Okay. All right. And I want to start with the
8 notes. And if you would please, if you could
9 -- if you could walk the Court through the
10 notes and explain to the Court what -- why you
11 have notes, first of all.

12 **A:** We have notes to try and make a complicated
13 thing a little easier to talk about, but it's
14 also as a reminder of our authority status.
15 Because people try to understand are you the
16 State are you not the State? We are the State.
17 But we're our own entity within the State. The
18 State is not liable for our debt, has no
19 obligations there. But we do have a lot of
20 access to capital that people wouldn't
21 understand just off the face of us. And
22 there's probably two parts to that. One is
23 that State has a pension plan and we
24 participate in the pension plan, but we don't
25 get the benefits of the investments. So under

1 our general accounting standards we have to
2 recognize some non-cash expenses coming through
3 for pension OPEB which will demonstrate a
4 little bit later on in the document. The other
5 part is that we're triple A debt. We are
6 backed by the United States government. If you
7 think about it, HUD is a credit enhancement
8 tool. It's like having your parent sign on
9 your loan, and we have the highest rating
10 possible for the debt that we issue. So the
11 notes just try to say, we're talking through,
12 here's who we are in the first section. Due to
13 that State relationship which I circle talk to
14 it, we do have a negative net asset position
15 which people unfamiliar with a governmental or
16 a state health system would say okay, that's
17 got to be a problem for you. It's happening
18 across the country with big medical -- academic
19 medical systems to where the State is holding
20 the investments for the pension and OPEB at
21 their level but passing the expenses down to
22 different components of the State which is
23 creating inequity for us.

24 Q: So is the -- for us, specifically, ---

25 A: Yeah.

1 Q: --- it's the Public Employee Benefit
2 Administration agency, PEBA, ---

3 A: Yes.

4 Q: --- that actually holds the investments for all
5 your employees, but the expense and the debt
6 for that is under your accounting rules
7 reflected on the MUHA financial statements.

8 A: Correct. And we're fine with that because a
9 byproduct the State maintains is high triple A
10 rating. It just pushes the liability down to
11 the lower organizations. We don't anticipate
12 actually having to pay this money back or call
13 on the pension. The State has made several
14 adjustments in PEBA as you referenced. The
15 entity to say, okay, they weren't -- perhaps
16 not the correct investments, they've moved.
17 They've also had some mitigating strategies
18 that we're starting to see unfold. So that --
19 the unexpected hits are slowing down and we
20 actually didn't have any in FY '19.

21 Q: Okay. And the link with -- what accounting
22 standards are applicable to the Hospital
23 Authority.

24 A: Governmental accounting standards boards.
25 There's -- the financial markets live in a

1 world of FASB, or Financial Accounting
2 Standards Boards. Governmental are usually,
3 you know, three to five years behind in
4 adaptation of things, and we are a governmental
5 entity, but we flip when we have to talk about
6 the markets to be comparable.

7 Q: Okay. But let's start with the -- and the
8 governmental accounting standards are GASB?

9 A: Correct.

10 Q: Okay. And what you were talking about a few
11 minutes ago in regards to the pension money,
12 there were rules under GASB that were adopted
13 that related to that; is that correct?

14 A: Correct.

15 Q: And what are those?

16 A: GASB 68 was the adaption that came in I think
17 it's 2015 that said, okay, you have this future
18 liability for people who participate in your
19 pension plan. The State of South Carolina did
20 not want to reflect it. They said all the
21 authorities or entities of the state will pick
22 up that expense. So that was about a \$600
23 million dollar -- not in cash -- but it was
24 just a hit to our balance sheet.

25 THE COURT: How do you spell that acronym GASB?

1 **A: G-A-S-B.**

2 **THE COURT: All right, that's it?**

3 **A: And it's a Governmental Accounting Standards**
4 **Board.**

5 **THE COURT: Okay.**

6 **Q: So it was GASB 68 and then followed by GASB 75?**

7 **A: Right. And then two years later they**
8 **recognized there was another benefit for**
9 **retirees related to health insurance that they**
10 **-- that 75 also said, hey, we want somebody to**
11 **reflect that liability on their balance sheet.**
12 **The State chose to pass on that and moved it**
13 **down to its subordinate organizations.**

14 **Q: The -- at Medical University when you took over**
15 **the position as the Chief Financial Officer**
16 **what changes if any, or processes -- new**
17 **processes if any did you put into place or**
18 **start to refine there for purposes of running**
19 **the finances?**

20 **A: The first thing was the month end close process**
21 **that we talked about to use it as a teaching**
22 **opportunity and transparency. The second**
23 **biggest thing was really a long range financial**
24 **planning process that had not been performed at**
25 **MUSC Health before. And so as we saw more**

1 projects occurring people get nervous and it's
2 helpful to say, okay, it's going to happen
3 today but it is going to happen five years from
4 now, seven years, whatever. When will that
5 happen? So you can start to time your cash
6 outflows and inflows related to all this
7 planning that was going on. So that was a
8 process driven from MUHA. The University and
9 MUSCP were invited to attended. We were trying
10 to figure that out. And a lot of that was with
11 this Nexton application and thinking through,
12 okay, where does this make sends. How long
13 will the CON process take? How long will it
14 take us to build it, and what does that look
15 like projecting our debt profile?

16 Q: And you came in June of 2017 and this Nexton
17 application or CON application was filed in
18 December of 2017?

19 A: Correct. Yes.

20 Q: Okay. Is it fair to say that some of the work
21 on Nexton had -- or some of the fault was
22 already in process when you arrived there and,
23 you know, you had to -- you had to take a
24 little bit of time to get acclimated to the --
25 to a position like this; is that fair to say?

1 **A:** You do. And I think it was -- something I do
2 everywhere I go is have a long range financial
3 plan, but it's also meted here and a good part
4 of my on boarding with the Board was this is
5 something you need to do and we have to
6 vigorously update it annually and make sure
7 we're in tune with it.

8 **Q:** And also on this -- in your notes -- you talk
9 about the HUD key requirements. What is the
10 Medical University Hospital Authority's
11 financing lender of choice or backer of choice?

12 **A:** Our backer of choice is HUD and typically
13 because if you have the federal government's
14 rating behind you the interest rates are lower.

15 **Q:** So you get a better deal?

16 **A:** You get a better deal.

17 **Q:** All right. And what HUD projects -- and we'll
18 go into this a little more later on -- but what
19 HUD projects has the Medical University
20 financed through the HUD backing? Or what
21 projects?

22 **A:** There's been several so in chronological order
23 the Power Plant which sits behind our wellness
24 center was a HUD enabled project. ART was
25 really the time I think the organization got

1 into the Ashley River Tower big time on that
2 piece. Children's, Shawn Jenkins, is a HUD
3 project, and we just completed the CHS
4 acquisitions and that was 134 million. We rate
5 locked on Friday at three percent as a HUD
6 issuance.

7 Q: Okay. And when you are tied to HUD the way
8 that the Medical University is, you've got
9 these key requirements. And what are the two
10 key requirements for the Medical University
11 given the fact that they have these HUD backed
12 debt?

13 A: That they signed our loan with us?

14 Q: Yes, that they signed your loan with you.

15 A: They want to make sure we have 21 days cash on
16 hand, and they want to make sure we have a 1.4
17 debt service coverage.

18 Q: Okay.

19 THE COURT: Say that again? I didn't get it.

20 A: Yes, sir. They want to make sure we have 21
21 days cash on hand and then debt service
22 coverage of 1.4.

23 Q: And explain -- well we'll go into a little bit
24 later, but explain a little bit about what you
25 mean by debt service coverage of 1.4?