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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

The Honorable Ralph King Anderson, III
Chief Administrative Law Judge

APPELLATE CASE NO. 2020-001323

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

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

v.

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

AND

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

v.

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

AND

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

v.

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

RECORD ON APPEAL - VOLUME 8 OF 12

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INDEX

RECORD VOLUME 1

ORDERS

PAGE

Order of the Court of Appeals, filed November 25, 2020	1
Amended Final Order of the Honorable Ralph King Anderson, III, filed September 4, 2020.....	4

PLEADINGS

Walterboro Community Hospital, Inc. d/b/a Colleton Medical Center's Request for Final Review Conference, filed August 3, 2018.....	75
Trident Medical Center, LLC's Request for Final Review Conference, filed August 6, 2018.....	364

RECORD VOLUME 2

491

Walterboro Community Hospital, Inc. d/b/a Colleton Medical Center's Petition for Administrative Review and Request for Contested Case Hearing, filed October 9, 2018.....	661

RECORD VOLUME 3

981

Trident Medical Center, LLC d/b/a Trident Medical Center and Summerville Medical Center's Petition for Administrative Review and Request for Contested Case Hearing, filed October 9, 2018	990
Trident Medical Center, LLC d/b/a Trident Medical Center and Summerville Medical Center's Prehearing Statement filed November 16, 2018	1344
Walterboro Community Hospital, Inc. d/b/a Colleton Medical Center's Prehearing Statement, filed November 19, 2018	1363
Trident Medical Center, LLC d/b/a Trident Medical Center and Summerville Medical Center, and Walterboro Community Hospital, Inc. d/b/a Colleton Medical Center's Motion to Alter or Amend (Reconsider) Final Order, filed July 20, 2020.....	1381
Medical University Hospital Authority's Response in Opposition to Petitioners' Motions to Alter or Amend Final Order, filed July 30, 2020	1400
South Carolina Department of Health and Environmental Control's Response in Opposition to Petitioner Trident Medical Center, LLC's Motion to Alter and Amend, filed August 4, 2020.....	1410

Joint Motion of the Appellants Trident Medical Center, LLC and Walterboro Community Hospital, Inc., for Relief from Appeal Bond Required by S.C. Code Ann. § 44-7-220(B) and Memorandum in Support, filed October 7, 2020	1425

Medical University Hospital Authority’s Motion to Dismiss Appeal and Return of Appellants’ Joint Motion for Relief from the Appeal Bond Required by S.C. Code Ann. § 44-7-220(B), filed October 29, 2020	1453

RECORD VOLUME 4.....1471

Trident Medical Center, LLC and Walterboro Community Hospital, Inc.’s, Reply to Respondent Medical University Hospital Authority’s Motion to Dismiss Appeal and Return to Motion for Relief from Appeal Bond, filed November 3, 2020	1471

Medical University Hospital Authority’s Reply in Support of Motion to Dismiss Appeal, filed November 13, 2020	1481

TRANSCRIPTS

Transcript of Administrative Hearing before The Honorable Ralph King Anderson, III, November 6 – 8, 2019; November 12 – 15, 2019; November 18 – 21, 2019.....	1488-4314

PATRICK BOSSE

DIRECT EXAMINATION BY MS. HOLLINGSWORTH.....	1582
CROSS EXAMINATION BY MS. JONES	1619
REDIRECT EXAMINATION BY MS. HOLLINGSWORTH.....	1638
RECROSS EXAMINATION BY MS. JONES	1643

BRET D. JOHNSON

DIRECT EXAMINATION BY MS. HOLLINGSWORTH.....	1646
CROSS EXAMINATION BY MS. CRUM	1785
REDIRECT EXAMINATION BY MS. HOLLINGSWORTH.....	1856
RECROSS EXAMINATION BY MS. CRUM	1864

MARK RICHARDSON

DIRECT EXAMINATION BY MS. SHOUN	1868
VOIR DIRE EXAMINATION BY MS. CRUM.....	1892
DIRECT EXAMINATION (CONT.) BY MS. SHOUN.....	1895

RECORD VOLUME 5.....1961

MARK RICHARDSON

CROSS EXAMINATION BY MR. WICEVIC	2004
CROSS EXAMINATION BY MS. CRUM	2032
REDIRECT EXAMINATION BY MS. SHOUN	2102

TODD G. GALLATI

DIRECT EXAMINATION BY MR. THOMAS	2128
VOIR DIRE EXAMINATION BY MS. CRUM.....	2146
DIRECT EXAMINATION (CONT.) BY MR. THOMAS.....	2148
CROSS EXAMINATION BY MS. CRUM	2208
REDIRECT EXAMINATION BY MR. THOMAS	2266

LISA VALENTINE

DIRECT EXAMINATION BY MR. SUMMER	2279
CROSS EXAMINATION BY MS. BAKER.....	2310
REDIRECT EXAMINATION BY MR. SUMMER	2321

JAMES O'NEAL HIOTT, III

DIRECT EXAMINATION BY MR. THOMAS	2328
CROSS EXAMINATION BY MS. JONES	2382
REDIRECT EXAMINATION BY MR. THOMAS	2404
RECROSS EXAMINATION BY MS. JONES	2412

VICTORIA CUMMINGS

DIRECT EXAMINATION BY MR. SUMMER	2417
VOIR DIRE EXAMINATION BY MS. BAKER	2421
DIRECT EXAMINATION (CONT.) BY MR. SUMMER	2423
CROSS EXAMINATION BY MS. BAKER.....	2438
REDIRECT EXAMINATION BY MR. SUMMER	2443

RECORD VOLUME 6 2449**DANIEL J. SULLIVAN**

DIRECT EXAMINATION BY MR. THOMAS	2449
VOIR DIRE EXAMINATION BY MS. CRUM.....	2470
DIRECT EXAMINATION (CONT.) BY MR. THOMAS.....	2484
CROSS EXAMINATION BY MS. CRUM	2686
REDIRECT EXAMINATION BY MR. THOMAS	2759
RECROSS EXAMINATION BY MS. CRUM	2772

MARGARET MURDOCK

DIRECT EXAMINATION BY MR. WICEVIC	2790
CROSS EXAMINATION BY MS. CRUM	2925

RECORD VOLUME 7 2941**MARGARET MURDOCK**

CROSS EXAMINATION BY MS. HOLLINGSWORTH	2945
CROSS EXAMINATION BY MR. SUMMER	3100

DR. PATRICK CAWLEY

DIRECT EXAMINATION BY MS. JONES.....	3139

CROSS EXAMINATION BY MS. HOLLINGSWORTH	3205
CROSS EXAMINATION BY MR. SUMMER	3308
 <u>DR. PHILLIP D. WARR</u>	
DIRECT EXAMINATION BY MS. JONES	3361
CROSS EXAMINATION BY MR. SUMMER	3385
CROSS EXAMINATION BY MS. LIPHAM	3398
 <u>LISA GOODLETT</u>	
DIRECT EXAMINATION BY MS. JONES	3405
 <u>RECORD VOLUME 8</u>	
CROSS EXAMINATION BY MR. THOMAS	3463
CROSS EXAMINATION BY MS. HOLLINGSWORTH	3545
REDIRECT EXAMINATION BY MS. JONES	3614
 <u>BECKY SMITH</u>	
DIRECT EXAMINATION BY MS. CRUM	3623
VOIR DIRE EXAMINATION BY MR. THOMAS	3640
DIRECT EXAMINATION (CONT.) BY MS. CRUM	3646
CROSS EXAMINATION BY MS. SHOUN	3727
CROSS EXAMINATION BY MR. THOMAS	3760
REDIRECT EXAMINATION BY MS. CRUM	3793
 <u>DAVID LEVITT</u>	
DIRECT EXAMINATION BY MS. CRUM	3801
 <u>RECORD VOLUME 9</u>	
CROSS EXAMINATION BY MR. THOMAS	4014
CROSS EXAMINATION BY MS. HOLLINGSWORTH	4109
REDIRECT EXAMINATION BY MS. CRUM	4177
 <u>BRETT JOHNSON</u>	
DIRECT EXAMINATION BY MS. HOLLINGSWORTH	4185
CROSS EXAMINATION BY MS. JONES	4210
 <u>DANIEL J. SULLIVAN</u>	
DIRECT EXAMINATION BY MR. SUMMER	4214
CROSS EXAMINATION BY MS. JONES	4293
REDIRECT EXAMINATION BY MR. SUMMER	4306

<u>RECORD VOLUME 10</u>	4315
<u>DHEC TRIAL EXHIBITS</u>	
1.....	4315
<u>RECORD VOLUME 11</u>	4801
<u>DHEC TRIAL EXHIBITS (CONT.)</u>	
1 (cont.).....	4801
<u>RECORD VOLUME 12</u>	5288
<u>DHEC TRIAL EXHIBITS (CONT.)</u>	
1 (cont.).....	5288
2 (pp. 1, II-4 through II-9).....	5330
3 (pp. 1, II-4 through II-11).....	5337
4.....	5346
7 (pp. 1107-1108).....	5492
8 (pp. 726-727).....	5494
<u>MUHA TRIAL EXHIBITS</u>	
2.....	5496
<u>TRIDENT TRIAL EXHIBITS</u>	
94.....	5540
<u>CERTIFICATE OF COUNSEL</u>	5542

1 **A:** That relates back to our -- that kind of that
2 first white and green chart that says on an
3 annual basis what are your mortgage, lease,
4 principal and interest payments and then how
5 much more does your free cash flow float above
6 those. So this is saying that on an annual
7 basis we know that we have to plan annually to
8 pay for the things in the green which is our
9 mortgage payment, capital lease is interest.
10 But based on our income level what we're
11 generating from operations, that ties it up to
12 the whole white line. So they just want to see
13 that we're 1.4 more than the green. Right now
14 we run anywhere from 3 to 2.8.

15 **Q:** So you're well above the 1.4?

16 **A:** Yes.

17 **Q:** Okay. Going back to the chart, the -- going to
18 the second section of the chart that begins
19 with the days cash on hand, what -- the
20 information that's reflected in here from
21 calendar year 2013 or fiscal year 2013, '14,
22 '15, '16, '17, '18 and '19, what is the source
23 of the information that's set forth in this
24 chart?

25 **A:** Our completed audits with KPMG.

1 Q: The audited financial statements?

2 A: Yes.

3 Q: And the -- as of 2019 what were the days cash
4 on hand as of 6/30/2019?

5 A: 81.

6 Q: 81 days cash on hand. And what was the
7 increase in your net position for the year
8 2019?

9 A: 55.2 million.

10 Q: Okay. And what does that mean?

11 A: That means after we ran, took care of all the
12 patients and paid all our bills they were at
13 about \$55.2 million dollars from operations
14 that we could spend as we choose.

15 Q: Okay. And you go through -- you go through the
16 pension and OPEB cash, non-cash expense, the
17 depreciation, the interest expense, and then
18 you come to a number that's entitled cash flow.
19 What do you mean by cash flow?

20 A: That's after operations to say this is how much
21 money, you know, true cash in the bank. We're
22 trying to get back to cash dollar that we would
23 be able to spend on anything that we wanted
24 going forward. So it's a -- we spin off
25 anywhere from 125 to \$180 million dollars a

1 year. And I think that was a big change for
2 MUSC to think -- MUHA to think of itself that
3 way.

4 Q: Uh-huh.

5 A: And so that's a lot of money to be invested.
6 Typically you could go buy new capital
7 replacement, build new buildings, open clinics.
8 But the first thing you gotta do is make sure
9 you make your mortgage payments. And so that's
10 where in the next line we'll say annually for
11 this year -- let's just pick 2017 maybe to walk
12 ---

13 Q: Okay.

14 A: --- or we'll walk through 2019.

15 Q: Do 2019 ---

16 A: Okay.

17 Q: --- because that's the most recent one.

18 A: All right.

19 Q: So the free cash flow for 2019 was 149,187,158.

20 A: Right. So from operation to -- we spun off a
21 \$186 million dollars. But we have or debt
22 obligation of 37 million. So then in or
23 planning we know, okay, we have about 149
24 million we could spend. We never want to be
25 maxed out when we bring in that debt service

1 coverage ratio from HUD to say, okay, we could
2 borrow something that the monthly -- annual
3 payment was \$106 million dollars, and that's a
4 lot of money. If you took that up to a five
5 percent loan for 25 years and we built some
6 mega hospital or something, we could borrow up
7 to an additional \$1.4 billion dollars based on
8 the results through June.

9 Q: Based for the result through June. And that's
10 what you call the adjusted free cash flow?
11 That's taking into consideration your HUD
12 covenant and what you have to keep that ratio
13 at 1.4?

14 A: Correct.

15 Q: With the 106 million reflected as of June 30,
16 2019 that would give you an additional ability
17 to borrow up to how much did you say?

18 A: An addition 1.4 billion.

19 Q: 1.4 billion. Okay. The -- the adjusted
20 operating margin percentage that is reflected
21 in your chart here, what does that related to?

22 A: That's where we're trying to be comparable to
23 other non-state entities that don't have that
24 pass down of expenses that they can't control.
25 And so if you add it back to our current

1 operating margins that's showing MUHA
2 comparable to other organizations. It's
3 running around with about 4 to 6.4 to 5.5
4 percent.

5 Q: And you look at that, is that something that
6 people you're looking to borrow money from are
7 interested in seeing?

8 A: Yes. With lenders there's an awareness
9 throughout the nation. Utah has the same
10 problem we do. California has the same problem
11 with how the state handles this. And so they
12 do this calculation when they evaluate us to
13 say we know you don't have to pay cash for the
14 pension or the OPEB piece and so they pull that
15 out and so you're true operation cash flow
16 margins is more in these arenas.

17 Q: Okay. And so you track that as part of your
18 normal operations because it's important to the
19 market that you go to to borrow money.

20 A: Right. And we're in constant contact with the
21 market and get calls all the time that people
22 want to meet and talk about loaning us money or
23 what are we doing with our new projects, and so
24 it's just helpful to always have a top line,
25 and it's our communication tool with the Board

1 as well. You know, if things aren't
2 particularly going right what course
3 corrections do we need to make or the --
4 because these are Board policies. You know, we
5 have HUD but our governing body sets a lot of
6 our debt management policies.

7 Q: And you're talking about the Board of Trustees
8 for the Medical University now?

9 A: Yes.

10 Q: All right. From -- on the chart from 2020
11 forward, 2020 to 2023, those numbers are
12 projections?

13 A: That's -- the first one will be our adopted
14 Board approved budget for 2020 and then post
15 that our projections and our long range
16 financial plan.

17 Q: Okay. And those are prepared in your
18 department under your supervision?

19 A: Correct. That's -- we call it our long range
20 financial process.

21 Q: And so for the budgeted part of it, that is a
22 budget that's already been approved by the
23 Board of Trustees; is that correct?

24 A: Correct.

25 Q: And then the projections are -- for 2021 and

1 '22 and '23 -- are based on what?

2 A: A ton of key assumptions. You know, what do we
3 see our growth rates. What do we see as
4 inflationary trends. What's probability of,
5 you know, recruiting new service lines that
6 we're deploying out to different locations.
7 And this is for all of MUHA which is not only
8 the four hospitals currently on the Charleston
9 campus inclusive of Shawn Jenkins being --
10 coming on line, Nexton's in here, and the
11 regionals as well.

12 Q: The four regionals?

13 A: Correct.

14 Q: And you use what you've seen in the past, what
15 the historic performance has been, when you
16 make your projections?

17 A: Correct. With some growth assumptions and
18 expense assumptions and physician recruitment
19 assumptions.

20 Q: All right. In the -- the Board of Trustees --
21 I think you mentioned this a few minutes ago --
22 has established or the Medical University and
23 the Board of Trustees has established a
24 corridor of safety, and what is that?

25 A: You'll see us reference them in various

1 financial ratios and it's just we don't want to
2 go below. You'll see those as absolutes in
3 like the red line for the 21 days cash on hand,
4 and then you'll see what we prefer and operates
5 more smoothly in these safety corridors to say
6 we won't be perfect -- they're not a hard line
7 -- but they're kind of ranges to see. There
8 are times when you grow and are expanding.
9 You're not efficient day 1. You know, it takes
10 about, you know, to really move into something
11 about three years with the CHS hospitals that
12 they'll be totally integrated into us.
13 Bringing a new building online it takes us
14 about 9 to 18 months to fully occupy. So
15 that's why we've adopted ranges in those and
16 call it a corridor.

17 Q: Okay. The other thing, the last thing that's
18 reflected in this chart is the -- is what? In
19 this bottom section?

20 A: That's our current annual payments on our
21 outstanding debt. So this is a part of our
22 long range financial plan. So we're projecting
23 forward how much debt will we have at 6/30/20.
24 The power plant will have about \$36 million
25 dollars left on it. It was issued in 2004 and

1 refinanced in 2013 at 3.85 percent. ART, the
2 Ashley Rutledge Tower, we will owe about 270
3 million on that at rate of about 2.94. We've
4 got some various capital leases that we have
5 entered in. We will assume the CSC lease for
6 the land which is about 38 million. And then
7 we have Children's coming online the debt for
8 Children's.

9 Q: That's the new Shawn Jenkins facility?

10 A: Yes, that's the new Shawn Jenkins. And so
11 we'll start making mortgage payments on that
12 when we inhabit it, but the balance is 316 with
13 a 3.59 rate. CHS is a 133 million. That was
14 the bridge loan that we got from TDBank. By
15 the end of December, we just got that new rate
16 on Friday and we'll lock that down at three
17 percent. And then we have a placeholder you'll
18 see future going forward for when we pull
19 Nexton online and start making that payment.
20 But here's our actual outstanding debt
21 projected as of 6/30/20.

22 Q: And right now it is \$750 million dollars.

23 A: Correct. Uh-huh.

24 Q: The -- a couple of the items up there, the --
25 oh, I know. When you were -- the two most

1 recent HUD projects. First of all, the
2 Children's. Yesterday -- well the Children's
3 Hospital actually came in higher than the debt,
4 the \$316 million dollars, correct?

5 A: Correct.

6 Q: All right. And if you would, please, could you
7 explain to the Court what the additional funds
8 were spent on and what was the source for the
9 payment of those other items?

10 A: Sure. When Shawn Jenkins was designed it was
11 approved in CON process and so the debt related
12 to it was going to be \$316 million dollars.
13 There was funding coming in from the State and
14 philanthropy. And as it was being built over
15 this ten year period Shawn Jenkins is really
16 the culmination of four CON's. There was the
17 base CON for approval which the financing was
18 linked to. Then there was a need to expand
19 some of the ORs that were going to happen so
20 there's not financing, leaving donations and
21 pledges for that. Then ---

22 Q: So you got donations and pledges for those
23 operating room suites?

24 A: Right.

25 Q: At Shawn Jenkins?

1 A: And then the ability to change the NICU beds.

2 Q: Uh-huh.

3 A: And then there were more beds that became
4 available. So philanthropy, some -- we got \$25
5 million dollars from the State -- all came in
6 fund these extra things. We have had a
7 hurricane five grade military where a
8 helicopter lands put in.

9 Q: Uh-huh.

10 A: And aquarium for the children and some new life
11 safety features. So as both normal things were
12 added through a CON process there were also
13 things paid more by philanthropy or people who
14 wanted to donate things. They're been very
15 generous with us.

16 Q: In support of the Children's Hospital?

17 A: Yes. Uh-huh.

18 Q: When the -- and I want to go back to the Ashley
19 River Tower. When it was -- that was -- or
20 either the power plant or the Ashley River
21 Tower were the first I guess work with HUD.
22 When Ashley River Tower was being reviewed by
23 HUD did HUD make any determinations about the
24 need for the Ashley River Tower?

25 A: Yes. For actually all the four hospitals on

1 the Charleston campus ---

2 Q: Uh-huh.

3 A: --- HUD was reliant upon DHEC and agreed with
4 the terminology that they're essential.
5 Meaning anything happened these hospitals need
6 to be active, replaced and thought about. So
7 that's why they're in our long range master
8 facility plan to enhance all the buildings and
9 move forward with that. But they were deemed
10 essential by HUD for funding. And why is that
11 important? HUD would not get behind if there
12 eight hospitals for 1,000 people -- I'm just
13 making that up.

14 Q: Right.

15 A: 'Cause they're not essential, you know.

16 Q: Right. How closely do you work with the folks
17 at HUD?

18 A: Fairly closely. We visit with them in person
19 once a year and talk to them probably on a
20 semi-annual basis. And then a lot depends on
21 our current activity.

22 Q: Uh-huh.

23 A: And what we're doing with them at a particular
24 time. We have a very transparent relationship,
25 and we're one of their favorite clients.

1 Q: And they've publicly talked about the Medical
2 University being a favorite client?

3 A: Uh-huh. Yes.

4 Q: What -- when the CHS acquisition work was being
5 done I think that's the most recent interaction
6 you've had with HUD?

7 A: Yes.

8 Q: And that final interest rate and financing for
9 the CHS acquisition was finalized on Friday?
10 Last Friday?

11 A: The rate was locked, yes.

12 Q: Okay.

13 A: All the paperwork will be completed by December
14 31st.

15 Q: All right. And for the construction of the
16 Berkeley County Hospital -- the CON application
17 that we're here in Court about today -- what is
18 the plan at the Medical University Hospital
19 Authority in regards to financing for, or the
20 payment for that facility? How are you going
21 to pay for it?

22 A: We have a couple options there. Our preferred
23 would be to make an application with HUD during
24 the construction process and have it be deemed
25 a HUD project and when it's complete go through

1 very similar like we did with CHS and put some
2 bonds out into the market. The second option
3 could be going through bridge financing like we
4 did with CHS while HUD'S still in it's approval
5 process. And then if HUD for some reason
6 decided they didn't want to enhance us that,
7 then we would just be out in the market with
8 whoever have our bridge loan. And we've had a
9 stable of fortified banks that have been
10 willing to pick up our debt in the past two
11 years with really no collateral and just the
12 good name that they would be repaid from MUHA.
13 And the examples of that, we did something we
14 call revenue anticipation notes which function
15 as a line of credit for Home 20 Million we've
16 paid by 65 million of those. There's no
17 collateral. We still got good rates. The
18 bridge loan because we're moving, you know,
19 that was TDBank just believing in the
20 profitability of them. So we do have a policy
21 that with the regionals they have to fund and
22 pay their own way and so we keep our markets
23 different. So Charleston money stays in
24 Charleston and the money related to the two
25 other markets they fund and float their own

1 capital needs.

2 Q: In regards to the CHS acquisition, the regional
3 hospitals that you purchased from CHS, at the
4 time of that transaction did you make
5 projections or did your department make
6 projections for the performance of those four
7 hospitals as they were acquired by MUHA?

8 A: We did.

9 Q: And can you tell the Court what the experience,
10 what the actual experience has been since April
11 the 1st, 2019 this year?

12 A: It's been favorable compared to the plan. It
13 is a three year plan to get all our IT
14 platforms in, our specialists deployed and
15 different things with them, but they're
16 performing very favorably with our planned
17 expectations.

18 Q: How have the revenues for the first four months
19 of the projects performed in regards to the --
20 I mean, in relation to what you've projected?

21 A: I got you. We bought them on March 1st and our
22 physical year ends June 30th, and they exceed
23 budget by about \$4.2 million dollars. So we
24 knew there would be activities and things going
25 on for this physical year that we're in that

1 will end June 30, we anticipate them making \$12
2 million dollars of operating margin. They're
3 going to come in probably about \$13 to \$14
4 million dollars, so slightly ahead of target.

5 Q: And what is the percentage on that operating
6 margin?

7 A: They -- and they're fully formed will get up
8 into about an 11 or a 12 percent range. When
9 people think about the CHS -- CHS is a for-
10 profit company.

11 Q: Right.

12 A: And so they had to make State hold through
13 demands. And these four hospitals we bought
14 had EBITDA that was below 11 percent. It was
15 in the 9 to 11 percent range. And so that's
16 why they had to make a market call. They put
17 them up for sale. But they were carrying a ton
18 of debt, like \$56 million dollars or so that
19 was just allocated from the corporation down to
20 them. These four hospitals that we bought will
21 have an annual debt service of about 9 million
22 so we just chopped that in half for them.

23 Q: Right. And we did that -- what effect did that
24 have on the EBITDA for the four regional -- or
25 the CHS hospitals?

1 **A:** We anticipate their EBITDA prior to acquisition
2 was about 16.5 and over a three year period
3 will roll up to 32 million and in excess of
4 that.

5 **Q:** In excess of 32 million ---

6 **A:** Yes.

7 **Q:** --- over three years?

8 **A:** Right. And the brand influence will be the
9 access to get into specialists. So we're
10 seeing volume pick ups from people returning to
11 the community. Part of the reason for the CHS
12 acquisition is 50 percent of South Carolinians
13 above Florence go into North Carolina to
14 receive their quaternary tertiary care. And so
15 if there's a way that we can decant Med U but
16 also attach and so it's easier access back then
17 we're starting to see some of those patients
18 are not going to North Carolina for those
19 services but actually coming back into
20 Charleston.

21 **Q:** And I want to ask you one other question about
22 the financial position going back to MUHA 29 at
23 -- it's page 15, which is the statement of net
24 position.

25 **(MUHA Exhibit Number 29 was referenced at this time.)**

1 Q: What is the current cash on hand, the dollar
2 amount, as of June 30th, 2019?

3 A: It was about \$420 million dollars or 81 days
4 cash on hand.

5 Q: And that's -- I mean, that's money in the bank?

6 A: It is money in the bank.

7 Q: Okay. Ms. Goodlett, I'd like to ask you a
8 couple of questions about the pro formas. For
9 the CON application for the Nexton Berkeley
10 County Hospital, there are a couple of items in
11 those pro formas I'd like to ask you about.
12 The first one is a question that -- you had
13 your deposition taken and you were asked a
14 series of questions during that -- but I want
15 you to explain to the Court why there's an
16 eight percent return margin shown for the
17 Berkeley Hospital that is different from the
18 downtown hospitals?

19 A: Sure. Community hospitals can run, you know,
20 in the 8 to 12 range. It's not abnormal for
21 that piece. The largest thing that makes it
22 different is really the cost of all the
23 corporate overhead is more down in Charleston
24 by the main hospital. And at the time MUSC was
25 not a system yet, and so it was just part of

1 life, there was not a need for a corporate
2 allocation or anything at that time, so the
3 expectation would be that these -- that Nexton
4 gets up and runs at a level higher to that.
5 We've since evolved because now we have three
6 markets we have to think about, and so you will
7 see us get more sophisticated from 2017 with
8 how we handle our corporate overhead.

9 Q: But in that pro forma in the CON application
10 the corporate overhead was all housed on the
11 downtown campus and none was allocated to the
12 Nexton Hospital?

13 A: Correct.

14 Q: Okay. All right. I want to go to MUHA Exhibit
15 30.

16 (MUHA Exhibit Number 30 was referenced at this time.)

17 Q: One of the documents submitted in the
18 application is this total project cost
19 estimate. And at the bottom under owner costs
20 there is shown there an owner contingency of
21 \$37,197,897. Could you please explain this
22 item?

23 A: Sure. There's three contingencies developed in
24 a project at this phase. They're labeled owner
25 or has not been drawn yet, inflation

1 contingency and then the traditional build
2 contingency. So an inflation contingency is
3 the last one that comes into play, still spikes
4 up or something like that. That could be five
5 to seven percent of the project. Construction
6 contingency is normally around 10, 10 to 12
7 percent of the total cost of the project, and
8 that's really for users to change their mind if
9 they realize there's a different need along
10 with way, and then this down here is when we
11 would have about a 20 percent bucket because we
12 haven't drawn the building yet at this time.
13 The land was -- you know, we don't know
14 anything about the land, what's going to be in
15 there. So these are just very, very
16 conservative ways to prepare for whatever we
17 might encounter.

18 Q: In this application I believe you signed the
19 pro formas that were submitted and the manpower
20 financial model attestations?

21 A: That's correct.

22 Q: What is the manpower financial attestation?
23 What does that relate to?

24 A: The staffing needs that we see incremental and
25 specific to that project.

1 Q: And when you submit that information it's shown
2 incrementally.

3 A: Yes.

4 Q: And why is that?

5 A: Because typically a building won't come online
6 and be very full the first day. It could take
7 anywhere from 9 to 18 months before patients
8 get routed in there and come in, so it would be
9 not financial viable nor needed for the care of
10 the patients to fully load it with all the
11 people who are going to be employed there 18
12 months or three yeas later.

13 Q: So you show that ramp up in the projection or
14 the analysis that you submit as part of the CON
15 application?

16 A: Correct.

17 Q: So you start with a smaller work force and then
18 work up as the patient level increases over
19 time?

20 A: And we have a pretty elaborate process because
21 we invite in during one of our what if sessions
22 when we're planning for something, the clinical
23 leaders to say, okay, how, you know, for this
24 many patients what do you see would be the
25 right level and stuff like that. So it's very

1 transparent.

2 Q: Okay. Does the Medical University Hospital
3 Authority need to build this 128-bed hospital
4 to fulfill its mission?

5 A: Oh, absolutely. There are people in South
6 Carolina and some our national and
7 international patients who aren't gettin' the
8 care they deserve. On any given month there's
9 50 to 60 quaternary tertiary patients who need
10 to get in for things only MUSC can do. What we
11 do in the downtown campus we run it 95 to 105
12 percent capacity. It's just creating that room
13 to have people go out and get care in the right
14 location is very important to us. With
15 telehealth we want to be able to keep care for
16 them in their location community so people are
17 traveling down 26 to get to us now and going
18 around 526 and all the different ways, but
19 we're just at capacity. So there's a bed need
20 I think for 155 more beds in Charleston for
21 MUSC so definitely need to be able to decant
22 and get some of our community patients out in
23 the right location so we can make more room for
24 quaternary tertiary.

25 Q: And is the location in Nexton up in Berkeley

1 County, is that a good location?

2 A: Yeah, I think the main artery is I-26 that
3 people come down and if you believe that you
4 would believe we were in the right place.

5 Q: Lisa, has Medical University Hospital Authority
6 ever in it's history failed to complete a CON
7 project?

8 A: Not to my knowledge.

9 Q: And is it -- has it had any issues with paying
10 its debts as they come due?

11 A: Not to my knowledge.

12 Q: Okay. And since you've been there have there
13 -- has anything like that been an issue?

14 A: Oh, no.

15 Q: Do you see any risk of default on a \$320
16 million dollar loan to build this hospital?

17 A: No.

18 Q: Do you have any concerns or reservations at all
19 that this Berkeley facility is not financially
20 feasible?

21 A: I do not.

22 Q: Okay. Do you have any reservations or concerns
23 or doubts about the Medical University Hospital
24 Authority's ability to complete the project,
25 get it fully funded or financed, staff it and

1 provide the care that you described?

2 A: I do not.

3 Q: In regards to the healthcare provision, the
4 services, do you see any risk or concern that
5 any of those services would be an unnecessary
6 duplication or be wasted by the Medical
7 University?

8 OBJECTION:

9 MR. THOMAS: Objection, Your Honor. She's not been
10 named as an expert in health planning or even
11 healthcare finance for that matter. So I think
12 that question calls for the opinion of an
13 expert in health planning?

14 THE COURT: What do you think?

15 MS. JONES: I don't think it -- you know, this lady
16 she is the head of the entire financial
17 picture. She sees on a day to day basis what
18 services are being provided.

19 THE COURT: But you're asking about the duplication
20 of services.

21 MS. JONES: Right. I am. I am. I'm asking her if
22 any of the ---

23 THE COURT: Duplication of ---

24 MS. JONES: --- any of the things that they're going
25 to put out there are going to be wasted.

1 THE COURT: Duplication with whom?

2 MS. JONES: I beg your pardon?

3 THE COURT: With whom?

4 MS. JONES: I beg your pardon?

5 THE COURT: Duplication with whom?

6 MS. JONES: Duplication of any services with the
7 Medical University or anybody else.

8 MR. THOMAS: Your Honor, might I add that the
9 standard for duplication of service is not
10 whether they would be wasted by the applicant.
11 I mean, the thing is is there somebody already
12 out there that's doing pretty much the same
13 exact thing and if you put our out there would
14 that duplicate them. But she -- they had the
15 opportunity to name this witness as an expert
16 in healthcare finance or healthcare planning.
17 And we would have then explored that in her
18 deposition. But this is a planner question.
19 They got a planner who's going up tomorrow.

20 MS. JONES: I'm not asking her as a planner; I'm
21 asking her from a financial perspective only.

22 THE COURT: But it ultimately results in an opinion,
23 doesn't it?

24 MS. JONES: Yeah, it's an opinion. Yes, it is.

25 MR. THOMAS: It's an operational opinion. She

1 doesn't ---

2 MS. JONES: It's an operational opinion from a
3 financial perspective.

4 THE COURT: I sustain the objection.

5 MS. JONES: Okay. Thank You.

6 Q: The CON application that you did the pro formas
7 on for this particular project, do you think
8 the financial projections stated in those pro
9 formas are reasonable?

10 A: I do.

11 Q: Do you think they were accurate?

12 A: I do.

13 Q: Do you think they're based on actual historical
14 data from the performance of the medical
15 university historically?

16 A: Of MUHA, yes.

17 Q: Yes, of MUHA.

18 A: Yes.

19 Q: And do you have any concerns about the charges
20 per case mix for the patients set forth in the
21 application?

22 A: I do not.

23 Q: Okay. Have you done any comparisons or did you
24 review any data in regards to the charges
25 comparison for what's projected and what the

1 actual historical numbers at the Medical
2 University for the DRG's that are set forth in
3 the application?

4 A: Yes. We engage with an outside person. This
5 is an annual routine for us. Her name is
6 Cleverly, and they compare our price points in
7 aggregate to our competitors. Roper, Trident,
8 Tenant over in East Cooper to see that. So our
9 charge down on the Charleston campus for a case
10 mix adjusted wage index adjusted discharge runs
11 about \$32 or \$37,000 per case. Roper is about
12 24 to 26,000 per case. And then Trident will
13 be up in the 45 to \$48,000 per case.

14 Q: And so the Medical University ---

15 OBJECTION:

16 MR. THOMAS: Your Honor, Your Honor, I'm sorry.

17 I've got to object. You know, she's talking
18 about something that was done by Cloverly that
19 she's relying on that was never produced to us
20 in discovery. And we would -- you know, our
21 document requests would have captured that
22 document. So now she's coming up saying, you
23 know, something about \$45,000 for Trident's
24 case adjusted mix. We've already had an expert
25 testify that that's not the case. So I'd like

1 to strike that testimony that she doesn't have
2 the basis for, and if she does, if she has a
3 basis for it, that document should have been
4 produced to us so that we could have deposed
5 her with that information, Your Honor. This is
6 classic sandbagging.

7 MS. JONES: There is no sandbagging going on, Judge.
8 She was deposed for four or five hours by them.
9 She was asked -- well, I mean, you know, she --
10 the pro formas that are in here that show the
11 charges were projections that she made, that
12 she put in the document, that she signed. They
13 had every opportunity to ask for anything they
14 wanted to about how she calculated any of those
15 numbers and what she used as a basis, and if he
16 didn't ask the question that's not my
17 responsibility.

18 MR. THOMAS: But that's not what she's saying, Your
19 Honor. She's starting to talk about what
20 Trident's charges are and what Roper's charges
21 are.

22 THE COURT: That's what I want to hear about.

23 MR. THOMAS: Yeah.

24 MS. JONES: I ask her -- well I ask her what her
25 basis was and if she did any checks to

1 determine the reasonableness of the basis of
2 the projections that she put in the pro forma
3 in the application.

4 MR. THOMAS: Your Honor, can I lodge a hearsay
5 objection. Because she is ---

6 THE COURT: Well that's I was going to do. She can
7 testify to her own knowledge. When you ask her
8 for the basis -- or the confirmation from
9 another source, that I would sustain the
10 objection on. But I will allow her to testify
11 to her own evaluation.

12 MR. THOMAS: I have no problems with that, Your
13 Honor. But I would ask that that part based on
14 -- I think she said Cloverly or Cleverly or
15 some third party that they use.

16 THE COURT: I'll strike that.

17 MR. THOMAS: Okay. Thank You, Your Honor.

18 **Q: The charges that you included in the pro forma,**
19 **what checks and balances do you perform to**
20 **determine the reasonableness of those charges?**

21 **A: We look at the charge per the related DRG's**
22 **case mix adjusted and wage index. Adjusted**
23 **going into the market and we use Medicare**
24 **publicly available data from 2018 to say what**
25 **are other people charging to make sure that**

1 we're in an appropriate zone.

2 Q: And just to be clear on this, Ms. Goodlett --
3 and for the record, Your Honor -- the
4 information that you look at, the public
5 information from Medicare payments and from
6 other sources -- and I understand what you
7 sustained -- is that something that you do as
8 a normal part of your responsibilities as the
9 Chief Financial Officer of a healthcare
10 organization?

11 A: Yes.

12 Q: And did you do it in the other positions that
13 you held at the other chief financial officer
14 positions at other hospitals?

15 A: Yes.

16 Q: Is it something that is normally used by CFO's
17 in healthcare systems to test and determine the
18 reasonableness of their charges?

19 A: Correct.

20 MS. JONES: On that basis, Your Honor, I just don't
21 know how you can -- there's not a hearsay
22 objection. It's something that's being used by
23 her in her position for the work that she does
24 on a routine basis as a part of her job.

25 MR. THOMAS: And I would say that she's relying a

1 study that's an out of court statement, and it
2 is classic hearsay.

3 MS. JONES: It is not hearsay when it's a normally
4 relied upon and used business record.

5 MR. THOMAS: It's not a business record.

6 MS. JONES: Just like the -- yes it is.

7 MR. THOMAS: Then why didn't they produce them?

8 THE COURT: Hold on. It's an expert to rely upon
9 statements such as what you're describing to
10 give an opinion. And what you're saying is --
11 what you're saying is the hearing at the
12 function of her job?

13 MS. JONES: It's a function of her job. It's just
14 like when she's ---

15 THE COURT: She relies upon -- I still ---

16 MS. JONES: It's a fact.

17 THE COURT: --- I'm still going to -- I'm going to
18 sustain the objection on that evidence. But
19 she can -- she still can testify to whether she
20 believe this evidence is -- or what she just
21 said was correct. We're just talking about
22 whether she's going to introduce statements of
23 others to rely upon that. So ---

24 MS. JONES: Well, that's correct, Your Honor. And I
25 understand this, but I also, you know, if -- as

1 I anticipate -- she's going to be asked on
2 cross-examination the basis of it ---

3 THE COURT: That opens the door.

4 MS. JONES: --- that opens the door.

5 THE COURT: Yeah.

6 Q: So, but as a final question, if you would
7 please, explain to the Judge why you believe or
8 know that the information you put in those pro
9 formas regarding the patients charges and the
10 projected financial performance of this
11 hospital in Berkeley is accurate, dependable,
12 reliable, and, you know, the reason you don't
13 have any doubts about it.

14 A: The steps in our bidding process is one that's
15 got a historical nature to it that we've had
16 experience with. And then too we do use
17 publicly available information to check is this
18 reasonable within the market we're going into.

19 Q: And did you do that in this case?

20 A: Yes.

21 Q: And do you stand by the pro formas and the
22 information that you put in there ---

23 A: I do.

24 Q: --- as being reliable and a predictable
25 outcome?

1 **A: Correct.**

2 **Q: Thank you, Your Honor, that's all the questions**
3 **I have.**

4 MR. WICEVIC: No questions.

5 MS. JONES: Oh, I need to put MUHA Exhibit 30 into
6 evidence which is part of the CON application.

7 MR. THOMAS: No objection.

8 THE COURT: Okay. Then it's admitted.

9 (MUHA Exhibit Number 30 was admitted into the record
10 at this time.)

11 THE COURT: All right. Who's up.

12 MR. THOMAS: That would mean me, Your Honor.

13 THE COURT: You want to take a short break, or?

14 MR. THOMAS: If anybody else does. I'm fine.

15 THE COURT: Are you going to go more than 30
16 minutes?

17 MR. THOMAS: Yes.

18 THE COURT: Huh?

19 MR. THOMAS: Yes, sir.

20 THE COURT: Okay. Well then we'll take a break.

21 (Off the Record)

22 MS. GOODLETT - CROSS-EXAMINATION BY MR. THOMAS:

23 **Q: Good morning, Ms. Goodlett. We met at your**
24 **deposition; do you recall that?**

25 **A: Good morning.**

1 Q: Fair to say you've moved around quite a bit in
2 terms of your financial work in the healthcare
3 industry?

4 A: Yes, I've moved to move up.

5 Q: Okay. And would you agree with me that one of
6 your jobs as CFO is to monitor the financial
7 performance of MUHA?

8 A: I would.

9 Q: Okay. And to some degree you do have to have
10 -- like be aware of how your hospital and other
11 hospitals in the market are performing
12 operationally, correct?

13 A: Correct.

14 Q: Okay. And one of your many responsibilities is
15 to make sure that responsible financial
16 decisions are made on behalf of MUHA, correct?

17 A: Correct.

18 Q: Okay. And you would agree with me -- I believe
19 you stated that MUHA is indeed an arm of the
20 State, correct?

21 A: Correct.

22 Q: All right. And ---

23 A: It's an entity.

24 Q: Fair enough. I'll go with that.

25 A: Arm sounds a little more powerful.

1 **Q:** All right. But you would agree with me as an
2 arm of the State that makes your job even more
3 important in terms of being a good financial
4 steward for say taxpayer dollars, correct?

5 **A:** MUHA's revenue basis is not taxpayer generate.
6 We are self-supporting. We get a very minor
7 fraction of gifts and grants and things from
8 the State, but the large part is really
9 derivative of how it delivers its clinical
10 services.

11 **Q:** Didn't you state earlier -- and perhaps I
12 misheard -- that you got a \$25 million dollar
13 grant from the State for the Shawn Jenkins
14 Children's Hospital?

15 **A:** A capital grant, yes. We do get funding on
16 occasion, it's just I wanted to be cautious to
17 make sure we weren't -- the proportion of that
18 related to what is clinical's revenue is
19 different.

20 **Q:** Understood. But that's ---

21 THE COURT: The phrases you used, you said MUHA's
22 revenue based is not ---

23 **A:** The majority -- MUHA's revenue base of about
24 \$2.1 billion dollars ---

25 THE COURT: Uh-huh.

1 **A:** --- is generated from clinical services. We
2 are fortunate and grateful that we will get \$20
3 million dollars for telehealth funding
4 recurring from the State, and then but the 20
5 million compared to 2.1 billion was the
6 perception.

7 **Q:** Sure. But the \$25 million dollars was a State
8 grant and that's taxpayer money for the Shawn
9 Jenkins Children's.

10 **A:** I would assume so, yes.

11 **Q:** Okay. Now at MUHA you rely on from time to
12 time a consulting firm called Kaufman Hall,
13 correct?

14 **A:** Correct.

15 **Q:** And they help you with financial strategic
16 decision making too, correct?

17 **A:** Yes. They are financial advisors.

18 **Q:** Okay. And you would agree with me that Kaufman
19 Hall assists MUHA with it's entire book of
20 business for all of its initiatives across the
21 MUHA enterprise; fair statement?

22 **A:** As our financial advisor they're involved in
23 our long range financial planning processes and
24 when we go to the market to issue that.

25 **Q:** And you rely on them, correct?

1 A: Oh, yes.

2 Q: Okay. Now when I deposed you back on September
3 11th, is it fair to say you couldn't recall if
4 you had ever spoken with Mr. David Levitt in
5 person or on the phone?

6 A: That would be fair.

7 Q: Okay. And you understand that he is -- what do
8 you understand Mr. Levitt's role is for MUHA?

9 A: He's a healthcare planner.

10 Q: Yeah.

11 A: He's been engaged with MUHA for several years.

12 Q: Okay. Have you had an opportunity to speak
13 with him in person since your deposition?

14 A: I did. I got to have lunch with him yesterday.

15 Q: Okay, great. Back in September you would agree
16 with me that you were not aware of the
17 healthcare services available at either Trident
18 Medical Center or Summerville Medical Center,
19 correct?

20 A: Not at a specific level, no.

21 Q: Okay. You would agree that you do not know for
22 a fact whether Trident was tertiary care
23 hospital, correct?

24 A: Correct.

25 Q: Okay. Do you know today?

1 **A:** I know it's a good community hospital.

2 **Q:** You wouldn't characterize the hospital that
3 does open heart surgery as tertiary?

4 **A:** I would.

5 **Q:** You also, when I deposed you you didn't know
6 how many general acute care hospital beds would
7 be within a ten mile radius of MUHA's Nexton
8 proposed location, correct?

9 **A:** Correct.

10 **Q:** Okay. If I told you it was 456 would that
11 surprise you?

12 **A:** No.

13 **Q:** Okay. And also when I deposed you weren't sure
14 that MUHA was locating its Berkeley County
15 hospital within Trident Medical Center's
16 primary service area, correct?

17 **A:** Correct.

18 **Q:** Okay. And you also didn't know if residents in
19 Berkeley County currently had access to type of
20 hospital services MUHA proposes to offer at its
21 Nexton location?

22 **A:** Correct.

23 **Q:** Okay. And you didn't know why the decision was
24 made to build the MUHA Nexton hospital on land
25 less than four miles away from Roper Berkeley,

1 correct?

2 A: Correct. I did not know the location
3 rationale.

4 Q: Okay. You would agree with me that being aware
5 of market share is something of importance to
6 you as a CFO?

7 A: Yes.

8 Q: All right. And market share is one of the key
9 metrics in health -- of a health system, isn't
10 it?

11 A: It's one of many, yes.

12 Q: Okay. But you would characterize it as a key
13 metric, wouldn't you?

14 A: I would.

15 Q: Okay. And one way to increase market share
16 would be increasing patient volume relative to
17 the providers in the market, correct?

18 A: Or access to care. You know, patients who
19 currently aren't getting the care they need or
20 seek at this point in time so I think it's
21 multi-factorial.

22 Q: But one way to do that would be increasing your
23 volume. So if You increase your access that
24 will allow you to increase volumes.

25 A: Uh-huh.

1 Q: Okay. You've got to say yes.

2 A: Yes.

3 Q: It's just hard for the court reporter to take
4 down an uh-huh. You would agree with me that
5 some strategies for increasing volumes would be
6 recruiting physicians?

7 A: Correct.

8 Q: Okay. Expanding -- and how about expanding
9 facilities and services?

10 A: Yes.

11 Q: Okay. You would agree with me that the premise
12 behind MUHA Nexton is that lower acuity
13 patients will use that hospital instead of the
14 downtown MUHA location which then is going to
15 make room for the tertiary and quaternary care
16 patients, right?

17 A: We'd like to have healthcare delivered in the
18 right location for the type patients, so, yes.
19 We do believe as community patients seek care
20 in the Nexton area it would decant the downtown
21 campus.

22 Q: Okay. Fair enough. But you would also agree
23 with me that MUHA could potentially pick up new
24 patients at the MUHA Nexton location rather
25 than just a one hundred percent redirect,

1 correct?

2 A: Correct.

3 Q: Okay. And this could also potentially include
4 tertiary patients like say a heart attack
5 patient who presents to the MUHA hospital based
6 ED instead of another ED; fair statement?

7 A: I'm pausing because there's protocols for heart
8 treatment patients and the location that they
9 need to go to from that piece.

10 Q: That's for an EMS transport patient, correct?

11 A: Right. Uh-huh.

12 Q: But some people show up, they've got chest
13 pains ---

14 A: That's true.

15 Q: --- they may just ---

16 A: They're going to go for the brand they feel
17 most comfortable with.

18 Q: Or they're going to go to the closest location
19 if they're having a heart attack, right?

20 A: Could be.

21 Q: Okay. Is it fair to say MUHA is going to place
22 a fair number of physicians, both primary care
23 and specialists, out in the Berkeley Dorchester
24 market to help support MUHA Nexton Hospital?

25 A: Yes.

1 Q: Okay. In fact, you would agree with me that
2 MUHA has already rented medical office space in
3 the Nexton area to locate both primary care and
4 specialty physicians?

5 A: Correct.

6 Q: All right. And it's your understanding that
7 that building is owned by Palmetto Primary Care
8 Physicians, correct?

9 A: Correct.

10 Q: Okay. Now you're familiar with trust Press
11 Ganey scores that are generated from patient
12 surveys, aren't you?

13 A: I am.

14 Q: Okay. And that's something you look at from
15 time to time, correct?

16 A: It is.

17 Q: Okay. You would agree with that Press Ganey
18 scores coming out of MUHA's pediatric ED and
19 its adult ED downtown are very strong, wouldn't
20 you?

21 A: Yes.

22 Q: Okay. You would agree that your inpatient and
23 outpatient related Press Ganey scores are so
24 good for both adult and pediatric care that
25 MUHA was ranked number one in the State of

1 South Carolina by U.S. News and World Report.

2 A: Along with other factors, yes.

3 Q: Okay. Are You familiar with HCAP scores or
4 hospital consumer assessment of healthcare
5 providers in systems?

6 A: I am.

7 Q: Okay. And that's a score that's generated by
8 CMS, isn't it?

9 A: Correct.

10 Q: Okay. And you would agree with me that MUHA's
11 HCAP scores are very good and correspond
12 closely with your Press Ganey scores, wouldn't
13 you?

14 A: I would believe that.

15 Q: Okay. All right. I think we've heard a little
16 bit about the MUHA purchase of four hospitals
17 outside of the Tri-County area. And just so we
18 get this clear for the record -- and I think it
19 is -- but MUHA bought Springs Hospital in
20 Lancaster County, correct?

21 A: Correct.

22 Q: Okay. Marion Regional Medical Center in Marion
23 County?

24 A: Correct.

25 Q: Okay. How about Carolina's Hospital Center

1 System in Florence?

2 A: Correct.

3 Q: And Chester Regional in Chester County?

4 A: Correct.

5 Q: Okay. And those are now MUHA branded
6 facilities, correct?

7 A: Yes.

8 Q: Okay. Combined those hospitals have roughly
9 715 acute inpatient beds; is that right?

10 A: Correct.

11 Q: Okay. You actually purchased for \$137 million
12 dollars more inpatient beds than MUHA actually
13 operates on the peninsula today, correct?

14 A: At that time, yes.

15 Q: Okay. Well has MUHA added up to 715 acute
16 inpatient beds at this time?

17 A: Not at this time.

18 Q: Okay.

19 A: Until the Shawn Jenkins comes online maybe.

20 Q: And you said that that's going to come online
21 in January or February of 2020?

22 A: Correct.

23 Q: Okay. Now you would agree with me that one
24 benefit of purchasing the CHS hospitals was to
25 submit the tertiary and quaternary referrals

1 down to MUHA in Charleston, correct?

2 A: Correct.

3 Q: All right. Let's go to DHEC Exhibit 1, page
4 591.

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

6 Q: If you can't at any time read what's on the
7 screen we can give you a binder.

8 A: Oh, thank you.

9 Q: Hopefully it will be readable. All right. So
10 let's go to 591, and I believe that's a letter
11 that you wrote. Okay. Do you recognize this
12 letter, Ms. Goodlett?

13 A: I do.

14 Q: Okay. And this letter is the funding letter
15 that is required to go into the CON
16 application; is that right?

17 A: That is right.

18 Q: Okay. Let's go to the next page which is 592
19 in DHEC 1. And have you seen this letter
20 before?

21 A: I have.

22 Q: Okay. And this is a letter from Mr. Pack to
23 Mr. Eubank who's the Director of the CON
24 program, correct?

25 A: Yes.

1 Q: And could you describe for the Court who Steven
2 Pack is?

3 A: MUHA uses two financial advisors. Kaufman
4 Hall, and then we also engage Armadale Capital
5 that our HUD financial advisor.

6 Q: Okay. What does he do for you?

7 A: He creates a relationship. You cannot approach
8 HUD directly. YOU need to have a financial
9 advisor in between us and them and he's been
10 familiar with MUSC since the ART project. So
11 he has weekly to monthly communications with
12 HUD updating them on our status. He serves as
13 an intermediary when we want to have dialog
14 with them or discussions or talk through
15 anything.

16 Q: Okay. Good. And so he's -- Mr. Pack is very
17 familiar with MUHA as an organization
18 financially and operationally, then?

19 A: He is.

20 Q: Okay. Let's go down to the third paragraph if
21 we could of this letter, and it starts with
22 MUHA has engaged; do you see that on the screen
23 there?

24 A: I do.

25 Q: Okay. It says, MUHA has engaged advisors and

1 consultants to examine the market demand and
2 the financial feasibility of the project. And
3 it says the preliminary indications have been
4 favor to support a successful facility; do you
5 see that?

6 A: I do.

7 Q: Okay. At that time the advisors engaged and
8 who?

9 A: Armadale Capital.

10 Q: Okay. So who did the market demand study that
11 Mr. Pack is referring to here?

12 A: That would have been performed either by David
13 Levitt or someone within our organization.

14 Q: Okay. That's referring to the CON application,
15 right?

16 A: Yes.

17 Q: Okay. Very good. And you would agree with me
18 that HUD does not accept the CON on face value;
19 fair statement?

20 A: That's correct.

21 Q: In fact you're going to have to do another
22 feasibility study along with the application to
23 HUD when you apply for the money, correct?

24 A: That's correct.

25 Q: Okay. Now, so that's line 2, right?

1 Ultimately a feasibility study will be
2 performed in accordance with HUD requirements
3 as part of the HUD application process; you see
4 that?

5 A: I do.

6 Q: Okay. You're not just going to vote a copy of
7 the CON application and send it into HUD are
8 you?

9 A: No.

10 Q: Okay. You're going to do a much more
11 sophisticated and refined feasibility study; is
12 that fair?

13 A: The CON serves as the base component for it and
14 then HUD will like to see stress testing and
15 difference scenarios, volumes, things like that
16 with their sensitivity that they will rely
17 heavily on the CON as we've submitted it.

18 Q: Okay. But there will also be another
19 operations piece showing projections apart from
20 the CON?

21 A: True.

22 Q: Okay. And then the third sentence Mr. Pack
23 says, MUHA has had a long and successful
24 relationship with HUD and ACI, is confident
25 that MUHA will meet or exceed HUD's loan

1 underwriting guidelines for the project; do you
2 see that?

3 **A:** I do.

4 **Q:** And then the fourth sentence Mr. Pack says,
5 notwithstanding the foregoing MUHA and ACI
6 recognize that there is no guarantee that HUD
7 will ultimately issue mortgage insurance
8 commitment for the proposed findings; fair
9 statement?

10 **A:** Fair statement. So what he's saying there is
11 there is not guarantee that we would get the
12 enhancement or the better credit rating by the
13 federal government signing off on our loan, but
14 it does not mean that the loan would not be
15 granted.

16 **Q:** Understood. I understand that.

17 **A:** Okay.

18 **Q:** But as you say, the actual backing which is
19 going to give You that vaulted triple A rating
20 ---

21 **A:** Right.

22 **Q:** --- for that debt is not guaranteed, correct?

23 **A:** Right. And so about a nine month process to go
24 through their vetting.

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

1 with respect to the CON application at issue
2 today, you're input consisted of reviewing the
3 pro formas for Berkeley County and really
4 nothing aside from that, correct?

5 A: I'm not sure I understand your question.

6 Q: Okay. We've got the CON application.

7 A: Right.

8 Q: That's why we're here. And my understanding of
9 your testimony at the time I deposed you was
10 that your input consisted of reviewing the pro
11 formas -- financial pro formas that I think you
12 and Ms. Jones were going over and nothing
13 really outside of that.

14 A: Correct. All components, yes.

15 Q: Okay. Now I believe you said you did the
16 typical does it look right and you performed a
17 few stress tests to some of the assumptions,
18 correct?

19 A: Correct.

20 Q: Okay. What stress tests did you run?

21 A: As we discussed earlier, our price point in the
22 market, DSH funding, if there was a swing in
23 case mix, if there was a swing in volume.
24 We'll run through various sensitivity
25 scenarios. You know, can we really backfill

1 it. Well I think one of the things we went
2 through is right now there's a bed need for 155
3 patients in Charleston so it's conceivable
4 there's more capacity there. We would think
5 through is MUHA running at capacity now, check,
6 yes. And then we know that we have about 50 to
7 60 patients each month that don't get into us
8 and people call us for. We also know that
9 people only call about five or eight percent of
10 the time because we've been notorious for five
11 or six years of not having capacity. So the
12 extrapolation on that said, yeah, there's
13 easily 128 patients that need care that we're
14 seeing today that can move out to the other
15 campus and open up room for the quaternary
16 tertiary patients.

17 Q: Okay. Now you understand the project
18 contemplates one hundred redirect of patients,
19 correct?

20 A: I do.

21 Q: So let's go to DHEC Exhibit 1 and I want to
22 look at the exact -- actual pro forms. Let's
23 go to page 596. Would You have reviewed this.

24 A: Yes.

25 Q: Okay. Let me ask you this, MUHA produced

1 various iterations of this pro forma. I
2 believe you testified You didn't see any of
3 those, did you?

4 A: We will do sensitivity testing while we're in
5 the room and then scenarios will be produced
6 where we talk through from those pieces. So I
7 wouldn't see the entire pro forma redone for
8 sensitivity.

9 Q: Did you see the pro forma that showed in your
10 three of operations that MUHA was not -- that
11 the actual project was earning no money. It
12 was actually still in the negative. Did You
13 ever see that one?

14 A: Potentially I could have. There were several
15 scenarios if it was slower to fill up with
16 patients, if we didn't DSH funding.

17 Q: Okay. But I thought you've already testified
18 that what You did was you reviewed it in terms
19 of just these pro formas?

20 A: We do as part of the process to say we're
21 looking at what the final signed product's
22 going to be. And then separately we may ask
23 questions to run the sensitivity or what does
24 this look like from that piece which I may or
25 may not see.

1 Q: Okay. Did you see the version of the pro forma
2 that was printed out that showed the project
3 losing money at all?

4 A: When you showed it to me at my deposition, yes.

5 Q: So that'd have been the first time you'd seen
6 it?

7 A: To my knowledge.

8 Q: Okay. Now let's go -- I want you to turn to
9 page 598. That's the actual pro forma for the
10 project; do You see that?

11 A: Uh-huh.

12 Q: And that shows loss of \$11.4 million dollars in
13 terms of net income in year one, right?

14 A: Yes.

15 Q: And then \$39,000 net income in year two. And
16 then a \$14 million dollar net income in year
17 three which is projected as 2025; is that
18 right?

19 A: Correct.

20 Q: Okay. Now had you seen any of the back up data
21 that was associated with this pro forma?

22 A: This would have been what I was shared with on
23 the screen.

24 Q: Okay. So let's go to TMC 22 real quickly.

25 (TMC Exhibit Number 22 was introduced into the record

1 at this time.)

2 Q: All right. This was a document, Ms. Goodlett,
3 that was produced to us in production -- during
4 the production discovery period of this case.
5 And it's a spreadsheet that is many pages long.
6 What I might do for this one because it's very
7 hard to put something like this on the screen.

8 MR. THOMAS: Permission to approach, Your Honor?

9 THE COURT: Yeah.

10 Q: It's much better if I actually give you the
11 notebook. Turn to Tab 22 in there.

12 A: So this is when you would do a sweep of all the
13 e-mails back and forth to find the document?

14 Q: I'm sorry?

15 A: So the process for which you -- this would be
16 when You look at all our e-mail stuff we turn
17 over to You?

18 Q: Correct.

19 A: Got you.

20 Q: Yeah. Okay. And if you look on page 1 there
21 at the top it does say Medical University
22 Hospital Authority, MUHA, Newco Hospital
23 Berkeley. Is this -- is it your understanding
24 that this description of the project is the
25 hospital out in Berkeley County?

1 A: It is.

2 Q: Okay. And there's some various iterations in
3 this document and -- but I understand you had
4 -- you said you hadn't seen it before, correct?

5 A: That's correct.

6 Q: Prior to your deposition, right?

7 A: Correct.

8 Q: Okay. And some of it was actually generated by
9 Kaufman Hall; is that right? I think You
10 testified in your deposition that Kaufman Hall
11 had pasted values in here?

12 A: We were putting the software in at the time.
13 I couldn't say if this was a Kaufman Hall
14 product or not.

15 Q: Okay. Fair enough. Turn over to -- let's see
16 what page this would be -- Trident if there is
17 a page number it's an exhibit page number, and
18 I'd like you to turn over to Trident Exhibit
19 22-010 if You could?

20 A: Is it a long one?

21 Q: It is -- it'd be 11 pages, yeah, and so if it's
22 front and back, one, two three -- yeah. I can
23 tell you at the top it looks a little bit like
24 this.

25 A: Got You. Okay.

1 Q: All right. Yeah, it's on the screen there too.
2 Were you aware that your budget did tie to
3 utilization numbers?

4 A: Yes.

5 Q: Yeah. Okay. For both inpatient and
6 outpatient?

7 A: Yes.

8 Q: Okay. Can we go to the next page? If you'll
9 look at the next page for me, Ms. Goodlett.
10 22-11 in the Exhibit. And you see you've got
11 down at the bottom the key cost analytics. Is
12 that something that you've ever stressed test
13 just to look at to determine if they were
14 right?

15 A: Yes.

16 Q: So you did stress the total cost of adjusted
17 discharge and total cost of adjusted patient
18 day?

19 A: Yes.

20 Q: Okay. And You were fine with that, correct?

21 A: Yes.

22 Q: All right. Now if we could go back to the pro
23 forms in the CON application. Sorry to jump
24 around but that kind of how it works.

25 A: I can put the book up.

1 Q: You can put the book up. And if we could go
2 back to DHEC 598. We may go -- may be going
3 back to the book. All right. There we go.
4 All right. So again, this -- just to orientate
5 you a little bit here. This is the project
6 only budget; do you see that?

7 A: Yes.

8 Q: Okay. And You understand that the applicant
9 for a project such as this as to do a project
10 only budget, they have to show the facility
11 budget separate and apart as if the project
12 wasn't going to take place, and then they have
13 to show a combine budget. Those are the pro
14 formas, correct?

15 A: Correct.

16 Q: Okay. And so you look at all three and made
17 sure that everything ticked in time?

18 A: Yes.

19 Q: Okay. Now you would agree with me that if you
20 look at the net income for the pro forma for
21 the project only, let's look at year 2025,
22 that's 14,000,029, correct?

23 A: Correct.

24 Q: Okay. If you turn one page back to DHEC 597.

25 A: Now this was a part of the official file of CON

1 ---

2 Q: This is ---

3 A: --- and not something from the e-mail.

4 Q: This is the official of CON for you.

5 A: Okay.

6 Q: Okay. Now You testified earlier 14 that the
7 net income in year 2025, 14029. All right.
8 And then we have for 2025 we have, what's the
9 net income -- and this is for the facility
10 only, Ms. Goodlett; do you see that?

11 A: Uh-huh.

12 Q: What is the net income there for 2025?

13 A: 70.9 million.

14 Q: Okay. And if you turn the page to 596 which is
15 the combined budget. All right. Let's look at
16 the net income there for 2025. What is it?

17 A: 84.9.

18 Q: Okay. So you would agree with me that what
19 these pro formas contemplated was the addition
20 of the total net income to the budget without
21 the project to get the net income for the
22 combined; fair statement?

23 A: Correct. For the Charleston location, yes.

24 Q: Okay. And you would agree with me that this in
25 an incremental budget, correct?

1 A: For the project?

2 Q: Right.

3 A: Yes.

4 Q: Thank You. Now let's go to TMC 38 if we could.

5 (TMC Exhibit Number 38 was referenced at this time.)

6 Q: This is an earlier version and You can see it

7 says draft that the bottom of the page. Can

8 you zoom out real quickly? It says 11/30/17.

9 And to You recognize this kind of being in the
10 same forma as ---

11 A: I do.

12 Q: --- the one we just looked at?

13 A: Uh-huh.

14 Q: Okay. And can we go to number 38, Trident 38
15 and go to dash 003 for me? And could you blow
16 up the net income there? All right. The net
17 income there, this is what I referenced
18 earlier. Can You see it there? Those three
19 years? There's negative 21 million, negative
20 12 million and then negative 536,000?

21 A: I do.

22 Q: Okay. But prior to your deposition You hadn't
23 seen this one before?

24 A: That's correct.

25 Q: Okay. Do you have any idea of the assumptions

1 that went into this and why this was negative
2 to the tune of about -- at least in year three
3 of operations -- about a \$14 million dollar
4 difference?

5 A: I do not.

6 Q: Okay.

7 A: I can assume it's a part of the process because
8 there's other people that work on a pro form
9 before it gets to me that they were testing
10 something, it could be patient ramp up, some
11 kind of expenditures, scenario testing.

12 Q: Perhaps a lack of assumption of outpatient
13 revenues.

14 A: Correct.

15 Q: Okay. Do you -- were you ever -- was that
16 process ever explained to you that, hey, we had
17 done earlier versions that showed a loss and
18 did you give any advice of how that could
19 change?

20 A: Not to my knowledge. It's normally -- I don't
21 get involved until they've had a chance to work
22 through most of the material.

23 Q: Okay. In fact, I believe at your deposition
24 you admitted you didn't make any changes to the
25 pro formas that were presented to you, correct?

1 **A:** Correct.

2 **Q:** Okay. And at the time you didn't really know
3 actually developed the inpatient and outpatient
4 utilization assumptions on which the pro formas
5 were based, correct?

6 **A:** Correct.

7 **Q:** Okay. At Your deposition we talked a little
8 bit about financing and I think you testified
9 consistent today with that about if You can't
10 get the HUD back financing then you may use the
11 bridge loan lender, correct?

12 **A:** Or any other lender, yes.

13 **Q:** Or any other lender. But would you agree with
14 me that if HUD decided not to back your loan
15 you might not be in the best financial position
16 to get another loan?

17 **A:** Not at all.

18 **Q:** But wouldn't you have had to fail their tests?

19 **A:** No, not necessarily. I mean, this is the
20 federal government. Many things could go and
21 become different with them. You know, they
22 can't make retroactive changes on their new
23 portfolio, but a new president, a new secretary
24 could do all kinds of different things with the
25 program.

1 Q: Okay. But that's not something your counting
2 on, is it?

3 A: That I'm counting they'll make changes to the
4 program?

5 Q: Yeah.

6 A: I know they will make some changes. We would
7 very much like to finance this with HUD, but if
8 we don't it's not going to block the process --
9 the project from happening.

10 Q: Okay. So you -- but you say you've got a lot
11 of banks waiting in the wings, right?

12 A: About four or five, yes.

13 Q: Okay. And doesn't HUD -- don't -- doesn't MUHA
14 have to go to HUD and ask permission if it
15 borrows -- if MUHA borrows more than \$40
16 million dollars?

17 A: If it's going to be attached to the HUD estate,
18 yes.

19 Q: Okay. And You had to go to HUD in order to do
20 that \$120 million dollar revenue anticipation
21 note that You got the bridge financing ---

22 A: Yes.

23 Q: --- for bridge financing for CHS, correct?

24 A: Yes.

25 Q: The facility you just purchased?

1 **A:** We have two outside of our Board we have to ask
2 SPAA, State Physical Accountability Authority,
3 for approval, and HUD for things that are
4 attached to them.

5 **Q:** Okay. Is the revenue anticipation note a
6 guarantee?

7 **A:** No.

8 **Q:** Okay. But you do have to get permission from
9 the state to do it, correct?

10 **A:** Correct.

11 **Q:** All right.

12 **A:** That issuance I think that's where it's over
13 the 40 million you were discussing.

14 **Q:** You would agree with me that back in September
15 you had no knowledge of what it would cost to
16 renovate the existing Children's Hospital if it
17 had more debts, correct?

18 **A:** Not top of line, no.

19 **Q:** Okay. You didn't have any knowledge, correct?

20 **A:** No. Thank You.

21 **Q:** Let's talk a little bit about traveling nurses
22 because there's been some different testimony.
23 But when I depose you back in kind of the first
24 part of September MUHA had about 70 traveling
25 nurses under contract, correct?

1 **A:** That's correct.

2 **Q:** Okay. And would you agree with me that this
3 type of nurse costs significantly more of the
4 nurses employed?

5 **A:** On the fact of it, yes. Sometimes they serve
6 a job if a flex staffing opportunity for us.
7 They're logical labor that we don't have a
8 full-time commitment to. They have their role
9 in health care.

10 **Q:** Sure. Oh, I'm not saying that, but you would
11 agree with me that that can be much more costly
12 ---

13 **A:** Yes.

14 **Q:** --- for the same R.N. that You can hire in the
15 market, correct?

16 **A:** True.

17 **Q:** And you would agree with me that it is possible
18 that clinical staff currently employed by the
19 Summerville and Trident Medical Centers may
20 apply for jobs at MUHA Nexton if the Nexton
21 hospital is permitted to be built.

22 **A:** They may apply now down to the Charleston
23 campus today.

24 **Q:** But they -- but also they could apply to work
25 at Nexton too, correct?

1 **A:** Correct.

2 **Q:** Okay. Now Ms. Jones asked You a little bit
3 about your 2019 audited financial statement.
4 If we could put that up. For us it's TMC
5 Exhibit 1. That may just be easier but I
6 believe it was admitted as a MUHA document.
7 Well let's just put TMC. Oh, so we've got it
8 admitted already.

9 MR. THOMAS: TMC 1?

10 **Q:** It's our very first Exhibit. And I want to go
11 to page 8. All right. You recognize this
12 document, correct?

13 **A:** I do.

14 **Q:** All right. Go to 8. All right. 8 of the
15 Exhibit. I think you're -- oh, I'm sorry,
16 let's go to 9. My bad. Okay. This is your --
17 for lack of a better term this is an income
18 statement, correct?

19 **A:** Correct. This is management's discussion
20 points, yes.

21 **Q:** Okay. And can we zoom out, please? So we can
22 see the document. If can't read it, then let
23 me know and we will get you the book version,
24 all right?

25 **A:** I'm good. Thank you.

1 Q: Okay. I believe earlier you testified that
2 there was \$55 million dollars in operating
3 margins for their -- in operating income for
4 2019?

5 A: That's correct.

6 Q: Okay. But your actual operating income from
7 healthcare operations was \$35 million dollars,
8 correct?

9 A: I'm not seeing -- oh, per our GASB layout?

10 Q: Yeah.

11 A: Yes.

12 Q: Okay. This is your audited financial, correct?

13 A: But -- right this is our audited financial.
14 What it doesn't take into account is the State
15 appropriations that fall down on that next line
16 of 26 million which do cover our operating
17 expenses, so it's a -- that's why the GASB mix
18 matches our two performance, and then also, the
19 very last line on there, the non-operating
20 payments is where we transfer to other entities
21 within the MUSC family. So if you add that 13
22 million back because we do not have to do that,
23 I mean, you get back the increase in that
24 position of 55 million.

25 Q: Okay. You're putting the 13,733 that is

1 reported as a loss you're actually saying you
2 added that to your increase in net position,
3 correct?

4 A: Correct. Because that was an option which will
5 -- you'll see that number later when you see
6 the KPMG format.

7 Q: Okay. I understand, but in terms of this
8 income statement your operating income off of
9 your actual operations at the Medical
10 University of South Carolina, your expenses,
11 your revenue, totals to \$35,254,000, correct?

12 A: This is management's portrayal of that. So all
13 the true GASB principalis on the KPMG statement
14 which will come up later in here you'll see the
15 55 million.

16 Q: Okay. And that again is because you get a
17 State appropriation of \$28 million, correct?

18 A: Correct.

19 Q: Okay. You get gifts and grand of \$11 million
20 dollars?

21 A: Correct.

22 Q: And there's not a guarantee of a state
23 appropriation and gift and grant going into the
24 future, correct?

25 A: It is at the discretion of the legislature.

1 Our best known people these are ongoing and
2 reoccurring for the telehealth and the
3 innovation funds.

4 Q: If the State hit hard times, you may hit hard
5 times, correct?

6 A: Just as anybody else, yes.

7 Q: Sure. So in terms of the operating income
8 above the loan, and this is what financial
9 markets look at, correct? When you said
10 there's FASB, GASB, right?

11 A: This is GASB.

12 Q: Right.

13 A: The financial markets will do just as I walked
14 you through, they will take the 35 million
15 operating income. They will add back the state
16 and appropriations of 36 million and then that
17 will come close to the 55 million that we
18 represent.

19 Q: Okay. All right. And we'll talk a little bit
20 more about that as well. And for 2018 the
21 operating income was a loss of \$6.6 million
22 dollars, correct?

23 A: On this and management's discussions too on the
24 true audited financial statements it will be
25 positive.

1 Q: Okay. To what -- to how much?

2 A: If you flip a couple pages we can see.

3 Q: Do you know what, I'm going to let Ms. Jones do
4 that.

5 MS. JONES: Oh just about five pages.

6 Q: Let's go to -- let's go to TMC 31, the long
7 range financial plan.

8 (TMC Exhibit Number 31 was referenced at this time.)

9 A: Okay.

10 Q: And you would agree with me that the net
11 position for 2019 was about \$623 million
12 dollars to the negative, correct? As reported
13 in the financial statement?

14 A: If you flip backwards one page ---

15 Q: No, let's go to -- I'm sorry. Let's go back to
16 the balance sheet which is TMC 1-8. All right.
17 This is the balance sheet. Do you recognize
18 that?

19 A: That's the income statement. I think if you go
20 ---

21 Q: Yeah, go to seven. I'm sorry.

22 A: You're gettin' close.

23 Q: There we go, there we go. This is the balance
24 sheet, correct?

25 A: That's correct.

1 Q: Okay. And then under your liabilities, your
2 long term debt, \$752 million dollars; do you
3 see that?

4 A: I do.

5 Q: Okay. And this pension liability and the OPEB
6 liability, those are the things that the State
7 of South Carolina is pushing down for you to
8 carry on your books; is that right?

9 A: Correct. They carry the investments at their
10 level and push the expense and the liability
11 down to the Authority level.

12 Q: Okay. And as I understand it the banks aren't
13 really that concerned with that money because
14 it's like a non-cash item; is that ...

15 A: Correct.

16 Q: Okay. All right. Let's go to -- let's go to
17 TMC 31 which I believe you referenced in your
18 deposition. Excuse me, in your testimony as --
19 as the something that you started doing. Is
20 that -- did you start doing this when you got
21 to MUSC?

22 A: Yeah, that's correct. This is a document where
23 we're trying to get all of our entitles online
24 to commit to enterprise wide financial planning
25 meaning the University, the five or six

1 entitles within MUSCP as well as MUHA. So we
2 were talking to a lot of people about doing a
3 lot of extra work.

4 Q: Right.

5 A: Trying to hit a timeline to get everything
6 going.

7 Q: Okay. So if we could go in this Exhibit to
8 under 031-003. This is -- it says MUHA Ability
9 to Arm. Okay. Have you seen this before?

10 A: I have.

11 Q: Okay. And the level one, this is -- is this --
12 what is the level one?

13 A: Those are ongoing just annual expectations for
14 similar to the 21 days cash on hand. They want
15 to see an operating margin greater than zero
16 under a FASB basis and the debt service
17 coverage of that 1.4.

18 Q: So HUD at least in an operating market they're
19 not looking for under a FASB basis. They just
20 want you to be a little bit above breaking
21 even, barely.

22 A: Over a three-year period, yes.

23 Q: Okay. Okay. And just on level two there are
24 two categories here under the HUD covenants and
25 it says must meet three of five, correct?

1 **A:** Yes. Of the total five you have to meet three.

2 **Q:** But -- and the two that you don't meet and my
3 understanding is that that again goes to that
4 pension liability and the OPEB healthcare
5 liability?

6 **A:** That's correct.

7 **Q:** Okay. All right. Let's go to TMC 63 if we
8 could. Dr. Cawley was asking questions about
9 this yesterday. Do you recognize this
10 document?

11 (TMC Exhibit Number 63 was referenced at this time.)

12 **A:** I do.

13 **Q:** Okay. Is it a document that someone on your
14 team put together?

15 **A:** It is.

16 **Q:** Okay. And you would agree with me that in
17 terms of the debt that's on here that the \$128
18 million dollar revenue anticipation note, that
19 debt is not listed on here, correct?

20 **A:** That's correct. That's a working capital loan
21 not a major project. And this list was
22 developed to explain there's a lot of CONS
23 being in play and a lot of projects
24 contemplated by the health system so it was to
25 denote who was really the funding source for

1 which projects.

2 Q: Understood. But the 120 isn't here, right?

3 The \$120 million?

4 A: Right, but it's not a debt issuance, it's a
5 revenue anticipation debt which functions as a
6 line of credit.

7 Q: Okay. And the \$40 million dollar, I think a
8 \$40 million dollar, you had to assume some long
9 term capital leases associated ---

10 A: Yes.

11 Q: --- with the CHS purchase?

12 A: Correct. Yes.

13 Q: Okay. And in terms of -- I think we've finally
14 established with the CHC and the imaging center
15 those two other entity funded, those are
16 related to the peds campus in North Charleston,
17 correct?

18 A: That's correct.

19 Q: Okay. And you would agree with me that what is
20 not on here, the micro hospital in Beaufort is
21 not in here, correct?

22 A: That's correct. It was a non-obligation of
23 MUHA that would be an obligation of South ---

24 Q: Strategic Venture?

25 A: No, Broad River South or South Broad River,

1 which is a joint entity by MSV and Beaufort
2 Hospital.

3 Q: Okay. But MSV is ---

4 A: South of Broad.

5 Q: Right. South of Broad. Yeah, South of Broad.

6 A: Which is owned by Broad River which is
7 Beaufort's model and MSV which is MUSC's model.

8 Q: Okay. And the MSV is an affiliated of MUSC,
9 correct?

10 A: Yes.

11 Q: Okay.

12 A: A component unit of the University.

13 Q: Sure. But that's not on the list, correct? In
14 terms of ---

15 A: Right, MUHA would have no obligation for that.

16 Q: Okay. All right. And then of course the
17 projects that Mr. Summer referenced in his
18 examination of Dr. Cawley yesterday such as the
19 Lancaster -- the Indian Land Hospital, that's
20 not on here either, correct?

21 A: That's correct. That was not contemplated when
22 this list was developed.

23 Q: Okay. And that could be potentially a \$200
24 million dollar-plus hospital, right?

25 A: In 2028, yes.

1 Q: Okay. 2028? Okay. That's when you said?

2 A: I think so by the time it goes through the CON
3 process, the build process before it's had to
4 be paid for in our projections it'd be about
5 2028.

6 Q: Okay. Fair enough. How about the Williamsburg
7 Hospital? How many beds is that going to be?

8 A: That again is not a funded project by MUHA.
9 The answer to the bed side is it will be
10 whatever the funds raised to build it. That is
11 -- two hospitals are being merged together to
12 build the new one. The State's committed 25
13 million to and philanthropy will be explored
14 for an additional hopefully 25 million, and the
15 gifted to MUHA to operate.

16 Q: Okay. So another \$25 million dollars of State
17 money, correct?

18 A: For Williamsburg and Lake City, yes.

19 Q: Okay. But MUHA's brand is going to be on that
20 building, right?

21 A: When it's operational after the build.

22 Q: Okay.

23 Q: But MUHA's brand is going to be on that
24 building, right?

25 A: When it's operational.

1 Q: Right.

2 A: After the build.

3 Q: Okay. Ms. Goodlett, you'd agree with me that
4 by adding a hospital in Berkeley County, MUHA
5 is growing its inpatient and outpatient
6 services in the tri-county market. Fair
7 statement?

8 A: Yes.

9 Q: Okay. You'll be adding about 311,000 square
10 feet of space and 120 beds and a complement of
11 outpatient services in an area where MUHA
12 doesn't have anything, correct?

13 A: We have some physician platforms there now ---

14 Q: Uh ---

15 A: --- but we don't have an acute presence.

16 Q: Okay. Fair enough. It's a green field
17 project, correct?

18 A: Meaning we're going in fresh land?

19 Q: Yes.

20 A: Yes.

21 Q: Okay. And you would agree with me that one of
22 the reasons that You would want to do this is
23 to increase your referral volumes, get better
24 access to capital, strengthen your pricing
25 power with third parties, correct?

1 **A:** The Nexton move, unlike the CHS hospitals, is
2 primarily drive to decant the campus so we can
3 have more quaternary tertiary patients and
4 deliver right care in the right location.

5 **Q:** Okay. So you're denying the fact that part of
6 this project is to capture new patients.

7 **A:** We will capture, that's gonna be a component of
8 what happens. Any area that we go into, people
9 see the brand and want to be taken care of by
10 MUSC.

11 **Q:** Okay. And you don't have any idea what that
12 percentage is sitting here today, do you?

13 **A:** Not off the top of my head for community
14 services, no, I don't.

15 **Q:** Okay. Have you seen the documents that talk
16 about capturing patient -- patients, based on
17 location?

18 **A:** I think you showed in your deposition -- in my
19 deposition some patient data.

20 **Q:** Okay. Let's go to TMC 78, if we could.

21 (TMC Exhibit Number 78 was introduced into the record
22 at this time.)

23 MR. THOMAS: Yeah. I'd like to, at this time, admit
24 TMC 63, Your Honor, which is the MUSC project
25 list dated June 2019.

1 MS. JONES: No objection.

2 MR. WICEVIC: No objection.

3 MS. HOLLINGSWORTH: No objection.

4 THE COURT: It's admitted.

5 (TMC Exhibit Number 63 was admitted into evidence at
6 this time.)

7 MR. THOMAS: All right.

8 Q: Ms. Goodlett, you're familiar with the HUD
9 conversation document, correct?

10 A: Correct.

11 Q: Okay. And it's dated June 27, 2018?

12 A: Correct.

13 Q: All right. And if we could go to page 3 of
14 this Exhibit. And again, if at any time You
15 can't read it -- hopefully Your eyes are better
16 than mine. So page 3 of the Exhibit, is this
17 what you and Ms. Jones were going over, maybe
18 a different version of earlier, but the days
19 cash on hand, the historical landscape?

20 A: Yes. That's our monitoring document.

21 Q: Okay. And it looks like the safety zone on
22 this document for MUHA's 45 days cash on hand,
23 is that right?

24 A: At that time, yes.

25 Q: Okay. Has it ---

1 **A:** Well, it's 45 to 55.

2 **Q:** Okay. All right. Would you agree with me that
3 on a financial market's basis, the 45 days cash
4 on hand is very low?

5 **A:** If you did not understand the State Authority
6 component, of whom MUSC is, I could see why
7 people would ask their questions.

8 **Q:** Okay. And ---

9 **A:** But it speaks to our mission. We're not trying
10 to build up a war chest or fund stakeholders
11 demands. We're able to access capital very
12 easily, so we rarely use our funding to build
13 things and enhance the services.

14 **Q:** Okay. Do you consider 100 days cash on hand a
15 war chest?

16 **A:** For some organizations it is, yes.

17 **Q:** I'm talking about for a non-profit hospital
18 organization, is that a war chest?

19 **A:** For some it could be. You know, for the small
20 micro hospitals, 20 days cash on -- yeah -- 20
21 beds and 20 days cash on hand, that would
22 probably be a war chest.

23 **Q:** Yeah. Is that a war chest for a 700-bed
24 tertiary quaternary care hospital?

25 **A:** Depends on their level of activity and their

1 cushion in the safety zone they've designed.

2 Q: Okay. Let's go to TMC 78, page 8 if we could.

3 (TMC Exhibit Number 78 was referenced at this time.)

4 Q: All right. Are you familiar with this document
5 which is in Your HUD conversation documents?

6 A: I am.

7 Q: Okay. And this is a comparison to budget
8 actual 2018 versus 2017 for looks like, maybe,
9 the end of third quarter?

10 A: Yes.

11 Q: Okay. And if we could go down. There's some
12 notes on here -- and I know you and Ms. Jones
13 talked about some notes earlier -- if we go
14 down to 6, to note 6, there's a couple there,
15 right? We got one that says, we anticipate the
16 pension expense to increase 7.5 million dollars
17 from fiscal '18 to '19, right?

18 A: Correct.

19 Q: Okay. And then the next one it says, we do
20 anticipate the OPEB, O-P-E-B, expense to
21 decrease 12 million dollars from '18 to '19, do
22 you see that?

23 A: Yes.

24 Q: All right. Can -- what does OPEB stand for?
25 I don't know that we got that on the record.

1 **A:** It is other pension employee benefits ---

2 **Q:** Okay.

3 **A:** --- roughly. The concept is outside of
4 pension, if anybody has retiree health
5 insurance from the State, that's what it's
6 meant to denote.

7 **Q:** Okay. Fair enough. And then, the next note,
8 the State has required additional contributions
9 into the pension plan of 1 percent or 2.4
10 million dollars over the next four years, do
11 you see that?

12 **A:** Yes.

13 **Q:** Is that 2.4 million per year or is that 2.4
14 million over four years?

15 **A:** That would be per year.

16 **Q:** Okay. And then, you state that You don't
17 anticipate the State to provide any relief on
18 pension or OPEB expenses, correct?

19 **A:** Correct. That was an assumption at the time.
20 It, luckily, proved to be false and the State
21 did issue a credit for entities of about this
22 1 percent, so we did not have this negative
23 impact.

24 **Q:** And that was because the economy's doing good
25 and they could issue a credit, correct?

1 **A:** I was just grateful they did.

2 **Q:** Okay. And then, if we could go to page 11 of
3 your HUD conversation document. And so this is
4 why grow scale and healthcare. These are four
5 concepts we discussed at your deposition, but
6 they're increased referral volumes, classic
7 cost economies, debtor access to capital and
8 stronger pricing power, correct?

9 **A:** Uh-huh. Yes.

10 **Q:** And in terms of stronger pricing power, that
11 means the ability to negotiate a higher rate
12 with an insurance company or at least to
13 maintain your current rates, correct?

14 **A:** Correct, to defend our position. What had
15 happened in the State of South Carolina during
16 2017, is we saw some consolidation. HCA had
17 bought Memorial down in Savannah, HCA has
18 Trident up in Summerville and over in Grand
19 Strand, so there was more of a pressure point
20 coming into South Carolina. Additionally, it
21 was -- in the summer of '17 is when PRISMA was
22 formed -- not named that at the time I don't
23 think -- but, Greenville and Palmetto were kind
24 of together, so Charleston was beginning to
25 feel really isolated down on the peninsula and

1 so we wanted to make sure we were able to
2 service more patients 'cause that's how you
3 protect or defend your pricing power.

4 **Q:** But you would agree with me that this doesn't
5 say protect or defend pricing power, this says
6 stronger pricing power, correct?

7 **A:** I'm -- I mean, it would say defend -- it's just
8 pricing power is an important thing.

9 **Q:** Yeah. But stronger means better, doesn't it?

10 **A:** Or not weakened, yes.

11 **Q:** We'll let the document speak for itself. Now,
12 let's go to TMC -- well, first of all.

13 MR. THOMAS: I'd like to move this evidence, the HUD
14 conversation document, TMC 78, into evidence,
15 Your Honor.

16 MS. JONES: No objection.

17 MR. WICEVIC: No objection.

18 MS. HOLLINGSWORTH: No objection.

19 THE COURT: It's admitted.

20 (TMC Exhibit Number 78 was admitted in evidence at
21 this time.)

22 **Q:** All right. Let's go to TMC 73. I think it may
23 be 162.

24 (TMC Exhibit Number 162 was referenced at this time.)

25 MR. THOMAS: Do You have a copy of that? We noticed

1 that we have the draft version of this document
2 -- here, Celeste -- in our list. This is the
3 -- not a draft.

4 **Q:** And so this is TMC 162. Have you seen this
5 document before, Ms. Goodlett?

6 **A:** I have.

7 **Q:** And, you know, for this one, if it's okay, I'm
8 going to give You a copy of it because it's in
9 small type. I may want to reference ... Okay.
10 And this -- the title of this document if MUHA
11 38 million dollars borrowing Nexton land
12 purchase and consolidated service center,
13 correct?

14 **A:** Right. This is a bank look that we would put
15 together when we start to talk to our investors
16 about different plans or financings that we
17 have. So it would orient them to MUSC as a
18 whole. Explained, You know, the things that
19 we're facing in the futures.

20 **Q:** Okay. So like, for instance, if we go to TMC
21 162-003, one thing you're telling the bank, You
22 tell them about the MUSC impact, the big
23 picture, correct?

24 **A:** Right. And that was important because to
25 start, just as we did openly invest in a lot of

1 different entities in the MUSC family ---

2 Q: Right.

3 A: --- one of them being strategic ventures which
4 was -- did not have much in it economically.

5 Q: Right.

6 A: And so, MUHA was going to buy the land, MSB was
7 going to contemplate perhaps buying the
8 consolidated service center so we can joint
9 venture that.

10 Q: Okay. And you would agree with me -- now
11 you're familiar with this document, right?

12 A: Yes.

13 Q: Your team had input into this document,
14 correct?

15 A: Yes.

16 Q: Okay.

17 MR. THOMAS: At this time, I'd like to admit TMC
18 Exhibit 162 into evidence.

19 MS. JONES: I -- the -- I don't object to its
20 authenticity, but I object to its relevancy or
21 what the purpose is.

22 MR. THOMAS: I can keep going, Your Honor, and then
23 offer it at that point. It's clearly relevant.
24 It's talking about mission statement.

25 Q: Anywhere in this document, Ms. Goodlett, that

1 you inform the banks that MUSC or MUHA wasn't
2 currently fulfilling its mission back in July
3 19, 2018?

4 A: Not to my knowledge.

5 Q: Okay. Because MUHA is fulfilling its mission
6 right now, correct?

7 A: We hope so.

8 Q: Okay. Let's go to -- there was several pages
9 in here -- let's go to 162-16, if we could. It
10 says plan of finance review. Let me know when
11 you get there.

12 A: Oh, up at the top.

13 Q: Yeah, it's the numbers at the top.

14 A: And what page was that again?

15 Q: 16.

16 A: Okay.

17 Q: Okay. And this particular plan of finance
18 review, what Kaufman Hall did, if you look at
19 that last bullet there, Kaufman Hall requested
20 bids from banks using a formal RFP process,
21 correct?

22 A: Correct.

23 Q: Okay. And it did issue the RFP, is that right?

24 A: That's correct.

25 Q: Who was this particular document shown to, do

1 you know? Was it shown to the board?

2 A: It has the appearance more that we were
3 preparing it for our lender, UCBI, to court
4 them to finance the build, not necessarily a
5 board document.

6 Q: Okay. And that's what this document does?

7 A: Uh-huh.

8 Q: Okay. Now, in terms of the banks that you
9 approached, do you remember the banks that were
10 approached for this particular project?

11 A: Sure. We would approach our -- we always try
12 to be inclusive of all our banks, Wells Fargo,
13 Bank of America, TD Bank. With this particular
14 debt issuance, we really wanted to focus on a
15 smaller lender, somebody who was looking for
16 something for us to do in the 50 million dollar
17 space, State Street, UCBI was a new bank for us
18 to do business with. BB&T on the -- some don't
19 have the bandwidth to handle the big
20 transaction ---

21 Q: Sure.

22 A: --- and so we're, kind of, in bed with the
23 local community provider. It was a interesting
24 project because it was a design build and we
25 knew at the time when You do design build, You

1 have to have a two-year seasoning period before
2 they can roll into the HUD estate. So it was
3 a -- we did a short-term loan that people
4 would, you know, be interested in doing. So it
5 was a good opportunity for us to have a new
6 banking relationship.

7 Q: Okay. Now I do want to go take a look at the
8 draft and that is TMC 73.

9 (TMC Exhibit Number 73 was introduced into the record
10 at this time.)

11 Q: Now who would have performed -- who would have
12 drafted the draft of MUHA 38 million dollar
13 borrowing for Nexton land purchase and
14 consolidated service center?

15 A: It could be anyone within a team of 10, it
16 could be Kaufman Hall, it could be somebody on
17 the finance division.

18 Q: Would you have reviewed the draft?

19 A: I may not see all the drafts.

20 Q: Okay. Well, let's go to page, in the draft, I
21 want to go through 70 -- let's go to 73-28.
22 And I'll just have some questions for You about
23 this. Okay. And -- this one, the bank RFP
24 summary did not make it into the final version,
25 do you have any idea why?

1 **A:** I do not.

2 **Q:** Okay. And some of the questions I have for you
3 on this, does -- are these the key terms and
4 provisions of the requested loan in the Kaufman
5 Hall RFP, if You know?

6 **A:** Yes.

7 **Q:** Okay. So, MUHA was the borrower of the
8 oppressive amount not to exceed 38 million
9 dollars; there was going to be no revenue
10 pledge for MUHA, correct?

11 **A:** Correct.

12 **Q:** Okay. Would you explain to the Judge what that
13 means, for the record?

14 **A:** It's basically a debt issuance with no
15 collateral. The building and the land were
16 going to be locked up by the developer because
17 it was a design build, so this loan would be
18 just on the good faith and the good name of
19 MUHA.

20 **Q:** Okay. And you look down there, the RFP issued
21 to seven banks, does that look like the list of
22 Your banks?

23 **A:** Yes.

24 **Q:** Okay. And UCBI, United Community Bank, matched
25 the terms requested in the RFP, correct?

1 **A:** Correct.

2 **Q:** Okay. And, on the next page, if we go to 29,
3 we're looking at the UCBI term sheet. Okay.
4 And does this look like the terms that UCBI and
5 MUHA agreed to for this loan?

6 **A:** There's always a negotiation process after we
7 identify which bank, that might have some
8 specifics in there, but this looks what it was
9 during that process.

10 **Q:** Okay. And if we could turn the page to Trident
11 Exhibit 73-30. In the draft, there was a list
12 of the various reasons why certain lenders did
13 not respond to the RFP, you recall that?

14 **A:** I do.

15 **Q:** Okay. And BB&T -- well, let's look at Bank of
16 America, I think everybody knows that one.
17 What were the reasons given for not responding
18 to the RFP by Bank of America?

19 **A:** This would be a small loan for Bank of America,
20 but they would often like to have the ability
21 of the State or other entities to step into
22 these debt issuances for MUHA, which is not
23 what we wanted to do at that time.

24 **Q:** Okay. Well, the second bullet point says,
25 levels of cash, leverage and pension

1 obligations with minimal State support make it
2 a difficult deal to underwrite, correct?

3 A: Correct.

4 Q: Okay. And then ---

5 A: They did, however, bid on -- also the 122
6 million that we did a year later, so.

7 Q: Okay. And that was the RAM, that was the one
8 when you got the permission from the State ---

9 A: Right.

10 Q: --- of South Carolina ---

11 A: And the bridge loan, too.

12 Q: Okay.

13 A: So.

14 Q: And then JPMorgan, they also said, third bullet
15 point, MUHA's pension liability coupled with
16 its high operating and balance sheet leverage
17 predictions, those were negatives for it in
18 terms of not responding to the RFP, correct?

19 A: Correct. For a loan of this size.

20 Q: Okay. The 38 million dollar smaller loan,
21 right?

22 A: Yeah.

23 Q: Okay. And then days cash on hand and restrict-
24 -- unrestricted liquidity to debt are weak,
25 too. That was another reason they gave,

1 correct?

2 A: Correct.

3 Q: All right. And then, unable to clarify the
4 exact strength of potential HUD step-down on
5 the front end, correct?

6 A: Correct.

7 Q: All right. And then, if we go to -- to Wells
8 Fargo, they said they're a relationship bank
9 and meeting with You would be required before
10 they would be able to provide credit, correct?

11 A: Correct. At the time, they were very
12 interested in having lunch with me. I do not
13 like to have lunch when we have active RFPs out
14 on the street and wouldn't meet with them.
15 They felt very entitled to MUSC's business.
16 That relationship manager has since been
17 changed.

18 Q: Okay. Fair enough. And, in terms of lunch, as
19 long as they don't pay for you, you're gonna be
20 okay.

21 A: Exactly.

22 Q: Okay. All right. And then BB&T, the inability
23 of MUHA to provide a revenue pledge, that was
24 a credit negative, correct?

25 A: Correct. Then also the other part, BB&T had a

1 lot of other MUSC family debt and was in
2 discussions with the MUSC Foundation for about
3 50 or 60 million. So they, while BB&T had just
4 issued MSB the ability for our Summey project,
5 they were about 52 million, they were in talks
6 at this time, a year later, with the Foundation
7 for 60 million.

8 Q: Okay. But You ---

9 A: You will get credit risk of the entire
10 portfolio. It can't all be MUSC, as much as
11 they may have liked that.

12 Q: Sure. But You would agree with me, at least
13 two of those banks that we've all heard of,
14 they felt that the pension liability of MUSC
15 was an important credit negative, correct?

16 A: Correct. I mean, it was fresh on the -- they
17 have a better awareness of it now then during
18 that time frame. It started small in 2016 and
19 became recurring in 2017, so we were walking
20 through that. And then the research, just as
21 I have explained to You about what was going on
22 in other states and other academic medical
23 health systems.

24 Q: Okay. And so UCB ended up lending MUHA 38
25 million dollars unrestricted -- or excuse me --

1 a 38 million dollar unsecured loan.

2 A: Correct.

3 Q: Okay. And that's a small local bank based out
4 of Greenville, isn't it?

5 A: I believe so.

6 Q: Okay. Did You ever visit their branch in
7 Charleston off of Orleans Road?

8 A: I did not.

9 Q: Okay. Let's go to the next page, 73 -- Trident
10 Exhibit 73-034. And there's a second bullet
11 point, and this is under MUHA credit profile
12 observations. The second bullet point is
13 MUHA's historical credit profile indicates
14 below investment grade ratings based on
15 combined analysis of margin, liquidity and
16 leverage metrics relative to its rating
17 medians, correct?

18 A: Correct.

19 Q: Okay. And in terms of -- well, strike that.
20 And this is something your office generated,
21 correct?

22 A: Correct. And that's without -- by rating,
23 meaning it's the interpretation that it was
24 compared to other FASB institutions as opposed
25 to the GASB.

1 **Q:** **Right. So using something like a Moody's or a**
2 **Standard and Poor or a Fitch.**

3 **A:** **Correct. It says -- You have to understand**
4 **MUHA to have an awareness of the unique impacts**
5 **of the State and the GASB accounting.**

6 **Q:** **Understood.**

7 MR. THOMAS: Your Honor, I would like to move 73
8 into evidence, Trident Medical Center 73.

9 MS. JONES: Your Honor, the pages he asked her about
10 that she recognized I have no objection to.
11 The rest of it is a draft document, it's not
12 the final document ---

13 THE COURT: Right.

14 MS. JONES: --- and it is ---

15 THE COURT: I see that point.

16 MR. THOMAS: How about we put in the TMC 162 so we
17 have the final and we have the draft. She said
18 her department generated this document and Ms.
19 Jones is free to redirect her on this document.
20 You got things in here about the 5-year
21 strategic plan, it actually talks about how
22 very good MUSC is in the community and that
23 type of thing, so if she just wants to ---

24 THE COURT: Well, that's Your position, her position
25 is that the other hasn't been addressed, so or

1 if You want to change it.

2 MS. JONES: My objection is that Ms. Goodlett has
3 told Counsel that she didn't see all the
4 drafts, she didn't prepare the draft and if his
5 ---

6 THE COURT: I'm just asking if you wanted to change
7 Your position.

8 MS. JONES: No.

9 THE COURT: Okay. Then I ---

10 MS. JONES: What do you want me to change my
11 position to?

12 MR. THOMAS: Just we'll put in the draft and the
13 final version. It's a MUHA document, it was
14 produced to us, Ms. Goodlett said it comes out
15 of her office and just 'cause she doesn't see
16 it doesn't mean she's not aware of the concepts
17 that's in the document.

18 MS. JONES: Again, I don't have an objection to the
19 final, I just don't think he -- it is proper to
20 introduce the draft when you've got the final
21 document. It's a draft and she is not able to
22 authenticate or testify about the draft.

23 THE COURT: As I remember, she said she's not aware
24 of it.

25 MS. JONES: She's not aware of it.

1 THE COURT: It is a draft, so ---

2 MR. THOMAS: Eye on the ball. All right.

3 THE COURT: I will let -- but I will let ---

4 MS. JONES: Move to strike Counsel's ---

5 MR. THOMAS: No, what I'll do is ---

6 MS. JONES: --- fortuitous comment.

7 MR. THOMAS: I would like then, from the draft, the
8 first page and the table of contents and the
9 specific pages I addressed with the witness,
10 Your Honor.

11 THE COURT: And You said You don't an objection to
12 that.

13 MS. JONES: I don't have an object to those.

14 MR. THOMAS: Okay.

15 THE COURT: All right.

16 MR. WICEVIC: No objection.

17 THE COURT: All right.

18 MR. THOMAS: Okay. Yeah, Vic even brings up a good
19 point. Just for the record, Your Honor, so
20 those would be, let's see, the, I believe, 73-
21 28 which is the bank RFP summary, 73-29 the
22 UCBI term sheet, 73-30 which is the specific
23 reasons the lenders decided to decline, and
24 then 73-34 the MUHA credit profile
25 observations, and then I would just ask that

1 the first page, 73-01 and 02 come in. And 33,
2 if I didn't say 33, apparently that's the one
3 on the screen now.

4 THE COURT: All right. It says ---

5 MR. THOMAS: Oh, yeah. I'm using the ---

6 THE COURT: It says 34 at the top, doesn't it?

7 MS. JONES: Says 34.

8 MR. THOMAS: Yeah. We're not -- I don't need that
9 one, Your Honor. I need -- yes, I do need 34.
10 All right, my apology. We have our -- each one
11 of our pages in the Exhibit individually
12 paginated ---

13 THE COURT: Yeah.

14 MR. THOMAS: --- for use in the record. Yes, 34 not
15 33 because I didn't ask her about that.

16 MS. JONES: Right. I had 28, 29, 30 and 34. So
17 we're good on those. And page 1.

18 MR. THOMAS: Yep. I think that's right. Yeah, can
19 we do the table of contents?

20 MS. JONES: Yes.

21 MR. THOMAS: Yes. And page 2, table of contents.
22 All right.

23 THE COURT: Those are admitted.

24 (TMC Exhibit Number 73, pages 1, 2, 28, 29, 30 and
25 34, was admitted into evidence at this time.)

1 MR. THOMAS: Thank you, Your Honor.

2 MS. JONES: The final.

3 MR. THOMAS: Yeah. TMC 162.

4 THE COURT: Well, it hasn't been offered, but ---

5 MR. THOMAS: I'd like to offer this into evidence.

6 MS. JONES: No objection.

7 MR. WICEVIC: No objection.

8 MS. HOLLINGSWORTH: No objection.

9 THE COURT: It's admitted.

10 (TMC Exhibit Number 162 was admitted into evidence at
11 this time.)

12 MR. THOMAS: Thank you, Your Honor. All right.

13 **Q: Okay. Ms. Goodlett, were you aware that the**
14 **CON application for this particular project,**
15 **the Nexton project, stated the plan was to**
16 **colocate the Nexton freestanding ED with the**
17 **hospital ED once the hospital was built?**

18 **A: I was.**

19 **Q: Okay. But you agree with me, that is no longer**
20 **the case, correct?**

21 **A: Agreed.**

22 **Q: Okay. And You haven't done any review of the**
23 **CON financials for the MUHA Nexton project in**
24 **light of this decision not to colocate the ED**
25 **after where the hospital is ---**

1 **A:** **Right. It would not be material to the overall**
2 **pro forma.**

3 **Q:** **Okay. Well, but you haven't done an analysis**
4 **to determine materiality, have You?**

5 **A:** **No. On the scope of it, I can tell that it's**
6 **not gonna be material.**

7 **Q:** **Okay. But you haven't done an analysis, right?**

8 **A:** **Correct.**

9 **Q:** **Okay. And do you realize that the underlying**
10 **documents assume that the freestanding ED**
11 **volume from the -- from that Nexton**
12 **freestanding ED would be folded into the volume**
13 **for the MUHA hospital for the purposes of the**
14 **pro forma?**

15 **A:** **Yeah, I believe you're getting into a timing**
16 **decision that the freestanding ED would be**
17 **available before the acute hospital was built**
18 **and came online. Subsequently, there's a**
19 **faster need to have the freestanding ED located**
20 **in a close, but not as close, proximity**
21 **location, so it's different types of patient**
22 **population base, so it wouldn't materially**
23 **impact the pro forma.**

24 **Q:** **Okay. But you would agree with me that the**
25 **freestanding ED CON application also assumed**

1 100 percent redirect, though, right?

2 A: I'm not familiar with that piece.

3 Q: Okay. You're not familiar with that. Do you
4 know one way or the other?

5 A: I do not.

6 Q: Okay. And were you aware that that
7 freestanding ED that was going to be folded
8 into the Nexton hospital ---

9 A: The bigger campus, yes.

10 Q: --- yeah, was going to generate 8.5 million
11 dollars in net revenue?

12 A: Net or gross?

13 Q: Yeah.

14 A: It was gross revenue.

15 Q: Are you sure about that?

16 A: No, I'm not sure about that. The concept was
17 to get a freestanding ED up and going in that
18 community and then move it into the main
19 capacity of the building and turn the space it
20 had formerly occupied into a physician clinic.

21 Q: Okay. I'm gonna put up 22 real quick, we've
22 already looked at this one, and I'd like to go
23 to page 21, if we could, of the document.

24 (TMC Exhibit Number 22 was referenced at this time.)

25 Q: Okay.

1 MR. THOMAS: And if you could blow up, Amanda, this
2 area here, kind of the bottom third of the
3 page. All right.

4 Q: Okay. Now, you'll see, Ms. Goodlett, I'll
5 point up here, emergency department volume and
6 then it's got an asterisk -- freestanding ED,
7 do you see that?

8 A: That's correct.

9 Q: Okay. And if we drop down to net patient
10 revenue and go over to -- we may have to come
11 down a little bit -- but each one of those is
12 in the 8 million dollar net patient revenue
13 range, correct?

14 A: Correct.

15 Q: Okay. So it's not gross, it's net, isn't it?

16 A: You're correct, it is net revenue. We lose
17 money on our ED, so the change to the bottom
18 line, which you showed, of the total net income
19 would be immaterial.

20 Q: Okay. You think it would be immaterial, is
21 that ... Okay. Do you know what the net
22 revenue per adjusted admission is for the
23 Nexton project?

24 A: Not off the top of my head.

25 Q: Do you know what it is for downtown's hospital?

1 **A:** Case mix adjusted and wage index suggested
2 about 32 to 37 million -- thousand per
3 encounter.

4 **Q:** And that's Your net revenue per adjusted
5 admission?

6 **A:** Yeah, adjusted for case mix index and wage
7 index.

8 **Q:** Okay. But you don't know what it is for
9 downtown -- okay, I'm sorry -- for Nexton.

10 **A:** Correct.

11 **Q:** Okay.

12 **A:** And that case mix adjusted a weight -- weight
13 index adjusted.

14 **Q:** Okay. Do you know what it is otherwise?

15 **A:** No.

16 **Q:** Okay. Let's go to TMC 71, which may be the
17 last Exhibit I'll show you, and know you'll be
18 happy about that.

19 (TMC Exhibit Number 71 was referenced at this time.)

20 **A:** I would be.

21 **Q:** And this is -- this document -- do you
22 recognize this report to MUSC Board of Trustees
23 proposed purchase of CHS health system?

24 **A:** I do.

25 **Q:** Okay. And let's go to page 8 of the Exhibit.

1 And are you familiar -- your team put this
2 together, correct, or parts of it?

3 A: Parts.

4 Q: Okay. Would -- is it fair to say that your --
5 the financial parts are probably what Your team
6 worked on?

7 A: That would be fair.

8 Q: Okay. All right. And one of the things that
9 -- in the second bullet point that you're
10 looking at is potential market share impacts,
11 correct?

12 A: Uh-huh. Yes.

13 Q: And the marquee services captured for MUHA --
14 and that's, if I look at the asterisk, that's
15 based on a 50 percent of market opportunity not
16 currently captured and conservative, correct?

17 A: Correct.

18 Q: So if you capture what you want to capture,
19 you're looking at a 7 million dollar EBITDA
20 margin, or an EBITDA pickup, correct?

21 A: Correct.

22 Q: And EBITDA is earnings before interest, taxes,
23 depreciation and amortization, correct?

24 A: Correct.

25 Q: Okay. Now one of the things I heard you say

1 earlier was that patients who used to go to
2 North Carolina are now going to go to places
3 like -- are gonna come all the way downtown,
4 right?

5 A: For their quaternary tertiary, typically 50
6 percent of the patients, the South Carolinians
7 needing those services from Florence up to the
8 North Carolina border are going into North
9 Carolina. By buying these hospitals, we
10 anticipate that 50 percent of that 50 percent
11 could be retained within South Carolina to
12 receive care.

13 Q: Okay. And I think I heard you say that the
14 reasons they were going from Florence and
15 Lancaster areas to North Carolina is 'cause
16 they couldn't get into MUHA.

17 A: Correct.

18 Q: Okay. How do you know that?

19 A: Based on the tracking patterns, now that we've
20 acquired them and then plus we also have that
21 call volume that on any given month, there's 50
22 or 60 quaternary tertiary patients trying to
23 get into us that call us and we know only about
24 5 to 10 percent actually make the phone call
25 and are still trying to get in.

1 Q: Well, don't you think people in Lancaster maybe
2 went up to Charlotte because that's where their
3 doctors referred them because it was 30 minutes
4 away and not three hours away?

5 A: They may have, but to get into a subspecialist
6 or a sub-subspecialist, wouldn't You want a
7 South Carolinian to be able to get into a South
8 Carolina facility?

9 Q: Well, as a South Carolinian, I'd want to go to
10 the closest place I could go to get the best
11 care.

12 A: Right. And ---

13 Q: But that's just me.

14 A: --- quaternary and tertiary care may be only
15 available in Charleston.

16 Q: Now are you saying that Atrium doesn't have
17 subspecialties?

18 A: They do, as many hospitals do. They may not
19 have the sub, sub, subs.

20 Q: All right. So you're going on -- based on
21 tracking patterns, but the fact of the matter
22 is that when You purchased these hospitals, all
23 of those physicians became MUSCP physicians,
24 correct?

25 A: They became employed by Health part- --

1 Carolina Family Care.

2 Q: Okay.

3 A: Which is an entity within the MUSCP structure.

4 Q: Okay. And those folks -- those physicians
5 don't necessarily have an academic appointment,
6 do they?

7 A: Well, they all have an associate faculty
8 appointment.

9 Q: Okay. Is it assistant clinical professor?

10 A: Could be.

11 Q: Okay. Do you know what that means?

12 A: Why yeah, it means that you're not as engaged
13 in the active teaching, but you do have
14 teaching responsibilities and you're not based
15 down in Charleston.

16 Q: Okay. And do all -- so you're -- your
17 testimony here today is that all of those
18 Carolina Family physicians have an academic
19 appointment?

20 A: They have an academic letter of some sort.

21 Q: Okay. And that was just provided to them the
22 day they became employees of MUSC, correct?

23 A: It's part of the employment model.

24 Q: Okay. And before, those physicians could have
25 gotten patients downtown to downtown Charleston

1 and routinely did, correct?

2 A: If they have the existing relationships.

3 Q: Okay. All right. Let's go to 71-10, if we
4 could, on the benefits of this particular
5 acquisition. And I'm interested in number 3
6 there, leverage. Size and location matters to
7 insurers, helps maintain favorable
8 reimbursement rates for MUSC and MUHA, correct?

9 A: Correct.

10 Q: And one of the reasons that I think you told --
11 well, about this -- you have more lives, you
12 can get more leverage and perhaps have a better
13 position at the negotiating table with
14 insurers, correct?

15 A: Or are able to defend Your current position.

16 Q: Okay. Or grow, correct?

17 A: Correct.

18 Q: All right.

19 A: And our conversation with Blue Cross is largely
20 defensive these days.

21 Q: Now, Ms. Goodlett, you're not aware of any kind
22 of separate set of CON Regulations that apply
23 specifically to academic medical centers, are
24 you?

25 A: Not to my knowledge.

1 Q: Okay. And in terms of -- I've just a few
2 questions to ask You just based on questions
3 that Ms. Jones asked you, but a lot of them I
4 have asked already. Did I hear you say that
5 the 137 million dollar purchase of the four CHS
6 hospital was not a large magnitude purchase?

7 A: Not in comparison to ART or Children's which
8 were three, sixty-three, thirty million.

9 Q: Okay. Or comparison to building this Nexton
10 hospital of 325 million dollars.

11 A: Correct.

12 Q: Okay. Now ---

13 A: And I think the key there is building. They're
14 existing already versus coming out of the
15 ground, and the expectations of the consumers
16 today.

17 Q: Okay. Is it your understanding that 21 days
18 cash on hand is -- would be, in terms of your
19 FASB rating agency, that would be in the junk
20 bonds status?

21 A: Potentially.

22 Q: Okay.

23 A: But then, You can't apply that to a State
24 Authority.

25 Q: Okay.

1 **A:** And the market's not applying that to a State
2 Authority.

3 **Q:** Now, I believe Ms. Jones asked you a few things
4 about some HUD requirements and relying on the
5 DHEC CON application, correct, relying on what
6 the State does?

7 **A:** For -- for the deeming of an essential
8 healthcare, which the Charleston campus with
9 those four hospitals was deemed at.

10 **Q:** Okay. And you would agree with me that nowhere
11 in the CON application does it mention anything
12 about the 450 beds within a 10 mile radius of
13 the MUHA Nexton location, is that a fair
14 statement?

15 **A:** I would not be familiar with that.

16 **Q:** Okay. Is that because you haven't read the CON
17 application?

18 **A:** That's correct.

19 **Q:** Okay. Now, you would agree with me, if HUD is
20 eventually gonna rely on the State of South
21 Carolina's CON application that it reviews, if
22 the State of South Carolina gets it wrong, HUD
23 could potentially get a 325 million dollar loan
24 wrong, too, correct?

25 **A:** Potentially.

1 Q: Okay.

2 A: But it's not -- I want to make sure we're
3 clear. The essential designation is not a
4 requirement by HUD for funding.

5 Q: Okay. Fair enough. Why does MUSC have to go
6 to the State to get permission for a revenue
7 anticipated -- anticipation note?

8 A: MUHA has to ---

9 Q: MUHA.

10 A: --- as part of its enabling legislation has to
11 get SPA approval.

12 Q: Okay. Now, you mentioned something about CHS
13 community health systems unloaded their
14 hospitals because they were only operating on
15 a 9 to 11 percent margin?

16 A: EBITDA.

17 Q: EBITDA ---

18 A: Yes.

19 Q: --- margin. Is the other reason they unloaded
20 them is because they got 14 billion dollars of
21 debt on their balance sheet and that they're
22 struggling financially?

23 A: Oh, yeah. I think the offload was to, when
24 they acquired HMA, they were not thoughtful in
25 their integration of their capacity, from my

1 perspective. And so that's why the debt load
2 of those hospitals carrying 54 million annually
3 compared to -- I'm sorry, 45 million annually
4 compared to MUHA's 9 is a big difference.

5 Q: Okay. Now, Ms. Jones asked you some questions
6 at MUHA 30, which is Your total project cost
7 estimate -- and I don't think we need to bring
8 it up unless You can't remember some of the
9 figures ---

10 A: Is that the project list?

11 Q: Yes.

12 A: Well that I can ---

13 Q: No, no. Not project list, it was the total
14 project costs, I believe. Y'all discussed
15 owner contingencies.

16 A: Oh, okay.

17 Q: Yeah. It was an owner contingency of 37
18 million dollars, I believe?

19 A: Yes.

20 Q: Okay. Were you here for Dr. Warr's testimony
21 yesterday?

22 A: I was not.

23 Q: Okay. Did -- do you understand -- do you know
24 what services are actually going into MUHA
25 Nexton?

1 **A:** Yes. The standard, it's in the -- probably
2 outlined in the CON, but standard services we
3 would see in a community hospital, probably
4 very similar to what's offered.

5 **Q:** Okay. Do you know why your chief medical
6 officer wasn't very sure of the services that
7 ---

8 **A:** He's been interim, so he's only been official
9 for three or four months and very Charleston
10 focused. For there, it would be appropriate
11 that there would be a different CMI for Nexton
12 who wants to -- up and operational would be
13 hands-on in Phillip's role.

14 **Q:** Okay. And what have you got budgeted for this
15 project, 325 million, correct?

16 **A:** Correct.

17 **Q:** And that is what you're going to go and try to
18 get HUD-based financing for, correct?

19 **A:** And all financing, yes.

20 **Q:** Okay.

21 **A:** HUD enhanced would be preferred.

22 **Q:** Okay. Ms. Jones showed you the FTE budget.
23 Could you go through the budget -- and I'm just
24 gonna ask you this question, if you say yes, we
25 can, but -- can you go through that budget and

1 tell me how many shift workers are on there?

2 A: I could not.

3 Q: Okay.

4 A: I could tell You by category who I would
5 anticipate, but I'd have to get clear on Your
6 definition of shift worker.

7 Q: Well, folks that are required to be there ---

8 A: Regular hours.

9 Q: Yeah.

10 A: Gotcha.

11 Q: All right. That's all the questions I have for
12 you. Thanks for enduring that and Ms.
13 Hollingsworth may have some questions for you
14 as well.

15 MR. THOMAS: Beg Your indulgence. We're good, Your
16 Honor. Sorry about that.

17 THE COURT: How long do you think you're going to
18 be?

19 MS. HOLLINGSWORTH: I would expect, Your Honor,
20 we're -- any -- from 30 to 45 minutes. If you
21 wanted to take lunch, though, I would probably
22 cut that down. 'Cause I do think there's a
23 fair number of a lot that I can try to ---

24 THE COURT: Sold.

25 MS. HOLLINGSWORTH: And I promise, I prefer to

1 under-promise, so I will cut it back ---

2 THE COURT: Okay. And it's 12:24 now. What time,

3 1:00?

4 MS. HOLLINGSWORTH: 1:15? Want to do a shorter

5 break?

6 MS. JONES: I don't want to do a shorter break.

7 Could we do 1:30?

8 MR. THOMAS: I'm walking back and forth to my

9 office. That's my problem.

10 MS. JONES: Yeah, I am too.

11 THE COURT: Thank y'all.

12 (Off the record from 12:24 p.m. until 1:28 p.m.)

13 THE COURT: Did You find your carving knife and ...

14 MS. HOLLINGSWORTH: I -- you're going to be so

15 impressed when just lines of blue ink fly by,

16 I promise.

17 THE COURT: Please.

18 MS. GOODLETT - CROSS-EXAMINATION BY MS.

19 HOLLINGSWORTH:

20 **Q: Hey, Ms. Goodlett.**

21 **A: Hi.**

22 **Q: Nice to see you again.**

23 **A: Good to see you as well.**

24 **Q: And I promise, this -- you will be impressed**

25 **with how fast this goes.**

1 **A:** I'd be delighted.

2 **Q:** And before I get into the really fun stuff, let
3 me just roll through a couple projects, and
4 I'll try not to repeat, but just go as quickly,
5 I'm looking at a -- sort of a summary and I
6 think major capital projects. And we've got
7 the Shawn Jenkins, but there's also the North
8 Charleston Pediatric Imaging Center, right?
9 You're aware of that project?

10 **A:** It's part of what we would call our capper, so
11 in the pavilion, that was two CONs merged
12 together.

13 **Q:** Okay. So the CON, there was a CON related to
14 the imaging component and then a CON related to
15 an ambulatory surgery center component, is that
16 right?

17 **A:** Correct. Yes.

18 **Q:** Okay. And then there was, or is -- is there a
19 surgery center in Mount Pleasant?

20 **A:** There is, yes.

21 **Q:** Okay. And separately, the musculoskeletal
22 institute?

23 **A:** That's correct.

24 **Q:** That's also in Mount Pleasant, right?

25 **A:** That's West Ashley and that's jointly funded by

1 MUHA and MUSCP.

2 Q: Okay. And then you are familiar, aren't you,
3 with the recent submission of a CON application
4 for a freestanding emergency department in
5 Johns Island?

6 A: Correct, yes.

7 Q: All right. And you talked, so far today, a
8 little bit about some State funding and I just
9 wanted to ask you what we talked about in your
10 deposition. Is it still approximately 22 to 24
11 million annually that You receive in State
12 funding?

13 A: Yes, I believe it's inched up to about 24 to 26
14 million due to additional innovation funds.

15 Q: Okay. And that innovation funding, is that
16 around 5 or 6 million dollars?

17 A: Correct, yes.

18 Q: And then other than that, the component that
19 you're using for the 24 to the 26, is that the
20 Telehealth services?

21 A: Yeah, Telehealth runs about 19 million. And
22 we're a pass-through conduit there, so the
23 State wanted one leader in the healthcare
24 space, so the operating expenses are down in
25 our normal operating expenses, although the

1 revenue is coming in from the State.

2 Q: Okay. And then, MUHA also participates in the
3 disproportionate share program, right?

4 A: That's correct.

5 Q: And has historically received substantial funds
6 through that medi- -- State Medicaid program,
7 right?

8 A: Proportionally so, yes.

9 Q: Right.

10 A: We have still not been restituted to --
11 community hospitals are about fully funded back
12 up to 100 percent ---

13 Q: Right.

14 A: --- and academics are still only 80 percent
15 funding, so, but it is a nice bit of money.

16 Q: Okay. All right. And then also, MUHA receives
17 graduate medical education payments, is that
18 right?

19 A: Correct.

20 Q: And then there's also some supplemental
21 teaching payments?

22 A: Those are to -- they flow through the
23 University of MUSCP, they do not impact MUHA.

24 Q: Okay. All right. Any other similar type, sort
25 of, ongoing funding sources related to South

1 Carolina's programs, State programs?

2 A: No, I would cap that at DSH and ---

3 Q: GME?

4 A: GME.

5 Q: Okay. All right. And you talked about the
6 project pro formas earlier, and as I understood
7 it, you did the financial attestation for those
8 pro formas in the CON application, right?

9 A: Correct.

10 Q: Okay. And you did review them, but what you
11 reviewed was the final version, so the version
12 that we see in that DHEC record, right?

13 A: Correct.

14 Q: Okay. And then you also did an assurance of
15 funding availability ---

16 A: Correct.

17 Q: --- right? And would you have been the one to
18 coordinate with Mr. Pack as well on the, sort
19 of, HUD-related correspondence that's in ---

20 A: Yes.

21 Q: --- that record? Okay.

22 A: Yes.

23 Q: All right. And then in terms of the services
24 that are planned at the community hospital, and
25 you talked about it a little bit this morning,

1 but those are services typically found in a
2 community hospital setting, right?

3 A: Correct. It would not be our intention to do
4 transplants there or anything of a high-level
5 quaternary nature. We would open up access to
6 some of our sub-subspecialists via Telehealth,
7 so they could have a visual presence on the
8 campus to care for patients.

9 Q: Okay. And then, but it will have an ED and
10 imaging, right?

11 A: Yes.

12 Q: A lab, obviously, the inpatient ---

13 A: Yeah.

14 Q: --- services, right?

15 A: Uh-huh.

16 Q: Okay. Observation capabilities?

17 A: Correct.

18 Q: Would it be much like what you expect would be
19 at the Roper Saint Francis Berkeley Hospital,
20 the 50-bed hospital?

21 A: I'm not as familiar with that, but I do -- and
22 it would be very similar to our Florence
23 facility and our Lancaster facility.

24 Q: Okay. And in looking at the -- you talked
25 about how you did the typical, does it look

1 right evaluation of the pro formas, correct?

2 A: Right. Uh-huh.

3 Q: And You did some stress tests to the
4 assumption, is that right?

5 A: Correct.

6 Q: And you talked in your direct, and I wanted to
7 explore it a little further because we didn't
8 get to talk about it before, but You analyzed
9 some metrics surrounding DRGs, is that right?

10 A: Yes. And so, given the slate of services we're
11 offering in a location, what's the
12 reimbursement for those services, where does --
13 how does that map with the Medicare payments.
14 Those kind of things would happen.

15 Q: Okay.

16 A: Because it wouldn't make sense to have
17 tertiary, You know, expect a reimbursement in
18 a community facility.

19 Q: Okay. Well, would you have been basing it off
20 of the similar experience that MUHA gets
21 downtown for those non-tertiary services or
22 would You have been looking elsewhere as -- for
23 that benchmark or comparison?

24 A: It would be relative to the community, patients
25 community appropriate that are in the downtown

1 campus. We did adjust down the charges by
2 about 15 percent in recognition from the total
3 of the Charleston campus that would be a
4 community base population.

5 **Q:** Okay. All right. And I think, let's see.

6 MS. HOLLINGSWORTH: Can we look at Trident 41?
7 (TMC Exhibit Number 41 was introduced into the record
8 at this time.)

9 MS. HOLLINGSWORTH: And if you just kind of blow up
10 those two charts.

11 **Q:** Ms. Goodman (ph), in terms of what you might
12 have had in terms of assumptions or volumes
13 related to the projections, would this sort of
14 information have been made available to you and
15 -- so I have in front of me DHEC 1, which is
16 the record for the application. And in terms
17 of the projections -- and I'll find it -- so
18 there's a projection -- the projection in the
19 application ---

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

21 MS. HOLLINGSWORTH: --- and just for the record,
22 this is DHEC 1, at CON 40 ---

23 **Q:** --- for project year one, there are 2,457
24 projected volume for the project. And so,
25 looking here at Trident 41 and that grand total

1 of 2457, would that information have been part
2 of how you're evaluating, sort of, this is the
3 mix for the DRGs to forecast those revenues or
4 not?

5 A: No, not -- I haven't seen this before, but,
6 typically, it would be something trended.

7 Q: Okay. So how would you evaluate, for purposes
8 of forecasting the revenues for this particular
9 facility, how are you evaluating what patients
10 are going to be going there and what are they
11 going there for? What are you looking at to do
12 that ---

13 A: We would look at ---

14 Q: --- testing?

15 A: --- with our DRGs, we classify them into
16 community based, quaternary and tertiary based,
17 and say, okay, based on the need of, You know,
18 that we project the patients that could be seen
19 in that area. Out of the home would create,
20 here's the anticipated revenue based on, as I
21 mentioned before, realizing that these would be
22 not the quaternary patients, we decreased the
23 charging down by 15 percent, so.

24 Q: Okay. All right. Let's take a look at -- make
25 sure I'm going to the right place. If we could

1 look at Trident 74.

2 (TMC Exhibit Number 74 was referenced at this time.)

3 Q: And you looked at this earlier and it's the pro
4 forma from the application, but this version
5 has some detail to the schedules that, I think,
6 would have available to you, it's just they
7 were not included in the application itself.

8 If you could look at, let's turn to ---

9 MS. HOLLINGSWORTH: Flip to the project pro forma,
10 so it's probably the third page of the PDF.
11 There You go. And then, if you could blow up
12 some of those assumptions.

13 Q: All right. And so, this would be the pro forma
14 from the project and those assumptions there in
15 the pro forma, those would be assumptions that
16 you're using in evaluating and doing that
17 stress testing that You talked about?

18 A: Correct.

19 Q: Is that right? So then, we've got -- and we'll
20 look at the volume schedule in a minute -- but
21 in terms of inpatient revenue, it's based on
22 average non-tertiary MUHA charge for discharge.
23 So is that further adjusted for the community
24 or it's MUHA's experience for those non-
25 tertiary discharges?

1 A: Are you asking me related to item number 1?

2 Q: It would be the third line, but yes.

3 A: Third line.

4 Q: Overall number 1. Inpatient revenue based on

5 average non-tertiary MUHA charge per discharge.

6 So is that ---

7 A: I'm sorry. I'm having trouble finding that.

8 Q: There You go, does that help?

9 A: Oh, yes. Uh-huh.

10 Q: Okay. So, it's ---

11 A: That would have the 15 percent in it.

12 Q: That's after the 15 percent?

13 A: Right.

14 Q: Okay. All right. And then, so similarly to

15 the outpatient gross revenue is a percent of

16 that total, is that right? It's the next line

17 down.

18 A: That's correct.

19 Q: Okay. Do ---

20 A: This was -- it's lower on the outpatient gross

21 revenue than what we typically do see down in

22 the Charleston campus.

23 Q: Okay.

24 A: They're more -- it's 5 percent inpatient to 45

25 percent gross patient revenue, so that was --

1 we had some discussions about why that number
2 was lower and what was potentially driving
3 that. And the thought was, in the community
4 hospital, since the freestanding ED was going
5 to be moving into that piece, that this -- it
6 didn't really swing it to make it material, but
7 it was different from the first one.

8 Q: Okay. And you felt comfortable with that
9 distinction for the community hospital
10 location?

11 A: Yeah, we drilled into it at the time and got
12 comfortable.

13 Q: Okay.

14 MS. HOLLINGSWORTH: And let's -- scroll down to -- I
15 think the next page should be the, what they
16 call the budgeted beds. Yeah, okay.

17 Q: And this would be a schedule that you would
18 have seen when You were doing that stress test
19 of the pro forma, is that right?

20 A: Not necessarily.

21 Q: Okay. You wouldn't have had the, sort of,
22 information behind this with the discharges for
23 inpatient, patient days, do you see those
24 calculations?

25 A: Yeah, we would have inquired -- I'm just not

1 recognizing this schedule.

2 Q: Okay.

3 A: The sure, sure ...

4 Q: Okay. Now in terms of some of your
5 assumptions, and we talked about some of this
6 at your deposition, there's a 10 million dollar
7 a year annual fundraising line item that you're
8 continuing forward in your projections, right,
9 that had been from Shawn Jenkins and you
10 anticipated ---

11 A: Yes.

12 Q: --- that is going to continue?

13 A: With our development, yes.

14 Q: Okay. And so, over the last couple years where
15 that -- those contributions have been related
16 to the fundraising for Shawn Jenkins, is that
17 right?

18 A: Primarily, yes.

19 Q: Okay. And -- but it's your understanding that
20 the foun- -- MUHA's foundation is committed to
21 continue that endeavor for now, is that right?

22 A: That's correct. Our, we call it development,
23 for fundraising in our world and that leader
24 just retired last June and we have extended an
25 offer to a new person. So coming off a big

1 building campaign like Shawn Jenkins, but
2 having a new person come in, we're re-tapping
3 -- You can have different roots in the
4 community.

5 Q: Okay. Has MUHA been approached or approached
6 any donors like Mr. Jenkins or the Tourville
7 family for the Berkeley Hospital project?

8 A: Not to my knowledge.

9 Q: Okay. And in the 2019 audited financials, and
10 we'll look at them in a minute, but You
11 mentioned a couple times that there was a 25
12 million dollar appropriation from South
13 Carolina for the Shawn Jenkins project, do you
14 recall ---

15 A: Several years ago, yes.

16 Q: Yeah. Okay. And -- but it's correct, isn't
17 it, that there was also a 10 million dollar
18 appropriation for Shawn Jenkins in the 2017?

19 A: I believe so, yes.

20 Q: Okay. So the total for Shawn Jenkins
21 appropriated from the State of South Carolina
22 has been 35 million, is that right?

23 A: Yes.

24 Q: In those two?

25 A: Uh-huh.

1 Q: Okay. And do you similarly expect that there
2 will be appropriated State funds for the
3 Summerville Hospital project?

4 A: Not at this time.

5 Q: Okay. All right.

6 A: I think their funds were appropriated because
7 it was the only children's hospital to be
8 constructed.

9 Q: Okay. And that 35 million, that was a
10 substantial amount of money, right?

11 A: Yeah, it's about, a little over 10 percent of
12 the costs of the project, so we were happy. A
13 little less than, I'm sorry, 10 percent, so
14 we're grateful.

15 Q: Okay. Now, if we could look at -- it's a
16 Trident Exhibit, but it's sort of a complicated
17 Excel -- and I wanted to ask You, the tab -- we
18 can look at just the single sheet of paper
19 first and I think this should be familiar, I
20 hope, with the -- that budgeted beds and
21 volumes information. Oh, I'm so sorry.

22 A: No, you're fine.

23 Q: And this, this sort of backup data behind the
24 pro forma, I just wanted to ask you about a
25 couple of the terms for metrics that are on

1 here. Could you just explain to us what the
2 adjusted total discharges are that -- what is
3 that -- what does that mean, this number
4 adjusted total discharges that in 2023 is
5 4,907? Do you see that, sort of, in the top
6 third of the page?

7 A: Gotcha. Adjusted total discharge is a
8 reflection to say there's gonna be outpatient
9 activity and inpatient activity and it's very
10 easy to count the inpatient discharge because
11 they stayed with You. And so it's a
12 mathematical formula, well it's been around for
13 a long time, that as soon as there's a
14 correlation between charges and revenue and to
15 -- and an adjustment to say that -- adjusted
16 those charges. So, in this example, maybe
17 there were 1,000 actual discharges are from
18 that base and then you would amplify it by the
19 amount of that revenue that was inpatient
20 versus outpatient. It's kind of an old
21 statistic that people have used in the past
22 since there is no good way to say, a patient
23 coming in for a live test is the same thing for
24 a same-day surgery.

25 Q: Okay. And is -- but this terminology, is it

1 familiar to you and what you do ---

2 A: Yes, it is, yes.

3 Q: Okay. And so, is that similarly adjusted total
4 patient days, is that a similar calculation ---

5 A: It would follow ---

6 Q: --- based on patient ---

7 A: --- the same ---

8 Q: Okay.

9 A: Correct.

10 Q: All right. And if you could, what -- these
11 bottom few numbers, key cost analytics and the
12 total cost/adjusted discharge, total
13 cost/adjusted patient day, at the bottom, what
14 do those numbers represent and what is that a
15 calculation of?

16 A: It would -- and I haven't seen this before, but
17 it's checking out to say in -- are you getting
18 more efficient as you have more volume going
19 through? As you'll see in 2023, the cost per
20 discharge is about 21.6 and then You gain
21 economies of scale because you look where
22 you're picking up patients and becoming more
23 efficient versus, as we talked about, it takes,
24 You know, 9 to 18 months for something to
25 become operationalized.

1 Q: Okay. So this is, during these three program
2 years, Your staffing is going up, but you're,
3 hopefully, achieving economies in other places,
4 so your costs overall are still coming down?

5 A: Correct.

6 Q: Okay. All right. And do you, in what you do
7 as CFO for MUHA, are You looking for any
8 particular threshold or metric here, or no?

9 A: No, because each one of our hospitals is a
10 little different, you know, in size and market
11 and what they're ---

12 Q: Okay.

13 A: --- doing.

14 Q: All right. And then, if you could look at the
15 other one that I handed you which is, again,
16 it's just another tab in that same -- it's
17 Trident 22 and it's a tab within an Excel
18 spreadsheet and we looked at this, too, in your
19 deposition, it had a number of pages.

20 (TMC Exhibit Number 22 was referenced at this time.)

21 Q: So this document, let me ask you this. What is
22 PYA, is that -- do you know who or what ---

23 A: I was gonna ask you.

24 Q: That's not good. Okay. All right. Well, what
25 I ---

1 A: 'Cause I don't remember the very top in what we
2 looked at, I don't think.

3 Q: So this is the tab of this document, it says,
4 projection model MUHA Berkeley PYA request-
5 copy. So in that production document -- where
6 that list. Oh, sorry -- is it maybe Pershing
7 Yoakley Associates, does that sound familiar?

8 A: That's who does our brand valuation. I would
9 ... not see them -- we do look funny -- if I'm
10 reading this, the way I would interpret are,
11 the red is some kind of new activity in
12 February of '19 and ---

13 Q: And if you look on ---

14 A: And the people in ---

15 Q: --- turn to the second page.

16 A: --- the PYA is doing the red, is that what ...

17 Q: I don't know. Maybe Mr. Leavitt will be able
18 to tell us.

19 A: Is this one of the official formal documents in
20 the CON or is this one ---

21 Q: This is one of the ---

22 A: --- copies?

23 Q: --- last drafts right before ---

24 A: So it's a draft.

25 Q: Uh-huh. It's like a couple thousand dollars

1 off.

2 A: I gotcha. So -- but it's a draft that was
3 covered in the email search?

4 Q: Right. Or in the discovery production.

5 A: Okay. In discovery production.

6 Q: Yes.

7 A: Okay.

8 Q: And really what I just want to ask you, if you
9 look on the second page and there's the
10 assumptions, and these assumptions, as we saw,
11 a lot of this text and a lot of what You see
12 in, sort of, black font, is very similar to
13 what the assumptions look like that are in the
14 application pro forma, but these just have a
15 little bit more detail to them. And I wanted
16 to ask You just a couple questions about the
17 assumptions. At the page, and just to take a
18 look at it.

19 A: Okay.

20 Q: And -- as I then look at it as you're ---

21 A: Oh, I'm sorry. I'll wait.

22 Q: The net patient service revenue/adjusted
23 patient day, what is that that's being
24 calculated? It's right below assumptions
25 overall two.

1 **A:** Looks like it's taking the anticipated net
2 patient revenue in 2023 of, say, 93 million
3 adjusted patients per day, so the net revenue
4 patient per day around 4,04- -- 4,045.

5 **Q:** Okay.

6 **A:** It's hard for me to tell if this was an
7 inpatient or -- looks more like a, maybe, an
8 outpatient something.

9 **Q:** Okay. Is net patient service revenue for
10 adjusted patient day, is that a calculation
11 that You do or are aware of for your hospital?

12 **A:** I'm aware of it, it's not one of our daily
13 indicators.

14 **Q:** Okay.

15 **A:** It would be helpful in a pro forma development.

16 **Q:** Do you have an idea, the last time you looked
17 at that, what the net patient service revenue
18 for adjusted day is for MUHA downtown?

19 **A:** I do not, off the top of my head.

20 **Q:** Okay. And is that something that you would
21 look at regularly or would it be something you
22 would look at when you're working on a project
23 development?

24 **A:** Only when we're working on a project.

25 **Q:** Okay. All right.

1 **A:** Or the budget maybe.

2 **Q:** Okay. And then, I wanted to ask you, turn to
3 the third page and it's -- I mean, my quality's
4 -- so it is an Excel spreadsheet, I tried to
5 kind of keep it so that it printed in a way
6 that made sense. But there's, there's sort of
7 references here -- it's at line 27 -- and I
8 should go back to the first page -- line 27,
9 maps to contractual services and other in the
10 pro forma. But on line 27, here on the third
11 page, it says, as percentage of -- and I think
12 this is net patient service revenue based on
13 MUHA less residents, etcetera, and it's 15
14 percent? Do you have any idea, so again,
15 thinking in terms of contractual and other --
16 contractual services and other line item in the
17 pro forma in the application, what that
18 calculation represents?

19 **A:** It looks like it's doing a run rate to test
20 some of the lines embedded because of interest
21 and depreciation, but I haven't seen this
22 before ---

23 **Q:** Okay.

24 **A:** --- so I'm a little bit guessing.

25 **Q:** Okay.

1 **A:** But it does look like it's a -- it's trying to
2 determine multi-year run rates and if something
3 reasonable or not.

4 **Q:** Okay.

5 **A:** Which I would expect in a draft.

6 **Q:** And so, what were you looking at, then, when
7 you were doing your stress testing and analysis
8 of what the reasonableness of the projection --
9 what would you have been looking at?

10 **A:** You would go and say, okay, multi-year
11 directional, is it trending in the right
12 direction, is it -- are there quantum leaps in
13 a certain line item that just shouldn't be
14 there. And then we would do simulation testing
15 if DSH were withheld at the State level program
16 for X number of period. Really a lot around
17 the volume assumptions to see how quickly does
18 it ramp up or take -- what's the percent of
19 supplies, is it, you know, total expenses or
20 net patient revenue, just to, kind of, do some
21 of those calculations. But I would see that
22 mainly on the top sheet for what would be on
23 display and then other people with laptops and
24 stuff would be running the calculations or
25 answering the questions.

1 Q: Okay. But do you know what might -- and again,
2 this is -- I keep losing my spot -- contractual
3 service and other based on MUHA less residents.
4 Do you know what that could mean, MUHA less
5 residents? What might be MUHA's line item that
6 would involve ---

7 A: It could support payments to the College of
8 Medicine at the Charleston campus. We have our
9 tri-part mission and the health system helps on
10 the other two going forward. And so we fund
11 GME differently and as a direct line item at a
12 loss of about 22 million a year on that piece.
13 So someone, and they have been trying to carve
14 out and make sure we didn't over-calculate our
15 physician expense line to -- and I'm just
16 guessing ---

17 Q: Sure.

18 A: --- of what they might be doing. But they're
19 looking for some kind of relational part to our
20 funding and subs- -- and carving out a group.

21 Q: Okay. And how does this tie -- if you and,
22 again, just based on your experience and
23 working with MUHA's financials -- how would
24 this tie to any teaching or residents that are
25 in MUHA downtown? Is this an expense related

1 to having residents at your clinical enterprise
2 downtown or it's not related to that?

3 A: I really can't tell. It's a draft, so I
4 probably -- I don't -- I have not seen it and
5 I would be, you know -- there's a lot of pages
6 here. It would be hard to see what's missing
7 or whatever, so.

8 Q: Okay. And so -- but would it be fair to say
9 that, in terms of the CON pro forma, you don't
10 know whether or how that is or is not
11 represented in the contractual line item in the
12 project pro forma?

13 A: I think we're pretty clear on our assumptions
14 on the contractual line item. I'm just saying
15 in this draft, I don't ---

16 Q: Okay.

17 A: --- know. I'm really not sure.

18 Q: Okay. All right. And just looking again, we
19 can look at the project pro forma. Do you
20 still have the DHEC record?

21 A: The big book?

22 Q: It's the -- yeah, DHEC's 1.

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

24 Q: So it would be the big notebook. And if You
25 could look at 598 -- we're trying to get the

1 **project pro forma.**

2 THE COURT: Did You say 598?

3 MS. HOLLINGSWORTH: Yes, Your Honor, I'm sorry, 598.

4 **Q: We'll do the pro forma for the hospital project**
5 **itself. And it's about to be on the screen, so**
6 **that might ---**

7 **A: Oh, okay, cool. Did You say 598?**

8 **Q: Yes, ma'am. 598.**

9 MS. JONES: If You just look at this page, the
10 number's at the bottom of the page.

11 **A: Okay. Thank You.**

12 **Q: The pro forma in the budget, we're at DHEC 1,**
13 **598, I was just curious, can you tell me what**
14 **the gross inpatient revenue per discharge is**
15 **for year one?**

16 **A: Not without the volume information.**

17 **Q: Okay. Well, if we -- the volume schedule we**
18 **looked at earlier, is not in the application,**
19 **but I would represent to you that what we have**
20 **from the other drafts, or the other**
21 **productions, is the volume was 3,135. So if**
22 **the total volume is 3,135, to get the gross**
23 **inpatient revenue per discharge, would we just**
24 **simply divide that into that top line item?**

25 **A: No, I think you're saying the plan discharges**

1 were about 3500?

2 Q: Yeah, 3135.

3 A: 3135. So, yes, you could divide that into the
4 206.

5 Q: Okay. All right. But that's how you would do
6 it if You were to -- You would just need the
7 total number of discharges and You would divide
8 it into the top inpatient revenue line, is that
9 right?

10 A: Yes.

11 Q: Okay. And I think you told me you don't know
12 what downtown's net patient per adjusted
13 discharge is, is that right?

14 A: Our net revenue per case mix and wage index
15 adjusted runs about 32, 35,000.

16 Q: And is that per discharge? So that would be --
17 -

18 A: Yeah, a case mix so it's adjusted for acuity.
19 So the charge would be somewhat higher than
20 that ---

21 Q: Okay.

22 A: --- but then brought down. Our case mix runs
23 about 2 to 2.10. So that would mitigate that,
24 so our average and that can be, maybe, around
25 65,000 -- 70,000 or so for downtown Charleston.

1 Q: 65,000 to 70,000 ---

2 A: As an estimated range just going off the
3 projections for what we're seeing today, which
4 would be in 2018. So you'd have to index that
5 out, You know, for inflation going forward.

6 Q: Okay. But in terms of just the net number
7 today, that would be somewhere, roughly, 65 to
8 70,000, again, at the downtown facility?

9 A: It could be, yes.

10 Q: Okay. All right. And those are all my
11 questions on the pro forma. I did want to ask
12 you some questions related to the financials
13 that you went through, but I won't ask You
14 anything else about the CON.

15 A: Can I put the book up?

16 Q: Yes.

17 A: Thank you.

18 Q: I hope. So would you agree with me that it's
19 important for an organization's financial
20 planning to be commensurate with its strategic
21 appetite?

22 A: Yes.

23 Q: Okay. And is it your role as CFO to -- I think
24 you used the word in your deposition, for
25 perpetually evaluate, sort of, the long-range

1 financial plan for Your organization?

2 A: Correct.

3 Q: So I think You described that long-range
4 financial plan just -- it's always living and
5 it's always going. There is no end to that, is
6 that right?

7 A: Correct. We update it, officially, annually
8 based on the audit results, but then we will
9 pull it out several times a year as we
10 contemplate new projects and which entities
11 should do them, how should they be funded?

12 Q: Okay. And is it your role, too, to evaluate
13 the financial metrics of your hospital or
14 hospitals to remain compliant with what your
15 outstanding commitments are and also project
16 what you can afford to do strategically?

17 A: Yes.

18 Q: Okay. And would you agree with me, it's
19 problematic when there's a misalignment between
20 your growth initiatives and your expense load?

21 A: Oh, not necessarily. Duration comes into play.

22 Q: Would You agree with me it's problematic when
23 there's a misalignment between your closed
24 initiative and Your expense load?

25 A: Not necessarily. Duration comes into play, you

1 know, we would be disrupted and are disruptive
2 when we bring a new asset online, so we don't
3 look normal for nine months to 18 months until
4 we absorb the new asset. There may be a
5 particular opportunity, you know, such as
6 buying the CHS Hospitals; it was a change in
7 how MUSC was perceived locally and nationally
8 and throughout the state. So it's not an
9 appointment time, but more directionally
10 trended and do we have contingency plans or
11 recoveratory plans should something not go
12 right because it is, you know, a highly fluid
13 and hot activity area.

14 Q: And knowing that sort of you're evaluating it
15 over time, but, for example, if you have a
16 particular month or quarter where you miss your
17 budget, can that at times be because there's
18 been a misalignment of Your growth initiatives
19 and your expense load?

20 A: More so it's not so much anything we're
21 contemplating in the future, but what's going
22 on current day.

23 Q: Right.

24 A: You know, like in 2018, we had two other events
25 that were unplanned for, so there's, you know,

1 a lot of things that happen and we did have to
2 have the staff spend the night. It's about \$2
3 million a day when we have a storm. We're
4 keeping them safe and keeping them with us, so
5 without revenue to offset. Now, we'll make it
6 up in the next month, You know, by scheduling
7 the surgeries and things like that. So I would
8 say it's more within the moment or things that
9 we're reacting to.

10 Q: Okay.

11 A: Did I answer your question?

12 Q: It did.

13 A: Okay.

14 Q: Fair explanation. Let's look at Trident 1, and
15 these are the 2019 audited financials that we
16 were taking a look at earlier. Would you like
17 them in front of you?

18 A: Oh, the screen's perfectly good.

19 Q: Okay. Fine. And while we pull that up, it's
20 my understanding, am I correct, that this
21 financial statement, and these are the audited
22 2019 financials, these are post-acquisition,
23 and so they do include metrics related to the
24 CH -- formerly CHS hospitals?

25 A: Correct. Yes.

1 Q: Is that right?

2 A: Uh-huh. Yeah.

3 Q: And so these will capture both revenues and
4 expenses related to those four facilities,
5 correct?

6 A: Yes.

7 Q: And if we could go to -- my numbering may be
8 off, I have page 7; it might be page 9; I'm not
9 sure, but if we could go to the balance sheet
10 summary. That's it. And You did some of these
11 numbers earlier; I won't -- just to try to kind
12 of summarize, you'll agree with me, looks like
13 on this 2019 audited financial statement, the
14 total assets and deferred outflows actually
15 improved -- let's see, 39 percent roughly, '18
16 to '19?

17 A: I have to scroll down a little.

18 Q: Oh, sorry.

19 A: That's fine. And you're saying deferred
20 outflows, it's probably on the prior page in
21 the balance sheet.

22 Q: Yeah, you might need to go to 5, I'm sorry.
23 Scroll up to 5.

24 A: Or it might be -- more of a flow to this one.
25 Okay.

1 Q: The PDF of the financials, page 5 on the
2 bottom.

3 A: Okay.

4 Q: And so year over year there was an improvement
5 in the total assets and deferred outflows,
6 right? Do you see that, from ---

7 A: Yes.

8 Q: --- 1.5 to 2.1?

9 A: Yes.

10 Q: So that's 2.1 -- roughly 2.1 billion in total
11 assets, is that -- is that correct?

12 A: Correct.

13 Q: All right. And then -- and then looking at the
14 total liabilities and deferred inflows at the
15 bottom of that page, that went up about 25
16 percent from 2.1 to about 2.7 billion, is that
17 right?

18 A: That's right.

19 Q: And am I reading correctly that the current
20 liabilities, so the first line item under
21 liabilities, current liabilities, increased
22 from 198.7 to 429.1, is that right?

23 A: That's right. There's a more detailed schedule
24 on page 15, which breaks out what that is ---

25 Q: Okay. Do you know ---

1 **A:** --- and what that increase is, yes.

2 **Q:** Do you recall the primary driver of that?

3 **A:** Yeah, part of it -- so we were at 200,000 in
4 2018, and it went up about 229,000 more. The
5 largest driver of that was the line of credit
6 or the revenue and test patient notes of 120
7 million that are being repaid within 18 months
8 of purchase. So we've already extinguished or
9 paid off 65 million of them, so we currently
10 have 55 million left. So this now has shrunk
11 down from this date of 4/25 by 75 million, so
12 we'll say it's about at 350. And then the
13 other big driver was the capital leases in
14 Florence. They had a lot of medical office
15 buildings and so then those had to be captured
16 in the GASB accounting as capitalized lease
17 liability.

18 **Q:** Okay. And then the long-term debt number that
19 rose in 2018, it was 467 is up to 752, so about
20 -- up about 61 percent, what would be the
21 primary driver of that additional long-term
22 debt?

23 **A:** It would be the 130 million at that time for
24 the actual purchase of the regionals -- we had
25 a bridge loan in place for 129,000 and it's

1 mapped out back on page 28. Because I've just
2 scanned it real quickly for anything. We also
3 had the 36 million for the consolidated service
4 loan we talked about earlier for the 38
5 million, so those would be the largest
6 components. And then the MOB leases.

7 Q: Okay. And certainly recognizing in the GASB
8 representation that you have in this portion of
9 the financials, the total net position is a
10 negative 623 million, right?

11 A: Correct. Yes.

12 Q: In the GASB representation, is that right?

13 A: That's correct.

14 Q: Okay. And so looking at the -- I wanted to ask
15 you if we turn to page I think review on the
16 screen maybe TMC 1-10 and it's page 8 of the
17 PDF of the financials. Under the net patient
18 service revenue discussion up in the middle of
19 the page ---

20 A: Uh-huh.

21 Q: --- are You there?

22 A: I am.

23 Q: Okay. There was a significant increase in the
24 disproportionate share of payment 2018 over
25 2019, is that because of capturing payments

1 that would have been made to the four CHS
2 hospitals or did MUHA's DSH payment go from
3 36.4 million to 57.3 million in 2019?

4 **A:** It was a combination of both things. The
5 hospitals prior -- because they were not DSH
6 eligible to participate and so they were in
7 here for four months of the fiscal year. Also,
8 there was a tiny issue related to one of our
9 residency programs and MUHA Charleston also
10 increased back up about 10 million in DSH.

11 **Q:** You agree with me that the disproportionate
12 share payments are uncertain in terms of future
13 reliability of the amount or how long they'll
14 continue?

15 **A:** Since I've been a CFO around 26 years, there's
16 always a verbalization of uncertainty around
17 DSH. There's one year they were withheld a
18 year, but that always seemed to come true. I
19 do think as any reimbursement mechanism a
20 change at the federal level could drive some
21 change, but just as in the crash of 2008, to
22 make sure the rural hospitals stayed in place,
23 all the DSH academic hospitals gave -- reduced
24 their reimbursement down to 80 percent and now
25 we're actively lobbying to get it back up to

1 the full 100 percent. So I don't know how we
2 function without DSH.

3 Q: Right.

4 A: Do I think DSH is always under threat of being
5 redesigned? Yes, but there will always have to
6 be some kind of component or some lightning
7 program ---

8 Q: Uh-huh.

9 A: --- to keep any health provider whole for when
10 we're taking care of underinsureds and, You
11 know, just covering the costs to care for
12 people.

13 Q: But for purposes of your audited financials and
14 the management's discussion, you agree with me
15 that, certainly, that at least the statement is
16 here that there can be no assurance that the
17 authority will continue to qualify for future
18 participation in the DSH program or that the
19 DSH program will not ultimately be discontinued
20 or material modified?

21 A: And equally there's no guarantee it'll go away.

22 Q: Right. Okay. All right. And then I wanted to
23 ask you, the next page of the document, the
24 patient business activity ---

25 A: Yes.

1 Q: So there's a little bit of information here
2 about changes in the activity year over year
3 and if you first go to that third paragraph
4 under patient business activity, it says the
5 addition of the regional facilities increased
6 inpatient days of care by 35,978, surgical
7 procedures by 6,499, outpatient visits by
8 78,991, and emergency/trauma visits by 42,953,
9 these numbers -- so first these numbers
10 represent volumes experienced by the other --
11 the new community hospitals ---

12 A: In the Florence and Lancaster markets, yes.

13 Q: Florence and Lancaster markets. What I was
14 wondering, because it's a little unclear to me
15 from the math, these -- the information above
16 that third paragraph, so the first and second
17 paragraphs, which gives year over year changes,
18 those volumes included in paragraphs 1 and 2,
19 so, for example, the inpatient patient days of
20 care increased by 16.9 percent from 252,938 in
21 2018 to 295,797 in 2019. That numbering, does
22 it or does it not include the 35,978 from the
23 regional facilities?

24 A: It does not. It's -- of that paragraph, the
25 first two are reflective of Charleston

1 activity, and then the part labeled the
2 regionals is covered by the other markets
3 coming into play.

4 Q: Okay. And so the reason I -- and I wasn't sure
5 when I looked at the inpatient ---

6 A: I think that's fair. We can label it better.

7 Q: Well, and let me ask you then, so the
8 emergency/trauma visits, which the second
9 paragraph, this was that last sentence that's
10 on your screen, emergency/trauma visits
11 increased to 123,664 in 2019 from 80,353?
12 That's what caused me to wonder about those
13 regional numbers.

14 A: I'd have to research that one for You.

15 Q: Okay. Okay. So if the regional numbers were
16 included in there, then we would subtract from
17 the 123,664 the volume that we see represented
18 from the regional centers, which was 43,953, is
19 that ---

20 A: I would understand they're falling in value.

21 Q: Okay. Do you know whether the 2019 ED trauma
22 visit volume for MUHA Downtown was closer to
23 73,711 visits?

24 A: I do not know off the top of my head.

25 Q: All right. If we could look at page 17 of the

1 PDF, it would be -- wait a minute. The
2 demonstrative that he did this morning ---

3 A: Uh-huh.

4 Q: --- and you might can direct me better and
5 actually might be page -- page 17 in your
6 exhibit slides, the calculation that you --
7 that we reached of potential additional debt
8 service payments based on 25 year bond at 5.5
9 percent, 1.4 billion ---

10 A: Uh-huh.

11 Q: --- is that -- were you working from this
12 audited financial statement ---

13 A: No.

14 Q: --- in doing those calculations? What would
15 have been sort of the underlying historical
16 source?

17 A: How it links in. How it ties.

18 Q: Right.

19 A: Yeah, if you look on the page 16, the page
20 before, what You have ---

21 Q: Okay.

22 A: --- and we'll just trace the document down for
23 '19, you see the income before payments to MUSC
24 entities was about 55 million?

25 Q: And we're looking on page -- is it page 16 ---

1 A: Yes. Uh-huh.

2 Q: --- of the financial statement?

3 A: Yes.

4 Q: Okay. All right.

5 A: It's toward the bottom, income before payments
6 to MUSC entities were 55 million ---

7 Q: Right.

8 A: And if you scroll down a little bit further to
9 show more of the top of the page, there you go,
10 you can add in the portion of the benefits, the
11 other post employee benefits, depreciation,
12 amortization, and interest expense, so those
13 components off the audit are what drove the
14 demonstrative document to say what generates
15 free cash flow. The statement you have on page
16 17 is a statement of cash flows of what
17 actually occurred in '19.

18 Q: Okay.

19 A: And so it's similar, but a little bit apples
20 and oranges because we're making decisions with
21 125 million that we spend, do we want to buy
22 more capital; do we want to issue more debt or
23 how does that go. And 17 is just the
24 articulation of how funds were used.

25 Q: Okay. So the 55,233 number on the

1 demonstrative and then there's a pension and
2 OPEB non-cash expense, depreciation, interest,
3 and that gives You a cash flow number, then
4 Your debt service number 37 million, takes you
5 to a cash flow used percentage. Where are You
6 pulling -- where are You pulling the pension
7 and OPEB line item?

8 A: That was part of the information that we have
9 with what we actually had to incur for the non-
10 cash that's back in the notes, I believe.

11 Q: Okay.

12 A: Or we are definitely putting it back there to
13 clear about this is a non-cash item. It
14 transferred down from the state. And I think
15 we have a whole in the back that outlines those
16 numbers that you'll see.

17 Q: Okay. And so the 1.4 billion capacity ---

18 A: How did we get to that?

19 Q: Well, that capacity number, so Your -- you're
20 taking out from the balance sheet line items
21 related to the pension, liabilities?

22 A: Right from the income from operations, and we
23 say depreciation's not a cash item, so that's
24 a add-back. We do need to pull an interest
25 expense and the OPEB, so all the non-cash items

1 and then we say what's available for our debt
2 service or our annual mortgage payments, which
3 is run between 37 and go up to about 60 million
4 dollars a year. And then saying if we have 100
5 million dollars left of that, if we were to
6 issue another large segment of debt for 25
7 years at five and a half percent, how much
8 could the mortgage be on that property and fit
9 into that -- our annual mortgage payment.

10 Q: Okay. But this number -- these numbers that
11 You have calculated from '19 and in budget and
12 forecasted out, these do not include the
13 community hospital project, is that right?

14 A: Oh, they do. It comes online and I think it's
15 2025 or 2022 ---

16 Q: Okay.

17 A: --- and you'll see it. Off the top of my head,
18 I think it's about 17 million dollars.

19 Q: 17, okay.

20 A: Which is just an estimate at that point in
21 time, but that would be by the time we build it
22 and get through this process, then two or two
23 and a half years to build it, we'd start paying
24 part.

25 Q: Okay.

1 **A:** So it does contemplate all large known projects
2 at this time.

3 **Q:** Okay. All right. And then using your sort of
4 this audited financial, I mean, can you tell me
5 what You calculate your operating cash flow
6 margin to be in 2019 or on this financial?

7 **A:** If I had my iPhone, I could.

8 **Q:** Would a calculator work?

9 **A:** A calculator would work. I have one here.

10 **Q:** Do you have one over there?

11 **A:** Yeah. If we could pull up that demonstrative
12 document again.

13 **Q:** We don't -- I have this one, if that'll work.
14 We don't have it on our screen.

15 **A:** The batteries are dead on ---

16 **Q:** Do You need a pen?

17 THE COURT: Go ahead.

18 **A:** I think I still need an iPhone calculator.

19 MS. JONES: You need an iPhone calculator?

20 **A:** Yeah, this one's dead. Just doing like I do in
21 real life. It's in my pocket. About 9.97
22 percent or 10 percent.

23 **Q:** Okay. And were you doing that off of the
24 audited financial?

25 **A:** Yeah, well, the ...

1 Q: I just meant in terms of the 2019.

2 A: That's fine.

3 Q: And is that -- so 9.9 percent, is that what you
4 would expect it to be?

5 A: Uh-huh.

6 Q: Do You know approximately what you -- or have
7 you forecasted changes to that in the
8 projections that you've done recently here for
9 projects or as part of your planning? Have You
10 forecasted changes to that?

11 A: No, it should stay fairly consistent because
12 it's a function of our operating margin, so
13 that will improve favorably. Yeah, and back
14 depreciation as we bring more assets on, that
15 base would get depreciated. And we've held
16 constant on the OPEB and pension non-cash
17 expense and we've held constant on the
18 telehealth, so it shouldn't erode. It should
19 improve favorably.

20 Q: So -- but have you forecasted it to increase or
21 do you know?

22 A: By mathematically it is going to increase some
23 in here.

24 Q: Okay. And do you have any idea how much or ---

25 A: Maybe up to two percent, and that's just off

1 the top of my head without a calculator.

2 Q: Okay. And do you -- would you expect that the
3 project pro forma for the community hospital
4 project would have a similar operating cash
5 flow margin?

6 A: Yes. Potentially higher because it doesn't
7 have the overhead expense of the full
8 Charleston-based facility.

9 Q: Okay. Great. Thank you. And ---

10 A: And the pension expense wouldn't be as full for
11 that. It would be a new location.

12 Q: So would there be, though, a metric sort of
13 tied with the staffing manpower budget? Would
14 there be a pension?

15 A: Yeah, typically, there's a delay that the
16 pension runs year round, but the reports come
17 out once a year after the actuary does their
18 evaluation in January. So depending on when it
19 went live, they could adjust.

20 Q: Okay. But would it be fair to say that
21 whatever the number is, it's sort of attributed
22 to MUHA some component of it would filter to
23 the project pro forma based on their staffing?

24 A: Well, and then, You know, the pro forma was
25 designed before the regionals and before we

1 took a lot of the significant pension hits
2 coming in, so I think the pro formas and the
3 cash flows are perfectly in tact.

4 **Q:** All right. And when you're evaluating debt
5 capacity, are You following a metric of 80
6 percent debt to revenue or what is sort of the
7 driving metric that you're following when
8 you're ---

9 **A:** There's three -- three relationships that we're
10 mindful of. The first is what's the loan to
11 value similar to when you're buying a house.
12 What did the house appraise at and how much
13 does your mortgage come in before You have to
14 deal with PTI or something like that. So we do
15 -- we hold that same industry threshold of
16 about 80 percent. We want our loan to book
17 value to be in that range. And then You pivot
18 over to the income test, so when you're buying
19 a house, it's 2.2 to two and a half times your
20 income that you want to maintain. Same ratio
21 for us for that service coverage. HUD just
22 requires that we take about a 1.4.

23 **Q:** But you internally are looking at two to two
24 and a half?

25 **A:** Yes. We like to stay around 2.8.

1 Q: And when you state that that's an income test,
2 what income number is that? Is that a gross
3 number, a net number, net after other?

4 A: It's an improvement in net position or
5 operating margin largely.

6 Q: I hope Ms. Crum knows I was also a history
7 major, so if I sound impressive, it's because
8 I've been practicing at home some of these. I
9 memorize and I actually don't know them.

10 A: How'd you get into law?

11 Q: There's not a lot for history majors out of
12 college. Okay. And so -- and I might have --
13 the third one is the debt ---

14 A: Operating margin.

15 Q: Operating margin, okay. All right. And that's
16 what informed your analysis of what Your GASB
17 is and projecting it forward?

18 A: Right, which we met with our two financial
19 advisors, as well.

20 Q: Okay. And we're in the homestretch. One last
21 topic. I did want to ask you about some of
22 your points about HUD and Your expectations
23 with HUD. And as I understood some of what you
24 were talking about, is it Your expectation that
25 the CON application itself is -- the

1 documentation that you'll need to satisfy the
2 need portion of HUD's requirements?

3 A: It will be reviewed and heavily relied upon.

4 Q: Okay. And because you are aware, aren't you,
5 that sort of the purpose of that funding
6 mechanism is for critically needed hospital
7 services, right?

8 A: Are You saying -- are you asking me if HUD only
9 does critically needed services?

10 Q: Sure. Are you aware that the purpose of the
11 HUD -- HUD backing on this is for the purpose
12 of critically needed hospital services? Are
13 You aware of that?

14 A: Right. On the designation sometimes they're
15 called essential. But needed in a community.

16 Q: Okay. And I think you described that you've
17 got the CON application and then you'll also do
18 a feasibility study, right?

19 A: Correct, yes.

20 Q: That hasn't been done yet, has it?

21 A: No.

22 Q: Okay. And you're aware, aren't you, that as
23 part of -- there's not only sort of the market
24 need component, but there's also a market
25 assessment component of that HUD application

1 process, right?

2 A: Correct.

3 Q: Okay. Are you aware of anywhere that there's
4 been letters in the CON application or
5 otherwise, but a detailed analysis of the
6 market landscape out in the southern Berkeley
7 area and an index competitor analysis? Are you
8 aware of that having been done yet?

9 A: I'm aware that there's a review of the activity
10 in the market. I have not seen the outcome of
11 such a study. But, again, the projects are
12 largely to -- from our perspective is to decant
13 the downtown campus and so there's 155 beds
14 needed in Charleston. We would have enough
15 patients to push them out into the Berkeley
16 arena and open up to backfill Charleston campus
17 in probably about three years with the
18 quaternary tertiary patients for South
19 Carolinians who are not getting access into us.

20 Q: Okay. Again, going back to what HUD -- HUD's
21 requirements, you're not aware, are you, of
22 there having been a detailed analysis of the
23 market landscape for the index competitor
24 analysis?

25 A: Right. And we didn't have to do that for the

1 children -- I mean, for the new CHS hospitals
2 that we acquired. So I'm trying to ascertain,
3 it's not that you have to have the blessing and
4 only be the only provider in the community for
5 HUD. So -- as the Florence market, McLeod's
6 right there, very similar to downtown
7 Charleston and Roper, not quite -- not within
8 200 yards, but cohabitating, so it's not -- You
9 don't have to be essential to get the HUD
10 funding.

11 Q: Okay. That's Your understanding?

12 A: That is my understanding.

13 Q: Okay. Let me ask you ---

14 MS. HOLLINGSWORTH: Can we pull up Roper St. Francis
15 Exhibit 116?

16 (Roper Exhibit Number 116 was introduced into the
17 record at this time.)

18 Q: Ms. Goodlett, you're familiar -- you testified
19 so far today and you're familiar with sort of
20 that HUD application process, right?

21 A: Yes.

22 Q: And would it be fair to say you were heavily
23 involved in the application process for the
24 most recent CHS acquisition funding?

25 A: Yes.

1 Q: Okay. And I wanna turn specifically to 116-
2 046. Are you familiar with the appraisal
3 report that was obtained on behalf of MUHA as
4 part of this?

5 A: I am. Uh-huh.

6 Q: And so are you familiar and I think it's on
7 116-119, are you familiar with the -- sort of
8 the replacement cost estimates that were
9 provided as part of that valuation process?

10 A: Yeah, the appraisal was required at the
11 downtown Charleston campus, going back to your
12 first question about the loan, the book value,
13 the net assets and so this reflects the outcome
14 of this valuation as the assets for MUHA
15 Charleston are about 200 million dollars more
16 than what's stated on the books from that
17 piece. But this would be they would say what
18 would be a replacement or a new cost estimated
19 by -- it's part of the three-part
20 triangulation, what's the income, what's the
21 replacement, and what to do if you're building
22 it from scratch, I believe.

23 Q: And some of these numbers in these valuations
24 are helpful even to you when you're doing some
25 of those analytics You were talking about when

1 **You were looking at loan to value for your debt**
2 **capacity, is that right?**

3 **A: Right. Just the total, not the ---**

4 **Q: Components of it?**

5 **A: Per square footage would not be of interest.**

6 MS. HOLLINGSWORTH: Your Honor, I would offer Roper
7 116 into evidence.

8 MS. JONES: Your Honor, I don't think there's been
9 any foundation or identification by the witness
10 as to what this document is.

11 MS. HOLLINGSWORTH: I'm pretty sure we did that in
12 the beginning, Your Honor. From the first page
13 and then into the appraisal report itself.

14 THE COURT: Yeah.

15 **A: But this is about the children's hospital,**
16 **correct?**

17 **Q: This is the 116 -- You can go back to the first**
18 **page of it.**

19 THE COURT: Are you offering the whole exhibit or
20 just the section you referred to?

21 MS. HOLLINGSWORTH: I mean, Your Honor, so the way
22 it was produced to us is it's a very large,
23 heavily redacted document. I would be -- I
24 really just want their appraisal report
25 document. I'd be more than happy to make it

1 simply the appraisal report document that ---

2 THE COURT: They're on the first page.

3 MS. HOLLINGSWORTH: So these are materials that
4 were submitted to HUD on behalf of MUSC through
5 Armadale Capital, so these are documents that
6 have been submitted to HUD.

7 MS. JONES: I still have my objection about the
8 foundation because I don't know which project
9 this was submitted for and I think that, for
10 the record, it needs to be properly identified
11 as to what is being offered and -- and what it
12 is.

13 MS. HOLLINGSWORTH: Well, Your Honor, we said at
14 the outset, it's the CHS Hospital acquisition
15 process the witness identified at the start of
16 our discussion. This document is dated May
17 2nd, 2019. It is related to the financing of
18 the debt for the acquisition of the CHS
19 Hospitals. And that's what it says on the ---

20 **A: I think the -- it's an appraisal of the**
21 **Charleston facilities.**

22 **Q: That's right. Within the -- within the**
23 **appraisal report, is that right?**

24 **A: Correct.**

25 MS. JONES: So it's just the appraisal report that's

1 being offered?

2 MS. HOLLINGSWORTH: I've offered the document; I'm
3 happy to limit it to the appraisal report if
4 You all ---

5 THE COURT: For the acquisition of the CHS
6 hospitals?

7 MS. JONES: For the acquisition of the CHS
8 hospitals. Okay. No objection.

9 THE COURT: To what? The whole exhibit or just the
10 appraisal?

11 MS. JONES: To the whole exhibit.

12 THE COURT: Okay.

13 MR. WICEVIC: No objection.

14 MR. THOMAS: No objection.

15 THE COURT: Okay. Well, I guess I'll admit it.
16 How many pages?

17 MS. HOLLINGSWORTH: I was trying to limit you on
18 that. It's -- and a lot of it's redacted.

19 THE COURT: Okay.

20 MS. HOLLINGSWORTH: I'd be happy to -- we can
21 certainly cut down and at least pull out the
22 redacted pages and just have gaps.

23 THE COURT: I would love for y'all to do that or do
24 you object to that?

25 MS. JONES: No, I don't have any objection to that.

1 I don't have any objection to working on
2 limiting it, too.

3 THE COURT: There's a great idea. Thank You.
4 (Roper Exhibit Number 116 was admitted into
5 evidence.)

6 Q: If we could look at Roper St. Francis 117.
7 (Roper Exhibit Number 117 was introduced at this
8 time.)

9 Q: And this exhibit similarly -- this is volume
10 two. We just saw the first page of volume one.
11 This is volume two, financial documentation
12 with the same May 2nd, 2019, date. Are you
13 familiar with the document that would be within
14 the volume two financial documentation?

15 A: To some degree, yes.

16 Q: CHS. And, again, I just want to ask you,
17 within this documentation that was provided to
18 HUD, was a feasibility study, right? A
19 feasibility study for this transaction to CHS?

20 A: For the four hospitals, yes.

21 Q: And that was acquired this year, right?

22 A: Correct.

23 Q: The feasibility study?

24 A: Uh-huh.

25 Q: We can turn to 117-015. Ms. Goodlett, are you

1 familiar with the feasibility study that was
2 performed for MUHA?

3 A: I am and for HUD they prefer a great deal of
4 conservatism in their projections.

5 Q: And the projections that are done, though,
6 would you agree with me that you as CFO, you
7 look at these projections and at times may
8 forecast Your own assumptions into the future
9 using this and I think it's referred to as the
10 Wipfli feasibility study as part of your
11 assumption, is that right?

12 A: Wipfli is the independent CPA firm that does
13 our feasibility work for HUD, yes. And so they
14 will make their assumptions and I am in charge
15 of the assumptions for our long range financial
16 plan. HUD would like to see very, very
17 conservative assumptions.

18 Q: And prior to this feasibility study that MUHA
19 had use of a feasibility study that was done as
20 part of the children's hospital ---

21 A: Yes.

22 Q: --- is that right? And I think we've seen that
23 -- I think a copy of that feasibility study is
24 actually in the DHEC record for this project
25 actually, and you're familiar with that one ---

1 A: Yes.

2 Q: --- as well, right? And if you could, if we
3 could turn to 117-065 in the document. If you
4 could just sort of that first section of that
5 chart. Now, and this is MUSC Charleston, is
6 that right? Do You see that, that top line,
7 MUSC Charleston ancillary utilization?

8 A: It appears to be, yes.

9 Q: This document also provides information about
10 the hospitals being -- well, the hospitals that
11 had been purchased and were proposing to
12 refinance that debt, right?

13 A: Correct.

14 Q: But specifically with regard to the utilization
15 in MUSC Charleston and the ED visits, am I
16 correct in reading that sort of bottom line ED
17 visits, the 2016 historical number was 84,060,
18 is that right?

19 A: Yes.

20 Q: In 2017, it was 82,337?

21 A: Yes.

22 Q: And in 2018, was 80,353?

23 A: Yes.

24 Q: And so -- and it looks like what was forecasted
25 was some decline in 2019 and 2020, is that

1 right?

2 A: Yes.

3 Q: Getting back to what we had looked at with the
4 2019 financials, do You think that number was
5 more likely the number that was in the 70,000s
6 and not 123,000 for the ED visits?

7 A: It was ED and trauma visits to include our
8 trauma surgery coming through.

9 Q: And where would that be noted on here?

10 A: I'm not sure it would be because this is a --
11 inpatient use rate is at discharge. So they
12 could have come through, been admitted, or it
13 could be in one of our outpatient rates. I'm
14 just not seeing that particular line item and
15 category for that piece. So I think what we
16 are ascertaining, the original number on the
17 note was like 124,000. We believe the
18 regionals were 43,000 of that and Charleston
19 with trauma and ED visits was somewhere in the
20 80,000s, so I think that would be what this
21 alignment was. 2019 being forecast and the
22 audit having the actual number, so we might
23 have been understated on the ED visits in this
24 projection if it wasn't the additional trauma
25 visits coming through.

1 Q: Okay. And if we could just look at page 117-
2 170. While she works on that, what is the
3 mortgage insurance premium that would be noted
4 in MUHA's financials or projections?

5 A: Are you asking me its purpose?

6 Q: Yeah. Like, what is it --- what is ---

7 A: Why are we doing it?

8 Q: Yeah, explain to the Court sort of that
9 additional premium that's paid related to HUD-
10 backed financing.

11 A: It's related to when they want to have a
12 certain level of insurance premiums related to
13 the monthly payment. Kind of like a person
14 when they might get into that PPI category of
15 being more than 80 percent, so they'll even
16 make You keep some on deposit or charge You a
17 different rate for that activity. And so it's
18 just one of the mechanics of the HUD financing
19 for the debt service coverage.

20 Q: Okay. So as part of HUD financing, MUHA pays
21 a mortgage insurance premium associated with
22 the amount of the debt tied to HUD's backing,
23 is that right?

24 A: During a certain amount of time of the bond and
25 then it goes away, so it doesn't stay in place

1 the full life of the bond.

2 **Q:** And in 2019, was that approximately 3.7
3 million?

4 **A:** Yes.

5 **Q:** Okay.

6 MS. HOLLINGSWORTH: Your Honor, I would offer Roper
7 117 in evidence and I would be happy to work
8 with counsel. I just would like to get the
9 feasibility study.

10 MS. JONES: That's fine. No objection.

11 MR. WICEVIC: No objection?

12 MR. THOMAS: No objection.

13 THE COURT: It's admitted for the feasibility
14 study.

15 (Roper Exhibit Number 117 was admitted into
16 evidence.)

17 MS. HOLLINGSWORTH: We'll take care of reducing the
18 pages on that, Your Honor.

19 MS. JONES: I have a relevancy objection to all of
20 this, but ---

21 THE COURT: I assume that means you have it, but
22 you're withholding it?

23 MS. JONES: I'm withholding it.

24 **Q:** Just a few more questions, Ms. Goodlett. You
25 testified this morning that HUD is the

1 preferred lender for MUHA.

2 A: Yes.

3 Q: Is that right? Will you agree with me, then,
4 that MUHA has limited access to capital apart
5 from HUD-backed financing?

6 A: I would not.

7 Q: Okay. So in the -- when we looked at Trident
8 Exhibit 162 on page 16 of the slide, for this
9 reason MUHA has limited access to capital apart
10 from FHA financing, what would be the reason
11 then that you would have limited access to
12 capital apart from FHA financing?

13 A: I think you're asking me why do I believe we
14 have other options? I think we've demonstrated
15 that in the past twelve months by the placement
16 of the 120 million dollar line of credit that
17 had nothing to do with HUD, just on good faith
18 of MUHA that it would be paid back. And then
19 the 129 million dollar bridge loan with TD Bank
20 that they would have been happy to leave in
21 place.

22 Q: Okay. And what was the term of the bridge
23 loan?

24 A: Oh, the bridge loan was for a year.

25 Q: Okay.

1 **A:** They offered to extend and we didn't see that
2 necessary.

3 **Q:** Would you agree with me, though, that the
4 transaction costs for HUD-back financing are
5 significant?

6 **A:** Comparatively, yes. We do pay a premium to get
7 the AAA rating, but over the life, it makes
8 sense because just as we locked at 3 percent on
9 Friday. If we stayed with TD Bank, we would
10 have been paying 3.21, 3.35, something in that
11 range, so amortizing that over 25 years, which
12 seems like a large up-front fee, pays for
13 itself.

14 **Q:** Okay. And what would -- what would the
15 comparable credit rating be for MUHA outside of
16 having the HUD guarantee?

17 **A:** When you look at MUSC Health in total, we've
18 had some analysis by Ponder and Bank of America
19 and it can be anywhere from an A to a BBB.

20 **Q:** And that's -- you had that looked at, you said,
21 by Bank of America?

22 **A:** Bank of America brought that to us, Ponder
23 brought that to us. If You evaluate the health
24 system as a whole.

25 **Q:** And what do You mean by the health system as a

1 whole?

2 A: That would be all the entities within MUSC
3 Health, MUHA, MUSCP, MSV.

4 Q: Okay. Well, looking at the audited financial
5 statement and your book, your book of business,
6 the 2019 audited financials for MUHA, what
7 would a comparable credit rating be if You
8 didn't have ---

9 A: I think it would be a high BBB, maybe a low A,
10 because of our growth, our capitated growth
11 rate over three years is very strong. That's
12 one of the main things they value. Within the
13 Charleston market, Roper's been a BBB,
14 sometimes an A, on the same category as that.

15 Q: Okay. And you mentioned Roper St. Francis this
16 morning, we were talking about the assets size
17 ---

18 A: Uh-huh.

19 Q: --- so do you consider the performance and the
20 financials of your facility similar to that of
21 Roper St. Francis?

22 A: I believe with an awareness of our statements,
23 but we actually exceed them on the operating
24 margin. On the same tasks we FASB and GASB
25 basis, I believe they've had a loss for the

1 past three years and MUHA's not. In
2 accumulation, we're running between a four to
3 a six percent operating margin compared to if
4 You read the papers what would be a loss for
5 Roper.

6 Q: Okay. All right. And you talk a little bit
7 about the nursing staffing and the use of
8 traveler nurses, you'll agree with me that
9 nationwide there's a nursing shortage, is that
10 right?

11 A: I think there's a -- there are a lot of nurses
12 out there. It's always what are hospitals
13 willing to pay for them. That's why I state
14 sometimes there's swings. In any business
15 there's a dynamic, so an agency nurse while
16 totally appropriate for a short-term need is an
17 expensive long-term proposition. But then
18 there's also the influx of more just wanna be
19 agency nurses, so it's kind of you have to view
20 it on the whole, but if there's such an acute
21 crisis, I believe hospitals would be shutting
22 down and they're not shutting down because they
23 don't have nurses. They're shutting down for
24 other reasons.

25 Q: Okay. You'll agree with me, though, traveling

1 nurses cost as much as 50 percent more than a
2 permanent staff?

3 A: They -- they could, yes.

4 Q: And in terms of your tenure at MUHA, right now
5 having about 70 traveler nurses, has that been
6 the same for the last two, three years or has
7 that number increased or decreased?

8 A: I think it ebbs and flows. We have a range
9 between 40 -- I think we're currently down in
10 the 40's to 50's to when I was deposed, we were
11 up at 70.

12 Q: Okay. And I think you described the staffing
13 shortages, the nurse shortages, are largely in
14 surgical services, is that still your ---

15 A: Oh, we have some hard to approve areas, yes.
16 Specialty services.

17 Q: And surgical services is one of them?

18 A: Yes, currently.

19 Q: Okay. And you'll agree with me, won't you,
20 that it's hard to predict where people are
21 going to go for healthcare?

22 A: Yes.

23 Q: And would you agree, though, that typically
24 they go to the closest location?

25 A: Not necessarily. We're finding people travel

1 in from the Sea Islands and John's Island and
2 past a lot of healthcare providers to get down
3 into the Charleston campus. Especially with
4 the new hospitals, we're seeing the brands
5 attracting more people who are driving past
6 other hospitals to get to wherever they wanna
7 go.

8 Q: Will You agree with me that at least when you
9 were deposed, we were talking that you believed
10 it's hard to predict where people are going to
11 go for healthcare, but typically they do go to
12 the closest location?

13 A: Depending on for emergency services. I think
14 there is an inclination for that. And if a
15 doctor moves, you know, one place he practices
16 to another. I think it's multi-factorial.

17 Q: All right. And will you agree with me that
18 growth in population does not automatically
19 equate to growth in inpatient patient days or
20 inpatient activity?

21 A: It's logical that it would. There could be
22 changing circumstances that interfere with
23 that.

24 Q: Okay. Would you agree with me that it's been
25 your experience or experience of your hospitals

1 that inpatient patient days are declining and
2 not increasing?

3 **A:** I think across the nation we are seeing, you
4 know, more procedures are moving to an
5 outpatient basis that could, if they're not
6 quaternary tertiary. We haven't seen a lot of
7 that move, but the community base certainly.
8 My mother just had a hip replacement and was
9 out in a day versus, You know, the five days it
10 used to be.

11 **Q:** Okay. And when we were talked at your
12 deposition, you were comfortable with the three
13 to four mile proximity between MUHA's proposed
14 community hospital and Roper's new community
15 hospital because of the proximity between Roper
16 Hospital downtown and MUHA downtown, is that
17 right?

18 **A:** Right. Now, we cohabitate very, You know, well
19 today and we're much closer.

20 **Q:** Okay. You'd agree with me, though, that MUHA's
21 downtown campus is unique not only to what
22 services are at Roper St. Francis downtown, but
23 throughout the State, right? The services that
24 you offer downtown.

25 **A:** I would.

1 Q: Okay. Because, certainly, Roper Hospital's not
2 doing quaternary services at their downtown
3 campus?

4 A: That's true.

5 Q: And the sub subspecialties that you talked
6 about and discussed, those are not available at
7 Roper Hospital, right?

8 A: Right. But not every patient in downtown
9 Charleston now is a quaternary type patient and
10 we do have a level fo community patients in
11 there.

12 Q: And you're aware, aren't you, that in the last
13 ten years, Roper St. Francis has been moving
14 beds off the peninsula and using them to
15 establish satellite facilities?

16 A: Yes.

17 Q: You're aware of that, right?

18 A: Uh-huh.

19 Q: But you'll agree with me, though, that the
20 hospital that Roper St. Francis has opened in
21 Berkeley County is a community hospital that
22 has typical community hospital services, right?

23 A: That's how they advertise it.

24 Q: Okay. And you'd agree with me that that
25 service compliment is similar to what you would

1 expect will be at MUHA's community hospital?

2 A: Oh, yes. Uh-huh.

3 Q: Let me make sure I didn't skip anything.

4 MS. HOLLINGSWORTH: Your Honor, just one moment.

5 Q: Thank You, Ms. Goodlett, I appreciate Your
6 time.

7 A: Thank You. Nice to meet You.

8 THE COURT: Re-direct? Do You need a break or are
9 You ready?

10 MS. JONES: Do you need a break?

11 A: How long are You gonna be?

12 MS. JONES: I'm not on her clock. It won't be 45
13 minutes. Not long.

14 MS. GOODLETT - REDIRECT EXAMINATION BY MS. JONES:

15 Q: A couple of things. The Williamsburg hospital
16 that's being planned, that's not going to be
17 funded by MUHA?

18 A: Correct.

19 Q: The plan is for MUHA not to be involved
20 financially in the building of that hospital,
21 but just to take it over once the State builds
22 it and operate it?

23 A: Correct.

24 Q: So it's not going to change anything to your
25 financial position?

1 **A: No.**

2 **Q: If anything, it will be an asset that will go**
3 **onto the MUHA books and ---**

4 **OBJECTION:**

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

6 **Q: --- and -- and -- and a space for revenue**
7 **operations when it comes online?**

8 **MS. HOLLINGSWORTH: I ask that the leading**
9 **examination be in questions with this witness,**
10 **please.**

11 **MS. JONES: I'll ask her directly.**

12 **THE COURT: Okay.**

13 **MS. JONES: It might take longer.**

14 **Q: Okay. So when the Williamsburg hospital comes**
15 **online after it's built, is it going to just be**
16 **run by MUHA?**

17 **A: Yes, and we will ---**

18 **Q: Who will get the revenues from it?**

19 **A: MUHA will.**

20 **Q: So how will that affect your financial**
21 **statement?**

22 **A: It will be helpful, one, because we'll be able**
23 **to recognize on the loan the book value of the**
24 **asset be it 40, 50 million dollars, whatever**
25 **that becomes. And then the impact on**

1 operations, it would have a positive operating
2 margin.

3 Q: And the State, the General Assembly, the plan
4 for building it, what is the -- what is your
5 understanding of the purpose why the General
6 Assembly wants to build the hospital?

7 A: They have two hospitals close by, Lake City,
8 which is doing well, but not at capacity and
9 does not offer advanced services. And then
10 Williamsburg was flooded out in one of the
11 hurricanes. They have a flat roof. And so the
12 building they own has got actual mold on the
13 outside. It could have been hazardous, so this
14 hospital's operating in trailers. They're
15 doing a good job, but just it's not a go
16 forward situation. But they got locked out of
17 the building, so they're paying an incredible
18 amount of leases and stuff for equipment they
19 can't get to. So the thought was combine both
20 and have small populations into one site with
21 a more efficient building structure.

22 Q: And did you go to the State on this or did the
23 State come to the Medical University with this
24 proposal?

25 A: We were approached after another competitor

1 then in the market quoting for a long time and
2 then pulled out.

3 **Q:** Okay. On the funding aspect of it, that was
4 raised on your cross-examination, the
5 telehealth services, what do you mean when you
6 say you're a past conduit for the telehealth
7 services for the State?

8 **A:** MUHA has given 17 to 19 million dollars a year
9 and is the holder of the funds until other
10 health systems deploy their telehealth
11 resources, so off the top, a million goes to
12 Anderson. And then in our expense base, you'll
13 see contracts with Greenville, Palmetto, other
14 entities, to either provide equipment providers
15 whatever they need and so the expenses are
16 there and they're offset by the revenues. And
17 so we ask -- we have contracts with each of the
18 entities -- each of the hospitals and say how's
19 Your telehealth program coming? Don't you need
20 dollars or do something and with different
21 factors. So kind of the oversight committee.

22 **Q:** The oversight committee. And in that regard,
23 when you are receiving the revenues from the
24 different hospitals around the State, what are
25 you delivering for it in exchange for the

1 money? What are You providing?

2 A: Physician services, equipment.

3 Q: The subspecialties?

4 A: How to run -- how to run programs, the
5 subspecialties, things like that.

6 Q: So that these other hospitals that don't have
7 the subspecialties can use the resource at
8 MUSC?

9 A: Correct. We have -- it was a pediatric
10 intensive I think we got a call in and then
11 something happened with the child and they
12 couldn't be transported and so we had one of
13 our pediatric intensive, You know, doing the
14 heart rhythms and the interventions until the
15 child could become stable and survive.

16 Q: Walking him through it?

17 A: Yeah.

18 Q: Okay. And so you're not just getting that
19 money for nothing. You're actually having to
20 employ these subspecialties ---

21 A: Yes.

22 Q: --- and use their skills from MUSC and
23 deploying them through the telemedicine network
24 to help those people that don't have those
25 subspecialties?

1 **A:** That's correct.

2 **Q:** Okay. The other thing they asked you about as
3 far as funding is the DSH and the GME. The
4 graduate medical education monies that are paid
5 to MUSC are in recognition of the teaching work
6 and the training of the allied health
7 professionals down there, right?

8 **A:** Correct.

9 **Q:** And any hospital system or medical school that
10 wants to get into the business of training the
11 next generation of physicians and allied health
12 professionals can qualify for GME?

13 **A:** They have to go through a program.

14 **Q:** But they can qualify if they do the work?

15 **A:** They can qualify. We recently had a
16 partnership with Trident ---

17 OBJECTION:

18 MR. THOMAS: Your Honor, I'm gonna object to this
19 line of questioning. She's starting to talk
20 about the GME programs. I think the question
21 was just about the funding of the programs.
22 She's now gonna go into the operations, how
23 another facility can qualify, that's not a
24 topic that was discussed by me or Ms.
25 Hollingsworth on direct. So ---

1 MS. JONES: No the implication ---

2 MR. THOMAS: --- I mean, on cross; I'm sorry.

3 MS. JONES: --- the implications on cross is the
4 GME funding was something that the Medical
5 University is getting for nothing and the fact
6 of the matter is is you run a medical school
7 and you run a graduate medical education
8 program and you train those professionals, you
9 get paid for that because that State recognizes
10 the inherent value of that. And so I get to on
11 re-direct put those parameters in place and not
12 leave the Court with the impression that you're
13 getting money for nothing.

14 MR. THOMAS: I'll agree with her if that is how you
15 took it, but I'm thinking 100 percent chance
16 you did not take it that way. As it was
17 getting ---

18 MS. JONES: Stipulate and I'll move on.

19 MR. THOMAS: --- that it was getting something for
20 nothing. I don't think that was the purpose of
21 the question. I heard it ---

22 THE COURT: Do You wish to stipulate?

23 MS. HOLLINGSWORTH: Your Honor, it was my
24 examination. I'd be happy to stipulate that
25 the ---

1 MS. JONES: Then I'll move on.

2 MS. HOLLINGSWORTH: --- GME payments are for the
3 effort undertaking the course. And I disagree
4 that it would have been taken any other way.

5 THE COURT: Okay. Alleged and accepted.

6 MR. THOMAS: Thank you, Your Honor.

7 THE COURT: I'm not even asking You. I'm accepting
8 it.

9 Q: All right. Now, I think this is -- all right.
10 The examination about the feasibility study for
11 the CHS hospitals, there was no CON fight or
12 contested case over the acquisition of CHS
13 hospitals?

14 A: That's correct. The CONs were purchased.

15 Q: Now, and in regards to the HUD, the questions
16 that were asked you about the critical need,
17 MUHA has been through at least four HUD
18 financing projects now in its existence?

19 A: Yes.

20 Q: And so the critical need determined by HUD for
21 the Powerplant, the Ashley River Tower, the
22 Children's Hospital, and the CHS purchases,
23 you've already passed through that four times,
24 right?

25 A: Yes.

1 Q: Okay. And let's see, has MUHA presented any
2 financing request to HUD in its history for an
3 expansion of the mission of the Medical
4 University that HUD did not find was essential
5 or critically needed?

6 A: Correct. They are not denying a request.

7 Q: And do you anticipate any issues whatsoever in
8 presenting the 128-bed facility in Berkeley
9 County to them as essential or critically
10 needed and them disagreeing with you?

11 A: I do not.

12 OBJECTION:

13 MR. THOMAS: Objection. Your Honor, she's ---

14 MS. JONES: That's all the questions I have.

15 MR. THOMAS: I'll want that last part stricken.

16 She -- she doesn't know whether or not they're
17 gonna disagree with them or not.

18 MS. JONES: I just asked her if she anticipated it.

19 THE COURT: She didn't -- she asked do You
20 anticipate it.

21 MR. THOMAS: But she's asking -- she's asking her
22 to speculate as to what HUD's gonna do.

23 MS. JONES: I am not. I laid the foundation.

24 THE COURT: I overrule that one. She just asked if
25 she anticipated.

1 MR. THOMAS: Okay.

2 MS. JONES: Thank You, Your Honor. Thank You, Ms.

3 Goodlett. We are done.

4 THE COURT: You may step down.

5 MS. GOODLETT: Thank You.

6 THE COURT: All right. Do we have another

7 witnesses?

8 MS. CRUM: We do. Yes, sir. We do.

9 THE COURT: Yes. How long is this next witness
10 going to go?

11 MS. CRUM: Possibly. I'm sorry. My ears a little
12 bit stopped up today.

13 THE COURT: How long is the next witness going to
14 go?

15 MS. CRUM: How long? I anticipate my direct to be
16 an hour to an hour and a half max.

17 THE COURT: Okay. All right.

18 (Off the Record)

19 THE COURT: Okay.

20 MS. CRUM: I'm going to call -- Medical University
21 Hospital Authority calls Ms. Becky Smith to the
22 stand.

23 BECKY SMITH, having been duly sworn, testifies as
24 follows:

25 MS. SMITH - DIRECT EXAMINATION BY MS. CRUM:

1 Q: Ms. Smith, would you please state your full
2 name for the record?

3 A: Rebecca Smith.

4 Q: I love that I can hear it with the microphone
5 too. Would you -- would you give the Judge a
6 brief but through educational history? Your
7 educational history?

8 A: Certainly. I did my undergraduate work at
9 Clemson University and received a Bachelor in
10 Design in 1983. And continued on with my
11 graduate studies to receive a Master of
12 Architecture in 1985.

13 Q: And -- excuse me -- have you taken additional
14 continuing education courses since then?

15 A: Oh certainly. Every year we're expected to do
16 the continuing education credits. In addition
17 I received my lead certification and, you know,
18 to enhance that credential to a lead BD plus C.
19 Lead is a credential for sustainable design.
20 Including sustainable design features into you
21 project -- projects.

22 Q: And does sustainable design equate in part to
23 energy savings?

24 A: Absolutely. It focuses on reducing energy cost
25 and operational costs for owners as they occupy

1 the building for the life of the building and
2 employing other methods to reduce the use of
3 water and limit the impacts on the environment.

4 **Q:** And what states are you -- do you -- are
5 currently licensed in as an architect.

6 **A:** I'm currently licensed in South Carolina, North
7 Carolina and Tennessee.

8 **Q:** Have you been licensed in other states?

9 **A:** In Wyoming as well.

10 **Q:** Would you please tell the ---

11 THE COURT: So how did you end up jumping all the
12 way to being licensed in Wyoming.

13 MS. SMITH: I followed my husband. He's an
14 architect who went to law school in Wyoming.
15 So I was support -- supporting person there.

16 THE COURT: Oh okay.

17 **Q:** Could you give the Judge your history in
18 architectural health care?

19 **A:** Certainly. I began my health care career in my
20 second job in Atlanta in 1986. I worked for a
21 firm called Harry W. Howell and Associates.
22 And found that health care design was an area
23 of design that I really enjoyed and I've been
24 doing it ever since. There I had the privilege
25 of working with Northside Hospital and

1 Eckleston Children's Hospital -- which is now
2 Children's of Atlanta. As well as Peidmont's
3 Hospital and worked on a variety of projects
4 for each of those institutions. From initial
5 planning studies to renovations to additions
6 and major additions into buildings. And also
7 did work on their medical office buildings and
8 medical office building uphits as well.

9 Q: When you left Atlanta, where did you go?

10 A: We went to Wyoming with a new born -- which was
11 really delightful. I ended up ending --
12 landing a job working for a nationally know
13 architect and the Wyoming partnering architect
14 for the American Hermitage Center and Art
15 Museum project. Which was -- the job I was
16 hired to do was to be full-time construction
17 administration person. So I spent everyday
18 walking the job site, documenting the work as
19 it progressed. Answering construction
20 questions and formulating questions and
21 responses for the design team. Also reviewing
22 pay applications and all those sorts of
23 interactions that the design team has with the
24 contractor and the owner during the progress of
25 the project.

1 Q: What did you end up doing on that project?

2 A: The project took a little bit longer to
3 construct than originally planned so the owner
4 had the architectural services of -- to provide
5 for 18 months as that contract was closed up
6 the contractor ended up hiring me to begin the
7 next day because he really appreciated the
8 record -- the method of documentation that was
9 provided and he desired a very consistent
10 record of their progress throughout the
11 project.

12 Q: And when you left Wyoming, where did you go?

13 A: We returned to South Carolina. We spent the
14 summer at Lake Murray to do the Ridge -- the
15 GAP Program. He took the BAR at the end of the
16 summer and as soon as he finished I went to
17 Charleston to go to work. Had some Colleagues
18 there who said, please come interview with us
19 at LS3P. And I joined LS3P in August of 1994
20 and have been there ever since.

21 Q: And what is your position with LS3P now?

22 A: I am now a vice president and principal and I
23 head our health care design studio in our
24 Charleston office.

25 Q: Would you just tell the Judge, briefly the work

1 -- some of the work that you have done in South
2 Carolina with hospitals and health care
3 facilities starting with Medical University of
4 South Carolina?

5 A: Certainly. My first project with MUSC was
6 probably around 1995 was a study to place a
7 small canteen between their library building
8 and their basic science building project --
9 building. And that continued on into multiple
10 projects throughout the course of the last 25
11 years. The first major renovation project that
12 I worked of for MUSC was the renovation of the
13 5th floor space to become their heart and
14 vascular institute. So that was to insert
15 interventional radiology and interventional
16 cardiology procedure rooms into very tight
17 floor to floor height constraints and to create
18 the pre and post procedure areas for that
19 service line.

20 Q: That 5th floor -- is that 5th floor of the --
21 the university hospital?

22 A: Actually a children's hospital.

23 Q: A children's hospital?

24 A: Yes.

25 Q: Okay. And did that involve renovation

1 challenges?

2 A: Absolutely. Because of the structure of the
3 building -- the existing building -- very
4 detailed drawings have to be provided regarding
5 the existing structure of the building because
6 we have very tall equipment that had to go into
7 these spaces and a very small volume of space
8 where the mechanical systems -- the electrical
9 conduits and communications conduits and all
10 those sorts of things have to go into place.
11 It was further compromised and complicated by
12 the fact that surgery -- the main surgery
13 platform for the hospital at the time was one
14 floor -- was directly below this. And so that
15 meant that the renovation any requirements that
16 there were penetrations put in the floors --
17 had to be carefully coordinated so that no more
18 than one operating room at time would be closed
19 down while those contracting activities took
20 place.

21 Q: Do I understand you to say that that meant that
22 you had to coordinate with the hospital on
23 which OR's could be used during a particular
24 day of renovation?

25 A: Absolutely. The contractor was primarily in

1 charge of that day to day coordination. But it
2 is something we were heavily involved in. Also
3 we had to provide phasing plans for that as
4 well as ---

5 THE COURT: What other things?

6 A: Phasing plans. The construction period takes
7 a good bit longer when you are working in the
8 middle of a hospital that's in operation 24/7,
9 365 days a year.

10 Q: And so when phasing, does that mean you have to
11 work with hospital as to when you're gonna do
12 what work?

13 A: Yes, ma'am.

14 Q: Okay. You talked about what was below the
15 vascular renovation, what was above it?

16 A: I don't remember. I'm sorry.

17 Q: Was there something operating above it that you
18 had to with also?

19 A: Yes, ma'am.

20 Q: And what kind of work did that involve?

21 A: We definitely had to coordinate with those
22 occupants above and the activities above. I
23 believe they were offices and clinical type
24 space. So again part -- only certain areas
25 could be accessed at a time and that would be

1 for the routing of any new plumbing,
2 ventilation systems, those could be collected
3 and not as numerous as the penetrations to the
4 floor below.

5 Q: Did you have to put in any new conduit or
6 electrical work?

7 A: Yes, ma'am. The communications systems that
8 were specific to that equipment had to be fully
9 upgraded an integrated as well as additional
10 power and those sorts of things. Mechanical
11 systems had to be upgraded in that area to meet
12 the new use of the space.

13 Q: When you started the renovation on the vascular
14 line -- excuse me -- did you have to work with
15 DHEC to determine whether or not you had to
16 bring that area up to the then current
17 regulation 61-16 code?

18 A: Certainly. We worked with Ealey McCaren with
19 DHEC and he continues to be our contact for
20 projects in our part of the state to determine
21 how great an impact the project would have on
22 that particular area. Typically, if we find we
23 are renovating more than 50 percent of the
24 floor area -- essentially anything beyond
25 flooring and finishes -- upgrading finishes, we

1 find that we have to update it to the current
2 codes. Rather than what the codes were at the
3 time that part of the building was constructed.

4 Q: As a general rule, is more expensive to update
5 -- excuse me -- to upgrade an existing facility
6 to current code than it is to -- for a green
7 field hospital?

8 A: That's a -- could be -- it's kind of difficult
9 to answer that. It really depends on the
10 amount of upgrades that are required. But, you
11 know, when an area is impacted more than 50
12 percent I would say that those general costs
13 are higher. The contractor has the added costs
14 of the phasing and all of the fire protection
15 measures, the infection control measures that
16 need to be put in place all those sorts of
17 things. So you might have a premium -- you
18 would most likely have premium to do that
19 renovation work.

20 Q: What is DHEC regulation 61-16, if you know?

21 A: Certainly. That the regulation that we use for
22 any hospital design projects. We use it in
23 conjunction with several other documents, such
24 as their radiation protection documentation as
25 well if we're doing x-ray type projects and all

1 **that.**

2 MS. CRUM: Your Honor, at this time, I would like to
3 ask that the court take judicial notice of
4 regulation 61-16. Which is the DHEC -- and I'm
5 reading minimum standards for licencing
6 hospitals and general infirmaries.

7 THE COURT: Let's see.

8 MR. THOMAS: I have no objection to the law of South
9 Carolina.

10 MS. SHOUN: No. No, Your Honor. Thank you.

11 MR. WICEVIC: No objection.

12 **Q: Now, let's see what other projects have you**
13 **done at -- in USC. Maybe the LDR test product?**

14 **A: Sure. We did about 10 years ago we did**
15 **renovations to the 5th floor west and east**
16 **portions of the building for labor and delivery**
17 **renovations as well as their postpartum area.**
18 **Those essentially were an interior upgrade.**
19 **Just primarily finishes -- knowing that the**
20 **hospital was planning on relocating -- or**
21 **hoping to relocate those services eventually to**
22 **the Shawn Jenkins Children's and Women's**
23 **Pavilion.**

24 **Q: And when you talked about the east and west,**
25 **what hospital -- what structure?**

1 **A:** I apologize. That's the University Hospital.
2 And we did several other renovations within the
3 hospital complex as well. Including their 13-
4 bed ICU and several other imaging projects and
5 the like.

6 **Q:** Let me ask, would you just please tell the
7 Judge the relationship between University
8 hospital and Children's hospital is?

9 **A:** Certainly. They are directly adjacent to each
10 other. They abut however, the floor to floor
11 heights within the buildings are a little
12 different. So especially as you get further up
13 in the building in the children's building,
14 there are ramps that are required to
15 interconnect to the University hospital.
16 Children's hospital has sort of spread into
17 University hospital and there are a couple
18 components that Children's hospital has within
19 University hospital.

20 **Q:** What is ART?

21 **A:** ART is the Ashley River Tower project. I was
22 lucky enough to be the project architect for
23 the entire interior of the hospital with the
24 exception of the conservatory space. LS3P
25 partnered with NBBJ, a nationally known firm to

1 do that work. NBBJ had the primary
2 responsibility of the exterior skin of the
3 building and that conservatory space. Which is
4 sort of their lobby type area.

5 Q: Excuse me -- have you done some other projects
6 -- I don't want you to name them all -- but
7 have you done other projects with MUSC?

8 A: Yes, ma'am. Most recently completed the
9 children's ambulatory campus or CAC as you may
10 have heard it referred to. It's also known as
11 the Keith Summey Health Pavilion. It has an
12 ambulatory surgery component as well as the
13 pediatric clinics for the children that
14 formerly were -- all these clinics were
15 formerly located on the main campus. And the
16 driver for the project was to start to get
17 these services out into the community to make
18 it easier for the patient. Well the patients
19 aren't usually driving with it being pediatrics
20 -- but make it easier for the families to
21 navigate. Get there, park in a surface parking
22 lot and go very easily and conveniently into a
23 building. Into get their services.

24 Q: Have you done any architectural work for the
25 Roper St. Francis Health System?

1 **A:** Yes, I have. I started work for Roper Hospital
2 probably around 1997 doing a medical office
3 building for them in Mt. Pleasant on Long Point
4 Road and that was a forty thousand square foot
5 medical office building that included what at
6 the time was called an emergency department.
7 Later that went into and took dispute from East
8 Cooper Hospital and so now it's called an
9 Urgent Care.

10 **Q:** Was that dispute a contested case, like we have
11 here? It was challenged? The DHEC decision
12 was challenged?

13 **A:** Yes, ma'am.

14 **Q:** Did you end up giving a deposition in that
15 case?

16 **A:** Yes. I was deposed in that case.

17 **Q:** Is that the only time that you've ever had to
18 testify?

19 **A:** The only time I had to testify, I was involved
20 in an arbitration one time in my career as
21 well.

22 **Q:** What else have you done for Roper?

23 **A:** For Roper I have done numerous medical office
24 building projects. We have also done -- I just
25 said medical office building projects -- so the

1 most recently completed was one on University
2 Boulevard. We've also done tenant upfits for
3 them within, you know, those medical office
4 building. And also various sites.

5 Q: What about hospitals? Do you work with the
6 hospitals?

7 A: Yes. For this hospital I worked on the cardiac
8 rehab project, which is now known as cardiac
9 wellness. It was a renovation to the hospital.
10 I also was involved in a multi ---

11 Q: Can I stop you right there?

12 A: Yes, ma'am.

13 Q: Was the hospital occupied when it was
14 renovated?

15 A: Yes, it was.

16 Q: Did you have some of the same staging issues at
17 Roper that you had at MUSC?

18 A: We did. It wasn't quite as complicated in this
19 case because it took some areas that were
20 service dock areas and the morgue and those
21 sorts of things. And we had to work around
22 those areas. But it was essentially sort of a
23 bath house area. We also had some functions
24 that had to be relocated into one of their
25 oldest wings of the hospital on the upper

1 floors and add sprinkler systems up there.

2 Q: What about -- did you do anything with parking
3 and campus clinical master plans for Roper?

4 A: Yes we did. We were involved in a study
5 several months long that studied the entire
6 Roper downtown campus. We looked at the age of
7 the buildings, the inner connections between
8 services and buildings and also some of their
9 out parcels in the downtown area to look at
10 parking. Parking garage options and those
11 sorts of things. And then additionally we were
12 -- I assisted on the helipad location up on
13 their roof to really speed up their delivery of
14 patients by -- via helicopter to the emergency
15 room for their outstanding work that they do
16 for their stroke victims in particular.

17 Q: What, if any work that you've done for the
18 Trident Health Systems?

19 A: I've done a few small projects for Trident
20 Health System. Including two renovations in
21 medical office buildings including the
22 installation of MRI equipment as well as their
23 women's services in the trident medical arts
24 building. And then for Summerville Medical
25 Center, I've worked on 3 or 4 small renovation

1 projects. Including their labor and delivery
2 area. And this was work that was done before
3 their most recent building opening. But -- so
4 the labor and delivery created a pediatric
5 inpatient unit and with that a pediatric
6 emergency department. And then also
7 renovations to their interior lobby areas and
8 public spaces. Those sorts of things.

9 Q: With the -- excuse me -- with the exception of
10 the office buildings and the planning, did the
11 projects that you've worked on at MUS -- MUHA,
12 Roper and Trident involve certificates of need?

13 A: Some of those did include certificate of need
14 planning projects. Most of those have been for
15 MUSC. Although I did also assist on Roper's
16 North Charleston emergency department CON
17 process.

18 Q: Okay. At briefly, have you done any other work
19 for South Carolina Hospitals?

20 A: Yes, ma'am. I've done work at Palmetto Health,
21 now Prisma Health. As well as work for Self
22 Regional Medical Center. A little bit of work
23 for Atrium Health also for Greenville Hospital
24 System as well. And then I also worked for
25 Clarendon Hospital and Hampton Regional.

1 **Q:** **Okay. Did you build a new hospital or design**
2 **a new hospital for Hampton Regional?**

3 **A:** **Yes. I was involved in that project.**

4 **Q:** **Okay.**

5 **OFFER AS EXPERT:**

6 **MS. CRUM:** At this point, Your Honor, I would offer
7 Ms. Smith as an expert in hospital design and
8 planning.

9 **MR. THOMAS:** I just got a couple of questions, Your
10 Honor.

11 **THE COURT:** Okay.

12 **MS. SMITH - VOIR DIRE EXAMINATION BY MR. THOMAS:**

13 **Q:** **Good afternoon, Ms. Smith. I'm Will Thomas, I**
14 **represent the Trident, Summerville and Colleton**
15 **Medical Centers in this case. I just have a**
16 **few questions for you related to your**
17 **qualifications and your opinions that you may**
18 **offer in this case. Am I right that you have**
19 **conducted no studies regarding what it would**
20 **take to renovate the children's hospital floors**
21 **and the maximum number of rooms that are based**
22 **on current guidelines and codes?**

23 **A:** **I've not been asked to do that formerly by**
24 **MUSC.**

25 **Q:** **Okay. And am I correct that you haven't done**

1 any studies, nor are you aware of any studies
2 pricing out what it would cost to add a bed
3 tower or two bed tower on the wellness center
4 site?

5 A: That's accurate.

6 Q: Okay. In terms of construction in the existing
7 children's hospital, with respect to adding
8 beds, you've done no studies with respect to
9 how the project can be phased to minimize
10 patient disruption, have you?

11 A: I'm sorry, could you repeat that?

12 Q: Yes. In terms of construction in the existing
13 children's hospital -- so the one that I think
14 you'll be testifying a little bit about today
15 -- you've done no studies with respect to how
16 the project could be phased to minimize patient
17 disruption, have you?

18 A: That's accurate. But based on my experience in
19 the rest of the building and in University
20 Hospital, I believe my opinions may be valid.

21 Q: Okay. Do you plan to offer opinions on the
22 case of the children's hospital in terms of
23 renovation?

24 A: Not in any specific detail.

25 Q: Okay. Also you did not do a study of space in

1 the existing children's hospital, the main
2 University Hospital that is to be vacated to
3 determine what could be done and perhaps moved
4 around in order to maximize space for the
5 addition of adult medical surgical beds,
6 correct?

7 A: Other than preparations for this trial I've not
8 been -- I've not been requested by MUSC to do
9 that, although in preparation as I needed to
10 dive into and determine the size of the rooms
11 and those sorts of things. And look at the
12 general configuration of the existing floor
13 plans.

14 Q: Okay. You were deposed on October 1st,
15 correct?

16 A: Yes.

17 Q: Okay. You haven't done anything since then
18 that we would need to know about, have you?

19 A: I may have looked a little bit deeper into the
20 floor plans that are available.

21 Q: Did you generate any documents or send anything
22 to Ms. Crum or her team?

23 A: Yes, and I believe they will be submitted.

24 Q: Are those the ---

25 MS. CRUM: Those are the trial exhibits that we gave

1 y'all on the 25th.

2 MR. THOMAS: Okay. All right.

3 Q: Almost done here. You have done no studies
4 with respect to floor to ceiling heights as to
5 what required infrastructure could be
6 accommodated in these areas to build out
7 additional beds in the existing children's
8 hospital, correct?

9 A: Based on my experience in the existing
10 buildings and the previous projects I have
11 worked on, I Have some inside information about
12 the floor to floor heights and the cramped
13 conditions that are provided.

14 Q: Okay.

15 A: So that is based on my previous experience.

16 Q: But you've done nothing, no studies to
17 determine what type of infrastructure could go
18 in there in order to accommodate any new
19 patient rooms, have you?

20 A: I've done enough projects in buildings that
21 were constructed in this day in the time of the
22 University hospital and the children's hospital
23 in my previous projects to know that the
24 ceiling heights that are the minimum required
25 are very difficult to achieve.

1 Q: Ma'am. I'm going to ask you again -- a third
2 time -- you haven't done any studies? I
3 understand you have ---

4 A: I've done no formal study.

5 Q: Okay. That's all I'm asking. You were not
6 involved with the master planning efforts for
7 MUHA's phase 1, 2 and 3 campus replacement,
8 correct?

9 A: For phase 1, LS3P was on the perimeter of that
10 study that was done back around 2001 to 2003.

11 Q: Okay. But since then, no involvement?

12 A: That's correct.

13 Q: Okay.

14 MR. THOMAS: Your Honor, I think -- I believe she's
15 qualified as an expert and as an architect,
16 certainly. As a planner, I think that goes to
17 space planning for hospitals. And not in the
18 health planning context. But I would want to
19 get that straight for the record -- and but I
20 just -- to the extent that she doesn't plan to
21 offer any opinions regarding the very specific
22 things that I've talked about in terms of cost,
23 design and, you know, the maximum number of
24 rooms, I'm fine with that. That -- I don't
25 think she has the basis to do that today

1 because she hasn't done anything. Any type of
2 research or studies and this is pretty involved
3 complex work about determining how many rooms
4 you can get in and that type of thing. If she
5 doesn't have any opinions about that, I'm fine.

6 MS. CRUM: Well first off, Your Honor, I need to
7 talk about his cross-examination goes to the
8 way of the evidence. And so I wouldn't
9 absolutely say that that she needs to be
10 qualified. I'll be more than happy if the
11 Court wants to ask her what is included in
12 health planning or the architectural planning.
13 I don't think it's limited to space. But I'll
14 be happy to ask that if the court desires. But
15 I was going to get into that anyway when I get
16 into my examination.

17 THE COURT: Or I can just qualify her right now as
18 an expert in health design and space planning
19 and then as it goes further we can see more.

20 MR. THOMAS: Okay. I'm fine with that, Your Honor.

21 MS. HOLLINGSWORTH: Your Honor, subject to Mr.
22 Thomas' questions on voir dire, I have no
23 objection with Your Honor.

24 THE COURT: Okay.

25 MR. WICEVIC: No objection.

1 THE COURT: She's so qualified.

2 MS. CRUM: Thank you, sir.

3 MS. SMITH - DIRECT EXAMINATION BY MS. CRUM (CONT.):

4 Q: Now were you part of the MUHA team that
5 developed the CON application for MUHA Barkly?

6 A: Yes, I was.

7 Q: What role did you play in that?

8 A: I was the leader of LS3P's team and was
9 intimately involved in every phase of the
10 project. We were requested to first develop a
11 program. A detailed program for the facility.

12 Q: Tell the Judge what you mean by detailed
13 program?

14 A: Program is the documentation that tell how many
15 of each type of space you expect to include in
16 the building project. It assigns it a certain
17 square footage, multiplied by the number of
18 those types of rooms and for each of the
19 departments. And we then gross up those
20 departments to include circulation and for --
21 within that department. And then we gross that
22 number up again to include the exterior walls
23 further circulation of support areas such as
24 the mechanical, electrical, stairs, elevators
25 and all those sorts of components that help

1 build -- help you come up to your total square
2 footage that you are aiming to include in a
3 project.

4 Q: Okay. And I stopped you, you were talking
5 about the program designs. What did you do?
6 What else did you do as the project architect?

7 A: Certainly. Once that program had been vetted
8 several times with the committee -- the MUSC
9 committee we proceeded to some preliminary test
10 fit plans. Space planning as Mr. Thomas called
11 it. At the same time we developed a rather
12 detailed project narrative that was to be
13 prepared to go to our cost estimator we have a
14 third party cost estimator that we employ to do
15 a more detailed cost estimate, given the size
16 and complexity of the project. We vetted his
17 numbers and looked to see which components we
18 felt were too high or which things were
19 missing. We also ---

20 Q: Let me stop you right there. When you say you
21 vetted his numbers, what did you do?

22 A: We looked through the cost estimate in a good
23 bit of detail. We do this on all of our
24 projects. We are very intimately revolved --
25 involved in the cost of a project. Primarily

1 because as a budget is set we as the design
2 team are expected to keep to those costs. We
3 can't design outside of our limits.

4 Q: And who did the project estimation for you?

5 A: That was Cumming. Cumming Cost Estimating.

6 Q: Is that a entity that is standardly used by
7 architects in the South Carolina area?

8 A: Yes. They are. They're quite popular in that
9 they do a very good job. Very through. They
10 have a very large database that they draw their
11 numbers from to, again help do some checks and
12 balances to make sure that the estimates that
13 we're arriving upon are feasible numbers.

14 Q: All right. And I'm sorry I interrupted you.

15 A: Certainly. We also developed a just a
16 narrative for the project. Just more of a
17 descriptive narrative that becomes part of the
18 CON letter. We provided a project schedule
19 going from construct- -- I'm sorry, from the
20 design phases all the way through the
21 construction of the project to help determine
22 when the facility might open. I'm trying to
23 think if there's anything else. We also did
24 some site planned options to do a test fit to
25 make sure that the project fits on the sites

1 that are available.

2 **Q:** Did you do schematic drawings?

3 **A:** Yes. So I would say very early schematic plans
4 were provided. Floor by floor.

5 **Q:** And what about a total project cost budget?

6 **A:** Yes. We helped MUSC develop that in own format
7 templet. We had a document that went back and
8 forth several times to help fill in all of the
9 cost for the project. And that would start
10 from our land cost, the cost of acquisition to
11 the site development costs. To the building
12 construction costs, contingencies, soft costs -
13 - which are those such as the engineering and
14 architectural services and all of the
15 consultant -- specialty consultants that are
16 involved in the design as well ---

17 **Q:** I'm going to ask you to go through all of that
18 in just a minute.

19 **A:** All right.

20 **Q:** But first let me get you to look at DHEC
21 Exhibit 1 page 72.

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

23 **Q:** Do you recognize that letter?

24 **A:** I do. That my letter to Sarah Bacik at the --
25 essentially the completion of our CON study

1 effort.

2 Q: Okay and would you look on the project budget?
3 What does the -- does it say the total final
4 cost of 325 million dollars?

5 A: Yes, it does.

6 Q: And that included land building, construction
7 equipment and other costs such as professional
8 fees, permits, geotechnical, environmental
9 inspections and financing interest costs?

10 A: Yes, ma'am. It's meant to be a total project
11 cost.

12 Q: And you certified the budget that was
13 subpoenaed by LS3P and the third party
14 estimator, is that correct?

15 A: Yes, ma'am.

16 Q: Okay. And look on down you see location legal
17 description? This is the site in Nexton,
18 right?

19 A: Yes, it is.

20 Q: Okay. And look on down at parking. You see
21 the last paragraph down there at the bottom of
22 parking highlighted?

23 A: Yes, ma'am.

24 Q: Is parking parking requirements, do you have to
25 have those to build in Nexton?

1 A: Yes, you do. You would had a similar
2 experience with any project.

3 Q: And is parking part of the infrastructure?

4 A: Yes, it is.

5 Q: Okay. And how many parking places were
6 required for the 128 bed hospital at Nexton?

7 A: We we estimated that would be roughly 870
8 parking spaces.

9 Q: Okay. And I'm going to get you go on up under
10 the project description. Is it a -- the
11 hospital was roughly three hundred eleven
12 thousand two hundred twenty one square feet of
13 space?

14 A: Yes, ma'am.

15 Q: 128 in patient beds?

16 A: Yes.

17 Q: Four operating rooms?

18 A: Yes.

19 Q: Two procedure rooms? Actually, we can read the
20 rest of that. I don't need to read it to you,
21 do I?

22 A: That's correct.

23 Q: Okay.

24 A: It is ...

25 Q: And it has a helipad?

1 **A:** It does.

2 **Q:** Okay. And you have certified to Ms. Bacik that
3 the hospital will meet the minimum standards
4 for licensing hospitals and general
5 institutions in South Carolina and other
6 related sections such as food services and x-
7 ray, correct?

8 **A:** Yes.

9 **Q:** Okay. Look on over to page 74. Do you
10 recognize that as the project budget?

11 **A:** Yes, I do.

12 **Q:** What input what input did you have on that?

13 **A:** We created the document and then with the
14 assistance of MUSC, filled in the values for
15 each of the cells that you see.

16 **Q:** Okay. Do projects of this size normally have
17 contingencies built into the construction cost?

18 **A:** Yes, they do because when you're putting
19 together the CON application you're trying to
20 come up with that total project cost. Not only
21 are you representing those cost -- those
22 dollars to DHEC for the CON application, but
23 also you're having to run it by the board of
24 the hospital and it's really not a very good
25 sign to have to go back and ask for more money.

1 Because you're in such a preliminary stage of
2 design, there are a lot of unknowns at that
3 point. At this early stage of the design
4 process. So we like to build in some
5 contingencies so that whatever surprises come
6 up along the process we are able to take in
7 stride and absorb.

8 Q: Is it your goal to overstate the project cost
9 as opposed to understate it for purposes of
10 reporting to the MUHA board?

11 A: We try to make it a comfortable number that we
12 know we can live with.

13 Q: All right. Now, lets look -- excuse me -- land
14 acquisition that was 10 million dollars, that
15 was the budget price, right?

16 A: Yeah. That's the number that MUSC provided for
17 us.

18 Q: Okay. And do you know whether or not that's
19 the actual price they paid?

20 A: I don't know. I would think it probably
21 includes some of the legal fees and broker
22 fees.

23 Q: Well we'll get down to that later.

24 A: Certainly.

25 Q: Okay. Look under site work. There's an

1 asterisk by that. That site work is eleven
2 million two hundred and thirty five thousand
3 plus, right?

4 A: Yes, ma'am.

5 Q: Okay now there's an asterisk -- well and
6 there's building construction. The building
7 construction cost is \$148,729,995, right?

8 A: That's correct.

9 Q: Are there any contingencies in there?

10 A: There is. There's a 10 percent contingency
11 that was included in Cummings' cost estimate.
12 Also that includes the escalation to the mid
13 point of construction, which at that point in
14 time was estimated to be February of 21.

15 Q: And what was the escalation cost percentage in
16 2017?

17 A: in 2017 Cumming Cost Consulting included a 2.37
18 percent escalation cost. We are seeing higher
19 numbers these days. Any where between -- you
20 know closer to 3 or 4 percent at this point in
21 time.

22 Q: So if I understand you correctly the 152
23 million plus, that has a 10 percent contingency
24 in it?

25 A: Yes, it does.

1 Q: So that would be about 15 million dollars, is
2 that right?

3 A: Yes, ma'am.

4 Q: Okay. And in addition to that includes the
5 escalation cost?

6 A: Yes.

7 Q: Okay. Now let's go ahead and look down the
8 next line say contingencies.

9 A: Yeah. We've got some more contingencies
10 included.

11 Q: Okay and what are those?

12 A: Again, those are for design unknowns at this
13 point in time. For example at this early stage
14 we don't have all the information about the
15 geotechnical conditions. The soils -- that's
16 the soils the bearing capacity. We don't know
17 -- we don't think there are any wetlands
18 issues, but there maybe some unsuitable soils.
19 Those sorts of things that come in. We also
20 don't know what code changes may occur between
21 2017 and the completion of the project so we
22 include those buffers. Likewise under
23 construction. And actually that unsuitable
24 soils topic would be more likely under the
25 construction contingency.

1 Q: Would that be like a soil testing if you had to
2 put boarings or something like that in?

3 A: It -- what it would be would be if we did our
4 soils testing initially and we designed the
5 project such that it say 60 foot piles. If
6 when they started installing the piles they
7 found that soils were much worse and they
8 needed to increase those pile depths to 80
9 feet. Multiply that by you know several
10 hundred piles, you've got numbers -- sorry --
11 the numbers really rack up very quickly. So
12 again, you like to have that contingency built
13 in.

14 Q: So is that a contingency that you developed?

15 A: It's just a straight multiplier.

16 Q: And that's something typically that you use in
17 your industry?

18 A: Yes, it is. And we recommend that that be
19 included early in the process. As the design
20 progresses, normally those contingency
21 percentages decrease.

22 Q: And the contingency, if I'm adding up the 7.65
23 million, 605 million times 2, that's about 15
24 million dollars?

25 A: Yeah.

1 Q: A little more than that?

2 A: Right.

3 Q: Now look under the owner cost -- well first
4 off, your architectural fees, additional
5 services -- those are under the professional
6 fee services. Professional fees and services.

7 A: Yes.

8 Q: Okay. And then the owner cost, what is AMCO?

9 A: AMCO is a term that MUSC asked us to include
10 and it's the amount to make the project
11 operational. So it would include their staff
12 members, project management time during the
13 course of design. Their training of staffs,
14 the moves and, you know, the training and the
15 move over to the new facility.

16 Q: Okay. And the next line item is financial
17 interest fees, who gave you that 5.75 ...

18 A: MUSC provided that number.

19 Q: Were you here this morning -- or I guess it was
20 this afternoon, when Ms. Goodlett said that for
21 the CHS hospitals they locked in a 3 percent
22 rate?

23 A: Yes that would certainly be -- would lead to
24 lower finance charges if we could secure a
25 similar rate.

1 Q: And then on down here where we got the legal
2 mortgage interest financing, is that a number
3 that you were given by MUSC?

4 A: Yes, ma'am.

5 Q: Okay. And down here we have this thing, owner
6 contingency. It's 31 plus million dollars.
7 What is that?

8 A: Again, that's a similar cushion that the owner
9 has built in. I would imagine that would be
10 reduced as the project progresses. That's just
11 to help cover some unknown programmatic things
12 that may come up. Or changes that MUSC might
13 have during the course of the design.

14 Q: All right. What is the total amount of
15 contingencies that is included in the total
16 cost project?

17 A: By my rough calculations, about 68 million
18 dollars of contingencies. Again, hopefully we
19 don't need all those contingencies. But again,
20 we like to stay within a number that we can
21 deliver the project.

22 Q: Okay. Would you -- who is RS Meads?

23 A: RS Meads is an agency that list cost data for
24 construction and it offers modifiers for the
25 region. The various regions where projects

1 might be located, but it's a nationally know
2 resource.

3 Q: Okay. Is RS Meads, is that utilized in South
4 Carolina.

5 A: Certainly. We use that to cross check numbers.
6 Contractors will often use it as well.

7 Q: Okay. And is that something that you typically
8 use?

9 A: We refer to it often when we are doing a cost
10 estimate -- cost estimate by ourselves.

11 Q: And what is the health care design magazine?

12 A: There are various resources, and not
13 necessarily just the health care design
14 magazine, but many many periodicals that have
15 cost information. Or gut check to see if
16 you're within the ballpark in terms of
17 construction costs. It's also a little bit
18 risky just to rely on data that's provided out
19 there in these resources. In that you don't
20 always know all the factors that are included
21 in a project. For example a project in
22 downtown Charleston may have higher costs
23 because of with length loads, the seismic
24 loads, the flood elevations and those sort of
25 criteria. And also in Charleston for example

1 the board of architectural review, those cost
2 dollars are not necessarily similar to what you
3 might have in another location.

4 Q: Let's look at DHEC page 89. That's DHEC
5 Exhibit 1, I'm sorry. Can you tell the Judge
6 what this is, please ma'am?

7 A: This looks like it's an attachment to the CON
8 application MUSC provided.

9 Q: Look at the page 92. Oh well 90 -- I'm sorry.
10 91, do you recognize that?

11 A: I do. These are images from our -- the 3D
12 modeling that LS3P uses for the planning
13 purposes.

14 Q: And look at pages 92 through 95 and tell the
15 Judge what this is?

16 A: These are the floor by floor test fit plans
17 that were provided by the hospital design.

18 Q: And what do you mean by test fit?

19 A: We know at this point -- at this point that the
20 design will definitely change. This is not the
21 ultimate layout. We don't even know who the
22 architect will be at this point. But you want
23 to do a layout of those programmatic spaces to
24 make sure that you fit with in the total square
25 footage you anticipated you would use.

1 Q: On the -- do you know whether or not the site
2 at Nexton -- excuse me -- has approval from the
3 architectural for the four engineers.

4 A: Let's see, which site?

5 Q: The site -- the chosen site that you have
6 identified -- look on page -- I have it 3 hole
7 punched it looks like it's 90.

8 A: On page 90, yes. Yes, we've got documentation
9 from the developers who own the entire property
10 the Nexton or Newland properties.

11 Documentation that the wetlands areas are --
12 that we're not in the wetlands areas.

13 Q: We don't have to worry about any wetlands
14 delineation with this project, right?

15 A: That's right. Now when we do -- when the
16 design progresses, you may come to an area that
17 has a lot more -- the water table is a little
18 different. You may run into some unforeseen
19 conditions, but ...

20 Q: Would those be underground conditions though?

21 A: Yes, ma'am.

22 Q: But that wouldn't be a core engineer's issue?

23 A: Right.

24 Q: Okay. All right. Look at page 18 -- 167 of
25 the application. DHEC 1. Are you familiar

1 with that?

2 A: Yes, I am. It's a document I created for the
3 project schedule on our Microsoft project
4 scheduler.

5 Q: Is that the time line that the ceiling rates
6 require now to put in the application?

7 A: Yes, it is. And this is our approach to it.
8 There's also a summary that's included in the
9 CON application that also identifies
10 milestones. But this is the way we would
11 develop project planning in the pricing efforts
12 and the permit phases and all that.

13 Q: Okay. Well now let me ask you this, how many
14 months are included from the date you are given
15 the go ahead, to start preparing the documents
16 until the hospital opening?

17 A: I believe it's about 45 months.

18 Q: Can you check it to make sure?

19 A: I'm sorry it's not quite as intuitive. I
20 checked it yesterday. And it was 45 months.

21 Q: Okay. If we were able to start the project in
22 April of 2020, based on this time line, when
23 would MUHA Berkeley be able see its first
24 patient?

25 A: It should be able to see it's first patients

1 around the first quarter of 2024.

2 Q: Okay. Do you have an opinion as to whether or
3 not the construction cost of MUHA Berkeley are
4 reasonable?

5 A: I believe they're reasonable.

6 Q: Why?

7 A: We had Cumming Cost Estimating doing the
8 overview of the cost estimate. In my
9 experience the costs have been rising for every
10 project that we've done. We did also factor in
11 some components for future growth on the campus
12 that also increased the cost a little bit ---

13 Q: What did you say? Let me stop you right there.
14 When you say future growth on the campus, which
15 campus are you talking about?

16 A: This is the Berkeley campus. We were asked to
17 do some upgrades to the structure to facilitate
18 a future expansion of beds if the need were to
19 arise. And it's prudent to put that in at the
20 beginning of the design in the foundations in
21 the steel in that area, because it's very
22 difficult to do afterwards.

23 Q: Does difficult translate to expensive?

24 A: Yes. Yes, ma'am.

25 Q: Okay. Now anything else as to why you think

1 the cost is reasonable?

2 A: That just based on our experience I would say
3 that they are reasonable. Comparative projects
4 are also in the same ballpark. If you --
5 particularly given the exterior that MUSC --
6 the exterior design of the hospital that MUSC
7 brand is leaning toward. They have a strong
8 desire to brand their buildings so that one can
9 tell it's an MUSC building when you arrive
10 there. So it would certainly have a higher
11 percentage of glass curtain wall type systems
12 and metal panel systems than many of the other
13 projects that the competitors -- Trident and
14 Roper are not doing.

15 Q: On branding the buildings, do you mean that the
16 buildings look alike?

17 A: Yes. That they're all part of a family of the
18 MUSC family.

19 Q: Let me ask you, do you have an opinion as to
20 whether the cost of new hospital in Nexton
21 versus the cost of a new hospital -- I'm going
22 to come that because I can't even say that
23 right now. Let's go on to show Trident, you
24 can see it at 145. That's the wrong one.

25 A: Yeah. I'm not familiar with this document.

1 **Q: No. I'm -- 34 let me get that right.**

2 THE COURT: That's a big change.

3 MS. CRUM: It's 145. I just can't read my writing.

4 Sorry about that.

5 THE COURT: All right. We've gone form 145 to 34 to

6 ---

7 MS. CRUM: To 145.

8 THE COURT: Okay.

9 MS. CRUM: We're back at 145.

10 (TMC Exhibit Number 145 was introduced into the
11 record at this time.)

12 **Q: Okay. And do you recognize that?**

13 **A: This appears to be the CON Application for the**
14 **Shawn Jenkins Children's Hospital.**

15 **Q: Scroll on down to the part A. There we go.**
16 **Did you look at this as part of your -- keep on**
17 **scrolling down -- as part of your preparation**
18 **or to testify in this case and your deposition?**

19 **A: Yes, ma'am.**

20 **Q: Okay. Now, let's look at how many beds, do you**
21 **see under there where it says med/surg?**

22 **A: Yes, ma'am.**

23 **Q: You're going to have to read it because I can't**
24 **read it from over here.**

25 **A: It's 98 beds for pediatrics.**

1 Q: Okay. Is that how many beds were transferred
2 from -- this is the application, is it not? To
3 transfer 225 beds from children's and
4 university hospital to Shawn Jenkins?

5 A: Yes, it is.

6 Q: Okay. So how many -- and down there at the
7 bottom it says that 225 beds transferred,
8 right?

9 A: Yes, ma'am.

10 Q: Okay. Now look at the number of bassinets.

11 A: It lists 66 bassinets.

12 Q: Okay. So is it your understanding that 66
13 bassinets will be transferred from children's
14 to Shawn Jenkins when Shawn Jenkins opens?

15 A: Yes, that's true but the existing bassinets are
16 located in large open bay rooms. Where it's
17 kind of a group setting. Where family members
18 are just a few feet adjacent to the next family
19 caring for their NeoNate. The new children's
20 hospital ---

21 Q: Can I ask you just a question ---

22 A: Sure.

23 Q: --- real quickly. The 66 bassinets, can those
24 be converted to patient rooms in accordance on
25 a one to one in accordance with the minimum

1 requirements for 61-16?

2 A: No. They can't. They require the bassinet
3 area layout is much more compact in small large
4 open bays as opposed to individual patient
5 rooms.

6 Q: Okay.

7 A: With toilets and all the things that you would
8 expect in an individual room.

9 Q: I was just going to ask you do the bassinets
10 have toilets?

11 A: No they don't. They use diapers, but but
12 family members would appreciate it.

13 Q: Okay. Now there were -- I'm not good with math
14 -- but if you take those 66 beds out, how many
15 beds are left that were transferred?

16 A: 140 -- 150 something.

17 Q: Okay. Do -- does regulation 61-16 the minimum
18 standards? What is the patient room size under
19 the minimum standards?

20 A: Minimum standard is 120 square feet. But again
21 it's just a minimum.

22 Q: Okay. What are the best practices for hospital
23 design?

24 A: Best practices for hospital patient rooms now
25 a days, those room sizes are almost double that

1 120 square foot minimum. The best practices
2 are that, not only is there room for the
3 patient bed, which was normally accounted for
4 in that 120 square feet, but also working space
5 for the care givers. As well as dedicated
6 space to the family members who are there as
7 advocates for the patient.

8 Q: Are the phrase best practices and standard of
9 care used interchangeably in the architectural
10 area?

11 A: Yes, ma'am.

12 Q: Okay. When you are looking at practices as an
13 architect designing a hospital, what kind of
14 national information or trends or
15 publications do you rely on?

16 A: There are many many examples that are provided
17 for us. Clemson University has very nice
18 patient room study that examines a lot of the
19 best practices. Also the advisory council and
20 other agencies. The AIA, which is the American
21 Institute of Architects also has a large
22 research board that does case studies that are
23 available for us to look at to see what the
24 current sizes are that hospital designers are
25 using across the country. The larger room size

1 really comes down to appealing to your patients
2 and making it a space that the patients and
3 families have a really good experience with in
4 that room. Rather than being in a cramped
5 cramped space. It effects, you know, how the
6 patient -- the patient and the family members
7 perceive the quality of their care.

8 Q: What about an ICU? What room size typically
9 meets the best standard of care for an ICU
10 room?

11 A: We typically would plan on about 100 -- sorry.
12 280 square feet for an ICU room. That is
13 primarily because there's a lot of additional
14 equipment that's located in the room with the
15 patient. Ventilators and those sorts of things
16 that are necessary for patient care.

17 Q: And that's necessary for quality of care, is
18 that right?

19 A: Yes, ma'am.

20 Q: Okay. Now, earlier you had talked about some
21 contingencies and what happens if there's a
22 change in a standard before something's
23 constructed; what is ANSI? A-N-S-I.

24 A: ANSI is one of the standards that designers
25 refer to for accessibility for projects. It is

1 used hand in hand with the ADA documentation.
2 Again the American Disabilities Act. To make
3 sure that we have adequate clearances for
4 persons with disabilities.

5 Q: And does DHEC reg. 61-16 adopt the ANSI
6 requirements?

7 A: Yes, it does.

8 Q: And during construction if ANSI requirements
9 change, do you have to change with that?

10 A: Normally you would not have to change it after
11 the documents have been approved for
12 construction. But, you know, you could run
13 into -- run a risk if your design process has
14 not been completed and in the last two or three
15 months of an old code -- you know, if you still
16 have two or three months left on an older code
17 and that code changes, you would be expected to
18 update your design standards.

19 Q: Am I correct, that in the time line in the CON
20 application, the design time is from -- is
21 about 12 to 13 months?

22 A: Yes, ma'am. That's a comfortable design
23 schedule. Sometimes we may be asked to
24 expedite but ...

25 Q: Does that design time include DHEC approvals of

1 the plans?

2 A: Yes, it does. Once the CON application has
3 been approved and project information form has
4 been submitted to the state we are allowed to
5 begin our reviews with the DHEC official for
6 the construction of facilities team. And he
7 would expect -- he or she would expect to have
8 reviews at the schematic design level.
9 Design/development level and construction
10 document level.

11 Q: Can you -- can the project move forward with
12 site work or construction until the plans are
13 approved by -- what's the department? The
14 department of facilities course construction at
15 DHEC?

16 A: Correct. Although, many times the owners will
17 request that the site development proceed at a
18 different schedule just because it takes --
19 those review take so long and there is some
20 advantage to begin to move the dirt around
21 early to get the site prepped before the
22 building construction work begins.

23 Q: Does -- are the existing university hospital
24 and children's hospital grandfathered for
25 purposes of the regulation 61-16 today?

1 **A:** If you don't change the use of the space it
2 would be grandfathered. But if you are
3 renovating and having to change a lot of the
4 space requirements, then you would be asked to
5 bring the -- up to the current building code.
6 That would involve also, not only architectural
7 code issues, but also the mechanical and
8 plumbing codes and electrical codes.

9 **Q:** Okay. Let's look at Trident Exhibit 89,
10 please, ma'am. Are you familiar with that?
11 (TMC Exhibit Number 89 was introduced into the record
12 at this time.)

13 **A:** I am these are some plans that were provided to
14 us from MUSC documenting their current vision
15 for the 52-bed CON and then the 29-bed CON
16 application.

17 **Q:** Are those documents documents that you were
18 questioned about during your deposition?

19 **A:** Yes, they are.

20 **Q:** Okay. Let's look on page -- and I'm going to
21 site to the MUHA page number so we can find
22 them here. It's MUHA -- can you read those?
23 Here we go. MUHA 029209. Can you tell the
24 court what that is?

25 **A:** This is what we would call a stacking diagram.

1 Under the purple column, you see the spaces and
2 the floors and the current assignments for what
3 is the children's hospital. The current
4 children's hospital. And then under the blue
5 bar you see the various wings and floor
6 designations for the university hospital.

7 Q: Do you understand, Ms. Smith, that a CON has
8 been approved for the, for an addition of 52
9 beds to MUHA?

10 A: Yes, I do understand that's approved.

11 Q: Okay. And do you understand that four of those
12 beds are going to be put -- are pack and put in
13 ART?

14 A: Yes.

15 Q: Do you understand that an additional 15 will be
16 put in Shawn Jenkins ---

17 A: Yes, that is my understanding.

18 Q: --- when it is completed?

19 A: Yes, ma'am.

20 Q: Okay. And do you understand that 33 of those
21 beds will be put in the university children's
22 hospital once Shawn Jenkins is open so the beds
23 can be vacated?

24 A: Yes, ma'am.

25 Q: Okay. Does this stacking diagram show you

1 that?

2 A: This first diagram really shows in the yellow
3 highlights the spaces that the children's
4 program occupy at this point in time to date.

5 Q: Okay. So let's go to the next page.

6 A: All right.

7 Q: Can you blow that up a little bit? Okay. Can
8 you explain to the court what that is?

9 A: This is the -- this is their preliminary back
10 bill plan, showing where they would plan to
11 utilize 25 patient rooms that were formerly --
12 or currently pediatric/adolescent rooms and
13 convert those to the 25 beds to the 52 beds
14 seen here.

15 Q: Okay. So that's where 25 of the 33 beds would
16 be put.

17 A: Uh-huh. Yes, ma'am.

18 Q: Do those beds ---

19 A: Yes. Yes.

20 Q: --- okay. Those beds meet the standard of
21 care?

22 A: Yeah. They're generally larger than the very
23 minimum. They're roughly 190 to 200 square
24 feet. So I would say that those rooms could
25 pretty easily be utilized. The restrooms are

1 tight, but the have the compliment of required
2 of handicap accessible rooms. So I wouldn't
3 say a lot of renovation work is required in
4 that area?

5 Q: And that's 25 beds?

6 A: Yes. Yes, ma'am.

7 Q: Okay. Let's go on over to the next page which
8 is MUHA 29211. Would you explain to the court
9 what that is?

10 A: That area is of an existing pediatric coronary
11 ICU area that would be converted to 8 ICU beds
12 in the future. It would require some pretty
13 major renovations to create 8 individual ICU
14 rooms. Because while you see there are several
15 rooms at the top or right-hand side that look
16 to be enclosed patient rooms. The balance of
17 the area is open and if they want to create
18 individual ICU rooms there would have to be
19 adding walls and reconfiguring the mechanical
20 systems. Adding toilets.

21 Q: Based on your knowledge, would that renovation
22 require that area to be brought up to code?

23 A: Yes, it would.

24 Q: And would that include making the bathrooms ADA
25 -- ANSI compliant?

1 **A:** Yes, it would.

2 **Q:** Let's go to the next floor, and this is MUHA
3 29212. Could you explain to the court what
4 this is, please ma'am?

5 **A:** Certainly. On the right-hand side. The upper
6 right-hand side, existing women's labor and
7 delivery services would be backfilled as 8 ICU
8 beds. Those rooms are larger because they were
9 labor and delivery areas. So again, not too
10 much renovation would be required in this case.
11 The lower red area is the existing antipartum
12 wing that they would propose to utilize -- this
13 says 21 beds.

14 **Q:** The lower area, are you talking about the
15 bottom right?

16 **A:** Bottom right, in red. Yes, ma'am.

17 **Q:** Do those -- those beds, are the conforming
18 beds?

19 **A:** They're about 190 square so feet each. Again
20 they do have the challenges with the restrooms,
21 but, you know, more detailed study of it would
22 determine if you had the adequate number of
23 handicap accessible rooms. There is a
24 challenge in all of these existing bathrooms in
25 that the new codes require a hand sink and each

1 individual toilet as well as in the patent
2 room. Where, you know that could mean more
3 involved renovations would be required.

4 Q: Okay. Now the vacant post partum nursery
5 that's right there in the center ---

6 A: Uh-huh.

7 Q: What did you do with those? Do those rooms
8 conform for standard in patient beds standard
9 care now?

10 A: Not as they are now. Those have a different
11 purpose at this point in time.

12 Q: What would you have to do to convert them to in
13 patent beds that would meet the standard of
14 care?

15 A: You would have to add individual toilet rooms.
16 For example on the upper right, those rooms
17 there are currently multi bassinet rooms. So
18 those would have to be adapted to include
19 toilets.

20 Q: Can I stop you? When you say multi bassinets,
21 do they have more than one bassinet in the
22 room?

23 A: Yes, they do. This is one of the areas where
24 nursery functions are ongoing now and are being
25 moved to Shawn Jenkins.

1 Q: Then those two arrows would encompass both of
2 those nurseries, right?

3 A: Yes, ma'am.

4 Q: Okay. And women's 5 east, there's 15 beds, are
5 there -- do those beds conform to the standard
6 of care?

7 A: Those rooms -- other than the issue with the
8 toilet are again, a little bit larger. They're
9 roughly 190 square feet. So they could be
10 fairly easily utilized. Although here in this
11 diagram they don't have a use for them.

12 Q: But if you were to use them, would you have to
13 bring the toilets up to code?

14 A: Yeah. That would probably be the case. We
15 would have a conversation again with our DHEC
16 official to see the extent.

17 Q: And if you had to bring them up to code based
18 on your experience would it require the area to
19 be brought up to current codes?

20 A: Yes, it would.

21 Q: I'm about through this. The next page is 2913;
22 could you explain to the court what this is?

23 A: This is the existing children's 7th floor area.
24 Primarily med/surg type beds. These are the
25 smallest rooms in the hospital. They're on

1 average 147/150 square feet each. And each of
2 the -- again, the toilets. Toilet rooms don't
3 include a sink. They're very very small. You
4 essentially have to climb over the toilet to
5 get into the shower component. They are
6 gathered around an atrium type space which is
7 necessary in order to get the daylight into
8 each of the patent rooms. That's currently
9 their play area for the children's hospital.

10 Q: Could you use that atrium play area to put
11 additional beds in?

12 A: You couldn't do it. Because if you did that
13 you would essentially be limited to the left-
14 hand portion of the building to have your
15 windows to the exterior.

16 Q: Is there a requirement under reg. 61-16 that
17 all rooms, patent rooms have windows or light?

18 A: Yes. They need to have access to daylight. It
19 can be through an atrium but you can't cut them
20 off.

21 Q: And if you were to renovate that area, would
22 that be a substantial renovation so you'd have
23 to bring the whole area up to code?

24 A: I believe so. I -- if I were to renovate that
25 area, I would essentially take 3 patent rooms

1 and turn them into two patent rooms that would
2 likely give us enough room and also to have
3 adequately sized toilets for each of the two
4 remaining rooms. Of course you've got
5 challenges with that because you have plumbing
6 stacks. Plumbing issues that have to connect
7 down and up.

8 Q: And what are the ceiling heights in that area?

9 A: The ceiling heights right now, again are very
10 very low. Again that floor to floor height in
11 that portion of the building is roughly 11
12 feet, 11'4" or something like that. And with
13 a minimum ceiling height requirement, that
14 leaves you very little space between the
15 concrete structure and the ceiling itself in
16 order to get lights, mechanical systems a
17 conduit and all that.

18 Q: And is that why ceiling height is important?

19 A: Yes, it is.

20 Q: You said lights and conduits, what are the
21 conduits for?

22 A: The conduits take -- provide the power. The
23 power to the rooms. So you have regular power
24 and emergency power needs. Also in the case of
25 pipes, you have the sprinkler system and

1 communication systems sometimes are in conduits
2 as well.

3 Q: What about electronic medical records?

4 A: Yes. The EMR needs -- EMR is the electronic
5 medical records -- the technologies in these
6 older areas of the building we would want to be
7 brought up to current standards to provide an
8 efficient clinical area.

9 Q: Okay. I got one more page here. And this is
10 MUHA 29214. What is this?

11 A: This is the 8th floor plan. The blue areas are
12 all much more open areas with bassinets
13 currently in a special needs nursery and in
14 their neonatal ICU and on the right-hand side,
15 I believe is the PICU, which is the pediatric
16 ICU. Renovations to those areas, if you were
17 to put beds would be quite extensive in order
18 to bring in the plumbing -- the plumbing and the
19 services needed.

20 Q: Are there are there any toilets in there?

21 A: No. Again, the PICU the plumbing needs for
22 PICU and the nursing areas are totally
23 different from patient beds.

24 Q: What are the ceiling heights there?

25 A: They're low again.

1 Q: So would you have the same issues with conduit,
2 electricity EMR?

3 A: You would with one advantage and that is the
4 you're -- well, one construction advantage in
5 that is basically the mechanical space.

6 Q: And you've talked about a number of these areas
7 that would require renovations and substantial
8 renovations. You earlier described the
9 problems that you encountered with the staging
10 with I think it was the vascular lab -- would
11 you have the same issues with each of these
12 areas in the hospital?

13 A: You would have. You would have issues on the
14 -- not so much on the 8th floor but on 7th
15 floor you've got lab services on the floor
16 below at least from that stacking diagram.
17 That's what I understand is directly below.
18 And the plans that we looked at earlier are
19 literally in the middle of the hospital. The
20 University hospital diagrams are -- were on 4th
21 and 5th floors in the middle of the ongoing
22 services that the hospital is providing in the
23 main hospital. Southern university hospital.

24 Q: So everywhere, and correct me if I'm wrong --
25 that you would renovate where you have ongoing

1 24/7, 365 services you have to deal with the
2 staging and protecting patients from dust,
3 fire, electrical outages, etcetera?

4 A: Yes, ma'am.

5 Q: Let me just show you real quickly, and this is
6 a demonstrative and it's MUHA RFE 29186. It's
7 some pictures. Do you recognize these
8 pictures?

9 A: I do. These are photographs I took in late
10 September, early October.

11 Q: I remember Mr. Thomas asked you if you carried
12 a really nice camera and what was your answer?

13 A: No. I took them with my iPhone, it's an older
14 iPhone.

15 Q: Would you explain to the Judge where these
16 pictures were taken?

17 A: This first photograph is in the children's
18 hospital. It's one of the patent rooms. And
19 as you can see, it's a very cramped cramped
20 room. There's barely enough space to walk
21 around the bed itself. The entrance to the
22 toilet room, is just behind that ventricle --
23 just behind the corner up there.

24 Q: Okay. Let's look at the next page. How far is
25 it from the end of the bed to the wall?

1 A: It's less than 3 feet.

2 Q: Is that in the standard of care?

3 A: That's not ideal. And as you can tell here,
4 you don't have 4 feet. I mean essentially
5 you've got very little walking space around
6 given the equipment that's required in the
7 room.

8 Q: You said it's not ideal, what is the standard
9 of care.

10 A: Well, the standard of care would be that you
11 have at least 4 feet clear, perhaps that's 4
12 feet clear. But now a days we're usually
13 providing much more room. Again that is to
14 provide a zone for the clinician to work in
15 that is uninterrupted by the patient or the
16 family members. The patient would have it's
17 area and primarily in the bed. And then there
18 would be an adjacent area for family members so
19 that they are able to actually room in the --
20 stay over night in the patient room.

21 Q: Look at page 29188. Is that the bathroom in
22 that room that you were just talking about?

23 A: Yes, it is. It includes the toilet and then a
24 -- essentially a 30 inch by 48 inch shower.
25 It's a very tight component -- confines. And

1 the door to the room is also smaller than a 3
2 foot door. So if you're a patient that needs
3 assistance getting to the rest room, it's very
4 difficult.

5 Q: Does that meet either ANSI or ADA standards?

6 A: No it doesn't. In all fairness, there are a
7 few restrooms on the floors that would meet the
8 ADA standards.

9 Q: Is it the majority?

10 A: Not the majority. In our newer hospital
11 designs, we're trying to include restrooms that
12 are much more accessible. Just because we know
13 that many patients may need assistance and we
14 want to facilitate that.

15 Q: Look at the next page. It's 29189.

16 A: This is on the children's in the children's
17 hospital again on the 7th floor. You see here
18 the ceiling itself is sitting just a few inches
19 about the door, the head of the doors. I think
20 that ceiling height is at about 8 feet, which
21 is the minimum. Except for small socket areas.

22 Q: Is that the current standard of care? 8 feet
23 ceiling?

24 A: No. It's very low. We like to try to have at
25 least a 9 foot ceiling or higher. But again,

1 this is simply a reflection of the tight floor
2 to floor heights that the structure has built
3 into it. And the need for the duct work and
4 all the utilities that are above the ceiling.

5 Q: Now tell me about -- or tell the Judge about
6 this equipment in the hall.

7 A: Certainly. In our designs today we are trying
8 to include alcoves off of the corridor in order
9 to get this equipment out of the 8 foot minimum
10 required corridor width. It certainly leads to
11 a more tidy work environment, but it also helps
12 facilitate transferring patients back and forth
13 and certainly in an emergency situation you
14 would not want equipment blocking access to
15 patient rooms.

16 Q: Okay. And the next one, what's that?

17 A: This is a nursing station. Just one of typical
18 ones on that floor. Certainly serviceable but,
19 you know, especially with the low ceiling
20 height it's not as friendly as newer hospitals.

21 Q: What about on pages 29191?

22 A: This is another of the beds in the children's
23 hospital. You see there again, the entry to
24 the toilet room is right around the corner.
25 That green wall. Essentially family, you know,

1 ---

2 **Q:** Out the window?

3 **A:** Yes. So entrance into the restroom is
4 essentially requires family members to get up
5 and move out of the way in order to get the
6 patent to the restroom.

7 **Q:** And what was that bench in there?

8 **A:** That bench is the sleeper sofa accommodation.

9 **Q:** For?

10 **A:** For the family members.

11 **Q:** Okay. Look at the next page. Is that a
12 duplicate?

13 **A:** Yes. That is a duplicate. But again, in this
14 you see how close like the trash can -- the
15 trash can doesn't even have a place that is out
16 of the way to let family members get back to
17 their area. There is some discussion about the
18 FGI guidelines increasing the minimum standard
19 square footage for patient rooms again, it
20 moves slowly.

21 **Q:** What is the FGI?

22 **A:** The FGI guidelines is a reference. It's called
23 the Facilities Guide Institute and it is
24 referenced by the DHEC 61-16 as a standard
25 which our designs are supposed to include for

1 reference -- reference material.

2 Q: All right. Let's look at 29193.

3 A: This is another patient room and as you can see
4 just by looking at the ceiling tiles, you've
5 got, you know a very tight space there. That
6 area in this patient room is intended to be the
7 clinical care zone in the hospital. In the
8 patient room.

9 Q: And where is the bathroom on this one?

10 A: It's to our right.

11 Q: And you see the lamp there, and up to the top
12 there's a little shiny electric box or
13 something, what is that?

14 A: I believe that's the control for the overbed
15 light.

16 Q: Okay. And then you see these little -- I don't
17 know what you call them, wall cover things?

18 A: I see -- I'm sorry, I don't -- this is a head
19 wall unit with the medical gasses and ideally
20 you don't have lamps and tables directly in
21 front of ---

22 Q: That's the medical gasses?

23 A: Yes, ma'am.

24 Q: Okay. And is it a good practice to have the
25 medical gasses right there by a lamp?

1 **A:** No, it's not.

2 **Q:** And let's look on finally to 29194. What ---

3 **A:** That's again a sleeper sofa. I apologize for
4 the quality of the image.

5 **Q:** And where is the bathroom located there?

6 **A:** It's just here on the right. See the door
7 handle is that silvery object on the right
8 side.

9 **Q:** Okay, let's look at 29195. What is that?

10 **A:** This is a photograph on the fifth floor walking
11 through that fifth floor space. The corridor's
12 there a little more clear, but.

13 **Q:** Okay. And the 29196 is just a duplicate, isn't
14 it?

15 **A:** Yes.

16 **Q:** Okay. Let's look on over to 29197.

17 **A:** This is down another corridor on the fifth
18 floor.

19 **Q:** Do you see the same equipment there?

20 **A:** Similar, yeah. That person is transporting and
21 I believe to a room.

22 **Q:** Okay. Are there any alcoves for the equipment
23 to be stored?

24 **A:** I know that there are on the Five East Project
25 because we put them in.

1 Q: Okay. What about on this floor?

2 A: This is the same floor but I don't believe this
3 corridor is the same one.

4 Q: Okay. And what is 29198? What does that show?

5 A: This is the fourth floor PICU space so it's the
6 pediatric ICU right now. It's one of the areas
7 that was indicated to become an ICU area for
8 adults.

9 Q: And this is the open space now?

10 A: Yes.

11 Q: Okay. And 29199 I'm not going to ask you about
12 because we can't see it.

13 A: It's too dark. Sorry about that.

14 Q: Okay. Are these rooms typical of the smaller
15 rooms at Children's and University?

16 A: Yes, they are.

17 Q: Okay. Now let's look at Exhibit 37, please,
18 ma'am. Do you recognize that?

19 (MUHA Exhibit Number 37 was introduced into the
20 record at this time.)

21 A: Yes, I do.

22 Q: Did you develop that?

23 A: I did. Based on the CON information for the
24 52-bed and the 29-bed.

25 Q: Your Honor, I think I forgot to move to

1 **introduce Trident 145. At this time I'd move**
2 **to introduce Trident 145.**

3 **(TMC Exhibit Number 145 was referenced at this time.)**

4 MR. THOMAS: No objection.

5 THE COURT: Y'all object?

6 MS. SHOUN: No objection, Your Honor.

7 MR. WICEVIC: No objection.

8 THE COURT: It's admitted.

9 **(TMC Exhibit Number 145 was admitted into evidence at**
10 **this time.)**

11 **Q: And let's go back to -- what was it -- 37. Did**
12 **you develop this?**

13 **A: Yes, I did.**

14 **Q: Okay. Go to the next page, please. Did you**
15 **develop that chart?**

16 **A: Yes, I did.**

17 **Q: I'm going to move to introduce MUHA 37.**

18 THE COURT: Any objection?

19 MR. THOMAS: Your Honor, I think I'd like for Ms.
20 Crum to lay a little bit more foundation.

21 MS. CRUM: Sure. I'm happy to Your Honor.

22 THE COURT: Okay.

23 MR. THOMAS: I just don't know.

24 MS. CRUM: Happy to do that.

25 **Q: Ms. Smith, you said that you developed this.**

1 Can you tell the Court where you got this
2 information?

3 A: I got this information from the slides we just
4 looked through from that CON back fill,
5 preliminary backfill, for the 52 and 29-bed --
6 those graphics that we looked at.

7 Q: And that was the backfill plan that was
8 produced to MU -- to the Petitioners and you
9 were questioned on in your deposition, correct?

10 A: Yes, ma'am.

11 Q: I would now move to introduce it.

12 MR. THOMAS: Is it a summary, Liz, of the back fill
13 plan?

14 MS. CRUM: Yes, it's a summary of the back fill
15 plan.

16 MR. THOMAS: Are you going to move the back fill
17 plan in?

18 MS. CRUM: I already did it.

19 MR. THOMAS: Oh, you already did. MUHA 89 is
20 evidence? THC 89?

21 MS. CRUM: Yeah, I just moved again and nobody
22 objected.

23 MR. THOMAS: That was -- you referenced a different
24 document.

25 MS. CRUM: I'm sorry. I should have moved to

1 introduce MUHA 189, Your Honor.

2 MR. THOMAS: No, 89.

3 MS. CRUM: TMC 189. 89.

4 THE COURT: Yeah, there you go. 89. All right.

5 Now how about the one we've already just
6 introduced? Is that one staying in? Is that
7 an accident?

8 MS. CRUM: I don't know what it was.

9 MR. THOMAS: 145 is the perinatal ...

10 MS. CRUM: Yeah. That is the Shawn Jenkins.

11 THE COURT: That's it. So it's in.

12 MR. THOMAS: I have no problem with that, Your
13 Honor.

14 THE COURT: Okay. So it stays in.

15 MR. THOMAS: Okay.

16 THE COURT: Now 89.

17 MS. CRUM: 89. Yes, sir. Sorry about that.

18 THE COURT: What's your position?

19 MR. THOMAS: My position is that yes, I want that
20 in.

21 MR. SHOUN: No objection, Your Honor.

22 MR. WICEVIC: No objection.

23 THE COURT: Then it's admitted.

24 (TMC Exhibit 89 is admitted into evidence at this
25 time.)

1 MS. CRUM: All right. So now let's go back to 37.

2 MUHA 37. It's a summary. And I move to admit
3 the summary of the information that was shown
4 on 89.

5 (MUHA Exhibit 37 was referenced at this time.)

6 THE COURT: All right.

7 MR. THOMAS: As long as it's consistent and it does
8 appear to be except for the -- here's the
9 problem. We got potential rooms, Your Honor,
10 on that fifth column. See where it says
11 potential rooms? And I'd ask this witness if
12 she'd done any studies about potential rooms
13 and she said no. This looks like it is a
14 study. I've never seen it before. And all of
15 this would have been done after her deposition.
16 So I'm a little concerned about that because
17 I'd like to see, you know, the underlying
18 documentation for it.

19 THE COURT: All right. Ms. Crum?

20 MS. CRUM: Your Honor, this is in fact a summary and
21 if you look at the asterisks where it says
22 potential room, that one asterisk? It requires
23 extension renovation, current configuration
24 will require new rooms toilets. That's what --
25 those were the areas that she was talking about

1 on the NICU PICU, and, Your Honor, we actually

2 ---

3 MR. THOMAS: What, what, what ---

4 MS. CRUM: Excuse me just a second.

5 THE COURT: How about if she just explains that?

6 MS. CRUM: I'm sorry, Your Honor?

7 THE COURT: How about if we just get her to explain.

8 MS. CRUM: Surely. And we did produce it to them as
9 a trial exhibit as RFA 3908 on October the
10 25th.

11 THE COURT: Okay.

12 MS. CRUM: So, yes, sir, I'll get her to explain it.

13 **Q: Ms. Smith, would you please explain this**
14 **summary to the Judge?**

15 **A: Okay.**

16 THE COURT: And you don't have to go through the
17 whole thing, just the potential rooms is what's
18 the debate.

19 MS. CRUM: Oh, all right, sir.

20 **Q: Would you just explain the potential rooms?**

21 **A: The rooms -- the area -- the column that says**
22 **potential rooms just identifies the locations**
23 **that are shown on -- they're the areas that are**
24 **listed as vacant on those diagrams that we just**
25 **looked through and then the qualifications**

1 about those areas in terms of whether they
2 would easily convert to a patient room. So for
3 example on 5C there's an area that was former
4 nursery space that in my rough guess would --
5 could convert to eight beds but it would
6 require quite some renovation. That coral
7 color just explains that it would require
8 separate rooms being created and the addition
9 of toilets. Similar responses to the areas
10 that are currently neonatal ICU, pediatric ICU
11 and special care nursery spaces on the eighth
12 floor of the children's hospital. Those areas
13 are large open areas now and, you know, we just
14 kind of spit balled the number of rooms that
15 could be created if you were to subdivide those
16 spaces into patient rooms. This is really in
17 response to the claim that we could get 128
18 beds so we were trying -- I was trying to see
19 if I could get to 128 beds at the existing
20 hospital.

21 MR. THOMAS: Your Honor, so I would object to the
22 entry of this document with the potential rooms
23 columns because I just heard two terms that are
24 not what I would call reliable. Spit ball and
25 a rough guess. And I just think that, you

1 know, they had plenty of time to retain this
2 witness to do a study. It's exactly why I
3 asked the question if she had done -- at her
4 deposition if she had done any studies to
5 determine how many patient rooms we can get.
6 Now she's on the stand rough guessing and spit
7 balling.

8 MS. CRUM: Your Honor, I'm very happy to withdraw
9 it.

10 THE COURT: Okay.

11 MS. CRUM: Very happy.

12 **Q: Now, Ms. Smith, you heard Mr. Thomas ask about**
13 **doing a study to determine how many rooms could**
14 **be -- maximized rooms could be used. If you**
15 **did a study and tried to maximize the number of**
16 **rooms, first off ---**

17 **A: Uh-huh.**

18 **Q: --- would that study have to be -- would you do**
19 **them at the standard of care today?**

20 **A: Yes, you would.**

21 **Q: And why?**

22 **A: Because that's what today's customers are**
23 **requesting.**

24 **Q: Well would you have to do sufficient renovation**
25 **that you would have to bring it up to code?**

1 A: Yes, you would.

2 Q: What is the requirement on the 6116 that
3 triggers you to have to bring a facility up to
4 code or part of a facility?

5 A: Again it's that percentage of renovation that's
6 required.

7 Q: Okay. And what is that percentage?

8 A: 50 percent. And that's no so much in DHEC 61-
9 16 as in the International Building Code, the
10 existing Building Code.

11 Q: And does the 61-16 adopt the International
12 Building Code?

13 A: Yes, it does.

14 Q: So is it then a part of 16?

15 A: Yes, ma'am.

16 Q: Okay. Now let's go back to -- let's go back to
17 Trident 89.

18 (TMC Exhibit Number 89 was referenced at this time.)

19 Q: All right. Now on -- let's look -- let's go to
20 the next page, please, ma'am. If I remember
21 your testimony -- and certainly correct me if
22 I'm wrong -- how many beds out of those 52 beds
23 in green are currently planned to be utilized
24 under the 52 bed CON application?

25 A: 25 beds.

1 Q: Okay. And your testimony those were larger
2 rooms?

3 A: Yes, they are.

4 Q: What renovation had to be done again?

5 A: Not as extensive renovation because they're
6 already individual rooms.

7 Q: And would those have that area have to be
8 brought up to code with the renovation cost be
9 50 percent?

10 A: Again we'd have to double check to see how
11 extensive the renovations are but I believe
12 this is a fairly easy renovation project.

13 Q: Now go to the next slide, please. This is the
14 fourth floor and the back fill plan does that
15 suggest building eight ICU beds out of the 52
16 beds ---

17 A: Yes, it does.

18 Q: --- in there? Does that require a significant
19 renovation?

20 A: It looks to me like it would require
21 significant renovation.

22 Q: You said it looks like to you. In your
23 opinion, you professional opinion, do think it
24 will require significant renovation?

25 A: Yes.

1 Q: Do you think DHEC would require that area to be
2 brought up to code based on your experience?

3 A: Yes.

4 Q: Okay. So let's go to the next one. University
5 Hospital -- okay, under the backfill plan that
6 there would be eight utilized beds for the ICU
7 out of the 29-bed; is that right?

8 A: Over on the upper right, yes.

9 Q: Okay. You know, I should have asked you this
10 first. What is the University backfill plan?

11 A: The University backfill plan as I -- as I
12 understand it is to utilize as much of the area
13 as possible while still maintaining their
14 strategic mission.

15 Q: Okay. Under the plan did they reserve areas
16 for other uses?

17 A: Yes. They are reserving areas. Their ultimate
18 goal is to -- to relocate the balance of the
19 beds of the hospital to the west side of campus
20 in a replacement hospital and then utilize the
21 existing University Hospital and Children's
22 Hospital as non-inpatient use and further
23 University use. And we ---

24 Q: When you say University use what -- are you
25 talking ---

1 A: Educational type ---

2 Q: Okay, thank you.

3 A: --- spaces.

4 Q: All right. I didn't mean to stop you. Go
5 ahead with that ---

6 A: That's okay, I forgot.

7 Q: Okay.

8 A: I forgot what the question was.

9 Q: Why don't we -- okay, let's move to -- very
10 quickly here, 36, MUHA 36. Do you recognize
11 this?

12 (MUHA Exhibit Number 36 was referenced at this time.)

13 A: Yes, I do.

14 Q: Go on to the next page, please. MUHA 39 4.
15 Did you do this ?

16 (MUHA Exhibit Number 39 was referenced at this time.)

17 A: Yes, I did. This is a comparison of patient
18 rooms sizes for the former Children's Hospital
19 and several other projects in the area that
20 have been done since that was constructed.

21 Q: Let me ask you, since the -- you said the
22 former Children's Hospital. Is it still the
23 extent Children's Hospital?

24 A: Yes, it is for another month or so.

25 Q: Okay. Thank you. Now where did you get the

1 information for the MUSC park bed room size?

2 A: That's a project that LS3P worked on in 2003
3 and on through 2008.

4 Q: And so you got that from your work papers?

5 A: Yes, but it's also in their CON application.

6 Q: Okay. Thank you. And in the MUSC Shawn
7 Jenkins Children's Hospital where did you get
8 that information?

9 A: From the CON application.

10 Q: And the MUSC -- let me go -- skip on that one
11 to Trident Berkeley Medical Center, where ---

12 A: From their CON application.

13 Q: Okay. Now what is the only hospital that has
14 patient room sizes that don't need a standard
15 of care for today?

16 A: The Children's Hospital.

17 Q: And you've already testified that not all of
18 the rooms don't need it, but that ---

19 A: That's correct.

20 Q: Okay. Now let's look at the patient rooms on
21 page 30 905. Explain to the Judge the existing
22 aren't rooms where versus the existing
23 children's room.

24 A: This is really meant to show the extreme
25 comparison between the 280 square foot or

1 Ashley River Tower patient rooms which are at
2 280 square feet versus the roughly half its
3 size children's rooms and also to help you see
4 the amount of space that's required in order to
5 provide that more modern standard of care so
6 that there is a zone just inside the door of
7 the room for the clinician who's coming in the
8 room to do their work. There's plenty of
9 circulation space around the bed itself.

10 There's storage space for -- for belongings and
11 then there's a zone up at the window area that
12 is a family zone. We have another slide I
13 think that shows the restrooms.

14 Q: Yes. Let's go to 3906.

15 A: Sorry, if you go back within the Children's
16 Hospital rooms if you imagine the footprint of
17 that, that patient bed duplicated over in the
18 children's room itself you will see that -- how
19 tight the circulation is around that and how
20 little room the family and the clinician have.

21 Q: When you say in the children's room were you
22 talking about the existing children's room?

23 A: Yes.

24 Q: Okay.

25 A: The existing children's room.

1 Q: Let's look on over to the next page, 3096.

2 Tell the Judge what this shows.

3 A: This is a comparison of toilet and shower sizes
4 for various projects. Do want to note as an
5 asterisk that the FGI guidelines which we
6 talked about earlier now require that
7 handwashing be in both the patient toilet and
8 in the patient rooms. The children's -- the
9 former children's hospital that typical patient
10 toilet size is 30 square feet. It has no
11 toilet -- no sink in that toilet room so those
12 spaces that required be brought up to the
13 current code would be required to have a sink
14 added into the space or somehow squeezed in.
15 The other spaces are in the art project in
16 Berkeley, the Berkeley plans and the Trident
17 Berkeley project which is listed as relative
18 square footages that are on those CON
19 applications. Another wrinkle to this is that
20 the standards -- the standard radius ---

21 Q: Let's go to the next page, please, ma'am.

22 A: Okay. Yeah.

23 Q: 3907.

24 A: This is a comparison again of the Children's
25 Hospital toilet room space and then what would

1 be required in a modern toilet room. That
2 diameter -- five foot diameter versus -- not
3 radius, diameter -- circle -- that dimension
4 has also recently changed. It's been increase
5 as wheelchairs are getting wider and more
6 accommodations need to be made. They are
7 certainly many more layouts that are
8 appropriate but this was one of the -- one of
9 the ones just to compare to see how much extra
10 space is actually needed.

11 Q: Do you -- excuse me -- have an opinion as to
12 whether or not the toilets in the Children's
13 Hospital -- the large majority of them don't
14 need the standard -- today's standard of care?

15 A: That's correct.

16 Q: Okay. Now let's look at MUHA 35.

17 (MUHA Exhibit Number 35 was referenced at this time.)

18 Q: No, let me go back just a minute real quickly
19 here. Based on the current industry standards
20 -- best practice or standards of care -- do you
21 have an opinion as to whether the 128
22 additional beds should be put into service in
23 the space vacated by the beds moved to
24 accommodate these?

25 A: I don't think that's the best use of MUSC's

1 resources.

2 Q: Do you have an opinion from an architectural
3 standpoint as to whether based on current
4 industry practice or standards of care the 128
5 beds should be put into service at the space
6 vacated by the beds moved to Shawn Jenkins?

7 A: Professionally I don't think that the standard
8 of care would be met by trying to squeeze those
9 patient rooms into the existing hospital. The
10 services are spread out over many different
11 parts of the hospital so cohesive nursing units
12 would not be provided. The existing room sizes
13 are inadequate to appeal to the patients and
14 their family members. There are many
15 challenges to the construction of that area and
16 I believe that the cost would be fairly
17 comparable. One of the main concerns about
18 providing -- about squeezing those 128 beds
19 into the -- into the facility -- would be that
20 none of the additional services -- the actual
21 clinical services, the therapies and the
22 radiology and all of that, would, you know,
23 that incremental increase in the services would
24 not be provided; you would simply be taxing the
25 services that are already in place. It would

1 also affect -- the parking needs are already
2 taxed -- parking environment in the downtown
3 location and many other -- many other issues
4 like that.

5 Q: Let me ask you, you mentioned the patients, if
6 you squeezed -- using your term -- the word --
7 the beds into the existing facilities, would
8 there be issues with the caregivers being able
9 to provide care?

10 A: I think we would have to essentially demolish
11 for example three patient rooms to create two
12 patient rooms which is a certainly more
13 involved renovation project than simply moving
14 into those vacated rooms as they are, and
15 whenever you are doing renovations inside the
16 hospital you have to think about the care of
17 the patients who are adjacent to it to the
18 renovation project to the spaces below and
19 above that, to the noise levels, the dust, the
20 infection control measures need to put in place
21 and those sorts of things. I do think that the
22 renovation work would also take a lot longer
23 because of the extended phases that would be
24 required and I just -- those are some of my
25 concerns.

1 Q: In your -- are they your concerns or your
2 professional opinion?

3 A: My professional opinion.

4 Q: Okay. In your professional opinion is
5 squeezing 128 beds into the existing downtown
6 hospital a superior alternative to building a
7 new hospital at Nexton?

8 A: It's not. It doesn't fall within the strategic
9 plan that MUSC has to provide more acute care
10 downtown and less acute care out in the
11 community where the patients are living.

12 Q: Okay. Irrespective of MUSC -- MUHA's strategic
13 plan, ---

14 A: Uh-huh.

15 Q: --- from your professional architectural plan -
16 - opinion -- is it more -- is it a superior
17 alternative to squeeze the beds in downtown as
18 opposed to building a new facility at Nexton?

19 A: It's not a superior plan to put them in the
20 existing space.

21 Q: Okay. Let me just real quickly and then we're
22 right at the end here, ask you about parking.
23 Let's look at MUHA 35. I think you'd already
24 mentioned parking. Does MUHA comply with --
25 have to comply with the Charleston off street

1 **parking requirements?**

2 **A: Yes, they are required to meet that -- those**
3 **ordinances.**

4 MS. CRUM: Your Honor, I'm going to ask that the
5 Court take judicial notice of Charleston's
6 Zoning Ordinance part 4, Off Street Parking
7 Requirements.

8 THE COURT: Any objections?

9 MR. THOMAS: No objection to the law.

10 MR. SHOUN: Same position, Your Honor.

11 MR. WICEVIC: No objection.

12 **Q: Now, Ms. Smith, did you prepare this Exhibit?**

13 **A: Yes, I did.**

14 **Q: What infor- -- turn onto to the next page,**
15 **please. What information did you use to**
16 **prepare this Exhibit?**

17 **A: I received information from John Ruynon who is**
18 **the Director of Business Services for MUSC.**

19 **Q: Did he provide you with the MUHA parking space**
20 **types and memberships ---**

21 **A: Yes, he did.**

22 **Q: --- as of October 1st?**

23 **A: Yes, he did.**

24 **Q: Okay. And did he provide you with the**
25 **transportation by quarter information?**

1 **A:** Yes, he did.

2 **Q:** Did he provide you with parking changes after
3 the 2020 changes?

4 **A:** Yes, he did.

5 **Q:** Did he provide you with the impact of
6 additional -- of the additional 5229 bed CON?

7 **A:** He did not do that. We did those calculations
8 based on the number of beds and the FTEs that
9 you provided.

10 **Q:** Was ---

11 **A:** So it was a combination.

12 **Q:** Let me ask this, you said since 5229 bed CON
13 parking, is that where the information came
14 from?

15 **A:** Yes.

16 **Q:** Okay. And then the combined bed needs post-
17 2020, the downtown beds, did you get that
18 information from Mr. Ruynon?

19 **A:** We did these calculations based on the city
20 zoning requirements.

21 **Q:** Okay. Great. Now let's go back here. Do you
22 have an opinion as to whether or not MUHA if
23 they put the additional 29 beds, 52 beds, and
24 the 128 beds anywhere on the MUHA campus, do
25 they have sufficient parking to meet the

1 parking requirements for the city?

2 A: They do not currently have the parking needs
3 met ---

4 Q: When you say ---

5 A: --- for that additional -- for those additional
6 beds.

7 Q: Just quickly here would you explain -- quickly
8 explain to the Judge what page 3897 is? What
9 it represents?

10 A: This is a breakdown of -- I believe they have
11 55 different locations where there are parking
12 spaces ranging from small lots with four spaces
13 to their large parking lot ---

14 Q: Let me say -- you said you believe they have
15 55. Do you know ---

16 A: I was told there are 55.

17 Q: Okay, and who told you?

18 A: Mr. Ruynon.

19 Q: Okay.

20 A: And it also breaks down the ownership of those
21 parking spaces whether they are owned by MUSC
22 or any of its affiliates, so that's called the
23 MUSC Enterprise. There are some leased parking
24 spaces that are owned by others, and then it
25 also categorizes the type of person using the

1 parking spaces from employee to student to
2 patient visitor to service vehicles and then it
3 identifies those that are leased out to Roper
4 and to the county government.

5 Q: And am I correct that MUSC currently has access
6 to 9,383 spaces?

7 A: Yes, ma'am.

8 Q: Let's go to page 3898. Does this -- tell the
9 Court what this depicts.

10 A: This is the number of people who are riding
11 buses to the MUSC campus area. There are
12 several bus stops at MUSC. The Carta Express
13 route are coming in from remote parking lots.
14 For example on James Island or Mount Pleasant,
15 and that ridership is 450 daily. And then
16 there are Carta service routes so those would
17 have been the normal routes that the public bus
18 system runs that are also dropping off riders
19 at the MUSC campus stops. There is an estimate
20 that about 55 percent of those riders are MUSC
21 or MUHA employees. The balance is likely to be
22 Roper employees or VA employees or folks who
23 work in the general vicinity of MUSC.

24 Q: And where did you get the estimated 55 percent?

25 A: I got this again from John Ruynon.

1 Q: Now explain the parking changes after 2020.

2 A: There are a number of leases that are in flux
3 at this point in time, and as of 2020 they
4 expect to lose roughly 210 spaces. Other
5 things to note are that the development just to
6 the north of the medical district in the west
7 edge initiative is expected to take away
8 additional parking spaces that MUSC relies on
9 and they feel like they will likely lose up to
10 roughly 1,140 spaces in the next two to five
11 years. Likewise they will also lose spaces as
12 they have sold the Harborview Tower and garage
13 where they also rely on spaces. So they
14 anticipate that just in order to keep up with
15 the existing square footage and services on the
16 campus that they will need close to 1,400
17 spaces, you know, as of 2020.

18 Q: And let's just quickly look at 3900. Does that
19 show the impact of the 52 and 29 bed parking at
20 MUHA?

21 A: It does. It ---

22 Q: And how many are, at a minimum, would be
23 needed?

24 A: Based on my calculations, 390 would be needed.

25 Q: Okay. And let's look at the impact on page

1 **3901. The impact of a 128-bed facility**
2 **downtown. The parking needs -- how many --**
3 **where did you get this information?**

4 **A: This again, is from the City zoning**
5 **requirements and this is based on a full, the**
6 **full CON program, so it would include all of**
7 **the services that would not be able to**
8 **accommodated in the Children's Hospital and**
9 **University Hospital if we were forced to do**
10 **that route.**

11 **Q: Would this be based on building a new hospital**
12 **on the MUSC campus?**

13 **A: Yes, it would.**

14 **Q: Okay.**

15 **A: Based on that, the one per bed for the 128 beds**
16 **plus the FTE numbers that were provided by MUSC**
17 **and also -- and those numbers were reduced**
18 **slightly since in this case there would be**
19 **fewer administrative type positions that would**
20 **need to be on campus, and the treatment rooms,**
21 **50 treatment rooms at 1.5 spaces per treatment**
22 **room would lead to roughly 750 spaces that**
23 **would be required for that as well.**

24 **Q: And the combined need, this 2526, is that the**
25 **additional bed need that MUHA would have?**

1 **A:** The 2526 would be the added between what they
2 would need for the West Edge development, the
3 Harbor View tower placement, replacement and
4 the 5229 beds and also a full downtown hospital
5 at 128 beds. So that would leave them with a
6 shortage of about 2500 parking spaces that
7 would need to be provided.

8 **Q:** Does -- on downtown campus, does MUHA have to
9 go through the Board of Architectural Review,
10 the technical review and the design review
11 committees?

12 **A:** Yes.

13 **Q:** Is that a process in Charleston?

14 **A:** Yes, it is.

15 **Q:** Is it a difficult process?

16 **A:** It is. Particularly the Board of Architectural
17 Review weighs in very heavily. We want to make
18 sure that the buildings look very nice from the
19 exterior. That typically for particularly, you
20 know, this looks like it would be a parking
21 garage. That really increases the cost of
22 building the garage. Whereas, in some areas,
23 you might get away with building a parking
24 garage for \$12,000 per space, in the City of
25 Charleston it's likely that those costs would

1 be upwards of \$30,000 or even higher per space.

2 Q: And you say it's likely that those costs would
3 be, what was it you said, 30,000 ---

4 A: \$30,000 higher per space.

5 Q: What is -- what do you base that on?

6 A: Historical information.

7 Q: Do you also base that on your experience?

8 A: Yes, in our experience.

9 Q: Okay.

10 A: In the Firm's experience.

11 Q: Okay. All right. In your professional
12 opinion, based on current industry best
13 practices or a standard of care, the City
14 parking requirements, do you have an opinion as
15 whether or not the 128 beds should be put into
16 services anywhere on the MUHA downtown campus
17 either in the existing towers or in a new
18 hospital?

19 A: I do have an opinion.

20 Q: And what is that?

21 A: In my opinion, the downtown campus is not the
22 location for this 128-bed addition in that it
23 doesn't confirm to their, to MUSC's long-range
24 plan, the spaces within the existing hospital
25 are not conducive to being easily implemented

1 as the 128-bed need is filled, nor I there
2 adequate space to provide the added services
3 incrementally to the existing services, and the
4 parking challenges, the flooding challenges,
5 the added cost of the Board of Architectural
6 Review, and particularly for the renovation
7 concept. I believe that the construction
8 phasing will drag out the time line for the
9 entire project as well.

10 Q: Okay.

11 MS. CRUM: Your Honor, I think I forgot to move
12 admission of MUHA 36, it's the room size, the
13 square footage and it showed the rooms and the
14 toilets.

15 MR. THOMAS: I don't have any objection with the
16 patient room size, Your Honor.

17 MS. HOLLINGSWORTH: No objection.

18 MR. WICEVIC: No objection.

19 MR. THOMAS: I would on the parking.

20 THE COURT: 36 is admitted.

21 (MUHA Exhibit Number 36 was admitted into evidence at
22 this time.)

23 MS. CRUM: All right, sir. And I'm going to move to
24 admit the MUHA 35, the MUHA downtown -- MUSC
25 MUHA downtown parking.

1 MR. THOMAS: I object. I think maybe she used it as
2 demonstrative. Let me tell you why, Your
3 Honor. I think she mentioned a buy named John
4 Runyon and I'm pretty sure that she never met
5 Mr. Runyon, I don't think she ever talked to
6 Mr. Runyon. The -- she referenced many leases
7 and that type of information which I don't
8 think were produced, all the different parking
9 leases. I don't know whether John Runyon spit-
10 balled or rough guessed the number of spaces
11 that they have at MUSC downtown. She didn't do
12 a thorough study on this; she just took
13 something from the Director of Business
14 Development who she never met before. She got
15 this on the day of her deposition, by the way.
16 And now she's put it in this form and I just
17 don't think that's proper or it's reliable
18 evidence, Your Honor.

19 MS. CRUM: Your Honor, in the first instance, Mr.
20 Runyon collects this data, he's in charge of
21 this, this is what he does in the daily course
22 of his business. This is the kind of data that
23 an expert routinely relies on.

24 THE COURT: Well, here's my problem. Number one,
25 both of the things he just said I haven't heard

1 from the witness. On the other hand, you
2 didn't object when she was testifying about
3 Runyon and that evidence all came in, of which
4 I was thinking to myself, I guess that you were
5 not objecting because it's something that she
6 would commonly rely on to formulate an expert
7 opinion. So, that's my struggle now, is ---

8 MR. THOMAS: It's more, but she used it as a
9 demonstrative and that's what she did. But I
10 think it's hearsay, Your Honor. I don't know
11 that it's the type of evidence that an
12 architect would rely on and that it would be
13 admissible. I don't know what the perception
14 of it involves ...

15 MS. CRUM: Your Honor, my memory may be faulty, but
16 I am quite confident -- well, it's not faulty
17 on this part. It's faulty on other stuff, but
18 in the deposition and as part of the exhibits
19 that we gave to the Petitioners in this case,
20 we had a memo from John Runyon and it even
21 talked about different dates. And so they've
22 known about John Runyon since we took Ms.
23 Smith's deposition. This isn't a surprise.
24 It's the type of information normally relied on
25 by a person of -- whose position is to deal

1 with this information. And also -- excuse me,
2 Your Honor, even if I've used it as a
3 demonstrative, it's certainly something that we
4 could admit now. But they've had this since
5 October the 25th ---

6 THE COURT: Right.

7 MS. CRUM: --- and this is the first problem we've
8 heard about it.

9 THE COURT: Well, just because they knew about it
10 doesn't mean they don't -- they're not entitled
11 to object. But I'll tell you what, I'd like to
12 hear the foundation that she is an expert, she
13 ---

14 MS. CRUM: I'm sorry, my ears are stopped up.

15 THE COURT: I'd like to hear the foundation that as
16 an expert she commonly relies upon this data.

17 MS. CRUM: All right, sir.

18 **Q:** Ms. Smith, when you are working with hospitals
19 and you have to deal with issues like parking,
20 where do you get your information?

21 **A:** We get that information from whoever is in
22 charge of the parking services for that campus.
23 It's almost in every case whenever we are
24 dealing with a medical campus or a university
25 campus, there is enough data that the parking

1 -- whoever is in charge of parking has on hand
2 to provide that data. We don't literally go
3 out and count each individual space. However,
4 I also have reviewed another parking analysis
5 that was done professionally by another
6 consultant as well and those numbers match
7 very, very closely to the figures that Mr.
8 Runyon provided. And for clarification, he's
9 the Director of Business Services, not business
10 development.

11 Q: And does Business Services -- first off, have
12 you had conversations with Mr. Runyon?

13 A: Yes, I have.

14 Q: Okay. Does Business Services include parking,
15 to your knowledge?

16 A: Yes, it does at MUSC.

17 MS. CRUM: Your Honor, I would renew our motion.

18 THE COURT: Okay.

19 MS. CRUM: I don't mean motion.

20 THE COURT: What's your position now, your request?

21 MR. THOMAS: You know, Your Honor, I don't think she
22 has talked to Runyon by the time I had actually
23 deposed her. So I think this is information
24 that came from the McNair Law Firm at that
25 time. Perhaps there was an email she received.

1 I'm trying to go back and look at this. Your
2 Honor, I just ...

3 THE COURT: Well, you've got to state your position,
4 too.

5 MS. SHOUN: It is my position, Your Honor. During
6 the deposition that was taken on October 1st of
7 this year. At that time, Ms. Smith testified
8 she had not requested this information from Mr.
9 Runyon. She wasn't -- I think she said she
10 wasn't sure, but that it came from counsel for
11 MUHA. She had not talked to Mr. Runyon, she
12 was not clear on what he had done to reach
13 these conclusions or gather this information.
14 In the documentation that she was presented
15 with that day, which we saw that day, there is
16 a reference in there to a memorandum which Ms.
17 Crum just mentioned. I asked, specifically,
18 where is that memorandum. We don't have the
19 memorandum. Ms. Crum indicated she would try
20 to find it and produce it. To this point, we
21 don't have that memorandum. So we, again, as
22 Mr. Thomas said earlier, this is information we
23 took this individual's deposition who had been
24 designated to testify in these areas, in that
25 role, on the 1st of October. I think it's a

1 reasonable expectation that at that point she
2 would be ready to offer her expert opinions and
3 conclusions. And any that may have been formed
4 afterward, it would have been the proper
5 approach to them provide us with that
6 information, not present it to us days before
7 this trial began.

8 THE COURT: All right.

9 MS. CRUM: Your Honor, the memorandum was the email.
10 I mean, you know, some people use words
11 loosely. We produced everything we've gotten
12 from Mr. Runyon. Now, in fact, we gave that to
13 Ms. Smith that day that she was driving up here
14 ---

15 THE COURT: When you say you produced it, you
16 produced it to ---

17 MS. CRUM: Yes, sir. We produced it that morning
18 when we got it at her deposi- -- actually we
19 might have given it to you a little bit before
20 the deposition, but it could have been at the
21 deposition. I don't remember, frankly.

22 MS. SHOUN: And, Your Honor, the memorandum, Ms.
23 Crum said, is an email. Actually, what Ms.
24 Crum represented at the time of the deposition
25 -- I've got the transcript here -- is she

1 thinks the information that was included in the
2 memorandum referenced by Mr. Runyon was cut and
3 pasted into an email, and by the way, there's
4 an agreement between the parties that they
5 don't search and produce emails. And to my
6 recollection, even at the time of the
7 deposition on October 1st, we received not only
8 information which is hearsay within hearsay as
9 to the CARTA. We didn't get any of that.

10 MS. CRUM: We're gonna let you win. We're not gonna
11 argue about it any more. So.

12 THE COURT: I want to take a two-minute break, so
13 don't go anywhere, just to think about this.

14 (Off the record)

15 THE COURT: Can you respond to one thing for me?

16 MR. THOMAS: Yes, sir.

17 THE COURT: This appears to be -- I don't have the
18 Exhibit memorized. Y'all have a better grasp
19 of it than I, but it appears to be a
20 compilation of that which she's already
21 testified to. And that's -- other than that,
22 I would rule for you, but that's my struggle
23 right now. If you would respond to that
24 comment.

25 MR. THOMAS: Well, I guess, Your Honor, what I would

1 say is, my thought was this to be a
2 demonstrative. It's based on other things and
3 the other things aren't in the record. So I
4 don't know if it would be proper ---

5 THE COURT: Well, when you say some other things,
6 are there ---

7 MR. THOMAS: --- based on Mr. Runyon's documents
8 that are in the record.

9 THE COURT: I'm sorry, I didn't hear you.

10 MR. THOMAS: Mr. Runyon, the Director of Business
11 Services ---

12 THE COURT: That's what I'm getting at. Were there
13 other things in this document that she did not
14 testify to already?

15 MR. THOMAS: I think there may be some. The thing
16 that I think -- none of the underlying
17 documents for this document are in evidence,
18 and so it's not a summary of anything.

19 THE COURT: Well, that's true. All right.

20 MS. SHOUN: What you said, Your Honor.

21 THE COURT: This is a close one. And the problem is
22 I think I'm going to let it in, but for the
23 CARTA data. That just ---

24 MS. CRUM: And that's fine, Your Honor.

25 THE COURT: That should come out. So whatever else

1 is left.

2 MR. THOMAS: Thank you, Your Honor.

3 MS. CRUM: Which we'll -- we'll prepare a new
4 Exhibit or everybody can tear that page out.

5 THE COURT: Yeah. What page?

6 MS. CRUM: It's 30 898.

7 THE COURT: Okay. It's admitted san 30 ---

8 MR. THOMAS: 898.

9 THE COURT: --- 898.

10 (MUHA Exhibit Number 35 was admitted into evidence at
11 this time.)

12 MS. CRUM: We'll send an email copy so y'all would
13 have the email copy directly.

14 THE COURT: Okay. All right.

15 MS. CRUM: Your Honor, that's -- I want to make
16 sure, but I think that's all we have of Ms.
17 Smith. That's all we have of Ms. Smith, Your
18 Honor.

19 THE COURT: All right.

20 MS. SHOUN: May it please the Court, Your Honor.

21 MS. SMITH: I would like to go to the restroom.

22 THE COURT: Yeah.

23 (Off the record)

24 MS. SHOUN: May it please the Court, Your Honor.

25 THE COURT: Yeah. How long are y'all going to go?

1 It's 5:43 now.

2 MS. SHOUN: I'm terrified to make an estimation at
3 this point.

4 THE COURT: Yeah. Everybody has been so wrong?

5 MS. SHOUN: Exactly.

6 MR. THOMAS: Mine will kind of depend on hers and
7 what ground she covers. We didn't really get
8 together, but I can ---

9 THE COURT: Well, can we get through say around 7?

10 MS. SHOUN: And it's what time?

11 MR. THOMAS: It's 5 ---

12 THE COURT: 5:43.

13 MS. CRUM: Can we mostly get through Roper by then?

14 THE COURT: I'll tell you what. Let's just do at
15 least one Cross and then we'll see where we
16 are.

17 MR. THOMAS: Okay, sure.

18 THE COURT: So have at it.

19 MS. SHOUN: And actually that might help narrow it
20 down what we want as ... May it please the
21 Court.

22 MS. SMITH - CROSS-EXAMINATION BY MS. SHOUN:

23 **Q: Ms. Smith, would you agree with me that you --**
24 **your firm was hired to assist MUHA in the**
25 **proposed Nexton site as early as January 2017?**

1 **A:** **No, not January 2017.**

2 **Q:** **If I represent to you that there's a letter to**
3 **Tom Steiber from Mark Marchant with LS3P**
4 **Associates dated January 23rd, 2017, would that**
5 **perhaps refresh your memory?**

6 **A:** **That might, but as I recall, the project**
7 **programming efforts started later in the year.**
8 **So it may be that Mr. Marchant sent him a**
9 **letter, but the project work did not begin**
10 **until much later.**

11 **Q:** **Yes, ma'am. My question was could it be that**
12 **your firm was hired as early as January 23rd,**
13 **2017?**

14 **A:** **It could be.**

15 MS. CRUM: Your Honor, if she would show her, the
16 witness ---

17 MS. SHOUN: Sure.

18 MS. CRUM: --- the letter she's talking about, it
19 might help refresh the witness ---

20 MS. SHOUN: Be happy to.

21 **Q:** **I'm sorry, all I have it one copy, but I'll be**
22 **happy to show it to you first.**

23 **A:** **Oh, this is actually misdated. This is January**
24 **23rd or 2017, but it should be 2018 and this is**
25 **for the additional services to be covered for**

1 the estimating the coming costs provided for us
2 that was not included in our original proposal
3 letter.

4 Q: So if this is to cover additional, then there
5 was something done before that.

6 A: Yes and that would have been, I believe that
7 started -- and I cannot recall whether it was
8 in the middle of the year or in the fall. I
9 know our project programming efforts really
10 began in the fall of 2017. We were -- because
11 I remember this because we were very grateful
12 that they gave us a reasonable time line for
13 the CON preparation.

14 Q: So if we assume then, based on the your
15 testimony that it started the fall of 2017, it
16 -- you would agree with me then, it's been
17 about two years since your active work began on
18 that.

19 A: Yes, ma'am.

20 Q: Okay. And in that two years, you've done no
21 study as to upfitting what is now the
22 Children's Hospital, what the cost of that
23 would be, have you?

24 A: We were not requested to do a study of the
25 upfit of the existing hospital. I did do some

1 very high-level study work when it was brought
2 to my attention that the claims from Roper and
3 Trident were that the hospital should be put --
4 that the 128 beds should be placed in the
5 existing facilities.

6 Q: And MUHA did not hire you or your firm to do
7 any study about potentially placing a bed tower
8 or double-bed tower on the spot that is
9 currently the wellness center?

10 A: That's true.

11 Q: Okay. And as Mr. Thomas asked you before, no
12 studies as to phase -- to offer opinions on the
13 phasing of construction as it would relate to
14 renovating te current Children's center.

15 A: The opinion I would offer would be based on my
16 history with MUSC in that my firm became
17 acquainted with the master plan, the original
18 mater plan for the MUSC campus back around the
19 early 2000s and as architects in the area, we
20 are very much interested in what is going to
21 happen to the -- what the long-range plan is
22 for MUSC.

23 Q: And you did not study as the current ceiling
24 heights of what is currently the Children's
25 Hospital, did you?

1 **A:** Based on my previous experience in that
2 building, the floor to floor heights are very
3 tight.

4 **Q:** Yes, ma'am. Was there a study?

5 **A:** No study was requested because we were not to
6 be -- we were not requested to look at that ---

7 **Q:** Yes, ma'am.

8 **A:** --- those heights. However, I have that
9 knowledge base because of the previous projects
10 I had worked on in that facility.

11 **Q:** So you recall the photographs that Ms. Crum
12 showed you earlier and that were placed on the
13 screen?

14 **A:** Yes, ma'am.

15 **Q:** Those photographs were taken the day or day --
16 maybe two days before your deposition; do you
17 remember that?

18 **A:** Yes, ma'am.

19 **Q:** And you talked about them being taken with you
20 iPhone; correct?

21 **A:** Yes, ma'am.

22 **Q:** And I think you told us, would you agree with
23 me, in your deposition that you didn't even
24 measure with you, you didn't measure the
25 ceiling height.

1 **A:** No, but I can look at the door frame height and
2 then there are 6 inches above that. At best,
3 that door frame height is 7 feet high, so that
4 would tell me that that corridor ceiling is
5 somewhere around 7-6 or 8 feet in height.
6 Architects do that; we also count ceiling
7 tiles.

8 **Q:** Well, let's talk about the ceiling tiles for a
9 second.

10 **A:** Yes, ma'am.

11 **Q:** Did you remove any of the ceiling tiles to
12 determine what could be placed above them as
13 far as what additional functions may be added
14 to -- may be needed to that space?

15 **A:** No, I did not.

16 **Q:** Okay. And in your photographs, there's lights
17 in the building, is there not?

18 **A:** Yes, there are lights in there.

19 **Q:** So there must be some kind of conduit for
20 electrical services.

21 **A:** Yes, ma'am.

22 **Q:** And the building's sprinkled ---

23 **A:** Yes, ma'am.

24 **Q:** So there must be something that provides water
25 to the sprinkler system, correct?

1 A: Yes, ma'am.

2 Q: And you would agree those are probably all
3 above those ceiling tiles.

4 A: Yes, ma'am.

5 Q: Okay.

6 A: As well as the duct work.

7 Q: Exactly. And when was this -- when was the
8 current Children's Hospital built, to your
9 knowledge?

10 A: It was built in the early '80s, late '70s.

11 Q: Maybe 1982 as I think I saw ---

12 A: Yeah, sure.

13 Q: --- on one of the documents? And since 1982,
14 in your professional opinion as an architect
15 and your history with construction and design,
16 would it be your testimony that you think
17 nothing in the HVA system in that building has
18 ever broken or needed to be replaced or
19 repaired?

20 A: Certainly those facilities have been repaired
21 and maintained.

22 Q: And those would be above the ceiling tiles,
23 would they not?

24 A: Yes, ma'am.

25 Q: Okay. And what you expressed as your concern,

1 your concern about the ceiling height. So we
2 know now that there's water there, there's
3 electricity there, there's HVAC there. Is the
4 Children's Hospital exempt from electronic
5 medical recording records, for the
6 requirements?

7 A: That I'm not familiar with, but the MUSC campus
8 has moved to the electronic medical records,
9 they use Epic and they have implementing those
10 systems.

11 Q: Did you see any computers in use when you were
12 in the Children's Hospital?

13 A: Absolutely.

14 Q: Okay. So you think they could probably get
15 what computer services that it needed in there.

16 A: Certainly.

17 Q: Okay. All right.

18 A: The real concern, of course, is the size of
19 those rooms.

20 Q: Yes, ma'am. Yes, ma'am. And that is a
21 concern, is it not?

22 A: Yes.

23 Q: It's not a Code violation, is it?

24 A: It's not a Code violation, but as any hospital
25 system would like to present itself to the

1 public, it would like to have rooms -- it would
2 like to have accommodations that are friendly
3 and appealing to its customers. I believe
4 Roper and Trident would also agree with that as
5 well.

6 Q: But it doesn't violate any Code?

7 A: No, those rooms are currently in use.

8 Q: Okay. And you said something at the end of Ms.
9 Crum's Direct Examination that the size of the
10 rooms may affect the caregivers. And is it
11 your testimony that the children that are in
12 the hospital now may not be getting adequate
13 care because of the size of the rooms?

14 A: No, they're getting adequate care, but when you
15 move to an adult population, you're gonna have
16 full-size hospital beds in all those rooms; you
17 won't have as many cribs and those sort of
18 accommodations. Although, the photographs I
19 took had hospital beds in there, but there may
20 also be also more patients of larger size;
21 bariatric patients that have larger beds. And
22 the patients in the hospitals are getting to be
23 more sick than we currently see. So as that
24 acuity level ramps up, there's more equipment
25 that's required to be by the bedside for each

1 of those patients.

2 Q: Well, at your deposition, I believe you told
3 Mr. Thomas and I that those were actually full-
4 size beds in those rooms that you photographed,
5 correct?

6 A: The photographs I took did have hospital beds
7 in them.

8 Q: Okay. And talk about the increase in acuity.
9 People are getting sicker; true?

10 A: Uh-huh.

11 Q: Right.

12 A: Those coming to the hospitals, yes.

13 Q: Okay. And it actually the lesser acuity
14 patients that you testified would be going into
15 this space according to MUHA's plan.

16 A: That was the plan for the Berkeley campus, that
17 lesser acui- -- excuse me, I almost swallowed
18 my mint -- lower acuity patients would be in
19 the Berkeley Hospital site.

20 Q: So the higher acuity would be going into this
21 space.

22 A: Their ultimate plan is to focus on higher-
23 acuity care at the main University Hospital.

24 MS. SHOUN: Excuse me, Your Honor. I'm actually
25 getting rid of questions. I apologize for the

1 dead time here. If we can put up MUHA 36.

2 (MUHA Exhibit Number 36 was referenced at this time.)

3 Q: Now, Ms. Smith, do you recognize this document?

4 You identified this document Ms. Crum was
5 asking you questions?

6 A: Yes, ma'am.

7 Q: Okay. And this is a document that represents
8 information that you gathered approximate to
9 room sizes, is that right?

10 A: Yes.

11 Q: Okay. And that on there shows again that the
12 construction at Children's Hospital and you put
13 on there is 1982, the current Children's
14 Hospital.

15 A: Uh-huh.

16 Q: Okay.

17 A: Yes, ma'am.

18 Q: And then would you agree with me that then the
19 next -- let's see, the next largest room on
20 there goes where?

21 A: It's actually the MUSC Berkeley ---

22 Q: Okay.

23 A: --- program.

24 Q: Which is 2018, that's the most recent, is it
25 not?

1 **A:** Yes, it is.

2 **Q:** Okay. And in 2017 the MUSC Shawn Jenkins
3 Children's Hospital drops down to 260, doesn't
4 it?

5 **A:** It increased to 260.

6 **Q:** Okay. You're right. It's going down, it
7 trends downward on this, isn't it?

8 **A:** I think it really is spotty. It really depends
9 on the project itself. The Ashley River Tower
10 project which is the largest size, those rooms
11 were all designed so that they could flex
12 between being an ICU room or a step-down room
13 or a regular patient room, that's called a
14 universal design. And so it's meant that the
15 patient does not have to be moved from one
16 location of the hospital to another and allows
17 the flexibility needed. So that's why those
18 rooms seemed a good bit larger.

19 **Q:** And they're at about 280 spare feet, is that
20 right?

21 **A:** Yes, ma'am. And that's -- they'll accommodate
22 all the equipment again that would be in a
23 higher acuity setting. The 200 square foot
24 bench mark that we use for Berkeley was one
25 that was agreed upon with MUSC. Again, we're

1 trying to keep the square footages for the
2 building down to a modest size, not trying to
3 overbuild.

4 **Q:** Because larger square footage means higher
5 construction costs?

6 **A:** Absolutely.

7 **Q:** Okay. And you have the designation, the
8 leadership in energy in environmental design
9 designation, do you not?

10 **A:** Yes, ma'am.

11 **Q:** Okay. And as an architect but particularly as
12 one that holds this distinction, you would
13 agree with me wouldn't you that larger rooms,
14 unneeded space, is more expensive to maintain?

15 **A:** You want to try to get in the sweet spot, you
16 want to meet the maintenance requirements and
17 but also accomplish the care that is required
18 for the patients and accommodations for the
19 family members.

20 **Q:** Yes, ma'am.

21 **A:** So we're trying to hit right the sweet spot,
22 not to overbuild, but also to have enough elbow
23 room in the space for all the players that are
24 in the rooms. Especially with MUSC being a
25 teaching hospital there are also accommodations

1 that are needed for residents that are also
2 encouraged to round the spaces, so there at
3 many times there are many more participants
4 inside the patient rooms than you might see in
5 a patient -- in a hospital that doesn't have a
6 resident.

7 Q: Yes, ma'am. Would those residents be in the
8 current Children's hospital?

9 A: They would.

10 Q: Okay. And you would agree with me, wouldn't
11 you, that 61-16 thinks that these rooms are
12 adequate size?

13 A: 61-16 lists the minimum ---

14 Q: Right.

15 A: --- requirement.

16 Q: Right. It's acceptable?

17 A: Yeah.

18 Q: Okay.

19 A: It is.

20 Q: And bigger rooms again lead to higher
21 electricity and gas bills, correct?

22 A: It's a balance. The utility costs might be
23 higher, yes. But you're also able to
24 accommodate more patients and their family
25 members and the caregivers in a more

1 accommodating setting.

2 Q: Yes, ma'am. And somebody pays for that extra
3 cost?

4 A: Yes, ma'am.

5 Q: Okay.

6 A: I would like to point out that the University
7 -- the University Hospital and Children's
8 Hospital are located in older facilities that
9 have skyrocketing maintenance costs and the
10 cost of maintaining, I would believe, those
11 older buildings is even higher than maintaining
12 newer buildings that have more efficient energy
13 criteria built into their program.

14 Q: What's the last maintenance cost you've looked
15 at for the MUHA Hospitals?

16 A: I recently saw a study in the -- I recently saw
17 studies that show that the deferred maintenance
18 costs and the utility costs of the hospital
19 system, if they are allowed to progress -- may
20 I?

21 Q: Sure.

22 A: If they are allowed to progress unchecked, if
23 they have costs here that have been slowly
24 going with the increase cost of energy, they
25 are going up. If they don't address these

1 issues that occur, you know, it just -- so what
2 their goal is is to make more efficient
3 buildings and get these bottom line costs down
4 so that they're going up. And that means
5 investing in new buildings, more efficient
6 buildings and reducing some of their physical
7 plant.

8 Q: Yes, ma'am. Just so I understand, are you
9 saying that specifically MUHA or ---

10 A: That's MUHA.

11 Q: Okay.

12 A: That would apply, I would say, generally for
13 costs of most hospitals in the United States.
14 The older facilities cost a lot more to
15 maintain and their energy costs are much higher
16 than the more efficient new energy systems that
17 are available now. Buildings were not required
18 to have the high insulation values, so a lot of
19 that -- a lot of the energy, the heating and
20 cooling that we provide are just simply leaking
21 out into the air.

22 Q: And we were just talking about the size of the
23 rooms in our -- and if I remember correctly you
24 had primary responsibility for the design ---

25 A: Yes, I did.

1 Q: --- or the opportunity I should say, maybe the
2 primary opportunity for the design of the
3 interior part, correct?

4 A: Yes, ma'am.

5 Q: Okay. And I would assume, and think you would
6 probably agree with me, that that was a big
7 project.

8 A: Yes, it was.

9 Q: What was the total cost of the ART project?

10 A: I believe the construction cost for the ART
11 facility itself was around \$256,000,000. I'm
12 just guessing.

13 Q: And I think you described it when you talked to
14 us in your deposition as the job of a lifetime.

15 A: Yes.

16 Q: Now we talked about that sweet spot just a
17 minute ago, the sweet spot to be able to allow
18 the caregivers to give care and for the
19 families to be comfortable, do you remember
20 that ---

21 A: Yes, ma'am.

22 Q: --- just a moment ago? Okay. And that doesn't
23 necessarily mean, does it, that there has to be
24 an art collection in a healthcare facility?

25 A: No, that doesn't mean an art collection is

1 required.

2 Q: Okay. Which ART has?

3 A: Yes. I had no part of that, part of the
4 design.

5 Q: I didn't think that you did. And it also
6 doesn't necessarily mean that patients should
7 be given the opportunity to order room service
8 effectively, right?

9 A: That really depends upon the meal service plan
10 that the facility is designed around.
11 Different facilities do a to order arrangement
12 versus here you have four meal choices and you
13 need to fill out a meal card and everything is
14 delivered at one single time during the day.
15 Many facilities are going to this order as you
16 please based on what's going on with their
17 care.

18 Q: Okay.

19 MS. SHOUN: Beg The Court's indulgence.

20 Q: A parking garage on the peninsula was part of
21 the ART Project, was it not?

22 A: Yes, it was.

23 Q: Okay. And I think you -- I know you testified
24 as to some issues with what you think would be
25 difficulty with parking ---

1 **A:** Yes, ma'am.

2 **Q:** --- if the current children's center were
3 backfilled sufficiently to put in 128, or some
4 larger number of rooms, correct?

5 **A:** Yes, ma'am.

6 **Q:** Okay. Were those parking concerns the same
7 when ART was constructed?

8 **A:** Yes, they were. But they provided a new
9 parking garage in conjunction with the central
10 energy plant as part of the project and also
11 the county garage was purchased so that the
12 parking needs were met.

13 **Q:** Yes, ma'am.

14 **A:** And also parking spaces below the building were
15 provided.

16 **Q:** And the same thing with the Shawn Jenkins
17 Children's Hospital, that new hospital,
18 correct?

19 **A:** I assume so. I was not involved in that
20 design.

21 **Q:** Correct. But the parking would still be an
22 issue.

23 **A:** Yes, ma'am. Again, their -- they must have
24 satisfied the requirements through the city
25 before the permits were allowed.

1 Q: Now I believe you also told us in your
2 deposition that MUHA had not asked you, had not
3 assigned to you, the task of determining
4 whether there was a way to accomplish an
5 alternative hospital on the peninsula, is that
6 correct?

7 A: That's true. It -- you know, they may have
8 been doing these things internally. They don't
9 tell us everything that they're doing.

10 Q: And speaking about doing it internally, you
11 were here for Dr. Cawley's testimony yesterday?

12 A: Yes, I was.

13 Q: Did you hear him speak of a feasibility study
14 that was done internally as to the three phase
15 project or the third of the three phase project
16 anticipated downtown?

17 A: I heard him speak to that. I think they have
18 been doing backfill feasibility studies
19 internally. They have a staff that has been
20 around hospital design so that they could map
21 out those areas that we reviewed for example
22 for the 52 and 29-bed facility. I have seen
23 the Ayers Saint Gross study that I believe you
24 pulled up an image from. In fact that was the
25 diagram that was revealed there on the large

1 size format. That seems to be a further
2 completion of the original master plan, just
3 the redevelopment of it. But that study, in my
4 perusal of it is that it was primarily focused
5 on the education portion of MUSC and had a very
6 light hand on the clinical redevelopment other
7 than to state that they plan to consolidate the
8 rest of the beds over the Westside Campus.

9 Q: You were aware of the three phase study for the
10 rebuild of MUHA's facilities on the peninsula?

11 A: Yes, since the early 2000s.

12 Q: Okay. And so ---

13 MS. SHOUN: We can put Demonstrative 7 up, TMC's
14 Demonstrative 7.

15 (TMC Demonstrative Exhibit Number 7 was referenced at
16 this time.)

17 Q: I probably couldn't see that from where you
18 are, but can you see that?

19 A: I can see it.

20 Q: It's the same thing on the screen.

21 A: Yes, it is.

22 Q: Okay. So, Ms. Smith, is it fair to say when
23 this hit the board yesterday you weren't
24 terribly surprised to see it?

25 A: No, not too surprised. In fact I've seen it

1 with future phases beyond that which a master
2 plan is something that is developed to offer
3 lots of options for how a facility might grow
4 and it might grow and change as priorities for
5 that facility change. The original master plan
6 had a phase four and a phase five including
7 locations over where the VA facility is
8 located.

9 Q: Yes, ma'am. Your firm -- you were aware of the
10 RFP on the work that resulted in some of the
11 planning in this, weren't you?

12 A: I personally was not.

13 Q: Okay. Your firm?

14 A: LS3P may have been, but I do not believe that
15 we perused them in that request.

16 Q: So MUHA didn't put phase three out for bit at
17 one point?

18 A: A master plan, phase three ---

19 Q: No, phase three of the master plan, this one.

20 A: I don't know how Ayers Saint Gross got that
21 contract. I do know that their partner on the
22 work was Compass Five. Compass 5 has an
23 indefinite deliver contract with MUSC so it's
24 very likely that that was all done under their
25 umbrella.

1 Q: Okay. So we know that based on this there has
2 been some indication or some consideration at
3 some point in the past of tearing down the
4 wellness center and placing a bed tower or
5 double bed towers on that spot.

6 A: Yes. And that's my understanding is that that
7 would be the replacement hospital for the
8 existing University Hospital and Children's
9 Hospital in order to move all of the inpatient
10 activities to the Westside.

11 Q: And that would be additional beds?

12 A: That would be ---

13 Q: Or some replacement ---

14 A: --- replacement -- I would think a replacement
15 hospital is what I've understood all along.

16 Q: And certainly you would agree with me that the
17 wellness center where it's located could
18 definitely be demolished, could it not?

19 A: It could be demolished. There would be a price
20 to relocate it that would certainly have to be
21 added to the project costs.

22 Q: Would it have to be relocated?

23 A: I believe it would if you wanted to reserve the
24 larger parcel for which that occupies, that's
25 the largest parcel that MUSC has.

1 Q: I asked that inartfully. I apologize. You did
2 answer my question.

3 A: Okay.

4 Q: Would there have to be another wellness center?

5 A: I believe that would be because that's the
6 service that is very well utilized by staff and
7 students ---

8 Q: And if ---

9 A: --- in the community.

10 Q: And if MUHA decided it did need to be rebuilt
11 or relocated if you will, it would not have to
12 be in the center of the campus, would it?

13 A: It wouldn't, but I would think that they would
14 try to co-locate it with the University because
15 the users of the facility are students, faculty
16 and employees of MUSC. So driving to a remote
17 location would not further increase their usage
18 of the site.

19 Q: Okay. Where does the -- where's the
20 replacement wellness center on this phased
21 plan, the relocation of it?

22 A: In my understanding it's one of the buildings
23 at the upper side of the plan, but I don't know
24 for sure.

25 Q: Okay.

1 **A:** It's not labeled on this plan.

2 **Q:** And you would agree with me that if the
3 wellness center was demolished and a hospital
4 and a bed tower, double bed tower placed in the
5 spot where it's currently located, there is
6 adequate room then for the construction of a
7 parking deck that would serve that?

8 **A:** Yes. That M Lot site would most likely become
9 the parking deck. However the sizing of that
10 parking deck would need to be -- accommodate
11 the number of beds and also anticipate future
12 growth for the facility.

13 **Q:** And in fact when ART was built, Ms. Smith,
14 weren't two wings of the wellness center
15 demolished to complete that project?

16 **A:** The original nursing dorms were -- two wings of
17 that were demolished to accomplish that. And
18 the same Ayers Saint Gross study, the remaining
19 portion of that is now a building that is older
20 than 50 years, so it is very difficult to
21 remove buildings in Charleston that have
22 reached 50 years old. So that may add a
23 complication to the whole master plan, but we
24 don't -- we're not asked to deal with that
25 problem right now.

1 Q: Okay. And you were aware due to your
2 involvement in ART that when it was constructed
3 there was also a multi-million dollar central
4 energy plant constructed there.

5 A: Yes, ma'am. I helped with the early planning
6 of that project.

7 Q: And I think we heard it referred to maybe
8 earlier today as the power plant.

9 A: I refer to it as the central energy plant.

10 Q: Okay. And you -- are you aware that there's
11 some, say, \$36,000,000 still owed on that
12 plant?

13 A: I'm not apprised of the financial arrangements.

14 Q: Okay. And when that CEP -- that's what you
15 call it?

16 A: Uh-huh.

17 Q: CEP was designed, it was actually designed to
18 take on future developments, was it not?

19 A: Yes, it was.

20 Q: Okay. And it specifically the anticipation was
21 there may be other hospitals built in the area.

22 A: Yes, based on the master plan.

23 Q: Okay. Again, going back to the master plan.
24 So again, that wasn't the only utility that was
25 constructed with forethought, was it? Wasn't

1 there also a multi-million dollar pump system
2 installed in that area?

3 A: I'm not aware of a pump system. Are you
4 talking about drainage issues or ---

5 Q: As I understand it it was actually a pump
6 system. It can pump out the area within an
7 hour.

8 A: I'm not aware of that.

9 Q: Okay. Are you aware that MUHA took over part
10 of Doughty Street?

11 A: Oh yes, in order to place the bed tower.

12 Q: Right. And when it did that it signed a lease
13 with the Federal Government, did it not?

14 A: I do not know those details.

15 Q: Okay. That's fair. And it relocated Doughty
16 Street around the tower, did it not?

17 A: Yes, ma'am.

18 Q: And that's what we now know as Ralph Johnson --
19 I think it's boulevard.

20 A: Yeah, I think that's correct. I'm not ...

21 Q: And you would agree with me that was probably
22 no small financial undertaking.

23 A: I believe what they were trying to do was
24 create a site that was large enough to
25 accommodate the bed tower and the diagnostic

1 and treatment portions of the phase one
2 project.

3 Q: Yes, ma'am.

4 A: And also to create a focal point at the end of
5 Doughty Street.

6 Q: With kind of a green space?

7 A: Yes, ma'am.

8 Q: Okay. But again, that was probably -- in your
9 years of being an architect and your
10 construction background and training, you would
11 agree with me that probably wasn't a small
12 price tag to get all done.

13 A: No, but it gave them the property that was
14 needed in order to accomplish the goal.

15 Q: Yes, ma'am. And you spoke earlier of getting
16 through, I think it's an ARB is what it's
17 called on the peninsula.

18 A: The BAR.

19 Q: BAR. It's ARB in Mount Pleasant. The BAR
20 downtown, and that can be a challenge.

21 A: Yes, it can.

22 Q: Okay. But you successfully, or somebody
23 successfully navigated that to construct ART.

24 A: Yes, we did.

25 Q: Okay. And it was successfully navigated in

1 order to construct the Shawn Jenkins Children's
2 Hospital?

3 A: Yes, ma'am.

4 Q: Okay. So it can be done?

5 A: Yes, ma'am.

6 Q: All right. Now I asked you about the
7 construction cost about -- or the investment if
8 you will that MUHA made when it constructed ART
9 and all that went around with it. We know the
10 investment that MUHA's made now for Shawn
11 Jenkins, but I want to focus on the investment
12 made in this -- in the implementation of at
13 least the first two phases of this three phase
14 plan, okay?

15 A: Okay.

16 Q: And then I want to look at that in conjuncture
17 with what you have estimated the cost to be at
18 the proposed MUHA Nexton site. Oh, you know
19 what, I think we already talked about that, in
20 stead of putting it up again. I think that's
21 DHEC 1 page 74.

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

23 Q: While she's doing that, Ms. Smith, I believe,
24 if I heard correctly, the number on the
25 proposed Nexton site for MUHA is \$325,000,000.

1 A: Yes, ma'am.

2 Q: Okay. And we talked a lot about the
3 contingencies there, did we not?

4 A: Yes, ma'am.

5 Q: Then we talked about the cost of the land which
6 you think might be about \$10,000,000?

7 A: That was the number provided to us by MUSC at
8 the time.

9 Q: Okay. And at the time of your deposition we
10 also asked you about a CEP or an energy plant
11 that would have to be located on that site as
12 well, correct?

13 A: Yes, ma'am.

14 Q: Okay. And you would agree with me that in your
15 experience and your education you would assume
16 that that plant would cost no less than
17 \$10,000,000, correct?

18 A: Yes, but that would be included in this overall
19 construction cost.

20 Q: Okay. As would the helipad for a million
21 dollars, right?

22 A: Yes, ma'am.

23 Q: Okay. Now if -- just let's say if,
24 hypothetically, MUHA decided to implement phase
25 3 where it's already been set up on the

1 peninsula, it already has the central power
2 plant that it can use, correct?

3 A: It does have access to a power plant.

4 Q: Okay. Which was designed to take on additional
5 capacity?

6 A: Yes, ma'am.

7 Q: Okay. And it already owns that property, does
8 it not?

9 A: Yes.

10 Q: Okay. So, again, we could get rid of the
11 \$10,000,000 or so that we know we have to spend
12 on the CEP in Nexton, and we can get rid of the
13 \$10,000,000 or so that we know that we have in
14 the land cost, right -- I mean in the CEP?

15 A: In general, yes.

16 Q: Okay. Now would you agree with me that it may
17 also be possible to get rid of the million
18 dollar helipad because it already exists at
19 MUHA's facility downtown?

20 A: That is feasible, yes.

21 Q: Okay. So we can shave those costs off of MUHA
22 Nexton. Looking at this, understanding I know
23 there's costs that go with this, I understand
24 that.

25 A: We would likely have to add another \$25,000,000

1 for the wellness center. We would have to add
2 a parking garage at exorbitant cost if their --
3 we would be taking the prime property for any
4 future development for MUSC by doing 128 beds
5 where we have capacity to do many many more
6 beds. Actually to relocate those other beds.

7 Q: You have capacity to do many more beds in
8 Nexton?

9 A: No. Right there (indicating).

10 Q: Oh, okay.

11 A: That has two patient towers. Because it has
12 two patient towers it is a large -- it has the
13 capacity to handle the replacement beds. If we
14 take one of those wings and put 128 beds there,
15 then we have effectively reduced their capacity
16 to relocate the other beds that are in the main
17 hospital.

18 Q: We -- they would still be getting the beds,
19 would they not?

20 A: They're asking for 128 additional beds in
21 addition to what they have now. That's part of
22 the CON. They're not replacement beds.

23 Q: Okay. Oh, one other question about those
24 costs, Ms. Smith. I think you also told us in
25 what you have, the schematics you have done or

1 whatever drawings you've done thus far for the
2 proposed MUHA site in Berkeley County, you know
3 I think it's shown on there there's a 2.3
4 million dollar cost for structure and roof in
5 anticipation of a future wing to be added, is
6 that right?

7 A: Yes, ma'am.

8 Q: Okay. And again, if phase 3 were implemented
9 that could be wrapped into that we think?

10 A: We would experience a similar cost to include
11 additional structure for future addition on
12 top.

13 Q: And you understand that addition to be related
14 to some cancer center, correct?

15 A: I don't understand how that will be used at
16 all. It's just prudent when doing preliminary
17 planning for a new hospital to include some
18 grown potential. Many facilities might grow
19 that horizontally rather than vertically. But
20 it's most prudent particularly to conserve the
21 land, to build it into your initial podium.

22 Q: Yes, ma'am. The -- a potential cancer facility
23 was never mentioned to you?

24 A: No. It was not mentioned to me.

25 Q: And you're aware that MUHA has a cancer center,

1 actually a quite distinguished cancer center on
2 it's peninsula site?

3 A: Oh absolutely. Hollings Cancer Center is
4 there, yes.

5 Q: I think that's all I have.

6 A: Thank you.

7 MR. THOMAS: I've got a few.

8 THE COURT: I figured.

9 MS. SMITH - CROSS-EXAMINATION BY MR. THOMAS:

10 Q: Good evening, Ms. Smith. I've got a couple
11 questions for you. Maybe more than two. The
12 last green field project you worked on was
13 Hampton Regional Medical Center some 10 to 15
14 years ago, correct?

15 A: That's true.

16 Q: Okay. And green field means just what it
17 sounds like, natural piece of land, new
18 hospital, right?

19 A: Much smaller facility.

20 Q: Right. This is a 25 bed critical access
21 facility, correct?

22 A: Yes, sir.

23 Q: Much lower utilization, correct?

24 A: Yes. It was about the same time as the Ashley
25 River Tower project. It started up about the

1 time Ashley River Towers was finishing.

2 **Q:** Thank you. Not trying to be rude at all. If
3 you could just answer my question, that way we
4 can get through this.

5 **A:** Sure.

6 **Q:** Thank you.

7 MS. CRUM: Your Honor, she gets to answer the
8 question. Now he asked her how long ago it was
9 and she was just putting that in context.

10 MR. THOMAS: I didn't ask her for context. I just
11 asked her when it was.

12 MS. CRUM: He asked whether it was 10 or 15 years
13 ago and she was just explaining when it was
14 'cause we talked at length about when the
15 Ashley River Tower was done.

16 THE COURT: He's got a right to ask her -- I'll tell
17 you what, if you want that particular approach
18 you need to ask her yes or no questions.

19 MR. THOMAS: All right. That's fair, Your Honor.

20 **Q:** You recall when I deposed you on October 1st,
21 correct?

22 **A:** Yes.

23 **Q:** All right. And it was the previous day before
24 the deposition you had received a MUHA parking
25 analysis, I believe from Mr. Ruynon, correct?

1 **A:** I believe that's correct.

2 **Q:** Okay. So until that point in time you had not
3 done a parking analysis nor had you seen one
4 with respect to MUHA, correct?

5 **A:** Yes.

6 **Q:** All right. The backfilled plan that I believe
7 is in evidence as maybe it's Trident 89, you
8 actually got that the morning of your
9 deposition, correct?

10 (TMC Exhibit Number 89 was referenced at this time.)

11 **A:** Yes.

12 **Q:** Okay. And you received that from Ms. Crum,
13 correct?

14 **A:** Yes.

15 **Q:** All right. You actually didn't ask anyone to
16 develop that for you, correct?

17 **A:** No.

18 **Q:** All right. And the day before I deposed you I
19 think that's when you walked around the
20 children's hospital and you snapped pictures of
21 maybe a couple of places in the children's
22 hospital?

23 **A:** Yes.

24 **Q:** All right. And you didn't realize the
25 children's hospital was a sprinkler facility

1 until we actually saw the sprinkler head coming
2 out of the ceiling, correct?

3 A: Sure. I didn't take note of it when -- when I
4 was doing my walk-through.

5 Q: Okay. Fair enough. And you visited the
6 seventh and eighth floor of the children's
7 hospital, correct?

8 A: Yes, sir.

9 Q: And then the fourth, fifth, and seventh floors
10 of the main hospital, correct?

11 A: Yes, sir.

12 Q: Okay. Now, you -- you know Ms. Sarah Bacik,
13 she's the Chief Development or -- or Chief
14 Strategy Officer for MUHA?

15 A: Yes, I know Sarah.

16 Q: Okay. And -- and you've worked on various CON
17 projects with her? Is that fair?

18 A: Yes.

19 Q: And her team?

20 A: Yes.

21 Q: All right. And -- and you've become aware of
22 various projects and some of the strategic
23 importance of those projects, correct?

24 A: To the extent that MUSC asks us to -- what --
25 what information they share with us.

1 Q: Okay. And -- and just to -- just to align the
2 Judge and so he can understand where this --
3 these things are, on this rendering here, and
4 this is -- what'd you say, ACY or what -- what
5 was the firm that -- that did this rendering?

6 A: Oh. Ayers Saint Gross.

7 Q: A -- AC -- ASG, how bout that? Ayers Saint
8 Gross ---

9 A: ASG, yes.

10 Q: All right. This is the B Street garage,
11 correct?

12 A: Yes, it is.

13 Q: All right.

14 A: An energy plant is ---

15 Q: Off to the side?

16 A: Yes.

17 Q: And the conduit runs all the way down Bravo
18 Street to the children's hospital here,
19 correct?

20 A: Yes, it does.

21 Q: Okay. And the children's hospital, physically,
22 looks like that, doesn't it?

23 A: Yes.

24 Q: Okay. And ART, physically, looks like that,
25 correct?

1 A: Yes.

2 Q: All right. And if I'm looking at this, that's
3 a patient tower -- that's the patient tower of
4 ART, right?

5 A: Yes.

6 Q: Okay. This is a very similar looking patient
7 tower that is now in the wellness spot,
8 correct? Wellness ---

9 A: Yes ---

10 Q: --- center.

11 A: --- but there are two of them.

12 Q: There are two. You are correct. And two -- we
13 know from Dr. -- were you here for Dr. Warr's
14 testimony?

15 A: No, I was not.

16 Q: Okay. Do you know how many beds the current
17 ART tower accommodates today?

18 A: I think it's close to 200.

19 Q: Okay. I'll represent to you, Dr. War said 202.

20 A: Very good.

21 Q: Okay. So, are these towers here bigger than
22 this tower here?

23 A: I can't tell how tall they are.

24 Q: Right.

25 A: The footprints look to be about the same, so I

1 would venture a guess that you could place
2 about 400 beds on that phase three location.

3 Q: Okay. And then what Ayers Saint Gross, what
4 they contemplated here was a garage on this
5 spot, which is now a flat lot, correct?

6 A: Yes, sir.

7 Q: Okay. And this is the old Charleston DAODAS
8 property, correct?

9 A: Yes.

10 Q: And MUSC, I believe you said in your
11 deposition, that they have this partial,
12 correct?

13 A: Yes.

14 Q: Okay. And that also represents pa- -- parking
15 garage there, too, correct?

16 A: Yes, it does.

17 Q: Okay. You would imagine, Ayers Saint Gross,
18 when they did this rendering, they put some
19 thought into, not only where the new wellness
20 center would go, which I believe may be here,
21 but they also put into -- some thought into
22 parking garages on ---

23 A: You're right.

24 Q: --- campus, is that fair?

25 OBJECTION:

1 MS. CRUM: Your Honor, I'm gonna object to his
2 asking her to speculate what thought another
3 architectural firm had.

4 THE COURT: She said ---

5 MR. SMITH: Yeah, I was just ---

6 THE COURT: All right. I overrule that one.

7 Q: Would you imagine that they're gonna present a
8 rendering like this to MUSC without thinking
9 through parking, where the existing services on
10 the wellness center plot are gonna go and other
11 such things?

12 A: I would think they would take that into
13 consideration. Now whether that's enough
14 parking for all the development that's shown,
15 I do not know.

16 Q: Okay. In the terms of John Ruynon, Mister --
17 Mr. Ruynon, did you say you did have some
18 conversations with ---

19 A: Yes. I have spoken with him on the telephone.

20 Q: Okay. Since -- since your deposition?

21 A: I cannot remem- -- ye- -- yes, it must've been
22 shortly after the deposition.

23 Q: Okay. It wasn't before, was it?

24 A: No. It was not.

25 Q: You had received an email, correct?

1 A: Yes.

2 Q: And there was a mistake in one of the -- in one
3 of his analyses and we got another one,
4 correct?

5 A: Yes. He replaced a portion of the information.

6 Q: Okay. Now, Shawn Jenkins was built on land
7 that -- that housed a former hospital, right?

8 A: Yes.

9 Q: That was the Charleston Me- -- Memorial spot?

10 A: Yes, sir.

11 Q: Okay. And so there was -- there was some
12 extensive site work done for that, correct?
13 Demolition?

14 A: Yes.

15 Q: Okay. Do you know how old that building was?

16 A: I believe it was constructed in the '50s and
17 may have been -- I believe the '50s.

18 Q: Yeah. So it was over 50 years old, wasn't it?

19 A: Uh-huh.

20 Q: And the VAR didn't have any problems with --
21 with that, did they?

22 A: Not that one. I don't know if he ever drove by
23 it.

24 Q: No. I've been at -- I did my residency at
25 MUSC. My admin residency. And I spent a

1 **little time in there.**

2 **A: Okay.**

3 MR. THOMAS: Let's go to TMC 145.

4 (TMC Exhibit Number 145 was referenced at this time.)

5 MR. THOMAS: And this is the -- the Shawn Jenkins
6 Children's Hospital application, which I
7 believe is already in evidence and, I think, if
8 you go to page -- the exhibit page 11, please,
9 for Ms. Smith.

10 **Q: All right. I want you to look at the lower**
11 **third of the page. Do you understand these are**
12 **the services that are being offered in the**
13 **children's -- in the new Shawn Jenkins**
14 **Children's Hospital, which is going in this**
15 **facility on the rendering here?**

16 **A: Yes, sir.**

17 **Q: Okay. And so, it's not just beds, right? It's**
18 **OR's, right?**

19 **A: Yes. That's what's written there.**

20 **Q: Yep. 10 OR's. It's got two cardiac cath labs**
21 **and a electrophysiology room, correct?**

22 **A: Yes.**

23 **Q: Okay. Diagnostic and imaging department,**
24 **correct?**

25 **A: Correct.**

1 Q: Ambulatory clinics, correct?

2 A: Yes.

3 Q: 11 labor and delivery rooms, right?

4 A: Yes.

5 Q: Okay. And a lot of logistics and support.

6 There -- there at the bottom, you've got your
7 food service, technology, and building support,
8 central sterile processing, and materials
9 management, correct?

10 A: Yes. That's what's listed.

11 Q: All of that stuff is vacating from the main
12 hospital and going over into the new children's
13 hospital, correct? Or from the existing
14 children's hospital at Shawn Jenkins?

15 A: I do not know what equipment is being tran- --
16 what -- what diagnostic services are being
17 moved, specifically. I don't know if they are
18 relocating three x-ray rooms, or if they filed
19 for new, like, new -- I don't know how they
20 handled that.

21 Q: Fair enough. And wouldn't it be important to
22 know exactly that information so you can know
23 what new capacity is gonna be available in the
24 existing hospital?

25 A: It would, but again, the first time that it was

1 brought to my attention that the existing
2 hospital would have been a better site, based
3 on the claims by Trident and Roper, was when I
4 was notified of -- of this -- this whole de- --
5 deposition and the -- and -- and the trial.

6 Q: About six weeks ago?

7 A: Yes.

8 Q: Okay.

9 A: And so no, our firm was not requested to look
10 into the details of -- of any of what's moving.

11 Q: Okay. Did you study whether that the
12 additional capacity could support more beds on
13 the campus or in th- -- or in the existing
14 children's hospital that's gonna cre- -- be
15 created by the move?

16 A: You're asking the same question again, in my
17 opinion, and my answer is, no, I was not --
18 that was not requested of LS3P. LS3P was
19 requested to look at the new hospital on the
20 Berkeley site.

21 Q: All right.

22 A: Other than this -- this trial.

23 Q: That's fine. And you -- you were involved in
24 the Ashley River Tower, correct?

25 A: Yes.

1 Q: Okay. And Ashley River Tower has -- has an ED,
2 correct? Emergency Department.

3 A: It has a emergency department that is focused
4 on cardiac care.

5 Q: Correct. And Shawn Jenkins is gonna have an
6 emergency department, too?

7 A: Focused on pediatric care.

8 Q: Okay. And then the idea for Phase 3, the Twin
9 Towers project, as I like to call it, they're
10 gonna have an ED in there, too, correct?

11 A: I have no idea.

12 Q: Now, are you aware that the Shawn Jenkins
13 Hospital -- there's been testimony, I believe,
14 Mr. Caw- -- Dr. Cawley, pardon me, he testified
15 that it was gonna come in at less than 400
16 million dollars construction, correct?

17 A: I believe I heard that yesterday ---

18 Q: Okay.

19 A: --- yes.

20 Q: And -- and you would agree with me that the
21 size of Shawn Jenkins Children's Hospital is
22 650,000 square feet, correct?

23 A: It's much larger than ours, yes.

24 Q: When you see me checking off things, that's
25 good Ms. Smith. Are you familiar with the term

1 free-leaning facility?

2 A: Yes. I was introduced to that yesterday.

3 Q: Okay. Had you not heard it before?

4 A: No.

5 Q: Okay.

6 A: But in concept, I understand it very well.

7 Q: Okay. Well -- and so, it was Ms. Bacik who
8 testified in her deposition that a free-leaning
9 facility is, generally, cheaper to build than
10 a comparable freestanding facility, because of
11 shared services available around that -- that
12 facility. Do you agree with that concept?

13 A: In principle, that could be true.

14 Q: Okay. Now, I believe, Ms. Shoun got in t- --
15 to this -- got into this with you a little bit,
16 but MUHA has not awarded the Nexton project to
17 LS3P, correct?

18 A: That's correct.

19 Q: And you would like to get the project. That
20 would be a great project for you and your team,
21 correct?

22 A: That's true for every healthcare architect in
23 -- within several states, or in the nation.

24 Q: I understand. It'll mean a sizeable fee for
25 your firm, too, correct? In the millions of

1 dollars?

2 A: Yes, it would.

3 Q: Okay. And you would agree with me that this
4 project, although not quite as a big as the
5 Shawn Jenkins Children's Hospital, is of -- of
6 an equal important significance? The Nexton
7 project.

8 A: Yes, this -- it's very important.

9 Q: Okay. And you would agree with me that one
10 reason that -- that a hospital like MUHA hires
11 architectural firms like yours is so that
12 solutions can be developed for potential
13 problems associated with parking, flooding, way
14 finding, and those types of things ---

15 A: Ye- ---

16 Q: --- correct?

17 A: --- yes, sir.

18 Q: All right. Now, I guess, you've already
19 testified to cost of the CEP. Do you know
20 whether -- the- -- there's been a lot of
21 testimony, I believe, y- -- you testified that
22 -- that this isn't just -- that Nexton isn't
23 just a 128-bed hospital, it's also gonna have
24 ancillary services to support those beds,
25 correct?

1 A: Yes.

2 Q: Okay. And you would agree with me that you
3 don't know the available capacity of MUHA's
4 current ancillary service complement to know
5 whether or not they could support just adding
6 128 beds, either in a tower facility -- in the
7 twin tower facility, or in a -- in another spot
8 on campus, do you?

9 A: Ye- -- I don't -- I don't have the -- the
10 detailed information available to answer that
11 question.

12 Q: Okay. Now, I believe, you -- you testified,
13 during your deposition, that, in terms of
14 renovating open space in the current children's
15 hospital, like, you know, the ICU -- U -- the
16 ICU space and the patient rooms, the cost would
17 be co- -- comparable to new construction.
18 Didn't you testify to that?

19 A: Yes, I did.

20 Q: Okay. In terms of -- strike that, I'm sorry.
21 With respect to Mr. Ruynon's parking
22 information that -- that you received, did you
23 independently verify that it was correct?

24 A: I took it at face value.

25 Q: Fair enough. Now you -- were you involved with

1 the 29-bed renovation CON application, Ms.
2 Smith?

3 A: I was not.

4 Q: Okay. Do you -- but you do know it's 29 beds
5 for 7.3 million dollars?

6 A: I do, and I have concerns about that CON
7 application.

8 Q: Okay. I'm sure you will voice them to MUHA.
9 But in terms of what MUSC represented to the
10 state, that's a \$251,000 per bed project,
11 correct?

12 A: I believe that's correct.

13 Q: Okay. Now MUHA also has a 52-bed project
14 that's gonna result in 33 beds -- 33 of those
15 beds backfilling the space in the existing,
16 either, the main or the children's hospital,
17 right?

18 A: That's what I understand.

19 Q: Okay. And are you aware that the entire cost
20 of that project is 9.2 million dollars?

21 A: That also is gonna be a very tight budget for
22 them; however, those beds are going into an
23 area, as I recall, going into an area where the
24 room sizes are larger and facilities are --
25 are, somewhat, upgraded already, so ---

1 Q: Fair enough.

2 A: --- hopefully fewer -- fewer construction
3 dollars for them.

4 Q: Okay. Well even if we attributed the entire
5 cost, the 9.2 million dollar cost, to -- to
6 just the 33 beds, that would be a \$278,000 per
7 bed project, correct?

8 A: That's what you're telling me. I'm trusting
9 your math.

10 Q: Okay. Did you say you moved back to Charleston
11 in 1994?

12 A: Yes.

13 Q: Okay. So -- so you -- you -- at least you got
14 to miss Hugo, right?

15 A: That's right ---

16 Q: Okay.

17 A: --- although, I came ---

18 Q: Some of us didn't.

19 A: --- I came a day -- a day afterward, because my
20 brother was living in -- at Folly Beach.

21 Q: Oh. I'm sorry. Flooding on the peninsula is
22 nothing new, and it's been an issue down on the
23 peninsula for decades, correct?

24 A: That's true.

25 Q: Okay. And despite this, MUSC has added 450

1 beds since 2008, correct? On to the peninsula?

2 A: I believe that's true.

3 Q: All right. And they're about to add another 62
4 beds on it -- the peninsula, correct?

5 A: That's true.

6 Q: And they've got plans for, sometime down the
7 road, to add another 400 beds on the peninsula,
8 correct?

9 A: All of these newer beds, though, are built such
10 that the beds, and all the critical services,
11 are well above the flood plain, which, unlike
12 the existing facilities, those standards were
13 not in place so those areas, other than the
14 roadways -- it, you know, those areas will not
15 be experiencing as much of the -- the flood
16 damage that -- that you might expect.

17 Q: And -- and that's because smart people, like
18 you, tell them what to do, in terms of building
19 these buildings, right?

20 A: Well, actually, the -- the codes require it
21 now. That was not the case earlier.

22 Q: I was just trying to throw you a compliment.

23 A: I'm not taking the credit.

24 Q: Now your understanding of the freestanding ED
25 at Nexton was to help establish MUHA's presence

1 in the Nexton area and to capture those
2 patients in the area, correct?

3 A: That's my understanding.

4 Q: Okay. And l- -- let's talk a little bit about
5 the backfill plan, then we'll be done. If we
6 could put up TMC 89.

7 (TMC Exhibit Number 89 was referenced at this time.)

8 Q: All right. This is plan dated October 1st,
9 2019, correct?

10 A: Yes.

11 Q: All right. And who -- who, physically, did
12 this?

13 A: I don't know. Someone at MUSC.

14 Q: Okay. So you never talked to that person who
15 actually drafted this up?

16 A: No, I did not.

17 Q: Okay. And we've got the stacking diagram. I
18 -- I'm a big fan of stacking diagrams. You
19 didn't go -- on the children's hospital, did
20 you ever go down to the sixth floor? If we go
21 to Exhibit 89-002. Did you go to the sixth
22 floor and tour?

23 A: I didn't walk through that floor. I focused on
24 the floors that I had heard were going to be
25 part of that backfill plan.

1 Q: Okay. Well, you would agree with me, that on
2 the sixth floor, we have three different
3 things, pharmacy, recovery, and peds cath,
4 right?

5 A: That's right.

6 Q: Okay. And we looked at the services of the
7 children's hosp- -- the new Shawn Jenkins
8 Children's Hospital earlier and there's,
9 indeed, a cath lab in the Shawn Jenkins Hosp-
10 -- Hospital, correct?

11 A: Fair enough.

12 Q: Okay. So what's gonna go in that space?

13 A: I'm sorry. I was not asked to put this list of
14 backfill plans together, so I don't know what
15 MUSC plans to do there.

16 Q: Okay. Pharmacy and recovery, they're gonna
17 have that in the Shawn Jenkins Children's
18 Hospital, too, right?

19 A: Likewise, I don't know what they plan to do
20 with any of those spaces, or the proportion of
21 the peds cath lab to -- to the recovery to the
22 pharmacy area.

23 Q: Okay. Did you ever see the space assessment
24 needs analysis fi- -- final report out,
25 prepared by the office of strategic planning?

1 **A:** Is that the SANA report?

2 **Q:** The SANA report.

3 **A:** Yes. That was produced to me.

4 **Q:** Okay. Let's go to TMC 86.

5 (TMC Exhibit Number 86 was referenced at this time.)

6 **A:** After.

7 **Q:** After. I hear you.

8 **A:** Yes.

9 **Q:** Produced to you after the fact. Fair enough.
10 Did you have any input into the SANA report?

11 **A:** I did not.

12 MR. THOMAS: Okay. Well there is a stacking diagram
13 I'd like you to take a look at on page 26. So
14 this is TMC 86, page 26. This is already in
15 evidence, Your Honor.

16 MS. CRUM: What page number? I'm sorry.

17 THE COURT: 26.

18 MR. THOMAS: Oh, I'm sorry. Liz, it's 29156.

19 MS. CRUM: Thank you.

20 MR. THOMAS: MUHA RFP. Okay.

21 **Q:** Now on this surgical beds, future state,
22 stacking diagram, I want you to look at the
23 children's hospital and I want you to look at
24 the sixth floor. What does it say in there,
25 for those two spots?

1 A: It says, vacant on this plan.

2 Q: It says vacant and vacant, right?

3 A: Yeah.

4 Q: Do you see that? How many square feet is -- is
5 that area, there?

6 A: I have no idea.

7 Q: Okay. And you don't know how many beds can be
8 added there either, right?

9 A: I believe that would be challenging because it
10 doesn't have the daylight. You would be
11 limited to just the perimeter around the -- the
12 areas with glass at the parameter of the
13 building. Nothing near what you could do on
14 the seventh or the eighth floors.

15 Q: Okay. But you can't tell us, today, how many
16 beds could go on that spot, right?

17 A: No.

18 Q: Okay. And if we could go to page ---

19 A: Also, I would like to note that, I believe,
20 this doc- -- document is filled with options
21 and I would believe that the planning team that
22 MUSC had in place was requested ---

23 Q: Like that ---

24 A: --- to provide different options.

25 Q: Okay. Did you -- did you talk to anyone about

1 this document?

2 **A:** No, but when I see draft, and when I see
3 subject to change, and when I see options, that
4 is the information it's giving me. It's
5 telling me there are many approaches that MUSC
6 could take.

7 **Q:** Fair enough. Yeah. I -- I agree with that.
8 There are many approaches MUSC could take.
9 Let's go to TMC 86-025. And if you look at the
10 backfill description here, it says, proposed
11 location seventh floor expansion to CH and that
12 children's hospital and collocation of all med
13 surge beds. How many incremental surgical beds
14 are they talking about there?

15 **A:** They don't list it here.

16 **Q:** It says 30 incremental surgical beds, correct?

17 **A:** I'm sorry. Yes, it does, and then it lists the
18 10 ob's beds.

19 **Q:** 10 ob's beds for overflow, correct?

20 **A:** Yes.

21 **Q:** And the estimated capital outlay for this area
22 is how much, 2.53 million?

23 **A:** That's what's represented here.

24 **Q:** Okay. Now I wanna toggle back to TMC 89, if we
25 could. Just have a few more questions for you

1 on this document. If we could go to Trident
2 Exhibit 89-004. There's a green square in the
3 middle, I believe, and that says, PCICU 4
4 center, and the backfill plan is to build 8 ICU
5 beds out of the 52-bed CON, correct?

6 A: Yes. That's what it says.

7 Q: Okay. Do you know what the cost is on that?

8 A: That information's not provided.

9 Q: Okay. Let's go to TMC 89-005. All right.
10 Let's focus, here, on the -- on the left --
11 well, kinda wanna look at it all together.
12 Women's five east says, 15 beds vacant,
13 correct?

14 A: That's correct.

15 Q: Okay. And we know that the labor and delivery
16 area, that's the 29 beds, I believe, you said
17 that there's, kind of, minimal renovation that
18 they have to do for that area?

19 A: That's right.

20 Q: Okay. And -- and -- and I'm looking at the --
21 at the -- the east wing, over here, and, are my
22 eyes deceiving me, or are the rooms about the
23 same size that I'm looking at -- so, in the
24 blue area, the rooms look the same size as they
25 do in the red area?

1 **A:** Yes. And the -- the backfill analysis that I
2 tried to do to summarize this, these were 15
3 beds that I felt could be fairly easily
4 implemented.

5 **Q:** Okay. And those -- because they were a little
6 bit larger, 190 square feet?

7 **A:** Yes, sir.

8 **Q:** All right. Let's go to the next page, TMC 89-
9 006. And this is the seventh floor of the
10 children's hospital, I believe ---

11 **A:** Uh-huh.

12 **Q:** --- is that correct?

13 **A:** Yes, sir.

14 **Q:** Oka- ---

15 **A:** So here we have a answer to your earlier
16 question.

17 **Q:** Right. And so, we've got 46 beds vacant. So
18 those are the 46 beds that are -- that you
19 believe some of them are too small?

20 **A:** Yes, that's true.

21 **Q:** Okay. And what is the square footage of these
22 three areas?

23 **A:** I don't have the combined square footage of the
24 area.

25 **Q:** Okay. And is it your representation these beds

1 are smaller than the beds we were looking at on
2 the previous page for ---

3 A: Yes.

4 Q: --- I think it was university hospital, third
5 floor?

6 A: Yes. Those rooms -- the -- the rooms on -- not
7 the side facing out towards the street, but the
8 side rooms on either bar are 147 to 150 square
9 feet, as opposed to the, roughly, 200 square
10 feet that the other rooms are.

11 Q: Well, we're talking about 190, right? That's
12 what you said they were ---

13 A: Yeah, 190.

14 Q: Okay. So 190 minus 147 is what, 43?

15 A: Uh-huh.

16 Q: Okay. Talking about 43 square feet, or an area
17 about six by seven, right?

18 A: Yeah, but every -- every square foot counts.

19 Q: I hear you. But ---

20 A: Plus the issues with the restrooms.

21 Q: Correct. But we have -- we have all the space
22 here and ---

23 A: Do you wanna go back to architecture school?

24 Q: Maybe. George Costanza, he was -- he always
25 represented himself as an architect. All

1 right. So, at the end of the day, you didn't
2 -- didn't do a study, or a detailed study or
3 analysis of how -- exactly how many rooms we
4 can get into that. You -- you did a, I think,
5 you -- you did a ballpark-type thing, correct?

6 A: Yes, sir.

7 Q: All right. Now let's go to the eighth floor,
8 and that's 89-007, and again, same question,
9 how many square feet are looking at in these
10 areas here?

11 A: I don't have that information.

12 Q: Okay. Now the peds cardiac unit, they -- they
13 believe they can get about 14 beds in this
14 area, correct?

15 A: Those are med/surg beds, so those don't have
16 the same requirements that a full patient room
17 would have.

18 Q: Okay. Well, how -- how big do these rooms need
19 to be for the -- the 14 med/surg beds?

20 A: I mean, a med surg observation area could be as
21 tight as the 120 square foot per bed.

22 Q: Do you know what the square footage is for the
23 rooms that we see there?

24 A: The smaller of the rooms are the 147, and the
25 other -- the large -- the, like, the two large

1 rooms in the middle, are close to 200 square
2 feet each.

3 Q: Okay. Now what's on the ninth floor, Ms.
4 Smith?

5 A: That's mechanical space.

6 Q: And the tenth floor's the roof?

7 A: Yes, sir.

8 Q: Okay. Make sure I've got everything here. My
9 last time to talk to you. In terms of the --
10 the total project cost, I'm not gonna bring it
11 up, but Miss -- Ms. Crum went over with you the
12 project cost estimate at DHEC in -- in the DHEC
13 Exhibit 1. Do you recall that? The various
14 contingencies?

15 A: Yes.

16 Q: Okay. At -- at the end of the day, the -- the
17 total project cost, that was reported to DHEC,
18 was 325 million dollars, correct?

19 A: Yes, sir.

20 Q: Okay. And it wasn't a range -- it wasn't a
21 range stated, based on probabilities or
22 contingencies, correct?

23 A: I'm sorry, could you repeat that?

24 Q: Yeah. There wasn't a range stated, it was just
25 a flat 325 ---

1 **A:** **No.**

2 **Q:** **--- right?**

3 **A:** **That was a -- that was the figure that the**
4 **planning team decided on.**

5 **Q:** **Okay. And in terms of the 15 million dollars**
6 **in legal fees, HUD fees, financing, mortgage**
7 **insurance, and consultant, did -- was that just**
8 **information provided to you by MUHA?**

9 **A:** **Yes, sir.**

10 **Q:** **Okay. All right. Just a couple more questions**
11 **about the parking. I think there was some**
12 **documents that you put up and I tried to write**
13 **it down 2,526 anticipated spaces, seve- -- but**
14 **there were 752, now this is downtown campus, if**
15 **you add the 128-bed hospital downtown, that**
16 **would require 752 more spaces, right?**

17 **A:** **I believe, when we added all those facilities**
18 **together, we would need, roughly 2,500 spaces,**
19 **including the shortage that they currently**
20 **have, due to the west edge and the Horizon --**
21 **the Harbor View Tower ---**

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

23 **A:** **--- project. I do know that the -- the M lot**
24 **parking area, surface parking area, has -- has**
25 **had some design work done for that and that**

1 total's 1,400 square feet -- 1,400 spaces.

2 Q: Okay. So 1,400 spaces minus the 2,526 would
3 give us, roughly, 1,126 spaces ---

4 A: Needed.

5 Q: --- that -- that were needed?

6 A: That's right.

7 Q: Okay. And then, we know there's some spaces
8 where they can do that on the -- on the campus
9 in the old spot ---

10 A: Right.

11 Q: --- and, perhaps, up here on the flat B Street
12 lot, correct?

13 A: That's correct. However, I believe, that the
14 -- the space that's shown there, where
15 Charleston -- where DAODAS and Center One
16 building is located, right there at Calhoun
17 Street, that -- that is a much smaller parking
18 garage than the other one. I believe the other
19 one -- and I really -- I would like to see it,
20 actually, on the screen closer to me ---

21 Q: Yeah.

22 A: --- before I make this statement.

23 Q: Yeah, or ---

24 A: Could you pull it up for me, please? Or bring
25 it to me? Thank you.

1 Q: Yeah. Yeah.

2 THE COURT: She's asked for it.

3 A: That'd be great.

4 Q: Well, yeah, if we could ---

5 A: Yeah, so ---

6 Q: Oh, there it is.

7 A: --- if you look at the garage at the M lot, the
8 width of that parcel is much wider ---

9 Q: That's M lot?

10 A: Yes. See, you can see that there are three
11 sections to that plan ---

12 Q: Right.

13 A: --- that means it's a three-bay garage. The
14 garage that's planned here, is much shorter and
15 it is only a two-bay garage. So the capa- --
16 you're not gonna re- -- and it's much shorter,
17 you're not gonna be able to capture as many
18 parking spaces. So they have a parking
19 problem.

20 Q: How many spaces can I put in this one?

21 A: That's the one that's designed for, roughly,
22 1,400 spaces.

23 Q: Okay. And how much can I put in this one?

24 A: I -- I don't know, but I would venture to say
25 far less. Again, perspective makes it very

1 difficult to ---

2 Q: 1,000 spaces?

3 A: Well, we would need 1,100, but then that
4 doesn't provide for parking for any of the
5 other new red buildings that are shown on
6 campus. So they have to go -- they have to go
7 beyond this master plan to create all those
8 parking spaces that they need.

9 Q: So with all those parking spaces that are
10 needed, what -- what facilities are you gonna
11 shut down on campus?

12 A: I don't know. I mean, I -- I didn't -- I
13 didn't do this ---

14 Q: Okay.

15 A: --- design.

16 Q: Well, what -- you said that they're g- -- gonna
17 need, even without this, about 1,100 spaces.
18 Where are they gonna put those?

19 A: Well, they're gonna put a portion of them, I
20 would guess, in that -- that garage on Courtney
21 Street, but they're gonna have to come up with
22 some additional parking as well.

23 Q: And -- MUSC as -- as an entity, is allowed to
24 actually condemn land by its enabling statute,
25 isn't it?

1 **A: That's not my bailiwick, I'm sorry.**

2 MR. THOMAS: Okay. That's fine. I got no further
3 questions.

4 MS. CRUM: I -- I don't have very many at all,
5 honestly.

6 MS. SMITH - REDIRECT EXAMINATION BY MS. CRUM:

7 **Q: Let me just start right there with M parking**
8 **lot. Do you know whether or not the -- the**
9 **garage on M parking lot is actually going to be**
10 **built?**

11 **A: I don't know.**

12 **Q: Okay. Mr. Thomas asked you a lot about the,**
13 **what he called, the twin towers. Do you know**
14 **whether or not that is going to be built?**

15 **A: I don't know that that will be built.**

16 **Q: Okay. He asked you about the 400 beds that**
17 **were quote, added, th- -- to the campus, you**
18 **remember that -- that line of questioning?**

19 **A: Yeah. I thought he corrected himself, but ...**

20 **Q: Okay. Well the -- the 400 plus beds, were**
21 **those new beds or were they replacement beds?**

22 **A: They were replacement beds, as far as I**
23 **understand.**

24 **Q: Okay. And ---**

25 **A: So, in that regard, you're talking about the**

1 Ashley River Tower and the Shawn Jenkins beds?

2 Q: Yes, ma'am.

3 A: Okay. Yes, replacement.

4 Q: That was just transferring beds ---

5 A: Yes.

6 Q: --- or replacing ---

7 A: Yes.

8 Q: --- all beds? Okay. Now, with the -- Mr.

9 Thomas also asked you about whether or not you
10 would like to get the work to do the mer- --
11 MUHA-Berkeley design and project, right?

12 A: Yes, ma'am.

13 Q: Do you know whether or not MUHA is required,
14 under state law, to go through a solicitation
15 to award the contract?

16 A: They certainly are.

17 Q: And have you done work for MUHA before when,
18 after you had done the initial work, they went
19 out to -- for solicitation and you weren't
20 awarded the contract?

21 A: Absolutely.

22 MS. CRUM: Could you pull up TMC 145 11? And --
23 yes, thank you.

24 (TMC Exhibit Number 145 was referenced at this time.)

25 Q: Going -- starting under surgery and all of the

1 bullet points, on down, kinda like those, are
2 any of those existing rooms?

3 A: I don't have that information in front of me.

4 Q: Well, is it surgery with OR, are -- are those
5 existing rooms?

6 A: I -- I would guess that those are relocated
7 ORs.

8 Q: Okay. But is the in- -- invasion ser- --
9 invasive services, are there any rooms there?

10 OBJECTION:

11 MR. THOMAS: Objection, Your Honor, she just said
12 she didn't know.

13 MS. CRUM: I -- I went on from the surgery. I've
14 moved down ---

15 THE COURT: Yeah, she ---

16 MS. CRUM: --- to the next thing. She ---

17 THE COURT: --- moved down to ---

18 MS. CRUM: --- might know that.

19 THE COURT: --- the next one.

20 MR. THOMAS: I'd thought she'd, basically, said ---

21 A: I believe those are the ones ---

22 MR. THOMAS: --- she didn't know about ---

23 A: --- that showed up on the diagram where you
24 pointed to the pediatric cath labs being on the
25 sixth floor. I would assume that those are

1 those procedural rooms ---

2 Q: Okay.

3 A: --- being relocated.

4 Q: Okay. To the extent, any of those services
5 were moved, hypothetically, assume all of those
6 services were moved from university and
7 children's to Shawn Jenkins, would those
8 services involve inpatient beds?

9 A: They would support the inpatient beds.

10 Q: But they're not inpatient rooms, are they?

11 A: Right. They are not inpatient rooms.

12 Q: Okay. The wellness center, Mr. Thomas asked
13 you about that, do you know whether or not the
14 cardiac rehab for -- for the patients is in the
15 wellness center?

16 A: Our firm did a cardiac rehab project that was
17 located in the side of the parking garage, of
18 the B Street parking garage, I believe, that is
19 where it is currently located.

20 Q: Okay. And then, Mr. Thomas has asked you a lot
21 about the -- whether you have done a study.
22 Based on your experience, how much would it
23 cost MUSC to have a study done to determine how
24 you could maximize additional bed space at
25 university and children's?

1 **A:** Because of a study like that, I believe, would
2 need to include the engineer's in order to get
3 that accurate assessment of the utility needs
4 and the infrastructure needs. I believe that
5 the study such as that would, likely, cost 50
6 to 100 thousand dollars.

7 MS. CRUM: Thank you, ma'am. I don't have anything
8 else. Can we let this witness go back to
9 Charleston?

10 THE COURT: You may step down and leave.

11 MS. SMITH: Thank you very much.

12 THE COURT: Unlike the rest of them. All right.
13 9:30 tomorrow?

14 MS. CRUM: Yes, that would be great.

15 MR. THOMAS: Your Honor, I -- I would ask for 10 and
16 here's why.

17 THE COURT: Are you gonna get through by 6?

18 MS. CRUM: No, we won't, Your Honor.

19 MR. THOMAS: Well, I -- I don't know how long Ms.
20 Crum goes, I -- I will tell you my cross will
21 not be more than hour of their expert.

22 THE COURT: Okay.

23 MR. THOMAS: And -- and the reason, you know, he was
24 slated to go on Thursday and we've, kind of,
25 moved him up now because they dropped a

1 witness, which I'm all about, believe me,
2 cause that puts me on -- on a plane on
3 Thursday to see my son and -- play soccer, so
4 -- but, at the end of the day, I just need the
5 extra time because I've been -- with all the
6 rejoggling and justling of the witnesses ---

7 THE COURT: 30 minutes, I'll give it to you.

8 MR. THOMAS: --- it'll help me out, believe it or
9 not.

10 MS. CRUM: Well, Your Honor, I just would like to be
11 finished tomorrow night with Mister -- Mr.
12 Levitt, cause the last thing I -- we wanna do
13 is not finish him tomorrow night. So I -- I
14 just wanna -- I -- I know how long you're gonna
15 be, but I don't know how long Roper's gonna be.

16 MS. HOLLINGSWORTH: We'll still be here the next
17 day.

18 MS. CRUM: Yeah, well, ob- -- obviously and -- and,
19 you know, we're all, understand, the last thing
20 I want is to have my witness have to be
21 overnight and let them get the time to get all
22 these additional questions ---

23 THE COURT: What -- what would be ---

24 MS. CRUM: I'm not sure that will necessarily be
25 reduced.

1 THE COURT: 10:00 o'clock.

2 MS. CRUM: Thank you, sir.

3 (DAY NINE of the hearing adjourned at 7:00 p.m.)

4 (DAY TEN - WEDNESDAY, NOVEMBER 20, 2019. The hearing
5 reconvened at 10:02 a.m.)

6 CALL TO ORDER:

7 THE COURT: Y'all be seated. Coming to the end.

8 MS. CRUM: Yes, sir. They say there's a light at
9 the end of the tunnel.

10 THE COURT: Yeah. And the only one blocking that
11 light is Mr. Levitt.

12 MR. LEVITT: Sorry.

13 MS. CRUM: Your Honor, just one bit of housekeeping.
14 Yesterday, I think Trident introduced Trident
15 145, which was Shawn -- portions of the Shawn
16 Jenkins Children's Hospital.

17 THE COURT: Yes. Yeah it was.

18 MS. CRUM: And we had not objected subject to the
19 right to producing ---

20 THE COURT: Supplement.

21 MS. CRUM: --- additional -- supplement. And we
22 have done that and have given the Court
23 Reporter a copy and the parties and copy. And
24 -- and what it is is Mr. Levitt's response to
25 the Department's request for additional

1 information.

2 THE COURT: Okay.

3 MS. CRUM: So. And what we'll do is we'll make sure
4 we send a copy of that in electronic form for
5 everybody.

6 THE COURT: Thank you.

7 MS. CRUM: Call Mr. David Levitt.

8 DAVID LEVITT, having been duly sworn, testifies as
9 follows:

10 MS. CRUM: Your Honor, there's one more bit of
11 housekeeping with Exhibit 22, we had moved
12 introduction and Mr. Thomas wanted a letter
13 from Mr. Levitt included in that. That letter
14 is actually in the DHEC record. Mr. Thomas, do
15 we need to put that letter in a second time?

16 MR. THOMAS: No. Let's just -- for the record,
17 let's say what pages.

18 MS. CRUM: Sure.

19 MR. THOMAS: I think I know.

20 MS. CRUM: It's right at the end of the Volume II.

21 MR. THOMAS: Yeah. So, what -- the -- for the
22 record, the pages that we would have wanted in
23 this exhibit and -- is that MUHA 22, Liz?

24 MS. CRUM: I'm sorry. This is 19.

25 MR. THOMAS: Okay. MUHA Exhibit 19?

1 MS. CRUM: Right.

2 MR. THOMAS: Okay. So, from the record, the pages
3 for the DHEC record, which is DHEC 1, we would
4 ask the CON Page 725 through 730 be included in
5 -- or -- or ---

6 THE COURT: Referenced.

7 MR. THOMAS: Be referenced to that exhibit. Yes,
8 sir.

9 THE COURT: Okay.

10 MR. LEVITT - DIRECT EXAMINATION BY MS. CRUM:

11 **Q: Mr. Levitt, would you please state your full**
12 **name for the record?**

13 **A: It's David Samuel Levitt.**

14 **Q: And where do you live?**

15 **A: I live in Beaufort, South Carolina.**

16 **Q: Did he swear you earlier?**

17 **A: He did.**

18 **Q: Okay. Sorry. Would you please the Court your**
19 **education?**

20 **A: I have an undergraduate degree from Virginia**
21 **Tech in Industrial Psychology and a Masters in**
22 **Health Administration from the George**
23 **Washington University.**

24 **Q: Excuse me. Would you also tell the Court your**
25 **employment history after college?**

1 **A:** Sure. So, as part of my graduate degree I did
2 a residency in a hospital in the Washington
3 metropolitan area. My plan was to be a
4 hospital administrator. I worked in a hospital
5 for about a year and a half and decided that
6 was not something I wanted to do for 30 more
7 years. I enjoyed the planning and consulting
8 aspects of healthcare, so I went to Atlanta to
9 a firm call Fowler Healthcare Affiliates as a
10 consultant. Fowler Healthcare was a healthcare
11 consulting firm that focused -- initially
12 focused in post acute care, so we did strategic
13 planning, feasibility studies and Certificate
14 of Need work for post acute services like rehab
15 -- acute rehab, long term acute care, LTAC,
16 skilled nursing care, home health, things like
17 that. The firm grew to general acute care
18 services and more Certificate of Need work. I
19 had left that firm after ---

20 **Q:** Let me -- let me stop you. What did you do
21 there? You were talking about what the firm
22 did, but what did you do?

23 **A:** All of that. So, I was a staff consultant. It
24 was a small firm. So, I did a lot of work on
25 all those different projects. We worked

1 nationally and internationally, then we -- a
2 core group of us left that firm to start
3 another firm, Gill Balsano Consulting. I was
4 a partner in that firm and we bought and sold
5 that firm a number of times to different
6 companies. Ultimately, I left the Legacy Firm
7 in 2006 to start Levitt Healthcare Affiliates
8 and I've been doing that ever since. For that
9 whole period of time since 1992, I've been
10 doing exclusive -- well, fairly exclusively
11 healthcare consulting. The -- right before I
12 left to start Levitt Healthcare Affiliates, we
13 were part of a not-for-profit governmental
14 consulting firm, Mitretek. They did much more
15 than just healthcare. They try -- they tried
16 to get me involved in some of the other
17 projects. I had no interest in that, so I've
18 done a few government defense projects and big
19 pharma projects, things like that. But -- but
20 99.9 percent of my work has been healthcare
21 strategic planning, financial planning, and
22 things along those lines.

23 Q: Would you please tell the Court about Levitt
24 Healthcare?

25 A: Levitt Healthcare, it's a sole proprietorship.

1 I am the sole owner. We have about six people
2 that work with me as independent contractors.
3 Those -- five of those six people, I've known
4 -- I've known and worked with for 20 years, 15
5 years some of them. So, it's a core group that
6 have worked together for a period of time. All
7 those individuals, except for one, worked at
8 the previous firms that I -- I worked at. So,
9 they sort of came with me to this firm. And I
10 do strategic planning, financial planning,
11 litigation support, certif -- sort of the
12 general gamut of healthcare consulting for all
13 services. I think I've -- in South Carolina,
14 I think I've filed an application in South
15 Carolina for every service that is reviewed
16 under the health plan, as well as obviously
17 others that aren't reviewed under the Health
18 Plan and ones that were previously reviewed
19 under the health plan. So, from sort of soup
20 to nuts on how healthcare consulting. Over the
21 course of nearly 30 ---

22 Q: May I stop you just a second? When you say
23 services, are you talking about services like
24 open heart?

25 A: Sure. Open heart, obstetrics, NICU, general

1 acute care hospitals, hospital expansions,
2 imaging, radiology, radiation therapy, PET.
3 Sort of the whole -- the whole array of
4 services that hospitals and health systems
5 offer. Ambulatory surgery. Over the course of
6 approximately 30 years, I've worked on over
7 1,000 CON applications, several hundred in
8 South Carolina. I've worked in 48 states in
9 the United States. I've not done work in North
10 Dakota or Alaska. I've worked in every other
11 state. I've done Certificate of Need work in
12 the southeast. I've been qualified as an
13 expert in health planning and healthcare
14 finance in most of the southeastern states;
15 Georgia, South Carolina, Florida, Alabama,
16 Mississippi, Tennessee, sort of the whole
17 southeast.

18 MS. CRUM: And at this point, Your Honor, I would
19 move admission -- move Mr. Sullivan's admission
20 as an expert in health planning and healthcare
21 finance.

22 MR. THOMAS: No objection.

23 A: I'm Mr. Levitt.

24 MS. CRUM: Mr. Levitt. Sorry.

25 MR. THOMAS: No objection to that either.

1 THE COURT: I think he definitely didn't have an
2 objection to the other one. Okay.

3 MS. HOLLINGSWORTH: And, Your Honor, we have no
4 objection to Mr. Levitt or Mr. Sullivan's
5 designation, but my only comment would be to
6 the extent in the Petitioner's case as there
7 were challenges to opinions of our health
8 planners and healthcare finance experts to the
9 extent they were challenged as being
10 interpretations of the law or what have you.
11 I mean, we just the Court that all of the
12 opinions that -- that Mr. Levitt would give to
13 the extent of similar information, we would
14 want the Court to consider that for the experts
15 that we provided.

16 THE COURT: So noted.

17 MS. HOLLINGSWORTH: Thank you, Your Honor.

18 MR. WICEVIC: No objection.

19 THE COURT: He is so qualified, again.

20 QUALIFIED AS EXPERT:

21 MS. CRUM: Thank you, sir.

22 **Q: Could you just briefly give the Court your**
23 **history with working with MUHA?**

24 **A: Yes. So, I think I worked with MUHA before**
25 **MUHA. So, I worked with MUSC hospital in the**

1 late '90s. Started in the late 90s. In 2000
2 created MUHA. I've done work for that entity,
3 which is sort of a legacy entity of the
4 previous hospital, since about that time. So,
5 about 20 -- a little more than 20 years, I've
6 been doing strategic planning and Certificate
7 of Need work for the University. And I've done
8 dozens of CON applications for them. You know,
9 examples would include, I did the Ashley River
10 Tower application back in 2003 and multiple
11 other applications before and after that.

12 Q: Did you do the Children's Hospital, Shawn
13 Jenkins Children's Hospital?

14 A: I did. I did the Shawn Jenkins Children's
15 Hospital. I did the 59-bed -- oh, I'm sorry,
16 52-bed application we've heard about. I did
17 the 29-bed application we heard about. I did
18 the freestanding ED app -- both the ---

19 THE COURT: For what?

20 A: Freestanding ED ---

21 THE COURT: Oh.

22 A: --- applications, both the Summerville and the
23 Sea Islands. I did both of those. So, I have
24 a long history with the University and their
25 planning process.

1 THE COURT: You said you've been doing strategic
2 planning for them for 20 years?

3 A: Approximately. Late '90s in started doing work
4 for them.

5 THE COURT: Okay. All right.

6 Q: How many -- can you tell the Court how many bed
7 -- additional bed needs MUSC -- MUHA has
8 generated since the 2004-05 State Health Plan?

9 A: Yes. So, in the 2000 -- I think it was the
10 2012 Health Plan, there was a need for 52 beds,
11 and so, we applied for those. That was the 52-
12 bed application I talked about. The current
13 plan shows a need for 157 beds in addition to
14 that, so that would be 209. No -- yeah. 209
15 beds has been generated as needed for
16 University Hospital.

17 Q: And that's under the State Health Plans?

18 A: That's under the State Health Plan methodology,
19 correct.

20 Q: All right. Would you just give the Court a
21 brief overview of the project at issue today?

22 A: Okay. So, I'm going last, so I think you've
23 heard a lot about it. But I'll give you sort
24 of a thumbnail sketch. There's need to plan
25 for additional beds. The University is full.

1 The hospital on the peninsula is full. Highest
2 -- average daily census, the highest bed need
3 in the Health Plan needs additional beds. In
4 order to accommodate the -- the need and
5 ability to treat those patients, we're
6 proposing to build a satellite hospital,
7 additional community hospital in Berkeley
8 County, just over the border of Dorchester and
9 Charleston Counties in the Nexton area to
10 address that need and to increase access to
11 residents that seek care at the University.

12 Q: Who will be the licensee for the hospital?

13 A: MUHA, Medical University Hospital Authority.

14 MS. CRUM: Mr. Bupp, would you pull up Trident

15 Exhibit 41, please?

16 (TMC Exhibit Number 41 was introduced into the record
17 at this time.)

18 Q: Do you recognize this, Mr. Levitt?

19 A: Yes. I -- I think this was shown to Dr. Warr
20 and I think it might have been shown to Lisa
21 Goodlett as well.

22 Q: What is it?

23 A: Well, it is one of the tabs from our bed need
24 worksheet, our model, sort of the Excel model
25 that did the calculations or I guess, in which

1 we did the calculations to project need at
2 Berkeley -- at the Berkeley Hospital.

3 Q: Okay. Is this a document you participated in
4 the development of?

5 A: Yes.

6 Q: Okay. There's been discussion about what
7 services are going to be offered at MUHA
8 Berkeley. Does this document ---

9 MS. CRUM: First of all, if you would go to the DHEC
10 1 to Exhibit 21, figure 21. It's in the first
11 volume, Mr. Bupp.

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

13 Q: What -- what is that Mr. Levitt?

14 A: So, this is the list of the tertiary DRGs that
15 we excluded. So, we said that these services
16 would not likely be offered in a community
17 hospital or certainly, in the proposed
18 hospital, psychiatric services, trauma, burns,
19 rehab, things like that. So, we excluded these
20 from the potential patients. So, basically, we
21 took all the patients seen at MUSC from their
22 patient origin, and we looked at that. And
23 then, we said of those, who would be likely to
24 be treated in our community hospital; so, we
25 did a subset of that and this is the subset we

1 took out.

2 **Q:** And who developed that -- that list of those
3 extreme DRGs?

4 **A:** I did.

5 **Q:** Okay. Now, let's go back to -- and that's in
6 the CON application, correct? And what page is
7 that?

8 **A:** It's page 41 of the CON application.

9 **Q:** Thank you. Now, let's go back to Exhibit --
10 MUHA ---

11 THE COURT: Let's see. That's Page -- what was the
12 Exhibit Number?

13 MS. CRUM: It's ---

14 THE COURT: DHEC.

15 MS. CRUM: It's DHEC Exhibit 1.

16 THE COURT: 1, Page 41.

17 MS. CRUM: Page 41. Yes, sir. And now, not to
18 confuse things, but we're going to look at TMC
19 Exhibit 41. So, just a coincidence.

20 **Q:** Mr. Levitt, you have the summary page. Explain
21 to the Court what the summary page represents.

22 **A:** So, this is the grouping of the expected volume
23 at the Berkeley Hospital into the ICCE
24 categories. MUSC has a designation they call
25 ICCE, I-C-C-E and that stands for Integrated

1 Center of Clinical Excellence. It's basically
2 a service line grouping, so they group services
3 into these services lines and then, they have
4 directors and physicians and others in charge
5 of those service lines to manage them in that
6 matter. So, this just groups -- you know, I
7 think you saw the 2457 was the year 1 project
8 non-OB volume at Berkeley Hospital. And you can
9 see the ICCE categories that are expected to be
10 treated up there. You know, with the highest
11 being 890 of those patients would fall under
12 the acute critical and trauma ICCE.

13 Q: Mr. Levitt, if you would look behind that --
14 that summary page, there is -- there are a
15 number of pages starting with two of 37 and
16 going all the way through 37. Can you explain
17 to the Court what that represents?

18 A: Yep. So, this adds up that number. So, this
19 -- this shows you the actual DRGs. So, of the
20 900,000 DRGs and those 180 roughly that we saw
21 on the last figure, Page 41 from the CON
22 application, this is what's left over. So,
23 based on the -- the patient ---

24 THE COURT: What's left over or this is what's
25 included?

1 **A:** This is what's included in Berkeley.

2 THE COURT: Yeah.

3 **A:** Of the 1,000, we took 180. So, this is what's
4 left of those 1,000.

5 THE COURT: Oh, okay.

6 **A:** And -- and this what we expect to see at the
7 Berkeley Hospital. And I think, a couple
8 things; so you can see the heading, ICCE,
9 Integrated Center of Clinical Excellence. That
10 groups them together, so it's a little
11 misleading when you say -- on the previous
12 slide it said, there's you know, cancer or
13 psych or whatever. That's the ICCE category,
14 but that's not necessarily the diagnosis. So,
15 you can see the -- the fourth one down,
16 seizures without major complicating conditions
17 falls under children and women ICCE, but it's
18 not a children's or women's DRG.

19 **Q:** Is that DRG 101?

20 **A:** Correct. MSDRG 101. And the same with heart
21 failure and shock just above it. Again, it's
22 not pediatric or it's not children or women
23 with heart failure or shock. That just happens
24 to be the ICCE that that medical diagnosis
25 would fall under, under MUSC's designations.

1 Q: And look on down to 621; what is that?

2 A: Yeah. So, that -- that would be another --
3 another example. So, that's basically
4 bariatric surgery, OR procedures for obesity,
5 falls under the cancer ICCE. So, it's not as
6 though someone in that DRG has cancer; that's
7 just the medical director in charge of that
8 ICCE is what they've called cancer. So -- so,
9 this is the list of services, diagnosis that
10 are expected to be treated at Berkeley
11 Hospital. It's consistent with general acute
12 care hospitals. It's a little different
13 because it has these MUSC ICCE categories, but
14 this is typical of any community hospital and
15 that designation that is in the CON application
16 for the tertiary DRGs is a commonly accepted
17 tertiary definition consistent with the way
18 Roper projected theirs in 2008 and Trident
19 projected theirs consistent with other hospital
20 applications I've done throughout the country.

21 Q: Let me just ask you a couple of questions. On
22 the MS DRG Code in column one, are those the
23 DRGs that that will be served at MU- -- at MUHA
24 Berkeley?

25 A: That's the expectation. Yes.

1 Q: Yes.

2 A: And so, those will be served as well as -- I
3 mean, there could be some of the -- the trauma
4 or the -- the tertiary DRGs we took out. Those
5 could still present and be served at the
6 community hospital, but it's not expected to be
7 a large volume.

8 Q: But this -- these are the volume projections?

9 A: Correct.

10 Q: Okay. Now, the second column is MSDRG name.
11 So, that's the name attached to the DRG; is
12 that correct?

13 A: Yes.

14 Q: And then, the third column is volume year
15 three. Is that the anticipated volume from
16 that particular DRG for year three?

17 A: It says that. I think it's been total -- if
18 you go to the very bottom, I think it tied back
19 to that 2457. I'm sorry. No. 3904. Yes.

20 Q: Yeah.

21 A: That would be the year three projections.

22 MS. CRUM: Okay. All right. I would move to admit
23 TMC, SMC, CMC Trial Exhibit 041.

24 THE COURT: Well, I heard TMC, but then you said
25 what else?

1 MS. CRUM: SMC and C -- it's a HCA ---

2 THE COURT: Oh, this is TMC here.

3 MS. CRUM: Yes, sir.

4 THE COURT: Okay. Exhibit what?

5 MS. CRUM: 041.

6 THE COURT: 41.

7 MR. THOMAS: No objection.

8 MS. HOLLINGSWORTH: No objection.

9 MR. WICEVIC: No objection.

10 THE COURT: It's submitted.

11 (TMC Exhibit Number 41 was admitted into evidence.)

12 **Q: Now, let's look at DHEC Exhibit 1, Page 356.**

13 **Mr. Levitt, does MUHA -- the location that MUHA**
14 **has in Nexton, does it already have the U.S.**
15 **Army Corps of Engineers, Department of Army**
16 **Wetlands Delineation approvals?**

17 **A: Yes.**

18 **Q: So, when the CON is issued, they would not have**
19 **to have any delay going to the Army Corps of**
20 **Engineers for Wetlands, would they?**

21 **A: No.**

22 **Q: Let's look at Trident Exhibit 141. Mr. Levitt,**
23 **can you explain to the Court what that is?**

24 **A: So, this is I think this was used with a**
25 **previous witness and it shows the Trident**

1 patient origin by zip code for 2014 through 11
2 months of 2018. And I think we're going to
3 talk a little bit about this in context of some
4 other exhibits, but I wanted to point out here
5 was that I guess there's been some criticism of
6 our application that we're not serving Berkeley
7 County, the majority of our patients aren't
8 going to come from Berkeley County, and that's
9 right. It's -- it's probably two miles from
10 the Dorchester border, three or four miles from
11 the Charleston border, but maybe five miles,
12 six miles from the Charleston border. So, it's
13 -- it's just over the border in Berkeley
14 County. But more importantly, it doesn't --
15 it's never intended to service solely Berkeley
16 County. You've heard testimony that says
17 there's not a fence around Berkeley County.
18 Well, the fence goes both ways. People can go
19 into Berkeley County for care; they can leave
20 Berkeley County for care. And this shows
21 people do leave for care. So, Charles -- so,
22 Trident Medical Center is in Charleston County.
23 And the top zip codes from which they draw
24 patients is not Charleston County. So, the
25 majority of the patients treated by Trident are

1 not Charleston County residents. And I don't
2 see anything wrong with that. That's because
3 of their location. They're also located very
4 close to the border of Dorchester and Berkeley
5 Counties. So, they serve a tri-county area,
6 just as Roper does, just as MUSC does and just
7 as we would at -- at the MUSC Berkeley
8 Hospital. So, if you look at their highest zip
9 code, 29445 -- so, most people treated at
10 Trident Medical Center are from Berkeley
11 County. The next one, 29483, Summerville.
12 That's Dorchester County. 29461, Moncks
13 Corner, Berkeley County. 29406, that's the
14 boot. I call it the boot. If you looked at a
15 map, it looks just like Italy. The zip code
16 looks just like Italy. That's where Trident's
17 located. So, fourth on the list is the first
18 zip code, which is in Charleston County. That's
19 where they're located. So, and the next one,
20 Summerville, is -- I think that's Dorchester
21 County and then Ladson's all three. That zip
22 code crosses all three counties. So, this just
23 points out, it doesn't matter where the
24 hospital is located as far as they can only
25 serve that county. So, Trident being in

1 Charleston County doesn't only serve Charleston
2 County. MUSC Berkeley isn't going to only serve
3 Berkeley County.

4 Q: Mr. Levitt, does this patient origin, does that
5 mean that's where the patients come from that
6 go to Trident Hospital?

7 A: Yes. This is where they live. This is the zip
8 code that they leave and they were treated at
9 Trident Medical Center.

10 Q: Did you look to see if there were any
11 Charleston peninsula zip codes that patients
12 redirect or go up -- I'm sorry, go up to -- up
13 to Trident?

14 A: I did. So -- so, there was some testimony that
15 south of the Broad, 29401, way down on the tip
16 of the peninsula, those people would never go
17 all the way up there for care. Well ---

18 OBJECTION:

19 MR. THOMAS: Objection, Your Honor. That's --
20 that's not -- he's mischaracterizing testimony.
21 He's flat out stating it wrong.

22 MS. CRUM: Your Honor, I -- I don't think so.
23 That's what I thought I heard.

24 MR. THOMAS: We never said they would never go up
25 there for care.

1 MS. CRUM: Are you stipulating that that wasn't
2 their testimony?

3 THE COURT: Well, what he's objecting to, if I can
4 clear this up and make it easier is Mr. Levitt
5 said they will never go to ---

6 MS. CRUM: Right.

7 THE COURT: --- that area. And I think Mr. Thomas
8 is making the objection ---

9 MR. THOMAS: Right.

10 THE COURT: --- that that's an overstatement.

11 MS. CRUM: Okay.

12 Q: Mr. Levitt, have you looked at this -- this
13 chart -- this patient origin exhibit to
14 determine if patients from the peninsula of
15 Charleston go up to Trident?

16 A: I have and they do. So, if you -- if you page
17 down to 29401, which is a zip code that was
18 raised as far as there was a question, I guess
19 maybe about whether or not those residents
20 would drive all the way up to our facility in
21 Berkeley, 29401, I -- in 20 -- the first -- the
22 last full year of data, which is the second to
23 the last column, 165 people from that zip code
24 went all the way up to Trident for care. And
25 then, 29403 is the other Charleston peninsula

1 zip code. And you can see 1,066 were treated
2 at Trident -- all the way up to Trident, which
3 they say is very close to our facility --
4 travel from peninsula up to Trident.

5 Q: Now ---

6 A: There were a few -- there's a few more, but
7 wait. 29414 -- that's West Ashley, 1,186
8 patients went all the way up to Trident for
9 care.

10 THE COURT: Where 1,100 at?

11 A: 29414. 1,186 was the last full year, so the
12 partial year was 1,073. 1,186 for the full
13 year.

14 THE COURT: Okay.

15 A: 29466, Mount Pleasant, 4 -- over 405 in 2017
16 and even just the partial year of 2018, 424
17 patients from that zip code drove all the way
18 up to Trident for care at Mount Pleasant.

19 THE COURT: And now, Mount Pleasant's not the
20 peninsula. Were the other three the peninsula?

21 A: No. I'm sorry. So -- so the -- the 401 and
22 403 were the peninsula.

23 MR. THOMAS: And Your Honor, right now he's asking -
24 - he's answering a question that hadn't been
25 asked.

1 THE COURT: Okay.

2 OBJECTION:

3 MR. THOMAS: And I'll object to the editorial.

4 MS. CRUM: I'll be happy to ask that question, Your
5 Honor.

6 THE COURT: Okay.

7 Q: Are -- did anybody come from Mount Pleasant to
8 go up to Trident?

9 A: They did. 29466, we just talked about 405
10 patients from Mount Pleasant. So, there was
11 some testimony earlier that people from Mount
12 Pleasant wouldn't drive up to the MUSC Berkeley
13 Hospital that drive from there to go to the
14 Trident Hospital.

15 Q: What about the Sea Islands?

16 A: The Sea Islands, 29412, Johns Island and 29414,
17 so 600 people. 29414, I think that's the West
18 Ashley Sea -- it's on the southwestern zip
19 code. And I've got a map in a minute that will
20 show where some of these are. You know, 1,000
21 people went from there out to Trident. So ---

22 Q: How many went from Walterboro?

23 A: Well, there are a couple of Walterboro zip
24 codes. So, there's that one, 488, right there,
25 over 2,000 in 2017 and partial year -- almost

1 2,000 in the partial year. And I think at the
2 very top, I think is a Walterboro or toward the
3 top. No. I'm sorry. That's the one that I
4 was thinking of. Yeah.

5 MS. CRUM: Now, I'm going to at this point move
6 Trident 41 in.

7 MR. THOMAS: It's already in, Your Honor. It's
8 already in.

9 THE COURT: It's in.

10 MS. CRUM: It's in? Okay. Thank you.

11 Q: Let's look at TMC 86. Are you familiar with
12 this document, Mr. Levitt?

13 (TMC Exhibit Number 86 was referenced at this time.)

14 A: Yes.

15 MS. CRUM: Would you look two pages over? Scroll up
16 two pages. There we go. If you could blow
17 that up.

18 Q: What does bullet three say?

19 A: Expands/migrates lower acute care into the
20 community and quaternary and tertiary care
21 remains on the peninsula.

22 Q: Now, this is the -- the -- what's been referred
23 to affectionately as the SANA Document?

24 A: Yes.

25 Q: And -- and what is this document?

1 **A:** This is the -- the -- well, just as the acronym
2 stands for Space Assessment Needs Analysis for
3 the university.

4 MS. CRUM: Would you go back to Page 1?

5 **Q:** Was this prepared in June or released on June
6 19th, 2017?

7 **A:** Yes.

8 **Q:** Do Space Assessments and Need Analysis in
9 planning change?

10 **A:** Yes. Of course.

11 **Q:** Okay. And did this document give certain
12 options for the needs assessment and space path
13 planning for MUSC for the back field -- the
14 removal of the beds from the University in
15 Children's to Shawn Jenkins?

16 **A:** It did. Now, I think Ms. Smith talked about
17 some of it yesterday.

18 **Q:** Okay. Do you know where, if at all, MUSC is
19 going to have a transplant center?

20 **A:** Yes.

21 **Q:** You don't happen to know what page that is, do
22 you?

23 **A:** I don't know the page number. No. I believe
24 it was on the fifth floor -- fifth or sixth
25 floor of the University Hospital. It's the

1 floor that connects to the pediatric cath lab.

2 MS. CRUM: It's -- keep on going down. Oh, go back
3 up just a little please, sir. Up a little --
4 one more.

5 Q: What has been the trend for the surgical
6 volumes at MUSC?

7 A: They've been increasing.

8 Q: And is that still true today?

9 A: Yes.

10 MS. CRUM: Up to the next slide. Okay. On down a
11 couple of more.

12 MS. JONES: It was on the last one.

13 MS. CRUM: Was it on the last one? Back up one
14 more. One more. Okay. Yeah.

15 Q: Look on Page 21 -- 29150, down there at that
16 bottom little bullet and over on -- on both
17 sides. Where does -- where is the transplant
18 -- transplant going to be?

19 A: So, at this time, it was on the fifth floor
20 University Hospital as I talked about. The --
21 also on here is the -- you can see on the fifth
22 floor the Siemens Zeego Biplane, so they were
23 going to backfill some of that space with some
24 imaging equipment and the transplant services.
25 As of today, I think you heard -- well, as of

1 two weeks ago before this trial started, before
2 I sort of went into a hole and hadn't talked to
3 anybody, the plan at MUSC, that was the only
4 finalized plan for the backfill was the --
5 well, the two -- two pieces, the transplant
6 center and the 29 beds.

7 Q: And where's the transplant center going to go?

8 A: It's on the fifth floor, again, connected to
9 the -- so, the University Hospital and
10 Children's Hospital don't necessarily line up
11 floor to floor. So, the fifth floor of one
12 connects to the sixth floor of the other. So,
13 I think that's the case on this one. It's the
14 fifth of University connecting to sixth floor
15 of Children's or it could be the fourth floor
16 connecting to the fifth floor. It's connecting
17 to whatever floor the pediatric cath lab is in
18 currently. And that's going to be used in the
19 transplant center.

20 Q: Okay. Let's look at the DHEC Exhibit 1 please,
21 sir.

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

23 MS. CRUM: And if you would pull up, Mr. Bupp, Page
24 173.

25 Q: Are you familiar with this document?

1 A: Yeah. This is an attachment to the CON
2 application.

3 Q: Okay. And look on down, about halfway down,
4 Brighton Park is Plan to have. Could you tell
5 the Court what's supposed to be in Brighton
6 Park?

7 A: So, you can see there's 250 apartments and 765
8 single family homes.

9 Q: And is there a 900-student elementary school
10 there?

11 A: Yes. And I -- I think that's the Nexton
12 Elementary, which is -- which is already there.

13 Q: Okay.

14 A: Or I should say open.

15 Q: And look on over if you would please, sir.
16 Where is Brighton Park?

17 A: In the Nexton Community.

18 Q: So, it's just part of that community?

19 A: It -- it is.

20 Q: Okay. Look on over to Page 400, please. Is
21 that another document that you're familiar
22 with?

23 A: It is. Again, another attachment to the
24 application about the traffic studies in the
25 area and it gives some information on the plan

1 development and the size of that development.

2 Q: Well, look under the history, first paragraph.

3 A: Yes. So, you can see almost 3,000 residential
4 units and then subsequently, you can see that
5 was the initial approval and then, 13,000
6 additional households. So, this is a planned
7 area with tremendous residential growth planned
8 and some of it's been developed already. The
9 rest of it is being developed.

10 Q: Okay. And look on over to Page 405, the
11 opportunity, down to the second paragraph. Do
12 you see where it says a build out?

13 A: Yeah. Full build out, 8,000 residents, and six
14 million square feet of commercial space. So,
15 you see this is a -- and this is just within
16 the sort of confines of the Nexton Community.
17 It doesn't include the adjacent communities,
18 Carnes Crossroads and some of those others.

19 Q: Or Brighton.

20 A: Or Brighton.

21 Q: Now, Mr. Levitt, is information like this the
22 kind of information health planners typically
23 rely on in determining need in a location?

24 A: It -- yes. It's -- it's -- you know, that
25 combined with population projections, often

1 times building permits or other factors are
2 necessarily included in population projections.
3 So, this tell us, in addition to what, you
4 know, clarifies or the state demographer or
5 others think the population is going to be,
6 this tells us what's -- what's being planned
7 and built in the area.

8 Q: Okay. And when is the build out projected for
9 here? Do you remember?

10 A: I don't know that -- I don't -- I don't recall
11 the final time line on that.

12 Q: If this hospital, when would it open? I think
13 you were here when Ms. Smith testified
14 yesterday.

15 A: Yes.

16 Q: When is the hospital expected to open if we had
17 a CON and approval to go forward in April?

18 A: I think it would be 2024 because it takes about
19 three years to build it. So, that would put us
20 into 2024.

21 Q: Okay. And if you would look at DHEC 497. Is
22 that a map of Berkeley County?

23 A: It is.

24 Q: Did you look at this in making your
25 determination of what your determination of

1 where the hospital should be located?

2 A: Well, it -- I think what this shows indirectly
3 -- so, what this shows is the -- sort of
4 composition of Berkeley County. I've done work
5 as I've said with MUSC for 20 years. I know
6 Berkeley County fairly well and so -- so where
7 within Berkeley County to put a facility, this
8 sort of illustrates the -- the lack of
9 population to the -- to the east. That's the
10 -- the National Forest, the lakes in the
11 central and northwestern portion, and then,
12 that little bit on top of the lake, sort of
13 this fairly isolated to go south. Going north
14 is Williamsburg and Florence. So, really the
15 -- the corridor -- we've heard a lot of
16 discussion about the corridor of growth there
17 on the I-26 and that's reflected in this -- in
18 this map. You can see that's where the
19 population can live and does live.

20 Q: From a health planning perspective is -- excuse
21 me -- is it important to put healthcare
22 facilities where people are?

23 A: Where people are and where people can access
24 it. Yes.

25 Q: All right. Let's -- Mr. Levitt, you have

1 developed a series of exhibits -- trial
2 exhibits, have you not?

3 A: I have.

4 Q: And those trial exhibits were, if you know,
5 produced on October the 25th, weren't they?

6 A: Yes.

7 Q: Do you know whether or not these exhibits are
8 substantially similar to the exhibits you were
9 deposed on?

10 A: That be -- yes. They are.

11 Q: Okay. Let's look at Roper Saint Francis
12 Exhibit 118. Could you explain to the Court
13 what that is?

14 (Roper Exhibit Number 118 was introduced into the
15 record at this time.)

16 A: So, this is an update from the CON application.
17 We submitted the CON application -- excuse me
18 -- in 2007. So ---

19 Q: Do you mean '07 or '17?

20 A: I'm sorry. '17. And this updates the
21 population for the most recent projections
22 available to see if the population change, you
23 know, is less population projected than when we
24 filed the application. And what it shows is
25 the population trends are consistent with the

1 previous trends two years earlier. You can see
2 the tri-county region, an eight percent growth
3 and you know, within the tri-county, East
4 Cooper, Moncks Corner, Sea Islands and North
5 Charleston, all of those are over eight
6 percent. And the peninsula is the lowest
7 growth area at five percent.

8 Q: And from a healthcare planning standpoint, do
9 you have an opinion as to whether or not it is
10 best to use the most recent data?

11 A: Generally, the most recent data is the best to
12 use?

13 Q: Look at Roper Saint Francis 119-1. Please
14 explain to the Court what this is?

15 (Roper Exhibit Number 119-1 was introduced into the
16 record at this time.)

17 A: So, this shows the comparison. So, this was
18 the growth -- the number of people, the number
19 of additional people that were projected. The
20 first column -- the first column with numbers
21 is the CON application information and then,
22 this the updated information to the right of
23 that. So, you can see the CON application, it
24 was projected to about 64,800 more people and
25 the current data shows 64,665. So, I heard

1 previous testimony that it's not grown as fast
2 as it was and I don't know if they're talking
3 about 200 people, but it -- it's still growing.
4 64,000 more people are expected to live in that
5 area in 2024. 64,000 more people were expected
6 to live in the area in 2022. And then, if you
7 look at where those population growths are, you
8 can see Moncks Corner at 6,000, North
9 Charleston at 19,000, and Summerville at
10 13,000. So, of the 64,000, 38,000 are in the
11 areas closest to our facility.

12 Q: What -- let me ask you. Did East Cooper and
13 West Ashley and the peninsula of Charleston
14 actually lose population?

15 A: No. They -- they projected to grow as well,
16 but the -- the focus of the growth -- the
17 largest growth areas were those three sub areas
18 that we talked about. And then, I think the
19 peninsula showed only 1,000 additional people
20 on the peninsula. So, the superior alternative
21 that they identified -- the oppositions
22 identified was put the beds on the peninsula
23 for those 1,800 more people.

24 Q: And I neglected to ask you, did you develop
25 Roper Saint Francis 118 01 and 119 01?

1 **A: Yes.**

2 **Q: Okay. And look at 1 -- Roper Saint Francis 119**

3 **3. Explain to the Court what this is.**

4 **(Roper Exhibit Number 119-3 was introduced into the**
5 **record at this time.)**

6 **A: So, this ---**

7 **THE COURT: I was -- I was typing. That was Roper**
8 **Saint Francis what?**

9 **MS. CRUM: 119 -- 119.**

10 **THE COURT: Okay. It's just another page number.**

11 **MS. CRUM: Yes, sir.**

12 **THE COURT: Okay.**

13 **MS. CRUM: They -- they made it all one big exhibit**
14 **and so they ---**

15 **THE COURT: I -- I got it.**

16 **MS. CRUM: --- have different pages.**

17 **Q: Would you explain to the Court what this is**
18 **please, sir?**

19 **A: This shows the -- from the revenue of fiscal**
20 **affairs department, the residents of Berkeley**
21 **County discharges and where they were treated.**
22 **And you can see from 2014 to 2018, there's been**
23 **a 37 percent growth in the volume going to**
24 **MUSC. A 33 percent growth in the volume going**
25 **to Trident and about a 10 percent growth in the**

1 -- going to Saint Francis.

2 Q: Do these patients represent all patients going
3 to MUSC downtown?

4 A: From Berkeley County. Yes.

5 Q: Okay. Now, again, did you develop this chart?

6 A: Yes.

7 Q: Okay. Let's look on 118 02. CON Exhibit 10.
8 Develop this?

9 (Roper Exhibit Number 118-2 was introduced into the
10 record at this time.)

11 A: Yes.

12 Q: Would you please tell the Court what it is?

13 A: So, this shows the discharges in 2018. 32,080
14 is the total discharges at the University
15 Hospital and where they came from. So, 18,144,
16 or about 56 percent of the discharges came from
17 the tri-county area, Dorchester, Berkeley, and
18 Charleston counties. And then, the reciprocal,
19 44, 45 percent came from outside those three
20 counties. You can see about 1,400 people came
21 from outside of South Carolina. About 7,600
22 people came from those secondary service areas
23 defined in the health plan -- or defined in the
24 CON application and then, another almost 5,000
25 from the tertiary area. So, we focused on the

1 -- on the -- on the tri-county area and you can
2 see, again, those areas closer to our Berkeley
3 Hospital, North Charleston, Summerville, and
4 Moncks Corner is a large percentage of that
5 population. And you can see the peninsula is
6 only about five percent. So, about five
7 percent of the patients at MUSC come from the
8 peninsula.

9 Q: Let's look at Roper Saint Francis 119, Number
10 2. And did you develop this?

11 (RSF Exhibit Number 119-2 was introduced into the
12 record at this time.)

13 A: I did.

14 Q: Explain to the Court what it represents.

15 A: So, this just compares the 2017 data that was
16 in the application to the 2018 data, which was
17 the most recent available. And you can see,
18 it's pretty consistent. So, in 2017, 56.1
19 percent came from the tri-county. In 2018,
20 56.6. And again, within those sub-market
21 closer to our Berkeley Hospital, North
22 Charleston, Summerville, and Moncks Corner,
23 those numbers are nearly identical.

24 Q: And going on down to the bottom. Do you see
25 where it says date produced 219-10-11?

1 A: Yes. Can you zoom down the bottom? There.

2 Yes.

3 Q: And this was -- look on over to the right, was
4 this produced by MUHA?

5 A: Yes.

6 Q: Okay. And this again is all patients, right?
7 Not just the non-tertiary ones.

8 A: This, I think, is all patients excluding OB.
9 But yes.

10 Q: Right. Okay.

11 A: Includes tertiary.

12 Q: Let's look at MUHA 38-J. Did you produce this
13 document?

14 (MUHA Exhibit Number 38j was introduced into the
15 record at this time.)

16 A: I did.

17 Q: I'm sorry. Okay. Explain to the Court what
18 this is.

19 A: I produced it and developed it.

20 Q: Produced and developed. Yes, sir.

21 A: It -- it is the patient origin. So, we looked
22 at those sub-markets, and now, these are the
23 zip codes within those sub-markets. So, in the
24 CON application, these definitions were
25 provided. So, the North Charleston area, which

1 is what MUSC has divided the market into these
2 zip codes. This is the definition that they
3 used for those zip codes.

4 Q: When you say they, who are you talking about?

5 A: The -- the -- I guess the planning department
6 and anyone else within medical University
7 Hospital authority when doing the planning.
8 So, if you were to -- to mention to somebody
9 sub-markets, they'd know what you were talking
10 about. I doubt they would know off the top of
11 their head what zip codes are included in those
12 areas because they grouped them together in --
13 in those areas that we talked about. So, North
14 Charleston comprises all of those zip codes
15 listed below and you can see that the
16 discharges vary by -- by zip code. So, 29404,
17 there were a total of 33 discharges. In 29495,
18 there were 1,700 discharges. So, the -- the
19 zip codes vary by -- by zip -- the discharges
20 vary by zip code. But what this shows is the
21 first column is the total discharges, and then,
22 we took out those tertiary DRGs that we
23 identified in the CON application. I think it
24 was 20 -- or Figure 21. The -- the -- not --
25 the tertiary DRGs. So, that -- the second

1 column is what's left over. So, these are the
2 ones that the pool of patients from which we
3 think would go to the Berkeley Hospital. The
4 redirection percentage for those zip codes and
5 then, the math. So, the first zip code, 29404,
6 there were 33 patients treated at MUSC. Four
7 of those were non-tertiary. 35 percent of
8 those would go to the MUHA hospital in Berkeley
9 County and that results in one projected
10 admission to the Berkeley Hospital.

11 Q: And -- and then, what you've got is what you
12 called what's left over. Is that -- does that
13 relate to Trident Medical Center TMC Exhibit
14 41, the non-tertiary, quaternary GRDs (sic)
15 that wouldn't be served?

16 A: DRGs. Yes. Uh-huh (affirmative response).

17 Q: Okay.

18 A: Those are the -- the -- that's the pool we're
19 talking about. So, this -- this all ties to
20 that. And I think it -- it shows if you were
21 to look at map by zip code, some of these are
22 closer, some of these are further because it's
23 that whole region of the North Charleston area.
24 So, some are on the north side, some are on the
25 south side. So, this was the -- this is the

1 underlying data by zip code for each of those
2 sub-markets, the zip codes, and the math to
3 show the redirection.

4 Q: And did you look at the DHEC 1, please. With
5 -- it's 20 -- 26. All right. Look at 27.
6 That's -- 27. It's -- I want DHEC CON Page 27.
7 Okay. You were talking about the designations.
8 Does that show what MUSC designates?

9 A: Yeah. If you show Figure 5, that shows the
10 map. So, we talked about North Charleston and
11 those zip codes in that green area kind of in
12 the middle. Those are the zip codes we
13 identified as North Charleston, Summerville
14 that blue area. Back on -- on MUHA 38-J shows
15 the, you know, eight or ten zip codes that are
16 included in that area. And you can see some of
17 them in the map. You can read a few of those,
18 you know, if you zoom in on the map. Under the
19 word Summerville, you can see there's a zip
20 code listed, 29473, 29477. So, those are the
21 ones that are listed in the table on MUHA 38-J
22 that correspond to that.

23 Q: Let's look at MUHA 38-K. Did you develop and
24 produce this document?

25 (MUHA Exhibit Number 38k was introduced into the

1 record at this time.)

2 A: I did.

3 Q: Would you please explain to the Court what it
4 shows?

5 A: So, 38-J was the -- the non-tertiary, this is
6 the OB. So, this is the same information, the
7 same format, showing the OB discharges, the
8 redirection by zip code and the resulting
9 expected volume at the Berkeley Hospital for OB
10 services.

11 Q: Let's look at Roper Saint Francis 118-4. Do
12 you recognize this document?

13 (Roper Exhibit Number 118-4 was marked for
14 identification purposes.)

15 A: Yes.

16 Q: Did you produce it?

17 A: I -- I prepared it and produced it. Yes.

18 Q: Please tell the Court what it is.

19 A: So, this shows the trend of -- the inpatient
20 trend in the tri-county area. So, in 2012,
21 there were about 75,000 discharges for age 16
22 and over, so adults basically. And that number
23 has gone up in 2017 to 84,000. So, nearly
24 10,000 additional discharges in the market, in
25 a five-year period. So ---

1 Q: Is that a significant increase?

2 A: It is. It's an 11 percent increase in
3 discharges. All of those are discharged from
4 a hospital. And so, it shows there's
5 increasing need in the tri-county area. More
6 people are using hospitals. That's due to
7 population growth and other factors. So,
8 there's need for more resources in the market.

9 Q: How -- how much discharge growth has MUSC had
10 in the -- in those years?

11 A: MUSC about 5,000 additional discharges. So,
12 2012, it was 26,000. Up to 31,000 by 2017.

13 Q: Is that about half of the total discharges
14 between 2012 and 2017?

15 A: Yes.

16 Q: Let's look at Roper Saint Francis 118-5.
17 (Roper Exhibit Number 118-5 was introduced into the
18 record at this time.)

19 Q: Did -- did you prepare -- oh. One thing. Let
20 me go back to 18 -- 118-4. Is this an updated
21 figure for the CON application?

22 A: Yes. I think it was the CON application for
23 the 12 -- I think it went through '16, 2016.
24 And then, we had a 2017 information available,
25 so we included that. I -- I think one more

1 thing. You mentioned the 5,000 additional
2 discharges at MUSC; that represents about 3.3
3 percent growth in admissions. And so, if you
4 remember in the CON application, I --
5 hopefully, somebody talked about the projected
6 growth in the CON application was 1.7 percent
7 annually. So, the volume projection growth in
8 the CON was half of the actual experience at
9 MUSC. So, I think it's a conservative
10 estimate.

11 Q: All right. So, let's go back to 118-5. Is
12 this again an update?

13 A: It -- it's an update. Yes. So, think we had
14 through 2017 in the application. 2018 is
15 updated and it shows those discharges we talked
16 about. Average length of stay, the days,
17 average daily census, and the occupancy. So,
18 you can see we're bouncing around 80 to 85
19 percent occupancy at the hospital. And it's
20 hard to operate at that level. That's on
21 average all year. So, we talked about -- you
22 heard testimony about their peaks during the
23 week; Monday -- Tuesday, Wednesday and
24 Thursday, I think or Monday, Tuesday,
25 Wednesday. So, there's peaks during the week.

1 Then there's peak -- there's seasonality. So,
2 this is on average. So, there are many days
3 where it's 100 percent occupied to get to that
4 85 percent overall average for the year.

5 Q: Would you look at RSA -- RSF 118-11. Did you
6 develop and produce this document?

7 (Roper Exhibit Number 118-11 was introduced into the
8 record at this time.)

9 A: I did. So, this takes the methodology ---

10 Q: It is an update to the CON application?

11 A: It is. So, it takes the methodology in the CON
12 application. That was based off 2017 data and
13 we used the same methodology and based it off
14 2018 data, and this was the result. So, it's
15 very similar, slightly higher projected
16 utilization because the volumes went up from
17 the projected zip codes.

18 Q: Let's look at Roper Saint Francis 118-12.

19 Could you tell the Court what this is?

20 (Roper Exhibit Number 118-12 was introduced into the
21 record at this time.)

22 A: Sure. So, this does the same thing for the OB
23 volumes. So, we updated the OB projections
24 based off the 2018 data. And I think actually
25 this one showed a little lower utilization

1 because OB use rates when down a little bit
2 than what was projected in the CON application.

3 Q: Why does the OB use rates go down?

4 A: They -- they are nationally. I -- I guess
5 people are not having as many kids as they used
6 to, but the OB use rates regionally and
7 nationally are going down.

8 Q: And this again is an update CON application?

9 A: It does.

10 Q: Roper Saint Francis 118-7. Did you develop and
11 produce this?

12 (Roper Exhibit Number 118-7 was introduced into the
13 record at this time.)

14 A: Yes. I produced this. This was developed --
15 you can see at the bottom produced by the
16 Enterprise Business Intelligence at MUSC. This
17 is something they normally look at. I think
18 Dr. Warr talked about some of this information.
19 This is a graph that they look at and what it
20 shows -- it was submitted in the CON
21 application, I think 20 -- FY 2017 was in the
22 CON application. This is for FY 2018 and it
23 shows the volume of requests and where they
24 came from.

25 Q: And they're requests for what?

1 **A:** For transfer. So, these hospitals have asked
2 to send patients to be admitted to at MUSC
3 Medical Center on the peninsula and -- the
4 largest coming from Tidelands, 1,900 patients,
5 they wished to transfer. And then, you can see
6 Roper is number three and Trident Summerville
7 was number four. So, both of those about 1,200
8 transfer request in 2018 each.

9 **Q:** And what is Colleton?

10 **A:** Colleton is about that. About 1,100.

11 **Q:** And Trident, Summerville, Colleton added
12 together, they're HS -- HCA hospitals. What's
13 the transfer request for all three of them?

14 **A:** It's 20 -- almost 2,400.

15 **Q:** Okay. Where is Tidelands?

16 **A:** Tidelands is in Georgetown.

17 **Q:** Okay.

18 **A:** And -- and Murrells Inlet. That's both the
19 Georgetown Hospital, and Georgetown and
20 Waccamaw Community Hospitals in Murrells Inlet.

21 **Q:** Okay. Look at RS -- RSF 118-8. Tell the Court
22 what this is. First -- first off, did you
23 develop and produce this?

24 **(Roper Exhibit Number 118-8 was introduced into the**
25 **record at this time.)**

1 **A:** Yes. So, this updates figure 24 in the CON
2 application using again 2018 data. And it
3 shows the -- the percentage. So, it just shows
4 the Tri -- Tri-County total in those
5 facilities. The specific facilities within
6 Trident and Roper that requested the transfers
7 to the Medical University.

8 **Q:** And I -- I should have asked you, on each one
9 of these exhibits that we've looked at, did you
10 include the source of the data that you used?
11 For example, you see down there, it says
12 source, MUSC internal data?

13 **A:** Yes, ma'am.

14 **Q:** Let's look at Roper Saint Francis 118-9. Did
15 you develop and produce that?

16 (Roper Exhibit Number 118-9 was introduced into the
17 record at this time.)

18 **A:** Yes. So, this shows from 2011 to 2018 the
19 volume of requests has gone up, the volume of
20 denials has gone down, but it's still over 657
21 in 2018 and we've got some details that show
22 some of the reasons why those denials occurred.

23 **Q:** Okay. When you talked about denials, you --
24 the denials for what?

25 **A:** MUSC has said they cannot admit that patient.

1 Q: It's a denial of the transfer request ---

2 A: Yes.

3 Q: --- for those? Yeah. Okay. Let's look at
4 Roper 11 -- Roper Saint Francis 118-10. Did
5 you develop and produce this?

6 (Roper Exhibit Number 118-10 was introduced into the
7 record at this time.)

8 A: I did. So, this updates is Figure 26 in the
9 CON application, adding the 2018 data. And you
10 can see that the number denied, that's 657, was
11 on the previous slide. And you can see that in
12 2018, 288 of those were denied because no beds
13 were available. And you can compare that to
14 2011 where only 92 of the denials were because
15 no beds were available. So, you can see it's
16 a problem and it's not getting better.

17 Q: As a percentage of total denial gone up?

18 A: The ---

19 Q: Look at the bottom line.

20 A: Well, the percent total denied because beds
21 weren't available have gone up substantially.
22 So, in 2011, six percent of the denials were
23 because beds weren't available and in 2018, 44
24 percent of the denials were because beds
25 weren't available.

1 Q: Let's look at RSF 118-6. Did you produce and
2 develop this?

3 (Roper Exhibit Number 118-6 was introduced into the
4 record at this time.)

5 A: I did.

6 Q: What is it?

7 A: So, this looks at the Figure 28 from the CON
8 application, adds 2018 data and shows the
9 percentage of the admissions -- I'm sorry --
10 the percentage of the ER visits that were
11 admitted. So, think Dr. Cawley and Dr. Warr
12 both mentioned around 20 or 25 percent, and
13 that's what the data showed. In 2018, it was
14 22 percent of the ER visits were admitted to
15 the hospital.

16 Q: Let us look at Roper Saint Francis 119-90. Did
17 you develop and produce this?

18 (Roper Exhibit Number 119-90 was introduced into the
19 record at this time.)

20 A: I did. This updates CON Figure 33 for the most
21 recent data that we had available at the time
22 and it shows nearly a thousand physicians on
23 staff at the University.

24 Q: And look at Roper Saint Francis 119-4. Did you
25 develop and produce this?

1 (Roper Exhibit Number 119-4 was introduced into the
2 record at this time.)

3 A: Yes. So, this -- this sort of shows the
4 detail, I think we showed in the exhibit
5 earlier that showed the volume of Berkeley
6 County patients and it shows that one location,
7 MUSC, had over 4,000 admissions and the three
8 combined Roper had a little less than that.

9 Q: Is -- is this all patients without regard to
10 DRG status?

11 A: It is.

12 Q: Okay. Look at Roper Saint Francis 119-5. Did
13 you develop and produce this?

14 (Roper Exhibit Number 119-5 was introduced into the
15 record at this time.)

16 A: I did.

17 Q: And would you explain to the Court what it is?

18 A: So, this shows the -- this sort of combines
19 some of those other figures. So, it shows that
20 the first sort of section is the adult
21 discharges, 16 and over and you can see the
22 discharges in Berkeley County went from about
23 14,000 in 2014 to over 17,000 in 2018. At the
24 same time -- so that's about a 4,000 additional
25 discharges. The same time in Charleston, only

1 a thousand additional discharges. So, more
2 people from Berkeley County are seeking care.
3 Same with Dorchester, that area, 12 -- 13,000
4 going up to 14,000. So, it shows the growth
5 area. It's consistent with the population
6 growth that that are to the north of Charleston
7 is the growing area. Looking at the population
8 estimates at the center part and then, we just
9 divided those two numbers to get that third
10 part of the use rate. So, you can see the use
11 rate in Berkeley County is going up about 16
12 percent from 2014 to 2018. That supports
13 additional need for resources in the area.
14 More people are being admitted to the hospital,
15 need to admitted to the hospital and supports
16 the proposed project to add more resources in
17 that area. Dorchester also growing, the use
18 rates growing, but Charleston, it's declining.

19 Q: Would you look at MUHA RFP 29308?

20 MS. CRUM: You know, Your Honor, I think something
21 got in here my mistake. It's in the wrong
22 place.

23 Q: Would you look at Roper Saint Francis 119-07?

24 Did you develop and produce that?

25 (Roper Exhibit Number 119-7 was introduced into the

1 record at this time.)

2 A: Yes.

3 Q: Please explain to the Court what it is.

4 A: So, I believe it was Dr. Cawley talked about OR
5 boarding hours and those are patients who have
6 had surgery, are finished with their surgery
7 and recovered and are waiting for a bed to
8 become available so they can be admitted to
9 that bed. This looks at the 12 months ending
10 in July of 2019. It shows the boarding hours
11 by month. I converted those hours into an
12 average daily census, so the last column shows,
13 you know, total for 2018. There's about, on
14 average there -- every day, there's about four
15 people waiting every day, 365 days a year,
16 who've had surgery and can't get into a bed.
17 I think it's important -- again, that's the
18 average, so it doesn't happen that way in the
19 hospital. It's not like every surgery is
20 spread evenly over the 24 hours. So, it could
21 be as high as three times this. You know, in
22 the morning or midday or afternoon when all the
23 surgery -- the bulk of the surgery is being
24 done and those people are finished. Beds
25 aren't available. So, this is on average.

1 This is very, very conservative for people
2 waiting for a bed because there's not one
3 available.

4 **Q:** Thank you.

5 MS. CRUM: Okay. Let's go to the next slide. The
6 next slide. Okay. Is there one back before
7 that?

8 **A:** The ---

9 MS. CRUM: I think one down. Okay.

10 **Q:** And that is Roper Saint Francis 119-008. Did
11 you develop and produce this?

12 (Roper Exhibit Number 119-8 was introduced into the
13 record at this time.)

14 **A:** Yes.

15 **Q:** And can you explain to the Court what it is?

16 **A:** This is the -- this is the boarding hours for
17 ER, so you can't quite -- if you can go up to
18 the right just a little bit. Yeah. ER
19 boarding hours and what it shows ---

20 **Q:** Is ED and ER the same?

21 **A:** I'm sorry. Yes. ED is emergency department.
22 ER is emergency room. It's ED boarding hours.
23 And it shows similar analysis. So, these are
24 people who have been treated in the emergency
25 room, have been cleared to be admitted to the

1 hospital, but a bed is not available for them.

2 So, if you go -- so, I -- I guess if you go
3 down to the bottom a little bit, I think one
4 thing to point out here is ---

5 MS. CRUM: Can you scroll down to the bottom,
6 please?

7 A: You can see there's a portion of patients that
8 stay greater than 48 hours, more than two days
9 in the ER, 25 to 48 hours. So, over a day, but
10 less than two days. So -- so, you can see
11 while the majority are less than four hours,
12 there's a group that stay a long time waiting
13 for a bed. And again, this is non-psych. So,
14 these aren't patients waiting for beds in the
15 Institute for Psychiatry, which is also very
16 well utilized. These are people waiting for
17 beds in the hospital.

18 Q: And if you go to 119-6.

19 (Roper Exhibit Number 119-6 was introduced into the
20 record at this time.)

21 A: That -- that would have tied back to ---

22 Q: Got one more.

23 A: 119-07. Yes.

24 Q: Okay.

25 A: Uh-huh (affirmative response).

1 Q: Is it the same thing as 119-08 developed the
2 same way?

3 A: Yes.

4 Q: Okay. Let's go to Roper Fran San -- San -- RSF
5 119-09. Did you develop and produce this?

6 (Roper Exhibit Number 119-9 was introduced into the
7 record at this time.)

8 A: Yes.

9 Q: And explain to the Court what it is?

10 A: So, this -- this just adds those together. So,
11 we talked about the -- the OR boarding hours
12 and the emergency room boarding hours. No.
13 I'm sorry. This is just the ED boarding hours.
14 So, this calculates from that last slide the
15 boarding hours, turns it into average daily
16 census. So, twice as many people in the ER are
17 waiting for a bed than in the O- -- from the
18 ORs, but still it's an average daily census of
19 8. And you can see by month. So, if you look
20 at January, the average was 10. Again, that's
21 not spread evenly over the day. So, it could
22 be as many as 20 or 30 in a day, a certain day
23 waiting. If it's a busy ER and a busy
24 hospital, those are the bad days. I think you
25 heard Dr. Warr call -- talk about EP3 status.

1 These are -- when that occurs is we got
2 patients that have to get in beds, we have to
3 get patients out of beds and get these other
4 patients into the beds.

5 Q: Okay. Let's look at RSF 119-17. Did you
6 develop and produce this?

7 (Roper Exhibit Number 119-17 was introduced into the
8 record at this time.)

9 A: I did.

10 Q: Please explain to the Court what it is?

11 A: So, this shows the bed distribution per capita.
12 So, the number of beds and the population. So,
13 there was some testimony earlier than this is
14 outdated. I -- I don't think it's outdated.
15 It's a very reasonable way of looking at
16 distribution and what it shows is the mal-
17 distribution of beds in the Tri-County area.
18 So, you can see Charleston County, 4.33 per
19 thousand beds. And then, Dorchester and
20 Berkeley County are less than one bed per
21 thousand. It's a very mal-distributed volume
22 of beds of the 1,800 or so beds in the area.
23 16 -- almost 1,700 are in Charleston County.
24 So, the Berkeley County, you can see the
25 asterisk there. We included 100 beds in

1 Berkeley County, the 50 beds at Roper and the
2 50 beds that Trident's been approved for. But
3 still, the bed to population ratio is .5. So,
4 half a bed per thousand population. State of
5 South Carolina is almost five times that; 2.4
6 beds per thousand. So, you can see, I think,
7 some previous testimony was it's getting better
8 because before it was zero beds per thousand.
9 Before Roper and Trident were approved in
10 Berkeley, it was zero per thousand. Now, it's
11 .5 per thousand. Adding our 128 beds, still is
12 pretty far from the state average. But again,
13 it is makes it better. Adding them in
14 Charleston County would make it worse. That
15 4.3 would go up significantly higher than the
16 state average.

17 Q: Let's look at Roper Saint Francis 119-18. Did
18 you produce and develop this?

19 (Roper Exhibit Number 119-18 was introduced into the
20 record at this time.)

21 A: Yes. So, this looks at all counties with
22 general hospitals and does that same analysis
23 and looks at where the beds per population can
24 -- in 2015 compared to the 2015 population.
25 And I think you can see Charleston is fourth

1 highest in the state. Pretty consistent with
2 Greenwood, lower than union and a lot lower
3 than Florence. So, Florence seemed to be the
4 most over-bedded area of the state. I think
5 what's important is to go to the bottom. The
6 lowest number of beds per population in the
7 entire state, Berkeley County.

8 Q: And if you had updated this, the total
9 population to 2018, what impact would it have
10 with regard to whether Berkeley County was
11 still the lowest in the state?

12 A: It -- it would still be the lowest. It would
13 be even lower because the -- the denominator
14 would be higher. So -- so, to say that Berkeley
15 County is well served, it has the lowest number
16 of beds to population in the entire state.

17 Q: Does -- does that -- the lowest bed to
18 population ratio, does that have anything to do
19 with accessibility?

20 A: It -- it absolutely does. So, you know, we
21 talked about there aren't fences around the
22 county, so people can cross the county line to
23 go to other care. There's some care in
24 northern Charleston County, but all -- the vast
25 majority -- I should say, the vast majority of

1 beds are in the peninsula. So, adding more
2 beds further away from this population -- and
3 you can see Dorchester is on the list too.
4 Dorchester is third from the lowest. So, adding
5 beds in the areas that are accessible to
6 Dorchester and Berkeley residents helps to
7 improve this. Adding beds on the peninsula
8 further -- that's -- I can think of a further
9 -- I guess there could be other areas of
10 Charleston County that are further from that
11 area, doesn't make sense. So, it makes it less
12 accessible to -- in the area that has a
13 demonstrated lack of an access to -- to beds.

14 Q: And how, if at all, does Roper Saint Francis
15 119-18 impact patient choice in particular for
16 MUHA aligned patients?

17 A: Well, so those residents in Dorchester and
18 Berkeley County have limited choices now. You
19 can see .8 and .5 beds per thousand. So, they
20 have limited choices now to the extent that
21 MUHA Berkeley is approved and operational,
22 it'll increase the access to those residents
23 and increase access to those residents at --
24 which wish to seek care at an MUHA facility,
25 much closer to home.

1 Q: Let's look at Roper Saint Francis 119-19. Did
2 you produce and develop this?

3 (Roper Exhibit Number 119-19 was introduced into the
4 record at this time.)

5 A: Yes.

6 Q: Would you please explain to the Court what this
7 shows?

8 A: So, this takes that 2.41 beds per thousand
9 population, that's the state average, and
10 applies to the projected pop -- or yeah. I'm
11 sorry. Yes. The estimated population in 2015
12 to get a bed need. So, this would say that if
13 Berkeley, Charleston and Dorchester all had bed
14 -- existing bed inventory consistent with the
15 state, here's how many beds they would have in
16 each of those counties. So, you'd have 488 in
17 Berkeley, 938 beds in Charleston and 367 beds
18 in Dorchester. Then, we showed a bed inventory
19 of existing beds in the market in each of those
20 counties. Again, we included both Berkeley
21 Hospital, one's operational now, one's
22 approved. And you can see, there's still a
23 need for 388 more beds in Berkeley County.
24 There's an oversupply of 750 beds in Charleston
25 and a need for 243 more beds in Dorchester

1 County. So, that would -- you know, if -- if
2 you were able to pick up and move the hospital
3 beds to make them evenly distributed between
4 the three counties, that's what it would look
5 like.

6 Q: Okay. Let's go to Roper Saint Francis 119-20.
7 Did you develop and produce this?

8 (Roper Exhibit Number 119-20 was introduced into the
9 record at this time.)

10 A: Yes.

11 Q: And would you explain to the Court what it is?

12 A: So, this says what is the need of Berkeley
13 County residents based on their actual
14 utilization. So, we talked about in 20 -- I
15 guess on a previous slide, there was an
16 increase in the use rate. This doesn't given
17 affect to that. This just says based on the
18 actual use rate, the number of discharges for
19 residents of Berkeley County. In 2018, it was
20 17,370. They had a length of stay of a little
21 less than four days. They had an average daily
22 census of 182 roughly. And so, at 75 percent
23 occupancy, how many beds would be needed to
24 treat those patients. And the number is 242.
25 So, again, there's not a fence around the

1 county. Not saying that these people can't go
2 somewhere else for care, but just saying if you
3 wanted to treat Berkeley County residents in
4 Berkeley County, you'd have to have 242 beds.

5 Q: Let's look at Roper Saint Francis 119-23. Did
6 you develop and produce this?

7 (Roper Exhibit Number 119-23 was introduced into the
8 record at this time.)

9 A: Yes.

10 Q: Would you please explain to the Court what this
11 shows?

12 A: So, this shows the -- based on the State Health
13 Plan, the experience Roper has had in 20 -- in
14 the 2016 Health Plan, they had 401 beds on the
15 peninsula and none off the peninsula. Then,
16 they started moving beds and they moved 85 beds
17 from the peninsula to Mount Pleasant to create
18 Roper Mount Pleasant Hospital. So, at that
19 point, they had 316 beds left on the peninsula
20 and 85 beds off the peninsula. Then, recently
21 they've moved 50 beds off the peninsula to care
22 the Roper Berkeley Hospital. So, that now
23 gives them 266 beds on the peninsula and 135
24 beds off the peninsula. So, Roper has
25 identified the mal-distribution of beds within

1 the tri-county area. They are trying to
2 address that. They've moved their beds off the
3 peninsula and MUSC doesn't want to move beds
4 that are already on the peninsula, it just
5 doesn't want to add more beds to the peninsula.
6 Let's put those beds somewhere else to help
7 remedy that mal-distribution of beds as well.

8 Q: Let me ask you under the dark blue top left
9 arrow, it says Roper Hospital 401 beds in 20 --
10 2006 State Health Plan. Never mind. I got it.
11 Okay. Let's go to Roper Saint Francis 119-24.
12 Did you develop and produce this?

13 (Roper Exhibit Number 119-24 was introduced into the
14 record at this time.)

15 A: I did.

16 Q: Please tell the Court what it is.

17 A: So, this goes back a little further. This --
18 this look at Roper and Saint Francis together.
19 You know, in 1989 they weren't a part of the
20 same system. But it looks at where they have
21 their beds. You can see in 1989, they had
22 almost 800 beds on the peninsula combined,
23 those two facilities. They had the old Baker
24 Hospital in North Charleston off the peninsula
25 and that was their distribution of beds. So,

1 then by 1993, that number went down to 381 beds
2 on the peninsula, 298 beds off the peninsula.
3 They've added some -- they added some beds at
4 Roper, closed Baker Hospital, added some beds
5 to Saint Francis. So, in 2001, there was 414
6 in 201 off the peninsula, and it sort of -- the
7 trend continues until 2009, 266 beds and 336
8 beds. So, you can see that -- it's recognized
9 in the market. Not all the beds should be on
10 the peninsula, need to be on the peninsula.
11 Better to be distributed among the tri-county
12 area.

13 Q: And would you please look at Roper Saint
14 Francis 119-25?

15 (Roper Exhibit Number 119-25 was introduced into the
16 record at this time.)

17 A: Sure. Those this just depicts that, showing
18 where the beds are, where they put them; off
19 the peninsula out into the tri-county area to
20 make it more accessible to residents to access
21 those resources. And these were all existing
22 beds they moved off the peninsula. Again, MUSC
23 is asking to move existing beds off the
24 peninsula, it's just asking to not add more
25 beds to the peninsula and add those beds

1 somewhere else.

2 **Q:** Did you develop this map?

3 **A:** Yes.

4 **Q:** Where -- where did the map come from?

5 **A:** From the information we just looked at.

6 **Q:** All right. Let's look at Roper Saint Francis
7 119-26. Did you develop and produce this?

8 (Roper Exhibit Number 119-26 was introduced into the
9 record at this time.)

10 **A:** Yes.

11 **Q:** What -- would you explain to the Court what it
12 is?

13 **A:** So, again, we updated the projections using the
14 2018 data versus the 2017 data. The first line
15 shows the projections in the CON application.
16 In 2025, we projected about a 4,500 non-
17 tertiary discharges using the updated data,
18 same methodology as outlined in the
19 application. That numbers up slightly, 4,700
20 discharges. So, updating the data shows about
21 300 more admissions would be expected using the
22 exact same methodology.

23 **Q:** Would it be expected at Roper Berkeley?

24 **A:** Yes.

25 **Q:** MUSC Berkeley.

1 **A:** **MUSC Berkeley.**

2 **Q:** **Okay. 119 -- Roper Saint Francis 119-27. What**
3 **is this?**

4 **(Roper Exhibit Number 119-27 was introduced into the**
5 **record at this time.)**

6 **A:** **So, this does that same thing for OB. As we**
7 **talked about, the OB use rates down slightly.**
8 **So, in 2018, there was slightly less OB**
9 **discharges than in 2017. So, about 19 less OB**
10 **discharges are projected at the MUHA Berkeley**
11 **hospital. Not a material difference.**

12 **Q:** **Did you produce and -- develop and produce**
13 **this?**

14 **A:** **Yes.**

15 **Q:** **And Roper Saint Francis 119-28. Explain to the**
16 **Court what this is please, sir.**

17 **(Roper Exhibit Number 119-28 was introduced into the**
18 **record at this time.)**

19 **A:** **Just is -- this just adds those together to say**
20 **that in the third year -- that 2025, in the CON**
21 **application, we projected about 4,467**
22 **discharges, average daily census of 64, for**
23 **occupancy about 57. Updating that information**
24 **using the same methodology, slightly more med**
25 **surge, a little less OB, but the average**

1 occupancy is now 61 percent or slightly higher
2 than what it was projected previously.

3 Q: And Mr. Levitt, you produced and developed
4 this?

5 A: Yes.

6 Q: But you said 2025.

7 A: Yes.

8 Q: We know now that the hospital can't open before
9 2024; is that right?

10 A: Correct. So, we -- we kept the time lines the
11 same for ease of comparison. So, in the CON
12 application, we assumed the third year would be
13 2025. So, we updated it. Assumed the third
14 year was still 2025. We know now the planning
15 horizon has shifted out further. So, these
16 numbers would be a little higher for one more
17 year, about 1.7 percent higher.

18 Q: And would you look at Roper Saint Francis 119-
19 29? Did you produce and develop -- develop and
20 produce this?

21 (Roper Exhibit Number 119-29 was introduced into the
22 record at this time.)

23 A: Yes.

24 Q: And would you please explain to the Court what
25 it is?

1 **A:** So, I'm sorry. I misspoke on the last one.
2 The last one was just med surge. This is OB.
3 This shows the comparison updated for OB. So,
4 again it shows CON application we projected to
5 about 61 percent occupied. And by 2018 --
6 using 2018 data, we'd be about 60 percent
7 occupied. So, again, not a material
8 difference. An average daily census of .2
9 lower.

10 **Q:** And let's look at Roper Saint Francis 119. Did
11 you develop and produce this?

12 **A:** 119.

13 **Q:** 199-36. I'm sorry.

14 (Roper Exhibit Number 119-36 was introduced into the
15 record at this time.)

16 **A:** Yes.

17 **Q:** Please explain to the Court what it is.

18 **A:** So, this in response to Mr. Hiott from
19 Colleton. His adverse impact analysis, just to
20 show how unreasonable it is. So, he assumed
21 for those four zip codes that Colleton Medical
22 Center would lose between 25 and 50 percent of
23 their patients from those zip codes ---

24 **OBJECTION:**

25 **MR. THOMAS:** I am objecting, Your Honor. This is not

1 what Ms. -- Mr. Hiott did. He also had a
2 category of 10 percent on here and that's not
3 -- that's left off. So, I'm objecting to -- to
4 the presentation.

5 THE COURT: You can rephrase that.

6 **Q:** Would you show me -- tell me what this shows,
7 Mr. Levitt?

8 **A:** So, we -- we looked at the two highest
9 scenarios that Mr. Hiott produced, the 25 and
10 the 50 percent impact on his facility and for
11 those four zip codes, what we showed at the top
12 is for those four zip codes, MUSC currently has
13 about 212 patients from those four zip codes.
14 Mr. Hiott thought that if we took 25 percent of
15 his patients, that would be 65 patients or if
16 we took 50 percent of his patients, that would
17 be 131 patients. If you add those together,
18 that would give us 227 under the 25 percent
19 scenario or 343 under the 50 percent scenario.
20 So, he thinks that we would impact -- the MUSC
21 combined market share of those four zip codes
22 would go up 30 or 61 percent. I think that's
23 just an unreasonable assumption and I have
24 another exhibit that'll show why it's
25 unreasonable. But he -- he -- he came up with

1 these two scenarios and said 25 and 50 percent
2 are going to be taking from us and the
3 resulting MUSC volume in those markets is
4 dramatically higher than it was historically.

5 **Q:** Mr. Levitt, based on your knowledge of the
6 geography you had in Low Country, South
7 Carolina, would the patients from these zip
8 codes be driving close to the Trident or
9 Summerville existing?

10 **A:** Yeah.

11 **OBJECTION:**

12 **MR. THOMAS:** I object, Your Honor. She hasn't laid
13 the foundation here for where in the drive
14 times where -- where 29437 ---

15 **MS. CRUM:** I'll -- I'll withdraw that, Your Honor.
16 We -- we'll get to that later.

17 **Q:** Would you look at RSF 119-37? Did you develop
18 and produce this?

19 **(Roper Exhibit Number 119-37 was introduced into the**
20 **record at this time.)**

21 **A:** I did.

22 **Q:** And please explain to the Court what this is?

23 **A:** So, this is Mr. -- Mr. Hiott's Colleton County
24 analysis. So, this look at what he said, using
25 that 50 percent scenario, if we took 50 percent

1 of his Colleton County volume at the Berkeley
2 Hospital, we would take 1,046 patients. That
3 would represent about 20% of the total
4 projected volume at MUHA Berkeley, which is
5 unreasonable to begin with. We have about 467
6 patients that come from Colleton County down
7 the peninsula. So, basically, he thinks that
8 MUSC's volume in Colleton County would go up by
9 224 percent based on that assumption and that's
10 just -- as I said, is unreasonable. The
11 thousand patients he thinks we'd take from him
12 would represent 20 percent of our total volume,
13 almost an hour away from his hospital. It's
14 just not reasonable.

15 Q: Look at Roper Saint Francis 119-38. This is --
16 Did you develop and produce this?

17 (Roper Exhibit Number 119-38 was introduced into the
18 record at this time.)

19 A: I did.

20 Q: What is it?

21 A: So, this shows the travel times. So, from
22 those four zip codes that he thought MUHA
23 Berkeley would take those patients from, shows
24 the travel time from our facility or from those
25 zip codes -- from the center of those zip codes

1 to the MUHA Berkeley facility compared to the
2 center of those zip codes to the Colleton
3 facility. So, we heard a lot of testimony
4 about location matters and all of those things,
5 but he thinks for whatever reason people will
6 drive twice as far to our facility than to his
7 facility.

8 Q: Look at Roper Saint Francis 119-19. Would you
9 explain to the Court what this is? Oh, wait.
10 Did you develop and produce this?

11 A: Yeah. So, we -- I think we've already looked
12 at this. This shows the transfer by facility
13 with, you know, and Tidelands being the
14 largest, Roper and Trident and Colleton on
15 there as well. I think this is sort of the set
16 up for the next one to say this is what the
17 detail looks like.

18 Q: And let's look at Roper Saint Francis 119-40.
19 (Roper Exhibit Number 119-40 was introduced into the
20 record at this time.)

21 A: Right.

22 Q: You -- which bring -- did you develop and
23 produce this?

24 A: Yes.

25 Q: Would you explain to the Court what this

1 represents?

2 A: This just shows the paramex distribution
3 percentages. And you can see the -- the purple
4 is Medicaid. So, these are transfers -- you
5 know, requests for facilities to transfer
6 patients to MUSC. Purple being Medicaid, sort
7 of a ---

8 MS. CRUM: Pull that out so that you can see the
9 columns.

10 Q: Okay. So, the Medicaid is purple. What is
11 Tricare?

12 A: Green.

13 Q: And Medicaid care?

14 A: Medicare is teal maybe.

15 Q: And Blue Cross Blue Shield, is that blue?

16 A: Yes.

17 Q: Okay. And commercial is ---

18 A: Red.

19 Q: Red. Okay. Now, let me let you back to -- and
20 talk about the Medicaid transfer please, sir.

21 A: So, the Medicaid transfers -- so, Medicaid and
22 self-pay or sort of identified as patients that
23 have issues with access often. But you can see
24 from the transfers, the facilities that
25 transfer the largest amount of Medicaid are the

1 Trident, Summerville, and Colleton Medical
2 Centers. Those have the largest percentage of
3 Medicaid that they have requested to transfer
4 through MUSC.

5 Q: Is this slide an update from the other one that
6 was, I think a FY 2017?

7 A: Yes.

8 Q: Okay. So, what are the top three hospitals in
9 terms of transfers?

10 A: As far as for the Medicaid?

11 Q: No, sir. Just overall.

12 A: The top three hospitals for transfer or
13 Tidelands ---

14 Q: For ---

15 A: Tidelands is the largest and then, we talked
16 about Summerville, Trident and Colleton
17 combined would be more. But are those are
18 three facilities instead of one.

19 Q: All right. Let's look at Roper Saint Francis
20 119-41. Can -- did you develop and produce
21 this?

22 (Roper Exhibit Number 119-41 was introduced into the
23 record at this time.)

24 A: Yes.

25 Q: Please explain to the Court what this is.

1 **A:** So, this shows the top 10 services that have
2 asked for referrals. So, you can see the
3 largest -- the highest volume, I think Dr. Warr
4 talked about this, the NRL is neurology. And
5 you can see the big orange, whatever color that
6 top bar is, being the largest and those are
7 consults only. So, this reflects the
8 telestroke program. So, a facility -- a
9 patient shows up with a stroke, they call MUSC,
10 say we want to send them, MUSC says just turn
11 on the video and let me take a look at them,
12 I'll tell you what to do. So, that's why you
13 have so many of those that were consults only.
14 They don't ---

15 **Q:** And that's part of the telemedicine program you
16 heard discussed yesterday.

17 **A:** It's a subsection of the telemedicine and
18 telestroke program. Yes. And you can see
19 hospitalist, that's Dr. Warr -- his area of
20 expertise is the -- it's really the Nexton
21 Neurology is the highest actual referral
22 request. So, 100 -- you can see the -- a
23 little over a thousand requests for a
24 hospitalist program. Pulmonology would be
25 probably the next highest and cardiology would

1 be with the others.

2 Q: And let's look at Roper Saint Francis 119-042.

3 Did you develop and produce this?

4 (Roper Exhibit Number 119-42 was introduced into the
5 record at this time.)

6 A: Yes.

7 Q: Would you explain to the Court what this shows?

8 A: So, this shows the actual admissions. So,
9 there are lots of requests for -- for patients
10 to be admitted. This shows the actual
11 admission and their primary payer source by the
12 top ten services. And so, you can see -- we
13 talked about Medicaid being a large percentage
14 of the two categories that have the most
15 Medicaid aren't surprising. OBGYN and the PEH;
16 and the PEH is the pediatrics. So, that --
17 that was the goal of the Medicaid program was
18 to cover women and children. So, it's not
19 surprising those are the two biggest.

20 Q: Let's look at Roper Saint Francis -- I'm sorry.
21 This is MUHA 38, please, sir. Did you develop
22 and produce this?

23 (MUHA Exhibit Number 38 was introduced into the
24 record at this time.)

25 A: Yes.

1 Q: And would you explain to the Court what it
2 shows?

3 A: So, this shows Roper's utilization. And you
4 can see Roper is less than 50 percent utilized
5 in all of its facilities. So, Saint Francis,
6 about 42 percent occupied. I heard Mr. Johnson
7 say that he didn't think 128-bed facility at 50
8 percent occupancy can be profitable. Well, all
9 of his facilities are less than 50 percent
10 occupied. The -- the interesting thing here is
11 -- so, Roper has -- Roper hospital 47 percent
12 occupied. They didn't want to move, but they
13 did move 50 beds from a half full facility out
14 to Berkeley County because they said that it
15 would increase access. So, the -- the beds
16 weren't full, they want to move. We we --
17 we're full. MUSC is full. We need more beds
18 and so, it sort of makes more sense. So, we
19 also want to improve accessibility. But we
20 have to because we're full. We need more beds.
21 They didn't more beds, but they thought it was
22 a good idea. So, it's sort of -- to me that
23 means our -- our proposal is a better idea. It
24 has the same need arguments they have, plus we
25 have an actual need for more beds. The -- the

1 occupancy at Roper is going to be exacerbated.
2 So, they're going to move 50 beds out there
3 that aren't full. The projected about 1,700 --
4 -

5 THE COURT: I didn't see Roper going to be exacer- -
6 --

7 A: I'm sorry.

8 THE COURT: You said the occupancy at Roper is going
9 be exacerbated.

10 A: The lower -- low occupancy. Yes. So, they're
11 at 47 percent now. They're going to move 40 --
12 I'm sorry -- move 50 beds out -- well, they
13 have moved 50 beds out to Berkeley. They
14 assumed there would be redirection of Roper
15 patients to that facility. So, the resulting
16 utilization of Roper Hospital is about 42
17 percent. So, they're moving empty beds out and
18 patients out, so the occupancy is still going
19 to be around 42 percent.

20 Q: Could you look at MUHA 38-A please, sir. Did
21 you produce and develop this?

22 (MUHA Exhibit Number 38a was introduced into the
23 record at this time.)

24 A: Yes.

25 Q: Would you please explain to the Court what it

1 represents?

2 A: So, this shows since 2013 the proposed projects
3 of Trident and Roper. And so, for Trident,
4 about 280 million dollars worth of projects,
5 and of that, 178 million has been outside of
6 Charleston County. So, to say that Dorchester
7 and Berkeley Counties are well served, don't
8 need additional resources, I think this sort of
9 disputes that. So, they've identified 178
10 million dollars worth of projects they think
11 should go in Dorchester and Berkeley Counties
12 to treat patients out there that need
13 additional resources and yet, it's a well-
14 served area. Roper, same thing; 154 million
15 dollars and a 127 million dollars of that is
16 outside of Charleston County. Theirs is
17 exclusive Berkeley County. So, Roper you can
18 see, 112 million dollars. I think they said
19 it's coming in to 117 for a new hospital, 2.8
20 million dollars for a cath lab that was
21 approved, but ultimately denied, but they
22 thought there was need in the area for cath
23 services in Berkeley County, a well-served
24 area, for cath services. Radiation therapy, 12
25 million dollar project in Berkeley County, a

1 well-served area. They want to -- they want to
2 spend 12 -- or they're going to -- they're
3 speeding, I think; it's underway, 12 million
4 dollars on a cath lab -- or laser therapy on
5 the campus of Berkeley Medical Center in an
6 area they think is well-served, just shows they
7 know there's need for more services out there.
8 They're applying for more services out there,
9 but they don't think we should.

10 Q: Mr. Levitt, in the 2018-19 State Health Plan,
11 does Trident Medical Center still have a bed
12 need?

13 A: They -- they do. They have a bed need. They
14 need more beds in that area. They're the
15 closest existing provider to that area. They
16 have more beds. I just remembered on here, one
17 thing that's not shown from Roper is their
18 rehab hospital. I -- I don't that on here.
19 Also in Berkeley County on the campus of their
20 hospital.

21 OBJECTION:

22 MS. HOLLINGSWORTH: Your Honor, I would object to
23 the testimony to just the extent it
24 mischaracterizes the nature of the application
25 as being just a Roper proposal that was

1 submitted.

2 MS. CRUM: I'm sorry. I couldn't hear what you
3 said. My ears are stopped up.

4 MS. HOLLINGSWORTH: I objected to the testimony to
5 the extent it mischaracterized the nature of
6 the project that was submitted. It was not
7 just a Roper application.

8 MS. CRUM: Your Honor, I would suggest that the
9 application speaks for itself.

10 THE COURT: Yeah. You object -- move to strike her?

11 MS. HOLLINGSWORTH: I guess move to strike her. I
12 just asked the witness to clarify his
13 testimony.

14 THE COURT: Well, okay.

15 MS. HOLLINGSWORTH: The application is not in
16 evidence, so it can't speak for itself.

17 THE COURT: Well, I'll just ---

18 MS. CRUM: I -- Your Honor, I'll ask another
19 question.

20 THE COURT: All right.

21 **Q: Mr. ---**

22 THE COURT: But your objection is noted.

23 MS. HOLLINGSWORTH: Thank you, Your Honor.

24 **Q: Mr. -- Mr. Levitt, do you know to who DHEC --**
25 **well, first of all, do you know whether or not**

1 the Roper application for the rehab hospital
2 has been approved by DHEC?

3 A: Yes. It has.

4 Q: And who was the licensee to which the CON was
5 issued?

6 A: I don't remember the specific entity. I know
7 Shannon Cantwell is the one that submitted that
8 application and she works for Roper.

9 Q: Let's see. Let's look at Roper -- MUHA 38B.
10 Did you develop and produce this?

11 (MUHA Exhibit Number 38b was introduced into the
12 record at this time.)

13 A: I'm sorry.

14 Q: 38B.

15 A: Yes.

16 Q: Did you develop and produce this?

17 A: Yes.

18 Q: Would you explain to the Court what this? What
19 is represents?

20 A: So, this was -- this is response to I think Mr.
21 Gallati said the 400 beds within 10 miles of
22 the proposed hospital. So, again, we talked
23 about Trident's service area isn't 10 miles
24 from the proposed hospital. They identify
25 their service area as a very broad area

1 including a number of zip codes with a
2 population of over 637,000. So, they're not
3 just serving a 10-mile area; they're serving a
4 much broader area of the tri-county area. And
5 then, this just applies that statewide use rate
6 to the population to say there's about 1,500
7 beds needed to serve those -- those people
8 within that -- that area that they identify as
9 their service area. They have 333 beds at
10 Trident. So, that would mean 1,200 more beds
11 needed. It's cut off there; the 458 is Trident
12 and Summerville, I believe -- 459. So, a
13 thousand more beds to treat the area that they
14 serve. So, that ten mile is factual; there are
15 that number of beds within a ten-mile region,
16 but they don't serve just that ten miles.

17 OBJECTION:

18 MR. THOMAS: Your Honor, I -- I'm -- I'm objecting
19 to this as being so prejudicial and -- and not
20 serving a probative of value of this case as
21 this is -- I'm reminded by a Latin phrase,
22 falsus in uno falsus in omnibus, Your Honor.
23 I mean, it just keeps hitting -- he's showing
24 here an exhibit that is so absurd and so
25 intellectually dishonest with this bed need

1 left unserved. I mean, we know there are 1,500
2 beds in the tri-county service area. And I'm
3 kind of at my wits' end with -- with these type
4 of exhibits that are -- this is irrelevant.
5 This has no basis to be in this CON litigation
6 and -- and it is absolutely crazy. I mean, to
7 -- to look at this when he knows what the bed
8 need is in the tri-county area. There's a
9 negative bed need. That's mainly Trident's
10 secondary and primary service area. So, I
11 would ask that this exhibit be stricken --
12 stricken and all the testimony be stricken as
13 well.

14 MS. CRUM: Your Honor, first off, this is based off
15 actual data. It's from their CON application;
16 hadn't said it wasn't. It's the existing
17 population. It's the existing service area
18 they showed in their -- I believe it was their
19 six-bed addition. And it's -- it's using data
20 from the State Health Plan. He may not like
21 it, but it is not -- not prejudicial. Your
22 Honor, I can certainly tell the difference
23 between that.

24 THE COURT: Well ---

25 MS. CRUM: And ---

1 THE COURT: --- it -- it may be prejudicial if I
2 believe it, but you have to -- that's what the
3 purpose of him offering his testimony and your
4 cross-examination is. So, I'm going to just
5 overrule the objection. I recognize that Mr.
6 Thomas believes that the inferences are
7 invalid, but that -- I'll allow you to cross-
8 examine regarding the -- the lack of rational
9 support for said inferences.

10 MR. THOMAS: Thank you, Your Honor.

11 Q: Mr. Levitt, is there anything else you wanted
12 to say about this exhibit?

13 A: I think that covers it.

14 Q: All right, sir. Let's look at MUHA 38C please,
15 sir. Did you develop and produce this?

16 (MUHA Exhibit Number 38c was introduced into the
17 record at this time.)

18 A: Yes.

19 Q: And would you explain to the Court what it is?

20 A: So, this shows the -- the travel time from
21 those zip codes -- from selective zip codes to
22 the downtown hospital. And this is at 8:00
23 a.m. in the morning and to the Berkeley
24 Hospital and the -- the drive time distances,
25 the variance. And then, the final column shows

1 the expected shift in volume. So, again that
2 -- that 29401, the peninsula of Charleston is
3 about two miles, 9 to 12 minutes to MUHA
4 downtown, about 28 miles to MUHA Berkeley,
5 about 30 to 40 minutes in the variance between
6 the two. Again, we assume that 65 percent of
7 those people would continue to go to the
8 peninsula and only about 35 percent would go up
9 to MUHA because of -- it's 20 minutes further,
10 but you avoid the parking, you avoid the one-
11 way streets of downtown Charleston, sometimes
12 flooding, traffic, and those other things you
13 -- you get on the interstate, you go up, you
14 get off the interstate, go to a community
15 hospital versus going to the MUSC complex of
16 buildings on the peninsula. So, it -- it's
17 further, but not substantially further, 20
18 minutes. If you get caught in traffic or some
19 lights, that could add up. So, that's what
20 this shows for all of those areas and why we
21 believe that redirection percentage is
22 reasonable and sometimes conservative. So, if
23 you look at Moncks Corner, we only assumed a 35
24 percent redirection, but it's 20 to 35 minutes
25 closer. So, perhaps that a higher percentage

1 and others are lower, but these are estimates
2 and I think reasonable estimates that show the
3 volume.

4 Q: Mr. Levitt, who actually developed the
5 percentage shifts?

6 A: We -- we did that as a group. Me and the
7 planning department worked on that together and
8 we talked to the planning -- I guess, the group
9 that was developing the CON application,
10 developing the project.

11 Q: Okay. Is this based on experience with MUSC
12 patients?

13 A: Yes. And -- and with the staff, as well as my
14 experience with other projects.

15 Q: All right, sir. Let's look at MUHA 38D. Could
16 you explain to the Judge what this is?

17 (MUHA Exhibit Number 38d was introduced into the
18 record at this time.)

19 A: This is that same analysis just looking at
20 evening traffic. And again, it shows in the
21 evening there's more traffic going north, but
22 still the -- the Berkeley Hospital is 20 to 30
23 minutes drive further for some of those
24 facilities or some of those zip codes, but
25 still a reasonable assumption.

1 Q: What are elected -- what are -- what is an
2 elective surgery?

3 A: Elective surgery is a scheduled surgery where
4 the patients and the physician decide when to
5 have that procedure done. Generally, those are
6 scheduled in the morning because oft -- before
7 noon -- because often times if they receive
8 general anesthesia, they have to fast, so they
9 haven't eaten since the night before. They
10 want to try to have the surgery early rather
11 than at the end of the day, so they've gone 24
12 hours without eating.

13 Q: Okay. And let's look at -- I'm not sure if I
14 asked you, but did you develop and produce 38D?

15 A: Yes.

16 Q: 38G. Did you develop and produce that?
17 (MUHA Exhibit Number 38g was introduced into the
18 record at this time.)

19 A: Yes.

20 Q: Would you explain to the Judge what this
21 represents?

22 A: So, this looks at the experience of other
23 providers in the state. There's been some
24 argument that putting a hospital four miles
25 away from existing hospital or proposed

1 hospital at the time, didn't make sense. The
2 state has many experiences like that. We've
3 talked about Roper being across the street from
4 MUSC downtown. It's a half a mile away based on
5 driving Google maps and you'll go around the
6 block, but I measured it. It's 346 feet from
7 the entrance of our emergency room to the
8 entrance of the Roper emergency room, 346 feet.
9 I think Mr. Thomas would call that a nine-iron
10 perhaps based on his other testimony in another
11 case where you said you could drive a golf ball
12 a mile and a half, so figure 346 feet is a
13 nine-iron. But you can see ---

14 MR. THOMAS: That's more of a wedge.

15 A: --- there's definitely ---

16 THE COURT: For you.

17 A: There's definitely a number of facilities that
18 are very close proximity; East Cooper, Mount
19 Pleasant, 7.2 miles; Trident and Summerville,
20 their own facilities are 5.8 miles apart;
21 Florence and McLeod three miles apart; Baptist
22 and Providence, a mile and a half; the Baptist
23 and Richland, two miles; back -- Parkridge and
24 Lexington, seven miles; Spartangburg and Mary
25 Black, three miles; Greenville and Saint

1 Francis downtown, total weight miles. Also, in
2 Greenwood -- Greenville, Eastside and Patewood
3 are across the street from one another, also,
4 point four -- half -- less than half a mile.
5 And Greer and Pelham, less than five miles
6 apart. So, there a number of parts in the
7 state where there are facilities across the
8 street from each other or within close
9 proximity, less than ten miles, less than eight
10 miles. These are listed less than eight miles;
11 and both those facilities are doing fine.

12 Q: Let's look at MUHA 38H. What is this?

13 (MUHA Exhibit Number 38h was introduced into the
14 record at this time.)

15 A: So, this is the Trident CON application for six
16 additional acute care beds.

17 Q: Okay.

18 MS. CRUM: Would you scroll on down? Okay. Thank
19 you. Now, go on up to the -- okay.

20 Q: What is Exhibit 2?

21 A: Exhibit 2 shows the patient origin for this
22 application. It's consistent with exhibit --
23 was it 141 that we talked about or 41? The
24 patient origin for Trident by zip code. This
25 is the -- consistent with that. And it shows

1 where the patients come from that are treated
2 at Trident Medical Center.

3 Q: Look at zip code 29488, Walterboro.

4 A: Yes.

5 Q: How many patients -- in-patients do they get
6 from Walterboro for the -- I guess it's the --
7 what is this? For the -- the service area for
8 this floor renovation and six-acute care bed
9 addition.

10 A: Yep. So, from that one zip code, they've got
11 almost 500 discharges.

12 Q: Do you know whether or not that zip code is --
13 is Walterboro?

14 A: Yes. It is.

15 Q: Okay. What else do you want to talk about in
16 this exhibit?

17 A: Well, I think if you you -- on exhibit 2, you
18 mean ---

19 Q: Yes, sir.

20 A: --- specifically? Just that, as we talked
21 about, so the -- the majority of their patients
22 don't come from Charleston County. There's
23 nothing wrong with that, but we talked about
24 those zip codes and what counties those zip
25 codes are in. And it's -- it's given -- due to

1 their proximity to those other two zip codes,
2 it makes sense. Just as our proximity to those
3 other two zip codes or those other two counties
4 -- I'm sorry; I said zip codes. Trident's
5 proximity to the two other counties, they get
6 patients from those counties. Our proximity of
7 those same counties would make it reasonable
8 that we get patients from all three counties at
9 our MUHA Berkeley Hospital.

10 Q: All right, sir. Anything else about that
11 exhibit?

12 A: I think that's it.

13 Q: Okay. Let's look at MUHA Exhibit 38J. Could
14 -- did you develop and produce this?

15 (MUHA Exhibit Number 38j was introduced into the
16 record at this time.)

17 A: I -- I -- I guess before we get off that last
18 exhibit, can we get to exhibit 3 of that last
19 exhibit?

20 Q: I don't have but one page, so.

21 A: Okay. Yeah. That's probably why we went past
22 it. So, this shows Trident Medical Center's
23 proposed service area. So, they say this is
24 their service area supporting their six-bed
25 addition. And if you could push it up just a

1 little bit, you can see it goes all the way
2 down the peninsula far north Berkeley County,
3 southwest Colleton County. So, it's a very
4 broad service area. Mr. Sullivan thought that
5 my tri-county area was too broad, but this
6 supports that to say hospitals draw from a
7 broad area in the tri-county area.

8 Q: Based on your reading of the six-bed CON
9 application for Trident, was it based on their
10 historic patient origin?

11 A: Yeah. And that's what we were just looking at.
12 Yes.

13 Q: And ---

14 A: It's based on that. This depicts though --
15 that information.

16 Q: And MUHA's 128-bed application, is it based on
17 MUHA's historic patient origin?

18 A: It is.

19 Q: Let's look at Page 38 -- MUHA 38-J. Did you
20 develop and produce this?

21 A: Yeah. And this is the one we have talked
22 about. This shows the distribution of zip
23 codes. And so, I think what -- what I want to
24 shows on this is if you go to the next page,
25 38-J. So, there's some criticism that

1 residents of the peninsula were -- were too
2 reliant on south of the Broad patients. And
3 you can see, if you look at 29401, we're
4 talking about 50 patients. So, we -- if you
5 remember back on the Trident patient origin,
6 they had more patients from 29401 than we're
7 projecting at their MUHA Berkeley Hospital.

8 Q: And you were looking at MUHA 38-J bates number
9 -- RFP Number 030934?

10 A: 30934.

11 Q: Right. Look at MUHA 38-K please, sir. This is
12 again, is a two-page exhibit?

13 (MUHA Exhibit Number 38k was introduced into the
14 record at this time.)

15 A: Yes. And I think -- I think again, on this, if
16 you go to the next page of the peninsula, you
17 can see from the 29401, south of the Broad, I
18 think seven people will have a baby at the MUHA
19 Berkeley Hospital.

20 Q: Okay. Now, did you produce and develop this?

21 A: Yes.

22 Q: And look at MUHA 38-L. Did you produce and
23 develop this?

24 (MUHA Exhibit Number 38l was introduced into the
25 record at this time.)

1 **A:** Yes.

2 **Q:** So, this was in the response to Mr. Sullivan's
3 criticism of my -- I think it was 94 zip code
4 service area. So, what we did was we -- we
5 looked at them from highest to lowest and
6 identified 85 percent of out patients. So,
7 normally, you'd define a service area as
8 between 70 and 85 percent of your patients,
9 that's your -- your primary service area.
10 Then, you're going to get in-migration from
11 outside of that. So, we arrayed the data.
12 Again, this is our projections. Didn't change
13 any of the volume numbers; we just looked at
14 them differently. So, instead of saying, these
15 are the 94 zip codes within the entire tri-
16 county service area, let's look at the -- let's
17 focus on those, the highest volume ones and
18 that represented about 80 percent -- 85 percent
19 of our total volume. And you can see, 21 zip
20 codes. That represents 21 zip codes. So, Mr.
21 Sullivan thought that was more of a reasonable
22 volume of the service area. So, this -- this
23 is consistent with it. So, again, remember,
24 this is -- this is our number. These our
25 numbers. We didn't change anything. We just

1 presented it differently. So, looking at just
2 the 21 zip codes instead of the 94 zip codes
3 represents 87 percent of out patients. You can
4 see that there. And then, we would assume
5 additional in-immigration. I think it's
6 important to show two, the lower part. So --
7 so, 3,600 patients are expected to come from
8 those 21 zip codes and about 384 patients from
9 the rest of the tri-county area. So, when we
10 identified all of those zip codes, we're not
11 expected a lot of volume from those zip codes.
12 And then, the secondary tertiary areas, we said
13 that attached N in the CON application was an
14 error; where it talked about 10 percent, it's
15 really two percent, and you can see those are
16 the numbers. A very, very small number from
17 outside of the tri-county area was expected at
18 the MUHA Berkeley. So -- so this -- this shows
19 what we're calling alternative service area
20 one. So, instead of a 94 zip codes, it's the
21 same zip codes, just presented only 21 of
22 those.

23 Q: Let's look at MUHA 38-M please, sir.

24 (MUHA Exhibit Number 38m was introduced into the
25 record at this time.)

1 **A:** **So, 38-M is a map. This shows the 21 zip codes**
2 **and you can see, it's focused within about a**
3 **30-minute drive time of the proposed hospital**
4 **and represents these zip codes from which we**
5 **would get 86 percent of out patients.**

6 **Q:** **Okay. Did you develop and produce this?**

7 **A:** **Yes.**

8 **Q:** **Okay. You had just said that the attachment N**
9 **was produced in error with the percentages.**
10 **Look at the DHEC Exhibit 1. DHEC Exhibit 1,**
11 **which is our CON application, Page 39, Figure**
12 **17.**

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

14 **A:** **Yes.**

15 **Q:** **What does that show?**

16 **A:** **Yes. You can see the two percent -- the all**
17 **other, that's a drive time of 71 minutes or**
18 **further or the secondary counties, we assumed**
19 **a two percent redirection of those patients.**
20 **So, that's what was described in the CON**
21 **application. That's how the calculations were**
22 **made. When attachment N was attached to the**
23 **application, it had some errors in the**
24 **redirection percentages and instead of two**
25 **percent, it said 10 percent. So, I heard Mr.**

1 Sullivan testify and rely on the exhibit in the
2 application. I had updated that exhibit. I
3 talked about it in my deposition, but he chose
4 to use the -- the other one.

5 Q: And -- and look on the line up above Figure 17.
6 Does it say the zip code direct -- redirection
7 percentages are provided below?

8 A: Yes.

9 Q: Okay. Let's go to MUHA 39-N -- 38-N. I'm
10 sorry. Did you develop and produce this?
11 (MUHA Exhibit Number 38n was introduced into the
12 record at this time.)

13 A: Yes.

14 Q: Would you please tell the Court what it shows?

15 A: So, 38 -- and again, we -- we came up with that
16 alternative service area. So, rather than look
17 at 94 zip codes, just looking at those 21 zip
18 codes and then, we assume a 15 percent in-
19 migration. So, we assumed -- you know, those
20 -- those 21 zip codes. We didn't assume this.
21 The 21 zip codes represented about 85 percent
22 of our volume. So, another 15 percent would
23 come from somewhere other than those 21 zip
24 codes. And that would be about 930 patients
25 for total discharges of 6,201, average length

1 of stay 4.7 days, same assumption in the
2 application, get us to 62 percent occupancy by
3 year three.

4 Q: And am I correct that the zip codes listed here
5 are based on historic MUHA patient utilization?

6 A: Correct. Again, so we -- we took the
7 historical volume, we reduced that by the
8 tertiary DRGs. We applied a redirection
9 percentage to get these numbers.

10 Q: Let's look at MUHA Exhibit 38-0. Have you --
11 did you develop and produce this?

12 (MUHA Exhibit Number 380 was introduced into the
13 record at this time.)

14 A: Yes.

15 Q: Would you explain to the Court what it
16 represents?

17 A: So, again, this shows the -- the -- the CON
18 application projections. The first column
19 there. Remember we -- we projected by year
20 three to about 57 percent occupied. So, using
21 just the 21 zip codes and a 15 percent in-
22 migration, gets us a number that's pretty
23 close, a little higher actually. So, if we had
24 taken that approached, we'd project a little
25 higher utilization of about 62 percent.

1 Q: And -- and -- look - have you -- you've
2 reviewed the -- some of the Trident
3 applications, haven't you?

4 A: Yes.

5 Q: Do they use in-migration?

6 A: Yes. And I think I was criticized by either
7 the Roper expert or the Trident expert that we
8 didn't include any in-migration. Well, the
9 reason we didn't is because we included all 94
10 zip codes. So, if we had done it with a
11 smaller zip code and in-migration, we'd get to
12 the same spot as what this is demonstrating.

13 Q: And is this what this exhibit is showing?

14 A: Yes.

15 Q: Okay. Let's go to MUHA Exhibit 38-P.

16 (MUHA Exhibit Number 38p was introduced into the
17 record at this time.)

18 MR. SUMMER: Your Honor, would it be possible to
19 take a short break?

20 THE COURT: Yeah. I think it's -- how much longer
21 is your direct going to be?

22 MS. CRUM: It's going to be a hour. It may be --
23 we'll be finished by 1:30.

24 THE COURT: Okay. Well, we'll go take at least a
25 five-minute break right now.

1 (Off the Record)

2 THE COURT: Y'all be seated.

3 Q: Mr. Levitt, do you see MUHA 38-P on the screen?

4 A: Yes.

5 Q: Do you recognize that?

6 A: Yes.

7 Q: Did you produce and develop it?

8 A: Yes.

9 Q: Would you please explain to the Court what it
10 is?

11 A: Sure. So, this takes that alternative service
12 area we talked about in the last exhibit and
13 remember that was about 86 percent of the
14 discharges. So, we excluded four zip codes,
15 two in West Ashley and -- or, I guess, sort of
16 southern West Ashley and East Cooper, two -- we
17 took those two -- those four zip codes out and
18 it takes us down to about 70 percent of our
19 admissions. And so -- so, you know, 30 percent
20 of our admissions would come from outside those
21 17 zip codes that we've identified. So, again,
22 rather than look at all 94 zip codes, if we
23 looked at 17 zip codes and said, that
24 represents 70 percent of our patients and
25 another 30 percent or 25 or 30 percent would

1 in-migrate, it would have a -- a similar
2 analysis. So, the next shows that in a map.

3 Q: It's 38 -- that's MUHA 38-Q?

4 (MUHA Exhibit Number 38q was introduced into the
5 record at this time.)

6 A: 38-Q. Correct. See ---

7 Q: Did you develop and produce that document?

8 A: I did. So, you can see the zip codes we took
9 out -- took out when the sort of the -- the
10 ones on the bottom, the 29455, 412, those Sea
11 Islands, West Ashley zip codes. And then, we
12 took out the East Cooper 464 and 466.

13 Q: And what ---

14 THE COURT: You took it out. What -- for what
15 purpose? What result?

16 A: Well, so there was a criticism that people from
17 that -- those zip codes wouldn't travel our
18 way, so we said, we don't need to rely on
19 these. So, if we -- if we take those out and
20 don't rely on them, this smaller service area
21 represents about 70 percent of our zip codes.
22 The rest would in-migrate from all the other
23 areas. We think that they will come those zip
24 codes. We show that residents from those zip
25 codes currently go to Trident.

1 THE COURT: Well, what I'm asking is if -- so, it
2 represents 70 percent of these zip codes.

3 A: Correct.

4 THE COURT: It -- I'm almost at a so what expression
5 after I find that out because how does that
6 correlate to need after that's removed?

7 A: Yeah. So -- so what it -- what -- I guess
8 what I'm saying, you're at so what. That's my
9 point is that we can look at 94 zip codes or we
10 look at 70 zip -- or 17 zip codes, we still get
11 to the same spot. The tri-county area is our
12 service area. We've identified all 94 zip
13 codes in that area.

14 THE COURT: Well, you're still get to the same spot;
15 what spot is that?

16 A: That would be on -- the -- about 4,000 --
17 starting point, 4,000 discharges inflated to
18 2025 gets us to about a 60 percent occupancy at
19 the MUSC Berkeley Hospital.

20 THE COURT: All right. Thank you.

21 Q: Let's look at 38-R.

22 (MUHA Exhibit Number 38r was introduced into the
23 record at this time.)

24 A: And that's what this shows. I'm sorry. So,
25 I've got to have myself. So, this shows that

1 if 70 percent -- those 17 zip codes, we get
2 another 20 percent in-migration from all -- all
3 of the areas including other parts of the
4 state, we'd be about 55 percent occupied on the
5 -- on the MUSC Berkeley Hospital.

6 Q: Did you develop and produce this document?

7 A: I did.

8 Q: Let's look at MUHA 38-S. Did you develop and
9 produce this?

10 (MUHA Exhibit Number 38s was introduced into the
11 record at this time.)

12 A: I did.

13 Q: And MUHA Berkeley -- tell -- tell the Court
14 what it is, please.

15 A: So, again, this just compares the CON
16 application. 2017, we projected about 57
17 percent occupancy using the 17 zip codes and
18 in-migration, we get to about 55 percent
19 occupancy. So, I think that goes to -- to your
20 point, Your Honor. So, what. If we do a
21 different way, we get to the same spot.

22 Q: And let's look at MUHA 38-T. Did you develop
23 and produce this?

24 (MUHA Exhibit Number 38t was introduced into the
25 record at this time.)

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

2 **Q:** **And would you please tell the Court what it**
3 **represents?**

4 **A:** **So, this is what Mr. Sullivan identified as our**
5 **reasonable service area. He identified these**
6 **zip codes as a reasonable service area. So, if**
7 **you adopt his definition of our service area,**
8 **assume the same redirection and a 25 percent**
9 **in-migration, get to the same spot; so, a 54**
10 **percent occupancy instead of the 55 percent**
11 **occupancy we just showed. Again, you can look**
12 **at it a lot of different ways, still get to the**
13 **same spot.**

14 **OBJECTION:**

15 **MR. THOMAS:** And I'm objecting to this side, Your
16 Honor. I mean, this is not what Mr. Sullivan
17 did. He -- he also had a different average
18 length of stay based on a -- a pretty in depth
19 analysis of the local market. So, I -- I just
20 want that to be clear for the record to -- Mr.
21 Sullivan did some other things here rather than
22 just assume, you know, all the same factors
23 that Mr. Levitt did.

24 **MS. CRUM:** Your Honor, I would suggest that's ---

25 **THE COURT:** I would ---

1 MS. CRUM: --- for cross.

2 THE COURT: Well, taking that as I did with Ms.

3 Hollingsworth's objection that is so noted.

4 MR. THOMAS: Thank you.

5 Q: Was there anything else you wanted to say about
6 MUHA 38-T?

7 A: No.

8 Q: Okay. Let's look at MUHA 38-U. Did you
9 produce and direct -- did you produce and --
10 I'm sorry. Did you develop and produce this?

11 (MUHA Exhibit Number 38u was introduced into the
12 record at this time.)

13 A: I did.

14 Q: And would you please tell the Court what it is?

15 A: So, again, this takes the service area Mr.
16 Sullivan identified, those zip codes, and we
17 assume 55 percent redirection. So, there was
18 criticism about 35 and 65 and all those other
19 things, so we assumed just 55 percent
20 redirection of those patients, gets us to 56
21 percent occupancy on our beds.

22 Q: Explain to the Court what you mean when you say
23 55 percent of redirection of those patients.

24 A: So, it's saying that -- if you go back up. So,
25 you can see there were 5,700 total discharges,

1 non-tertiary and there were 1,700 OB
2 discharges. If you had those together and you
3 take 55 percent of those or if you get 4,676.
4 So, basically, if a little more than half of
5 those patients that historically went to the
6 peninsula go to the new facility in what Mr.
7 Sullivan identified as a reasonable service
8 area for MUHA Berkeley, this is the result.

9 Q: Would you look at MUHA 38-V please, sir? Did
10 you develop and produce this?

11 (MUHA Exhibit Number 38v was introduced into the
12 record at this time.)

13 A: Yes.

14 Q: Would you please tell the Court what this is?

15 A: This summarizes everything. So, this shows all
16 the different scenarios in the results. So,
17 the CON application, we projected about 5,700
18 discharges with an occupancy about 57 percent.
19 Updated that for 2018, we get to about a 60
20 percent occupancy. Updating that for a
21 different service area, looking at 85 percent
22 of out patients with a 15 percent in-migration,
23 gets us at 62 percent occupancy. Looking at 70
24 percent of our patients with a 30 percent in-
25 migration, gets us at 55 percent occupancy.

1 Looking at Mr. Sullivan's service area,
2 assuming half of our patients that used to go
3 to the peninsula go to the new facility, gets
4 us at a 53 percent occupancy and assuming Mr.
5 Sullivan's service area with a 55 percent
6 redirection gets us at 56 percent occupancy.
7 So, there's a number of different alternative
8 scenarios that gets us to the same spot.

9 Q: Mr. -- Mr. Levitt, these scenarios, are they
10 all based on the non-tertiary patients?

11 A: They are. The actual non-tertiary patients
12 that were treated on the peninsula at MUSC.

13 Q: All right, sir. And at each one of these
14 levels is the hospital financially feasible?

15 A: Yes.

16 Q: Is it making money?

17 A: Yes.

18 Q: At the end of year three?

19 A: It's projected to make money at the end of year
20 three under all these scenarios.

21 Q: Okay. Let's look at MUHA ---

22 OBJECTION:

23 MS. THOMAS: Wait. Your Honor, I -- I'm not aware
24 of a pro forma is done for each one of these
25 different scenarios. I haven't seen those and

1 they haven't been introduced into evidence.

2 So, he just said that -- that this thing's

3 making money under every scenario.

4 THE COURT: He said, they're projected to make

5 money, right?

6 MR. THOMAS: Yes, sir. But, I haven't seen the

7 projections. So, I'm not sure what he's basing

8 that on. I know he didn't do the pro formas in

9 this case and he's already admitted that under

10 oath. So, we'd like to see those if he's got

11 them and he's done that analysis.

12 THE COURT: Cross-examination? I'm asking.

13 MR. THOMAS: I can do that on cross, but I mean, I'm

14 -- it's -- it's -- the objection is that it

15 assumes facts not in evidence.

16 THE COURT: All right.

17 MR. THOMAS: Sorry about that. I should have said

18 that up front, like that.

19 THE COURT: Okay.

20 MS. CRUM: Your Honor, we -- we can get to that and

21 we'll get to that.

22 THE COURT: All right. Rule of evidence on that.

23 **Q: Look at MUHA 38-W please, sir.**

24 **(MUHA Exhibit Number 38w was introduced into the**

25 **record at this time.)**

1 A: Yes.

2 Q: Could you please tell the -- did you develop
3 and produce this?

4 A: I did.

5 Q: Please tell the Court what it is.

6 A: So, this is the -- this is a response to Mr.
7 Sullivan's exhibit 298 or I guess it's bates
8 Sullivan 298, where he did a projection of our
9 facility, where he changes some assumptions.
10 And so, I -- I -- what this shows is, I think,
11 the unreasonableness of his projections. So,
12 he changed the volume numbers and some
13 assumptions on expenses and based on his
14 numbers, if you go to the very bottom, we would
15 lose 36 -- almost 37 million dollars to a loss
16 of about two million dollars. So, what I
17 showed to the right is what was from the CON
18 application. So, we projected about break
19 even, \$39,000 and about a 14 million dollar
20 profit in -- in the third year. So, if you go
21 up to the top, this sort of highlights Mr.
22 Sullivan's -- the unreasonableness of his
23 projection. So, he's saying that if -- if we
24 had 4,106 discharges, which is about -- what
25 about 100 discharges more than what we

1 projected in the CON application, right next to
2 a 39/90, rather than break in, we'd lose two
3 million dollars. So, I guess what this shows
4 is in our CON application, at about 4,000
5 discharges, we break even and make money. So,
6 under that last scenario where we showed all
7 those different scenarios and I was asked if
8 they made money, it -- they're all higher than
9 that or projected to make money at that level,
10 we'd obviously be projected to make money at
11 those projections in those different scenarios.

12 Q: Would you look at MUHA 38-X, please? Did you
13 produce and develop this?

14 (MUHA Exhibit Number 38x was introduced into the
15 record at this time.)

16 A: I did.

17 Q: And would you please tell the Court what this
18 shows?

19 A: Sure. So, this -- this sort of -- again, Mr.
20 Sullivan has testified that we used 100 percent
21 variable expenses. That was a mistake. It
22 wasn't a mistake, it was intentional
23 conservative assumption. So, what it did was
24 it probably overstated expenses; so, it was
25 conservative. So, he testified that that was

1 wrong, but then he used those numbers. So, it
2 overstated expenses, but then he used it as a
3 starting point to say, okay, so this is your
4 starting point expenses and you have fixed and
5 variable relationships. If your volume goes
6 down, you're still going to have these fixed
7 expenses. But he started -- he started at the
8 highest point. So, I did the exact same
9 methodology he did using the exact same
10 assumptions she did, but I used year one as the
11 starting point instead of year three. So, you
12 can see the same volume of discharges, 4,106;
13 same ratio of outpatient revenue that he used
14 to -- to get adjusted discharges the same. So,
15 our revenues are because he used the same
16 charge assumption we did. So, based -- year
17 one or year three, it's the same. Going down,
18 contractual adjustments, same. Net revenue
19 would be the same because the volume is the
20 same. So, where he overstated our expenses, I
21 showed them based on year one. So, page down.
22 So, he thinks our personnel expenses would be
23 64 million dollars because he took the highest
24 year, held that was a percent fixed and then,
25 applied a reduction to the expenses based on

1 the variable. Well, if you do that based on
2 year one, you only 48 million dollars in
3 personnel expenses. Same with supplies, he
4 overstated the supply expense -- assuming the
5 fixed percentages starting in year three.
6 Again, depreciation -- same with contractual
7 services. Depreciation is constant. Doesn't
8 matter what the volume is. It's going to be
9 the same. So, where he showed a two million
10 dollar loss, we'd actually have a 19 million
11 dollar gain. So, his observation that our 100
12 percent fixed cost was wrong -- I'm sorry. 100
13 percent variable cost was wrong, what it was
14 wrong was it overstated expenses, so we really
15 make more money than we projected.

16 Q: So, why did we use variable expenses?

17 A: I'm sorry.

18 Q: Why did we use -- excuse me. Why did we use
19 the variable -- variable instead of fixed?

20 A: We used 100 percent variable expenses to be
21 conservative, to say look, if everything goes
22 up with volume, which it doesn't as Mr.
23 Sullivan pointed out, which is reality. We
24 have a fixed cost. We have one administrator.
25 Whether we have 30 percent occupancy or 100

1 percent occupancy, we have one administrator.
2 So, that's cost would be fixed. Nursing, we
3 would vary based on volume. We have more
4 patients, we need more nurses. So, we -- we
5 just assumed 100 percent variability in supply
6 cost, contract services, just to be
7 conservative that we have enough expenses in
8 our pro forma to cover what could possibly
9 happen to our facility. Still showed a
10 positive operating income.

11 Q: Let's look at MUHA ---

12 THE COURT: So, where I can understand, your
13 48,438,000 personnel figure is accounting for
14 the fact that you're going to have, let's say
15 net -- less nurses because the volume is going
16 to be reduced?

17 A: Well, so -- so, my 4 -- yes. My 48 million
18 personnel expense says that our fixed costs in
19 year one are fixed. And then, we have
20 incremental -- I think Mr. Sullivan assumed 40
21 percent variable costs on personnel or maybe it
22 was higher. Whatever his assumption was is
23 what I used to get to the 48 million dollars
24 based on volume.

25 Q: Mr. Levitt, do hospitals normally staff to

1 occupancy?

2 A: Absolutely. And -- and to the best they can.
3 So, there -- there are certain minimum staffing
4 you've got to have, so if you have you know,
5 lower volume of senses on a unit, you still
6 have to have at least two nurses on the unit,
7 24-7. So, you may have overstaffing on those
8 units just because you have to have staff to
9 cover it. But generally, once you reach --
10 it's sort of a step volume. So, you have a
11 number of patients, a range of patients where
12 you have a number of nurses. You get another
13 patient, you got to get a another nurse, so
14 then it's overstaffed until the volume goes up
15 and then, you need to get another nurse. So,
16 it's sort of step function on staffing for
17 clinical -- clinical staff.

18 Q: And is the same thing true with supplies and
19 contractual services?

20 A: Yeah. Sure. So, supplies, you'd have
21 disposable supplies with each patient that --
22 if you have more patients, you'd have more
23 supplies, but you'd have fixed supplies for
24 patients regardless of the number of patients
25 you'd have, if you got a certain number -- a

1 certain amount of supply expense.

2 Q: Let's look at the next page -- the map.

3 A: 38-Y.

4 Q: 38-Y. Mine doesn't have it.

5 (MUHA Exhibit Number 38y was introduced into the
6 record at this time.)

7 A: Yes.

8 Q: 38-Y. Okay. Do you recognize that?

9 A: I do.

10 Q: Did you develop and produce it?

11 A: I did.

12 Q: And explain the Court what it is.

13 A: So, I did a sensitivity projection to say there
14 was some question about our outpatient revenue,
15 double counting of ER services in the -- in the
16 freestanding ED versus the hospital. I heard
17 Ms. Goodlett talk about the outpatient revenue
18 being on the low side. Generally, from a
19 community hospital perspective, outpatient,
20 inpatient revenue are about the same, so a
21 50/50 split. So, that's the last scenario and
22 we'll get to that. But -- so, the first column
23 is what was in the CON application. The
24 operating income of 15 million dollars was
25 projected based on the volume in the CON

1 application. That's assumes 35 percent of the
2 outpatient -- 35 percent of the revenue was
3 associated with outpatient. I think that's too
4 low. Ms. Goodlett agreed. She thought it was
5 too low. As I said, ---

6 OBJECTION:

7 MS. HOLLINGSWORTH: Your Honor ---

8 A: --- normally, it's about 50/50, so that's the
9 starting point.

10 MS. HOLLINGSWORTH: I -- I would object, Your Honor.
11 Actually, that mischaracterizes -- Ms. Goodlett
12 yesterday said that she thought the 65/35 split
13 was appropriate for a community hospital and
14 that's why she approved that number. She did
15 not testify yesterday that that number should
16 be increased. So, I just -- Mr. Levitt should
17 have his opinion, but that is not what Ms.
18 Goodlett testified to.

19 THE COURT: All right. I don't remember distinctly
20 one way or the other, so.

21 MS. CRUM: Your Honor, I wasn't here during her --
22 her testimony, so -- I was here during those --
23 -

24 THE COURT: Ms. Jones, you wish to respond to that.

25 MS. JONES: Yes. Your Honor, she -- she said that

1 that's the number that she selected and
2 approved for the pro forma. She said it was a
3 low number, but she thought it was appropriate
4 for making a conservative projection.

5 THE COURT: The 65/35?

6 MS. JONES: Yes.

7 THE COURT: And your response to that.

8 MS. HOLLINGSWORTH: Well, Your Honor, I -- that's
9 right. Ms. Goodlett testified the 65/30, she
10 thought that that was the number appropriate
11 for this hospital. So, I object to the
12 characterization that she said that number
13 could be different because she -- she testified
14 that was the appropriate number and she
15 approved that number. So, I object to ---

16 MS. JONES: That's not what I ---

17 MS. HOLLINGSWORTH: --- mischaracterization of the
18 testimony.

19 MS. JONES: That -- okay. So, what Ms. Goodlett
20 testified to is that she approved the 65/35 as
21 the percentages, but that -- and -- and it was
22 to be conservative. So, it was on the low
23 side. I -- you know, I don't think there's
24 anything inconsistent with any of the
25 testimony.