

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

THE COMMUNITY HOSPITALS' DEPOSITION DESIGNATIONS

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Attorneys for the Community Hospitals

The Community Hospitals, by and through their undersigned counsel, submit the deposition designations for (1) the deposition of Dr. Matt Austin, and (2) the deposition of Dr. Karen van Caulil. The highlighted deposition designations are attached as Exhibit A (M. Austin Deposition Transcript Designations) and Exhibit B (K. van Caulil Deposition Transcript Designations). The parties agreed to highlight affirmative designations in yellow, counter-designations in blue, and reply designations in pink.

In addition, The Community Hospitals submit the following tables reflecting the specific pages and lines of deposition testimony designated for trial. These tables include The Community Hospitals' deposition designations, The Leapfrog Group's objections and counter-designations, and The Community Hospitals' reply designations and objections to The Leapfrog Group's counter-designations.¹

The Community Hospitals intend to present these deposition designations at trial and reserve the right to remove any portion of these designations before or during trial. If any witness The Community Hospitals intend to call live becomes unavailable or does not appear, The Community Hospitals reserve the right to present that witness's deposition testimony and will amend designations accordingly. The Community Hospitals also reserve the right to submit any testimony that has been designated by The Leapfrog Group either affirmatively or in its counter designations. The Community Hospitals reserve the right to play video recordings of the selected designations during the trial. The Community Hospitals object to repetition of any video segments and understand that each segment of the transcript that has been designated, countered, or replied

¹ The Community Hospitals served The Leapfrog Group with objections and counter-designations to The Leapfrog Group's proposed deposition designations of Dr. Matt Austin and Regina West. It is the parties' agreement that The Leapfrog Group will file those objections and counter-designations as served.

by either party, subject to the Court's rulings on objections, will be played once and in sequence.

The Community Hospitals reserve the right to use all designated testimony in pre-trial and post-trial submissions. Finally, the Community Hospitals reserve the right to use additional designations for purposes of impeachment, rebuttal, or sur-rebuttal, in accordance with the Court's rules.

The Community Hospitals have used the following abbreviations for objections:

AA	Asked & Answered/Duplicative
C	Compound
CU	Cumulative
H	Hearsay
IH	Improper Hypothetical
L	Leading
LF or F	Lacks Foundation
M	Mischaracterizes Testimony
MD	Mischaracterizes Document
N	Non-Responsive
O	Inadmissible Opinion or Conclusion
PK	No Personal Knowledge/Lacks foundation
R	Relevance
S	Calls for Speculation
T	Time Wasting
UP	Unfair Prejudice
V	Vague & Ambiguous

Table 1: The Community Hospitals' Deposition Designations of Matt Austin - 9/25/2025								
Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Plaintiffs' Reply Designations		Objections to Plaintiffs' Reply Designations
From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line	
11:21	12:3	None						
13:9	13:17	None						
27:5	27:15	None			No Objection.			
33:15	34:11	None						
35:10	35:15	None						
37:14	38:6	None						
39:17	40:2	None						
40:9	41:3	None						
41:7	42:15	None						
42:18	44:1	None						
45:9	46:7	Completeness	47:20	47:21	No Objection.			
			48:3	48:10	No Objection.			
			48:15	48:16	No Objection.			
47:4	47:18	Completeness	47:20	47:21	No Objection.			
			48:3	48:10	No Objection.			
			48:15	48:16	No Objection.			
48:16	48:19	No objection						
49:16	50:20	R	47:20	47:21	No Objection.			
51:2	51:5	No objection						
51:10	57:17	No objection						
57:20	59:9	Completeness	59:19	59:20				
61:2	61:13	None						
61:16	63:5	Completeness	63:20	64:2	No Objection.	64:3	64:10	No objection.
			64:15	65:10	No Objection.			

Table 1: The Community Hospitals' Deposition Designations of Matt Austin - 9/25/2025

Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Plaintiffs' Reply Designations		Objections to Plaintiffs' Reply Designations
From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line	
78:15	79:7	None						
79:14	80:21	None						
81:10	84:2	None						
84:9	85:1	Completeness	85:3	85:3	No Objection.			
85:5	86:17	None						
87:19	88:5	Completeness	88:6	88:11	Objection. N.			
			89:9	89:21	Objection. T.			
			90:3	90:13	Objection. N.			
88:12	88:18	R, Completeness	88:6	88:11	Objection. N.			
			89:9	89:21	Objection. T.			
			90:3	90:13	Objection. N.			
90:15	90:17	H, R	89:9	89:21	Objection. T.			
			90:3	90:13	Objection. N.			
90:21	91:15	Completeness	89:9	89:21	Objection. T.			
			90:3	90:13	Objection. N.			
92:5	97:16	H, R, UP, Completeness	97:20	98:4	No Objection.			
			98:8	98:12	Objection. N.			
98:14	100:8	None						
101:8	102:13	None						
102:18	102:21	F, PK	103:2	103:8	No Objection.			
103:9	103:20	F, PK	103:2	103:8	No Objection.			
104:1	106:6	H, R, Completeness	106:7	107:10	No Objection.	107:11	107:16	No objection.
			108:10	110:7	No Objection.			

Table 1: The Community Hospitals' Deposition Designations of Matt Austin - 9/25/2025								
Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Plaintiffs' Reply Designations		Objections to Plaintiffs' Reply Designations
From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line	
110:10	111:1	Completeness	111:2	111:21	No Objection.			
112:1	112:5	R, UP, Wasting Time						
112:11	113:12	None						
113:17	114:13	None	113:14	114:14	Objection. Cumulative.			
115:15	116:2	Completeness	116:13	116:18	No Objection.	119:5	119:9	No objection.
			117:7	118:5	No Objection.			No objection.
			118:15	119:4	Objection. O, H.			No objection.
120:7	121:13	Completeness	118:15	119:4	Objection. O, H.	119:5	119:9	No objection.
121:19	123:16	H, R, UP						
125:5	128:1	H, PK as to for 127:20—128:1						
128:17	130:11	None						
131:1	132:19	R, Wasting Time, UP, Cumulative						
133:8	133:17	R, Wasting Time, UP, Cumulative						
137:10	138:21	R, Wasting Time, UP, Cumulative						
139:9	142:17	H, R, UP						
143:8	143:21	H, R, Wasting Time, UP						
144:3	144:6	H, R, PK						
144:15	144:18	H, Completeness	145:4	145:14	Objection. N.	145:15	145:17	No objection.

Table 1: The Community Hospitals' Deposition Designations of Matt Austin - 9/25/2025								
Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Plaintiffs' Reply Designations		Objections to Plaintiffs' Reply Designations
From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line	
144:21	145:1	H, Completeness	145:4	145:14	Objection. N.	145:15	145:17	No objection.
145:19	147:18	H, PK, Wasting Time, UP						
148:15	150:10	H, R, Completeness	150:13	150:20	No Objection.	150:11	150:12	No objection.
			151:1	151:4	No Objection.			
151:5	151:13	H, R, Completeness	152:12	152:16	No Objection.			
151:18	152:2	Completeness	152:12	152:16	No Objection.			
153:3	153:13	H, R, UP, Wasting time, Completeness	152:3	152:6	No Objection.			
156:3	156:19	None						
157:5	157:14	None						
157:16	158:6	Completeness	159:7	159:12	No Objection.			
160:1	160:10	None						
163:5	164:18	H, PK	165:1	165:3	Objection. R. T.	164:20	164:21	No objection.
165:9	166:10	H, Wasting time						
168:13	168:15	H, Completeness	168:16	168:20	No Objection.			
			169:3	169:21	No Objection.			
170:7	170:13	H, Wasting time, UP						
170:15	171:14	None						
173:7	173:14	H, Completeness	168:16	168:20	No Objection.			
			169:3	169:21	No Objection.			
173:17	173:17	H, (not testimony of the witness), Wasting time, UP						

Table 1: The Community Hospitals' Deposition Designations of Matt Austin - 9/25/2025

Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Plaintiffs' Reply Designations		Objections to Plaintiffs' Reply Designations
From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line	
173:19	174:3	R, Wasting time, UP						
174:7	174:11	H (not testimony of the witness), Wasting time, UP						
174:13	175:14	H, Wasting time, UP, PK	168:16	168:20	No Objection.			
			169:3	169:21	No Objection.			
			175:15	176:11	No Objection.	176:12	176:21	R, Wasting time
181:5	182:3	H, UP, Cumulative as to 181:21-182:3	175:15	176:11	No Objection.	176:12	176:21	R, Wasting time
185:5	186:16	H, R, Completeness	186:17	186:18	Objection T/CU.			
			186:21	187:2	Objection T/CU.			
187:4	188:13	H, R, PK, Completeness	188:15	188:19	Objection T/CU.			
188:20	190:1	H, R, PK	188:15	188:19	Objection T/CU.			
190:5	190:18	No objection						
190:20	192:15	H, R, PK						
192:17	193:20	H to 193:13-20, Completeness	175:15	176:11	No Objection.			
194:15	195:7	H, R, PK, Completeness	195:8	195:11	No Objection.			
195:14	197:19	H, R, Completeness	198:1	198:2	No Objection.	198:10	198:11	F, R
			198:12	198:14	No Objection.			F, R

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Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Plaintiffs' Reply Designations		Objections to Plaintiffs' Reply Designations
From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line	
198:15	199:4	No objection						
202:5	202:17	R, Wasting time, UP, Cumulative						
205:8	205:16	Form (not witness testimony)						
206:1	206:16	R, PK						
206:19	207:2	PK						
207:5	207:9	Form (Counsel's question), PK						
207:17	207:19	None						
208:1	208:15	None						
208:17	209:20	None						
210:8	210:8	None						
210:10	211:9	None						
211:13	214:17	Completeness	214:18	215:5	No Objection.			
215:6	215:12	None						
217:2	217:16	None						
218:4	218:6	None						
218:12	220:4	H, UP, Wasting time						
220:9	221:17	H, F, PK, Wasting time, UP						
221:20	223:5	H, F, PK, Wasting time, UP						
223:10	225:17	H, F, PK, Wasting time, UP						

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Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Plaintiffs' Reply Designations		Objections to Plaintiffs' Reply Designations
From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line	
225:19	227:18	H, F, PK, Wasting time, UP						
228:1	228:16	H, F, PK, Wasting time, UP						
228:18	229:5	H, F, PK, Wasting time, UP						
230:13	233:9	H, F, PK, Wasting Time, UP	233:16	234:5	Objection. R, T.			
234:6	235:9	H, F, PK, Wasting Time, UP, Completeness	235:10	236:6	Objection. R, T/CU.			
			237:7	237:9	No Objection.			
236:15	237:5	H, F, PK, Wasting time, UP, Completeness	235:10	236:6	No Objection.			
			237:7	237:9	No Objection.			
237:11	238:21	H, F, PK, Wasting Time, UP, Completeness	239:4	239:17	No Objection.			
239:19	240:7	F, PK, UP	240:8	240:9	No Objection.			
			371:7	372:14	No Objection.			
240:11	240:20	No objection						
243:16	243:18	Form (this is not witness testimony), Completeness	247:3	247:14	No Objection.	248:5	248:7	Non-responsive, R
244:5	246:5	H as to 245:17-21, Completeness	247:3	247:14	No Objection.	248:5	248:7	Non-responsive, R

Table 1: The Community Hospitals' Deposition Designations of Matt Austin - 9/25/2025

Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Plaintiffs' Reply Designations		Objections to Plaintiffs' Reply Designations
From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line	
246:11	247:1	Completeness	247:3	247:14	No Objection.	248:5	248:7	Non-responsive, R
			237:7	237:13	No Objection.			
			249:18	250:16		248:5	248:7	
248:8	249:9	None						
251:6	252:9	H, F, PK						
253:13	254:11	R, Wasting time, UP						
254:13	255:10	R, Wasting time, UP						
255:15	257:7	H, F, PK, Completeness, UP	257:9	257:15	Objection T/CU.			
			263:10	263:20	Objection T/CU.			
257:16	257:19	H, R, F, PK						
258:2	263:9	H, R, F, PK, Wasting time, UP	263:10	263:20	Objection T/CU.			
263:21	264:13	Completeness	268:1	268:10	No Objection.			
266:11	267:16	Completeness	268:1	268:10	No Objection.			
268:11	270:13	Completeness	268:1	268:10	No Objection.			
271:4	271:18	H						
271:20	274:2	H, F, PK						
274:11	278:11	H to 277:21-278:11, Completeness	268:1	268:10	No Objection.			
			280:20	281:7	No Objection.			
			281:9	281:10	No Objection.	281:11	281:13	No objection.
282:3	282:17	Completeness	268:1	268:10	No Objection.			
283:10	285:21	H, PK						

Table 1: The Community Hospitals' Deposition Designations of Matt Austin - 9/25/2025								
Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Plaintiffs' Reply Designations		Objections to Plaintiffs' Reply Designations
From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line	
286:3	287:7	H, R, Wasting time, UP						
288:16	291:13	Completeness	291:15	291:17	No Objection.			
292:1	292:20	Completeness	292:21	294:6	No Objection.			
			294:10	294:16	No Objection.	294:7	294:9	No objection.
						294:17	295:14	No objection.
			295:15	296:10	No Objection.	296:11	297:17	No objection.
298:2	298:20	None						
302:2	302:15	Completeness	302:16	304:1	No Objection.			
			306:1	306:13	No Objection.			
306:15	306:17		90:3	90:13				
			303:1	304:1	No Objection.			
312:17	312:20	Form (this is not witness testimony)						
320:3	320:14	H, R, UP, Completeness	317:10	320:2	No Objection.			
			320:15	320:17	No Objection.			
			308:21	309:5				
320:18	320:21	H, Completeness, UP	317:10	320:2	No Objection.			
			320:15	320:17	No Objection.			
			353:10	353:20	Objection T/CU.			
			354:1	354:9	Objection T/CU.			
355:9	355:19	R, Wasting Time, UP						

Table 1: The Community Hospitals' Deposition Designations of Matt Austin - 9/25/2025								
Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Plaintiffs' Reply Designations		Objections to Plaintiffs' Reply Designations
From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line		From: Page:Line	To: Page:Line	
356:18	357:20	R, Wasting Time						
360:8	361:17	R, Wasting Time						
397:3	398:6	H, R, Wasting Time						
399:21	405:5	H, R, Wasting Time, UP						
411:18	412:3	None						
412:9	412:20	Completeness	412:21	413:12	No Objection.			
413:13	414:5	None						
414:14	415:19	H, R, Wasting Time, Cumulative						

Table 2: The Community Hospitals' Deposition Designations of Karen van Caulil - 9/25/2025								
Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Reply Designations		Objections to Reply Designations
From: Page:Line	To: Page:Line		From: PageLine	To: PageLine		From: Page:Line	To: Page:Line	
6:25	7:2	No objection						
9:7	10:5	Completeness	10:6	10:8	No Objection			
11:12	12:3	Clarification/Completeness	12:4	13:9	No Objection			
24:18	26:22	Clarification	18:3	18:12	Objection. IH, N.	34:15	35:24	R
			24:7	24:17	No Objection	24:5	24:6	No objection.
27:12	28:7	Completeness, UP	26:23	27:11	No Objection			
			28:8	29:3	Objection. R, T.			
49:25	50:16	Completeness, F	46:22	47:24	Objection R, T.			
			48:8	49:23	Objection. T	48:6	48:7	No objection.
51:6	51:8	Cumulative						
51:20	52:2	Completeness, PK	52:6	52:23	Objection. R, T.			
			25:18	26:22	No Objection			
			51:9	51:19	No Objection			
53:22	53:25	Cumulative						
56:23	57:2	PK, Completeness	54:9	55:12	Objection. R, T/CU, PK.			
			57:3	57:12	Objection N, R, T, PK	57:14	58:16	No objection.
61:3	61:15	PK	59:5	60:11	No Objection	58:17	59:4	No objection.
67:11	67:16	R, Cumulative						
68:21	69:1	R, H	28:8	28:15	No Objection			

Table 2: The Community Hospitals' Deposition Designations of Karen van Caulil - 9/25/2025

Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Reply Designations		Objections to Reply Designations
70:17	71:18	R, PK	72:18	72:23	Objection. Outside the scope of affirmative designation.			
75:17	76:25	PK, F, UP, H	52:20	52:23	Objection. R, T/CU, NR. (Duplicative designations)			
			77:1	77:6	Objection. Improper designation, no question designated.			
77:18	78:9	PK, F, UP, H	52:20	52:23	Objection. R, T/CU, NR. (Duplicative designations)			
			77:1	77:6	Objection. Improper designation, no question designated.			
			78:19	79:10	Objection. PK, LF. Improper designation, no question designated.			
			79:17	79:22	Objection. Improper designation, no question designated.			
			80:18	81:4	Objection. Completeness	81:5	81:10	PK, UP, R, Wasting time
81:12	81:16	Form (this is not witness testimony)	80:23	80:23	Objection. Outside the scope of affirmative designations.			
			81:17	81:17	Clarification.			

Table 2: The Community Hospitals' Deposition Designations of Karen van Caulil - 9/25/2025

Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Reply Designations		Objections to Reply Designations
81:18	81:22	PK	52:20	52:23	Objection. R, T/CU, NR. (Duplicative designations)			
			77:1	77:6	Objection. Improper designation, no question designated.			
			79:17	79:22	Objection. Improper designation, no question designated.			
			80:18	81:4	Objection. Completeness	81:5	81:10	PK, UP, R, Wasting time
83:12	83:19	PK, UP, H	83:20	84:11	Objection. T, PK.	84:17	84:24	PK, Wasting time
			77:1	77:6	Objection. Improper designation, no question designated.			
			79:19	79:22	Objection. Completeness Improper designation, no question designated.			
85:8	85:12	Form (this is not witness testimony), UP, R	85:13	85:13	No Objection.			
			83:20	84:11	Objection. T, PK.	84:17	84:24	PK, Wasting time
85:14	85:16	UP, R	83:20	84:11	Objection. T, PK.	84:17	84:24	PK, Wasting time
			85:13	85:13	No Objection.			
100:12	101:24	R, UP, PK, H	80:18	81:4	Objection. Completeness	81:5	81:10	PK, UP, R, Wasting time

Table 2: The Community Hospitals' Deposition Designations of Karen van Caulil - 9/25/2025

Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Reply Designations		Objections to Reply Designations
			82:15	82:22	Objection. PK, Completeness.	82:23	83:11	No objection.
			80:24	81:4	Objection. Outside the scope of affirmative designations. Clarification: Duplicative designation.			
			83:20	84:11	Objection. T, PK.	84:17	84:24	PK, Wasting time
102:23	103:9	F, PK, H, R, UP, BER	Exhibit 7 to van Caulil's Dep.		Objection. Completeness. NR. Clarification. Not deposition testimony.			
104:5	104:14	F, PK, H, R, UP	83:20	84:11	Objection. T, PK.	84:17	84:24	PK, Wasting time
			82:15	82:22	Objection. PK, Completeness.	82:23	83:11	No objection.
			80:24	81:4	Objection. Outside the scope of affirmative designations. Clarification: Duplicative designation.			
104:22	105:8	F, PK, H, R, UP	83:20	84:11	Objection. T, PK.	84:17	84:24	PK, Wasting time
			82:15	82:22	Objection. PK, Completeness.	82:23	83:11	No objection.
			80:24	81:4	Objection. Outside the scope of affirmative designations.			

Table 2: The Community Hospitals' Deposition Designations of Karen van Caulil - 9/25/2025

Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Reply Designations		Objections to Reply Designations
					Clarification: Duplicative designation.			
			105:9	105:16	No Objection.			
105:18	105:22	R, UP, PK	83:20	84:11	Objection. T, PK.	84:17	84:24	PK, Wasting time
			82:15	82:22	Objection. PK, Completeness.	82:23	83:11	No objection.
			80:24	81:4	Objection. Outside the scope of affirmative designations. Clarification: Duplicative designation.			
106:6	106:6	No objection						
106:20	107:11	No objection						
108:1	108:4	Cumulative, Completeness	83:20	84:11	Objection. T, PK.	84:17	84:24	PK, Wasting time
			82:15	82:22	Objection. PK, Completeness.	82:23	83:11	No objection.
			80:24	81:4	Objection. Outside the scope of affirmative designations. Clarification: Duplicative designation.			
			107:22	107:25	No Objection			
108:13	108:17	F, PK, H, UP, BER, Completeness	52:17	52:21	Objection. R, T, NR, PK			
			83:20	84:11	Objection. T, PK.	84:17	84:24	PK, Wasting time

Table 2: The Community Hospitals' Deposition Designations of Karen van Caulil - 9/25/2025

Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Reply Designations		Objections to Reply Designations
			108:18	109:3	Objection. PK, T/CU.	109:12	109:18	Non-responsive, R, PK, Wasting time
115:3	115:21	F, PK, H, UP, BER	114:1	114:7	Objection. PK, T.	114:20	115:2	R, Wasting time.
			81:18	81:22	No Objection.			
			52:20	52:23	Objection. R, T/CU, NR. (Duplicative designations)			
			71:25	72:7	Objection. Completeness.			
			77:1	77:6	Objection. Improper designation, no question designated.			
			115:22	116:12	Objection. PK, T, Completeness.	116:10	116:14	No objection
116:16	116:20	Form (this is not witness testimony), UP, R, H	116:21	116:21	No Objection.			
116:23	116:23	F, PK, H, UP	114:1	114:7	Objection. PK, T.	114:20	115:2	No objection.
			116:21	116:21	No Objection.			
118:15	118:21	F, PK, H, UP	116:2	116:10	Objection. PK, T, Completeness. Clarification: designation is duplicative of other written designation.			

Table 2: The Community Hospitals' Deposition Designations of Karen van Caulil - 9/25/2025

Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Reply Designations		Objections to Reply Designations
		Cumulative, PK, R	77:1	77:6	Objection. Improper designation, no question designated.			
			82:15	82:22	Objection. PK, Completeness.	82:23	83:11	No objection.
119:15	119:23		18:3	18:12	Objection. IH, R	34:15	35:24	R, Time Wasting.
			24:7	24:17	No Objection	24:5	24:6	No objection.
			33:18	33:19	Objection. Completeness (no question testimony, incomplete answer), R, T/W, C.			
			34:5	34:10				
			120:3	120:7	Objection. Outside the scope of affirmative designations.PK.	120:7	120:17	No objection.
129:22	130:18	R, F, PK (as to 130:6-18)	129:1	129:10	No Objection.	129:11	129:14	R, PK, Time wasting
131:11	132:16	R, H, UP	135:3	135:18	R, T.	130:20	131:2	R, Wasting time.
140:21	142:7	H, UP, PK	142:8	142:10	Objection. PK	142:11	142:14	R, PK, UP, Wasting time
			137:22	138:3	Objection. T. Completeness.	138:20	139:24	R, Wasting time, UP
						140:6	140:19	No objection.
149:9	149:12	F, PK, H	147:9	148:10	Objection. Completeness, R, T/CU.			

Table 2: The Community Hospitals' Deposition Designations of Karen van Caulil - 9/25/2025

Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Reply Designations		Objections to Reply Designations
			149:13	149:25	Objection. Testimony retracted by witness. T.			
150:13	150:25	A, F, H, PK, UP	147:9	148:10	Objection. Completeness, R, T/CU.			
			149:13	149:25	Objection. Testimony retracted by witness. T.			
			151:14	152:4	Objection. R, T.	151:8	151:13	R, Mischaracterizes.
152:5	152:13	H, R, UP	147:9	148:10	Objection. Completeness, R, T/CU.			
			149:13	149:25	Objection. Testimony retracted by witness. T.			
153:13	154:7	F, PK, H, UP	149:13	149:25	Objection. Testimony retracted by witness. T.			
			152:14	153:12	Objection. T/CU.			
			154:13	154:20	Objection. PK.			
155:20	155:25	F, PK, H, R, UP	147:9	148:10	Objection. Completeness, R, T/CU.			
			137:22	137:25	Objection. T. Completeness.	138:20	139:24	R, Wasting time, UP
						140:6	140:19	No objection.
			149:13	149:25	Objection. Testimony retracted by witness. T.			

Table 2: The Community Hospitals' Deposition Designations of Karen van Caulil - 9/25/2025

Plaintiffs' Affirmative Designations		Objections to Plaintiffs' Designations	Leapfrog's Counter-Designations		Objections to Leapfrog's Counter-Designations	Reply Designations		Objections to Reply Designations
			156:1	156:25	Objection. Witness retracts this testimony. Completeness.	156:25	157:22	No objection.
159:7	159:24	F, H, R, UP	147:24	148:10	Objection. Completeness, R, T/CU.			
			153:3	153:12	Objection. PK, T/C..			
160:6	160:12	F, PK, R, UP	48:8	48:15	Objection. R, T/C	48:6	48:7	No objection.
161:7	161:18	H, R, UP	147:9	148:10	Objection. Completeness, R, T/CU.			
			149:13	149:25	Objection. Testimony retracted by witness. T.			
			160:24	161:6	Objection. Completeness.	159:25	160:5	UP, Wasting time
168:17	171:2	H, R, UP	147:9	148:10	Objection. Completeness, R, T/CU.			
			149:13	149:25	Objection. Testimony retracted by witness. T.			
171:21	174:15	F, PK, H, R, UP	147:9	148:10	Objection. Completeness, R, T/CU.			
			149:13	149:25	Objection. Testimony retracted by witness. T.			
						176:2	176:14	No objection.
			174:25	174:9	No Objection.	176:17	179:8	H, R, Wasting time

Dated: December 29, 2025

Respectfully submitted,

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EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

GOOD SAMARITAN MEDICAL)
CENTER, et al.,)
)
Plaintiffs,) CASE NO.
)
v.) 9:25-CV-80526-DMM
)
THE LEAPFROG GROUP,)
)
Defendant.)
_____)

The in-person, video-recorded deposition of Matthew Austin, taken pursuant to Federal Rule of Civil Procedure 45 and Southern District of Florida Local Rule 26.1, at the offices of Zuckerman Spaeder, LLP, 100 E. Pratt Street, Suite 2440, Baltimore, Maryland 21202, by Plaintiffs in the above-referenced action, beginning at 9:09 a.m. The deposition was taken before Marlene Kerr, a Certified Shorthand Reporter, Registered Professional Reporter, Registered Merit Reporter, Certified Realtime Reporter, Federal Certified Realtime Reporter, Notary Public.

Job No. 7616361

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11 CURTIS ROGINSKI - Videographer

12

13

14

15

16

17

18

19

20

21

INDEX OF EXAMINATION

WITNESS: MATTHEW AUSTIN

Good Samaritan, et al., The Leapfrog Group

Thursday, September 25, 2025

EXAMINATION	PAGE
By Mr. Crain	11
By Ms. Wood	362
By Mr. Crain	397
Certificate of Reporter	417
Certificate of Deponent	418
Errata	419

INDEX OF EXHIBITS

WITNESS: MATTHEW AUSTIN

Good Samaritan, et al., The Leapfrog Group

Thursday, September 25, 2025

EXHIBIT NUMBER	DESCRIPTION	PAGE
Exhibit 1	Email from Ms. Binder	20
Exhibit 2	from Mr. Austin to Ms. Danforth dated May 1	23
Exhibit 3	Document that outlines Grading methodology	29
Exhibit 4	Email from Mr. Austin to Ms. Danforth, cc'ing Ms. Wood	30
Exhibit 5	Matthew Austin Linked In Profile	35
Exhibit 6	Contract b/w Johns Hopkins University and The Leapfrog Group	42
Exhibit 7	Document from the Leapfrog Safety Grade website, hospitalsafetygrades.org	71
Exhibit 8	Printout of a webpage from Leapfrog's Hospital Safety Grade website	78
Exhibit 9	Hospitalsafetygrades.org website page of Frequently asked questions	102

INDEX OF EXHIBITS (cont.)

WITNESS: MATTHEW AUSTIN

Good Samaritan, et al., The Leapfrog Group

Thursday, September 25, 2025

EXHIBIT NUMBER	DESCRIPTION	PAGE
Exhibit 10	Email thread leading up to April 12th, 2024, Expert panel meeting	113
Exhibit 11	Slide deck and meeting Invite of April 12th meeting	113
Exhibit 12	Certified transcript of Expert panel meeting	128
Exhibit 13	Meeting notes from Preeti Joshi	139
Exhibit 14	Email from Matt Austin to Matt Austin, notes from Hospital Safety Grade Expert panel meeting	160
Exhibit 15	Email from Mr. Austin to Ms. Campione, Ms. Danforth, and Ms. Joshi	163
Exhibit 16	Email between Mr. Austin and Leapfrog staff	185
Exhibit 17	Email thread between you and Ms. Joshi dated May 14.	197

INDEX OF EXHIBITS (cont.)

WITNESS: MATTHEW AUSTIN

Good Samaritan, et al., The Leapfrog Group

Thursday, September 25, 2025

EXHIBIT NUMBER	DESCRIPTION	PAGE
Exhibit 18	Email from Ms. Binder to Ms. Campione, cc'ing Mr. Austin and Ms. Danforth	205
Exhibit 19	Delray Medical Center Hospital Safety Grade page	217
Exhibit 20	Continuation of prior email with Ms. Binder's comments	230
Exhibit 21	Email from the Leapfrog Help desk to Ms. Campione	234
Exhibit 22	Comment submitted through Leapfrog's Zendesk platform	242
Exhibit 23	Notes for today's call with Dr. Romano	255
Exhibit 24	Email with Leapfrog Hand Hygiene Report Analysis June 3, 2024, attachment	272
Exhibit 25	Final updates to Leapfrog Hospital Safety Grade Methodology for Fall 2024	283
Exhibit 26	2013 prepublished ahead of Print publication from the Journal of Patient Safety	286

INDEX OF EXHIBITS (cont.)

WITNESS: MATTHEW AUSTIN

Good Samaritan, et al., The Leapfrog Group

Thursday, September 25, 2025

EXHIBIT NUMBER	DESCRIPTION	PAGE
Exhibit 27	Meeting Agenda Notes	307
Exhibit 28	August 25, 2021 email between Mr. Austin, Ms. Danforth, Mr. Card, and Emma Domico	312
Exhibit 29	Email from Mr. Austin to Ms. Campione, Ms. Danforth, and Ms. Bailey from 2025 Re: Lives Saved, Lives Lost	321
Exhibit 30	Article by Deena Kelly Costa	330
Exhibit 31	Excel Spreadsheet to Calculate lives lost Lives saved	355
Exhibit 32	Email dated June 5, 2019 from Mr. Derk to Mr. Austin	356

P R O C E E D I N G S

THE VIDEOGRAPHER: Good morning.

We are going on the record at 9:09 a.m., on September 25th, 2025. This is media unit one of the video-recorded deposition of Dr. Matthew Austin taken in the matter of Good Samaritan Medical Center, Inc., et al., v. The Leapfrog Group, the United States District Court for the Southern District of Florida, West Palm Beach Division; Case No. 9:25-CV-08526 [sic.] -DMM.

My name is Curtis Roginski, representing Veritext. I'm the videographer. The court reporter is Marlene Kerr, also with Veritext.

Will counsel please identify yourselves and state whom you represent.

MS. LAWSON: Sara Lawson from Zuckerman Spaeder on behalf of the witness, Dr. Matthew Austin, and the Armstrong Institute.

MR. CRAIN: Lee Crain from Gibson Dunn & Crutcher for Plaintiffs.

MS. WOOD: Courtney Wood, Wilson Elser, on behalf of the Defendant, The Leapfrog Group.

1 MR. TOGIAS: Iason Togias on behalf of
2 Plaintiffs with Gibson Dunn & Crutcher.

3 THE VIDEOGRAPHER: Thank you.

4 Would the court reporter please swear in
5 the witness.

6 THE COURT REPORTER: Sure.

7 Would you please raise your right hand to
8 be sworn.

9 (Witness complied.)

10 THE COURT REPORTER: Do you promise and declare
11 under penalty of perjury the testimony you are about to
12 give will be the truth, the whole truth, and nothing but
13 the truth?

14 THE WITNESS: Yes.

15 THE COURT REPORTER: Thank you.

16 (Witness sworn.)

17 MR. CRAIN: I'm sorry. Could we pause for a
18 second?

19 THE COURT REPORTER: Sure.

20 MR. CRAIN: Do we have the realtime?

21 THE COURT REPORTER: You should.

1 MR. CRAIN: Oh, okay. We've got it there.

2 THE COURT REPORTER: Okay.

3 MR. TOGIAS: Is it on, though?

4 THE COURT REPORTER: It's up and running.

5 MR. CRAIN: Actually, can we go off for a
6 second? I'm sorry.

7 (Discussion held off the record regarding
8 the realtime feed.)

9 THE VIDEOGRAPHER: Off the record. The time is
10 9:10 a.m.

11 (Brief pause.)

12 THE VIDEOGRAPHER: This marks the beginning of
13 media unit number two. We're going back on the record.
14 The time is 9:12 a.m.

15 EXAMINATION

16 BY MR. CRAIN:

17 Q. Good morning, Dr. Austin.

18 A. Good morning.

19 Q. My name is Lee Crain. I am counsel for
20 Plaintiffs in this action.

21 Could you please just state your full name

1 for the record.

2 A. Yeah, my full legal name is John Matthew
3 Austin, but I go by Matt Austin.

4 Q. And have you gone by any other names besides
5 those two?

6 A. No, I have not.

7 Q. Okay.

8 Have you ever been deposed before?

9 A. I have not.

10 Q. Okay.

11 I want to go through just some ground rules
12 at the start so we're on the same page. A couple of key
13 rules. You understand the court reporter is taking down
14 what you and I say to create a written transcript?

15 A. Uh-huh.

16 Q. And you understand this deposition is being
17 video-recorded?

18 A. Yes, I do.

19 Q. Because of Marlene and to help her out, we want
20 to make sure that we're taking time between the
21 questions and answers. So I'll do my best to let you

1 finish, and you do your best to let me finish. Fair
2 enough?

3 A. Sounds good. I'll do my best.

4 Q. It's a little unnatural, but we'll get through
5 it.

6 Answers need to be audible, so no shaking
7 heads or nodding, that sort of thing. Fair enough?

8 A. Fair enough.

9 Q. You understand you're under oath today as if
10 you were testifying in court?

11 A. Yes.

12 Q. Are you under any medications that would impair
13 your ability to testify truthfully today?

14 A. No.

15 Q. Is there any other reason you can't give
16 truthful testimony today?

17 A. No.

18 Q. Okay.

19 Occasionally, it will happen where I will
20 ask a bad question. Don't hesitate to ask if you have
21 questions, if you want me to restate the question, or if

1 you're confused. If you don't, I'm going to assume you
2 understand the question, but feel free to clarify any
3 time. Fair enough?

4 A. Fair enough.

5 Q. And then the last -- two last things. From
6 time to time, your attorney or Ms. Wood may object.
7 Unless they're instructing you not to answer, we're
8 going to ask you to answer the question. Clear enough?

9 A. That's clear enough.

10 Q. And then the last thing is we can take a break
11 any time, any time you need, any time anybody else
12 needs. The only thing we ask is not while a question is
13 pending. So we'll go through the question and answer
14 and then we can take a break, if that makes sense?

15 A. Yeah, that makes sense.

16 Q. Great.

17 Okay. So I want to just start right at the
18 top. Did you prepare for this deposition?

19 A. I did.

20 Q. Can you tell me what you did to prepare for the
21 deposition?

1 A. I met with my attorney and a paralegal
2 yesterday and also reviewed some documents that they had
3 sent me.

4 Q. Did you only meet with counsel one time?

5 A. To prepare for the deposition, yes.

6 Q. Did you meet with counsel other times regarding
7 this case?

8 A. We did have an early sort of exploratory call
9 shortly after Sara was named as my counsel.

10 Q. Okay.

11 MS. LAWSON: And I'm just going to object, just
12 interpose an objection just to make sure that Dr. Austin
13 understands that you can answer with respect to sort of
14 basic details, the who, what, where, when, why, and how
15 of our discussions, but those discussions are protected
16 by the attorney-client privilege. So I would just ask
17 and instruct you not to reveal the substance of any
18 discussions that you've had with me or any other of your
19 counsel from Zuckerman Spaeder, like my partner Marty
20 Himeles as well. So just to make that clear.

21

1 BY MR. CRAIN:

2 Q. Yes. And none of my questions are getting at
3 that. So I do not want the substance of your
4 communications with counsel. Fair enough?

5 A. Fair enough.

6 MR. TOGIAS: And just to flag, this is -- the
7 Zoom link, I don't see a live feed.

8 MR. CRAIN: We'll do it after.

9 BY MR. CRAIN:

10 Q. So how long did you meet with counsel --
11 yesterday, you said?

12 A. Yesterday, correct.

13 Q. And how long was that meeting?

14 A. It was approximately three hours.

15 Q. Was anybody else in attendance besides
16 Ms. Lawson -- did I get that right? I'm sorry -- and a
17 paralegal?

18 A. That was it.

19 Q. Okay. And you reviewed documents during that
20 session?

21 A. We reviewed some documents.

1 Q. Okay. Did you review documents outside of that
2 session with your counsel to prepare today?

3 A. No.

4 Q. Okay. Did you watch any videos?

5 A. No.

6 Q. Did you listen to any audio recordings?

7 A. No.

8 Q. Okay. Did you review any other -- any
9 transcripts from depositions in this case?

10 A. No.

11 Q. Did you review any transcripts of anything
12 else?

13 A. No.

14 Q. Let's see. Who have you talked to about this
15 deposition besides counsel?

16 A. So I've talked to my boss, Allen Kachalia, to
17 let him know that I was being deposed. I spoke to
18 Jordan Derk who at the time of -- or at least at the
19 start of the period was working with me on The Leapfrog
20 Group contract; and with Preeti Joshi, who currently is
21 working with me on the Leapfrog contract, my partner at

1 home, and my father who is an attorney.

2 Q. And just going down the line, what did you tell
3 Mr. Kachalia about the deposition?

4 A. I had let him know that there was a lawsuit and
5 that I was being deposed for testimony.

6 Q. And what did you talk to Mr. Derk about?

7 A. I let Mr. Derk know that he was going to be
8 receiving a subpoena for documents. We talked a little
9 bit about the lawsuit, as well as some other related
10 items.

11 Q. Did you talk about the methodology, the
12 Leapfrog Hospital Safety Grade methodology with him?

13 A. We didn't talk about that in detail.

14 Q. And what did you talk about with Ms. Joshi?

15 A. I let her know that there was going to be a
16 lawsuit and that she should come to me with any
17 questions or concerns that she had about that. And then
18 when she received notice that she needed to supply
19 documents, we talked about what she needed to supply and
20 how that would go.

21 Q. Okay. And she's a current employee at

1 Armstrong?

2 A. Correct.

3 Q. Okay.

4 And then with regard to your partner and
5 your father, did you talk about the substance of this
6 case at all?

7 A. I talked about what I was aware of based on the
8 public press releases that both organizations had put
9 out.

10 Q. And what did you say? Just can you give us a
11 general sense?

12 A. Yeah. My general sense is it felt like there
13 was a lot of factual errors in the press release in
14 terms of what tenant was claiming, that those things
15 were just factually wrong.

16 Q. I guess we'll come back to that.

17 And then a couple of other questions. Did
18 you talk to anybody at Leapfrog about this case?

19 A. Not -- so Leapfrog did give me a heads-up that
20 I was going to be receiving a subpoena. So that was the
21 sort of extent of the conversation.

1 Q. Okay.

2 And then did you also speak with counsel at
3 Wilson Elser, Ms. Wood's firm?

4 A. We had a brief conversation the day that I was
5 notified that I was going to be receiving a subpoena.

6 Q. Okay. And have you exchanged emails with
7 Wilson Elser?

8 A. I have not beyond the counsel at Johns Hopkins
9 requested Courtney and Kim's names and emails, and so I
10 supplied them with those.

11 Q. Okay.

12 Now, I want to just start with an exhibit
13 just to mark it. This will be Exhibit 1.

14 (Exhibit No. 1 was marked for
15 identification as of 9/25/2025.)

16 BY MR. CRAIN:

17 Q. Dr. Austin, do you recognize this document?

18 A. I do.

19 Q. And it was produced, if you see the bottom
20 right, by the Armstrong Institute?

21 A. Correct.

1 Q. And it's an email from Ms. Binder to a number
2 of folks, including yourself. Do you see that?

3 A. Yes, I do.

4 Q. And Ms. Binder told you, if you look towards
5 the bottom, she asked everybody in the email not to
6 email or talk about the case in writing. Do you see
7 that?

8 A. Can you point me to where that says that?

9 Q. Yes. So it says, number two: "Do not
10 communicate in writing about this matter, such as on
11 slack or email or texting."

12 Do you see that?

13 A. Yes.

14 Q. Did you adhere to that guidance?

15 A. So outside of sort of the need to communicate
16 with, say, my boss or with counsel, I did follow that.

17 Q. Okay.

18 And then she asks -- she says, number
19 one -- do you see that right above? -- "Please refer all
20 questions or concerns, whether you have them personally
21 or you hear them from external sources, to me, Missy,

1 Lauren, or Karen. Do not put them in writing. Call us
2 or come by my office."

3 Do you see that?

4 A. I do.

5 Q. Did you call any of those folks listed in
6 bullet one?

7 A. I did not.

8 Q. Okay.

9 And then did you come by her office?

10 A. I did not.

11 Q. Okay.

12 Now, did -- I want to talk just for a
13 second about the safety grade expert panel. Do you know
14 what I mean when I say that?

15 A. Yes.

16 Q. I assume you spent a decent bit of time with
17 that group.

18 A. Correct.

19 Q. Did you discuss the lawsuit with the expert,
20 the safety grade expert panel?

21 A. So we did have a meeting with the expert panel

1 already scheduled, and at that meeting, the decision was
2 to share with the expert panel that a lawsuit had been
3 filed.

4 Q. And what was discussed at the meeting? Like,
5 can you give a little more of a play-by-play?

6 A. I don't know if I can give a play-by-play
7 without specific notes in front of me. I don't even
8 remember who shared with the panel that the lawsuit had
9 been filed. I don't know if that was Ms. Binder,
10 Ms. Danforth, if it was counsel for Leapfrog. I really
11 don't remember who shared that information with them.
12 And it was more just to let them know since they had
13 been involved in the safety grade.

14 Q. Okay.

15 I'm going to mark another exhibit. This is
16 Exhibit 2, another Armstrong document.

17 (Exhibit No. 2 was marked for
18 identification as of 9/25/2025.)

19 BY MR. CRAIN:

20 Q. So Dr. Austin, do you recognize this document?

21 A. I do.

1 Q. And it's another, if you look at the bottom
2 right, another Armstrong-produced document?

3 A. Correct.

4 Q. And the email at the top, which you'll see as
5 we go through that usually the first email is the last
6 one in the way it's printed out, but you'll see it's
7 from you to Ms. Danforth. Do you see that?

8 A. Yes.

9 Q. And if you go to the next page, there's an
10 email -- actually, it starts on the bottom of page 1
11 from you. Do you see that, that May 1?

12 A. Correct.

13 Q. And then it's an email from you, it looks like,
14 to the Hospital Safety Grade Expert Panelists. Do you
15 see that?

16 A. Correct.

17 Q. And just to get a sense, take a second if you
18 haven't read it. I just want to know was anything
19 discussed on the expert panel that goes beyond what was
20 said in this email?

21 (Witness peruses document.)

1 THE WITNESS: I don't remember it being much
2 discussion beyond what's in the email.

3 BY MR. CRAIN:

4 Q. Does the email accurately depict what was
5 discussed?

6 A. Yes.

7 Q. Okay.

8 And if you go up in the email, there's an
9 email response from Ms. Danforth to you on May 1 at
10 12:35, p.m. Do you see that?

11 A. Yes.

12 Q. And she says, "Thanks, Matt. I've added Leah
13 Binder and Thomas Duff from Wilson Elser for the first
14 agenda item." Do you see that?

15 A. Correct.

16 Q. Does that refresh your recollection as to
17 whether Ms. Binder was there or whether she spoke at the
18 meeting?

19 A. I know that Ms. Binder was there, and I know
20 counsel was there, but I can't remember exactly who
21 actually led the conversation.

1 Q. Okay.

2 Do you typically lead the conversations in
3 those meetings?

4 A. We have a formal agenda, and we have sometimes
5 different individuals leading different agenda items
6 depending on the item. But I would say I'm one of the
7 primary folks for doing that.

8 Q. Okay.

9 And then just going to the top email, this
10 is an email from you to Ms. Danforth later that day. Do
11 you see that?

12 A. Yes.

13 Q. And it looks -- you say -- it's three lines
14 down -- "I quickly pulled the breakdown of Spring 2025
15 grades by survey submission status. Will work on adding
16 in percentages." Do you see that?

17 A. Yes.

18 Q. Percentages. I just -- I assume that refers to
19 the percentages that these numbers reflect?

20 A. Correct.

21 Q. Okay. And why did you pull these stats?

1 A. To have ready for the expert panel an
2 understanding of how hospital grades break down by the
3 imputation status that Leapfrog uses or did use in the
4 Spring 2025 grades.

5 Q. And just so we're on the same page, can you
6 tell me in your words what's Step 1, what's Step 2?

7 A. Yeah. So Step 1 is that if the hospital has
8 completed a recent Leapfrog Hospital Survey, which I
9 believe is currently defined as within the last survey
10 cycle, that that historical information is used for the
11 hospital.

12 Step 2 is if the hospital does not have a
13 recent survey on record, there is an imputation
14 methodology that is laid out in the methodology document
15 that explains how those scores will be imputed.

16 Q. And just to be clear, the methodology document,
17 is it the one that's linked on the website that's about
18 28, 29 pages?

19 A. I would need to --

20 MS. LAWSON: Object to form but go ahead. Go
21 ahead.

1 THE WITNESS: I would need to see it to
2 confirm.

3 BY MR. CRAIN:

4 Q. Okay. Yeah, let me -- what did you mean when
5 you said the methodology document?

6 A. Leapfrog makes available a public document that
7 explains the Hospital Safety Grade methodology.

8 Q. We'll grab additional documents.

9 And then on Step 1, you said survey cycle.
10 How long is that?

11 A. So if the hospital had completed a survey --
12 this is where I'm doing this from memory. So this is
13 where --

14 Q. It's not a memory test.

15 A. -- I want to be -- I believe what we've changed
16 it to is if the hospital had completed a survey in the
17 prior survey cycle, so if you're looking at 2025, if
18 they completed a 2024 survey, we'll use the 2024 survey
19 results.

20 Q. Okay.

21 So each cycle, just so I understand, is

1 once a year?

2 A. The survey itself is a once-a-year cycle.

3 Q. And the grades are issued twice a year?

4 A. Correct.

5 Q. I think we have that document for you just to
6 make sure we're on the same page.

7 MR. CRAIN: So we'll mark this as Exhibit 3.
8 I'm taking good notes today.

9 (Exhibit No. 3 was marked for
10 identification as of 9/25/2025.)

11 BY MR. CRAIN:

12 Q. You'll see there are other exhibit markings --
13 oh, sorry.

14 You'll see there are other deposition
15 stickers on here, but is Exhibit 3 of your deposition
16 the document you're referring to?

17 A. Yes.

18 Q. Okay.

19 Is there another document you're aware of
20 that outlines the methodology besides this?

21 A. There is a second document that explains how

1 numerical scores are converted into letter grades.

2 Q. What's the name of that document?

3 A. I don't know the official name of it. It is
4 publicly available on Leapfrog's Hospital Safety Grade
5 website.

6 Q. Got it.

7 Does that document includes also the
8 imputation methodology?

9 A. It does not.

10 Q. Okay.

11 All right. Keep on going.

12 MR. CRAIN: And then just for completeness, can
13 we do 64. And then I'm going to mark this Exhibit 4.

14 (Exhibit No. 4 was marked for
15 identification as of 9/25/2025.)

16 BY MR. CRAIN:

17 Q. This is another email produced by the Armstrong
18 Institute. Do you see that on the bottom right?

19 A. Uh-huh.

20 Q. And it's -- the top one is from you to
21 Ms. Danforth, cc'ing our friend Ms. Wood across the

1 table. Is that correct?

2 A. Correct.

3 Q. And you say, "Missy, thanks so much for putting
4 me in touch with Courtney and Kim. I just spoke with
5 Jordan about the lawsuit. I've copied Jordan on the
6 email chain so he has Courtney and Kim's contact
7 information."

8 Do you see that email?

9 A. Yeah, I do.

10 Q. Do this reflect what we discussed earlier, the
11 discussions you had with Mr. Derk and with Wilson Elser?

12 A. Correct.

13 Q. Any other discussions beyond those talked about
14 in this email?

15 MS. LAWSON: Object to form.

16 BY MR. CRAIN:

17 Q. Yeah, let me fix it.

18 About the case?

19 A. I had had a -- yeah, I had had a conversation
20 with Jordan earlier that day.

21 Q. Okay.

1 A. We talked about the subpoena coming.

2 Q. Okay.

3 And did you have conversations, either
4 phone or Zoom or in person, with Ms. Wood and Ms. Blair?

5 A. On the 25th of July, I had a call scheduled
6 with The Leapfrog Group to discuss regular work. That
7 was the day that the subpoenas were issued for Jordan
8 and myself. So as I remember, Courtney and Kim joined
9 that call to talk about the subpoenas and that we should
10 contact Johns Hopkins University to let them know we
11 were receiving subpoenas, and also that we shouldn't be
12 chatting with our colleagues at The Leapfrog Group about
13 the lawsuit.

14 Q. Conventional wisdom.

15 A. Yeah. But that we could talk about regular
16 business.

17 Q. Okay.

18 One other question before we shift gears.
19 You came today with a folio.

20 A. Uh-huh.

21 Q. What's in that folio?

1 A. It's actually the subpoenas.

2 Q. Okay.

3 A. And my pad of paper and a pen.

4 Q. Okay. I have to ask.

5 And when you say "the subpoenas," you mean
6 the document and the deposition subpoenas that led to us
7 being here today?

8 A. Correct.

9 Q. Okay. Anything else?

10 A. No.

11 Q. Okay.

12 I want to shift gears and just talk a
13 little more about your history and your education.

14 A. Uh-huh.

15 Q. So you went to the University of Michigan for
16 undergraduate?

17 A. Correct.

18 Q. Go blue!

19 And you graduated in 1995?

20 A. Correct.

21 Q. You later went to the University of Wisconsin,

1 Madison, right?

2 A. Correct.

3 Q. Okay. And you graduated with a Masters of
4 Science in Industrial Systems Engineering?

5 A. Correct.

6 Q. And then you went on to do your Ph.D.?

7 A. Correct.

8 Q. And just in a brief nugget, what is your Ph.D.
9 in?

10 A. My Ph.D. is in Industrial and Systems
11 Engineering with a focus on Healthcare Systems.

12 Q. When did you start getting interested in
13 healthcare?

14 A. 2005.

15 Q. Okay. And that was during -- that was at
16 Wisconsin, Madison?

17 A. Prior to Wisconsin, Madison.

18 Q. Got it.

19 What were you doing then?

20 A. I actually was working for Continental
21 Airlines.

1 Q. Interesting. How did that convert into a
2 healthcare interest?

3 A. I was interested in transitioning out of the
4 airline industry, and healthcare felt like a prime
5 opportunity for that.

6 Q. Okay.

7 And then you earned your Ph.D. I think in
8 2011. Is that right?

9 A. Correct. Yeah.

10 Q. And then between I think 2008 and 2012, you
11 were a director for The Leapfrog Group. Is that right?

12 A. That was my title --

13 Q. Okay.

14 A. -- that Leapfrog gave me, but I was not
15 employed by The Leapfrog Group.

16 Q. Okay.

17 Let's, just to ground us, I'm going to give
18 you everybody's favorite. LinkedIn.

19 MR. CRAIN: This will be Exhibit 5.

20 (Exhibit No. 5 was marked for
21 identification as of 9/25/2025.)

1 BY MR. CRAIN:

2 Q. Dr. Austin, what I've handed you is what --
3 well, tell me what I've handed you.

4 A. This is what appears to be my LinkedIn profile.

5 Q. Does it look generally accurate to you?

6 A. It does.

7 Q. Great.

8 And just going back, because it's not a
9 memory test, so I figured I'd ground you on the dates,
10 it says you were a director of Leapfrog Hospital Survey
11 from January 2008 to May 2012. Do you see that?

12 A. Correct.

13 Q. Is that -- is that generally right?

14 A. That is -- I actually was employed by the
15 Center for Health Systems Research and Analysis. So my
16 employer was --

17 Q. Got it.

18 A. -- actually CHSRA.

19 Q. Okay. The one right below?
20
21

1 (Whereupon, the court reporter seeks
2 clarification, which colloquy will not be
3 captured on the written record.)

4 BY MR. CRAIN:

5 Q. So you said you were employed by CHSRA during
6 that period?

7 A. Correct.

8 Q. Okay.

9 And you said a moment ago you weren't
10 employed by Leapfrog then. Have you ever been employed
11 by Leapfrog?

12 A. No.

13 Q. Okay.

14 Can you tell us the nature of your title as
15 director?

16 A. So in my role as a researcher at the Center for
17 Health Systems Research and Analysis, I was on a
18 contract with a PI who had a contract -- PI, principal
19 investigator -- with The Leapfrog Group, and I was
20 helping support that work.

21 Leapfrog wanted me to have the title

1 director of Leapfrog Hospital Survey, but that was not
2 my official work title. My official work title at
3 University of Wisconsin was researcher.

4 Q. Was the relationship you had between CHSRA and
5 Leapfrog a contractual relationship?

6 A. Yes.

7 Q. Got it. So Leapfrog had a contract with CHSRA?

8 A. Correct.

9 Q. And who was the PI at the time?

10 A. Barb Rudolph.

11 Q. Okay. And who is she?

12 A. She -- Dr. Barb Rudolph, she has a Ph.D. in
13 social work. She was a senior scientist at the Center
14 for Health Systems Research and Analysis.

15 Q. And what was her role at Leapfrog?

16 A. She helped support them with their measurement
17 and public reporting activities.

18 Q. Was she on the Leapfrog board?

19 A. She was not.

20 Q. Okay.

21 And who was the -- I can't recall if it's

1 president or CEO, but who was the leader of Leapfrog at
2 the time?

3 A. So Suzanne Delbanco was the CEO at that time.

4 Q. Okay.

5 And when did Ms. Binder take that role?

6 A. I believe it was early 2008.

7 Q. Okay. So approximately at the start of your
8 time working with Leapfrog. Is that right?

9 A. So I actually started working with The Leapfrog
10 Group in March of 2007 as part of a student research
11 assistantship.

12 Q. Okay. Got it.

13 So Ms. Binder came in towards the first
14 year or two of your time?

15 A. Correct.

16 Q. Okay.

17 What were your responsibilities either as a
18 director or researcher at the time?

19 A. Yeah. So I was responsible for developing
20 survey questions, analyses of data, working with experts
21 on developing measures, measure specifications, scoring

1 algorithms. Really everything related to putting out a
2 survey around quality and safety of hospitals.

3 Q. And at that time, did Leapfrog assign hospital
4 safety grades?

5 A. No.

6 Q. Approximately, when did that start?

7 A. That started in the Spring of 2012.

8 Q. Okay. We'll come to that a little bit more.

9 Just to round out, after you left
10 Wisconsin, where did you go?

11 A. I came here to Baltimore and to Johns Hopkins
12 University.

13 Q. And you've been here for about 12 years. Is
14 that right?

15 A. Correct.

16 Q. And during that whole time, have you worked
17 with The Leapfrog Group continuously?

18 A. Technically, my contract with The Leapfrog
19 Group didn't start until I think July of 2012, and I had
20 arrived here in May.

21 Q. Got it.

1 A. So just to clarify that.

2 Q. So from July 2012 to the present?

3 A. Correct.

4 Q. I want to shift gears and just talk about your
5 relationship and Armstrong's relationship with Leapfrog.

6 A. Uh-huh.

7 Q. So you said before, I think, there's a
8 contractual relationship between Armstrong and Leapfrog.
9 Is that right?

10 A. Correct.

11 Q. Tell me generally about how that works.

12 A. Yeah. So I serve as the principal investigator
13 on the contract for a portion of my time. So as a
14 research faculty member, I need to cover my effort with
15 grants and contracts, and so Leapfrog is part of that
16 coverage for the work I do.

17 Q. And forgive me. I just don't know. Generally,
18 what is a principal investigator?

19 A. The lead, the lead on a grant or contract.

20 Q. Got it. Okay.

21 And you said it covers a certain portion of

1 your time. Approximately, what time percentage is that?

2 A. It has ranged between 40 and 70.

3 Q. Forty and seventy. Okay. Forty and
4 seventy percent of your time?

5 A. Correct.

6 Q. And Leapfrog also covers funding for you,
7 correct?

8 A. That is the funding that I'm speaking of.

9 Q. Got it.

10 And does that come to you in the form of
11 compensation?

12 A. That money is paid to Johns Hopkins University

13 --

14 Q. Okay.

15 A. -- who pays me a salary.

16 Q. Got it.

17 Let's look at a couple of documents.

18 MR. CRAIN: Maybe start with -- let's start
19 with 4. I'm going to mark this Exhibit 6.

20 (Exhibit No. 6 was marked for
21 identification as of 9/25/2025.)

1 BY MR. CRAIN:

2 Q. So Dr. Austin, do you recognize this document?

3 A. I do.

4 Q. And it's another Armstrong-produced document,
5 right?

6 A. Correct.

7 Q. What is it?

8 A. This is the contract between Johns Hopkins
9 University and The Leapfrog Group.

10 Q. And this is a 2018 version. Do you see that?

11 A. Correct.

12 Q. And if you look at Fees and Payment, it's
13 number 4A on the first page. Do you see that?

14 A. Yes.

15 Q. And it says: "Contractor shall be paid a fee
16 not to exceed \$143,898." Do you see that?

17 A. Yes.

18 Q. Does this reflect the funding that you were
19 talking about, the payment to Armstrong?

20 A. The payment goes to Johns Hopkins University.

21 Q. Got it. Not specifically to Armstrong?

1 A. Correct.

2 Q. And then if we can keep going to page -- I'm
3 going to refer to these numbers as Bates numbers. Do
4 you know what I mean when I say that? And I can tell
5 you if not.

6 A. Page number?

7 Q. Bates numbers.

8 A. No, I don't know what that is.

9 Q. So Bates numbers are these Armstrong numbers on
10 the bottom right.

11 A. Oh, okay. Okay.

12 Q. They're just a stamp that folks give when they
13 produced. And for some reason, there are two of them on
14 these pages, but I'm going to look at the top little
15 one, which is the page number.

16 So if you could go to Armstrong ending in
17 Bates 006, which also happens to be page 6 of the
18 contract.

19 A. Uh-huh.

20 Q. And do you see there first at the top it's
21 signed by Erica Mobley and Thomas F. Burns? Do you see

1 that?

2 A. Yes.

3 Q. And Erica Mobley, who is she?

4 A. She was at the time the director of operations
5 for The Leapfrog Group.

6 Q. She's since moved on?

7 A. Correct.

8 Q. Okay.

9 And then there's a budget further down,
10 down there. Do you see that?

11 A. Uh-huh.

12 Q. And it sort of delineates faculty, analysts,
13 and a few other things. Do you see it says faculty
14 \$59,799?

15 A. Correct.

16 Q. And that says: "40 percent of J. Matt Austin's
17 time." Do you see that?

18 A. Uh-huh.

19 Q. And that refers to you, correct?

20 A. Correct.

21 Q. And does that reflect an amount that's

1 earmarked to you ultimately at the end of the day, or
2 how does that work?

3 A. That is an amount that the university will bill
4 Leapfrog Group for my efforts on the project.

5 Q. Okay. So the university bills Leapfrog for
6 your time, correct?

7 A. Correct.

8 Q. Is it hourly or just a flat fee?

9 A. I don't know for sure.

10 Q. Got it. Okay.

11 And does your compensation rise with this
12 -- or rise -- let me strike that. Bad question. That's
13 the first of many bad questions today.

14 If Leapfrog didn't pay this money, would
15 that affect your compensation?

16 A. Can you clarify that?

17 Q. Yeah.

18 I'm trying to understand -- so this, you
19 said, doesn't get paid to you directly, correct?

20 A. Correct.

21 Q. It gets paid to the university, right?

1 A. Correct.

2 Q. And the university gives you a salary, right?

3 A. Correct.

4 Q. What is the relationship between your salary
5 and grants generally? Let's start with that.

6 A. So as a faculty member, I'm on a three-year
7 contract, and that contract is at risk for nonrenewal if
8 I'm not covering a portion of myself in terms of grants
9 and contracts.

10 Q. Got it. Okay.

11 A. So there would be long-term impact to -- if
12 Leapfrog didn't pay the money to the university, but the
13 short-term is that there isn't an impact. I still
14 receive my salary.

15 Q. Got it. Okay.

16 So it affects your future contract with the
17 university, if any, right?

18 A. Correct.

19 Q. Okay.

20 A. As one of many grants and contracts that I've
21 had.

1 Q. Yeah, how many --

2 A. So it's not --

3 Q. Can you ballpark how many do you have in a
4 year?

5 A. Most contracts or grants last multiple years.
6 In my 12 years at Hopkins, I've probably had 10 to 11
7 different grants and contracts.

8 Q. Okay. All toll. And that includes Leapfrog as
9 one of those 10?

10 A. Correct.

11 Q. Okay. And the reason I clarify is there are
12 multiple contracts, right?

13 A. Yeah, right.

14 Q. Yeah.

15 Okay. And then what -- so I understand
16 this number is not directly paid to you. Can you give a
17 ballpark of what percentage that number is of your total
18 compensation?

19 A. The 40 percent.

20 Q. So this \$59,799 is 40 percent of your salary in
21 that year, correct?

1 A. Correct. And then direct costs are added in
2 overhead as well.

3 Q. Yeah. And those are things like -- like what?

4 A. That includes fringe rights, so coverage of
5 health benefits --

6 Q. Got it.

7 A. -- and that stuff and --

8 Q. Got it.

9 A. -- then the university tacks on a percentage.

10 Q. Commission.

11 A. Yeah.

12 MS. LAWSON: Objection.

13 MR. CRAIN: Fair enough.

14 BY MR. CRAIN:

15 Q. Okay. So I just want to go through a couple of
16 these. Over -- do you have a general sense of over
17 time -- so this is a 2018 contract, correct? Has the
18 grant amount changed during -- you know, in the
19 preceding -- in the last six years?

20 A. Can you clarify when you say the grant has
21 changed?

1 Q. Yeah.

2 So I'm trying to get a sense of where the
3 numbers have gone. So there's the total number we saw
4 on the first page that's paid to Johns Hopkins.

5 A. Uh-huh.

6 Q. Has that generally gone up year over year?

7 A. There has been some fluctuation.

8 Q. Okay.

9 A. I'm trying to -- so there have been times where
10 Leapfrog has requested additional researchers at Hopkins
11 be included in the work, and so just by pure numbers,
12 the value, the dollar value of the contract has gone up
13 for that.

14 Q. Okay.

15 A. My salary has changed over time. So it has
16 increased based on just sort of salary changes, and
17 there's been some fluctuation in efforts.

18 Q. So when your salary has changed, the number
19 sort of earmarked to you as a percentage of your salary
20 goes up, correct?

21 MS. LAWSON: Object to form, but you can

1 answer.

2 THE WITNESS: Yeah, I mean, right. Leapfrog is
3 paying for a portion of my effort, of my total effort,
4 right. So if my salary goes up, they're paying more for
5 the portion of the effort that they're paying for.

6 BY MR. CRAIN:

7 Q. And when you say a portion of your effort, just
8 so it's clear, that means like your time on the job?

9 A. Correct.

10 Q. Let's take a look just before we move off this.
11 I want to look at Exhibit A, which is page little number
12 7.

13 A. Uh-huh.

14 Q. And this -- it says scope of work. Do you see
15 that?

16 A. Yes.

17 Q. And are you familiar generally with -- it's a
18 couple -- it's a few pages. Are you familiar with the
19 scope?

20 A. Yes, I am.

21 Q. Does this accurately depict the scope of work,

1 I'll say plus or minus, that you performed in your role
2 for Leapfrog?

3 A. Yes.

4 Q. Okay.

5 And I want to focus on particularly page
6 little Bates 9. Do you see that?

7 A. Uh-huh.

8 Q. And there's -- about halfway down the page, it
9 says: "Manage the hospital safety score expert panel
10 process." Do you see that?

11 A. Uh-huh.

12 Q. And it says -- I think it's bullet A -- "Have
13 periodic communications with client-approved national
14 expert panel either via teleconferences and/or written
15 communication, to solicit guidance on: One, which
16 performance measures should be considered for inclusion
17 in future versions of the safety score composite; and,
18 two, suggested adjustments for weighting individual
19 measures within the composite. The polling of panel
20 members of these topics will involve the use of
21 structured communication techniques; e.g., the Delphi

1 method."

2 Do you see that paragraph?

3 A. Uh-huh.

4 Q. Does this reflect your work with the Hospital
5 Safety Grade expert panel?

6 A. It does generally reflect that work.

7 Q. What -- are there any meaningful differences
8 between this language and what you actually do?

9 A. We've moved away recently from doing formal
10 polling of panel members.

11 Q. Okay. Does that -- is that what the Delphi
12 method refers to?

13 A. Yeah, that would be a --

14 Q. What is the Delphi method?

15 A. The Delphi method is a -- an approach to gain
16 and understand consensus where you basically go through
17 different rounds of voting where based on the first
18 round, you sort of narrow down to a smaller subset and
19 work towards where there's consensus.

20 Q. And is that -- I see it in here, but is that
21 how it actually worked at the expert -- at the safety

1 grade expert panel?

2 A. In earlier meetings of the safety grade expert
3 panel, 2011, 2012, 2013, we did put a little more of a
4 focus on having a formal process for that.

5 Q. Okay.

6 And I think you said that you -- I don't
7 have the realtime, so I don't remember exactly what you
8 said, but you said in recent years, you've sort of
9 gotten rid of the polling feature. Is that what you
10 testified to?

11 A. Correct.

12 Q. And approximately, when did that dissipate?

13 A. Probably 2014, 2015.

14 Q. Okay. So a little while ago?

15 A. Yeah.

16 Q. Yeah, okay.

17 And then B says -- if you go back to the
18 document, it says: "Work with the national expert panel
19 to gain consensus on the direction of future versions of
20 the safety score composite and/or understand and
21 document the differences among panel members on their

1 future visions."

2 Do you see that as well?

3 A. Yes.

4 Q. Accurate depiction of what you've done for
5 Leapfrog over the years?

6 A. Yes.

7 Q. Okay.

8 And then C: "Understand the direction set
9 by client's Board of Directors on the hospital safety
10 score and keep the national expert panel conceptually
11 aligned with the board's direction."

12 Do you see that?

13 A. Yes.

14 Q. Is that -- so the first question is, is that an
15 accurate statement of what you've done for Leapfrog, you
16 know, since, let's say, 2018 to the present?

17 A. Yes. My one caveat is I think the Board of
18 Directors has been less hands-on with the safety grade
19 as they were early on.

20 Q. Okay. And when you say "early on," what time
21 period are we talking about?

1 A. 2011 through 2014.

2 Q. Okay.

3 So is it fair to say in the early days when
4 the safety grade was being created, the Board was more
5 active?

6 A. Yes, that would be a fair statement.

7 Q. And over the years, the Board has been less
8 involved with respect to changes to the safety grade
9 methodology?

10 A. I have become less involved in communicating
11 with Leapfrog's board. So I can't speak to what
12 Ms. Binder or Ms. Danforth have been communicating to
13 the Board but --

14 Q. Got it. Okay.

15 So let me ask it this way then. This
16 document says one of your services -- if you look at the
17 top, it says: "Contractor will provide client with the
18 following services: Understand the direction set by the
19 client's Board of Directors on the hospital safety
20 score."

21 Do you feel since those early days that

1 you've had a sense of the direction set by the Board of
2 Directors?

3 A. I have not received any feedback that the
4 direction we're going is conflicting with what the Board
5 would want to do.

6 Q. Okay.

7 And have you received feedback that it's
8 consistent with what the Board would want to do?

9 A. As mentioned, I don't have as much
10 communication with the Board members. So Leapfrog staff
11 is sort of the filter for that. So I have not heard any
12 feedback that it's one way or another.

13 Q. Okay. So your understanding comes from
14 Leapfrog staff?

15 A. Correct.

16 Q. And it's your understanding of what the
17 organization wants, as opposed to the Board?

18 MS. LAWSON: Object to form.

19 BY MR. CRAIN:

20 Q. Well, what is your understanding? I'm trying
21 to get a sense of do you have an understanding of what

1 the Board wants, or do you have an understanding of what
2 Leapfrog staff want?

3 A. My direction that I've been given has been from
4 Leapfrog staff.

5 Q. Okay.

6 A. I don't know if that represents their own
7 thoughts or it represents their own thoughts and the
8 Board. I can't speak to that piece.

9 Q. And when you say "staff," who are we talking
10 about?

11 A. Leah Binder, the CEO, and Missy Danforth, the
12 senior vice president of healthcare ratings.

13 Q. Are those folks your primary contacts for
14 Leapfrog?

15 A. Yes.

16 Q. Are there others as well that you interact
17 with?

18 A. A couple of Missy Danforth's direct reports, so
19 Katie Burgraff Stewart and Jean-Luc Tilly. I have quite
20 a bit of contact with them as well.

21 Q. And Ms. Campione?

1 A. Yes, and Alex as well.

2 Q. And what's Ms. Campione's role?

3 A. She -- I don't know her exact title, but she's
4 the one that supports the Hospital Safety Grade program
5 from Leapfrog's side in terms of the analytics and all
6 that goes with that.

7 Q. And does she work with you closely in that
8 regard?

9 A. Yeah.

10 Q. And Mr. Tilly, what's his role?

11 A. Jean-Luc Tilly has a couple of areas of the
12 Leapfrog Hospital Survey that he champions and leads, as
13 well the ambulatory surgery center survey.

14 Q. Okay.

15 And then Ms. Stewart, what's her role?

16 A. Once again, she has certain areas of the
17 Leapfrog Hospital Survey that she champions.

18 Q. Okay.

19 Who do you interact with most at Leapfrog?

20 A. Missy Danforth.

21 Q. Who is the second?

1 A. Probably Katie --

2 Q. Okay.

3 A. -- Stewart.

4 Q. Stewart, yeah.

5 Okay. Let's just keep going. Okay. You
6 can set that -- or wait, actually. Sorry. There's one
7 other thing I want to take a look at.

8 If you go to page 7, just one page back --

9 A. Uh-huh.

10 Q. -- and there's a list of services called manage
11 the research base. Do you see that?

12 A. Yes.

13 Q. Can you just say generally what that entails?

14 A. Yeah. So this item is related to the Leapfrog
15 annual hospital survey, and it's just sort of being
16 aware of where -- what performance measures have been
17 recently endorsed, which are sort of out there in
18 national programs, doing literature reviews on topics.
19 So basically, ensuring that the measures that Leapfrog
20 is using in its Leapfrog Hospital Survey are valid,
21 reliable, evidence-based measures.

1 Q. Got it.

2 So stepping back a little bit, Leapfrog has
3 its hospital survey and its safety grades, right?

4 A. Correct.

5 Q. Are those the primary, like, sides of the
6 house, so to speak?

7 A. Those are their two primary reporting
8 initiatives, but there is the Leapfrog Ambulatory
9 Surgery Center Survey as well.

10 Q. Are you involved in any capacity in all three?

11 A. I am in all three.

12 Q. You are what? Sorry.

13 A. I am involved in all three.

14 Q. Okay. I thought you said I am an author. I
15 was going to say an author of what? But I guess I'll
16 ask that question. Do you author any of the hospital
17 survey? Do you draft any of it?

18 A. I do draft some of the survey questions,
19 measure specifications, end notes, FAQs.

20 Q. A lot of work.

21 A. It is a lot of work, yeah.

1 Q. Do you review each iteration of the hospital
2 survey?

3 A. I do.

4 Q. Top to bottom?

5 A. Not top to bottom.

6 Q. Okay. I would think that would take some time.

7 A. Yeah.

8 Q. Yeah.

9 The survey is about 350 pages. Am I right?

10 A. Correct.

11 Q. Okay.

12 And then with respect to the safety grade,
13 can you just explain your role?

14 A. Yeah. So the role has been to provide Leapfrog
15 with guidance and recommendations on the methodology,
16 and that includes what measures should be included in
17 the safety grade, how we might assign relative weights
18 to each of those measures.

19 Are you asking about currently or sort of
20 historically through the last 11 years?

21 Q. Fair question. I guess I'll start with has it

1 changed meaningfully in the past 11 years?

2 A. I would assess that my role has actually
3 diminished as Alex, Leapfrog, has gained more sort of
4 independence in what they're doing.

5 Q. Got it.

6 So let me ask you about that. The contract
7 in here says that you're being retained to provide
8 strategic -- let me just find the right word. What does
9 it say? Strategic counseling I think. Is that the --
10 do you recall that language?

11 A. I don't recall that language. The language I
12 typically use is to say strategic guidance.

13 Q. Guidance. That's it. Yeah, it's on page 7
14 under background, second paragraph, last sentence. You
15 see it says --

16 A. Uh-huh.

17 Q. -- you were retained to provide client, meaning
18 Leapfrog, with strategic guidance. Do you see that?

19 A. Uh-huh.

20 Q. So to your point of Leapfrog gaining more
21 independence, has the need for strategic guidance

1 diminished over the years?

2 A. Not for strategic guidance, no.

3 Q. So what is diminished as compared to strategic
4 guidance?

5 A. So as an example, in the early years of the
6 Hospital Safety Grade, I actually would be the one to
7 put together a histogram of the hospital safety scores
8 from the prior round, the current round, and we would
9 discuss that as a group in terms of what changes we were
10 seeing. That is now something that Alex would do.

11 So there's sort of an analytic piece that
12 has moved more internal to Leapfrog --

13 Q. Got it. Okay.

14 A. -- but not the strategic guidance part.

15 Q. And just what does strategic guidance mean?

16 A. Yeah. Strategic guidance is thinking about
17 what measures do we currently have in the composite
18 score, what are the changes that are happening like
19 within national programs, CMS, like measures that might
20 be retired, what are new measures that are out there,
21 what are gaps that we would like to try to fill, and are

1 there measures out there that we could use for that.

2 So it's trying to sort of think about
3 what's the right combination of measures to have in a
4 composite score of patient safety and then to also help
5 them think about how we might relatively weight those
6 against each other.

7 Q. So fair to say it's like more holistic as
8 opposed to something more granular that Ms. Campione
9 might do?

10 A. Correct.

11 Q. Okay.

12 I'm not going to put every contract in
13 front of you. You see me flipping.

14 Let me ask a question about just grants
15 before we move on.

16 A. Uh-huh.

17 Q. So you said, for instance -- so we see in the
18 contracts the percentage has changed over time as well,
19 that the grant towards your salary goes to. Do you
20 recall that?

21 A. Correct.

1 Q. Okay.

2 So we saw in 2018 the number allocated to
3 you was 40 percent, right? Of the remaining 60 percent,
4 does that come from other grants?

5 A. Correct.

6 Q. Okay. And how many grants fill that 60,
7 ballpark?

8 A. Two or three depending on the size of them.

9 Q. Okay. And are any of them as significant in
10 proportion as Leapfrog?

11 Let me -- let me -- that's a sort of
12 unwieldy question. Let me fix that. I saw you
13 thinking. So I'll build it a little more clearly.

14 So in 2018, the amount allocated to your
15 salary was 40 percent. Is that right?

16 A. Correct.

17 Q. Okay.

18 You said of the remaining 60 percent, there
19 were two or three other grants that filled that,
20 essentially, right?

21 A. Correct.

1 Q. Are any of those two to three grants also
2 40 percent?

3 MS. LAWSON: And are you asking just specific
4 to 2018?

5 BY MR. CRAIN:

6 Q. Specific to 2018, yeah, if you recall.

7 A. I don't recall, but I could find that out.

8 Q. Okay.

9 A. I just don't remember offhand.

10 Q. Generally, you know, to the extent you know, do
11 you -- have you had other grants that were the same
12 significance in size as Leapfrog over the years?

13 A. This would be the most significant --

14 Q. Okay.

15 A. -- ongoing contract.

16 Q. Okay. Got it.

17 And the other two or three grants, as a
18 percentage of your compensation, can you ballpark
19 generally what they are?

20 MS. LAWSON: Object -- objection to form. And
21 maybe if you can clarify over time --

1 MR. CRAIN: Yeah.

2 MS. LAWSON: -- because I think he testified
3 earlier that he's had like nine or ten other grants.

4 MR. CRAIN: Yeah, I hear you.

5 MS. LAWSON: Yeah.

6 BY MR. CRAIN:

7 Q. So in a given year, let's say between 2018 and
8 2025, the other grants that are not Leapfrog, if you
9 can, approximately what percentage of your compensation
10 do they -- are they?

11 A. It varies from year to year. I'm more trying
12 to just think about what's on my CV and what those
13 efforts are. They might total up to another 50 percent.

14 Q. Total. Okay. Got it. Okay, so --

15 A. So a typical breakdown might be one that's 20,
16 one that's 20, and one that's 10.

17 Q. Okay. Got it. Okay. And I didn't mean it to
18 be a memory test.

19 A. No, no, no, no, no. I'm trying to answer
20 truthfully, but I don't really remember.

21 Q. Just your best estimate.

1 A. My best estimate, yeah.

2 Q. Okay.

3 MS. LAWSON: And if you're not sure, it's okay
4 to tell him that you're not sure because he wants to
5 know --

6 MR. CRAIN: Yeah.

7 MS. LAWSON: -- what you know.

8 THE WITNESS: Okay.

9 MR. CRAIN: I'm not asking you to guess.

10 THE WITNESS: Okay. Okay.

11 MS. LAWSON: Yes, he's not asking you to guess.

12 THE WITNESS: Okay.

13 MR. CRAIN: But your best estimate --

14 THE WITNESS: Okay.

15 MR. CRAIN: -- approximation as the expert of
16 you.

17 THE WITNESS: Right. Okay.

18 BY MR. CRAIN:

19 Q. So let's shift gears a little bit. Are you
20 doing okay on time?

21 A. Yeah.

1 Q. Okay, good. I mean break.

2 A. Yeah.

3 Q. Okay.

4 So I want to talk a little bit more about
5 the safety grade and what it does and what's it's
6 purpose. So --

7 MS. LAWSON: Actually, if we're going to
8 totally switch gears --

9 MR. CRAIN: Yeah. You want to --

10 MS. LAWSON: -- do you mind if we take a --

11 MR. CRAIN: Yeah, yeah. No, now is fine.

12 MS. LAWSON: A break? Yeah.

13 MR. CRAIN: Yeah. Good.

14 THE VIDEOGRAPHER: This marks the end of media
15 unit number two. We're going off the record. The time
16 is 10:05 a.m.

17 THE COURT REPORTER: This gives us a chance to
18 get the realtime going, too.

19 MR. CRAIN: Oh, yeah.

20

21

1 (Whereupon a short break was had, after
2 which the proceedings continued as
3 follows:)

4 (Exhibit No. 7 was marked for
5 identification as of 9/25/2025.)

6 THE VIDEOGRAPHER: This marks the beginning of
7 media unit number three. We're going back on the
8 record. The time is 10:22 a.m.

9 BY MR. CRAIN:

10 Q. Welcome back, Dr. Austin.

11 A. Thank you.

12 Q. It's like a commercial break on TV.

13 So I've given you what's been marked as
14 Exhibit 7. Do you recognize this document?

15 A. I do not.

16 Q. Okay. So I'll represent to you this is from
17 the Leapfrog Safety Grade website,
18 hospitalsafetygrades.org. Is that familiar to your?

19 A. I'm familiar with that website.

20 Q. Do you know -- like, are you -- do you look at
21 the website periodically or no?

1 A. Once in a great while.

2 Q. Okay.

3 So I'm just going to -- I sort of want to
4 walk through what the safety grade is and focus on some
5 of the language in this document if we can. And I -- so
6 starting with paragraph -- the first paragraph, you see
7 there's a sentence "the purpose" -- do you see that --

8 A. Uh-huh.

9 Q. -- at the bottom?

10 A. Uh-huh.

11 Q. "The purpose of the Leapfrog Hospital Safety
12 Grade is to bring this information to light in a way
13 that's easy for you, the consumer, to use."

14 I realize it says "this information," so I
15 probably need to go back. So I'll start at the top.

16 "One of the most significant problems with
17 today's healthcare system is the failure to make safety
18 and quality information available to the public. But
19 the public deserves this information so they can make
20 informed choices about where to receive care.

21 "The purpose of the Leapfrog Hospital

1 Safety Grade is to bring this information to light in a
2 way that's easy for you, the consumer, to use."

3 Do you see that?

4 A. Yep, I do.

5 Q. Do you agree with that paragraph?

6 MS. LAWSON: So I'll just object to form.

7 And just I want to clarify. I think
8 Dr. Austin, you testified you had not seen this before.

9 THE WITNESS: Correct.

10 I would generally agree. I would maybe
11 reframe the first sentence slightly differently.

12 BY MR. CRAIN:

13 Q. How so?

14 A. I might say that one of the significant
15 problems of today's healthcare system is how to best
16 share safety and quality information with the public.

17 Q. Okay.

18 A. I think information is available. I think
19 we've struggled to help people connect to that.

20 Q. So the difference being the failure language?

21 A. Yeah. I wouldn't say failure to make.

1 Q. Okay.

2 And then do you agree that the purpose of
3 the Leapfrog Hospital Safety Grade is to bring this
4 information to light in a way that it's easy for you,
5 the consumer, to use?

6 A. Yes.

7 Q. Okay.

8 And then is it right that -- if you go down
9 to the second page -- "Our letter grade scoring system
10 allows consumers to quickly assess the safety of their
11 local hospital and choose the safest hospital to seek
12 care." Do you see that?

13 A. Yes.

14 Q. Do you agree with that statement?

15 A. Yes.

16 Q. And then it says: "As consumers use the
17 Leapfrog Hospital Safety Grade more and more, we hope
18 more hospitals will be compelled to be open about their
19 safety and quality and participate in meaningful public
20 reporting."

21 Do you see that as well?

1 A. I do.

2 Q. And do you agree with that sentiment?

3 A. I don't know what the evidence or research
4 supporting the first clause is. I wouldn't necessarily
5 be able to speak to that part, about whether consumers
6 are using the safety grade more and more, but I would
7 agree with the last part.

8 Q. The last part being we hope more hospitals will
9 be compelled to be open about their safety and quality
10 and participate in meaningful public reporting?

11 A. Yes.

12 Q. Okay.

13 And just to be clear, do you have any role
14 in the creation, drafting, revision of Leapfrog's
15 websites?

16 A. If I'm asked to review something, I will review
17 it --

18 Q. Okay.

19 A. -- and provide back comments and feedback. But
20 they don't ask me to review every single thing on their
21 website.

1 Q. Okay. How often do they ask you to review the
2 website?

3 MS. LAWSON: Object to form.

4 BY MR. CRAIN:

5 Q. Generally, just over, you know, the last six
6 years.

7 A. Not very often. I mean, I don't know
8 everything that's on their website. You know, so I
9 don't know what the full scope is, so I can't speak
10 to --

11 Q. No, I hear you. Just so we're on the same
12 page, I'm talking about hospitalsafetygrades.org.

13 A. Right.

14 Q. Are you familiar generally with that website?

15 A. Right. Yeah, yeah, yeah, yeah. Right.

16 Q. And Leapfrog -- I forget the other one but the
17 Leapfrog.org website.

18 A. Uh-huh, right.

19 Q. And one of them refers typically to the survey,
20 right?

21 A. Uh-huh.

1 Q. And the other one is about the safety grades,
2 correct?

3 A. Correct.

4 Q. And do you have any specific recollection
5 sitting here today of any particular page on either of
6 those two websites you were asked to opine on?

7 A. I don't remember exactly. I'm sure through
8 12 years there has been something that I have reviewed,
9 but I couldn't speak to what that is and if it's still
10 up or if it's been taken down.

11 Q. Just asking for your memory today.

12 A. Yeah, yeah. I don't. I don't know.

13 Q. And just to fine-tune it a little bit, do you
14 have any specific recollection of opining on any part of
15 the website regarding the imputation methodology?

16 A. Can you be more specific with what exactly
17 you're referencing there?

18 Q. Yeah. So are you aware of any part of
19 Leapfrog's website that articulates its imputation
20 methodology on the safety grades for nonparticipating
21 hospitals in the survey?

1 A. I know there's some information in a prior
2 exhibit that we discussed that talks about the
3 imputation. I don't know if there's something on a
4 webpage itself. I just don't know what is actually --
5 what all the pages are and what's on them.

6 Q. Okay. Just to my question, do you have any
7 specific memory --

8 A. No, I don't have any specific memory.

9 Q. Let me just finish the question so it's clear.

10 Do you have any specific memory of being
11 asked the opine or otherwise opining on any portion of
12 Leapfrog's website regarding the imputation methodology?

13 A. I don't remember being asked to do that.

14 Q. Okay.

15 MR. CRAIN: Let's go to 67. I'll mark another
16 document. This will be Exhibit 8.

17 (Exhibit No. 8 was marked for
18 identification as of 9/25/2025.)

19 BY MR. CRAIN:

20 Q. Dr. Austin, do you recognize this document?

21 A. I recognize that this is a printout of a

1 webpage from Leapfrog's Hospital Safety Grade website.

2 Q. Do you have any reason to think that it's not
3 an accurate depiction of the website?

4 A. No, I have no reason to think so.

5 Q. Are you familiar generally with the "About the
6 Grade" website?

7 A. I'm familiar with that webpage, yes.

8 Q. I want to ask you a couple of questions about
9 the language on this page, just to your understanding.
10 Did you -- do you recall having any role in drafting
11 this page?

12 A. It is possible but I don't remember exactly
13 today.

14 Q. So page 1 -- and I apologize. There's no page
15 numbers on it but the first page and the second
16 paragraph, it says: "The Leapfrog Hospital Safety Grade
17 uses up to 30 national performance measures from the
18 Centers for Medicare & Medicaid Services, CMS, the
19 Leapfrog Hospital Survey, and information from other
20 sources of supplemental data."

21 Do you see that?

1 A. Yes.

2 Q. Is that a correct articulation of what the
3 Leapfrog Hospital Safety Grade uses?

4 A. That represents a summary of what has been the
5 formation of the Hospital Safety Grade in sort of its
6 entirety.

7 Q. Okay, fair enough. So let me ask you it this
8 way. Is that correct for the methodology as it exists
9 today?

10 A. Yes, minus that currently the safety grade I do
11 not believe is using information from other supplemental
12 data sources.

13 Q. Okay. What is the safety grade currently using
14 as a data source?

15 A. We're using data from the Centers for Medicare
16 & Medicaid Services and from the Leapfrog Hospital
17 Survey.

18 Q. Okay. So today there's no other supplemental
19 data sources being used with the grade, correct?

20 A. That is my recollection from the current
21 methodology.

1 Q. And when did that change? Approximately.

2 MS. LAWSON: So it really is a memory test.

3 THE WITNESS: It is a memory test.

4 BY MR. CRAIN:

5 Q. If he has a memory.

6 A. I don't know the year.

7 Q. Okay. Let me refresh your recollection a
8 little bit.

9 A. Okay.

10 Q. So in 2024, am I right that the imputation
11 methodology changed?

12 A. That is my recollection, yes.

13 Q. And then prior to that, there was a different
14 imputation methodology, right?

15 A. Correct. We've actually used four or five
16 different imputation methodologies over the 11, 12 years
17 of the Hospital Safety Grade.

18 Q. Okay.

19 Can you, at a high level, I'm not asking
20 for a memory test, just generally trace what you recall
21 of those four or five different models?

1 A. Yeah, yeah, yeah.

2 So when we met with the expert panel early
3 on to talk about the idea of the Hospital Safety Grade,
4 one of the identified issues was that we were likely to
5 encounter missing data, and how did we want to address
6 the issue of missing data.

7 The expert panel laid out five different
8 ideas of sort of generally-accepted approaches of how
9 that has been addressed.

10 The -- if I can remember the five --

11 Q. I can show you a document.

12 A. Okay.

13 And so we started initially with if we
14 didn't have data for a hospital for our measure, we
15 ignored that measure and put greater weight on the
16 measures for which we did have data. That evolved into
17 using supplementary data sources, specifically the
18 American Hospital Association survey was one of the key
19 data sources for that.

20 That evolved into calculating or assigning
21 the mean performance for hospitals based on cohorts, so

1 sort of the national mean based on the cohort that the
2 hospital fell into, and that has since evolved into
3 assigning the hospitals a lower performance score.

4 Q. That's the current methodology?

5 A. That's the current methodology.

6 Q. And when you say "lower performance score,"
7 that's limited achievement?

8 A. That is correct, how Leapfrog has
9 operationalized that.

10 Q. And in the current model, am I right that there
11 are two steps, right? The first step is the historical,
12 as you said earlier?

13 A. Correct.

14 Q. The second step is the limited achievement that
15 you were referring to, correct?

16 A. Correct.

17 Q. Okay.

18 So going back to the document, when we talk
19 about supplemental data sources, generally, am I right
20 that the AHA data was a supplemental data source?

21 A. Correct.

1 Q. And AHA is American Hospital Association?

2 A. Correct.

3 Q. I always mess that up. That's my aha moment.
4 I've been playing with that one.

5 MS. LAWSON: You delivered it well.

6 MR. CRAIN: Thank you. I'm going to use that
7 one at trial.

8 BY MR. CRAIN:

9 Q. So other forms of supplemental data, is there
10 any -- because CMS is not supplemental data, right?
11 Because it's covered on this page otherwise, correct?

12 A. Correct.

13 Q. Are there any other supplemental data that you
14 can recall Leapfrog using in the Hospital Safety Grade
15 scoring at any time?

16 A. Yes. So the American Hospital Association did
17 a separate survey around health information technology,
18 and we did use that to inform the scores for
19 computerized prescriber order entry. And that's one
20 that comes to my mind. There's none others that
21 immediately come to my mind, but that's not to say there

1 weren't others.

2 Q. Okay.

3 A. I just don't recall.

4 Q. Yeah, okay. So that's helpful.

5 I want to keep going down this document.

6 If you go to the bottom of that paragraph: "The
7 Leapfrog Hospital Safety Grade methodology has been peer
8 reviewed and published in the Journal of Patient
9 Safety."

10 Do you see that?

11 A. Yes.

12 Q. Now, does the Journal of Patient Safety --
13 there's a hyperlink there. Do you see that?

14 A. Uh-huh.

15 Q. And I don't have the document with me, but I'll
16 represent to you it goes to what I think is a 2014
17 article.

18 A. Correct.

19 Q. Does that article, the peer review that this
20 sentence is talking about to your knowledge?

21 A. Yes.

1 Q. And what does peer review mean, generally?

2 A. Peer reviewed, in at least the medical world,
3 which is really the only world I know, so that's all I
4 can speak to, when you submit to a journal, they
5 actually identify two to three external individuals to
6 actually read the manuscript, provide feedback, provide
7 recommendations of how to improve it. Those go back to
8 the editor of the journal, and the editor makes the
9 decision of what to share back with the authors in terms
10 of requested updates or revisions.

11 The peer reviewers could decide -- could
12 recommend that the article be rejected, right. They
13 don't feel like it's a high enough quality. And so it's
14 a process to sort of have some external review of the
15 work.

16 Q. And the 2014 article was peer reviewed?

17 A. Correct.

18 Q. Do you recall generally by whom?

19 A. I don't -- as an author, you're unaware of who
20 the peer reviewers are.

21 Q. Oh, interesting.

1 A. There's a movement recently toward moving --
2 making that transparent, but that has not necessarily
3 been the practice.

4 Q. Got it. Okay.

5 Do you remember any feedback they gave on
6 the article?

7 A. You're really testing my memory here.

8 Q. If you don't, that's okay.

9 A. Yeah, I don't. That was 10 years ago, 11 years
10 ago. I don't remember. I'm sure there was feedback
11 from -- almost every article has some degree of
12 feedback, but I don't remember what the feedback was or
13 to the degree.

14 Q. And I don't at all mean to stretch your memory.
15 If you don't remember --

16 A. Right. I don't.

17 Q. -- that's a perfectly fine answer, yeah, but I
18 have to ask.

19 So now going back, this article, it
20 analyzes an older methodology, right?

21 A. Correct. It was the methodology that was in

1 place at the time for the Hospital Safety Grade.

2 Q. In 2014, correct?

3 A. 2014, although -- it got published in 2014. We
4 wrote it in 2013, so this is probably an earlier
5 version.

6 Q. So do you think it's fair to say that the
7 current methodology has been peer reviewed?

8 A. I think it's fair to say that the general
9 approach remains consistent from 2013, 2014. The
10 individual measures that are included in the safety
11 grade has evolved over time.

12 Q. And just to be clear, though, to my question,
13 is it a fair statement to say the Leapfrog Hospital
14 Safety Grade methodology has been peer reviewed and
15 published in the Journal of Patient Safety in 2025?

16 A. I could argue that it does not say the current
17 Leapfrog Hospital Safety Grade methodology. It just
18 says that the methodology has been peer reviewed.

19 Q. If this is on the public consumer-facing
20 website today, do you think the consumer would
21 understand, looking at this, that this is referring to a

1 2014 methodology, not a 2025 methodology?

2 MS. LAWSON: Object to form. Go ahead.

3 BY MR. CRAIN:

4 Q. You can answer.

5 MS. LAWSON: You can answer.

6 THE WITNESS: I don't know what a consumer
7 would think or not think. Like, I haven't studied that.

8 BY MR. CRAIN:

9 Q. When you first -- this was the first time you
10 recall reading this sentence in a while, at least,
11 right?

12 A. The sentence meaning the one about the patient
13 safety?

14 Q. No, the one I read back to you. The Leapfrog
15 Hospital Safety Grade methodology has been peer reviewed
16 and published in the Journal of Patient Safety.

17 A. Uh-huh.

18 Q. You knew what that referred to, right?

19 A. Yes, I did.

20 Q. Did you think to yourself that's the same for
21 2025 as it was for 2014?

1 MS. LAWSON: Object to form, but you can
2 answer.

3 THE WITNESS: As I mentioned, I think the
4 general format of what we're doing with a composite
5 score made up of 25 measures that are weighted in two
6 domains remains consistent and solid throughout that
7 time frame.

8 Measures, for whatever -- I mean, measures
9 are going to come and go, right. CMS makes decisions
10 about retiring certain measures. They've added new
11 measures. So the safety grade does continue to evolve,
12 and I would say appropriately, right, like to sort of
13 keep up with the latest information and evidence.

14 BY MR. CRAIN:

15 Q. Has the imputation methodology or the
16 imputation model been peer reviewed?

17 A. That has not.

18 Q. Okay.

19 Okay. Let's keep going. I want to go to
20 -- let's see. Here we go. It's -- and I apologize.
21 There's no page number. If you go to the document, it's

1 the first, second, third, fourth, fifth page to the
2 paragraph starting "A hospital."

3 A. Uh-huh.

4 Q. Do you see that?

5 A. Yep.

6 Q. "A hospital must have enough safety data
7 available for our experts to issue them a letter grade.
8 Hospitals missing more than six process measures, more
9 than five outcome measures, or PSI90 are not graded.
10 All hospitals are encouraged to voluntarily report
11 additional safety data through the Leapfrog Hospital
12 Survey, but they are not required to do so to receive a
13 safety grade."

14 Do you see that language?

15 A. I do.

16 Q. So let's start with process measures. Do you
17 see it says hospitals missing more than six process
18 measures...are not graded?

19 A. Uh-huh.

20 Q. Is that an accurate statement?

21 A. As far as I know. I'm not the one implementing

1 the methodology, so I don't -- I can't speak to --

2 Q. Fair enough.

3 A. -- how it got implemented.

4 Q. Yeah, let me fix the question.

5 Based on your knowledge of how the
6 methodology works, not whether it's been implemented
7 faithfully or not, but purely based on your
8 understanding of the methodology, is that an accurate
9 explanation or articulation of the methodology?

10 A. Yes.

11 Q. Okay.

12 A. That is what we have set as minimum data
13 thresholds.

14 Q. So I want to talk about some process measures.
15 BCMA, are you familiar with that term?

16 A. Uh-huh.

17 Q. What is BCMA?

18 A. Barcode medication administration.

19 Q. And what is CPOE?

20 A. Computerized physician order entry.

21 Q. And you're familiar with hand hygiene?

1 A. Correct.

2 Q. As a measure, not generally.

3 And are you familiar with IC -- IPS?

4 A. Yes, ICU physician staffing.

5 Q. And those I'm going to generally talk about now
6 as we move forward as the four imputed measures.

7 A. Uh-huh.

8 Q. Do you understand what I'm talking about?

9 A. Uh-huh. Yes, I do.

10 Q. When a hospital does not report to Leapfrog's
11 survey, does Leapfrog have any data about the hospital's
12 performance on any of those four measures?

13 A. In the imputation method for Step 1, if a
14 hospital submitted a survey in the prior year, there may
15 be data on one or more of those four measures.

16 Q. Fair enough. What about for Step 2?

17 A. For Step 2, there wouldn't be recent data,
18 right. So there wouldn't be either a survey that was
19 submitted the prior year or a survey submitted this
20 year.

21 Q. Yeah. So if a hospital has never reported to

1 Leapfrog's survey, is it fair to say that Leapfrog has
2 no data on the actual performance of that hospital on
3 those four imputed measures?

4 A. We do not have any data that's been reported
5 through the survey, correct.

6 Q. So why is that not missing data?

7 A. Some I guess it could be one's definition of
8 missing. Those missing data thresholds were really
9 intended to not assign grades to small hospitals that
10 may not have enough data from CMS. So, as an example,
11 there are smaller hospitals that may not have had enough
12 central lines inserted during the reporting period to
13 actually have a central line associated blood stream
14 infection rate.

15 And so the intent of those missing data
16 thresholds was really to make sure we weren't assigning
17 grades to hospitals for which we had unreliable
18 information. It was not necessarily intended to allow
19 hospitals not to report.

20 Q. So is missing data really supposed to be absent
21 data? Like, you mentioned folks that don't have enough

1 central lines.

2 A. Missing data would refer to a measure for which
3 we don't have a value.

4 Q. And so just to put it concretely, when you say
5 "we don't have a value," who do you mean?

6 A. Meaning The Leapfrog Group doesn't have a
7 value.

8 Q. So how is that different -- so one of my
9 clients is Delray Medical Center in Florida, right. And
10 we always use Delray as the example. I don't know why,
11 but Delray is the example. We can pick any of them.

12 Leapfrog gave Delray a limited achievement
13 for hand hygiene. Are you generally aware of that?

14 A. I have not reviewed Delray's results but I --

15 Q. But you understand, as the plaintiff in this
16 case, it's a nonparticipating hospital, right?

17 A. Yes, that's my understanding.

18 Q. And it's -- one of the core elements of the
19 case is the Step 2 methodology, right, for imputation?

20 A. Correct.

21 Q. So based on that, you understand that Leapfrog

1 gave Delray a limited achievement for hand hygiene,
2 right?

3 A. That would be my understanding of how that
4 would get applied.

5 Q. And but -- so there's -- to your point a minute
6 ago, which I've now lost but I will find, you said
7 missing data would refer to a measure for which we don't
8 have a value. Isn't it right that Leapfrog has no value
9 for hand hygiene for Delray?

10 A. That would be correct.

11 Q. Okay.

12 So this paragraph is not correct, right,
13 the one we looked at on the document?

14 A. I think the distinction I would make is whether
15 an imputed score is considered missing or if it's
16 considered a value.

17 Q. You're going to have to say more about that
18 one. What do you mean by that?

19 A. Right. So Leapfrog imputed a score for Delray
20 for hand hygiene of 15 points out of 100.

21 Q. Yes.

1 A. So to me it sort of comes down to is that -- we
2 have a score for Delray for that measure. So it's not
3 missing.

4 Q. And how did Leapfrog pick that score?

5 A. Leapfrog -- so the reason Leapfrog chose
6 limited achievement is that has always been the bottom
7 performance category and it -- basically, given the lack
8 of information that we have about the hospital's
9 performance in hand hygiene, it felt like that was the
10 appropriate score to give, given the absence of
11 information that would tell us something otherwise, that
12 they were performing on a higher level.

13 Q. So is the assumption that Delray is performing
14 at the lowest level for hand wipe -- hand hygiene?

15 A. Given the lack of other information from them,
16 that is our assumption.

17 Q. One of the things that hand hygiene evaluates
18 is whether a hospital has a handwashing policy, right?

19 Let me strike that.

20 One of the things that the survey asks
21 about handwashing is about handwashing training. Are

1 you aware --

2 A. Correct. Yes.

3 Q. Do you have any knowledge of any hospital that
4 does not train doctors and nurses on hand hygiene?

5 MS. LAWSON: Object to form. You can answer.

6 BY MR. CRAIN:

7 Q. Your knowledge.

8 A. There are -- to be clear, what's asked in this
9 survey isn't just about training. It's the way that the
10 training is done, who is trained, and that was not
11 necessarily universally done across all hospitals. So
12 it extends just beyond training employees.

13 Q. Okay. Fair enough.

14 So coming back to this document again, so
15 the four imputed measures, do you agree that they are
16 process measures?

17 A. They are considered either process or
18 structural measures.

19 Q. But in terms of -- I understand that Leapfrog
20 puts its measures into two buckets, process or
21 structural or outcome. Is that right?

1 A. Correct.

2 Q. They all fit the process or structural, right?

3 A. Correct.

4 Q. There are also three others, three other
5 process measures that when a nonreporting hospital is
6 graded are left out of the scoring methodology, right?

7 A. Can you clarify that?

8 Q. Yeah.

9 Are you familiar with safe practice one?

10 A. Yes.

11 Q. And can you remind me what it is? If you
12 don't, I can pull it out.

13 A. Yeah, it's like leadership.

14 Q. Yeah. And are you familiar with safe practice
15 two?

16 A. Yes, which is culture measurement.

17 Q. And are you familiar with total nursing care
18 per patient hour?

19 A. Yes.

20 Q. Those are the three measures that -- for
21 nonparticipating hospitals that do not go into the

1 grade, correct?

2 A. Those are not imputed, correct.

3 Q. Those are not imputed. They're just discarded,
4 right?

5 A. They are ignored, and their relative weights
6 are assigned proportionately to the others.

7 Q. Redistributed, right?

8 A. Redistributed.

9 Q. Yeah. I don't mean to put words in your mouth,
10 but I think it's the word I've seen.

11 So then those are process and structural
12 measures, too, right?

13 A. Correct.

14 Q. So that's seven, right?

15 A. Correct.

16 Q. Okay.

17 And just to be clear, this document doesn't
18 say -- this is the Leapfrog website. I'm looking at it
19 again. Hospitals missing more than six process measures
20 are not graded. That's what it says. It doesn't say
21 hospitals -- strike that.

1 We just walked through Leapfrog does not
2 have data for seven process measures, right?

3 MS. LAWSON: Object to form. You can answer.

4 THE WITNESS: Okay.

5 BY MR. CRAIN:

6 Q. If you're confused, I can rephrase. Let me
7 build it up.

8 So we talked about the four imputed
9 measures, right?

10 A. Correct.

11 Q. We talked about the three what I'll call
12 discarded measures, correct? Do you understand what I'm
13 saying when I say that?

14 A. Yeah, I know the three you're referring to.

15 Q. And they're all process or structural measures,
16 right?

17 A. Correct.

18 Q. And there are seven of them?

19 A. Correct.

20 Q. And yet this document tells consumers that
21 hospitals missing more than six process measures are not

1 graded. Do you see that?

2 A. That is what the document says.

3 Q. And can you tell me again why that's accurate?

4 A. For me, it comes back to the question of is it
5 an imputed score, a score, or is it missing. And I
6 would argue it's a score. So for those four imputed
7 measures, those hospitals have scores. They aren't
8 missing data.

9 Q. Aren't missing data even though Leapfrog has no
10 data for those scores?

11 A. Even though Leapfrog does not have any
12 information that was reported by the hospital through
13 the Leapfrog Hospital Survey.

14 Q. Okay.

15 Okay. All right. Let's keep going. I
16 want to also talk about -- let's see if it's on this
17 page.

18 MR. CRAIN: Can we go to tab 65. This will be
19 Exhibit 9.

20 (Exhibit No. 9 was marked for
21 identification as of 9/25/2025.)

1 BY MR. CRAIN:

2 Q. So Dr. Austin, I've been giving you a document.
3 This one has, fortunately, a URL at the bottom. Do you
4 see that?

5 A. Uh-huh.

6 Q. And has page numbers, fortunately, too.
7 Do you recognize this document?

8 A. I do not.

9 Q. Okay. Do you have a general sense just from
10 looking at it what it purports to be at least?

11 A. Yeah, I do.

12 Q. Okay.

13 So I'll represent to you -- and you can see
14 on the URL at the bottom we pulled this off of
15 hospitalsafetygrades.org, which we talked about earlier
16 that's one of Leapfrog's websites, right?

17 A. Uh-huh.

18 Q. And this is a frequently asked questions page.
19 Do you see that?

20 A. Yes.

21 Q. Okay.

1 And I want to talk through a few things on
2 this document. First I want to start with there is a
3 "why." "Why should people" -- yeah. "Why should people
4 worry about a hospital's patient safety. Aren't all
5 hospitals the same?"

6 Do you see that on page 2?

7 A. Yes.

8 Q. And if you go down to about midway down the
9 paragraph, it says "and all." Do you see that?

10 A. Uh-huh.

11 Q. And it says: "And all hospitals are not the
12 same. Some hospitals are much safer than others. Johns
13 Hopkins Medicine researchers estimate that patients are
14 twice as likely to die of a preventable problem at a
15 "C," "D," or "F" hospital than an "A" hospital, and over
16 50,000 lives would be saved if all hospitals performed
17 the way "A" hospitals did."

18 Do you see that?

19 A. Yes.

20 Q. And I know you didn't write this, but do you
21 have any reason to think you are not the Johns Hopkins

1 researcher?

2 A. No, that is me.

3 Q. And do you have any reason to think that's not
4 referring to your white paper?

5 A. I have no reason to believe that it does not
6 refer to the white paper.

7 Q. And tell me, just so we're on the same page,
8 what is the white paper to which this is referring?

9 A. The white paper that -- so we, in 2016, did a
10 white paper that was referred to as "lives lost, lives
11 saved." And in 2019, we did an update to that. So I
12 don't know -- I believe this is referring to the 2019
13 updated white paper.

14 Q. And the 2019 updated white paper did not
15 analyze "A," "B," "C," "D," and "F" hospitals under the
16 current methodology, right?

17 A. No. They were -- that was done through -- I
18 would have to go back and look at the document but
19 probably based on like the Fall 2018 safety grades. I
20 don't -- yeah. I think we put it out in 2019, but I
21 think it may have been Fall of 2018 that we actually

1 used.

2 Q. And have you published any estimates of that
3 patients are twice as likely to die of a preventable
4 problem at a "C," "D," or "F" hospital than an "A"
5 hospital based on the 2025 methodology?

6 A. No, we have not.

7 Q. Do you have any understanding as to whether
8 that is correct today, or you just don't know?

9 A. We have done some early analysis around this
10 based on 2025, and these statements would remain true.

11 Q. Okay. Based on that early analysis?

12 A. Correct.

13 Q. Okay. And when did you conduct that analysis?

14 A. We started that back in March, April, somewhere
15 in that time frame.

16 Q. Okay. And so even though this is referencing
17 the 2019 white paper and the prior methodology, you're
18 saying based on the current imputed methodology the
19 twice as likely to die language is still correct?

20 A. Yes, I would stand by that.

21 Q. You would stand by it or you do?

1 A. I do.

2 Q. Okay.

3 And how did that analysis transpire?

4 A. Transpire? Can you clarify?

5 Q. How did it come to -- how did you -- why did
6 you conduct that analysis?

7 A. Yeah. So The Leapfrog Group asked that we look
8 at doing an update from the 2019 in 2025. So it was an
9 effort to follow through on that request and to provide
10 an updated analysis of where we're at.

11 Q. And have those analyses been released publicly
12 yet?

13 A. No.

14 Q. Okay, and why is that?

15 A. We -- you would have to ask The Leapfrog Group
16 on their decision and timing on that.

17 Q. Okay.

18 And you've not -- have you drafted a new
19 white paper?

20 A. I have started working on drafting a new white
21 paper. I have not finished that.

1 Q. Okay. Do you have any sense of when you're
2 going to publish that?

3 A. I don't have a sense of it.

4 Q. How far into the drafting are you?

5 A. I don't know how to estimate that. I mean,
6 it's actually updating the 2019 white paper. So I've
7 gone through at this point and made notes on which
8 values need to be updated, where we need to update
9 tables, but all that work would still need to be done.

10 Q. And is your analysis, would you say, an apples
11 to apples analysis between what you're doing today and
12 what was done in 2019?

13 A. It mirrors the spirit of what we did in 2019 in
14 that the measures themselves have changed between 2019
15 and now, but the approach of how we've estimated lives
16 lost and lives saved has remained consistent.

17 Q. And can you explain generally what that
18 approach is?

19 A. Yes. So what we've done is we have -- to
20 estimate the lives lost for looking at "A" hospital as
21 an aggregate, "B" hospital as an aggregate, "C" an

1 aggregate, and "D" and "F" hospitals an aggregate, we
2 look at the mean incidence rates of each of the patient
3 safety events that are included in the Hospital Safety
4 Grade. And from the literature, we've identified an
5 attributable mortality rate to each of those events.

6 So as an example, for central line
7 associated blood stream infections, one in every seven
8 patients who acquires one in the hospital passes away
9 from that. So if you are in a hospital that has a
10 higher rate of those, your risk of dying from one of
11 those increases.

12 And so we apply that against the admissions
13 that are in each of those buckets, so "A" hospitals,
14 "Bs", "Cs", "Ds", and "Fs" to estimate the number of
15 lives lost due to the preventable medical mistakes that
16 are included in the Hospital Safety Grade.

17 And we estimate. Let me put that word out
18 there very clearly. It's an estimate of the number of
19 lives that are lost.

20 Q. And why do you emphasize estimate?

21 A. Because we're -- for example, one assumption

1 that we have to make is the attributable mortality rate,
2 right. We're using that same rate in all four buckets,
3 "As," "Bs," "Cs," "Ds," and "Fs." The reality is we
4 might actually see that "A" hospitals have a lower
5 mortality rate when a patient develops a CLABSI than,
6 say, like a "D" and "F." But we're assuming that that
7 mortality rate is similar across all hospitals.

8 Q. Got it. Okay. Okay, we'll come back to that a
9 little bit more.

10 Okay. So then I want to go back to this
11 FAQ just before we go into other topics.

12 A. Sure.

13 Q. I want to talk about -- let's see. I lost the
14 question. Oh, here it is, page 3. It says: "Does a
15 hospital get a better safety grade if it reports to the
16 Leapfrog Hospital Survey?" Do you see that?

17 A. Uh-huh.

18 Q. And it says: "The Hospital Safety Grade
19 reflects how well a hospital does on safety, not whether
20 they complete the Leapfrog Hospital Survey." Do you see
21 that?

1 A. Uh-huh.

2 Q. And just one question on this line. Do you
3 believe, as, you know, familiar as you were with the
4 methodology, is that accurate with respect to
5 nonparticipating hospitals?

6 A. There are nonparticipating hospitals that have
7 received "As," "Bs," "Cs," "Ds," and "Fs."

8 Q. And do you think that is -- the Hospital Safety
9 Grade reflects how well a hospital does on safety, not
10 whether they complete the hospital survey. Do you agree
11 with that statement?

12 A. I do agree with that statement. I think
13 transparency is an important component of safety.

14 Q. Okay. Why do you say that?

15 A. Yeah. So hospitals that are choosing to share
16 their data through the Leapfrog Hospital Survey are
17 making that information transparent, and I think that
18 does tie to a safety culture of one where we want to
19 make information publicly available, hold ourselves
20 accountable. So I do think there is a link between
21 transparency and safety.

1 Q. Have you conducted any analysis to assess
2 whether hospitals that do not participate in the
3 Leapfrog survey are actually less safe than hospitals
4 that do?

5 A. Not that I can think of.

6 Q. Okay.

7 MR. CRAIN: I'm going to shift gears.
8 Everybody good on time? I'm going to switch topics.
9 You good?

10 BY MR. CRAIN:

11 Q. So I want to talk about the development of the
12 imputation models. So I'm going to focus you on the
13 2024 period. Is that fair enough?

14 A. Yep.

15 Q. Okay.

16 So in April 2024, the expert panel met to
17 discuss, among other things, imputation model. Do you
18 recall that meeting?

19 A. That sounds correct. I know we had a meeting
20 with them, and I think that was the timing of when we
21 talked about that topic.

1 Q. Yeah. And I'll get you a document.

2 MR. CRAIN: Can we get 32A, just to ground the
3 discussion. This will be Exhibit 10.

4 (Exhibit No. 10 was marked for
5 identification as of 9/25/2025.)

6 BY MR. CRAIN:

7 Q. Dr. Austin, do you recognize this document?

8 A. Yes.

9 Q. Okay. And this is an email thread leading up
10 to before and after I think the April 12th, 2024, expert
11 panel meeting. Do you see that?

12 A. Yes.

13 Q. Okay. And I want to just start at the -- where
14 is the attachment?

15 MR. CRAIN: Do we have the slide deck? 32 I
16 need also. Sorry. We have them separately.

17 So let's look at the deck, which was
18 attached to this email, but I think it's separate.
19 This will be Exhibit 11.

20 (Exhibit No. 11 was marked for
21 identification as of 9/25/2025.)

1 BY MR. CRAIN:

2 Q. Okay. So now this is the deck. Do you see
3 that, Dr. Austin?

4 A. I do, yeah.

5 Q. Okay. And it's attached to a Zoom invite -- or
6 to a meeting invite you sent on -- at some point but for
7 a meeting at April 12th at 4 to 5 p.m. Do you see that?

8 A. Yes.

9 Q. Okay.

10 And this was for the safety grade expert
11 panel's meeting for I think that year, right?

12 A. I believe that was the only meeting we held
13 with them in 2024.

14 Q. Okay.

15 And so going to the deck, I'm just going to
16 walk through it with you. And if you go to slide two,
17 which is Bates ending 437364 -- do you see that?

18 A. Uh-huh.

19 Q. And you lay out three topics, right?

20 A. Uh-huh.

21 Q. The first topic is update on swearing DHA

1 military treatment facilities.

2 (Whereupon, the court reporter seeks
3 clarification, which colloquy will not be
4 captured on the written record.)

5 BY MR. CRAIN:

6 Q. The second is feedback on reevaluating
7 imputation model, and the third is feedback on two
8 possible new outcome measures.

9 Do you see that?

10 A. Yes, I do.

11 Q. Okay.

12 And I want to focus on the middle one. So
13 if we can skip to what is page 7366 [sic].

14 A. Uh-huh.

15 Q. Now, do you see this slide is entitled "Problem
16 that We are Working to Solve?"

17 A. Uh-huh.

18 Q. And I want to just go back to the prior
19 exhibit. Well, I'll ask before we go there. Do you
20 recall who drafted this slide? If you don't, I can
21 refresh you.

1 A. I believe I actually am the one who probably
2 drafted this.

3 Q. Yeah. So if you look at the prior exhibit --

4 A. Uh-huh.

5 Q. -- this is Exhibit 10.

6 A. Uh-huh.

7 Q. On page 74782, do you see that?

8 A. 782, yes.

9 Q. And there's an email at the bottom from you to
10 Ms. Campione, Ms. Danforth, and Ms. Joshi. Do you see
11 that?

12 A. Yes.

13 Q. And it goes to the next page. And you say,
14 "Attached is an updated version of the slides. Alex,
15 these are looking good. I added in a slide at the start
16 of the imputation section that outlines the problems we
17 are trying to solve." Do you see that?

18 A. Yep.

19 Q. Does that refresh your recollection as to
20 whether you drafted --

21 A. Yep --

1 Q. -- this slide?

2 A. -- it does.

3 Q. Okay.

4 Just remember to let me finish before --

5 A. I'm sorry.

6 Q. -- and vice versa, just for Marlene.

7 So going back to the slide, why did you
8 draft this slide?

9 A. I thought it was helpful to remind the expert
10 panel of what are some of the challenges we are facing
11 with the current Hospital Safety Grade methodology and
12 why we might want to consider moving in a different
13 direction for imputation.

14 Q. Okay. And the challenges you're talking about
15 are the two bottom bullets, right?

16 A. Correct.

17 Q. Okay. And so the first one is imputed scores
18 have crept up, making imputation a more favorable choice
19 for lots of hospitals and has de incentivized true
20 transparency of performance, right?

21 A. Correct.

1 Q. Now, when you say imputation scores have crept
2 up, what's that based on?

3 A. So the imputation methodology at the time was
4 that it involved -- there was still the historic element
5 of Step 1.

6 Q. And I'll help you. I don't mean to interrupt,
7 but there's a slide that lays it out if it's helpful to
8 you.

9 A. Okay.

10 Q. It's 7369.

11 A. Uh-huh.

12 Q. Do you see that?

13 A. Yep, I do.

14 Q. Okay. Just in case it's helpful. But go on.

15 A. So the Step 1 was assigning the most recent
16 scores from the four past rounds of the safety grade,
17 and then Step 2 was actually looking at two different
18 mean performances. And what we had seen was a trend
19 with those scores were creeping up, which incentivized
20 hospitals to not report to the survey and, instead, to
21 take the imputed score.

1 Q. And how did you know it was driving that
2 incentive, that was the reason they were not reporting?

3 A. That feedback was clear from hospitals. They
4 had verbally shared that with Leapfrog.

5 Q. With you?

6 A. Not with me, with Leapfrog.

7 Q. Did you talk to any hospital that shared that
8 with you personally?

9 A. No.

10 Q. Okay.

11 And who did they share it with at Leapfrog?

12 A. From what I remember, Missy Danforth.

13 Q. Any sense of how many hospitals?

14 A. I don't have a sense of that.

15 Q. And do you have any other basis of knowledge to
16 support that statement besides what you said about
17 Ms. Danforth?

18 A. We have -- we numerically had been tracking the
19 mean score. So we did have empirical evidence of that
20 going up.

21 Q. Empirical evidence of scores going up?

1 A. Correct.

2 Q. But not necessarily empirical evidence of
3 nonparticipating hospitals making the decision not to
4 participate because the scores were going up?

5 A. I don't remember any evidence in that way.

6 Q. Okay.

7 Then the second -- just going back to slide
8 I think it's five, which is 7367 on the Bates number,
9 you see -- so the first bullet we just talked about is
10 primarily a problem with Step 2 in this old methodology.
11 Is that right?

12 A. Correct.

13 Q. And the second bullet is about Step 1, right?

14 A. Correct.

15 Q. And it says: "Hospitals are using Step 1
16 imputation, using their individual hospital's historical
17 data as a reason to not report on the current year
18 survey." Right?

19 A. Correct.

20 Q. Okay. So tell me a little bit about that
21 issue.

1 A. Yeah. Leapfrog had seen patterns where
2 hospitals were choosing to report one year, not report
3 the next year, report the next year as a way to sort of
4 keep their scores sort of used in the Hospital Safety
5 Grade without having to report to the survey every year.

6 Q. And what was your understanding of why those
7 hospitals weren't reporting every year?

8 A. I can't speak to why the hospitals were
9 choosing not to report.

10 Q. You have no understanding?

11 A. I have theories but I don't -- I haven't had
12 conversations with hospitals specifically about their
13 decision not to report.

14 Q. So same thing with respect to Step 1 -- 2 that
15 we just talked about, right? You said you --

16 MS. LAWSON: Object to form.

17 BY MR. CRAIN:

18 Q. Yeah, let me fix it.

19 So you said I have theories but I haven't
20 had conversations with hospitals specifically about
21 their decision not to report. That goes for either

1 decision not to report about Step 1 or Step 2, right?

2 A. That is for me personally I never had
3 conversations with hospitals about that.

4 Q. And did you ever have conversations with
5 Ms. Danforth about the hospitals that are deciding not
6 to report in the Step 1 context?

7 A. Yes.

8 Q. Okay. Tell me about those conversations.

9 A. So that was a similar point of feedback, that
10 she had had conversations with hospitals who had
11 indicated -- Leapfrog also has regional leaders, which
12 you may be familiar with. I think the regional leaders
13 were also hearing from hospitals that, oh, yeah, we're
14 not going to report this year because our scores still
15 get used in the Hospital Safety Grade.

16 So there had been sort of a current of
17 we're choosing to bypass transparency.

18 Q. And was that in relation to the burden of
19 completing the survey?

20 A. That's what I can't speak to.

21 Q. So you have no knowledge about the why?

1 A. I don't have any firsthand knowledge of the
2 why.

3 Q. Do you have any secondhand knowledge about the
4 why?

5 A. My secondhand knowledge would be burden would
6 be a consideration.

7 Q. Okay. And when you say "burden would be a
8 consideration," what do you mean by that?

9 A. So what I hear from hospitals generally, not
10 specific to this, is that at times, they feel like they
11 need to prioritize other quality improvement efforts and
12 may make a decision on where those priorities exist from
13 year to year.

14 Q. And when you say what you hear from hospitals,
15 that's not firsthand, right?

16 A. That has been firsthand, yes.

17 Q. So you do talk to hospitals?

18 A. I do talk to hospitals, not specifically about
19 whether they are reporting every year or every other
20 year.

21 Q. Okay.

1 A. I have had conversations with hospitals --
2 well, I guess I have had conversations with hospitals
3 about their decision to pause reporting.

4 Q. Okay. How many conversations, approximately?

5 A. Five to ten through ten years.

6 Q. Okay.

7 And have you had conversations with
8 hospitals about this imputation methodology at all at
9 any time?

10 MS. LAWSON: Well, I just want to object to
11 form.

12 Just to clarify, the imputation -- this
13 imputation methodology, are you asking about the current
14 2024?

15 MR. CRAIN: Yes.

16 MS. LAWSON: Yes. So just to clarify that.

17 THE WITNESS: I do not believe I've had any
18 conversations with hospitals about that.

19 BY MR. CRAIN:

20 Q. Okay.

21 So your knowledge today about hospitals'

1 decision-making with respect to reporting onto the
2 survey primarily comes from Ms. Danforth?

3 A. That would be a fair statement.

4 Q. Okay.

5 Okay. So going back to the deck, there's a
6 number of tables, and I want to go to slide -- it's the
7 slide with your proposal. Oh, here we go. Slide 13,
8 which is 7375.

9 A. Uh-huh.

10 Q. And this is the proposed future imputation
11 methodology. Do you see that?

12 A. Yes.

13 Q. Okay. This is not the methodology that
14 Leapfrog ultimately adopted, right?

15 A. Correct.

16 Q. Okay. Was this the methodology discussed at
17 the meeting?

18 A. Yes. This is what we put forward to the expert
19 panel.

20 Q. Okay. And you received feedback about this
21 proposal?

1 A. Correct.

2 Q. Right.

3 Okay. And just generally, can you explain
4 what the proposal was?

5 A. The proposal was that we would basically move
6 to a single form of imputation which would be the --
7 that we would use Step 2b imputation for all hospitals.

8 Q. And you would -- to your point, a single form
9 of imputation, that's the retire Step 1 bullet?

10 A. Correct. We would retire Step 1, and we would
11 move all hospitals to Step 2b.

12 Q. Okay. And which is 2b?

13 A. 2b, as it's described here, is that hospitals
14 would be assigned to cohorts and then the means of
15 scores from the first year of reporting would be used to
16 calculate the means.

17 Q. Okay.

18 A. And then the hospital would be assigned that
19 mean.

20 Q. Got it. Okay.

21 And then I just want to go -- so that was

1 the proposal you put out, correct?

2 A. Correct.

3 Q. And it was not the one that was adopted?

4 A. Correct.

5 Q. And we'll get to the why, but before we do
6 that, if you could go one slide back, slide 12.

7 A. Uh-huh.

8 Q. You see it says: "A slight dip in survey
9 participation occurred this past year as hospitals opted
10 to use past survey results in Step 1 imputation." Do
11 you see that?

12 A. Correct.

13 Q. So what is that based on? How did you know
14 that the slight dip was caused by hospitals using past
15 survey results in Step 1 imputation?

16 A. That is probably more just a -- based on
17 conversations that Ms. Danforth had had with hospitals.
18 I don't know if that's -- if we have anything
19 empirically to back up that statement.

20 Q. Okay. So you don't know whether that's
21 accurate or not?

1 A. I don't know whether that is -- yeah, correct.

2 Q. Okay.

3 So I want to talk a little bit about the
4 meeting itself. Do you recall whether other expert
5 panelists proposed alternative imputation methodologies?

6 A. I really don't remember the details of that
7 call.

8 Q. Okay.

9 Do you remember who was on it?

10 A. We have meeting notes of -- from that meeting,
11 but I don't recall who exactly was on that call.

12 Q. Okay.

13 So I want to go to tab 33. This is a
14 document I don't think you've seen before, so I'll just
15 preface that so you know.

16 A. Okay.

17 MR. CRAIN: And this will be Exhibit 12.

18 (Exhibit No. 12 was marked for

19 identification as of 9/25/2025.)

20 BY MR. CRAIN:

21 Q. It's huge. I'll walk you through it. So are

1 we good?

2 A. We're good.

3 Q. Okay.

4 So if you look back at exhibit -- the
5 exhibit with the email, which I think is Exhibit 10.

6 A. Uh-huh.

7 Q. Okay?

8 Do you see at the top there'd an email from
9 Ms. Campione to you?

10 A. Uh-huh.

11 Q. And it says, "Here is the link to the recording
12 if you need it for notes. Please let me know if you
13 have any issues with it."

14 A. Uh-huh.

15 Q. And it gives a URL and password, right?

16 A. Uh-huh.

17 Q. So the expert panel meeting was recorded?

18 A. Correct.

19 Q. Was that typically how it was done?

20 A. Yes.

21 Q. Okay.

1 And do you recall watching the video of the
2 recording at any point?

3 A. I did not.

4 Q. Okay. Do you recall reviewing a Zoom
5 transcript at any point?

6 A. I do not.

7 Q. Okay.

8 So I will represent to you this, what you
9 have in front of you, is a certified transcript of that
10 recording --

11 A. Okay.

12 Q. -- just for discussion purposes. And so I want
13 to just walk through a couple of things with you. So --
14 and I know you haven't seen this before, so I'll walk
15 you through it.

16 So if you go to the back of the document,
17 there's an index. Do you see that?

18 A. Uh-huh -- yes.

19 Q. Sorry. Yes?

20 A. Yes.

21 Q. Okay.

1 So the index, I want to just focus on a few
2 things. If you go to page 9 and you go to "L," do you
3 see the word "limited" appear on the index?

4 A. I do not.

5 Q. And I want to go to the word A -- excuse me, to
6 the portion of the index for "A." Do you see the word
7 "achievement"?

8 A. I see achieving but not achievement.

9 Q. Okay. And where is achieving? There it is.
10 Do you want to -- let's flip to 36.3. So page 36, line
11 3. Tell me when you're there.

12 A. I am there.

13 Q. And it says: "But achieving consensus is
14 difficult." Do you see that?

15 A. Yes.

16 Q. So that doesn't refer to limited achievement,
17 right?

18 A. It does not use that phrase.

19 Q. So based on this index, and to the best of your
20 recollection, did anybody at any time during the meeting
21 raise the idea that you could impute limited achievement

1 scores to nonparticipating hospitals?

2 A. I don't remember what was exactly said. I
3 would not be surprised if the Hospital Safety Grade
4 expert panelists weren't familiar with the term "limited
5 achievement."

6 Q. Sorry. Say that again. I think that was a
7 double negative.

8 A. I would not be surprised if the Hospital Safety
9 Grade expert panelists were not familiar with the term
10 limited achievement.

11 Q. Got it. Okay.

12 Is there another term they might use?

13 A. They might have used lowest performance score.

14 Q. Okay. What about zero?

15 A. It's possible that zero could have been
16 mentioned.

17 Q. Okay.

18 So I want to go to zero, too, in the index,
19 just to close that loop.

20 MS. WOOD: And Lee, I do just want to object to
21 form. I've never seen this document before either. Has

1 this been produced in discovery?

2 MR. CRAIN: It is being produced today.

3 MS. WOOD: Okay. And when was it -- was it
4 prepared on September 11th?

5 MR. CRAIN: I do not know the date, but we can
6 talk off the record. So your objection is noted.

7 BY MR. CRAIN:

8 Q. So do you see zero, Dr. Austin, in the index?

9 A. Uh-huh.

10 Q. Okay.

11 If you go to 40, it said -- in the index,
12 it said line 7, 7 to 11. Do you see that?

13 A. Yes.

14 Q. And I just want you to look at this page from,
15 say, line 6 to 11. Does this reflect anybody proposing
16 to impose a zero score for nonparticipating hospitals?

17 A. No, it doesn't.

18 Q. Okay.

19 Okay. So is it accurate to say that no one
20 suggested, based on the index, based on your memory,
21 that imposing a zero score for nonparticipating

1 hospitals?

2 MS. LAWSON: Object to form.

3 THE WITNESS: I honestly don't remember the
4 conversation.

5 BY MR. CRAIN:

6 Q. Okay.

7 A. I will clarify that what has been assigned is
8 not zero to hospitals.

9 Q. I understand.

10 So do you remember any other proposal made
11 during the expert panel meeting besides the one that you
12 proposed in the slides that we looked at?

13 A. I don't remember.

14 Q. Okay.

15 So I'll take you to one other that is in
16 here. Do you recall -- who is Dr. Pronovost, Peter
17 Pronovost?

18 A. He is one of the Hospital Safety Grade expert
19 panelists.

20 Q. Okay. And you worked with him previously at
21 Armstrong, right?

1 A. Correct.

2 Q. Okay.

3 Now, he proposes -- if you go to pages --
4 if you go to page 25 --

5 A. Uh-huh.

6 Q. -- oh, wait. Sorry. Page 26.

7 A. Uh-huh.

8 Q. And you see at line 18 it says Peter Pronovost
9 and colon?

10 A. Uh-huh.

11 Q. And he says, "Peter Pronovost: Missy, though,
12 to Arjun's point, I wonder in our model do we include
13 that if they're in the lowest quartile, that they stay
14 in that? You know what I mean? At least to reduce the
15 gaming."

16 Do you recall him saying that?

17 A. That's what it says here.

18 Q. Yeah. Do you have any independent --

19 A. I don't remember.

20 Q. Okay.

21 Do you know generally what that means, the

1 lowest quartile?

2 A. I would need to go back further up in the
3 document --

4 Q. If you want to take a look and --

5 A. -- to understand what the context was --

6 Q. Yeah, why don't you go back to page --

7 A. -- because I don't know what the discussion was
8 at that point.

9 Q. Go back to page 24 and start with
10 Dr. Srinivasan.

11 Who is Dr. Srinivasan?

12 A. He's at the Centers for Disease Control and
13 Prevention.

14 Q. Okay. And take a second.

15 (Witness peruses document.)

16 THE WITNESS: So I've read it. And can you
17 repeat your question?

18 BY MR. CRAIN:

19 Q. Yeah. I wanted to know if you have an
20 understanding of what Dr. Pronovost was referring to
21 when he's talking about the bottom quartile. And I

1 think Dr. Srinivasan talks about the bottom quartile,
2 too. And I will also preface, if you don't remember, I
3 can show you an email subsequently about the bottom
4 quartile, but I wanted to know if you have an
5 independent recollection.

6 A. I don't have a recollection of that.

7 Q. Okay. That's fine. It's not a memory test.
8 Again, we'll get to another document. I'm just going
9 through this.

10 I want to look at one other quick thing in
11 the index. If you go to "W," do you see the word
12 "willing"?

13 A. I do.

14 Q. Let's see. Where is it?

15 A. Oh, no. I don't see it.

16 Q. Yeah, I didn't see it.

17 Just to confirm, do you see the word
18 "willing" in the index?

19 A. I do not.

20 Q. Okay.

21 Do you know what the phrase "willing to

1 report" means?

2 A. That is the term that Leapfrog used prior to
3 limited achievement.

4 Q. Okay. So that was the lowest performing score,
5 right?

6 A. That was the phrase that was used for that in
7 the past.

8 Q. Okay. Do you recall when it was retired?

9 A. I could estimate 2018, 2019, somewhere around
10 there.

11 Q. And just -- I'm representing to you that the
12 index is from a certified court reporter. Based on this
13 index, the phrase "willing to report" or even just the
14 word "willing" was not discussed at this meeting,
15 correct?

16 A. I do not see the word "willing" in the index.

17 Q. Okay.

18 And you have no independent recollection of
19 a discussion of the phrase "willing to report" at the
20 meeting, right?

21 A. I do not.

1 Q. Okay.

2 Okay. I'm going to set this aside, and
3 we'll come back to it, so don't lose it.

4 (Whereupon, a discussion was held between
5 counsel regarding lunch schedule, which
6 portion was not included in the written
7 record.)

8 BY MR. CRAIN:

9 Q. Okay. So let's keep going.

10 So you mentioned there were minutes after
11 the meeting, right?

12 A. Correct.

13 Q. I want to start with tab 33A, which will be
14 Exhibit 13.

15 (Exhibit No. 13 was marked for
16 identification as of 9/25/2025.)

17 BY MR. CRAIN:

18 Q. So Dr. Austin, do you recognize this document?

19 A. I recognize the meeting notes that are behind
20 it.

21 Q. Behind it. Okay.

1 A. And I recognize the email.

2 Q. Yeah. Okay. So you have no reason to think
3 this wasn't sent and received?

4 A. Correct. Yes.

5 Q. Okay.

6 And you'll note in the bottom it's an
7 Armstrong-produced document, right?

8 A. Correct.

9 Q. So it's an email originally from the 16th from
10 Preeti Joshi. And remind us, who is she again?

11 A. Preeti is an analyst that works for me.

12 Q. Okay. And she works on the Leapfrog account?

13 A. Correct.

14 Q. Okay.

15 And she says first in that email, "Matt,
16 please review the attached Leapfrog Hospital Safety
17 Grade HSG" -- is that Hospital Safety Grade?

18 A. Uh-huh. Correct.

19 Q. -- "expert panel meeting notes, and let me know
20 your suggestions."

21 Then she follows up, right?

1 A. Correct.

2 Q. And she says -- it looks like it's a few hours
3 later that same day, April 16th -- "Matt, please
4 disregard the attachment of previous email and consider
5 the attached document for review. I accidentally attached
6 a different file with previous email."

7 Do you see that?

8 A. Yes.

9 Q. Okay.

10 And then going on to the notes, this is,
11 fair to say, her draft of the notes, right?

12 A. Correct.

13 Q. Okay.

14 And then just stepping back, does every
15 expert panel, safety grade expert panel have meeting
16 notes like these?

17 A. Yes. Could there be one or two for which we
18 just somehow didn't do them? Possibly. But the intent
19 is, yes, to have meeting notes like this.

20 Q. And is this the normal process where the person
21 who is reporting to you starts the first draft and you

1 revise?

2 A. Correct.

3 Q. Okay. And do you generally try to be accurate
4 with the meeting minutes?

5 A. Yes.

6 Q. Okay. What do you look for when you revise?

7 A. I look for accuracy. I try to highlight
8 broader themes. So as an example, often when the
9 analyst first starts working with me, the notes will be
10 incredibly, like, detailed. Sara said this. Bob said
11 this, right. So I try to sort of move it up a level,
12 right, and I try to be clear with sort of action items
13 of what we need to do next and to be clear with decision
14 points.

15 Q. Okay. And you still try to be faithful to the
16 discussion, right?

17 A. Correct.

18 Q. Okay.

19 So I'm going to set this one aside, and I
20 want to go to your version of the notes. Let's see.
21 Oh, wait. Come back. Sorry. Sorry. Let's start with

1 this. I'm all out of order.

2 Okay. So if we go down to Preeti's version
3 of the notes, do you see number two?

4 A. Uh-huh.

5 Q. Proposed changes to the imputation model,
6 right?

7 A. Uh-huh.

8 Q. And if you go, it looks like one, two, three
9 bullets down, it says "Peter asked."

10 A. Uh-huh.

11 Q. "Peter asked whether Leapfrog has a way to keep
12 the low-performing hospitals in the lowest quartile
13 using this Step 2 imputation model." Do you see that?

14 A. Uh-huh.

15 Q. Okay. Was that what we looked at in the
16 transcript a little while ago?

17 A. I don't know because I actually didn't fully
18 follow what Peter was trying to ask there.

19 Q. Okay. Got it.

20 A. To be really, really honest, I -- it didn't
21 make much sense to me.

1 Q. I've been trying to understand it, too, so I
2 get it.

3 Does this seem like a fair articulation of
4 what he was saying in the call?

5 A. If it's in the notes, I would say it's probably
6 a fair articulation, but I don't remember that myself.

7 Q. Okay.

8 Now, just to be clear, looking at this,
9 there is no indication -- and you can read the bullets.
10 They're pretty short -- that anyone was proposing giving
11 hospitals a zero or limited achievement or willing to
12 report, right?

13 A. Can you repeat your question, please?

14 Q. Yeah.

15 Is there any indication in these notes that
16 someone raised the idea during the meeting of giving
17 nonparticipating hospitals a zero or limited achievement
18 or willing to report for the imputed measures?

19 MS. LAWSON: Object to form, but you can
20 answer.

21 THE WITNESS: It doesn't necessarily explicitly

1 say that in these notes.

2 BY MR. CRAIN:

3 Q. Okay.

4 You say "explicitly." Do you have a reason
5 to believe those topics were discussed?

6 A. There was concerns about -- that Arjun raised
7 about a hospital that was performing very poorly and
8 that they would actually get an imputed score, so a
9 better score than what they would actually be -- so to
10 me that seems to be raising the question of whether the
11 current imputation model was rewarding poor performing
12 hospitals.

13 So, I mean, there could be an
14 interpretation of that.

15 Q. So you said the question was raised. My
16 question is was the answer provided, proposed answer?

17 A. I don't remember.

18 Q. Okay.

19 And do you see anything on this page from
20 what you read a few minutes ago from the transcript to
21 suggest that those solutions were proposed that I just

1 mentioned?

2 A. I don't see anything here that would indicate
3 that the actual solution that we landed on is what was
4 explicitly proposed by the expert panel.

5 Q. Okay. Let me ask you this question. Who
6 proposed the solution that you landed on?

7 A. I don't recall with certainty.

8 Q. Okay. Do you think it was Leapfrog, or do you
9 think it was the expert panel?

10 A. I'm guessing it was Leapfrog that proposed that
11 solution based on the concerns that the expert panel was
12 raising.

13 Q. Got it.

14 So to your framing before, the question was
15 raised and Leapfrog was supplying an answer?

16 A. Is your question during this call?

17 Q. During this period. April 2024 --

18 A. I don't remember with certainty how the
19 solution that is currently in use was developed.

20 Q. Okay.

21 I want to also take a look a couple bullets

1 down. It says, "Matt mentioned." Do you see that?

2 A. Uh-huh.

3 Q. And Matt, I take it, is you?

4 A. Correct.

5 Q. "Matt mentioned it is important to see whether
6 there is an actual difference in hospitals' performance
7 and whether there is some sort of bias in the
8 measurement against them. He said to minimize the
9 second, and if there are differences in hospitals'
10 performance, we can address the structural issues to fix
11 them."

12 Do you see that?

13 A. I do.

14 Q. So taking that one by one, what does the first
15 sentence mean?

16 MS. LAWSON: Might it be helpful for him to
17 just review the transcript of what he said?

18 MR. CRAIN: Yeah. I'm pulling that out now.

19 THE WITNESS: That would be helpful.

20 BY MR. CRAIN:

21 Q. But you know what, let's start with this

1 document and what's your understanding of this sentence,
2 and I'll try to find a line.

3 A. It's unclear to me what "them" is referring to
4 in this sentence. Like, I don't have the context to
5 remember what "them" is. To me, I was suggesting that,
6 perhaps, we needed to look at difference in performance
7 between -- yeah, I don't have a great sense just from --

8 Q. I can take you where the -- if you go back to
9 the transcript, page 27 is where you talk about bias.

10 MS. LAWSON: And you might want to just start
11 from the page preceding, which is the page we reviewed
12 previously, and just keep going on the discussion. I
13 think that might help.

14 (Witness peruses document.)

15 THE WITNESS: The context from the transcript
16 is such that we were talking about safety net hospitals
17 and some sort of concerns about bias in measurement for
18 those safety net hospitals.

19 BY MR. CRAIN:

20 Q. Only for them?

21 A. That is the context that Kathy McDonald had

1 brought up was the safety net hospitals.

2 Q. Fair enough. I get that she says that from
3 lines 3 to 11 on page 27, but you follow up, and you
4 say, "I think where I struggle is what is a true --
5 well, where is there a true difference in performance,
6 right, and where is there some sort of bias in the
7 measurement against them. Right?" And then Kathy says,
8 "Right." And then you say, "And I think we want to
9 minimize the second."

10 And so I guess the question I have out of
11 that is what does bias mean in that context?

12 A. Bias would refer to that there is some sort
13 of -- that there is some sort of structural -- I'm
14 trying to think of the right words for this. That there
15 is some sort of structural sort of -- there's something
16 structural about safety net hospitals that disadvantages
17 them.

18 Q. So you're talking about bias about the
19 hospitals or bias about the scoring methodology?

20 A. The bias in the hospitals. And I say that
21 because I think on the next page I talk about that

1 marginalized communities tend to receive care at less
2 safe hospitals. So I think the concern is that there is
3 a bias against safety net hospitals in terms of quality
4 and safety.

5 Q. So this doesn't refer to bias in the survey --
6 in the scoring methodology -- excuse me -- against
7 safety net hospitals?

8 A. I believe what this is referring to is actually
9 the bias in the challenges that safety net hospitals
10 face to prioritize quality and safety of care.

11 Q. And how does that factor into the imputation
12 methodology?

13 A. So safety -- well, to be clear, safety net,
14 there is no formal definition of that. If they are a
15 critical access hospital, they don't receive a Hospital
16 Safety Grade.

17 Q. What is a critical access hospital?

18 A. Critical access hospital, there is about 1,400
19 of them in the United States. They're small hospitals
20 that have 25 beds or less --

21 Q. Got it.

1 A. -- that are generally in rural areas and for
2 which the funding from the government is different,
3 basically to keep their doors open, and they are
4 generally in small, rural communities.

5 Q. And so I get there is no definition of safety
6 net hospital. What's your general understanding of what
7 that means?

8 A. One definition that I commonly use is it's
9 hospitals that care for greater proportions of patients
10 who have Medicaid as their primary insurance.

11 Q. Got it. And they can be for-profit or
12 nonprofit hospitals?

13 A. Correct.

14 Q. Okay. And so what type of -- so how does the
15 safety -- how does the imputation -- like, how does that
16 fact -- let me state the question in a real way rather
17 than stuttering way.

18 How does the safety net bias that you're
19 talking about here relate to the imputation methodology
20 that was the topic of the agenda here?

21 A. I believe what Kathy is looking at is -- was

1 looking at some of the safety net hospitals and just
2 making sure that they were going to be treated fairly.

3 Q. Okay. And is that -- is a difference in the
4 safety net hospitals, as compared to non-safety net
5 hospitals, their capacity to complete the survey?

6 A. I couldn't speak to that.

7 Q. Do they have fewer resources than non-safety
8 net hospitals?

9 A. They typically are more resource constrained
10 hospitals than larger hospitals -- or not larger
11 hospitals, than hospitals that are better funded.

12 Q. So did you understand Kathy to be saying that
13 she wanted to recognize the burden that they were
14 experiencing as compared to non-safety net hospitals?

15 A. I don't know if that was what she was implying
16 there.

17 Q. Okay.

18 So and then going back to your point about
19 bias, how would the imputation methodology -- strike
20 that. Sorry.

21 Going back to your point about bias, how

1 could the imputation methodology take that into account?

2 A. Which imputation methodology are we discussing?

3 Q. Any one, whether -- well, how could any
4 imputation methodology take into account the bias that
5 you're identifying here apparently as to safety net
6 hospitals?

7 A. Well, there's the concern that -- I mean, one
8 potential bias is that if other safety net hospitals are
9 performing less well and you choose to not complete the
10 survey, you're going to maybe get assigned the same
11 value as your average safety net hospital. So that
12 would be one way that a safety net hospital might face a
13 bias.

14 Q. Okay. But you need the definition of what
15 qualifies as a safety net hospital, right?

16 A. Correct. And Leapfrog has its own definition
17 that it uses for that.

18 Q. Is it different from yours?

19 A. I don't know.

20 Q. Okay. You have no knowledge of what that
21 definition is?

1 A. I couldn't say with exact certainty what their
2 definition is.

3 Q. Do you know in what context they have that
4 definition?

5 A. They have it in some of their data files
6 because a lot of their data licensees like to be able to
7 drill down on that type of detail, but I don't know what
8 -- how they get that source or what they are using for
9 them.

10 Q. Okay. Okay.

11 So going back to the notes, which I believe
12 is Exhibit 13, I want to go back to the bullet. Preeti
13 said, "Matt mentioned it is important to see whether
14 there is an actual difference in hospitals' performance
15 and whether there is some sort of bias in the measures
16 against them. He said to minimize the second, and if
17 there are differences in hospitals' performance, we can
18 address the structural issues to fix them."

19 Do you see that?

20 A. I do.

21 Q. Now, she doesn't mention safety net hospitals

1 there, right?

2 A. She does not.

3 Q. Okay. So -- okay. I'll leave it there.

4 MR. CRAIN: I think maybe we'll take a break
5 now. Do you want to do the lunch break now?

6 MS. LAWSON: We're off the record.

7 THE VIDEOGRAPHER: This marks the end of media
8 unit number three. We're going off the record. The
9 time is 11:49 a.m.

10 (Whereupon a lunch break was had, after
11 which the proceedings continued as
12 follows:)

13 THE VIDEOGRAPHER: This marks the beginning of
14 media unit number four. We're back on the record. The
15 time is 12:56 p.m.

16 BY MR. CRAIN:

17 Q. Okay. Welcome back.

18 A. Thank you.

19 Q. I hope you had a nice lunch.

20 A. Yeah. Thank you.

21 Q. So we were talking about the April 12th meeting

1 before we broke. Do you recall that?

2 A. Yes.

3 Q. I want to go back in time just a little bit.

4 The April 12th meeting, if you recall correctly from the
5 notes we saw, was between 4 and 5 o'clock.

6 A. Correct.

7 Q. And if you keep the notes out, if you look at
8 the portion where it says the attendees, do you see
9 that?

10 A. Yes.

11 Q. Dr. Romano is not on that list, right?

12 A. Correct.

13 Q. Okay. And do you recall that -- whether you
14 met with Dr. Romano earlier that day with regard to the
15 safety grade expert panel?

16 A. I can't say with certainty.

17 Q. Okay.

18 A. But I believe we met with him at some point
19 around that meeting.

20 Q. Okay. And that was -- do you recall who
21 attended that meeting?

1 A. I don't recall with certainty. I could
2 estimate who I think would be there, but I can't say
3 with certainty.

4 Q. That's okay. That's okay.

5 And before we go to -- I'll refresh you
6 with a document, but before we go there, who is
7 Dr. Patrick Romano?

8 A. So Dr. Patrick Romano is one of the Hospital
9 Safety Grade expert panelists.

10 Q. And what's his background?

11 A. He is a physician and health services
12 researcher at the University of California, Davis.

13 Q. And fair to say he's an expert in something?

14 A. He is.

15 MS. LAWSON: Object to form but go ahead.

16 THE WITNESS: Yeah. He would be perceived as
17 being an expert in quality measurements in healthcare.

18 BY MR. CRAIN:

19 Q. And have you worked with him for a long time?

20 A. Yes, I have.

21 Q. Did you work with him in the early days when

1 the safety grade was being developed?

2 A. Yes.

3 Q. And was he involved in the development of the
4 first imputation model around 2020, 2021?

5 A. We worked with Dr. Romano in thinking through
6 different options for the imputation.

7 Q. Okay. And do you know how long Dr. Romano has
8 been involved in any capacity with Leapfrog?

9 THE COURT REPORTER: I'm sorry. We just lost
10 connection.

11 MR. CRAIN: Should we go off?

12 THE COURT REPORTER: Could we?

13 MR. CRAIN: Can we go off the record.

14 THE COURT REPORTER: Just one quick second.

15 THE VIDEOGRAPHER: This marks the end of media
16 unit number four. We're going off the record. The time
17 is 12:58 p.m.

18 (Whereupon, the proceedings paused due to
19 technical difficulty, after which the
20 proceedings continued as follows:)

21 THE VIDEOGRAPHER: This marks the beginning of

1 media unit number five. We're going back on the record.

2 The time is 1 o'clock p.m.

3 BY MR. CRAIN:

4 Q. Great. Okay. We're back after a technical
5 glitch, and I'm going to ask the question that we
6 started before.

7 So was Dr. Romano involved in the
8 development of the first imputation model around
9 2020/21?

10 A. He was. To clarify, that wasn't -- it depends
11 on your definition of what is an imputation model. We
12 had had other imputation approaches prior to '20 to '21.

13 Q. Fair enough.

14 Was he involved in the development of that
15 model in --

16 A. Yes. He helped provide input and guidance.

17 Q. Okay.

18 MS. LAWSON: And just make sure that Mr. Crain
19 has finished his question, yes.

20 BY MR. CRAIN:

21 Q. And I think I had asked during the technical

1 glitch, so I'll make sure we get it, how long has
2 Dr. Romano been involved with Leapfrog?

3 A. Since 2011.

4 Q. Okay. So he came on after you joined or after
5 you got involved with Leapfrog, let's say?

6 A. He was part of the Hospital Safety Grade expert
7 panel that was formed in 2011.

8 Q. When the safety grade was originally being
9 developed?

10 A. Correct.

11 Q. Okay.

12 MR. CRAIN: Okay. So I'm going to mark as
13 Exhibit 14...

14 (Exhibit No. 14 was marked for
15 identification as of 9/25/2025.)

16 BY MR. CRAIN:

17 Q. Dr. Austin, do you see this is an
18 Armstrong-produced document?

19 A. Yes.

20 Q. And it's an email from you to you. Do you see
21 that?

1 A. Correct.

2 Q. Does this reflect notes that you took on
3 April 12th, 2024?

4 A. It reflects --

5 Q. I'll direct you to the subject matter, the
6 subject of the email.

7 A. Yes. It was my notes from the Hospital Safety
8 Grade expert panel meeting.

9 Q. And do you have a practice of sending yourself
10 notes over email?

11 A. I do.

12 Q. Okay. So this is a true and accurate, to the
13 best of your knowledge, copy of your notes from that
14 day?

15 A. Yes.

16 Q. Okay.

17 And on the top, it says: "Patrick
18 recommend keep Step 1." Do you see that?

19 A. Yes.

20 Q. Does that refresh your recollection of whether
21 you had a meeting with Dr. Romano on April 12th?

1 A. As I mentioned, I know we met with Dr. Romano
2 around that time because he was unable to make the
3 primary call, but I don't remember the exact timing of
4 when that was.

5 Q. Okay.

6 Do you -- is it correct that these bullets
7 one, two, and three below, "Patrick recommend keep Step
8 1," reflect your notes from the discussion with
9 Dr. Romano?

10 A. That would be likely to be true, yes.

11 Q. Okay. You don't have a specific memory, but
12 that's what the document --

13 A. Correct.

14 Q. -- indicates?

15 A. Yes.

16 Q. Okay. Again, just let's try not to talk over
17 each other.

18 Okay. And then the remainder of this
19 email, just going down, do those reflect your notes from
20 the subsequent expert safety grade panel meeting later
21 that day?

1 A. Yes.

2 Q. Okay.

3 That's all we need to talk about with this
4 document. You can set it aside.

5 MR. CRAIN: Now, I want to go to another
6 document. This will be 15, tab 34.

7 (Exhibit No. 15 was marked for
8 identification as of 9/25/2025.)

9 BY MR. CRAIN:

10 Q. And you will see on the bottom this was a
11 deposition exhibit from Ms. Campione as well. Do you
12 see that blue sticker?

13 A. Yes.

14 Q. Okay.

15 So the top email is from you to
16 Ms. Campione, Ms. Danforth, and Ms. Joshi. Do you see
17 that?

18 A. Yes.

19 Q. And I want to just go through -- if we could
20 start at the bottom, which is the first email, this will
21 be page -- if you could go to page 8331, the second to

1 the last page to orient. Good? Are you there?

2 A. Can you repeat that, please?

3 Q. Sorry.

4 Can you go to page 8331, the second to the
5 last page.

6 A. Yes.

7 Q. Okay.

8 And there's an email from Ms. Campione to,
9 among others, you at 12:17 p.m.?

10 A. Yes.

11 Q. And the subject is imputation changes. Do you
12 see that?

13 A. Yes.

14 Q. So Ms. Campione writes to you and others, "Hi
15 all, please find the table we discussed below. I also
16 included the underlying issues. Please feel free to
17 edit the response to this email." Do you see that?

18 A. Yes.

19 Q. Okay.

20 Do you have a recollection of her sending
21 this email?

1 A. I do remember seeing that table at the bottom
2 of the email, but I didn't remember the context of the
3 email.

4 Q. Do you remember seeing it from back then? Do
5 you remember from seeing it more recently?

6 A. I -- in showing this to me today, I very
7 distinctly remember her sending an email with this
8 table.

9 Q. Okay. Do you remember -- and you said you
10 don't remember the context. Do you remember anything
11 about why she sent it?

12 A. I would guess, based on what's here, it was to
13 sort of further refine a potential direction that we
14 would go for the imputation models.

15 Q. And this was about 10 days after the expert
16 panel meeting, right?

17 A. Correct.

18 Q. Okay.

19 So I want to just go through this chart a
20 little bit just to make sure we're on the same page.
21 Are you looking at the chart on 8332?

1 A. Uh-huh.

2 Q. Okay. So "no change" is the left-most column.

3 Do you see that?

4 A. Yes.

5 Q. And that's -- is it right that's basically the
6 model you had, right, at the time?

7 A. Correct.

8 Q. "Small change" says: "Shorten imputation to
9 past two rounds for Step 1." Do you see that?

10 A. Yes.

11 Q. Is that what you ultimately did, or is it
12 "moderate change" that Leapfrog ultimately imposed?

13 A. Are you asking about recent survey
14 participants?

15 Q. I'm asking -- yeah, I'm asking about Step 1 for
16 recent survey participants. I'll walk you through it.
17 I'll build it a little more clearly.

18 Under "small change" for Step 1, it says:
19 Shorten imputation to two past rounds. Do you see that?

20 A. Uh-huh.

21 Q. Does that reflect, to the best of your

1 understanding, an imputation of a historical score in
2 the past two rounds of the hospital survey?

3 A. Can you repeat that again, please?

4 Q. Yeah.

5 To the best of your understanding, does
6 this column, does this "small change" box in Step 1
7 reflect that you would propose to impute the historical
8 score for a nonparticipating hospital for the past two
9 rounds of the hospital survey? Am I reading that right?

10 A. That is not exactly my understanding.

11 Q. Okay. Can you give me your understanding?

12 A. Yeah. My understanding is what's being
13 proposed is for hospitals that have recently completed
14 the survey, how far of a lookback would we do to see if
15 there was a recent survey.

16 Q. Got it. And was that different from what I
17 said because I said nonparticipating hospitals?

18 A. Correct.

19 Q. Yeah, okay. Let me fix that. That's a fair
20 point.

21 For hospitals that are not participating

1 every year, is that a more apt understanding of what the
2 Step 1 is?

3 A. I would frame it as hospitals that have not
4 submitted the most recent hospital survey.

5 Q. Got it. But for which there exists a
6 historical survey response?

7 A. Correct.

8 Q. Okay.

9 So on the top in Step 1, small change, you
10 go back to the two past rounds of the survey, right?

11 A. That is what's being proposed under small
12 change.

13 Q. Then moderate change is you shorten imputation
14 to one past round, right?

15 A. Correct.

16 Q. And is that what you testified earlier -- is
17 that what ultimately Leapfrog did for Step 1?

18 A. I would have to defer to the methodology --

19 Q. Okay.

20 A. -- document on how that gets phrased or framed.

21 Q. Okay.

1 What do you think is the difference?

2 A. Difference from what?

3 Q. What's your hesitation as to why this is not
4 the same thing as you understand Leapfrog is doing today
5 for Step 1?

6 A. I guess I'm a little unclear on what moderate
7 change would actually be. So that's where I'm now sort
8 of second-guessing like, well, did we implement moderate
9 or did we implement small change?

10 Q. Okay.

11 A. My understanding, putting the words aside, is
12 that what we moved to was the ability for a hospital --
13 we would look back and see if a hospital submitted a
14 survey last year --

15 Q. Got it.

16 A. -- and if we did, we would use that.

17 Q. Okay.

18 A. But we wouldn't go any further back than that.

19 Q. Okay.

20 A. So I don't know how that translates into these
21 exact words.

1 Q. Okay.

2 I mean, I would read one past round to be
3 last year, but I don't know if that's right. You're not
4 sure about that either?

5 A. I'm not sure about that either.

6 Q. Okay.

7 Okay. And then "drastic change" is
8 eliminate Step 1. Do you see that?

9 A. Yes.

10 Q. And that you did not do, right?

11 A. Correct.

12 Q. But that was the proposal at the April 12th
13 meeting, to retire Step 1?

14 MS. LAWSON: Object to form.

15 THE WITNESS: The proposal that we introduced
16 at the Hospital Safety Grade expert panel meeting was to
17 eliminate Step 1.

18 BY MR. CRAIN:

19 Q. Yeah. Okay.

20 Now, in Step 2, if you could just go -- I
21 don't know if you feel more comfortable walking me

1 through it, or I could walk you through it, but Step 2,
2 the no change, it says: "Impute with the mean of first
3 time scores for their cohort." Do you see that?

4 A. Yes.

5 Q. And is that a no change, or is that sort of an
6 adaptation? I had understood the Step 2 to be the mean
7 of first time versus the mean of the cohort generally,
8 right?

9 A. At the time, the nonsurvey -- so Step 2 was --
10 yes, it was the lower of the mean of either first time
11 respondents or the mean of the cohort.

12 Q. Yeah, okay. So slightly different from what
13 the no change says here, right?

14 A. Correct.

15 Q. Okay.

16 And that small change -- there's a no
17 change, which is interesting. Do you see that?

18 A. Correct.

19 Q. Okay.

20 And then moderate change says: "Assign
21 hospitals to the bottom quartile or several standard

1 deviations below the mean." Do you see that?

2 A. Yes.

3 Q. Now, we saw in the transcript that we looked at
4 in the notes the discussion of the lowest quartile. Is
5 this what that's referring to, to the best of your
6 understanding?

7 MS. LAWSON: Object to form.

8 THE WITNESS: I would need to re-review the
9 transcript to refresh myself on what exactly the
10 conversation was about lowest quartile.

11 BY MR. CRAIN:

12 Q. Okay. I'm trying to think should we do that.
13 Would you like to do that? I'm happy to take you back
14 to it unless you have an understanding.

15 A. I don't have -- I mean, I saw in the
16 transcript there was conversation about lowest quartile.

17 Q. Yeah.

18 A. And there's, obviously, conversation here about
19 bottom quartile. I don't know if those two
20 conversations are the same thing. That's what I don't
21 know.

1 Q. Okay. So you don't have an independent
2 recollection of whether this column comes from the
3 discussion of the expert panel meeting or not?

4 A. Correct. I do not have an independent
5 recollection.

6 Q. Okay.

7 And then on the last one, the drastic
8 change, it says: "Impute with limited achievement
9 scores," right?

10 A. Correct.

11 Q. Okay.

12 And, again, we looked at the index, and
13 there was no discussion of limited achievement, right,
14 at least based --

15 MS. LAWSON: Object to form.

16 BY MR. CRAIN:

17 Q. At least based on the index?

18 MS. LAWSON: Object to form.

19 THE WITNESS: Correct. There was no use of
20 that explicit term.

21 BY MR. CRAIN:

1 Q. Yeah.

2 And there was no use of the term
3 willingness, as in willingness to report, right?

4 MS. LAWSON: Object to form.

5 THE WITNESS: Correct.

6 BY MR. CRAIN:

7 Q. Okay.

8 And in the index at least, when we looked
9 at the word "zero," there was no discussion of anybody
10 proposing that nonparticipating hospitals should get
11 zero in Step 2, right?

12 MS. LAWSON: Object to form. Go ahead.

13 THE WITNESS: Correct.

14 BY MR. CRAIN:

15 Q. Okay.

16 So let's go up a little bit on this box.
17 And you respond, do you see that, 12:27 p.m.?

18 A. I --

19 Q. I can give you a page number if you need it.

20 A. I do -- yep.

21 Q. Got it?

1 A. Yep. I do, yes.

2 Q. And you said, "Alex, this looks great. I'm
3 wondering do we, one, want to reflect that we're
4 already" -- doing -- "using" -- sorry -- "drastic change
5 for Step 2 for IPS? And, two, do we want to use a
6 different term for drastic change, like large change?"

7 Do you see that?

8 A. Yes.

9 Q. So just breaking that down, number one, can you
10 tell me what you understood yourself to mean when you
11 said: Do we want to reflect that we're already using
12 drastic change for Step 2 for IPS?

13 A. So as I remember it, we had already moved
14 imputation for IPS to be limited achievement.

15 Q. And when did that come about?

16 A. I don't remember exactly.

17 Q. Okay. And do you remember the basis?

18 A. The basis is we actually had information from
19 CMS, Centers for Medicare and Medicaid Services, that
20 could tell us whether a hospital operated an ICU. And
21 if they operated an ICU, and they had not submitted

1 information to the Leapfrog Hospital Survey about their
2 staffing, we were coming to the conclusion that they
3 didn't meet the staffing model that Leapfrog requires.

4 Q. Got it.

5 So you made the assumption based on the
6 existence of an ICU that they were performing at a level
7 of limited achievement?

8 A. To clarify, I'm not sure we were making an
9 assumption. We were -- we had a lack of information
10 about their staffing models. That would be the
11 equivalent of assigning limited achievement.

12 Q. Got it.

13 And is that, to your knowledge,
14 communicated anywhere on the Leapfrog website to
15 consumers?

16 A. I don't know.

17 Q. Okay.

18 Is that communicated in the methodology
19 document, that that's why Leapfrog assigns limited
20 achievement for IPS for nonparticipating hospitals?

21 A. I don't know for certainty.

1 Q. Okay. Do you want to take a look?

2 A. I can.

3 Q. I'm happy to take you there. That's Exhibit 3.

4 A. That sounds correct.

5 Q. I wrote them down today.

6 A. If my memory serves me right.

7 Q. Do you have it, Dr. Austin?

8 A. I do.

9 Q. And if you go to page 10, it talks about the
10 IPS model -- or the measure.

11 MS. LAWSON: This is for Spring 2025?

12 MR. CRAIN: Correct.

13 BY MR. CRAIN:

14 Q. The IPS, as you testified a minute ago, I
15 think, did not change, right, the imputation
16 methodology?

17 A. That was my comment back to Alex.

18 Q. Okay. Yeah.

19 But to the best of your recollection today,
20 between 2024 and 2025, Step 2 for IPS was always limited
21 achievement, right?

1 A. Correct.

2 Q. Okay.

3 So are you on page 10?

4 A. I am.

5 Q. Okay. So just take a look and read the IPS
6 block.

7 A. Yep. I have, yes.

8 Q. And does it provide any explanation, the
9 explanation you just gave for why hospitals receive
10 limited achievement if they don't participate in the
11 survey?

12 A. You would need to follow the last line that
13 says if a hospital didn't submit a survey, you need to
14 look at using secondary data sources.

15 Q. Okay. Let's go to that page. That's page 15?
16 Take a look. And it's on 15 and 16?

17 A. Yes.

18 Q. Yeah. Is there an explanation there?

19 A. On page 16 there is.

20 Q. Let's see. Where is it?

21 A. Note about IPS: Only hospitals that operate an

1 adult or pediatric medical and/or surgical or neuro ICU
2 are eligible for Step 2 imputation of the IPS measure.
3 A hospital's ICU designation is determined from the
4 number of beds reported on Worksheet 5-3 Part 1 of the
5 hospital's most recent CMS cost report. If your
6 hospital does not operate an ICU but shares a CMS
7 certification number, please contact the help desk.

8 Q. Sorry. I see that on page 15. You see it on
9 16?

10 A. I see it on 16.

11 MS. LAWSON: I also see it on 16.

12 THE WITNESS: Under Step 2.

13 BY MR. CRAIN:

14 Q. Step 2. Okay.

15 And your testimony is that language
16 communicates that if a hospital has an ICU and doesn't
17 participate, it automatically gets limited achievement?

18 A. That is the first sentence under Step 2.

19 Q. Okay.

20 A. If the hospital does not have historical data
21 from the last two rounds of the safety grade, the

1 hospital is assigned a point value that is equivalent to
2 receiving limited achievement for this measure on the
3 Leapfrog Hospital Survey.

4 Q. And so what you testified a minute ago, though,
5 was that the -- tell me if I'm misunderstanding -- that
6 the assumption is if a hospital has an ICU and is not
7 reporting, it's not meeting Leapfrog's standards, right?

8 A. We have assigned a score to hospitals. If we
9 know they operate an ICU based on the CMS cost report,
10 and they don't report to the Leapfrog Hospital Survey,
11 we are assigning them a score of limited achievement.

12 Q. Yes, but that was not directly responsive to my
13 question which was -- and I'll go back just to make sure
14 I say it the right way.

15 What you said a minute ago was that the
16 assumption is that if a hospital has an ICU, and they
17 are not reporting, that they are not meeting Leapfrog's
18 standards, right? That's what you said.

19 A. Correct. And then I corrected myself and did
20 not use the word "assumption." That was a poor choice
21 of word there.

1 Q. Okay. That's what I'm trying to understand.

2 A. Correct.

3 Q. Okay.

4 So maybe you tell me in your words then,
5 because now I'm a little confused by the change, why
6 does a hospital get assigned limited achievement if it
7 has an ICU and does not participate?

8 A. They receive a score of limited achievement
9 because we know they have an ICU, and we don't have any
10 information that would tell us whether or not they are
11 meeting the staffing models that Leapfrog asks hospitals
12 to have in the ICU.

13 Q. So why not impose some achievement and not
14 limited achievement?

15 A. Because the way Leapfrog's standards are set in
16 the survey is there are clear criteria of what needs to
17 be met for some achievement, considerable achievement,
18 and achieved the standard. And if you don't meet the
19 criteria for some achievement, you're in the limited
20 achievement bucket.

21 Q. But, again, you don't know either way whether a

1 given hospital is meeting some versus limited or -- I
2 forgot -- the top one, right?

3 A. Correct.

4 Q. Okay.

5 Okay. So let's go back to this document.
6 So that covers IPS Step 2.

7 The second part says, "Do we want to use a
8 different term for drastic change like large change?"
9 Why did you not like the phrase "drastic change"?

10 MS. LAWSON: Object to form.

11 BY MR. CRAIN:

12 Q. Did you not like the word "drastic change"?

13 A. I did not like the word "drastic change."

14 Q. With that now established, why did you not like
15 the phrase "drastic change"?

16 A. I'm trying to think. It felt -- it felt
17 sensational.

18 Q. Okay. What do you mean by sensational?

19 A. I personally think of the word "drastic" as
20 having sort of a sensational connotation, right. It's
21 extreme.

1 Q. Got it. Dramatic?

2 A. Dramatic. That would be a better word.

3 Q. We work with words for a living.

4 MS. LAWSON: I struggled not to interpose my
5 own.

6 BY MR. CRAIN:

7 Q. So did you feel dramatic was inaccurate or it
8 was a problem with the messaging and how it might be
9 received?

10 A. My concern was the messaging and how it would
11 be received.

12 Q. Okay.

13 MR. CRAIN: Oh, I'm sorry. Iason tells me I
14 said dramatic. No, I meant dramatic.

15 MR. TOGIAS: Oh, you meant it?

16 MR. CRAIN: Yeah.

17 MR. TOGIAS: Okay. Sorry.

18 MR. CRAIN: I meant dramatic.

19 BY MR. CRAIN:

20 Q. Let's see. Okay. So let's keep going up. Let
21 me see if there's anything else here. So you see the

1 chart is revised on page 8330?

2 A. Yes.

3 Q. And that, as best I can tell, is just changing
4 to reflect the limited achievement, you know, for IPS,
5 right?

6 MS. LAWSON: And Dr. Austin, you can read --
7 feel free to read through the whole email chain if you
8 need that to refresh your recollection.

9 (Witness peruses document.)

10 THE WITNESS: Can you repeat your question,
11 please?

12 BY MR. CRAIN:

13 Q. Yeah. I'm just looking at 8330, and it looks
14 like the change on the chart is just as you noted
15 before, that IPS was already doing the impute limited
16 achievement.

17 A. Correct.

18 Q. So there's no change there, right?

19 A. That is the only change from the prior chart.

20 Q. Yeah. Sorry. There's no change to IPS under
21 this chart?

1 A. Correct.

2 Q. Yeah.

3 Okay. Let's set this aside. Keep it at
4 the ready.

5 MR. CRAIN: Can I get 36. I'll mark this as
6 Exhibit 16.

7 (Exhibit No. 16 was marked for
8 identification as of 9/25/2025.)

9 BY MR. CRAIN:

10 Q. So Dr. Austin, do you recognize this document?

11 A. Yes. It's an email between myself and Leapfrog
12 staff.

13 Q. You get the hang of it now, these documents.

14 And you see on the bottom right it's an
15 Armstrong-produced document, right?

16 A. Correct.

17 Q. Okay. I want to start -- just go to the bottom
18 again to the first email in the chain, and if you need a
19 minute, take it. Whenever you're ready.

20 (Witness peruses document.)

21 THE WITNESS: Yes.

1 BY MR. CRAIN:

2 Q. Okay.

3 So the first email on the bottom is from
4 Ms. Campione, and it's to Ms. Danforth, you, and
5 Ms. Joshi. Do you see that at 5:41 p.m.?

6 A. Yes.

7 Q. And the subject is Step 2 imputation scores.
8 Do you see that?

9 A. Yes.

10 Q. And she says, "Hi all. I have some bad/good
11 news. The Step 2 scores aren't what we would like.
12 Turns out the hospitals that do the survey perform very
13 well. The BCMA scores below will likely drop with the
14 methodology changes, though."

15 Do you see that?

16 A. Yes.

17 Q. Do you have any understanding today of what she
18 meant by the Step 2 scores aren't what we would like?

19 MS. LAWSON: Object to form. Go ahead.

20 (Witness peruses documents.)

21 THE WITNESS: Where I'm hesitating is my sense

1 is she was looking at a subset of hospitals, and I don't
2 remember what that subset of hospitals was.

3 BY MR. CRAIN:

4 Q. Okay.

5 Do you remember the purpose of her running
6 that subset?

7 A. My recollection is it's somehow connected back
8 to conversations with the expert panel about imputation
9 and one of the scenarios that maybe someone suggested we
10 look at, but I couldn't explicitly say which scenario
11 that was.

12 Q. So we talked a little bit about quartile,
13 right? Do you remember that discussion?

14 A. Uh-huh.

15 Q. If you look at the chart right below her text,
16 do you see it says Mean of Bottom Quartile?

17 A. Yes.

18 Q. Okay. And it says the CPOE, hand hygiene, and
19 BCMA scores. Do you see that?

20 A. Yes.

21 Q. And I'll work you up the email now.

1 (Whereupon, the court reporter seeks
2 clarification, which colloquy will not be
3 captured on the written record.)

4 BY MR. CRAIN:

5 Q. Let's go up. You respond. Do you see that?

6 A. Yes.

7 Q. And you say, "Alex, would it be easy to look at
8 the same for first time reporters? We may have to
9 consider the option of just assigning the score for
10 limited achievement, which is actually consistent with
11 how we are approaching IPS."

12 Do you see that?

13 A. Yes.

14 Q. Okay.

15 Does this refresh your recollection as to
16 what she was running and why she was doing this?

17 A. Not really.

18 Q. Okay. It doesn't have to. That's okay.

19 A. Okay.

20 Q. Okay. So she responds it looks like five
21 minutes later. She says, "Not too difficult. I would

1 predict they're just slightly lower." And then you
2 respond at the top, "Thanks. Then maybe not worth the
3 effort."

4 Do you see all of that?

5 A. Yes.

6 Q. Okay.

7 Do you have any recollection today about
8 why you would say it's not worth the effort?

9 A. What I interpreted from Alex's statement was
10 that the results wouldn't be much different than what
11 she had originally produced.

12 Q. And the -- go ahead. Sorry.

13 A. So it didn't seem worth the analytical effort
14 to update it for something that wasn't meaningful
15 different -- meaningfully different in terms of Leapfrog
16 deciding how it wanted to move forward.

17 Q. And meaningfully different in this case meaning
18 lower, right?

19 A. Correct. She indicated that they would be
20 slightly lower.

21 Q. And you all wanted the numbers to be lower,

1 right?

2 MS. LAWSON: Object to form.

3 BY MR. CRAIN:

4 Q. You can answer.

5 A. There were concerns that the mean scores that
6 we had been using for imputation had been going up
7 considerably which created a disincentive for hospitals
8 to actually complete the survey.

9 Q. Yes. We saw that in the safety grade meeting,
10 right, that there were concerns that imputation scores
11 were creeping up?

12 A. That was one of the noted -- yeah.

13 Q. Right. On the slide that you drafted.

14 A. Correct.

15 Q. That was one of the bullets, right?

16 A. Correct.

17 Q. And in response to that, we saw that
18 Dr. Pronovost suggested a quartile approach, right?

19 MS. LAWSON: Object to form.

20 THE WITNESS: Once again, I -- in reading the
21 transcript, it wasn't super clear what Peter was exactly

1 discussing or suggesting.

2 BY MR. CRAIN:

3 Q. Let me phrase it a little bit differently that
4 I hope will be easier.

5 At the expert panel meeting, in the
6 transcript we saw him say the word "quartile." Fair?

7 A. Fair.

8 Q. Okay.

9 And then 10 days later -- let me just
10 double check. More than 10 days later we have
11 Ms. Campione sending around a chart that lays out, among
12 other things, the mean of bottom quartile. Do you see
13 that? That's on the last page.

14 A. Yes.

15 Q. Okay.

16 But the numbers are too high there, right?

17 MS. LAWSON: Object to form.

18 THE WITNESS: I don't know how to respond to
19 that. I mean, all of the data are here.

20 BY MR. CRAIN:

21 Q. So let's go to Ms. Danforth's email of

1 9:11 p.m. This is on page 2128. Do you see it?

2 A. Uh-huh.

3 Q. She said, "This is sort of what I was afraid of
4 but somehow more stark seeing the actual numbers. I do
5 think that we need to at least go wider" -- which I
6 understand to mean consider -- "going to limited
7 achievement." Do you see that?

8 A. Yes.

9 Q. Okay.

10 Do you understand what she is saying in
11 this email?

12 A. My understanding is she was indicating that the
13 numbers aligned with what she thought might be the case
14 and was recommending that we need to consider going to
15 limited achievement.

16 Q. Okay.

17 So just to build this out a little bit, at
18 this time, under the methodology that was governing, the
19 imputation under Step 2 was a straight mean, not a
20 lowest quartile mean but a straight mean, right? Do you
21 understand what I mean?

1 A. It was a -- there were two values that were
2 calculated for each hospital. There was the overall
3 mean and I believe that of -- the first time reporters
4 in the hospital got the lower of those two values.

5 Q. And the concern was those means were too high,
6 right?

7 A. The concern was that those means
8 disincentivized hospitals to report into the survey.

9 Q. Yes. Okay. Because they were too high, right?

10 A. Because they would give hospitals a lot of
11 credit when they wouldn't have to necessarily
12 demonstrate anything for that.

13 Q. Okay.

14 And you say when they wouldn't have to
15 demonstrate anything for that, but do you have any
16 empirical knowledge of whether that credit, so to speak,
17 would have been due as a matter of performance?

18 A. We don't have any empirical evidence on what a
19 hospital's performance would be when they don't report
20 because we don't actually have those data.

21 Q. On the measures for which you don't have data,

1 right? What I mean is you have other data, like CMS
2 data for those hospitals?

3 A. Correct.

4 Q. That's all I meant.

5 So then Ms. Campione runs a different mean,
6 right? The mean in this email is not the mean that you
7 all had been imputing as a part of Step 2 in the prior
8 methodology. Is that right?

9 A. My understanding is the very bottom table --

10 Q. Uh-huh.

11 A. -- where it says current Step 2 means for
12 reference are what the means had been that we were using
13 at the time.

14 Q. Okay.

15 And so but the mean in the top part where
16 it says the Mean of Bottom Quartile, am I understanding
17 right that that's taking the bottom quartile of
18 hospitals and calculating the mean of those hospitals?

19 A. That's what I don't know was what sample of
20 hospitals she was using for that calculation. I don't
21 know if it was all hospitals or if it was a subset of

1 hospitals.

2 Q. Okay.

3 So how would it work to calculate the mean
4 of bottom quartile for all hospitals?

5 A. I would take the full dataset of hospitals for
6 which we have data, identify the bottom 25 percent, and
7 calculate the mean of that sample.

8 Q. Okay. And do you have any reason to think
9 that's not what she did?

10 A. I don't have any reason to think it's not what
11 she did, but I also don't know that is what she did.

12 Q. Okay. Okay.

13 Okay. So we can set that aside.

14 MR. CRAIN: Okay. Let's go to tab 38. This
15 will be Exhibit 17.

16 (Exhibit No. 17 was marked for
17 identification as of 9/25/2025.)

18 BY MR. CRAIN:

19 Q. Okay. Dr. Austin, you have Exhibit 17, and you
20 see on the bottom it's an Armstrong document ending
21 16473?

1 A. Yes.

2 Q. And this is an email thread between you and
3 Ms. Joshi, right?

4 A. Yes.

5 Q. And this, if you look at the bottom two emails
6 on the first page, that's the emails we saw at a prior
7 exhibit where she's sending you her draft of the notes,
8 right?

9 A. Yes.

10 Q. Okay. And you say -- this is on May 14th. Do
11 you see that date?

12 A. Yes.

13 Q. So it's a few days after the email we just
14 looked at, which was dated April 22nd. Do you see that?

15 A. Yes.

16 Q. Okay. So this is after you've gone through the
17 analysis of the bottom quartile mean. It's after you've
18 gone through that email thread we just saw, right?

19 A. Yes.

20 Q. Okay.

21 In between that period of April 12th and

1 now May 14th, do you recall any other discussions you
2 had with members of the expert panel about the
3 imputation model?

4 A. I don't remember.

5 Q. Okay. You don't -- just to be clear, you don't
6 remember either way?

7 A. I don't remember either way.

8 Q. Okay.

9 So I want to go to the Word document here
10 of the attachment. And do you see -- is it -- these are
11 your revisions to the notes, correct?

12 A. Yes.

13 Q. And I want to walk through a few of these. You
14 start by at the top adding Tim Vogus to the attendees?

15 A. Yes.

16 Q. Any idea how you remembered he was there a
17 month later?

18 A. To be clear, I sent the edits back to Preeti a
19 month later.

20 Q. That's what the email suggests. If you look --
21 look on page 1.

1 A. But that doesn't mean I made the edits a month
2 later.

3 Q. Oh, so I'll represent to you that the metadata
4 shows that these are your changes.

5 A. Okay.

6 Q. I'm trying to see if there is a comment, too.
7 No. But I'll represent to you that the attachment shows
8 that you -- like you inserted the track changes.

9 Do you have any reason to think you didn't?

10 A. No. I'm wondering about the timing of when I
11 made the edits.

12 Q. Got it. Okay. That I don't know as well. So
13 you're saying you could have made these edits earlier?

14 A. Correct.

15 Q. Got it. Okay.

16 Do you recall, to do these edits, did you
17 watch the video of the meeting?

18 A. No.

19 Q. Okay. So you were going from memory, you
20 think?

21 A. Yes, and my own notes.

1 Q. And your own notes. And your own notes, would
2 they have been different from the email we saw earlier
3 where you sent it to and from yourself?

4 A. No. That was the extent.

5 Q. So I'm going to skip bullet one, which is on
6 the military treatment facilities again, and I want to
7 focus on your edits to bullet two. Do you see those?

8 A. Yes.

9 Q. Okay. And you say, "Matt provided the expert
10 panel with a quick overview of the current imputation
11 model approaches Leapfrog has been using and some of the
12 challenges those approaches have created for issuing
13 accurate grades." Do you see that?

14 A. Yes.

15 Q. Okay. And to the best of your recollection,
16 that is an accurate statement of what occurred at the
17 meeting, right?

18 A. Yes.

19 Q. Okay.

20 Then you say, "The current imputation model
21 has two steps when data are missing." Do you see that?

1 A. Yes.

2 Q. And I won't read them because we've been
3 through them, but just looking yourself at Step 1 and
4 Step 2, consistent with the slide deck that we saw?

5 A. Yes.

6 Q. And then you say, "Leapfrog's proposal was to
7 retire Step 1 of the model and use only Step 2,
8 assigning hospitals the mean score for their cohort."
9 Do you see that?

10 A. Yes.

11 Q. And then I want to skip down a bullet that you
12 delete. Do you see that?

13 A. Yes.

14 Q. And it says, "Missy gave an example of Stewart
15 Health System and said that Leapfrog's purpose by
16 implementing the Step 2 imputation model is not to
17 penalize hospitals or to motivate them to submit a
18 survey, but they don't want to report hospitals with the
19 highest scores when hospitals are not submitting the
20 hospital survey."

21 Do you recall why you deleted that bullet?

1 A. I believe I deleted that bullet because it felt
2 like a little too micro of a note to include in a
3 meeting summary.

4 Q. Got it. So it was not an edit for substance?

5 A. Can you define that?

6 Q. Yeah. Fair enough.

7 Did you delete it because you disagreed
8 that anything -- with anything in that bullet?

9 A. No, that was not my reason for deleting it.

10 Q. Okay.

11 Then let's keep going. So you then go --
12 there's a bullet we looked at before. "Matt mentioned
13 it's important to see whether there is an actual
14 difference in hospitals' performance and whether there
15 is some sort of bias in the measurement against them.
16 He said to minimize the second, and if there are
17 differences in hospitals' performance, we can address
18 the structural issues to fix them."

19 Do you see that?

20 A. Yes.

21 Q. And you deleted that one as well, right?

1 A. Yes.

2 Q. And similar, not to be so granular in the
3 meetings?

4 A. Yes.

5 Q. And then you added a bullet and you say, "The
6 experts' panel were in support of having hospitals share
7 their current performance, so liked the idea of imputing
8 the equivalent of willing to report to hospitals that do
9 not submit a survey."

10 Do you see that?

11 A. Yes.

12 Q. Now, you recall looking at the index of the
13 transcript, right?

14 A. Yes.

15 Q. And we saw the phrase "willing" did not appear
16 at least in the index, correct?

17 A. Yes.

18 Q. Where did this line come from?

19 A. So as mentioned, I'm not sure the expert panel
20 would have necessarily used the term "willing to report"
21 in their conversation. I would need to go back to the

1 transcript, but my guess is that there was communication
2 about putting them in the lowest performance category.

3 Q. Okay. So the phrase you would be looking for
4 is lowest performance category?

5 A. Or some context of that.

6 Q. Okay. And presumably you would want to review
7 the whole thing before committing one way or another?

8 A. Correct.

9 Q. Fair enough.

10 Okay. So to the best of your
11 recollection -- so strike that.

12 When creating the notes, you would have
13 wanted to be accurate, right?

14 A. Correct.

15 Q. Okay. And so just looking at these notes and
16 your edits, your best understanding of these edits is
17 that at some point somebody discussed the concept of
18 giving them the willing to report grade, right?

19 A. Correct.

20 Q. Okay.

21 A. And that others agreed with that point of view.

1 Q. Okay.

2 And then just to go back, do you remember
3 the chart we looked at, the drastic change chart?

4 A. Yes.

5 Q. You want to look at it again just so we're
6 not -- and that is exhibit --

7 A. Fifteen.

8 Q. Fifteen. Let's look at 15. And we can go to
9 the last page, 18332. Do you see that?

10 A. Yes.

11 Q. Okay.

12 And is it your testimony that the bottom
13 right box is the same as this willing to report?

14 A. Yes.

15 Q. Okay. And the bottom right box says impute
16 with limited achievement scores, right?

17 A. Yes.

18 Q. So your testimony is that at the meeting at
19 least somebody discussed the notion of imputing limited
20 achievement scores, maybe not by that word, and that
21 others agreed, right?

1 MS. LAWSON: Object to form.

2 THE WITNESS: From my notes here, it indicates
3 that the expert panel supported the idea of assigning
4 the bottom performance category.

5 BY MR. CRAIN:

6 Q. Okay. And do you recall -- strike that.

7 Okay. You can set that aside.

8 MR. CRAIN: Let's go to tab 43. This is going
9 to be Exhibit 18.

10 (Exhibit No. 18 was marked for
11 identification as of 9/25/2025.)

12 BY MR. CRAIN:

13 Q. All right. This is an email. The top one is
14 from Ms. Binder to Ms. Campione, cc'ing you and
15 Ms. Danforth. Do you see that?

16 A. Yes.

17 Q. Okay. And do you recognize this document?

18 MS. LAWSON: You can take a minute to read
19 through it all.

20 THE WITNESS: The email or the --

21 BY MR. CRAIN:

1 Q. Let's start with the email. Do you recognize
2 the email?

3 A. Yes.

4 Q. Okay. You recall it today?

5 A. Can you clarify that?

6 Q. Yeah. Do you recall receiving it?

7 A. I do recall Alex putting together a document
8 with the proposed changes to the methodology that would
9 go out for public comment.

10 Q. And is that the document, at least in edited
11 form, on page 9813?

12 A. Yes.

13 Q. Okay. And do you recall did any members of the
14 expert panel review and revise the document?

15 A. I don't remember explicitly if we shared this
16 document with them.

17 Q. Yeah. Okay. I mean -- I'll move on from that.
18 I'll move on from that.

19 So the attachment, do you see it says
20 Request for Public Comment?

21 A. Yes.

1 Q. Do you recall reviewing the document?

2 A. I don't recall.

3 Q. Okay. Just your best answer. That's all we
4 ask.

5 So I want to go -- I'll represent to you on
6 page 9814 these are Ms. Binder's tracked change edits to
7 the documents, and I want to just note a few things that
8 she tweaked. So if you go to the second -- tell me when
9 you're ready. No worries.

10 MS. LAWSON: The font is so small.

11 MR. CRAIN: Yeah, it is small. Sorry about
12 that.

13 BY MR. CRAIN:

14 Q. Are you good, Dr. Austin?

15 A. Yes.

16 Q. Okay.

17 So if you go to the second paragraph, to
18 ensure, do you see that?

19 A. Yes.

20 Q. And I apologize. It's in black and white, too,
21 which makes it harder.

1 But go down to the third line. The
2 original text said: "The panel recognized that the
3 current imputation method, which is used to fill in
4 missing data among hospitals that did not complete the
5 most recent Leapfrog survey, have influenced hospital
6 survey participation and may no longer be valid."

7 Do you see that?

8 A. Yes.

9 Q. Okay. She changed it to: "The panel advised
10 that Leapfrog modify the current imputation method,
11 which is used to fill in missing data among hospitals
12 that did not complete the most recent Leapfrog survey."

13 Is that consistent with your recollection
14 of who was advising? Did the panel actually advise
15 Leapfrog to change the methodology?

16 MS. LAWSON: Object to form but go ahead.

17 THE WITNESS: The Leapfrog Group has full
18 decision-making authority around its ratings and rating
19 systems and methodologies. So myself and all of the
20 expert panels are acting in an advisory capacity to
21 Leapfrog for that.

1 BY MR. CRAIN:

2 Q. Okay.

3 So is this accurate, this change?

4 A. Yeah, that change would be accurate.

5 Q. Okay.

6 And then if we go down, I want you to look
7 at -- can you read what she cut in the next paragraph?

8 A. Yes.

9 Q. Okay. "Note that Step 1 imputation will be
10 temporarily paused" -- oh, sorry. That's not the one I
11 wanted.

12 Go back up, excuse me, to the prior
13 paragraph. She cut a sentence: "The collective
14 recommendation was for Leapfrog to modify its current
15 imputation approach to encourage survey participation
16 and to improve user's confidence in the data that are
17 used to calculate scores."

18 Do you see that?

19 A. Yes.

20 Q. Okay. Was that accurate?

21 MS. LAWSON: Just to be clear, you're asking

1 was the sentence that she struck, that the collective
2 recommendation, was that sentence accurate?

3 MR. CRAIN: Correct. Not the strike. I don't
4 want to know if the strike was accurate. I want to know
5 if the sentence as written was accurate.

6 THE WITNESS: Okay.

7 (Witness peruses document.)

8 THE WITNESS: Yes.

9 BY MR. CRAIN:

10 Q. Okay.

11 Now, I want to go to her email. And what
12 she says is -- are you at the top?

13 A. Yes.

14 Q. The second paragraph: "I don't think we need
15 the sentence about influencing survey participation and
16 giving people confidence in validity. It sounds
17 defensive, like nobody participates in the survey and
18 our own TEP questions our validity. Actually, this
19 change affects a minority of hospitals and optimizes the
20 grade's already strong validity. Anyway, it's not
21 necessary to get into the why. It's enough that the

1 expert panel advised us to do the imputation in a
2 different way and not treat older, better data in an
3 equivalent way to new data."

4 Do you see that?

5 A. Yes.

6 Q. Okay.

7 And then did you agree that it sounded
8 defensive -- that's my first question -- the changes
9 that she cut?

10 MS. LAWSON: Object to form.

11 I think, just to clarify, do you agree that
12 the sentence she cut sounded defensive?

13 MR. CRAIN: Correct.

14 (Witness peruses document).

15 THE WITNESS: That wouldn't be the word I would
16 use to describe that sentence.

17 BY MR. CRAIN:

18 Q. What word would you use?

19 A. Explanatory.

20 Q. Okay.

21 And do you agree -- I mean, she says it

1 sounds like nobody participates in the survey and our on
2 TEP questions our validity. Did you have that same
3 reaction reading it?

4 A. That wasn't my own read of that sentence.

5 Q. What was your read of the sentence?

6 A. That we wanted to improve confidence in the
7 data that we were using and the score.

8 Q. And to encourage participation?

9 A. That would be a byproduct of that change.

10 Q. How would that be a byproduct?

11 A. If we're no longer imputing the mean scores, it
12 might encourage some hospitals, specifically those that
13 are performing better than the mean, to actually come in
14 and share their performance. I take that back. They
15 would have been already incentivized to do that.

16 It would incentivize hospitals that didn't
17 report and were below the mean to come in and report.

18 Q. Because the new score would be lower than their
19 performance?

20 A. Correct.

21 Q. Okay. And the new score would not necessarily

1 reflect their actual performance?

2 A. It's undetermined whether it would reflect
3 their performance or not.

4 Q. Because you don't know either way?

5 A. Because we don't know, exactly, where each
6 hospital is at.

7 Q. Yes. Okay.

8 And then I want to go back to her email.
9 And she says, "I think when we respond to the public
10 comments, we can be more pointed and specific about the
11 survey and imputation reasoning, if necessary. The
12 comments will give us a good gauge on the extent to
13 which we need to reveal all our reasoning and whether
14 the expert panelists will truly stand up for it when
15 push comes to shove."

16 Do you see that paragraph?

17 A. Yes.

18 Q. What's your understanding of what she meant
19 here?

20 A. That the -- putting out the proposed changes
21 wasn't the time to share all of the logic which led to

1 the decision to propose this, that that could come out
2 during the responses to the comments.

3 Q. And do you have any understanding by what she
4 means of whether the expert panelists will truly stand
5 up for it when push comes to shove?

6 A. I believe she meant that there could be some
7 pushback from hospitals about this proposed change and
8 would the expert panel stand with Leapfrog in this -- in
9 moving forward in this direction.

10 Q. Had the expert panel ever not stood with
11 Leapfrog in a change to the methodology?

12 A. No.

13 Q. Okay. So any understanding as to why this
14 might be different?

15 A. This change was the most direct in confronting
16 hospitals about their lack of participation in the
17 survey.

18 Q. What do you mean by direct?

19 A. In the past, all the imputation models, from
20 ignoring the measure to using secondary data sources to
21 calculating, assigning you the national mean didn't

1 necessarily direct -- confront a hospital to say you're
2 not submitting data and that's a problem with us.

3 We gave them sort of a pass. We found
4 another way to give them a score. So this was the most
5 direct confrontation on that.

6 Q. Was that the goal of the change?

7 A. I think the goal was multifold.

8 Q. Okay.

9 A. I think one, as mentioned, was to improve the
10 confidence of the data in terms of what data we were
11 using to calculate the scores. A secondary goal was to
12 increase or incentivize survey participation.

13 Q. Okay.

14 And then the confidence of the data, how
15 does it improve the confidence of the data to
16 automatically assign nonparticipating hospitals limited
17 achievement on the four imputed measures?

18 A. In the framework of the idea being that if we
19 don't have any information about your hospital -- so the
20 historical use of willing to report, the idea was that
21 was to acknowledge hospitals who were willing to be

1 transparent but didn't meet the standards that Leapfrog
2 had set.

3 So we don't have -- can you repeat your
4 question again, please?

5 Q. Sure. Sure.

6 I said -- you said -- so you talked about
7 one goal was the confidence of the data, right, and what
8 I asked was how does it improve the confidence of the
9 data to automatically assign nonparticipating hospitals
10 limited achievement on the four imputed metrics?

11 A. So when we were calculating the national mean
12 for hospitals, we don't necessarily have any information
13 that that hospital is an average performer in that area.
14 We are assuming they are average, and in a normal
15 distribution, half of hospitals are below the average.

16 So because we don't know anything about the
17 hospital and their performance in that way, in some ways
18 this idea of willing to report actually better reflects
19 what we do know.

20 Q. Better -- okay.

21 So I want to go and look at -- let's get

1 concrete with this.

2 MR. CRAIN: So this is Exhibit 19.

3 (Exhibit No. 19 was marked for
4 identification as of 9/25/2025.)

5 BY MR. CRAIN:

6 Q. So Dr. Austin, do you recognize this page, at
7 least generally?

8 A. Yes.

9 Q. Okay. This is the Delray Medical Center
10 Hospital Safety Grade page, right?

11 A. Yes.

12 Q. Have you ever seen Delray in particular?

13 A. No.

14 Q. Okay. But you know generally the format of how
15 these pages work, right?

16 A. Yes.

17 Q. Okay. So it's not necessarily the best because
18 it's a paper, and you can see it on a website instead,
19 but you get the gist, right?

20 A. Yes.

21 Q. So I want to go down the page. You see at the

1 top it says big "F," right, for Delray?

2 A. Yes.

3 Q. Okay.

4 And I want to go to page 2. And so this is
5 specifically on the handwashing measure, right?

6 A. Yes.

7 Q. And if you go just back to page 1, and it's a
8 little hard to tell because -- but if you line up the
9 handwashing at the top of page 2 with the gas gauge, do
10 you see that?

11 A. Yes.

12 Q. And there's a red gas gauge above handwashing,
13 right? And then it says: The hospital's score is 15,
14 right?

15 A. Yes.

16 Q. And it says: Worst hospital's score is 15,
17 correct?

18 A. Yes.

19 Q. And then it says: What safer hospitals do.

20 And before I go into that, I just want to
21 clarify again. Did you have any role in editing this

1 website, not specific to Delray but the safety grade
2 pages, generally?

3 A. I did review and help edit the descriptions
4 that are -- the handwashing and what safer hospitals do.

5 Q. Okay. So you're familiar with this language?

6 A. Yes.

7 Q. Okay.

8 And it says: "What safer hospitals do.
9 Hospitals provide training and implement policies to
10 make sure all hospital staff cleans their hands before
11 touching a patient." Do you see that?

12 A. Yes.

13 Q. Okay.

14 Now, you said a goal of the new
15 methodology, the first goal was -- let me just go back
16 to what it was. It's confidence in the data, right?

17 A. Correct.

18 Q. How does putting Delray at a 15 for handwashing
19 give confidence in the data?

20 A. Once again, we don't have any information from
21 Delray Medical Center about how they are doing toward

1 meeting Leapfrog's standard for hand hygiene, and,
2 therefore, in the absence of information, we're going to
3 assign the equivalent of willing to report, which is now
4 limited achievement.

5 Q. Even though they're not willing to report,
6 right? Correct?

7 A. Correct.

8 Q. Yeah.

9 So how does a consumer looking at this
10 page, though, feel confidence that the grade is
11 accurate?

12 A. I haven't studied how consumers review and
13 interpret this information, so I don't know if I can
14 speak to how they would interpret this.

15 Q. You buy things, right?

16 A. I do.

17 Q. And do you look at consumer reports, other
18 ratings types for products?

19 A. Yes.

20 Q. Do you trust that the rating is accurate that
21 those reports provide?

1 MS. LAWSON: Object to form. Go ahead.

2 THE WITNESS: I think it depends on the source.

3 BY MR. CRAIN:

4 Q. Fair enough. Give me one that you trust.

5 A. I can't think of one offhand, but I'd be more
6 inclined to trust something that was an individual
7 reviewing products against similar products.

8 Q. Okay. I'm not sure I understood that, but can
9 you clarify? Sorry.

10 A. Yeah. Meaning like if I wanted to buy a new
11 coffee maker --

12 Q. Yeah.

13 A. -- I would be more inclined to trust someone
14 who has reviewed coffee maker A against B, C, and D --

15 Q. Okay. Got it.

16 A. -- than someone just chiming in about coffee
17 maker A and what their experience was.

18 Q. Okay. That's -- okay. We can work with that
19 one.

20 So my question is if you have coffee maker
21 -- in your first analogy, right, coffee maker A, B, C,

1 and D, he's reviewing them all. If you find out that
2 for a subset of the coffee makers he's giving you
3 information about the quality of the product without
4 actually having reviewed it, does that instill
5 confidence in you or no?

6 A. It might give me pause.

7 Q. And how is that different from what we see
8 here?

9 A. Can you clarify that question?

10 Q. Yeah. So you said it might give you pause if
11 for certain of the coffee makers the ultimate rating
12 included measures for which the reviewer didn't have any
13 information, right? How is that different from
14 handwashing for Delray?

15 A. So I think what's notable is that the score has
16 an asterisk, which explains, I believe, how that score
17 was arrived at.

18 Q. So we'll come to the asterisk in a second. I'm
19 trying to get a sense of you said one of the goals of
20 the new model was to instill confidence in the data.
21 And you said another goal was to encourage

1 participation, right? How does it instill confidence in
2 data to represent that a hospital got the lowest score
3 on hand hygiene when you have no information about their
4 performance otherwise? Doesn't that undermine
5 confidence in the data?

6 MS. LAWSON: Object to form.

7 MR. CRAIN: Two questions.

8 MS. LAWSON: Two questions.

9 BY MR. CRAIN:

10 Q. You can pick either one or I can restart,
11 either or.

12 A. Can you restart?

13 Q. Sure. So -- that's a fair ask.

14 So I want to understand how does it instill
15 confidence in data to represent that a hospital got the
16 lowest score in hand hygiene where this page says
17 hospitals that are safer provide training and implement
18 policies to make sure all hospital staff cleans their
19 hands before touching a patient. How does it instill
20 confidence in data to give a hospital the lowest score
21 on that metric with no information?

1 A. That's what we're representing here is that we
2 have no information. That's what the asterisk is
3 telling you is we have no information.

4 Q. Okay. So the asterisk, you're saying -- so
5 does the asterisk undermine the score?

6 A. No. The asterisk is saying the hospital
7 declined to report their performance, so the score
8 reflects the lack of information available.

9 Q. So then how can the consumer feel confident
10 that the ultimate grade is accurate?

11 A. So Leapfrog is fully transparent with the
12 information it presents. A patient can review each of
13 the measures, decides what's important to them, what's
14 not important to them, and make decisions based on that
15 and other pieces of information that they may look for
16 and acquire.

17 Q. So I take the talking point. Do -- when you
18 say they're fully transparent, is that referring to the
19 methodology document that we looked at as Exhibit 3?

20 A. That is the methodology document. That is how
21 each of the individual scores on each of the individual

1 measures make up the composite.

2 Q. So let's take a different hospital. Delray,
3 you understand, got Step 2 imputation, right?

4 A. Yes.

5 Q. If I showed you a hospital for Step 1
6 imputation, is the website any different?

7 A. I don't know the answer to that.

8 Q. Okay. I will represent to you it's the same
9 asterisk. How does a consumer know whether a
10 nonparticipating hospital got Step 1 or Step 2
11 imputation?

12 A. I don't know enough about what those different
13 scenarios are on the website, so I can't.

14 Q. Do you have any reason to believe that Leapfrog
15 actually communicates to the consumer that Wood hospital
16 or Austin hospital got Step 1, as opposed to Crain
17 hospital Step 2?

18 MS. LAWSON: Object to form. Go ahead.

19 THE WITNESS: To answer that, I would need to
20 see an example of a hospital that had Step 1 imputation.

21 BY MR. CRAIN:

1 Q. Okay. But you have no reason today to think
2 that there is any difference in the presentation?

3 A. I don't know whether there is or is not.

4 Q. Okay.

5 Where on the page in front of you does it
6 say how the score was assigned?

7 A. Can you clarify that question?

8 Q. Yes.

9 So you pointed to the asterisk on this
10 package, right, and it says a score was assigned, right?

11 A. Correct.

12 Q. And you said you had a role in at least
13 reviewing that asterisk, right?

14 A. I don't know that that's true or not true.

15 Q. Okay. You said you had a role in reviewing
16 something on this page.

17 A. I reviewed the descriptions underneath
18 handwashing and what safer hospitals do.

19 Q. Got it. But you don't recall whether you
20 reviewed the asterisk?

21 A. Correct.

1 Q. Okay.

2 So it says a score was assigned, right?

3 Where does it say how the score was assigned?

4 A. Can you clarify the "how"?

5 Q. Sure. I'll give you an example. This was --
6 let's say a hospital is assigned a score through Step 1.

7 Where would it say that on this page?

8 A. I don't know where Leapfrog chose to put that.

9 Q. Okay.

10 Where does it say that Delray received a
11 score under Step 2?

12 A. That's what the asterisk is noting is that it
13 was -- they declined to report their performance, so a
14 score was assigned to reflect the lack of information
15 available.

16 Q. So you're saying that somebody reading that
17 will understand that the assignment of the score was
18 under Step 2?

19 MS. LAWSON: Object to form.

20

21 BY MR. CRAIN:

1 Q. Is that what you're saying?

2 A. I don't know how people read and interpret
3 things.

4 Q. Okay.

5 Do you think this is a clear explication of
6 how the score was assigned?

7 A. I think it puts in words what Leapfrog did. It
8 puts Step 2 into words.

9 Q. How does it put Step 2 into words?

10 A. There was a lack of information available --

11 Q. Uh-huh.

12 A. -- so a score was assigned to reflect the lack
13 of information.

14 Q. But a score could be assigned in any way,
15 right? How would a consumer know that it was assigned
16 with an automatic limited achievement?

17 MS. LAWSON: Object to form.

18 THE WITNESS: From the text that's there and
19 the asterisk, I'm not sure they would know how that was
20 assigned.

21 BY MR. CRAIN:

1 Q. Okay. Thank you.

2 And are you aware of any other page on
3 Leapfrog's website where that's explained besides
4 Exhibit 3, the methodology document?

5 A. I don't know if it is or not.

6 Q. Okay.

7 MR. CRAIN: Okay. Let's -- let's see. How
8 long have we been going? About an hour. Are you good
9 to keep going, or do you want a break?

10 THE WITNESS: Yep. I'm good.

11 MS. LAWSON: I was going to say can we take a
12 quick break?

13 MR. CRAIN: Yeah, that's fine. It's been about
14 an hour. It's not an endurance test.

15 THE VIDEOGRAPHER: This marks the end of media
16 unit number five. We're off the record. The time is
17 2:13 p.m.

18 (Whereupon a short break was had, after
19 which the proceedings continued as
20 follows:)

21 THE VIDEOGRAPHER: This marks the beginning of

1 media unit number six. We're going back on record. The
2 time is 2:38 p.m.

3 BY MR. CRAIN:

4 Q. So Dr. Austin, we were talking about the
5 website, and I think that's what you have in your hand.
6 You can put that aside for now. We're going to go back
7 to what we were talking about before we went down the
8 website rabbit hole.

9 You recall we were looking at Ms. Binder's
10 edits to the -- the public comment document. Do you
11 recall that?

12 A. Yes.

13 Q. Okay.

14 I just want to show you another email.

15 MR. CRAIN: This will be Exhibit 20.

16 (Exhibit No. 20 was marked for
17 identification as of 9/25/2025.)

18 BY MR. CRAIN:

19 Q. All right. Dr. Austin, you see the document,
20 the email at the top is from you?

21 A. Yes.

1 Q. Okay. Do you recognize this email thread?

2 A. Yeah. It's a continuation of the prior one.

3 Q. Yeah, the one -- the prior one being where

4 Ms. Binder gave her comments, right?

5 A. Correct.

6 Q. And do you see Ms. Danforth forwards you

7 Ms. Binder's email that we were looking at before, and

8 she says, "Hi, Matt. Since she mostly updated the parts

9 Peter and Patrick helped with, you can take a look and

10 let us know if you have any concerns? We'd love to get

11 this out Monday or Tuesday next week."

12 Do you see that?

13 A. Yes.

14 Q. First of all, does this refresh your

15 recollection as to whether Peter and Patrick helped with

16 this document?

17 A. Yeah. I will take it at its value or face

18 value. That's what it says, so that's what they had

19 done.

20 Q. And Peter refers to Dr. Pronovost?

21 A. Correct.

1 Q. And Patrick refers to Dr. Romano?

2 A. Correct.

3 Q. Okay. Both of whom have been involved with
4 Leapfrog for many years, right?

5 A. Correct.

6 Q. And you respond at 4:25. Do you see that?

7 A. Yes.

8 Q. And you say, "My only note is the "why" has
9 been edited out the explanation. So you don't really
10 explain why this change is being done. But it reads
11 fine. No concerns." Do you see that?

12 A. Yes.

13 Q. So you noted that the "why" was edited out,
14 right?

15 A. Yes.

16 Q. Would you have preferred to keep it in?

17 A. Prefer is, perhaps, a strong term. The
18 communication is coming from The Leapfrog Group, so they
19 get the final call on what it says. I thought it was --
20 it would be stronger to sort of explain why we were
21 doing this.

1 Q. So you thought -- okay. Got it.

2 And why did you think it would be stronger
3 to explain why you were doing it?

4 A. I think generally people like a context to why
5 something is being done.

6 Q. Would it have been more transparent to explain
7 the reasoning?

8 A. I don't know if transparent is the word I would
9 use for that. It would have been more complete.

10 Q. Okay.

11 Okay. You can set that one aside.

12 Let's see. So just going back to the
13 comment document, right, that we saw. You're aware that
14 it was issued to the public, right?

15 A. Yes.

16 Q. And you're aware that the public commented on
17 the proposal, right?

18 A. Yes.

19 Q. Did you have any role in reviewing the
20 comments?

21 A. I don't remember.

1 Q. Okay. Do you remember anything about the
2 comments generally?

3 A. I don't.

4 Q. Okay. Let's take a look at some and just see
5 if it jogs your memory.

6 MR. CRAIN: Iason, can you give me 45.

7 This will be Exhibit 21.

8 (Exhibit No. 21 was marked for
9 identification as of 9/25/2025.)

10 BY MR. CRAIN:

11 Q. Okay. Exhibit 21. So take a look at this
12 document, Dr. Austin. Do you recognize it at all?

13 A. I do not.

14 Q. Okay. I'm just going to read -- this is an
15 email from the Leapfrog help desk to Ms. Campione. I'm
16 just going to read -- do you see down the page it says
17 Becky Wenthold?

18 A. Yes.

19 Q. And she said, "I was [sic.] disappointed with
20 the 2024 proposed changes. These changes will penalize
21 hospitals that do not submit a Leapfrog survey. The

1 public will not understand nor dig into the methodology
2 of these grades, and hospitals will be falsely
3 represented with a lower grade because they choose not
4 to complete a survey. The survey is extremely time
5 intensive and, in a time when hospitals are barely
6 breaking even financially, they do not have the
7 resources to commit to this survey."

8 Do you see that?

9 A. Yes.

10 Q. You don't recall comments to this effect?

11 A. I do not remember reviewing Ms. Wenthold's
12 comments.

13 Q. Do you recall any other comments?

14 A. I don't remember reviewing the comments.

15 Q. Do you recall comments in favor of the change?

16 A. I don't remember seeing the comments that came
17 in from the public comment period.

18 Q. Okay. So just to close the loop, you have no
19 memory either way?

20 A. I have no memory of seeing them, but I see a
21 lot of information and a lot of -- so if someone

1 produced something and said I had reviewed it, it's
2 probably true, but I don't remember reviewing the
3 comments.

4 Q. Okay. It's possible but you just don't have a
5 recollection?

6 A. Correct.

7 Q. Okay.

8 And fair to say you disagree with what I
9 read, with her comment, or no?

10 MS. LAWSON: Object to form but go ahead.

11 BY MR. CRAIN:

12 Q. I can rephrase if it's helpful.

13 A. Could you rephrase?

14 Q. Yeah.

15 Is there any portion of what I read to you
16 from her comment that you agree with?

17 A. Of the sentences you've read or the ones that
18 go beyond that?

19 Q. Will your answer change?

20 A. It will.

21 Q. Okay. Start with the sentences I've read.

1 A. The sentences you have read, obviously, the
2 first sentence is her own opinion of what she sort of
3 sees the situation as. I don't disagree that the
4 changes will penalize hospitals that don't submit a
5 Leapfrog survey.

6 Q. Okay.

7 A. Her statement about the public won't understand
8 or dig into the methodology of these grades, I'm not
9 sure her nor I really know that to be the truth.

10 Q. Okay.

11 A. Hospitals will be falsely represented with a
12 lower grade I don't think is necessarily a truthful
13 statement.

14 Q. Is it possible because you don't know the
15 actual performance of nonrepresenting hospitals --
16 nonparticipating hospitals, excuse me?

17 A. Correct. So if she said possibly represented
18 with a lower grade.

19 Q. So let me ask it this way. Is it possible that
20 at least some hospitals will be falsely represented with
21 a lower grade than they otherwise would achieve based on

1 performance?

2 A. Right. So imputation by definition is trying
3 to estimate performance, and there is almost, by
4 definition, going to be some error, and that error may
5 be in the measured entity's favorite. It may be in the
6 measured entity's unfavor or disfavor.

7 But, I mean, it's imputation, right. So we
8 don't know the answer. So, therefore, we're trying to
9 estimate or guess an answer. So by definition,
10 imputation is going to have an error associated with it.

11 So when we were imputing higher scores with
12 a means for many hospitals, there was an error
13 associated with that as well.

14 Q. So it's your testimony that imputation is an
15 estimation of actual performance?

16 A. Correct.

17 Q. And is that true with regard to the automatic
18 assignment of limited achievement?

19 A. If we're imputing a score like we were doing
20 with limited achievement, there is the possibility for
21 error.

1 Q. So my question is a little bit different. So
2 let's break it down a little bit.

3 A. Okay.

4 Q. In the prior model for imputation, prior to
5 2024, let's go prior to 2021, you used American Hospital
6 Association data -- we had our aha moment -- to impute a
7 score for the hospitals, right?

8 A. Correct.

9 Q. Okay. And was that an estimation based on the
10 AHA data?

11 A. Yes.

12 Q. Okay.

13 Then when you get to 2024, you impute
14 limited achievement, correct?

15 A. Correct.

16 Q. Is that an estimation of performance or no?

17 A. That is an estimation of performance.

18 Q. Okay.

19 So going back to the website we looked at,
20 again for Delray you impute limited achievement on
21 handwashing, right?

1 A. Correct.

2 Q. So you are saying that's an estimation of their
3 actual performance on handwashing?

4 A. Yes.

5 Q. Okay. And that, again, is based on no data to
6 support it, right?

7 A. That is based on a lack of data.

8 Q. Yes. Okay. But it's an estimate, right?

9 A. It's an estimate.

10 Q. Okay.

11 Okay. Let's go back to the comment.

12 A. Okay. This extremely time intensive, once
13 again, extremely is a relative term, so I don't know how
14 Ms. Wenthold would define extremely.

15 Q. How would you characterize the burden?

16 A. What I hear from hospitals or I've heard from
17 hospitals is that it takes about 40-person hours to
18 complete it the first time but that in future years, as
19 hospitals refine their internal processes for reporting,
20 that that burden decreases.

21 Q. Okay. And which hospitals have you heard that

1 from?

2 A. I've heard that from Johns Hopkins Hospital
3 when I queried them on that question. I've heard that
4 from other hospitals that I couldn't necessarily name,
5 but that's just from poor memory.

6 Q. Fair enough.

7 Ballpark, how many did you ask?

8 A. I've maybe have heard that from three or four.

9 Q. Okay.

10 So going back to the comment.

11 A. Yeah. So what I would -- she is correct that
12 there is no option for the submission for a survey for a
13 health system; that Leapfrog's policy, since its
14 inception, has been for each individual brick and mortar
15 hospital to complete its own survey.

16 And her statement about excellent outcomes
17 will no longer be able to receive an A is actually
18 incorrect because there were two hospitals that actually
19 did get an A that did not complete a survey.

20 Q. Nationwide, right?

21 A. Nationwide.

1 Q. And that was on that first email we looked at
2 where you were pulling information --

3 A. Yes.

4 Q. -- for the lawsuit, right?

5 A. Yes.

6 Q. Just to make sure, I think that was Exhibit 1.

7 Okay. That's helpful.

8 MR. CRAIN: Okay. Let's go to tab 47. This
9 will be Exhibit 22.

10 (Exhibit No. 22 was marked for
11 identification as of 9/25/2025.)

12 BY MR. CRAIN:

13 Q. I'm sorry. This one is very small.

14 Dr. Austin, this is another comment, which
15 I think was submitted through what I believe is
16 Leapfrog's Zendesk platform. Do you see that?

17 A. Yes.

18 Q. My guess is -- have you not -- have you seen
19 this document before?

20 A. No, I haven't.

21 Q. Okay. So I want to just take you to the

1 bottom, and I think that's the comment. Do you see it's
2 from it looks like Alana Noble?

3 A. Yes.

4 Q. And she says, "We strongly disagree with the
5 proposed Fall 2024 Step 2 imputation. If Leapfrog is
6 going to implement this change, they need to offer
7 hospitals an option to opt out of being graded rather
8 than penalize a hospital for not submitting the resource
9 intensive survey. The survey is very resource intensive
10 outside of existing regulatory, quality operations and
11 quality improvement efforts. Hospitals that do not have
12 the resources to do the survey annually should not be so
13 adversely punished, especially in the post-COVID era
14 when resources are increasingly hard to come by and
15 retain."

16 And my question to you is: Why can't
17 Leapfrog give hospitals an option to opt out of being
18 graded?

19 MS. LAWSON: Object to form.

20 You can answer.

21 BY MR. CRAIN:

1 Q. To your understanding.

2 MS. LAWSON: I mean to your understanding.

3 BY MR. CRAIN:

4 Q. It's always to your understanding.

5 A. Right.

6 So the impetus for the Hospital Safety
7 Grade -- let me take us back a little bit in time.

8 So since 2001, Leapfrog has been doing a
9 voluntary survey of hospitals around quality and safety
10 practices. It has collected those data and made those
11 publicly available. One of the concerns for that model
12 is Leapfrog was collecting a lot of different data
13 points and reporting those out as individual data
14 points.

15 And what we know from conversations with
16 consumers and patients is that they strongly prefer
17 composite scores, star ratings, letter grades, that they
18 find that much more digestible.

19 Q. Easier to understand?

20 A. Easier to understand.

21 In addition to wanting to move towards a

1 letter grade, Leapfrog also wanted to -- the model that
2 Leapfrog was working from was the restaurant ratings in
3 like New York City, Los Angeles, right, where the health
4 department comes in. They do an assessment of the
5 restaurant, and the hospital has to post a letter grade
6 in their window with an A, a B, or a C.

7 And one of Leapfrog's board members
8 supposedly thought, oh, wouldn't it be great if we could
9 ask hospitals to do the same thing around the idea of
10 patient safety.

11 The concern with making it voluntary is
12 that it is a relative score, right. So the methodology
13 is such that hospitals are being compared to the
14 national mean, the standard deviation of the national
15 sample. And so it would be difficult to issue grades if
16 we were pulling from a selected subset of hospitals.

17 Q. Is that still true today where 80 percent of
18 inpatient beds are I think represented on the Leapfrog
19 survey?

20 A. So I see that as a little bit of a chicken and
21 egg situation.

1 Q. Okay. Tell me why.

2 A. That if Leapfrog made it voluntary, one
3 potential consequence of that would be fewer hospitals
4 would report to the survey, and, therefore, you would
5 lose that 80 percent capture that is currently there.

6 Q. Is it fair to characterize that as a slippery
7 slope problem?

8 A. I don't know how to characterize a slippery
9 slope.

10 Q. Okay.

11 I guess what I mean by that is you're
12 suggesting that if you make it voluntary, the number
13 20 percent of inpatient beds that were not responding
14 would increase, right?

15 A. That could be a potential consequence.

16 Q. Okay.

17 So to encourage greater participation, it
18 cannot be voluntary. Is that right? Take your time.

19 A. So one of the challenges Leapfrog was trying to
20 address with the Hospital Safety Grade was that there
21 had been a plateauing of hospital participation in the

1 survey.

2 Q. Okay.

3 A. And, therefore, we only had quality and safety
4 information for a -- not a small, a fraction of the
5 hospitals in the United States. And so by making it
6 nonvoluntary was an opportunity to have safety
7 information out there about as many hospitals in the
8 U.S. as possible.

9 And so if you make it voluntary, you sort
10 of defeat that goal of trying to have safety information
11 for as many as possible.

12 Q. Has that goal overtaken any goal to report
13 accurately on safety?

14 A. No.

15 Q. Okay. And why is that? Because -- strike
16 that.

17 We've talked a lot about how there are
18 errors, right, with any imputation methodology. Isn't
19 the most accurate way to get safety information out
20 there to not impute?

21 A. Can you rephrase the question?

1 Q. Yeah.

2 A. Or not rephrase but repeat the question.

3 Q. Oh, repeat? Yeah, repeat I can do because I
4 have the realtime.

5 We've talked a lot about how there are
6 errors with any imputation methodology, correct?

7 A. Correct.

8 Q. Isn't the most accurate way to get safety
9 information out there to not impute?

10 A. Are we discussing the scores, or are we
11 discussing the grades?

12 Q. Let's do both. Start with the score.

13 A. So for the score, I think that would have a
14 little more of an influence -- let me say that again.
15 The decision to impute a score would impact the overall
16 score.

17 Q. The overall grade?

18 A. The overall -- so just to clarify, when we
19 calculate the grade, what we're actually calculating is
20 a score, a numerical score. So each hospital has a
21 numerical score that's calculated. Those numerical

1 scores then get converted into letter grades.

2 Q. Yes. Got it.

3 A. So the letter grade, by definition, is a range
4 of scores, right. So it's less sensitive to the
5 decision to impute one measure or not to impute a
6 measure.

7 If we're talking about the actual numerical
8 score, the accuracy would be improved without
9 imputation.

10 Q. Okay.

11 So is it right that Leapfrog has
12 prioritized as a goal increasing participation as
13 compared to the accuracy of the score?

14 A. So when you say participation, what are you
15 referring to?

16 Q. Participation in the survey. Let me rephrase
17 it so it's clear.

18 Is it fair to say that Leapfrog has
19 prioritized encouraging greater participation in the
20 survey as compared to greater accuracy in the scoring of
21 a safety grade?

1 A. I don't see it as an absolute tradeoff in that
2 way.

3 Q. Okay. Is it -- why is that?

4 A. Because I think you can work towards both
5 goals. I don't think you necessarily have to completely
6 have one goal be worked towards at the detriment of the
7 other goal.

8 Q. You don't think that's what's happening with
9 imputation?

10 A. So to be clear, the decision to impute scores
11 is primarily driven by the desire to have more accuracy
12 in what we are issuing as a score grade. A potential
13 benefit of that is that hospitals may choose to come in
14 and report to the survey.

15 So that's why I don't see them as
16 necessarily diametrically opposed goals.

17 Q. Is the most accurate way to score excluding
18 imputation altogether?

19 A. Yes. As previously stated, you would have a
20 more accurate score without imputation.

21 Q. Okay.

1 And so going -- I don't know if I got an
2 answer to this question, though, but let me just be
3 really clear. So this comment says if Leapfrog is going
4 to implement this change, they need to offer hospitals
5 an option to opt out, right?

6 First, I guess stepping back, do you recall
7 any discussion of an opt out internally to either the
8 expert panel or Leapfrog?

9 A. No. That's never been the conversation.

10 Q. Okay. And why can an opt out not be provided?

11 A. If -- is your question is it possible for
12 Leapfrog to implement an opt out?

13 Q. Well, so --

14 A. Or --

15 Q. Yeah, fair question.

16 So there's the question of whether it's
17 physically possible. I assume it's physically possible
18 to implement an opt out, right?

19 A. Yes.

20 Q. Yeah.

21 Why does -- to your knowledge, why does

1 Leapfrog feel it can't allow an opt out?

2 A. This is my own speculation because I have not
3 discussed with Leapfrog this scenario. One might be
4 concerned that if you allow hospitals to opt out, most
5 of them will, and now what is your rating program if you
6 don't have many participates.

7 Q. And it's also -- what is your rating program,
8 meaning the grade, the survey, or both?

9 A. Potentially both.

10 Q. And going back to the restaurant analogy. You
11 mentioned the L.A. restaurant grades. Do you think
12 that's a fair analogy to what Leapfrog is able to do?

13 MS. LAWSON: Object to form.

14 BY MR. CRAIN:

15 Q. To your knowledge.

16 A. So Leapfrog can't require hospitals to post a
17 letter grade in their window.

18 Q. It also, unlike a regulatory agency, can't
19 compel participation, right? As a legal matter, right?

20 A. I will defer to lawyers on that.

21 Q. Fair enough. Okay.

1 Let me ask --

2 A. Leapfrog, what it's doing is it's using
3 publicly available data to make an assessment of a
4 hospital's patient safety performance.

5 Q. And it's also using the lack of data, right, to
6 make an assessment of performance?

7 A. That's using what data are available.

8 Q. Yeah.

9 A. And in some situations, that is data that's not
10 available.

11 Q. Yeah. Okay.

12 Okay. You can set that one aside.

13 I want to talk a little bit about the
14 imputed measures themselves so -- and we talked about
15 earlier in the day, it feels like hours ago, BCMA, CPOE,
16 IPS, and hand hygiene, right?

17 A. Correct.

18 Q. So I've been trying to understand why are those
19 the four that are imputed as compared to the three what
20 I called earlier in the day discarded measures. You may
21 feel free to call them something else, but why are those

1 different?

2 A. It is somewhat a function of historical
3 artifact and when the measure was introduced to the
4 Leapfrog Hospital Survey. So within those three
5 measures, we put the two safe practices into one bucket
6 and hand hygiene in the other bucket.

7 Q. Okay.

8 A. The safe practices I put in the sort of
9 historical artifact bucket in that when the decision was
10 to move towards secondary data sources, like the aha,
11 AHA hospital survey --

12 Q. That's my favorite.

13 A. There wasn't any data within that AHA survey
14 that matched up with those safe practices. Like, there
15 was nothing about leadership. There was nothing about
16 culture measurement.

17 So at that time, the decision was, okay,
18 we're going to continue to hold those in the
19 we're-just-going-to-ignore-the-measure-if-you-don't-have
20 -it bucket, which was the original imputation.

21 That historical sort of artifact has just

1 sort of rolled forward.

2 Q. Okay. Fair to say it was grandfathered in?

3 A. Yeah. It's a historical artifact of where we
4 started and where we're at.

5 The nursing workforce --

6 Q. Yep.

7 A. -- was just recently introduced to the Leapfrog
8 Hospital Survey, and the collective wisdom was perhaps
9 we don't have enough experience in data with that to
10 impute scores.

11 Q. So very helpful on the three.

12 I want to ask you also about the four, why
13 they are imputed, and I have a document that I think
14 might help us in what I've been trying to figure out.

15 MR. CRAIN: So this will be Exhibit 23.

16 (Exhibit No. 23 was marked for
17 identification as of 9/25/2025.)

18 BY MR. CRAIN:

19 Q. So this is another Armstrong-produced document.
20 You see that on the bottom, right?

21 A. Yes.

1 Q. And it's one of your notes to yourself. Do you
2 see that?

3 A. Yes.

4 Q. And it says: "Notes for today's call with
5 Dr. Romano." [sic] Right?

6 A. Yes.

7 Q. Okay.

8 April 12th, coincidentally, 2019. Do you
9 see that? I say coincidentally because the expert panel
10 meeting was also April 12th.

11 A. Okay.

12 MS. LAWSON: Of 2024.

13 MR. CRAIN: Yeah, of 2024. Sorry. It was my
14 own aha moment.

15 BY MR. CRAIN:

16 Q. So going down, you say, "Patrick, to guide
17 today's call, I put together some quick notes." Do you
18 see that?

19 A. Yes.

20 Q. And I can't tell if you sent this to him or
21 they were just talking points. Any sense?

1 A. They were notes for myself, I believe, for the
2 conversation with Dr. Romano.

3 Q. And do you remember this conversation? Feel
4 free to take a second to read through it if it's
5 helpful.

6 (Witness peruses document.)

7 THE WITNESS: Okay.

8 BY MR. CRAIN:

9 Q. Do you remember the context of this discussion?

10 A. I don't with certainty but based on the --

11 Q. Context clues?

12 A. -- context clues, it would be to talk about
13 maybe changing the imputation approach --

14 Q. And --

15 A. -- and missing data thresholds.

16 Q. Okay.

17 And you see it mentions AHA responses sort
18 of towards the bottom third of the page?

19 A. AHA responses?

20 Q. There's a bullet that says exceptions are BCMA.

21 A. Yes.

1 Q. Okay.

2 And just stepping back for a second, do you
3 recall a time where Leapfrog no longer had access to the
4 AHA data?

5 A. There was a point where AHA revoked Leapfrog's
6 license to use the data.

7 Q. Do you know why they did that?

8 A. My understanding is they had gotten -- strike
9 that.

10 I don't know why AHA revoked the license.

11 Q. When you said "my understanding," did you have
12 something that you heard about it?

13 A. I had heard that, you know, they were getting
14 complaints from their member hospitals about how those
15 data were being used by Leapfrog.

16 Q. Got it.

17 And complaints with respect to the
18 imputation into the methodology?

19 A. Complaints on two fronts. One was how the data
20 were being translated into scores for Leapfrog. Also,
21 some of the hospitals' data were pretty old, and they

1 felt like it was outdated and there really wasn't a
2 mechanism for them to update it. And there were sort of
3 logistical challenges, and my understanding is I think
4 AHA was like, we're out.

5 Q. We're out of this business?

6 A. Right -- what's that?

7 Q. We're out of this business?

8 A. We're out of this business.

9 Q. And when you say old, so I know like CMS data
10 has a lag, right? Yes?

11 A. Some of it does, yes.

12 Q. Was the AHA data a bigger lag than CMS?

13 A. I don't know the exact lag period for the AHA
14 survey.

15 Q. And what you had heard about why the AHA did
16 not want to license anymore, do you recall who that came
17 from?

18 A. The information that I heard from?

19 Q. Yeah, that you just shared with us about --

20 A. From Missy Danforth.

21 Q. Got it. Okay. So Ms. Danforth told you that.

1 Do you know where she got it?

2 A. I don't know.

3 Q. Okay.

4 Anything else you remember about why AHA
5 stopped licensing?

6 A. That's all I'm aware of.

7 Q. Okay.

8 So I want to look specifically at -- you
9 see in this document imputing data?

10 A. Yes.

11 Q. If you go down to the third bullet -- well,
12 let's go to the second bullet first for context. It
13 says: "Current Approach: Exclude the measure and
14 recalibrate the weights for the affected hospitals using
15 only those measures for which data are available."

16 Do you see that?

17 A. Yes.

18 Q. And can you sort of translate what that means?

19 A. Yeah. So the earliest approach of imputation
20 that we followed was to -- if a hospital was missing a
21 measure, we ignored that measure and we redistributed

1 the weights to other measures for which they did have
2 data.

3 Q. Okay.

4 And then there's a -- the next bullet says
5 exceptions, right?

6 A. Correct.

7 Q. And it says: "Exceptions are BCMA, CPOE, and
8 IPS, in which case we have created crosswalks between
9 the AHA responses and Leapfrog performance categories."

10 Do you see that?

11 A. Yes.

12 Q. What does the crosswalk mean?

13 A. The crosswalk was we looked at -- for hospitals
14 that reported to both the AHA survey and to the Leapfrog
15 Hospital Survey, we were able to compare their responses
16 on both and understand in an aggregate way what the
17 relationship was between a hospital's responses to the
18 AHA survey and how they were performing on the Leapfrog
19 Hospital Survey standards.

20 Q. So just to rearticulate, is it fair to say that
21 you had identified that the AHA data was a reasonable

1 enough proxy for the BCMA, CPOE, and IPS scores for
2 Leapfrog?

3 A. In our review and discussions of the AHA
4 survey, we felt like it represented a reasonable
5 approximation of the same quality -- or the same safety
6 standards.

7 Q. And is that the original reason why those three
8 became imputed measures, as opposed to discarded
9 measures?

10 A. Yes.

11 Q. Okay.

12 After Leapfrog lost the AHA data, do you
13 recall any time at which other crosswalks were
14 considered?

15 A. We explored other potential secondary data
16 sources. I can specifically remember having lots of
17 calls with HIMMS, H-I-M-M-S, which is a technology
18 consortium, to see if we could get relevant data related
19 to computerized physician order entry. And as we
20 reviewed their data, we didn't feel confident in that it
21 was getting us the same thing that we needed.

1 So we explored other options, just nothing
2 met.

3 Q. Okay.

4 So is it fair to say that those three
5 measures were essentially grandfathered in from the
6 period in which Leapfrog was using AHA as the crosswalks
7 to the Leapfrog scores?

8 A. We had been imputing scores for those measures
9 using the AHA datasets. That would be true.

10 Q. And it was grandfathered into the next
11 instantiation of the imputation methodology?

12 A. I would need to have better notes on what was
13 the next phase of the imputation methodology --

14 Q. Okay.

15 A. -- to remember what came next after that.

16 Q. Fair enough. Fair enough.

17 So subsequently -- like, the current
18 methodology still imputes on these three measures,
19 right?

20 A. Correct.

21 Q. Is there any particular reason, except for the

1 historical fact of Leapfrog having those crosswalks to
2 the AHA data, that those three are imputed as opposed to
3 other measures that are discarded that you're aware of?

4 A. I could argue that there is, perhaps, some
5 clinical, additional clinical relevance to those. I
6 mean, they do get higher weights in the safety grade.
7 They have been shown to be more effective as it relates
8 to safety and improving safety. So that's what I would
9 speak to.

10 Q. So my question is a little different, though.
11 You are, I think, providing a reason for why those are
12 valuable measures, right?

13 A. Correct.

14 Q. And, in fact, I could show you websites. I'll
15 just represent to you that sometimes Leapfrog puts out
16 information that says those are among the most important
17 measures. It sounds like you might agree with that?

18 A. Correct.

19 Q. Yeah. And they're significantly weighted,
20 right?

21 A. They have higher weights than some other

1 measures.

2 Q. I think the four imputed measures are
3 approximately a quarter to 30 percent of the grade. Are
4 you aware of that?

5 A. I couldn't agree or disagree with that.

6 Q. I mean, it's in the methodology document.

7 A. Right.

8 Q. We can set it aside. I'm not trying to, you
9 know, test you on it. It's all right.

10 So you're giving me reasons for why they
11 are important measures, correct? I want to know the --
12 whether there's an empirical reason or an evidence-based
13 reason for continuing imputation of them outside of the
14 crosswalks that we see in this email.

15 MS. LAWSON: Do you understand the question?
16 Are you clear on what the question is?

17 THE WITNESS: I think I am.

18 MS. LAWSON: Okay. I think he's asking is
19 there a historical -- like, other than the historical
20 experience --

21 MR. CRAIN: I think I'd asked just for no

1 speaking objections or coaching.

2 MS. LAWSON: Yeah, but I just want to make sure
3 that he's clear because we're covering this a second
4 time. We've asked it a -- you know, and I understand.
5 So I understand what your question is, and I just want
6 to make sure he understands so he can answer what you're
7 asking.

8 BY MR. CRAIN:

9 Q. Let me ask it again because I want to make sure
10 the record is clear.

11 So I said: You're giving me reasons for
12 why they are important measures, correct?

13 A. Correct.

14 Q. And I want to know whether there is an
15 empirical reason or some evidence-based reason for
16 continuing to impute these three measures in this email
17 outside of the crosswalks that Leapfrog had identified
18 between the AHA responses and Leapfrog performance
19 categories.

20 A. So the reason it would be important to keep
21 those measures in and to be imputed is because they have

1 a significant impact to patient safety. So to create a
2 composite score that doesn't include those measures
3 would be missing some very key components.

4 Q. For Step 2, where you're automatically
5 assigning limited achievement, doesn't that rationale
6 cut the other way?

7 A. I would disagree. We're actually imputing a
8 score for those because those measures are important.

9 Q. So I take it that those measures are important.
10 Set that aside for a second.

11 We've talked about the limited achievement,
12 right, the automatic assignment is not grounded in any
13 actual evidence about a given hospital's performance,
14 right, today?

15 A. The imputation is -- has an error component to
16 it by definition.

17 Q. Yes. So just -- I want you to answer my
18 question yes or no. The automatic assignment is not
19 grounded in any actual evidence about a given hospital's
20 performance today, correct?

21 A. Can you repeat that?

1 Q. Yeah. Glad to.

2 The automatic assignment of limited
3 achievement for the four imputed measures for a
4 nonparticipating hospital is not grounded in any actual
5 evidence about a nonparticipating hospital's performance
6 today, correct?

7 A. Back to the earlier point, we know the hospital
8 is not being transparent about their safety performance
9 and that safety is an important component of a culture
10 of safety.

11 Q. Okay. So I'll go down the line. An automatic
12 assignment of limited achievement for BCMA is not
13 grounded in any actual facts about a hospital's
14 performance on BCMA, right?

15 A. An imputed score is based on an assumption.

16 Q. Okay. And not actual facts on the ground about
17 performance, right?

18 A. Correct.

19 Q. Okay.

20 A. And that's true of all imputation.

21 Q. It wasn't necessarily true when you had the

1 crosswalks, right?

2 A. That's not completely true.

3 Q. Okay. Explain it for me.

4 A. Because when we had the crosswalks, we were
5 looking at large numbers of hospitals. So we might have
6 had 500 hospitals that reported to both the Leapfrog
7 Hospital Survey and the AHA survey. What we looked at
8 was what was basically the average performance.

9 If a hospital answered this in the AHA
10 survey, how did they, on average, perform on the
11 Leapfrog Hospital Survey? Some of the hospitals
12 performed better. Some performed worse. So there is a
13 degree of error there in imputation.

14 Q. But you had some sort of analysis to build that
15 out, right?

16 A. We had some secondary data sources to help us
17 inform those imputed scores.

18 Q. And today, for the methodology, there is no
19 secondary data source to help you inform the imputed
20 assignment of limited achievement?

21 A. Correct.

1 Q. Okay.

2 So is it fair to say that the reason these
3 three remain as imputed measures is largely, as you said
4 for the other ones, a historical artifact or no?

5 A. I think it's a combination of historical
6 artifact and their importance to the broad concept of
7 patient safety.

8 Q. Got it. Okay. So they're significant, so
9 Leapfrog didn't want to lose them, and also they had
10 been imputing based on other secondary data sources.
11 That combination is why they are still imputed measures
12 today. Is that fair?

13 A. Fair.

14 Q. Okay.

15 Why hand hygiene, which is not represented
16 here? Can you give me the history of that one?

17 A. So hand hygiene was introduced to the Leapfrog
18 Hospital Survey after -- well, don't quote me on this.
19 I believe after the AHA had pulled their data license.

20 Q. Okay. Got it.

21 Okay. So you had no opportunity to create

1 the crosswalk, correct?

2 A. Correct.

3 Q. Okay.

4 I want to show a document. So talking
5 about hand hygiene, again, is it your testimony today
6 that the limited achievement automatic assignment of
7 hand hygiene for nonparticipating hospitals in Step 2 --
8 stay with me -- is an accurate reflection of a
9 hospital's hand hygiene performance, an accurate
10 estimation?

11 A. My testimony is that it's an imputed score for
12 that hospital's performance on hand hygiene.

13 Q. And is it an accurate estimation of their
14 performance on the ground?

15 A. Imputation, by definition, has error.

16 Q. Okay. So for certain hospitals it may be
17 inaccurate?

18 A. Correct.

19 Q. Okay.

20 So I want to look at --

21 MR. CRAIN: This will be Exhibit 24.

1 (Exhibit No. 24 was marked for
2 identification as of 9/25/2025.)

3 BY MR. CRAIN:

4 Q. This is an Armstrong-produced document. Do you
5 see that on the bottom right?

6 A. Yes.

7 Q. And the top email is from you to a group of
8 folks at Leapfrog, I think, and Preeti Joshi. Do you
9 see that? And maybe a couple others.

10 A. Yes.

11 Q. And there's an attachment. It says: Leapfrog
12 Hand Hygiene Report Analysis June 3, 2024. Do you see
13 that?

14 A. Yes.

15 Q. And you write to the group, "As a follow-up
16 from our meeting a few weeks ago, attached are the
17 requested analyses for the hand hygiene report. I think
18 the analyses are pretty self-explanatory, but we are
19 happy to have a call to review if that would be
20 helpful."

21 Do you see that?

1 A. Yes.

2 Q. And then you go in I guess starting with --
3 first question: Did you draft -- I'm looking at page
4 5116. Do you see that?

5 A. Yes.

6 Q. Did you draft what looks like it's titled
7 Leapfrog Hand Hygiene Analysis for Landslide Report?

8 A. Preeti Joshi did this.

9 Q. Okay. Did you review it?

10 A. Yes.

11 Q. Okay. And what was the purpose of this
12 document?

13 A. Leapfrog was interested in putting out a
14 national report on its hand hygiene standard and where
15 hospitals had -- how they've improved over time on the
16 standard.

17 Q. Okay.

18 And so you go, it looks like to me, you go
19 question by question through the Leapfrog survey. Is
20 that right?

21 A. We looked at it both at the individual question

1 level -- yes. In this first part, it's looking at each
2 individual question.

3 Q. Okay. And fair to say for some questions there
4 is pretty -- you know, there's change between 2020 and
5 2023, and for others there's less change. Is that
6 right? I can be more concrete.

7 MS. LAWSON: I was going to object to form
8 there.

9 MR. CRAIN: Fair enough. I'll take it back.

10 BY MR. CRAIN:

11 Q. So question number one is provision of hand
12 hygiene training. Do you see that?

13 A. Yes.

14 Q. And in 2020, it looks like 92.8 percent --
15 well, tell me what the percentage reflects.

16 A. Yeah, that represents the percentage of
17 hospitals -- yeah, the denominator is the number of
18 hospitals that submitted responses to the hand hygiene
19 section of the Leapfrog survey. So the numerator would
20 be those that answered yes, that they meet Leapfrog's
21 requirements for that question.

1 Q. So 92.8 percent of hospitals in 2020 responding
2 to the survey met question one. Is that right?

3 A. Yes.

4 Q. Okay.

5 And that increases to 96.8 percent in 2021,
6 96.8 percent in 2022, and 97.9 percent in 2023. Do you
7 see that?

8 A. Yes.

9 Q. Okay.

10 And I guess the question that I have on any
11 of these, really, is: Is it your assumption that a
12 hospital that is not participating in the survey will
13 perform worse than these numbers as compared to the
14 participating hospitals?

15 A. Can you say that one more time, please?

16 Q. Yeah. So I'm trying to get at -- let's back up
17 a little bit.

18 So I'm trying to understand why Leapfrog
19 imputes for hand hygiene, right. And my question is it
20 seems like, at least based on this analysis, that most
21 hospitals, at least that report, do fairly well on the

1 hand hygiene questions. Is that fair to say or no?

2 A. So Leapfrog actually has fairly high standards,
3 and so for a hospital to meet a domain, they actually
4 have to answer "yes" to all of the questions in that
5 domain.

6 So, for example, in domain training and
7 education, only 85.7 percent answered yes to question
8 two in 2023. So at most, 85.7 percent of hospitals meet
9 that domain, and it's probably something less than that,
10 right.

11 So looking at individual questions may not
12 be the most accurate indicator of how hospitals are
13 doing on each of the domains as Leapfrog has defined
14 them.

15 Q. Okay. So in each of these four domains, you're
16 saying only the lowest denominator respondent are those
17 that passed the domain?

18 A. The lowest percentage within a domain would be
19 the absolute ceiling of the percentage of hospitals that
20 can meet that domain.

21 Q. Got it. Okay.

1 So for domain one, the most -- the highest
2 number of hospitals that would have met that domain are
3 85.7 percent of responding hospitals in 2023, correct?

4 A. Correct.

5 Q. Okay.

6 And do you have any basis to suggest that
7 nonperforming hospitals would be so much worse in
8 performance than 85.7 percent?

9 A. We don't have any information to know how they
10 would perform.

11 Q. So why is it fair to those hospitals to give
12 them the lowest score when the gross majority of
13 hospitals, at least in this domain, pass?

14 MS. LAWSON: Object to form. Go ahead.

15 THE WITNESS: So there are 15 percent of
16 hospitals, at least, that are not meeting the domain,
17 right. So how would we know if hospitals that don't
18 report are part of that 15 percent or part of the
19 85 percent?

20

21 BY MR. CRAIN:

1 Q. You don't know either way, right?

2 A. We don't know either way.

3 Q. Okay. But you assume that the hospitals in
4 that domain that are not reporting are necessarily part
5 of the 15 percent, right?

6 A. We don't have any information about those
7 hospitals, so we are imputing a score.

8 Q. You're imputing a score that estimates that
9 their performance is failing, essentially?

10 A. That they are in the bottom performance
11 category.

12 Q. Okay.

13 And then if you go to domain two, this is
14 infrastructure, do you see that?

15 A. Yes.

16 Q. And this is things like hand sanitizers?

17 A. Correct.

18 Q. Okay.

19 Forgive the question, but have you ever
20 been to a hospital for care?

21 A. Yes.

1 Q. Do you recall any room that you were in without
2 a sanitizer?

3 MS. LAWSON: Object to form.

4 THE WITNESS: So the Leapfrog survey questions
5 about hand sanitizers are fairly specific about the
6 location of them, whether they produce the correct
7 amount of alcohol-based hand gel, and whether or not the
8 hospital does audits to know if they actually have hand
9 gel in them. Because I think we've all experienced
10 going up to one and nothing comes out.

11 BY MR. CRAIN:

12 Q. Not fun.

13 A. So there is more than just about do you have
14 hand sanitizer dispensers. There's a lot more to that
15 standard.

16 Q. Fair enough.

17 So taking your bottom number, if you look
18 at domain two, this would imply that 90.5 percent, at a
19 maximum, passed this domain, right?

20 A. Ninety-one -- 90.5 --

21 Q. Ninety point five, right.

1 A. -- in 2023 --

2 Q. In 2023, correct.

3 A. -- would be the absolute ceiling.

4 Q. Yes.

5 Do you have any sense for what the number
6 actually is for the number of hospitals that passed this
7 domain?

8 A. I don't know offhand.

9 Q. Okay. Fair to say it's likely quite high
10 because of these numbers?

11 MS. LAWSON: Object to form but go ahead.

12 THE WITNESS: Yeah, I mean, I could -- you
13 know, you could assume that all of these were
14 independent, and if you multiply them together, you
15 would come up with an answer that's somewhere in the
16 63 percent, which is probably the floor. So it's
17 somewhere between 63 and 90.5.

18 BY MR. CRAIN:

19 Q. Okay.

20 So but, again, for hospitals that don't
21 participate, for this domain, effectively, they get the

1 lowest possible score, right?

2 A. So to be clear, the hand hygiene standard has
3 five domains. For a hospital to be in achieved the
4 standard, they need to -- if they're only collecting 100
5 hand hygiene observations a month, they need to meet all
6 five domains, which means they're saying "yes" to every
7 single question.

8 Q. Okay.

9 A. Seventy-four percent of hospitals in 2023
10 achieved the standard, so 26 percent did not.

11 Q. Yep. Okay. And that achieved the standard is
12 the highest, right?

13 A. Correct.

14 Q. Then how do you quantify the next three down?

15 A. We have a scoring algorithm that's available
16 online that details that. I couldn't recite what that
17 is, but the idea is basically if you meet a subset of
18 the domains, you get one category; if you meet fewer
19 domains, you get a lower category.

20 Q. Okay.

21 A. It's sort of assessed at the domain level but

1 then it rolls up into an overall score.

2 Q. Okay. No, fair enough.

3 So I guess then my question is why is hand
4 hygiene one of the imputed measures and not one of the
5 discarded measures?

6 A. Because its clinical relevance to patient
7 safety is paramount.

8 Q. Okay.

9 So, again, it's the same point. When we
10 talked about the other three, there were two reasons.
11 The first was the historical what I call grandfathering
12 in combined with the significance, right?

13 A. Correct.

14 Q. For this one, there's no historical, but it's
15 just, you're saying, it's so important, Leapfrog feels
16 it has to impute?

17 A. Correct.

18 Q. Okay. Okay. Let's leave it at that.

19 A. Okay.

20 MR. CRAIN: All right. I think we've been
21 going about an hour. Do you mind if we take a break?

1 MS. LAWSON: That's fine.

2 MR. CRAIN: Okay. Courtney, are you good?

3 MS. WOOD: Uh-huh.

4 THE VIDEOGRAPHER: This marks the end of media
5 unit number six. We're going off the record. The time
6 is 3:26 p.m.

7 (Whereupon a short break was had, after
8 which the proceedings continued as
9 follows:)

10 (Exhibit No. 25 was marked for
11 identification as of 9/25/2025.)

12 THE VIDEOGRAPHER: This marks the beginning of
13 media unit number seven. We're going back on the
14 record. The time is 3:43 p.m.

15 BY MR. CRAIN:

16 Q. Thank you, Dr. Austin.

17 So I've handed you what has been marked as
18 Exhibit 25. Do you see that document?

19 A. Yes.

20 Q. And this is an email from you to what I think
21 is the safety grade expert panel. Do you see that?

1 A. Yes.

2 Q. Okay. And the subject is: Final updates to
3 Leapfrog Hospital Safety Grade methodology for Fall of
4 2024. Do you see that?

5 A. Yes.

6 Q. And generally, can you tell me what this email
7 is?

8 A. This email is an email to the expert panel with
9 the attachment of the final updates to the safety grade
10 methodology for Fall of 2024.

11 Q. Okay. And you say, "Based on the expert
12 panel's thoughtful input and guidance, Leapfrog has
13 decided to move forward with updates to imputation
14 methodology used in the Hospital Safety Grade, effective
15 Fall '24." Do you see that?

16 A. Yes.

17 Q. Okay. Fall of 2024. Sorry. I think I said
18 that wrong. Do you see that as well?

19 A. Yes.

20 Q. Okay.

21 Now, just for the record, I want to be

1 clear. Did Leapfrog decide to adopt this methodology,
2 or did the expert panel decide to adopt it?

3 A. Leapfrog makes all the decisions about their
4 ratings and ratings programs. The work of the expert
5 panel, expert panels, myself, is all in a recommendation
6 advisory capacity.

7 Q. Okay. And are you aware of any document in
8 which the expert panel weighed in on this final proposal
9 as a group?

10 A. Not that I am aware of. Not that I'm aware of.

11 Q. Okay.

12 Do you know sitting today whether the
13 entire expert panel approved of this path forward?

14 A. We did not query the expert panel about whether
15 they approved this or not.

16 Q. Okay. Is it your view that they did approve
17 it?

18 A. It is -- from my point of view, we heard their
19 input and guidance. Leapfrog made a decision of how it
20 wanted to move forward, and we communicated that to the
21 expert panel.

1 Q. Okay.

2 Okay. All right. You can set that aside.

3 MR. CRAIN: Okay. I want to move on to another
4 topic. Tab 15, please. This will be Exhibit 26.

5 (Exhibit No. 26 was marked for
6 identification as of 9/25/2025.)

7 BY MR. CRAIN:

8 Q. All right. So Dr. Austin, you have in front --
9 well, what do you have in front of you?

10 A. I have in front of me our 2013 prepublished
11 ahead of print publication from the Journal of Patient
12 Safety.

13 Q. And we talked about this document a little bit
14 earlier today, right?

15 A. Correct.

16 Q. Okay. This is the document that was peer
17 reviewed that analyzed the methodology at least as it
18 stood back in 2023, right?

19 A. This was the methodology in 2012, early 2013.

20 Q. Okay. And you are the lead author on this
21 paper, correct?

1 A. Correct.

2 Q. As well as it looks like other folks on the
3 expert panel, safety grade expert panel?

4 A. Correct.

5 Q. And I see, for instance, Dr. Romano is here,
6 right?

7 A. Correct.

8 Q. Okay.

9 I want to ask you a few questions about
10 this. I'm going to go to -- starting at the top, do you
11 see the little -- on the left side at the top it says
12 "Methods."

13 A. Yes.

14 Q. And it says: "The Leapfrog Group sought advice
15 [sic.] from a panel of national patient safety experts
16 to develop a composite score." Do you see that?

17 A. Yes.

18 Q. Does that describe generally what this paper is
19 about?

20 A. The paper describes how -- the process Leapfrog
21 used to develop a composite score.

1 Q. Okay. And it says, the next sentence --

2 A. And we do some analyses of early rounds of the
3 grades to demonstrate what that looks like.

4 Q. Some early rounds of the grades to
5 demonstrate -- say more about what you mean.

6 A. Yeah. So let me look in the -- so we had done
7 some data analysis using composite safety scores for
8 2,652 general acute care hospitals, and we calculated
9 safety scores for those.

10 Q. Okay.

11 A. And we show that in figure one.

12 And then in tables two and three, we did
13 some analysis to look at how those safety scores varied
14 by different hospital characteristics, as well as by
15 state in the United States.

16 Q. Okay. And this is the document that we saw
17 that was linked to Leapfrog's website, right?

18 A. Correct.

19 Q. Okay.

20 I want to go to page 4, and I think it's
21 Bates number 668.

1 A. Yes.

2 Q. And there's a section, Dealing with Missing
3 Data. Do you see that?

4 A. Yes.

5 Q. And it says: "Although the expert panel
6 selected nationally reported measures, some data were
7 missing for hospitals that did not report to The
8 Leapfrog Group, and other data were missing because
9 hospitals did not meet CMS's minimum sample requirements
10 to publicly report their results."

11 Do you see that?

12 A. Yes.

13 Q. So this is the section that's, for lack of a
14 better word, dealing with missing data, right?

15 A. Correct.

16 Q. Okay.

17 So the next paragraph lays out, what it
18 looks like, five possible approaches for assessing
19 hospital performance when data were missing. Do you see
20 that?

21 A. Yes.

1 Q. Okay. And I'm going to not march through, but
2 it looks like number four is: "Give the hospital zero
3 credit for the measure." Do you see that?

4 A. Yes.

5 Q. And that's not -- Leapfrog has never done zero,
6 right?

7 A. Correct.

8 Q. They've done limited achievement, correct?

9 A. Correct.

10 Q. Okay. And limited achievement, just to be
11 clear, is the lowest measure, which can range anywhere
12 from 5 to 25 depending on the measure, right?

13 A. Correct.

14 Q. Okay.

15 And then number five says: "Exclude the
16 measure and recalibrate the weights for the affected
17 hospitals using only those measures for which data are
18 available." Right?

19 A. Correct.

20 Q. Now, the -- if you look at -- further down
21 there's a paragraph that says "After." Do you see that?

1 A. Yes.

2 Q. Okay. And it says: "After conducting
3 sensitivity analyses using each of the above approaches,
4 the panel recommended approach number five to address
5 missing data, excluding the measure for a hospital and
6 recalibrating the weights for those measures for which
7 performance data were available, for most measures."

8 Do you see that?

9 A. Yes.

10 Q. Okay. And was that generally the approach that
11 Leapfrog took in the ensuing years?

12 A. That was the approach Leapfrog used initially
13 with the hospital safety grades.

14 Q. Okay.

15 A. As previously mentioned, Leapfrog has evolved
16 its imputation approaches, working through actually at
17 least four out of the five here.

18 Q. Fair enough, yeah. So it's been a moving
19 target.

20 A. It's been evolving.

21 Q. Evolving. Fair enough.

1 So then the paragraph keeps going. The
2 next sentence is -- let's see. It's on the top of page
3 4 on the right side. "In this way." Do you see that?

4 A. Yes.

5 Q. "In this way, we avoided making questionable
6 assumptions about the performance of hospitals with
7 missing data, and we also maintain variation of the
8 final calculated scores by not imputing identical values
9 for all missing observations."

10 Do you see that language?

11 A. Yes.

12 Q. Okay.

13 So at least as of 2013, Leapfrog -- this
14 group of authors peer reviewed, came to the conclusion
15 that excluding the measure was the way to avoid making
16 questionable assumptions about the performance for
17 hospitals. Do you see that?

18 A. Yes.

19 Q. Okay. That changed, right?

20 A. That has evolved.

21 Q. Okay. Is it your view that Leapfrog is making

1 questionable assumptions today about the performance of
2 hospitals?

3 A. I don't believe that to be true.

4 Q. Okay. What's changed between this analysis and
5 today?

6 A. So what has changed is that the -- that we've
7 actually evolved through different imputation
8 approaches. So we started with number five, right.
9 Then we moved to number two, imputing based on other
10 available data. Then we moved to number one, which is
11 imputing performance at the national mean or median,
12 although we did that by cohorts. And then we eventually
13 landed here now at number three, which is imputing a
14 score above or below the median or mean.

15 So all of these are valid imputation
16 approaches. I think the choice of an imputation
17 approach needs to be in the context of sort of time,
18 place, situation.

19 So in 2012, when Leapfrog rolled out these
20 hospital safety grades, hospitals did not know these
21 were coming. So that needed to be sort of the context

1 in which an imputation decision was made.

2 If we fast-forward to 2024, now we've been
3 issuing safety grades for 25 rounds. Hospitals are very
4 aware of the grades. They're very aware of the measures
5 that go into the survey, and so you might have your
6 imputation approach evolve with that.

7 Q. So the assumptions change?

8 A. I don't know if assumptions have changed, but
9 the context has changed.

10 Q. So let me -- so first going back, you said
11 number three, impute a score above or below the median
12 or mean; e.g., minus one standard deviation. Do you see
13 that?

14 A. Yes.

15 Q. That's not what Leapfrog does today, right?

16 A. It is imputing a score below the mean.

17 Q. Below the mean, fair, but not by one standard
18 deviation, right?

19 A. That was just an example of how that could be
20 operationalized.

21 Q. The measure of limited achievement is more than

1 one standard deviation below, right?

2 A. I have not looked at a distribution of scores
3 to be able to answer that.

4 Q. Do you have an estimate as to what -- how much
5 lower than the standard deviation below -- one standard
6 deviation below the mean it is?

7 A. I don't know what that would be.

8 Q. Okay.

9 Okay. So going back, do you recall what
10 the questionable assumption the authors were worried
11 about in this paper was?

12 A. So I think the biggest concern was around
13 option number four, which would be to give the hospitals
14 zero credit for not reporting to Leapfrog.

15 Q. Why is that the biggest concern?

16 A. That was a concern in that hospitals didn't
17 know that this was coming, that we weren't really being
18 fair to hospitals to just assign zero right from the
19 get-go for not reporting.

20 Q. Is it more fair to assign -- would it be more
21 fair to assign zero now?

1 A. From my point of view, it feels like the
2 context and times have changed, and so I would say, yes,
3 that would feel like a more fair decision to make.

4 Q. More fair. Okay.

5 Is it more or less fair than limited
6 achievement?

7 A. It's probably less fair to assign zero than
8 limited achievement. With limited achievement,
9 hospitals are getting some credit. They're not getting
10 zero credits.

11 Q. No one gets zero, right?

12 A. No one gets zero.

13 Q. Okay. Zero is not an available score, correct?

14 A. Correct.

15 Q. Okay.

16 Then so the questionable assumption, just
17 to make sure I understand it, is about the startup of
18 the safety grade, as opposed to assumptions about
19 performance generally?

20 A. It's assumptions about the rollout of the
21 imputation and whether or not it was fair to assign a

1 score that penalized hospitals when they didn't know
2 that the safety grades were coming.

3 Q. Do you know if that language is in this paper?

4 A. I'm not sure that that -- I would have to
5 reread it.

6 Q. I mean, if you want to take a second and read
7 this section, which I think is the only section dealing
8 with this and just goes to the next page, I'm curious
9 does it articulate that as the questionable assumption
10 in here.

11 A. So in the -- that paragraph at the top of page
12 4, in the second paragraph it says: Finally, the third
13 and fourth approaches were rejected to avoid creating a
14 structural bias in favor of Leapfrog reporting
15 hospitals.

16 So as I mentioned, there was a concern
17 about doing that right from the get-go.

18 Q. But that doesn't say get-go, though. It's
19 talking about reporting versus nonreporting, right?

20 A. It was at that -- the article was written at a
21 point in time with experience only up until that point

1 of time, and that was our experience up 'til that point.

2 Q. Is there any structural bias today in favor of
3 reporting hospitals?

4 A. There are hospitals that report to the Leapfrog
5 Hospital Survey that score limited achievement. So a
6 score of limited achievement is not just for hospitals
7 that don't report. There are some hospitals that report
8 that receive that score as well.

9 Q. What does structural bias mean?

10 A. I guess in that context I would think of it as
11 some sort of bias in how we assign scores based on
12 whether they report or don't report to Leapfrog.

13 Q. And so based on that definition, you're still
14 maintaining there's no structural bias in favor of
15 reporting hospitals?

16 A. Based on what we just discussed, I would say
17 there is a structural bias against nonreporting
18 Leapfrog -- nonreporting hospitals.

19 Q. Okay. There is a structural bias?

20 A. There is a structural bias.

21 Q. Okay. That makes sense. Okay.

1 And that's one of the reasons this group of
2 authors, which included yourself and many of the safety
3 grade expert panelists, like Dr. Romano, rejected this,
4 it looks like, the third and four approaches, right?

5 A. At that point in time.

6 Q. Okay. And your position is the structural bias
7 has changed?

8 A. It's not that it has changed. It is more
9 apparent and can be addressed, right. So in the early
10 days of the safety grade, hospitals didn't even know
11 these grades were coming. A lot of them had never
12 completed the Leapfrog Hospital Survey.

13 Fast-forward 12 years, we're in a different
14 place where hospitals are very aware of the safety
15 grades. They're very aware of the survey, and so the
16 context has changed.

17 Q. So just to be clear, when you say addressed,
18 that's not addressing within the methodology. That's an
19 addressing in the context of hospitals could decide to
20 report?

21 A. Correct.

1 Q. Got it.

2 So the methodology doesn't take any
3 measures to address that structural bias?

4 A. Correct.

5 Q. Okay.

6 Okay. And then the other -- if you keep
7 going on that paragraph, it says: "By scoring hospitals
8 on" -- tell me when you're ready.

9 "By scoring hospitals on the available
10 data, the composite scores were based on what was known
11 about the hospital's performance, with no penalties for
12 missing data."

13 Do you see that?

14 A. Yes.

15 Q. Okay. Now, that also is different for today,
16 right?

17 A. That is different than today.

18 Q. Okay.

19 And at this time, scoring hospitals based
20 on what was known about the hospital's performance was
21 something this group of authors deemed advisable, right?

1 A. So to be clear, what we're representing is the
2 Hospital Safety Grade methodology. Not all authors were
3 part of the expert panel. And just to remind you, all
4 of the decisions about the methodology are ultimately
5 Leapfrog's to make.

6 Q. Yes.

7 A. So what we're writing up is the implications of
8 that decision. So when you asked about whether authors
9 agreed, to me it's not an agreement or disagreement.
10 It's were we stating what the facts were at that time.

11 Q. Okay. No, that's fair. So I got it. So
12 you're saying it's an empirical observation?

13 A. Correct.

14 Q. So the observation is by scoring hospitals on
15 the available data, the composite scores were based on
16 what was known about the hospital's performance with no
17 penalties for missing data. You're saying, just to make
18 sure I understand, you're not making a judgment about
19 whether that's good or bad. You're saying it's what's
20 being done?

21 A. Correct.

1 Q. Okay. Got it.

2 Now, this is the paper that Leapfrog touts
3 as having peer reviewed its methodology, right?

4 A. Correct.

5 Q. But there are multiple components, at least in
6 this paragraph that we've seen, that don't apply
7 anymore, right?

8 A. There are -- can you repeat the question?

9 Q. So we've walked through this paragraph about
10 different observations, the questionable assumptions,
11 the structural bias, and then the penalties for missing
12 data, all of which you said are not what Leapfrog does
13 today. They're not reflective of the methodology
14 Leapfrog uses today, correct?

15 A. Correct.

16 Q. Is it fair to say that this paper is a peer
17 reviewed assessment of the methodology today?

18 A. I'm going to be a little careful because I
19 don't know if Leapfrog's website says that it's a peer
20 reviewed of today, right. It's a peer reviewed of their
21 methodology, right.

1 So I'll go back to the previous point that
2 I think the overall structure of the composite score,
3 that it's based on two domains of measures, the data
4 sources, we're going to do relative weights, has
5 remained consistent and constant through time.

6 Have some of the individual decisions about
7 imputation -- obviously, some of that has evolved and
8 changed. So I don't know how to say whether or not it's
9 a fair representation of Leapfrog's methodology or not.

10 Q. Do you agree, yes or no, that Leapfrog's
11 current methodology has been peer reviewed?

12 A. Are you speaking of the Fall 2024 methodology?

13 Q. The one that's operative today.

14 A. I think it sort of depends on your definition
15 of what we mean by methodology. And I don't mean to get
16 into semantics, but I would still come back to like the
17 general structure of all of this is still the same.
18 Some of the nuance differences are different, but that
19 happens continuously throughout the last 12 years.

20 So I don't know how you would write a new
21 paper every time we change one measure or re-weight one

1 measure.

2 Q. So we talked about, maybe an hour ago, that the
3 imputed measures are significant, right?

4 A. I don't know if that's what we discussed.

5 Q. Okay. You talked about how they're
6 clinically -- they matter, right?

7 A. Correct. They're important elements of patient
8 safety.

9 Q. Yes.

10 A. Yes.

11 Q. And they weight quite heavily, right?

12 A. They make up somewhere between 20 and
13 30 percent.

14 Q. Yes, as we talked about.

15 A. Yeah.

16 Q. Is it -- so 30 percent, 20 to 30 percent of the
17 methodology is derived from an imputation model that
18 this paper did not comment on, correct?

19 MS. LAWSON: Object to form. Go ahead.

20 THE WITNESS: As listed under the imputation
21 methods, one of them is exactly what we're doing today.

1 BY MR. CRAIN:

2 Q. Which one? Three?

3 A. Number three.

4 Q. Okay. Impute a score below the mean, correct?

5 A. Correct.

6 Q. Okay. I guess this doesn't say how much far
7 below, right?

8 A. Correct.

9 Q. Because if the means that we saw earlier from
10 Ms. Campione's emails were in the 70s, 80s, and 90s, and
11 the imputation is 15, was that the type of difference
12 below the mean that you were contemplating when you
13 wrote this piece?

14 A. I think there was room for -- there was room
15 for decisions to be made around number three and what
16 sort of score above or below the mean or median. The
17 minus one standard deviation was just an example.
18 Obviously, number four is a more extreme example of
19 zero. So there's a range of options in between those
20 two.

21 Q. Okay.

1 So then I guess going back to my question,
2 we've talked about the imputation methodologies being 20
3 or 30 percent, being significant. Is it fair to say
4 that the current methodology has been peer reviewed
5 given that that substantial portion of it was never
6 reviewed?

7 A. I don't know how to answer that. I feel like
8 it is fair to say that because the primary structure of
9 the methodology has remained the same. Now, others
10 could have a different assessment of that. Some could
11 say, oh, wow, the imputation approaches make this
12 nonrepresentative. I guess that's just a disagreement
13 in how maybe we see the world.

14 Q. Okay. Fair enough.

15 So let me ask this question. The
16 imputation model, has that been peer reviewed?

17 A. No.

18 Q. Okay.

19 Okay. You can set that aside.

20 MR. CRAIN: Let's go to tab 21. This will be
21 Exhibit 27.

1 (Exhibit No. 27 was marked for
2 identification as of 9/25/2025.)

3 BY MR. CRAIN:

4 Q. Okay. So this is another, you see at the
5 bottom, Armstrong-produced document?

6 A. Yes.

7 Q. Do you recognize this one?

8 A. Yes. Well, it's been a while.

9 Q. What does it look like?

10 A. It says it's the meeting agenda. What it
11 actually represents is notes from the meeting.

12 Q. Maybe somebody built out the notes within the
13 agenda?

14 A. Correct.

15 Q. Okay.

16 A. And we just forgot to change the title.

17 Q. Any reason to think this isn't a true and
18 accurate depiction?

19 A. No.

20 Q. So I just have a couple of questions. If you
21 go to -- where is it again -- page 76, do you see theirs

1 is a big, bold "Unintentional consequences of how we
2 currently treat missing data"? Do you see that header
3 on page -- it's the first page?

4 A. Yes.

5 Q. Okay. And I want to go to page 2. And do you
6 see the bullet number two?

7 A. Yes.

8 Q. It says: "Imputation of the score when we have
9 missing data."

10 A. Yes.

11 Q. And it says: "Matt mentioned that expert panel
12 discussed this in the past and did not feel it supported
13 the goal of the safety grade." Do you see that?

14 A. Yes.

15 Q. So I want to break this down a little bit.

16 Now, do you recall making this statement at
17 an expert panel meeting? I recognize it's a while ago.

18 A. I don't remember --

19 Q. Okay.

20 A. -- that conversation.

21 Q. Is it accurate, to the best of your knowledge

1 today, that, looking at the top bullet, imputation of
2 the score when you have missing data is something the
3 expert panel discussed in the past?

4 A. So, yes, we have discussed imputation with
5 them.

6 Q. Okay. Just to build out the --

7 A. Right. Yes, that's fine.

8 Q. Just to get on the same page.

9 A. Yes.

10 Q. And now it says: Did not feel it supported the
11 goal of the safety grade.

12 A. I don't know what that refers to.

13 Q. Okay.

14 A. I will take ownership that the note-taking here
15 may not have been all that accurate, because I don't
16 even know what that refers to because I don't think they
17 -- they have never indicated that imputing scores
18 doesn't support the goal of the safety grade.

19 Q. Okay.

20 A. So I'm thinking that there might have been some
21 nuance to that that wasn't captured in the notes.

1 Q. What could the goal have been referring to?

2 A. I don't know for sure.

3 Q. Okay.

4 So if you go to the next bullet, do you see
5 how -- "Imputing scores for individual measures, like
6 safe practices, would incentivize them to report on the
7 survey." Do you see that?

8 A. Yes.

9 Q. First of all, does that reflect that the safety
10 grade expert panel considered imputing for safe
11 practices?

12 A. That was something that was, I guess, discussed
13 at that meeting.

14 Q. And as we talked about before, was decided
15 against, right?

16 A. Leapfrog has never imputed scores for --

17 Q. Safe practices?

18 A. -- safe practices.

19 Q. One or two?

20 A. One or two.

21 Q. Now, imputing -- it says: "Imputing scores for

1 individual measures would incentivize them to report on
2 the survey." Is that different from the goal reflective
3 in bullet one?

4 A. That I don't know how those connect.

5 Q. We've talked a little bit today about what the
6 goals of the safety grade are. I think we've talked
7 about information, right, as one goal, getting
8 information out there, correct?

9 A. Correct.

10 Q. We've talked about accuracy as another goal,
11 correct?

12 A. Yes.

13 Q. Are there any other goals that you can think
14 of, of the safety grade, that we haven't -- besides
15 those two?

16 A. None come to -- immediately come to mind.

17 Q. Okay.

18 So looking at this bullet, you noted
19 earlier today you endeavor to be accurate in these
20 notes, right?

21 A. That is our goal.

1 Q. And goal -- we talked about goals.

2 So you have no recollection or
3 understanding as to why imputation, at least at this
4 time, would be deemed not supportive of the goal of the
5 safety grade, at least the two goals that we've talked
6 about?

7 A. Yeah. I do not understand how that note ties
8 to everything else I know and understand.

9 Q. Okay. So you just don't remember, or it just
10 doesn't make sense anymore?

11 A. I don't remember what that was intending to --

12 Q. To say?

13 A. To say.

14 Q. Okay. I have to ask.

15 Okay. Let me just see. Yeah. Okay. You
16 can set that aside.

17 MR. CRAIN: And then just one more historical
18 document. Can we do tab 30. This is Exhibit 28.

19 (Exhibit No. 28 was marked for
20 identification as of 9/25/2025.)

21

1 BY MR. CRAIN:

2 Q. Dr. Austin, you have in front of you an email
3 thread between you, Ms. Danforth, Mr. Card, and Emma
4 Domico. Do you see that?

5 A. Correct.

6 Q. Who is Emma Domico?

7 A. Emma was the research analyst who was working
8 for me at the time on the Leapfrog contract.

9 Q. What Ms. Joshi does now?

10 A. Correct. She was in between Jordan and Preeti.

11 Q. Got it.

12 And who is Mr. Card?

13 A. Mr. Card worked for The Leapfrog Group and was
14 the analyst who was supporting the Hospital Safety
15 Grade. So he preceded Alex.

16 Q. Got it.

17 So I want to just look -- so it's a little
18 bit of a confusing email, but I'm going to walk you
19 through at least how I think I read it. So go to the
20 bottom, which is the first one.

21 A. Yes.

1 Q. And it's from you and it's dated August 25th,
2 2021, right?

3 A. Yes.

4 Q. And just for context, is this around the time
5 where AHA was rescinding the license?

6 A. I don't know -- I don't know the timing of the
7 AHA license.

8 Q. Okay. Do you remember generally what was
9 happening in 2021?

10 A. I don't other than COVID was.

11 Q. Fair enough. We all remember that one.

12 A. Yeah, but I don't remember what -- I don't
13 remember the timing of the AHA data because that was all
14 between Leapfrog and --

15 Q. Got it. Okay.

16 So I will at least represent to you that
17 this was -- well, we'll go through the document.

18 A. Okay.

19 Q. So you write -- you say, "Missy, Andrew: Next
20 Friday is the HSG" -- Hospital Safety Grade. Yes? Is
21 that right?

1 A. Yes.

2 Q. Okay.

3 A. Correct.

4 Q. -- "expert panel call. As Emma and I were
5 walking through agenda items, we would benefit from your
6 input/expertise." Do you see that?

7 A. Yes.

8 Q. And I want to focus on number two and start
9 with the bold. Do you see there's two pieces of text.
10 There's a bold and a sort of grayer one on each line?

11 A. Yes.

12 Q. Okay. So let's start with the bold. You say,
13 number two: "How to score hospitals missing
14 process/structural measures. Are we looking for
15 suggestions on imputation methods?" Do you see that?

16 A. Yes.

17 Q. And then if you go to four, it says:
18 "Penalizing hospitals if they don't report. Is this
19 part of agenda item number two? And is Leapfrog really
20 open to this idea? If not, I don't want to keep asking
21 their opinions."

1 Do you see that?

2 A. Yes.

3 Q. Now, we'll come back to this, but I just want
4 to explain to you what the gray is. So if you go one
5 up, the prior page, you see Ms. Danforth writes: "See
6 below"?

7 A. Yes.

8 Q. Okay.

9 So the gray, is it correct to say, those
10 are her comments interlined with your agenda?

11 A. Yes.

12 Q. Okay.

13 So on number two, she says in response to
14 your agenda point, she says, "Yes, and the idea to
15 impute for all missing, including safe practices and HH.
16 I will send a follow-up to the email that Andrew sent."

17 So can you tell me generally what are you
18 proposing as an agenda item, and what did you
19 understanding her response was?

20 A. So what we were proposing as an agenda item was
21 to discuss with the expert panel our imputation methods

1 for process and structural measures.

2 Q. Okay.

3 A. And Missy suggested back the idea that maybe we
4 impute for all missing, including safe practices and
5 hand hygiene.

6 Q. Okay.

7 And then if you go to four, you say -- you
8 have a separate agenda item, right?

9 A. Correct.

10 Q. And it says: "Penalizing hospitals if they
11 don't report. Is this part of agenda item number two?
12 And is Leapfrog really open to this idea?" You all caps
13 "really." Do you see that?

14 A. Yes.

15 Q. So why were you all capping really?

16 A. So back to attachment 27, back to Old Town
17 Alexandria, the Hilton, that was actually a point where
18 the expert panel actually brought up the idea of moving
19 towards an imputation approach where -- to penalize
20 hospitals --

21 Q. Okay.

1 A. -- if they didn't complete the Leapfrog
2 Hospital Survey.

3 So even though it got implemented in 2024,
4 as far back as 2017 conversations were happening about
5 whether or not this was the direction to go into.

6 Q. Okay.

7 A. So in 2021, it was like, is Leapfrog open to
8 this? Are they not open to this? I don't want to keep
9 asking the expert panel over and over again about this
10 if Leapfrog is not open to moving in this direction.

11 Q. Okay.

12 A. So that was the intent of that.

13 Q. And by this direction, you mean a penalty?

14 A. It could be a penalty. It could be an
15 imputation below the mean or median. It could take many
16 different forms, and I don't think a specific proposal
17 had been floated at that point.

18 Q. Okay.

19 And then -- so look at her response. She
20 says: "Remove. This is really covered in number two."
21 Do you see that?

1 A. Correct.

2 Q. Okay. And it sounds like you agree with that?

3 A. Well, I agree that that decision is part of
4 imputation, right. So as we go back to the five
5 imputation methods, number three was one of the possible
6 options, right. So that is part of the imputation
7 discussion is do we impute that a hospital is an average
8 performer? Do we impute that they're a better
9 performer? Right? Like, those are all decisions around
10 imputation.

11 Q. So and when you say "those," you mean the
12 decision of whether to penalize a hospital is part of
13 the analysis of how to impute or whether to impute?

14 A. So there were a couple of approaches that could
15 be taken, right. So if we go back to number 27, Old
16 Town Alexandria, one suggestion from the expert panel
17 was, well, would we want to assign some sort of explicit
18 negative penalty.

19 So we wouldn't necessarily work that into
20 the imputation of individual scores, but we would take
21 so much off of the final score for not being

1 transparent. So that was one idea of how that could be
2 manifested. This could be other ways of manifesting it.

3 Q. Yeah. No, I get that. I'm just trying to
4 understand. So the agenda item number two is how to
5 score hospitals missing process and structural measures.
6 Do you see that?

7 A. Correct.

8 Q. And the question of penalizing hospitals is
9 bound up in that discussion as well, correct?

10 A. I think what Missy was saying is she didn't see
11 that as being a unique part of the agenda, that that
12 would be -- could be incorporated into number two.

13 Q. Well, she said covered in number two, right?

14 A. Correct.

15 Q. And you agree with her?

16 A. I would agree that that, as we've discussed,
17 that that is an option for imputation.

18 Q. And is it fair to say over the years when this
19 topic has come up, the notion of penalizing hospitals
20 has been covered by the topic in number two?

21 A. It's been brought up in that space, yeah.

1 Q. Okay. Okay.

2 Let me take another look. I think that may
3 be it for this email. Yeah, we can set this one aside.

4 So I'm going to shift gears again. We're
5 getting there.

6 A. How many gears are there on this car?

7 Q. I've got a lot of gears. I've got a lot of
8 gears. We're getting close to the end gear. I've only
9 got so much time.

10 I want to talk about the 2019 white paper.

11 A. Okay.

12 Q. Okay? Oh, you seem excited for it.

13 A. I love it.

14 Q. Okay.

15 MR. CRAIN: So I want to start with -- let's go
16 to tab 58. And this is Exhibit 29.

17 (Exhibit No. 29 was marked for
18 identification as of 9/25/2025.)

19 BY MR. CRAIN:

20 Q. So, Dr. Austin, you see this is an email from
21 you to Ms. Campione, Ms. Danforth, and Ms. Bailey from

1 2025.

2 A. Yes. So this is not in reference to the
3 2019 --

4 Q. Yes.

5 A. -- report.

6 Q. It's the lives saved, lives lost, right?

7 A. Correct.

8 Q. Okay. This was the update you were talking
9 about, right?

10 A. This is the update that we've worked on but
11 have not published.

12 Q. Okay. I want to walk through this one, if I
13 can.

14 A. Okay.

15 Q. Okay. So maybe I was a little unfair. I'm
16 starting with 2025 and then I want to lead into the
17 white paper --

18 A. Okay.

19 Q. -- but I want to talk about your numbers here.

20 A. Okay.

21 Q. Okay?

1 So let's go to page -- so I want to look
2 at -- you see Ms. Campione's email on the bottom? It's
3 from her to you, and there's a table on page 0900. Do
4 you see that?

5 A. Yes.

6 Q. Okay. Now, this table -- tell me what this
7 table is.

8 A. So what this table represents is for three
9 points in time, 2016, 2019, and 2025, we have estimated
10 the number of lives lost due to preventable medical
11 mistakes that are captured through the Leapfrog Hospital
12 Safety Grade measures.

13 We also have estimated the number of lives
14 that could be saved if "B," "C," "D," and "F" hospitals
15 all performed as well as "A" hospitals. So we've
16 estimated that at three different points in time.

17 We also have done relative comparisons
18 between "B" and "A" hospitals, "C" and "A", "D" and "A"
19 and "F", and then we break the numbers down.

20 Q. So the chart that we're looking at here on page
21 0900, is it correct that the 2016 column reflects the

1 analysis done on the 2016 white paper, and the 2019
2 reflects the update?

3 A. Correct.

4 Q. Okay. And 2025 reflects, at least in draft
5 form, what the current numbers would be?

6 A. They represent, if we were to maintain the same
7 methodology we used in 2019, what the numbers would look
8 like in 2025.

9 Q. Okay. Can you -- and I'm happy to give you
10 documents if it's helpful, but can you generally
11 describe what that methodology is?

12 A. Yep.

13 Q. And if you need a document, we can get you that
14 document.

15 A. No, no. I can.

16 So what we do is for each grade, "A", "B",
17 "C", and we lump "D" and "Fs" together --

18 Q. Why is that?

19 A. Primarily due to small sample sizes of "F"
20 hospitals.

21 Q. Got it.

1 A. We're looking at less than 20 or 25.

2 Q. Okay.

3 A. For each of the outcome measures that are
4 included in the Hospital Safety Grade, we calculate a
5 mean incidence rate for each cohort of hospitals. So
6 "A" hospitals, how do they do on foreign objects
7 retained? "B" hospitals, how do they do on foreign
8 objects retained?

9 So we have basically an estimated incidence
10 rate of these events by hospitals.

11 Q. And just to translate that, estimated incidence
12 rate means how many times this thing happened?

13 A. Correct.

14 So we display it as a percentage, right?
15 You can think of like, oh, 1.2 percent of patients
16 develop a central line associated blood stream infection
17 in an "A" hospital. Some of those measures, outcome
18 measures are applicable just to patients who have had
19 surgery. Some are just applicable to patients who have
20 been in the intensive care unit.

21 And so we discount the total patients based

1 on who those -- who those measures apply to.

2 Q. Yep.

3 A. Then in terms of estimating the lives lost,
4 from the literature, we've identified the attributable
5 mortality rate to that event happening to a patient in a
6 hospital and their -- yeah, attributable mortality rate.

7 So as previously discussed, like for
8 central line associated blood stream infections, one out
9 of every seven patients who develop C infection in the
10 hospital will die.

11 And we're using that same attributable
12 mortality rate for all categories of hospitals. So that
13 is one of our limitations. We may have variation in
14 that "A" hospitals could actually have a lower mortality
15 rate than "D" and "F" hospitals, but we're making the
16 assumption of that mortality rate.

17 And so that is -- and then in addition to
18 the outcome measures, we're also using ICU physician
19 staffing because there is strong evidence linking
20 improvements in intensivists managing and comanaging
21 patients in the ICU and reduced mortality hospital-wide.

1 Q. Okay.

2 A. Well, both in the ICU and hospital-wide. And
3 so that's the one process and structural method that we
4 use as part of the analysis.

5 Q. So looking at this chart again, just as a
6 grounding mechanism, it looks like to me that there are
7 19 outcome measures and 1 process measure. Is that
8 right? That's what I'm seeing, the 19 and the 1.

9 A. Correct.

10 Q. Okay. And the one is, as you said, ICU
11 physician staffing, correct?

12 A. Correct.

13 Q. Okay. And so basically you're taking the
14 incidence times the mortality and outputting the amount
15 of estimated deaths?

16 A. We are for the outcome measures.

17 Q. Okay.

18 A. What we're doing for ICU physician staffing is
19 we're going back to the historical literature that
20 established the standard to say that there is a
21 30 percent reduction in hospital-wide mortality between

1 no intensivist and high intensivist staffing.

2 And so we actually go back to seventh or
3 eighth grade math, and we have the slope of a line. And
4 this is where hospitals are now at, and, therefore, if
5 we calculate the slope, it would be this point on the
6 line.

7 Q. Oh, boy. You're testing my math skills.

8 A. I test my own as well.

9 And so basically, hospitals that are fully
10 implemented we think have -- we estimate that they have
11 achieved the full impact of that.

12 Q. Okay.

13 A. And if hospitals are somewhere along that
14 continuum, they've achieved a portion of that impact.

15 Q. Okay.

16 So the mortality rating for ICU physician
17 staffing, am I right that it is based on a 2004 article
18 by Dr. Pronovost?

19 A. It's definitely by an article by Dr. Pronovost.
20 I couldn't speak to the year.

21 Q. Okay. Can we grab it?

1 A. I don't disagree with you that it was 2004.

2 Q. You don't know for sure?

3 A. I don't know for sure.

4 Q. I'll represent to you it's 2004. We may as
5 well pull it out. We have it if you want to take a
6 look.

7 A. Okay.

8 Q. My question is have you looked at the research
9 that's come sense to test that estimate?

10 A. So Leah Binder at The Leapfrog Group has asked
11 us to look at that. We have not found anything recently
12 that would be a better way for us to estimate that
13 value.

14 Q. Okay.

15 So I guess, one, have you heard of --
16 there's an article by -- do you know who Deena Kelly
17 Costa is?

18 A. I do not.

19 Q. Okay. I guess I'll just mark it to see if
20 you've seen this article before.

21 MR. CRAIN: Let's mark it as Exhibit 30.

1 (Exhibit No. 30 was marked for
2 identification as of 9/25/2025.)

3 BY MR. CRAIN:

4 Q. Does this article look familiar to you at all?

5 A. I'm not familiar with it.

6 Q. Okay.

7 So the title is: The Association Between
8 Daytime Intensivist Physician Staffing and Mortality in
9 the Context of Other ICU Organizational Practices: A
10 Multicenter Cohort Study.

11 Do you see that?

12 A. Yes.

13 Q. Do any of the authors -- are they familiar to
14 you, Dr. Wallace, Dr. Kahn, and Dr. Costa?

15 A. I do not know any of them.

16 Q. Okay.

17 Do you know the journal here?

18 A. I am familiar with critical care medicine, yes.

19 Q. Reputable journal?

20 A. As far as I know.

21 Q. Okay.

1 Now, I want to go down to Measurements and
2 Main Results, and there's a sentence just at the end
3 which seems to sort of give the bottom line starting
4 with "there." Do you see that?

5 A. Yes.

6 Q. "There was no association between daytime
7 intensivist physician staffing and in-hospital
8 mortality. After adjusting for interprofessional rounds
9 and protocols for mechanical ventilation, the effect of
10 daytime intensivist physician staffing remained
11 nonsignificant."

12 Do you see that?

13 A. Yes.

14 Q. I know you haven't read this article, but at
15 least based on the first page -- and feel free if you
16 want to flip through -- does this undermine the
17 assumptions that the white paper makes with respect to
18 IPS and mortality?

19 MS. LAWSON: Object to form.

20 THE WITNESS: So I think in research there
21 is -- I don't think one can look at one study

1 individually to assess whether there is a relationship
2 or not a relationship, right. I think if we think about
3 -- through humankind, there's lots of studies that have
4 been done. One will show red wine is good for the
5 heart. The next one will show, oh, no, you should stay
6 away from alcohol, right. And over time we sort of
7 build a body of literature.

8 What an additional -- one of the strengths
9 of the Pronovost article, if I'm remembering it
10 correctly, is it was actually a meta analysis. So it
11 actually looked at 15 to 20 different studies and
12 synthesized those results.

13 So it's not to say that every study is
14 going to show a relationship, but one study doesn't
15 necessarily negate a wider body of literature.

16 BY MR. CRAIN:

17 Q. Okay.

18 This is dated 2015. Do you see that?

19 A. Correct.

20 Q. And you've not seen this article, right?

21 A. I have not seen this.

1 Q. Okay. Is it something that you think you
2 should review in the next iteration or no?

3 A. I would be happy to review it and see what we
4 come to in terms of a conclusion.

5 Q. Okay. Okay.

6 So I want to go back to -- I want to just
7 go back to the chart again.

8 A. Yeah. Okay.

9 MS. LAWSON: Is that Exhibit 29?

10 MR. CRAIN: Yeah, 29, the email and the invite.

11 BY MR. CRAIN:

12 Q. Now, I want to just look at the differences in
13 mortality, right. So when you look at -- just take --
14 starting with "D" and "F," right, at the bottom. Do you
15 see that?

16 A. Yes.

17 Q. It says, focusing primarily -- focusing on the
18 outcome measures. It says 1.46 in 2019. Do you see
19 that?

20 A. For "D" and "F," correct.

21 Q. Correct.

1 And is that, just to make sure I understand
2 the numbers, is 1.46, that's 1.46 deaths?

3 A. Correct.

4 Q. Okay.

5 And then if you go down to "C," it's 1.40,
6 right?

7 A. Correct.

8 Q. To "B," it's 1.31, right?

9 A. Correct.

10 Q. And 1.22 for "A." Do you see that?

11 A. Correct.

12 Q. Is the difference just for outcome measures
13 between 1.22 for an "A" and 1.46 statistically
14 significant in your view?

15 A. I would need to do a statistical test to
16 determine whether that there is a statistical difference
17 there.

18 Q. Okay. It's not twice, right? There are not
19 two times as many deaths between -- in that comparison,
20 right?

21 A. Not in just comparing the outcome measures.

1 Q. Just comparing the outcome measures.

2 A. Correct.

3 Q. With respect to the ICU physician staffing,
4 fair to say the difference is more substantial, right?

5 A. Correct.

6 Q. Is the -- would you agree that the analysis
7 places -- like the number of deaths in the analysis is
8 significantly weighted to the ICU physician staffing
9 metric?

10 A. Yes. Although, there is a methodological
11 clarification that I should make because this will help
12 explain it to some degree. We actually take the number
13 of outcome measures, or we take the lives lost in the
14 outcome measures and actually divide that by two.

15 Q. Okay.

16 A. And the reason we do that is because we
17 recognize that there are some deaths that are probably
18 occurring in the ICU that are a result of not good care,
19 right.

20 So you may have developed a central line
21 blood stream infection. We didn't want to count that

1 twice, both in the outcome measures and the ICU
2 physician staffing.

3 So the methodological decision was to cut
4 the outcome measures in half. So we take each value and
5 divide by two so that we aren't double counting between
6 the two.

7 Q. And what was that based on? That's the
8 50 percent number?

9 A. Yeah, the 50 percent. That was just an
10 educated guess.

11 Q. Okay. Is it based on a study or is it based on
12 --

13 A. No. It was just sort of a collective wisdom of
14 people.

15 Q. The authors or other people?

16 A. Other people as well.

17 Q. Who were the other people?

18 A. So the initial work for this actually came out
19 of some work that The Leapfrog Group had done, Leah
20 Binder, with another consultant.

21 Q. Okay. Who is that?

1 A. I don't remember his name.

2 Q. Okay.

3 A. I can sort of picture him, but I don't remember
4 the name. And so it was out of that that the decision
5 was made to multiply it by 50 percent.

6 Q. Okay.

7 So if we look at the bottom, you're saying
8 that "D" and "F," the actual number is closer to 3 than
9 1.46?

10 A. Correct.

11 Q. Okay. Got it.

12 Okay. So then that's still I guess -- my
13 question still remains. The biggest difference, at
14 least it appears to me, between a "D" and "F" hospital
15 and an "A" hospital is the physician staffing mortality.
16 Is that right?

17 A. That is -- from what we're able to quantify in
18 terms of harm, that is where the biggest differences
19 are.

20 Q. Okay. And the mortality rating for that is
21 based on the Pronovost article, right?

1 A. Correct.

2 Q. Okay.

3 And then so let's go to another document.
4 I want to look primarily -- let's look at the chart,
5 actually, on the right side, so the 2025 metric.

6 A. Okay.

7 Q. Now, in all -- this is the first time, at least
8 for IPS and I think everywhere else, there's a slash.
9 Do you see that?

10 A. Yes.

11 Q. What does the slash reflect?

12 A. The slash is reflecting if we -- the value to
13 the right of the slash would be if we were to remove the
14 imputed scores for IPS.

15 Q. Yeah. And say more about that. You mean
16 remove the mortality for nonparticipating hospitals?

17 A. No. We would remove -- if a hospital had an
18 IPS score that was imputed, we would remove that from
19 the calculation.

20 Q. Okay. And that's the right side?

21 A. That is the right side.

1 Q. So the left side reflects -- tell me if this is
2 wrong. I'm just trying to understand. The left side of
3 the slash reflects the hospitals that are participating
4 with IPS scores based on their actual performance data,
5 and the right side includes nonparticipating hospitals
6 with the limited achievement assignment?

7 A. So the left-hand side would be the scores for
8 all hospitals that received a safety grade, including
9 those that were imputed.

10 Q. Okay.

11 A. The right-hand side would be just hospitals
12 that had a score reported through the Leapfrog Hospital
13 Survey.

14 Q. And that's the 80 percent of inpatient beds
15 we've been talking about?

16 A. Correct.

17 Q. Okay. Got it.

18 So the numbers are pretty different, right,
19 at least in certain categories?

20 MS. LAWSON: Object to form. Go ahead.

21 THE WITNESS: I don't know how you would define

1 pretty different.

2 BY MR. CRAIN:

3 Q. Fair enough.

4 If you go to "D" and "F," the difference is
5 7.98 on the left and 3.89 on the right. Do you see
6 that?

7 A. Correct.

8 Q. And if you go to "C," 4.92 and 2.52, right?

9 A. Correct.

10 Q. Now, the differences get smaller. So "B," it's
11 2.12 and 2.01, right?

12 A. Correct.

13 Q. And then "A," it's 1.53 versus 1.5, right?

14 A. Correct.

15 Q. And if I recall correctly, there were only two
16 hospitals that got an "A" with imputed scores, right?

17 A. Correct.

18 Q. So that -- did that explain why that's so close
19 together? Correct?

20 A. I would need to go back and look at the math,
21 but your statement about that there's two hospitals is

1 correct.

2 Q. Yeah. Okay.

3 Do you have a theory as to why the numbers
4 are so different left and right, at least for "D" and
5 "F" and "C"?

6 A. The difference between the two values is the
7 inclusion or exclusion of the imputed values.

8 Q. Is the number on the left or the right more
9 likely an accurate estimate?

10 MS. LAWSON: Object to form.

11 BY MR. CRAIN:

12 Q. Let me step back. You're trying to estimate
13 mortality of "A," "B," "C," "D," and "F" hospitals,
14 right?

15 A. Correct.

16 Q. You want to be accurate in the estimate as best
17 you can?

18 A. Yes, recognizing it's an estimate.

19 Q. Yes. So I'm going to posit that 4.92 versus
20 2.52 for the "C" hospitals, pretty different number of
21 deaths. Is that fair to say or you disagree? I mean,

1 it's almost double, right, on the left side.

2 A. That last part is true. It is almost double.

3 Q. So we'll just go with numerical. It's almost
4 double.

5 What is a more accurate estimate of the
6 mortality of "C" hospitals as a result of ICU physician
7 staffing? Is it 4.92 or is it 2.52?

8 A. I will say both are incorrect.

9 Q. Okay. I'm eager to hear why.

10 A. Well, one includes imputed values, which, by
11 definition, are not exact values.

12 Q. Okay.

13 A. The other one is excluding hospitals that we
14 don't have any data for. So there is some lives lost
15 attached to them. So both of them are actually -- both
16 of them are estimates in two different scenarios.

17 Q. You said a moment ago both of them are
18 incorrect.

19 A. Okay. Both of them are incorrect.

20 Q. Okay.

21 A. It's an estimate, so unless you hit it right on

1 the dot, an estimate is going to be incorrect.

2 Q. Which one is more incorrect?

3 A. I don't know how to judge that.

4 Q. Okay. So you don't know one way or another?

5 A. I don't know one way or another.

6 Q. Okay.

7 MR. CRAIN: So I want to take a look at a few
8 documents here. Give me one second. Oh, no wonder I
9 can't find it. It's actually in this document. Iason
10 knows them better than I do.

11 THE WITNESS: Which one?

12 BY MR. CRAIN:

13 Q. So this is Exhibit 30, what we were just
14 looking at -- oh, sorry, 29 I mean was the chart.

15 MS. LAWSON: 29.

16 MR. CRAIN: Yeah, Exhibit 29 with the chart.

17 BY MR. CRAIN:

18 Q. Okay. And this is from you to Ms. Campione,
19 Ms. Danforth, and Ms. Bailey, right?

20 A. Correct.

21 Q. Okay. So you send an email, and the tenor -- I

1 can read it all, but the tenor seems to be there's a
2 discussion about whether you include the imputed scores
3 in the mortality or not, right?

4 MS. LAWSON: Take a minute and read the email.

5 MR. CRAIN: Yeah, take a second.

6 (Witness peruses document.)

7 THE WITNESS: So, yeah, this is -- the tenor is
8 about the table that we just went through.

9 BY MR. CRAIN:

10 Q. Whether to include the imputed scores or not,
11 right?

12 A. Correct.

13 Q. Okay.

14 And you at the end say, "I would vote for
15 keeping the imputed IPS scores in place. My guess is
16 the averages with the imputed scores are closer to the
17 truth than averages excluding the imputed scores."
18 Right?

19 A. Correct.

20 Q. So what's that based on?

21 A. Well, I think I used the word "guess," so I

1 will qualify that. I guess it's somewhat informed by
2 that, you know, hospitals that choose not to disclose
3 likely may not be meeting Leapfrog's standards. Because
4 if they were meeting them, they would be more likely to
5 disclose them. So it was probably with that assumption.

6 Q. So that -- so okay. But it's multiple levels
7 of assumptions, right? I can build it out to see what I
8 mean.

9 So assumption one is that hospitals that
10 are not reporting are not meeting Leapfrog's standards,
11 right?

12 A. That is the assumption I just stated.

13 Q. And assumption two is that the failure to meet
14 Leapfrog's standards yields a higher mortality rate?

15 A. Correct, based on the literature.

16 Q. Okay. So it's an assumption, but you're saying
17 it's backed by literature?

18 A. Correct.

19 Q. And, again, meaning the Pronovost article?

20 A. Correct.

21 Q. Okay. So your guess is based on those two

1 assumptions?

2 A. Correct.

3 Q. Okay.

4 Do you have any understanding of where
5 Leapfrog is landing on this question, whether to include
6 the imputed or nonimputed?

7 A. I do not know.

8 Q. And just going back to the chart, I want to
9 just look at the numbers. Just go right to the top.
10 You see lives lost, lives saved? Do you see that?

11 A. Yes.

12 Q. Okay. And it's -- the numbers, again, you
13 know, are -- so I'll be factual about it. Lives lost,
14 if you exclude the imputed hospitals, it's about 30,000
15 fewer, right?

16 A. Correct.

17 Q. Okay. And if you exclude the imputed values,
18 it's also about 30,000 fewer on lives saved, right?

19 A. Correct.

20 Q. Okay. And so your view is that it is -- your
21 best guess is that those 30,000 are -- bear some

1 relation -- have some accuracy to them -- strike that.
2 That was a bad question. I know you were going to
3 object. And it was fair.

4 So let me ask another question then.

5 You said the numbers bear out the twice as
6 likely mortality point. Do you remember earlier in the
7 day we talked about Leapfrog says on its website that
8 Johns Hopkins researchers say you're two times likely to
9 die if you go to a "D" or an "F" hospital, as opposed to
10 an "A"?

11 A. I remember that conversation, but I don't
12 remember in what context.

13 Q. We were looking at the website, which we can
14 look at if someone will tell me the exhibit number, and
15 we talked about -- so maybe we can get that document out
16 just to ground us. I think it's exhibit --

17 MR. TOGIAS: It was tab 65.

18 MR. CRAIN: Sixty-five. So that's Exhibit 9.

19 MR. TOGIAS: Frequently asked questions.

20 MR. CRAIN: Yeah.

21 MS. LAWSON: It's on page 2.

1 MR. CRAIN: Yeah, I think that's right.

2 BY MR. CRAIN:

3 Q. Page 2 and it's under the second -- we talked
4 about -- remember this question? "Why should people
5 worry about a hospital's patient safety?" Do you
6 remember that?

7 A. Yes.

8 Q. And if you go to the end of that paragraph:
9 "All hospitals are not the same. Some hospitals are
10 much safer than others. John Hopkins Medicine
11 researchers estimate that patients are twice as likely
12 to die of a preventable problem at a "C," "D," or "F"
13 hospital than an "A" hospital, and over 50,000 lives
14 would be saved if all hospitals performed the way "A"
15 hospitals did."

16 Do you see that?

17 A. Yes.

18 Q. Okay. Now, first of all, the 50,000 lives,
19 based on this chart, going back to Exhibit 29, refers to
20 2019, right?

21 A. Correct.

1 Q. Okay.

2 Your 2025 numbers, I understand, are in
3 draft form, but it would either be 49,000 or 20,000
4 depending on the imputed scores, right?

5 A. Correct.

6 Q. Okay.

7 Now, this Johns Hopkins Medicine
8 researchers estimate that patients are twice as likely
9 to die of a preventable problem at a "C," "D," or "F"
10 hospital than an "A" hospital, do you see that?

11 A. Yes.

12 Q. Now, that -- is that based on the 2019 numbers?

13 A. Yes.

14 Q. Okay.

15 Now, you had said that that was also true
16 as for 2025, albeit in draft form. Do you recall that
17 testimony?

18 A. I think I mentioned that we were seeing
19 probably similar trends.

20 Q. Okay. Is that reflected here? Can you explain
21 to me just on this chart how that works?

1 A. Yeah. So I think Leapfrog took a little
2 liberty with the "twice," but if you take the 87 and the
3 91.8 --

4 Q. Where are you on that?

5 A. Sorry. 2019.

6 Q. Yep. Yep. I see that.

7 A. Those are close to 100 percent, or one could
8 make the argument, so that would be twice as likely --

9 Q. From 2019?

10 A. From 2019.

11 Q. Okay.

12 And what about today?

13 A. And then today the numbers are actually higher.
14 I was just sort of hedging a little bit about what that
15 would be because they range anywhere between
16 46.6 percent and 353.6.

17 Q. Okay. So that's -- it's different whether you
18 include the imputed or not, right?

19 A. Correct.

20 Now, as I look at this further, what I
21 think I would argue is that the number of lives saved

1 when we take out the imputed scores, the 20,252, is such
2 a significant drop-off. I don't know if that's --
3 that's where I had caution about why I thought that
4 seemed questionable to exclude the imputed scores.

5 Same with the 105. To be more clear, the
6 105 is quite a drop, and I don't think we've seen that
7 level of improvement in patient safety in the country,
8 and so I think that would oversell our efforts in
9 patient safety.

10 Q. Is this an annual number?

11 A. That would be an annual number.

12 Q. Okay.

13 A. Correct.

14 Q. So you're saying it would surprise you if it
15 was only 105,000 patients dying, as opposed to 161,000?

16 A. Correct.

17 Q. Okay. Got it. Okay.

18 A. So the 134 on the face felt like more of a
19 reasonable level of improvement that we would have seen.

20 Q. Because it's fewer lives -- it's more lives
21 lost?

1 A. It's fewer lives lost. So we've seen
2 improvements. We've gone from 161,000 lives lost due to
3 medical error to 134,000.

4 Q. It's fewer lives lost than 2019 but more lives
5 lost than without the imputed values?

6 A. Correct.

7 Q. Okay.

8 And then you're saying -- so how does that
9 equate now to the twice as likely to die for "C," "D,"
10 and "F"? Can you walk me through that?

11 A. Yeah, yeah. So that's what I was -- if you
12 look at the --

13 Q. The percent.

14 A. -- 2019 column --

15 Q. Yes, that I'm clear on.

16 A. The "C" versus "A", "D" and "F" versus "A,"
17 those are somewhere in the 100 percent range. Like I
18 said, I think Leapfrog took a little liberty there.

19 Q. Yeah.

20 But 2025?

21 A. For 2025, if we exclude -- if we include the

1 imputed scores, it's actually 133 to 353,000. We would
2 have to do some sort of blended average of those since
3 it says "C," "D," and "F."

4 Q. Yeah. And if you don't include it, it's 46 to
5 204?

6 A. Correct.

7 Q. Okay. And as you said, blended average because
8 there are -- I think there are more "C" hospitals --

9 A. There's a lot more "C" hospitals, right.

10 Q. Okay. Got it.

11 So maybe you just don't know today, but do
12 you have an estimate today as to whether it's really
13 accurate that you're twice as likely to die if you go to
14 a "C," "D," or "F" hospital as compared to an "A"
15 hospital?

16 A. Well, given my statement in the email about
17 Leapfrog, that I feel like the numbers with the imputed
18 scores are more reflective of the actual reality, that
19 would be something greater than twice. It would be
20 probably two and a half times.

21 Q. So --

1 A. So what we're seeing nationally is bigger gaps
2 between "A" hospitals and hospitals at the back of the
3 pack.

4 Q. And what's driving that in your view?

5 A. I believe it's -- I think hospitals have --
6 some hospitals have chosen to really invest time,
7 resources, energy, have created more of a learning
8 health system. I think they have just prioritized
9 safety in ways that other hospitals have chosen not to.

10 Q. And when you say those hospitals, you're
11 talking about the ones that report or the ones that
12 don't report?

13 A. A combination.

14 Q. Okay.

15 Okay. And then I'm going to show you one
16 more document.

17 So if you actually keep that exhibit in
18 front of you, 29, do you see there's a document -- go to
19 the first page.

20 A. Of 29?

21 Q. Of 29, yeah.

1 A. Okay.

2 Q. The email that we've been talking about with
3 the chart.

4 A. Yeah.

5 Q. Do you see there's an attachment that says
6 Lives Lost, Lives Saved Calculator 250515?

7 A. Yeah.

8 Q. Okay.

9 MR. CRAIN: So I just want to mark this as
10 Exhibit 31.

11 (Exhibit No. 31 was marked for
12 identification as of 9/25/2025.)

13 BY MR. CRAIN:

14 Q. So this is an Excel Spreadsheet. Do you see
15 the document?

16 A. Yes, I do.

17 Q. Do you know what this document is?

18 A. Yeah. It's the excel file we use to calculate
19 the lives lost and lives saved.

20 Q. And is that the one attached to this email?

21 A. This is the 2025 -- actually, this is the '25

1 version, yeah, 2025 version.

2 Q. And are you the author of this document?

3 A. Myself and the analyst together.

4 Q. Okay. Got it.

5 Okay. And this is a true and correct copy
6 of the Excel Spreadsheet we're talking about?

7 A. As far as from what I can see, yes.

8 Q. Yeah. And the two pages, right?

9 A. Yeah.

10 Q. Okay.

11 MR. CRAIN: Okay. Can we take five? Go off.

12 THE VIDEOGRAPHER: This marks the end of media
13 unit number seven. We're going off the record. The
14 time is 4:55 p.m.

15 (Whereupon a short break was had, after
16 which the proceedings continued as
17 follows:)

18 (Exhibit No. 32 was marked for
19 identification as of 9/25/2025.)

20 THE VIDEOGRAPHER: This marks the beginning of
21 media unit number eight. We're going back on the

1 record. The time is 5:07 p.m.

2 BY MR. CRAIN:

3 Q. All right. Thank you, Dr. Austin. We're in
4 the home stretch.

5 I've given you what's been marked as
6 Exhibit 32. Do you see it's an Armstrong-produced
7 Document, 14327?

8 A. Yes.

9 Q. Okay. And it's an email from Mr. Derk to you.
10 Do you see that?

11 A. Yes.

12 Q. And it's dated June 5th, 2019?

13 A. Yes.

14 Q. And it says, Subject: Lives Saved
15 Presentation. Do you see that?

16 A. Correct.

17 Q. And there's an attachment. Can you read that
18 attachment into the record?

19 A. Lives lost, Leapfrog partners 02190610.pptx
20 [sic.]

21 Q. And the rest of the document, is that the pptx

1 you just mentioned?

2 A. In reviewing it, I believe that is the case,
3 but there's nothing on here indicating the file name
4 so --

5 Q. Fair enough.

6 If you look at the title, it says: Lives
7 Lost, Lives Saved: The Comparative Analysis.

8 Do you see that?

9 A. Yes.

10 Q. And it's dated June 10th, 2019?

11 A. Yes.

12 Q. Okay.

13 So to the best of your understanding, this
14 is the PowerPoint attached to the email?

15 A. Yes.

16 Q. And I'll also note Armstrong produced it
17 sequentially from 14327 and forward.

18 A. Yeah. The only thing that strikes me as a bit
19 odd is how the presentation is dated June 10th, 2019,
20 but he sent the email on June 5th, 2019.

21 Q. Could it have been a draft?

1 A. That's a possibility.

2 Q. Like for a future presentation?

3 A. Yeah. That makes sense.

4 Q. So flip through the PowerPoint and just -- you
5 know, does it look like a true and accurate depiction of
6 the PowerPoint presentation that either you or he
7 prepared?

8 A. Are you asking me to verify whether each slide
9 is accurate?

10 Q. No, no. Fair enough. Let me start over.

11 Do you recognize this PowerPoint
12 presentation?

13 A. I don't remember this PowerPoint presentation.

14 Q. Okay. Do you recall giving a presentation in
15 2019 on the lives lost, lives saved?

16 A. I don't remember that --

17 Q. Okay.

18 A. -- but that's not to say I didn't do it.

19 Q. Okay.

20 Any reason to think this is not -- you
21 know, again, produced by Armstrong -- this is not a true

1 and accurate depiction of the email and the attachment?

2 A. No, there's no reason to believe that.

3 Q. Okay.

4 Do you remember anything about this
5 presentation at all?

6 A. I don't other than I think we were trying to
7 summarize the lives lost, lives saved analysis.

8 Q. Okay. So just flipping through, that's what
9 this PowerPoint does, it summarizes the methodology?

10 A. Yes.

11 Q. Okay.

12 And then I think you can set that one
13 aside.

14 And then just a question going back to the
15 2019 white paper. Was the 2019 white paper peer
16 reviewed?

17 A. It was not peer reviewed.

18 Q. Was the 2016 white paper peer reviewed?

19 A. The 2016 paper was reviewed by a couple of my
20 colleagues.

21 Q. Is that peer reviewed in the way that we talked

1 about earlier?

2 A. Peer reviewed in terms of journal articles is
3 usually the editors selecting who is going to review
4 your paper. This was me asking two colleagues who I
5 knew and trusted to look through it and provide input
6 and comments.

7 Q. So not peer reviewed in the academic sense?

8 A. Correct.

9 Q. Okay.

10 And 2019 was not peer reviewed in any
11 sense?

12 A. Correct, in the sense that it was an update
13 from 2016. So all we had done was update numbers.

14 Q. Is it right that Ms. Binder edited the white
15 paper in 2019?

16 A. It is possible that Ms. Binder provided some
17 edits to the white paper.

18 Q. Okay.

19 MR. CRAIN: With that, I will, pursuant to the
20 agreement of the parties, for division of time, pass the
21 witness and reserve the balance for recross.

1 MS. WOOD: You want to go off the record while
2 I get mic'd up?

3 MR. CRAIN: It's up to you. I'm happy to go
4 off. Yeah, that's fine. Let's go off.

5 THE VIDEOGRAPHER: This marks the end of media
6 unit number eight. We're going off the record. The
7 time is 5:11 p.m.

8 (Whereupon a short break was had, after
9 which the proceedings continued as
10 follows:)

11 THE VIDEOGRAPHER: This marks the beginning of
12 unit number nine. We're going back on the record. The
13 time is 5:13 p.m.

14 EXAMINATION

15 BY MS. WOOD:

16 Q. Dr. Austin, my name is Courtney Wood. I
17 represent the defendant, The Leapfrog Group, in this
18 matter.

19 I know you testified earlier that we had
20 met before previously when the subpoena came in. It's
21 good to see you again.

1 A. Good to see you as well.

2 Q. I don't have much to ask you today. However, I
3 have enjoyed listening to all of your testimony today,
4 and we appreciate you being here, so I just want to
5 thank you for that.

6 But to start, are you familiar with the
7 hospital grade calculator?

8 A. Yes, I am.

9 Q. Okay. And so is it fair to me -- fair for me
10 to say that there are 10 outcome measures that are
11 included on that grade calculator?

12 A. I couldn't speak to the current version of the
13 calculator. I have not seen it.

14 Q. Okay. But to your knowledge, are there 10
15 outcome measures that are used in the methodology
16 currently?

17 A. Can I refer to the --

18 Q. Sure. Yeah.

19 A. Okay.

20 Q. Was that Exhibit 3?

21 A. I think it's Exhibit 3, yeah.

1 Q. My apologies because I'm not going to know what
2 page it's on but --

3 A. That's fine. I actually know. It is actually
4 on page 6 and 7; 10, correct.

5 Q. Okay. Perfect.

6 And then is it fair to me -- for me to say
7 that those 10 outcome measures all come from CMS data?

8 A. For the five healthcare-associated infections,
9 the primary data source is the Leapfrog Hospital Survey,
10 and a secondary data source is the Centers for Medicare
11 & Medicaid Services.

12 Q. Correct.

13 And then for the process and structural
14 measures, there are 12 of those. Is that correct?

15 A. Correct.

16 Q. Okay.

17 And then are you aware that of those --
18 well, let's strike that.

19 So the 12 structural and process measures
20 come from survey data. Is that correct?

21 A. The seven of them, the Leapfrog Hospital Survey

1 is the primary data source. For 5 out of the 12, the
2 Centers for Medicare & Medicaid Services is the primary
3 data source.

4 Q. Right. And then we call those HCAHPS.

5 A. Correct.

6 (Whereupon, the court reporter seeks
7 clarification, which colloquy will not be
8 captured on the written record.)

9 BY MS. WOOD:

10 Q. Okay. And so to your knowledge, if a hospital
11 does not respond to the Leapfrog survey, then it does
12 not receive a score for the safe practices 1, safe
13 practices 2, and then the nursing care hours per patient
14 day. We were talking about that earlier. Is that still
15 correct?

16 A. Correct.

17 Q. Okay.

18 And so then to your knowledge, when a
19 nonreporting hospital does not respond to the hospital
20 survey, then those weights are redistributed to the
21 other nine measures in that process and structural?

1 A. Correct.

2 Q. Okay.

3 MR. CRAIN: I'm just going to object to form.

4 BY MS. WOOD:

5 Q. Okay. And then of those nine measures, we had
6 just indicated that five of those are the HCAHPS and
7 then the other four are the imputed measures that we
8 were talking about earlier. Is that correct?

9 A. So of the 12, process and structural measures,
10 5 of them come from HCAHPS, which is a patient
11 experience survey that goes to patients. The other
12 seven, the Leapfrog Hospital Survey is the primary data
13 source.

14 As previously discussed, four of those are
15 imputed if the hospital doesn't respond to the survey
16 and three are not imputed.

17 Q. Right. Okay.

18 So what I'm trying to get at is when the
19 hospital doesn't respond -- so those three that we were
20 talking about, the safe practice 1, the safe practice 2,
21 and then the nursing, we take those out and then the

1 weights are redistributed on those other nine, which are
2 the five HCAHPS and then the four imputed measures. Is
3 that correct?

4 MR. CRAIN: Objection to form. I just want to
5 lodge a standing objection to the leading, and then I
6 won't interrupt. But is it okay to stipulate to that?

7 MS. WOOD: Sure.

8 BY MS. WOOD:

9 Q. Is that your understanding?

10 A. Yes.

11 Q. Okay.

12 And would you agree with me when I say --
13 if I made the assertion that if a hospital performed
14 poorly on their HCAHPS scores, then those measures now
15 are getting greater impact on the overall grade?

16 MS. LAWSON: Object to form.

17 BY MS. WOOD:

18 Q. Yeah, let me rephrase it.

19 So since the weights are now a little bit
20 heavier on those HCAHPS scores and the four imputed
21 scores, it would be arguable that those five HCAHPS

1 scores now play a bigger role in going into the Hospital
2 Safety Grade. Is that correct?

3 MS. LAWSON: Object to form.

4 MR. CRAIN: Objection.

5 MS. LAWSON: You can still answer.

6 THE WITNESS: If the hospital does not have
7 data for those three measures, safe practice 1, safe
8 practice 2, nursing workforce, or nursing hours per
9 patient day, more weight is put on the remaining nine
10 measures and that would include the five HCAHPS
11 measures.

12 BY MS. WOOD:

13 Q. Right.

14 So is it fair to say then that if a
15 hospital had poor HCAHPS scores, then those would be
16 weighed heavier and could have a greater impact on the
17 Hospital Safety Grade?

18 MR. CRAIN: Objection to form.

19 THE WITNESS: So independent of the hospital's
20 performance, more weight would be put on those nine
21 measures. So I guess I'm just clarifying that whether

1 they're a good performer or poor performer, more weight
2 is going to be put on those.

3 BY MS. WOOD:

4 Q. Understood. And I would agree with that.

5 And do you have any opinion on how
6 significant that impact can be, whether, you know, say
7 if you're a great hospital and you have great HCAHPS
8 scores, and say you have bad -- and then you get the
9 imputed score because you're a nonresponding hospital,
10 do you have any opinion on what that impact might look
11 like on the Hospital Safety Grade?

12 MR. CRAIN: Object to form.

13 MS. LAWSON: Object to form.

14 THE WITNESS: So the -- I mean, one could test
15 out different scenarios of that question, right. So one
16 could -- the hospital may do really well on certain
17 measures, may not do well on others. There's not
18 necessarily universal, like, just because you're doing
19 well on one HCAHPS, that you're doing well on all
20 HCAHPS.

21 So one could sort of empirically test

1 different what-if scenarios, but I don't know if there's
2 a universal answer to your question.

3 BY MS. WOOD:

4 Q. Okay.

5 And so would it be true that if a hospital
6 was performing well on those five HCAHPS scores and then
7 still got those low imputed scores, that maybe those
8 five HCAHPS scores would actually -- let me rephrase
9 that.

10 So if the five HCAHPS scores were really
11 great scores and then you got those four imputed scores,
12 would it be fair to say that maybe those four imputed
13 scores wouldn't really have an impact then on the
14 overall Hospital Safety Grade?

15 MR. CRAIN: Objection to form.

16 THE WITNESS: There would be a potential
17 scenario where if the hospital does well on the HCAHPS
18 scores and does well on the outcome measures, that they
19 could have a pretty good safety score and safety grade.

20 BY MS. WOOD:

21 Q. Okay. And then would that be applicable as

1 well if there were poor scores for the HCAHPS?

2 A. Once again, it's -- the measures are not looked
3 at simply in isolation, right, because I think one would
4 also need to look at the outcome measures. So just --
5 it needs to be a slightly more holistic view of
6 performance.

7 Q. Okay.

8 And then we were talking about earlier how
9 there is never a zero that is imputed for any of those
10 four measures. Is that correct?

11 A. To the best of my recollection, that is
12 correct.

13 Q. Okay. And do you know why that is?

14 A. So we -- for the Leapfrog Hospital Survey
15 measures, we did have to come up with a way to assign a
16 numerical value to the performance categories, right.
17 So in the Leapfrog Hospital Survey, for those four
18 imputed measures hospitals get reported out as achieved
19 the standard, considerable achievement, some
20 achievement, and limited achievement. But for purposes
21 of incorporating those into the Hospital Safety Grade,

1 we needed to translate those into some sort of numerical
2 value.

3 And so we've used different approaches
4 through the years and for different measures for how to
5 assign those values. If we use hand hygiene as an
6 example, the assigned values are 100, 75, 50, and 25.
7 It was basically to give hospitals some numerical credit
8 for being in a performance category.

9 Q. And is it true that those numerical values on
10 the performance is used for both reporting and
11 nonreporting hospitals?

12 A. So the imputed values for those four measures
13 match what hospitals who report and get limited
14 achievement receive.

15 Q. Okay.

16 And do you ever recall speaking with
17 anybody, whether it's the expert panel or anybody at
18 Leapfrog, about considering imputing a zero for any of
19 those four measures rather than doing the limited
20 achievement, the considerable achievement?

21 A. I don't remember any explicit discussion about

1 zero; although, it's not to say that that hasn't come up
2 as a potential option.

3 Q. Okay.

4 And I want to look at Exhibit 27 again, and
5 this is the -- I think you had said earlier that these
6 were actually your notes from this expert panel meeting.
7 Was that right?

8 A. These were a set of notes.

9 Q. Okay. Because it just had said agenda at the
10 top, but then I think you had said that these were notes
11 following --

12 A. These are notes. I don't -- your question was
13 are these my notes. I don't know if they were my notes
14 or if these were notes prepared by someone else.

15 Q. Oh, okay. That's fair. But these would have
16 been notes following that meeting on this day?

17 A. Correct.

18 Q. And then if we can flip to that second page and
19 number three, and it's the last bullet point under
20 number three. It says: "The panel wondered what the
21 distributions would look like if Leapfrog assigned a

1 score of zero or lowest score possible for the missing
2 elements. Matt and Jordan will look into this following
3 the meeting."

4 Does that refresh your recollection in any
5 way on whether you or Jordan looked into that?

6 A. I don't remember what scenarios we actually ran
7 as a result of that meeting. It's possible that we -- I
8 don't remember. We could have just ran the lowest
9 possible scores. I don't know if we ran zero. I would
10 have to be refreshed on that.

11 Q. Yeah. That's okay.

12 And then do you remember anything else
13 regarding -- any other discussions during this meeting
14 about imputing zeros for those imputed measures?

15 A. Other than what's in the notes --

16 Q. Okay.

17 A. -- that the panel discussed that as a potential
18 scenario.

19 Q. Okay.

20 And then even after seeing this bullet
21 point, you don't recall speaking to anybody else on the

1 expert panel about this?

2 A. I don't remember.

3 Q. Do you recall if you ever spoke with Arjun
4 about this?

5 MR. CRAIN: Objection to form.

6 THE WITNESS: I don't remember if I spoke to
7 Arjun in particular about this topic.

8 BY MS. WOOD:

9 Q. Okay.

10 And usually, after following expert panel
11 meetings, do you ever reach out to some of the panelists
12 to discuss bullet points like this independently?

13 A. Yeah, we do.

14 Q. Okay. So it wouldn't be weird if you had
15 spoken with Arjun, but you just don't recall today?
16 That's something that you might do?

17 A. Correct.

18 Q. Okay. In addition to other panel members as
19 well. Arjun is just an example.

20 A. Correct.

21 MR. CRAIN: Objection to form.

1 BY MS. WOOD:

2 Q. Okay. And so then we were -- I was going to
3 use the handwashing as an example as well. So it's your
4 understanding that 15 is the imputed score for limited
5 achievement for handwashing?

6 A. Let me refer to Exhibit No. 3.

7 Q. Sure. No problem.

8 A. So slide 16 hand hygiene. Was that your --

9 Q. Yep.

10 A. Fifteen is the --

11 Q. Limited?

12 A. -- yep, limited achievement.

13 Q. Perfect. Thank you.

14 And then we were looking at Exhibit 3 again
15 for that, page 16. Hand hygiene, limited achievement,
16 the corresponding measure score is 15.

17 And so I think what you had just testified,
18 that that is both for nonreporting and reporting
19 hospitals, correct?

20 A. That is the score that's assigned to
21 nonreporting hospitals as well as reporting hospitals

1 who failed to meet the some achievement criteria.

2 Q. Right.

3 And so would you agree with me that
4 nonreporting hospitals are actually still receiving a
5 benefit by reviewing a score -- receiving a score that
6 is based on responding hospitals?

7 MS. LAWSON: Object to form.

8 MR. CRAIN: Object to form.

9 THE WITNESS: They are receiving a score -- can
10 you maybe explain more about when you say benefit?

11 BY MS. WOOD:

12 Q. Sure.

13 So if I'm a reporting hospital and I meet
14 the criteria for limited achievement, I get a 15
15 imputed. Is that correct?

16 A. Repeat that one more time.

17 Q. Sure.

18 So a hospital that responds to the survey
19 and they are filling out the hand hygiene portion of the
20 survey and based on the criteria they receive a 15 and
21 they get the limited achievement?

1 A. If the hospital doesn't meet the criteria for a
2 higher performance category --

3 Q. Correct.

4 A. -- they will get limited achievement.

5 Q. Right.

6 But then for the nonresponding hospitals,
7 we don't necessarily know what their hand hygiene
8 policies may be -- or I think earlier we were talking
9 about the hand sanitizer. You had mentioned that there
10 were several different criteria, correct?

11 A. Correct.

12 Q. And so would you say to me -- or would you
13 agree with me when I say that assigning a nonresponding
14 hospital the same score for limited achievement as a
15 responding hospital is giving the nonresponding hospital
16 a benefit?

17 MR. CRAIN: Objection to form.

18 MS. LAWSON: Object to form also.

19 THE WITNESS: I think that's a little bit in
20 the eye of the beholder. Is it better than zero? Yes.
21 Is it as good as 50? No.

1 BY MS. WOOD:

2 Q. Right.

3 A. So I don't know how to really answer that.

4 Q. Okay. So I guess I can ask it another way.

5 So if Leapfrog is not imputing a zero,
6 rather, they're imputing the 15, is Leapfrog making an
7 assumption that the hospitals who are not reporting are
8 actually performing to some extent rather than not
9 performing at all?

10 MR. CRAIN: Objection to form.

11 THE WITNESS: So Leapfrog in that situation is
12 giving nonreporting hospitals an equivalent score to
13 hospitals that have not met the criteria for some
14 achievement, and that can be a range, right. That can
15 be from a hospital that barely missed some achievement
16 to a hospital who has done nothing.

17 So there is a range of hospitals that are
18 getting the limited achievement based on responding.

19 BY MS. WOOD:

20 Q. Understood.

21 And now I want to look at Exhibit 19

1 quickly, and I will have you -- I'm sorry. I'll wait
2 until you're there. And then it's like this webpage.
3 Yes.

4 Okay. And can you flip to the second page
5 that we were talking about earlier. And then you see
6 the asterisk next to the number 15, and it says "This
7 Hospital's Score"?

8 A. Yes.

9 Q. And you would agree with me that that's the
10 limited achievement score for handwashing, correct?

11 A. That 15 is the same value that's assigned, yes,
12 to hospitals that receive limited achievement.

13 Q. Okay.

14 And then right next to it on the right
15 there it says "handwashing." So this would indicate
16 that this hospital, Delray Medical Center, received a 15
17 on the handwashing measure?

18 A. Yes.

19 Q. Okay.

20 And then I know earlier we were talking
21 about the asterisk next to the number 15 indicates to

1 the reader to go down to the end of the webpage there to
2 that disclosure.

3 A. Yes.

4 Q. Okay. And that disclosure says: "The hospital
5 declined to report their performance on this measure, so
6 a score was assigned to reflect the lack of information
7 available." Is that right?

8 A. Yes.

9 Q. Okay.

10 And I think earlier we were talking about
11 the "how," and I believe the question that you were
12 asked was does this webpage show how the score was
13 assigned. Do you recall being asked that question?

14 A. Yes.

15 Q. Okay. And would you agree with me that when it
16 says, so a score was assigned to reflect the lack of
17 information available, that that does indicate the how
18 here?

19 MR. CRAIN: Objection to form.

20 THE WITNESS: So I personally would agree with
21 that. I think the opposing counsel saw that

1 differently.

2 BY MS. WOOD:

3 Q. That's fair. I would agree with you on that
4 one.

5 So let's take it one step further. So if
6 we go back up to where the asterisk is linked to under
7 the hospital safety score 15 asterisk, and then do you
8 see right below that it says best hospital's score 100?

9 A. Yes.

10 Q. And then right below that it says average
11 hospital's score 74.40?

12 A. Yes.

13 Q. And then right below that it says worst
14 hospital's score 15?

15 A. Yes.

16 Q. Okay.

17 And so would you agree with me now, looking
18 at it from this perspective, considering those four
19 hospital scores in conjunction with the asterisk and the
20 disclosure at the bottom, that that shows how the scores
21 are assigned for this handwashing measure?

1 MS. LAWSON: Object to form.

2 MR. CRAIN: Object to form.

3 THE WITNESS: I personally don't think that the
4 display of the other three scores, the best hospital
5 average and worst, helps nor hurts the explanation of
6 how that 15 was assigned.

7 BY MS. WOOD:

8 Q. Okay. But do you think it makes it easier for
9 the reader of this webpage to look and see that if 15 is
10 this hospital's score and 15 is the worst hospital's
11 score, they can come to the conclusion that this
12 hospital is being assigned the worst hospital's score?

13 MS. LAWSON: Object to form.

14 MR. CRAIN: Objection to form.

15 THE WITNESS: I don't want to speculate what
16 people who come to the website, how they understand the
17 material.

18 BY MS. WOOD:

19 Q. That's fair.

20 But you would agree with me that at the
21 top, when it says this hospital's score 15 asterisk,

1 that matches at the bottom the worst hospital's score
2 15? It just doesn't include the asterisk?

3 A. Correct.

4 Q. Okay.

5 And I think earlier you may have testified
6 about whether or not the imputation model and the
7 current methodology penalizes hospitals. Do you
8 remember testifying about that?

9 A. We had a lot of conversation about imputation
10 today, so I would need to be refreshed on what --

11 Q. Sure.

12 A. Yeah, more detail might be needed there.

13 Q. Sure.

14 In your view, when Leapfrog was considering
15 the Fall 2024 methodology change, was the intent or the
16 purpose to change this imputation model to penalize
17 hospitals?

18 A. The goal was not to assess a penalty. The
19 goals were to improve the accuracy of the data and to
20 incentivize -- as a sub goal, incentivize survey
21 participation.

1 Q. Okay.

2 And then would it be fair to say that,
3 rather, the result then of the Fall 2024 methodology
4 change may be that hospitals feel penalized by receiving
5 those limited achievement scores?

6 MS. LAWSON: Object to form.

7 MR. CRAIN: Object to form.

8 THE WITNESS: I can't speak to how hospitals
9 feel.

10 BY MS. WOOD:

11 Q. Okay.

12 I think you said earlier that the
13 penalization is a byproduct of the imputation score. Do
14 you remember? And I'm not trying to mischaracterize
15 your testimony in any way. I just remember you
16 referencing it as being a byproduct.

17 A. Yeah, there may be a feeling of, yes, a
18 penalty.

19 Q. Okay. But that wasn't the intent or the
20 purpose of Leapfrog, to your knowledge?

21 A. That was not the stated intent.

1 Q. Okay.

2 Do you believe that hospitals should report
3 to the Leapfrog Hospital Survey?

4 A. I do.

5 Q. And why do you believe that?

6 A. Because I am a strong believer in transparency.
7 I think in transparency we create a better healthcare
8 system where we understand where our successes are,
9 where our failures are, and that those who are using the
10 healthcare system and those who are paying for the
11 healthcare system know how it's operated.

12 Q. And I know you have testified earlier that
13 sometimes you speak with hospitals in various
14 capacities. Have you ever heard any hospitals refer to
15 the Leapfrog Hospital Survey as kind of a benchmark or
16 an outline to improve their patient safety?

17 A. I -- can you repeat the question?

18 Q. Sure. Yeah.

19 I just know earlier you had testified that
20 sometimes you speak to hospitals in different
21 capacities. So the question I'm about to ask you, I'm

1 not insinuating that you have heard this before. I'm
2 asking if anybody at a hospital has discussed this with
3 you before.

4 But have any of the hospitals told you
5 that -- sorry. Now I'm forgetting my own question --
6 oh, that the Leapfrog Hospital Survey helps them put in
7 benchmarks and outline how they can improve on patient
8 safety measures?

9 A. So for purposes of the Leapfrog Hospital
10 Survey, I have had at least one conversation with a
11 hospital who does see the survey as an opportunity for
12 benchmarking their performance relative to others.

13 Q. And do you believe that to be true?

14 A. I believe it is a source of information for
15 hospitals on a very broad quality improvement journey.

16 Q. And based on your experience in working with
17 Leapfrog, would you understand that you -- or would you
18 testify to me that you understand the mission of
19 Leapfrog?

20 MR. CRAIN: Objection to form.

21 MS. WOOD: Yeah, I can fix that. I tripped

1 over that one.

2 BY MS. WOOD:

3 Q. Based on all your experience and working with
4 Leapfrog, it's been over a decade, almost two decades,
5 would you say that you understand what Leapfrog's
6 mission is?

7 A. Yes.

8 Q. And can you explain that to me in your own
9 words?

10 A. To me, it would be to drive improvements in the
11 quality of our healthcare system primarily using
12 transparency as the mechanism to do that.

13 Q. And do you believe that that's always been
14 Leapfrog's mission?

15 A. Yes.

16 Q. And do you believe that continues to be
17 Leapfrog's mission today?

18 A. Yes.

19 Q. Okay.

20 And so in your experience as a researcher
21 and as a principal faculty member at the Armstrong

1 Institute for patient safety and quality, do you believe
2 that Leapfrog's Hospital Safety Grade provides a benefit
3 to consumers?

4 A. I think sharing information in summary form is
5 what patients and consumers are seeking. So whether
6 that be a star rating, a letter grade, the research is
7 clear that that is what they find helpful for their
8 decision-making.

9 Q. Okay.

10 And have you done any research on whether
11 or not the patients benefit from those star ratings or
12 the Hospital Safety Grade?

13 A. No, I have not done any research on that.

14 Q. Have you read any research or peer reviewed
15 articles on that?

16 A. I have read some research on consumers' use of
17 publicly available quality and safety information. I
18 can't say it's the most recent. There may be more
19 recent information out there.

20 Q. And do you believe that consumers would lose
21 any sort of benefit if hospitals were not graded through

1 the Hospital Safety Grade?

2 MR. CRAIN: Objection to form.

3 THE WITNESS: Can you repeat the question one
4 time?

5 BY MS. WOOD:

6 Q. Sure.

7 If Leapfrog stopped grading hospitals, do
8 you think that that would have any negative impact on
9 consumers?

10 A. So the greatest benefit that's been noted for
11 public reporting of quality and safety information has
12 actually been the hospital's use of that information to
13 drive improvements within their own healthcare system.

14 -- hospital or healthcare system.

15 I don't want to be the bottom performer,
16 right, so I'm going to do what I need to do to get out
17 of the bottom. So in a sense, that improvement in
18 quality and safety has universal benefit, right.

19 Every patient that comes to that hospital
20 has some benefit of the hospital working to improve
21 their quality and safety.

1 Q. And would you say that the Hospital Safety
2 Grade also creates some competition between the
3 hospitals?

4 A. I don't know enough about that.

5 Q. Okay. I just wasn't sure if that's what you
6 were getting at. So that's okay.

7 And so then is it fair to say that if
8 Leapfrog stopped grading hospitals and now patients did
9 not have access to information on patient safety and
10 these measures, that could potentially harm patients?

11 A. I don't know about what the implications of
12 that would be.

13 Q. Okay.

14 Do you think that when patients have the
15 most accurate and transparent data when making their
16 informed decisions on where to treat, that that makes
17 them safer and protects them?

18 MS. LAWSON: Object to form.

19 MR. CRAIN: Object to form.

20 THE WITNESS: I believe that having information
21 is helpful in making a decision to where to receive

1 care.

2 BY MS. WOOD:

3 Q. And are you aware of any other rating systems
4 that are comparable to Leapfrog?

5 MR. CRAIN: Objection to form.

6 THE WITNESS: Can you define comparable?

7 BY MS. WOOD:

8 Q. Sure.

9 Do you believe think -- do you believe that
10 Leapfrog has any direct competitors?

11 A. There's no other entity I know that's putting
12 out a composite, composite and noncomposite
13 information -- well, let me start again.

14 I'm not aware of any other entity that's
15 putting out a composite score around the specific area
16 of patient safety. There are other entities, like the
17 Centers for Medicare & Medicaid Services that do publish
18 information about the quality and safety of care,
19 similar to what Leapfrog does.

20 Q. And do you have any knowledge about the CMS
21 star ratings?

1 A. I do.

2 Q. And what is your knowledge with regard to the
3 CMS star ratings?

4 MR. CRAIN: Object to form.

5 BY MS. WOOD:

6 Q. I guess we can start with do you have
7 experience with working with CMS in regard to those CMS
8 star ratings?

9 A. I do. I served on their technical expert
10 panel.

11 Q. Okay. Can you explain to me a little bit what
12 that was like?

13 A. Yeah. So that is a -- this is actually written
14 into federal legislation that CMS needs to publish a
15 star rating for hospitals. It is considered to be a
16 summary of all of the information that is shared on
17 their care compare website.

18 So early on in the technical expert panel
19 meetings, I would say, well, what are we actually trying
20 to measure? And the contractor was like, well, we're
21 supposed to summarize all the information. I'm like,

1 well, what's the underlying construct? We're just
2 supposed to summarize the information.

3 So it's not clear exactly what CMS is
4 measuring, but it is intended to be a summary of
5 information. And so what they do is they take the
6 measures that are publicly reported and have put those
7 into domains, and different domains get different
8 weights. They use Z-scores. It's all -- it's very
9 similar to how Leapfrog has gone about calculating
10 scores but just with a different set of measures and a
11 different set of constructs.

12 Q. To your knowledge, does CMS have any patient
13 safety measures that go into that star rating system?

14 A. They do.

15 Q. Okay.

16 And I know Leapfrog on their website
17 usually says, when looking at the Hospital Safety Grade,
18 consider other options or look to other sources. Does
19 that sound familiar to you?

20 MS. LAWSON: Object to form.

21 MR. CRAIN: Object to form.

1 THE WITNESS: I don't know what's said on the
2 website so...

3 BY MS. WOOD:

4 Q. Okay. Have you ever heard people at Leapfrog
5 discuss that patients should not only consider the
6 Hospital Safety Grade when choosing where to seek care?

7 A. Yes.

8 Q. Okay. And would you say that other -- strike
9 that.

10 Another source that patients could look at
11 is CMS star ratings. Is that correct?

12 MR. CRAIN: Object to form.

13 THE WITNESS: That is another publicly
14 available rating of hospitals.

15 BY MS. WOOD:

16 Q. And do you have any knowledge on how, I guess,
17 popular those star ratings are? You know, in your line
18 of business or speaking with hospitals, do you tend to
19 see that people rely on them or talked about relying on
20 them?

21 MS. LAWSON: Object to form.

1 MR. CRAIN: Objection to form.

2 THE WITNESS: So I can speak to my experience
3 with Johns Hopkins Medicine. The Board of Directors for
4 Johns Hopkins Medicine, as well as senior leaders,
5 have -- are very, very interested in the hospital safety
6 grades. And when they see that the safety grades are
7 dropping, there is usually a call for what's going to be
8 done to get us back to an "A" or to a "B."

9 So I think it's been a way to engage health
10 system leaders, Board of Directors, around the issue of
11 patient safety. That's just my experience with Johns
12 Hopkins Medicine.

13 BY MS. WOOD:

14 Q. Yeah.

15 And then does Johns Hopkins Medicine also
16 discuss their star ratings?

17 A. I believe so.

18 MS. WOOD: I think that's all that I have for
19 you.

20 THE WITNESS: Thank you.

21 MR. CRAIN: I have a little recross.

FURTHER EXAMINATION

BY MR. CRAIN:

Q. So just a few questions, Dr. Austin.

At one point counsel was asking you questions about whether the Leapfrog survey was a benchmark. Do you recall that line of questions?

A. Correct.

Q. And you said something like hospitals don't want to be the bottom performers. Do you recall testifying something to that effect?

A. Correct.

Q. Why don't hospitals want to be a bottom performer?

A. What I hear is that, specifically when you're dealing with physicians, they generally are individuals who have excelled throughout their lifetime in terms of academics and don't want to be perceived as being at the bottom.

Q. So to put it concretely, doctors working at a hospital don't want to work for an "F." Is that fair to say?

1 A. I can't speak for doctors working at "F"
2 hospitals.

3 Q. But the ones, the doctors you were just talking
4 about --

5 A. Yeah, they would -- yes. They would not want
6 to work at an "F" hospital.

7 Q. And fair to say that an "F" can damage a
8 hospital's reputation?

9 MS. LAWSON: Object to form.

10 THE WITNESS: I don't know -- well, what
11 reputation are you referring to?

12 BY MR. CRAIN:

13 Q. Fair enough.

14 So hospitals -- in your experience, do
15 hospitals have reputation in their communities, just
16 reputations for quality of care, for safety, that sort
17 of thing?

18 A. I think there are perceptions within
19 communities around which hospitals have higher quality
20 care than others.

21 Q. Can an "F" hospital -- can an "F" grade from

1 Leapfrog influence that perception?

2 A. I don't know.

3 Q. You have no opinion one way or another?

4 A. You didn't ask my opinion. You asked what I
5 knew.

6 Q. Okay. Fair enough. Fair enough.

7 Do you have an opinion?

8 You're getting good at this.

9 A. I don't know how much -- if reputation is --
10 well, let me start over.

11 I don't know how -- I don't know the
12 literature well enough to know how hospitals form
13 reputations in their communities.

14 Q. Okay.

15 A. Obviously, a component of that is consumers and
16 patients directly. There is media. There's a lot of
17 different influences, and I don't know how each of those
18 is tying into the Hospital Safety Grade and influencing
19 the reputation.

20 Q. Okay. Fair enough. I get it.

21 Okay. We talked -- you went back --

1 counsel went back to look at the Delray website again,
2 right. And you testified something to the effect of the
3 asterisk at the bottom of the page explains the how a
4 grade is assigned, right?

5 So I don't have a piece of paper for you,
6 but I'm going to do something a little avant-garde and
7 show you a website.

8 So I want to just direct you -- and just so
9 counsel can see, it's another Hospital Safety Grade
10 website. Do you see that?

11 So this is a hospitalsafetygrade.org
12 website. Can you see it okay?

13 A. I can.

14 Q. And do you see it says Pikeville Medical
15 Center? Do you see that?

16 A. Yes.

17 Q. And Pikeville is in Pikeville, Kentucky. Do
18 you know anything about Pikeville, Kentucky?

19 A. I do not.

20 Q. Okay.

21 What's the grade it gets?

1 A. They received a "D" in the Spring 2025 Hospital
2 Safety Grade.

3 Q. Okay.

4 So I want to go down and just look at safe
5 medication administration. Do you see that's toggled
6 there?

7 A. Yes.

8 Q. And that is the BCMA?

9 A. Correct.

10 Q. Okay.

11 So now, do you see what their score is?

12 A. It's a 25.

13 Q. Okay. And what's the worst score?

14 A. Twenty-five.

15 Q. Okay. And it has the little asterisk, right?

16 A. Correct.

17 Q. Now, read the asterisk for me. Can you read it
18 into the record?

19 A. The hospital declined to report their
20 performance on this measure, so a score was assigned to
21 reflect the lack of information available.

1 Q. Do you have any idea how the score was imputed?

2 A. Are you asking me do I know that, or do I know
3 that from what I'm reading there?

4 Q. From the information you have gathered from
5 this website or otherwise -- but you don't know
6 Pikeville, so I assume it's from this website -- how was
7 Pikeville's limited achievement score assigned?

8 A. I, Matt Austin, know that it was assigned based
9 on them not reporting to the survey, and they get
10 assigned a score based on that nonsubmission.

11 Q. So that's why it was assigned, right? It was
12 assigned because they didn't report, right?

13 A. Uh-huh.

14 Q. The question of how it was assigned I see as
15 conceptually different. Does that seem fair to you or
16 no?

17 A. I guess I see them as linked and maybe one in
18 the same. That's where I'm struggling to distinguish.

19 Q. So let me -- I can make it more concrete.

20 The imputation methodology as it applies
21 today has two steps, right?

1 A. Correct.

2 Q. Right? There is Step 1, historical, and Step
3 2, limited achievement, right?

4 A. Correct.

5 Q. Do you have any idea how Pikeville -- which
6 step was applied to Pikeville?

7 A. I know from the Hospital Safety Grade
8 methodology that declining to report on the measure is
9 what resulted in them getting a score assigned.

10 Q. But I'm asking a different question. I'll just
11 do it more directly. Did Pikeville get assigned limited
12 achievement through Step 1 or Step 2?

13 A. I don't know from what this is telling me
14 whether --

15 Q. And yet, to be clear, you testified earlier
16 that this asterisk explained how the score was assigned,
17 right?

18 A. I testified that the why and how to me were
19 sort of one in the same.

20 Q. Okay. So then just setting the semantics
21 aside, just looking at this asterisk, you have no idea

1 whether Pikeville got limited achievement through Step 1
2 or Step 2, correct?

3 A. I don't know that.

4 Q. Now, you -- sorry. Just to be clear. Correct?

5 A. Correct. I do not know whether they were
6 assigned a Step 1 or Step 2.

7 Q. Now, is it fair to say Step 1 is a little more
8 accurate because it relies at least on the prior year's
9 survey that Pikeville or another hospital might submit?

10 A. The underlying assumption is that a hospital's
11 specific information from a recent time period would be
12 a better indicator of current performance than just a
13 general imputed score.

14 Q. So Step 1 can be a better, I think you said,
15 better indicator of current performance, right?

16 A. Correct.

17 Q. Okay. And yet you have no idea whether
18 Pikeville is Step 1 or Step 2, right?

19 A. Not from what's shown here.

20 Q. Which, again -- can you state for the record
21 what is being shown here?

1 A. What's being shown here is the hospital's score
2 with an asterisk, which says the hospital declined to
3 report their performance on this measure, so a score was
4 assigned to reflect the lack of information available.
5 So that could be either Step 1 or Step 2.

6 Q. Great. Okay.

7 So we'll set Pikeville aside, our dear
8 friends in Kentucky.

9 A couple other questions. So counsel
10 raised the question of whether the limited achievement
11 score was a benefit, right? Do you recall that line?

12 A. Yes.

13 Q. Okay. Is it your testimony that assigning
14 limited achievement automatically in Step 2 is a
15 benefit?

16 A. I did not testify to that.

17 Q. I just want to understand if it is your
18 testimony.

19 A. That is my testimony, that it is not
20 necessarily a benefit.

21 Q. Can it be a benefit ever?

1 A. For some hospitals it could be a benefit.

2 Q. Now, why is that, though?

3 A. If the alternative was to assign zero,
4 assigning a 15 is better than a zero. But if we
5 assign -- if the decision was to assign 50, assigning 15
6 would be a negative. So I don't know if there's a
7 universal way of answering that question.

8 Q. Fair enough. So let me just lay it out this
9 way. If a hospital participated in the survey and
10 failed on every hand hygiene question, what score did
11 they get?

12 A. They would receive limited achievement.

13 Q. They wouldn't achieve zero, right?

14 A. They would be scored as limited achievement.

15 Q. So what is the benefit vis-à-vis the
16 nonparticipating hospital and the hospital that scores
17 zero down the line? Is there a benefit? Let's start
18 with that.

19 A. Can you repeat that again?

20 Q. Yeah.

21 Counsel was suggesting there's a benefit

1 that Leapfrog gives limited achievement versus zero.

2 But just to be clear, no hospital gets zero, right?

3 A. In the current scoring methodology, no hospital
4 gets zero.

5 Q. Even if the hospital failed every one of the
6 questions we looked at for hand hygiene, they would get
7 I think it's 15, right?

8 A. Correct.

9 Q. Okay.

10 A couple other lines. So we talked about
11 the Alexandria, Virginia notes. Do you remember that
12 document?

13 A. Yes.

14 Q. I think that was Exhibit --

15 A. Twenty-seven.

16 Q. -- 27. And you said at one point other than
17 the notes, I don't remember anything. I just want the
18 record to be clear. Do you remember the meeting, or are
19 you just looking at the notes?

20 A. I remember having an in-person meeting with the
21 expert panel. I can picture a conference room. I

1 honestly can't remember if it was this meeting or a
2 different meeting.

3 Q. I guess what I'll say is do you remember,
4 actually have a memory of what was said, or you just
5 have no reason to doubt the notes?

6 A. I have -- I do remember at this in-person
7 meeting, I do remember the conversation about whether an
8 explicit penalty should be something that's on the table
9 or if Leapfrog should consider assigning an explicit
10 penalty.

11 Q. Okay.

12 A. I do remember that, but I don't remember
13 whether it was this meeting or another meeting. But
14 when I look at these notes, this seems to corroborate
15 that it was this meeting.

16 Q. Okay. Fair enough.

17 And then I want you to just tell me
18 everything you remember about the discussion about the
19 penalty you're referring to just so it's clear.

20 A. So what I remember, which may be different than
21 what's in the notes, is specifically Dr. Andrew Bindman,

1 who at the time was the head of -- the director of the
2 Agency for Healthcare Research and Quality, which is the
3 federal agency that oversees quality and safety work.
4 From what I remember, Andy is -- broached the subject
5 of, well, hospitals should just be reporting to the
6 survey. Shouldn't we just like assign some sort of
7 penalty for them if they aren't reporting? That will
8 get them to report.

9 Q. Fair enough. Okay.

10 A. So that's what I remember.

11 Q. Yep.

12 A. Because I sort of remember where I was sitting,
13 where he was sitting.

14 Q. Okay. And anything else you remember about
15 that --

16 A. No. That's what I remember.

17 Q. Okay.

18 A couple of last questions. HCAHPS. So
19 you talked a little bit with counsel about HCAHPS,
20 right?

21 A. Correct.

1 Q. What does HCAHPS measure?

2 A. HCAHPS measures the patient experience of their
3 inpatient hospital stay.

4 Q. Okay. So if a hospital is loud, is that
5 reflected in HCAHPS?

6 A. So there are different domains within the
7 HCAHPS survey. One is quietness of the hospital
8 environment.

9 Q. Okay. Can you give us a sense of the others?

10 A. Yeah. So the five that are included in the
11 Hospital Safety Grade include physician communication,
12 nurse communication, communication about medicines.

13 Q. Not a memory test.

14 A. The other -- the five that we've included are
15 all related to communication --

16 Q. Okay.

17 A. -- and sort of the importance of communication
18 as it relates to patient safety.

19 Q. And there are other HCAHPS domains that are not
20 included?

21 A. Correct.

1 Q. Okay.

2 And HCAHPS, as you said, relates primarily
3 to patient satisfaction?

4 A. Patient experience.

5 Q. Experience. I'm sorry.

6 A. Yes, which is considered a different construct
7 than patient satisfaction.

8 Q. Got it. And is it a different construct from
9 safety?

10 A. There are -- there is probably some conceptual
11 overlap between safety and patient experience.

12 Q. Okay.

13 A. There's probably some overlap between patient
14 experience and patient satisfaction, to be fair.

15 Q. So like a Venn diagram?

16 A. Correct.

17 Q. Okay. Got it.

18 I think the last sequence, I want to go
19 back to Exhibit 3, the methodology document that you
20 were asked about. Do you recall that?

21 A. I remember being asked about the number of

1 measures --

2 Q. Yes.

3 A. Yes, in each domain.

4 Q. So I want to just -- a quick question for you.
5 Does Leapfrog -- for nonparticipating hospitals that are
6 imputed, does Leapfrog impute secondary data to assign a
7 score?

8 A. Is -- can you repeat that?

9 Q. Yeah, let me break it down. So let's go back
10 to the AHA days, right. So back then when Leapfrog was
11 using the American Hospital Association data, it was
12 using the AHA data as a secondary source that it was
13 imputing into the safety grade score. Is that fair or
14 no?

15 A. Correct. So the AHA data was the data that was
16 being used to impute a score.

17 Q. Okay. Because the imputation model is not
18 secondary data itself. It's a method of imputing
19 secondary data, right?

20 A. Correct.

21 Q. Okay. To impute, one needs secondary data,

1 right?

2 A. No.

3 Q. No. Okay. Tell me why.

4 A. So as outlined in the famous email where we
5 list the five different imputation options, one of them
6 is using secondary data to arrive at some sort of
7 estimate of the hospital's performance.

8 Q. Got it.

9 A. But one could just assign zero. One could
10 assign some value above or below the mean, right. So
11 one does not necessarily require secondary data to
12 impute a score.

13 Q. Okay. But if one is imputing secondary data,
14 there needs to be a secondary data source, in theory,
15 right?

16 A. Correct.

17 Q. Okay.

18 So I want to go to page 5 of the
19 methodology document, Exhibit 3. You see it's the
20 measures you were talking about before?

21 A. Yes.

1 Q. And do you see the top three at least are three
2 of the imputed measures, right?

3 A. Which page are you on?

4 Q. I'm looking at five.

5 A. Okay.

6 MS. LAWSON: Is it four of the slide, or is it
7 five of the slide?

8 BY MR. CRAIN:

9 Q. Oh, I'm sorry. It's the one -- I may be --
10 page 4. You're right. Page 4.

11 A. Okay.

12 Q. Okay. I'm pulling it off my electronic
13 version.

14 So my question is do you see where it says
15 Computerized Physician Order Entry right there?

16 A. Yes.

17 Q. And Primary Data Source is the 2024 Leapfrog
18 Hospital Survey, right?

19 A. Right.

20 Q. That's accurate, correct?

21 A. Correct.

1 Q. Secondary data source says the imputation model
2 applied, right?

3 A. Correct.

4 Q. For any hospital under Step 2, there isn't a
5 secondary data, right?

6 A. In the -- are you asking about the current?

7 Q. Yes.

8 A. In the current methodology, there is not
9 secondary data, correct.

10 Q. Under Step 2?

11 A. Under Step 2.

12 Q. Is there under Step 1, or would you not call
13 the historical secondary data?

14 A. I wouldn't call that secondary data.

15 Q. Okay.

16 So fair to say for CPOE, BCMA, IPS, and
17 hand hygiene there is no secondary data?

18 A. We are currently not using secondary data as
19 part of the imputation models.

20 Q. Okay.

21 MR. CRAIN: Okay. Nothing further from me.

1 You good?

2 You're free to go unless Sara wants to go.

3 MS. LAWSON: We can go off the record.

4 MR. CRAIN: Off the record.

5 THE VIDEOGRAPHER: This concludes the
6 deposition of Dr. Matthew Austin. This ends media unit
7 number nine. We're off the record. The time is
8 6:06 p.m.

9 THE COURT REPORTER: Ms. Lawson, will you be
10 handling signature for the witness, or are you waiving
11 signature?

12 MS. LAWSON: We'll read and sign.

13 She'll prepare a transcript of it so that
14 you can review your testimony and note any corrections.

15 THE COURT REPORTER: Ms. Wood, do you need a
16 rough draft as well?

17 MS. WOOD: Yes, if I can get a rough as soon as
18 possible.

19 (The deposition adjourned at 6:06 P.M.)
20
21

1 I, Marlene Kerr, a Notary Public of the
2 District of Columbia, do hereby certify that the
3 within-named witness personally appeared before me at
4 the time and place herein set out, and after having been
5 duly sworn by me, according to law, was examined by
6 counsel.

7 I further certify that the examination was
8 recorded stenographically by me, and this transcript is
9 a true record of the proceedings.

10 I further certify that I am not of counsel
11 to any of the parties, nor in any way interested in the
12 outcome of this action.

13 As witness my hand this 29th day of
14 September, 2025.

15 
16

Marlene Kerr

Notary Public

17
18 My Commission Expires:

19 July 28, 2026.
20
21

CERTIFICATE OF DEPONENT

I hereby certify that I have read and examined the foregoing transcript, and the same is a true and accurate record of the testimony given by me.

Any additions or corrections that I feel are necessary will be made on the Errata Sheet.

Matthew Austin

Date

(If needed, make additional copies of the Errata Sheet on the next page or use a blank piece of paper.)

Job Number: 7616361

PAGE/LINE	SHOULD READ	REASON FOR CHANGE
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This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

September 29, 2025

Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog Group

DEPOSITION OF: Dr. Matthew Austin (# 7616361)

The above-referenced witness transcript is available for read and sign.

Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those on the attached Errata Sheet.

The witness should sign and notarize the attached Errata pages and return to Veritext at errata-tx@veritext.com.

According to applicable rules or agreements, if the witness fails to do so within the time allotted, a certified copy of the transcript may be used as if signed.

Yours,

Veritext Legal Solutions

Page 420

[& - 161,000]

&	366:20 368:7	11 4:6 6:8 48:6	134,000 352:3
& 2:3 9:18 10:2	403:2,12 404:1	62:20 63:1	139 6:11
79:18 80:16	404:6,7,14,18	81:16 87:9	14 6:12,19
364:11 365:2	405:5 415:12	113:19,20	160:13,14
392:17	1,400 150:18	133:12,15	143,898 43:16
0	1.2 325:15	149:3	14327 357:7
006 44:17	1.22 334:10,13	113 6:6,8	358:17
02190610.pptx	1.31 334:8	11:49 155:9	14th 196:10
357:19	1.40 334:5	11th 133:4	197:1
08526 9:9	1.46 333:18	12 6:9 40:13	15 6:15 96:20
0900 323:3,21	334:2,2,13	48:6 77:8	163:6,7 178:15
1	337:9	81:16 127:6	178:16 179:8
1 5:6,7 20:13	1.5 340:13	128:17,18	204:8 218:13
20:14 24:10,11	1.53 340:13	299:13 303:19	218:16 219:18
25:9 27:6,7	10 6:6 48:6,9	364:14,19	277:15,18
28:9 79:14	68:16 87:9	365:1 366:9	278:5 286:4
93:13 118:5,15	113:3,4 116:5	128 6:9	305:11 332:11
120:13,15	129:5 165:15	12:17 164:9	376:4,16
121:14 122:1,6	177:9 178:3	12:27 174:17	377:14,20
126:9,10	191:9,10	12:35 25:10	379:6 380:6,11
127:10,15	363:10,14	12:56 155:15	380:16,21
159:2 161:18	364:4,7	12:58 158:17	382:7,14 383:6
162:8 166:9,15	100 1:13 2:16	12th 6:6,8	383:9,10,21
166:18 167:6	96:20 281:4	113:10 114:7	384:2 406:4,5
168:2,9,17	350:7 352:17	155:21 156:4	407:7
169:5 170:8,13	372:6 382:8	161:3,21	16 6:17 178:16
170:17 179:4	10166-0193 2:7	170:12 196:21	178:19 179:9
197:21 200:3,7	102 5:19	256:8,10	179:10,11
209:9 218:7	105 351:5,6	13 6:11 125:7	185:6,7 376:8
225:5,10,16,20	105,000 351:15	139:14,15	376:15
227:6 242:6	10:05 70:16	154:12	160 6:12
327:7,8 365:12	10:22 71:8	133 353:1	161 3:5
	10th 358:10,19	134 351:18	161,000 351:15
			352:2

[163 - 2025]

163 6:15	243:5 267:4	41:2 54:3	359:15 360:15
16473 195:21	271:7 308:5	286:19 293:19	360:15 361:10
16th 140:9	347:21 348:3	2013 7:19 54:3	361:15
141:3	365:13 366:20	88:4,9 286:10	2020 158:4
17 6:18 195:15	368:8 403:3,12	286:19 292:13	274:4,14 275:1
195:16,19	404:2,6,18	2014 54:13	2020/21 159:9
18 7:6 135:8	405:5,14 415:4	56:1 85:16	2021 8:7 158:4
205:9,10	415:10,11	86:16 88:2,3,3	239:5 275:5
18332 204:9	2,652 288:8	88:9 89:1,21	314:2,9 318:7
185 6:17	2.01 340:11	2015 54:13	2022 275:6
19 7:8 217:2,3	2.12 340:11	332:18	2023 274:5
327:7,8 379:21	2.52 340:8	2016 105:9	275:6 276:8
197 6:18	341:20 342:7	323:9,21 324:1	277:3 280:1,2
1995 33:19	20 5:6 7:9	360:18,19	281:9 286:18
2	68:15,16	361:13	2024 6:6 7:16
2 5:7 23:16,17	159:12 230:15	2017 318:4	7:18 28:18,18
27:6,12 93:16	230:16 246:13	2018 43:10	81:10 112:13
93:17 95:19	304:12,16	49:17 55:16	112:16 113:10
104:6 118:17	306:2 325:1	66:2,14 67:4,6	114:13 124:14
120:10 121:14	332:11	68:7 105:19,21	146:17 161:3
122:1 143:13	20,000 349:3	138:9	177:20 234:20
170:20 171:1,6	20,252 351:1	2019 8:15	239:5,13 243:5
171:9 174:11	200 2:6	105:11,12,14	256:12,13
175:5,12	2001 244:8	105:20 106:17	272:12 284:4
177:20 179:2	2004 328:17	107:8 108:6,12	284:10,17
179:12,14,18	329:1,4	108:13,14	294:2 303:12
182:6 186:7,11	2005 34:14	138:9 256:8	318:3 384:15
186:18 192:19	2007 39:10	321:10 322:3	385:3 414:17
194:7,11 200:4	2008 35:10	323:9 324:1,7	2025 4:4 5:4
200:7,16 218:4	36:11 39:6	333:18 348:20	6:4 7:4 8:4,10
218:9 225:3,10	2011 35:8 54:3	349:12 350:5,9	9:4 26:14 27:4
225:17 227:11	56:1 160:3,7	350:10 352:4	28:17 68:8
227:18 228:8,9	2012 35:10	352:14 357:12	88:15 89:1,21
	36:11 40:7,19	358:10,19,20	106:5,10 107:8

[2025 - 40]

177:11,20 322:1,16 323:9 324:4,8 338:5 349:2,16 352:20,21 355:21 356:1 401:1 417:14 419:4 420:2 2026 417:19 204 353:5 205 7:6 21 7:11 159:12 234:7,8,11 306:20 212.351.2454 2:8 21202 1:14 2:17 2128 192:1 217 7:8 22 7:12 242:9 242:10 22nd 196:14 23 5:7 7:14 255:15,16 230 7:9 234 7:11 24 7:15 136:9 271:21 272:1 284:15 242 7:12 2440 1:14 2:16 25 4:4 5:4 6:4 7:4,17 8:4,7	90:5 135:4 150:20 195:6 283:10,18 290:12 294:3 325:1 355:21 372:6 401:12 419:4 250515 355:6 255 7:14 25th 9:4 32:5 314:1 26 7:19 135:6 281:10 286:4,5 26.1 1:13 27 8:6 148:9 149:3 306:21 307:1 317:16 319:15 373:4 407:16 272 7:15 28 8:7 27:18 312:18,19 417:19 283 7:17 286 7:19 29 5:8 8:9 27:18 321:16 321:17 333:9 333:10 343:14 343:15,16 348:19 354:18 354:20,21 420:2	29th 417:13 2:13 229:17 2:38 230:2 2b 126:7,11,12 126:13 3 3 5:8 7:16 29:7 29:9,15 110:14 131:11 149:3 177:3 224:19 229:4 272:12 337:8 363:20 363:21 376:6 376:14 411:19 413:19 3.89 340:5 30 5:10 8:12 79:17 265:3 304:13,16,16 306:3 312:18 327:21 329:21 330:1 343:13 30,000 346:14 346:18,21 307 8:6 31 8:13 355:10 355:11 312 8:7 312.821.6139 3:7 31896 417:16 32 8:15 113:15 356:18 357:6	321 8:9 32a 113:2 33 128:13 330 8:12 33a 139:13 34 163:6 35 5:12 350 62:9 353,000 353:1 353.6. 350:16 355 8:13 356 8:15 36 131:10 185:5 36.3. 131:10 362 4:7 38 195:14 397 4:8 3:26 283:6 3:43 283:14 4 4 5:10 30:13,14 42:19 114:7 156:5 288:20 292:3 297:12 414:10,10 4.92 340:8 341:19 342:7 40 42:2 45:16 48:19,20 66:3 66:15 67:2 133:11 240:17
--	---	---	--

[410.949.1181 - a.m.]

410.949.1181 2:18 417 4:11 418 4:12 419 4:13 42 5:13 43 205:8 437364 114:17 45 1:12 234:6 4500 3:5 46 353:4 46.6 350:16 47 242:8 49,000 349:3 4:25 232:6 4:55 356:14 4a 43:13	58 321:16 59,799 45:14 48:20 5:07 357:1 5:11 362:7 5:13 362:13 5:41 186:5 5th 357:12 358:20	7367 120:8 7369 118:10 7375 125:8 74.40 382:11 74782 116:7 75 372:6 76 307:21 7616361 1:21 418:18 419:21 420:4 78 5:17 782 116:8	35:21 42:21 71:5 78:18 102:21 113:5 113:21 128:19 139:16 160:15 163:8 185:8 195:17 205:11 217:4 230:17 234:9 242:11 255:17 272:2 283:11 286:6 307:2 312:20 321:18 330:2 355:12 356:19 90.5 279:18,20 90.5. 280:17 90s 305:10 91.8 350:3 92.8 274:14 275:1 96.8 275:5,6 97.9 275:6 9813 206:11 9814 207:6 9:09 1:16 9:3 9:10 11:10 9:11 192:1 9:12 11:14 9:25 1:6 9:9
5	6	8	
5 5:12 8:15 35:19,20 114:7 156:5 290:12 365:1 366:10 413:18 5-3 179:4 50 68:13 336:8 336:9 337:5 372:6 378:21 406:5 50,000 104:16 348:13,18 500 269:6 5116 273:4	6 5:13 42:19,20 44:17 133:15 364:4 60 66:3,6,18 60601 3:6 63 280:16,17 64 30:13 65 102:18 347:17 668 288:21 67 78:15 6:06 416:8,19	8 5:17 78:16,17 80 245:17 246:5 339:14 80526 1:6 80s 305:10 8330 184:1,13 8331 163:21 164:4 8332 165:21 85 277:19 85.7 276:7,8 277:3,8 87 350:2	
	7	9	a
	7 5:15 51:12 60:8 63:13 71:4,14 133:12 133:12 364:4 7.98 340:5 70 42:2 70s 305:10 71 5:15 7366 115:13	9 5:19 52:6 102:19,20 131:2 347:18 9/25/2025 20:15 23:18 29:10 30:15	a.m. 1:16 9:3 11:10,14 70:16 71:8 155:9

[ability - actually]

ability 13:13 169:12	accurate 36:5 55:4,15 79:3	131:7,8,16,21 132:5,10 138:3	405:10,14 406:12,14
able 75:5 154:6 241:17 252:12 261:15 295:3 337:17	91:20 92:8 102:3 111:4 127:21 133:19 142:3 161:12 199:13,16	144:11,17 173:8,13 175:14 176:7 176:11,20 177:21 178:10	407:1 achieving 131:8,9,13
above 1:15 21:19 218:12 291:3 293:14 294:11 305:16 413:10 420:5	203:13 209:3,4 209:20 210:2,4 210:5 220:11 220:20 224:10 247:19 248:8 250:17,20 271:8,9,13	179:17 180:2 180:11 181:6,8 181:13,14,17 181:17,19,20 184:4,16 188:10 192:7 192:15 204:16	acknowledge 215:21 acquire 224:16 acquires 109:8 acting 208:20 action 1:15 11:20 142:12 417:12
absence 97:10 220:2	276:12 307:18 308:21 309:15 311:19 341:9 341:16 342:5 353:13 359:5,9 360:1 391:15 404:8 414:20 418:5	204:20 215:17 216:10 220:4 228:16 238:18 238:20 239:14 239:20 267:5 267:11 268:3 268:12 269:20 271:6 290:8,10 294:21 296:6,8 296:8 298:5,6 339:6 371:19 371:20,20 372:14,20,20 376:5,12,15 377:1,14,21 378:4,14 379:14,15,18 380:10,12 385:5 402:7 403:3,12 404:1	active 56:5 activities 38:17 actual 94:2 146:3 147:6 154:14 192:4 201:13 213:1 237:15 238:15 240:3 249:7 267:13,19 268:4,13,16 337:8 339:4 353:18
absent 94:20	accurately 25:4 51:21 247:13		actually 11:5 24:10 25:21 33:1 34:20 36:14,18 39:9 53:8,21 60:6 63:2 64:6 70:7 78:4 81:15 86:5,6 94:13 105:21 108:6
absolute 250:1 276:19 280:3	achieve 237:21 406:13		
academic 361:7	achieved 181:18 281:3 281:10,11 328:11,14 371:18		
academics 397:17	achievement 83:7,14 95:12 96:1 97:6		
accepted 82:8			
access 150:15 150:17,18 258:3 391:9			
accidentally 141:5			
account 140:12 153:1,4			
accountable 111:20			
accuracy 142:7 249:8,13,20 250:11 311:10 347:1 384:19 420:8			

[actually - aha]

110:4 112:3 116:1 118:17 143:17 145:8,9 150:8 169:7 175:18 188:10 190:8 193:20 208:14 210:18 212:13 216:18 222:4 225:15 241:17,18 248:19 267:7 276:2,3 279:8 280:6 291:16 293:7 307:11 317:17,18 326:14 328:2 332:10,11 335:12,14 336:18 338:5 342:15 343:9 350:13 353:1 354:17 355:21 364:3,3 370:8 373:6 374:6 377:4 379:8 390:12 393:13 393:19 408:4 acute 288:8 adaptation 171:6 added 25:12 49:1 90:10 116:15 202:5	adding 26:15 197:14 addition 244:21 326:17 375:18 additional 28:8 50:10 91:11 264:5 332:8 418:15 additions 418:7 address 82:5 147:10 154:18 201:17 246:20 291:4 300:3 addressed 82:9 299:9,17 addressing 299:18,19 adhere 21:14 adjourned 416:19 adjusting 331:8 adjustments 52:18 administration 92:18 401:5 admissions 109:12 adopt 285:1,2 adopted 125:14 127:3 adult 179:1 adversely 243:13	advice 287:14 advisable 300:21 advise 208:14 advised 208:9 211:1 advising 208:14 advisory 208:20 285:6 affect 46:15 affected 260:14 290:16 affects 47:16 210:19 afraid 192:3 agency 252:18 409:2,3 agenda 8:6 25:14 26:4,5 151:20 307:10 307:13 315:5 315:19 316:10 316:14,18,20 317:8,11 320:4 320:11 373:9 aggregate 108:21,21 109:1,1 261:16 ago 37:9 54:14 87:9,10 96:6 143:16 145:20 177:14 180:4 180:15 253:15	272:16 304:2 308:17 342:17 agree 73:5,10 74:2,14 75:2,7 98:15 111:10 111:12 211:7 211:11,21 236:16 264:17 265:5 303:10 319:2,3 320:15 320:16 335:6 367:12 369:4 377:3 378:13 380:9 381:15 381:20 382:3 382:17 383:20 agreed 203:21 204:21 301:9 agreement 301:9 361:20 agreements 420:14 aha 83:20 84:1 84:3 239:6,10 254:10,11,13 256:14 257:17 257:19 258:4,5 258:10 259:4 259:12,13,15 260:4 261:9,14 261:18,21 262:3,12 263:6 263:9 264:2 266:18 269:7,9
---	---	---	--

[aha - apparently]

270:19 314:5,7 314:13 412:10 412:12,15 ahead 7:19 27:20,21 89:2 157:15 174:12 186:19 189:12 208:16 221:1 225:18 236:10 277:14 280:11 286:11 304:19 339:20 airline 35:4 airlines 34:21 al 1:4 4:3 5:3 6:3 7:3 8:3 9:7 419:3 420:3 alana 243:2 albeit 349:16 alcohol 279:7 332:6 alex 59:1 63:3 64:10 116:14 175:2 177:17 188:7 206:7 313:15 alex's 189:9 alexandria 317:17 319:16 407:11 algorithm 281:15 algorithms 40:1	aligned 55:11 192:13 allen 17:16 allocated 66:2 66:14 allotted 420:15 allow 94:18 252:1,4 allows 74:10 alternative 128:5 406:3 altogether 250:18 ambulatory 59:13 61:8 american 82:18 84:1,16 239:5 412:11 amount 45:21 46:3 49:18 66:14 279:7 327:14 analogy 221:21 252:10,12 analyses 39:20 107:11 272:17 272:18 288:2 291:3 analysis 7:16 36:15 37:17 38:14 106:9,11 106:13 107:3,6 107:10 108:10 108:11 112:1	196:17 269:14 272:12 273:7 275:20 288:7 288:13 293:4 319:13 324:1 327:4 332:10 335:6,7 358:7 360:7 analyst 140:11 142:9 313:7,14 356:3 analysts 45:12 analytic 64:11 analytical 189:13 analytics 59:5 analyze 105:15 analyzed 286:17 analyzes 87:20 andrew 314:19 316:16 408:21 andy 409:4 angeles 245:3 annual 60:15 351:10,11 annually 243:12 answer 14:7,8 14:13 15:13 51:1 68:19 87:17 89:4,5 90:2 98:5 101:3 144:20	145:16,16 146:15 190:4 207:3 225:7,19 236:19 238:8,9 243:20 251:2 266:6 267:17 276:4 280:15 295:3 306:7 368:5 370:2 379:3 answered 269:9 274:20 276:7 answering 406:7 answers 12:21 13:6 anybody 14:11 16:15 19:18 131:20 133:15 174:9 372:17 372:17 374:21 387:2 anymore 259:16 302:7 312:10 anyway 210:20 apologies 364:1 apologize 79:14 90:20 207:20 apparent 299:9 apparently 153:5
---	--	---	--

[appear - asked]

appear 131:3 202:15	319:14 372:3	arguable 367:21	332:9,20 337:21 345:19
appeared 417:3	approaching 188:11	argue 88:16	articles 361:2
appears 36:4 337:14	appropriate 97:10	102:6 264:4 350:21	389:15
apples 108:10 108:11	appropriately 90:12	argument 350:8	articulate 297:9
applicable 325:18,19 370:21 420:7 420:14	approve 285:16	arjun 145:6 375:3,7,15,19	articulates 77:19
applied 96:4 403:6 415:2	approved 52:13 285:13 285:15	arjun's 135:12	articulation 80:2 92:9 144:3,6
applies 402:20	approximately 16:14 39:7 40:6 42:1 54:12 68:9 81:1 124:4 265:3	armstrong 2:13 9:17 19:1 20:20 23:16 24:2 30:17 41:8 43:4,19 43:21 44:9,16 134:21 140:7 160:18 185:15 195:20 255:19 272:4 307:5 357:6 358:16 359:21 388:21	artifact 254:3,9 254:21 255:3 270:4,6
apply 109:12 302:6 326:1	approximation 69:15 262:5	armstrong's 41:5	aside 139:2 142:19 163:4 169:11 185:3 195:13 205:7 230:6 233:11 253:12 265:8 267:10 286:2 306:19 312:16 321:3 360:13 403:21 405:7
appreciate 363:4	april 6:6,8 106:14 112:16 113:10 114:7 141:3 146:17 155:21 156:4 161:3,21 170:12 196:14 196:21 256:8 256:10	arrive 413:6	asked 5:20 21:5 75:16 77:6 78:11,13 98:8 103:18 107:7 143:9,11 159:21 216:8 265:21 266:4 301:8 329:10 347:19 381:12 381:13 399:4
approach 53:15 88:9 108:15,18 190:18 209:15 257:13 260:13 260:19 291:4 291:10,12 293:17 294:6 317:19	apt 168:1	arrived 40:20 222:17	
approaches 82:8 159:12 199:11,12 289:18 291:3 291:16 293:8 293:16 297:13 299:4 306:11	area 216:13 392:15	article 8:12 85:17,19 86:12 86:16 87:6,11 87:19 297:20 328:17,19 329:16,20 330:4 331:14	
	areas 59:11,16 151:1		

[asked - attorney]

411:20,21 asking 62:19 67:3 69:9,11 77:11 81:19 124:13 166:13 166:15,15 209:21 265:18 266:7 315:20 318:9 359:8 361:4 387:2 397:4 402:2 403:10 415:6 asks 21:18 97:20 181:11 assertion 367:13 assess 63:2 74:10 112:1 332:1 384:18 assessed 281:21 assessing 289:18 assessment 245:4 253:3,6 302:17 306:10 assign 40:3 62:17 94:9 171:20 215:16 216:9 220:3 295:18,20,21 296:7,21 298:11 319:17 371:15 372:5 406:3,5,5	409:6 412:6 413:9,10 assigned 100:6 126:14,18 134:7 153:10 180:1,8 181:6 226:6,10 227:2 227:3,6,14 228:6,12,14,15 228:20 372:6 373:21 376:20 380:11 381:6 381:13,16 382:21 383:6 383:12 400:4 401:20 402:7,8 402:10,11,12 402:14 403:9 403:11,16 404:6 405:4 assigning 82:20 83:3 94:16 118:15 176:11 180:11 188:9 200:8 205:3 214:21 267:5 378:13 405:13 406:4,5 408:9 assignment 227:17 238:18 267:12,18 268:2,12 269:20 271:6 339:6	assigns 176:19 assistantship 39:11 associated 94:13 109:7 238:10,13 325:16 326:8 364:8 association 82:18 84:1,16 239:6 330:7 331:6 412:11 assume 14:1 22:16 26:18 251:17 278:3 280:13 402:6 assuming 110:6 216:14 assumption 97:13,16 109:21 176:5,9 180:6,16,20 268:15 275:11 295:10 296:16 297:9 326:16 345:5,9,12,13 345:16 379:7 404:10 assumptions 292:6,16 293:1 294:7,8 296:18 296:20 302:10 331:17 345:7 346:1	asterisk 222:16 222:18 224:2,4 224:5,6 225:9 226:9,13,20 227:12 228:19 380:6,21 382:6 382:7,19 383:21 384:2 400:3 401:15 401:17 403:16 403:21 405:2 attached 113:18 114:5 116:14 140:16 141:5,5 272:16 342:15 355:20 358:14 420:10 420:12 attachment 7:16 113:14 141:4 197:10 198:7 206:19 272:11 284:9 317:16 355:5 357:17,18 360:1 attendance 16:15 attended 156:21 attendees 156:8 197:14 attorney 2:12 14:6 15:1,16
--	--	---	---

[attorney - back]

18:1 attorneys 2:2 3:2 attributable 109:5 110:1 326:4,6,11 audible 13:6 audio 17:6 audits 279:8 august 8:7 314:1 austin 1:11 2:12 4:2 5:2,7 5:10,12 6:2,12 6:13,15,17 7:2 7:7 8:2,7,9,16 9:5,16 11:17 12:3,3 15:12 20:17 23:20 36:2 43:2 71:10 73:8 78:20 103:2 113:7 114:3 133:8 139:18 160:17 177:7 184:6 185:10 195:19 207:14 217:6 225:16 230:4,19 234:12 242:14 283:16 286:8 313:2 321:20 357:3 362:16 397:3 402:8	416:6 418:11 419:2 420:4 austin's 45:16 author 61:14 61:15,16 86:19 286:20 356:2 authority 208:18 authors 86:9 292:14 295:10 299:2 300:21 301:2,8 330:13 336:15 automatic 228:16 238:17 267:12,18 268:2,11 271:6 automatically 179:17 215:16 216:9 267:4 405:14 available 28:6 30:4 72:18 73:18 91:7 111:19 224:8 227:15 228:10 244:11 253:3,7 253:10 260:15 281:15 290:18 291:7 293:10 296:13 300:9 301:15 381:7 381:17 389:17 395:14 401:21	405:4 420:6 avant 400:6 avenue 2:6 average 153:11 216:13,14,15 269:8,10 319:7 353:2,7 382:10 383:5 averages 344:16,17 avoid 292:15 297:13 avoided 292:5 aware 19:7 29:19 60:16 77:18 95:13 98:1 229:2 233:13,16 260:6 264:3 265:4 285:7,10 285:10 294:4,4 299:14,15 364:17 392:3 392:14	back 11:13 19:16 36:8 54:17 60:8 61:2 71:7,10 72:15 75:19 83:18 86:7,9 87:19 89:14 98:14 102:4 105:18 106:14 110:8,10 115:18 117:7 120:7 125:5 127:6,19 129:4 130:16 136:2,6 136:9 139:3 141:14 142:21 148:8 152:18 152:21 154:11 154:12 155:14 155:17 156:3 159:1,4 165:4 168:10 169:13 169:18 172:13 177:17 180:13 182:5 187:7 197:18 202:21 204:2 209:12 212:14 213:8 218:7 219:15 230:1,6 233:12 239:19 240:11 241:10 244:7 251:6 252:10 258:2 268:7
		b	
		b 5:13 54:17 105:15 108:21 221:14,21 245:6 323:14 323:18 324:16 325:7 334:8 340:10 341:13 396:8	

[back - benefit]

274:9 275:16 283:13 286:18 294:10 295:9 303:1,16 306:1 316:3 317:3,16 317:16 318:4 319:4,15 327:19 328:2 333:6,7 340:20 341:12 346:8 348:19 354:2 356:21 360:14 362:12 382:6 396:8 399:21 400:1 411:19 412:9,10 backed 345:17 background 63:14 157:10 bad 13:20 46:12,13 186:10 301:19 347:2 369:8 bailey 8:10 321:21 343:19 balance 361:21 ballpark 48:3 48:17 66:7 67:18 241:7 baltimore 1:14 2:17 40:11 barb 38:10,12 barcode 92:18	barely 235:5 379:15 base 60:11 based 19:7 50:16 53:17 60:21 82:21 83:1 92:5,7 95:21 105:19 106:5,10,11,18 118:2 127:13 127:16 131:19 133:20,20 138:12 146:11 165:12 173:14 173:17 176:5 180:9 224:14 237:21 239:9 240:5,7 257:10 265:12 266:15 268:15 270:10 275:20 279:7 284:11 293:9 298:11,13,16 300:10,19 301:15 303:3 325:21 328:17 331:15 336:7 336:11,11 337:21 339:4 344:20 345:15 345:21 348:19 349:12 377:6 377:20 379:18 387:16 388:3	402:8,10 basic 15:14 basically 53:16 60:19 97:7 126:5 151:3 166:5 269:8 281:17 325:9 327:13 328:9 372:7 basis 119:15 175:17,18 277:6 bates 44:3,7,9 44:17 52:6 114:17 120:8 288:21 bcma 92:15,17 186:13 187:19 253:15 257:20 261:7 262:1 268:12,14 401:8 415:16 beach 1:2 9:9 bear 346:21 347:5 becky 234:17 beds 150:20 179:4 245:18 246:13 339:14 beginning 1:15 11:12 71:6 155:13 158:21 229:21 283:12 356:20 362:11	behalf 9:16,21 10:1 beholder 378:20 believe 27:9 28:15 39:6 80:11 105:5,12 111:3 114:12 116:1 124:17 145:5 150:8 151:21 154:11 156:18 193:3 201:1 214:6 222:16 225:14 242:15 257:1 270:19 293:3 354:5 358:2 360:2 381:11 386:2,5 387:13 387:14 388:13 388:16 389:1 389:20 391:20 392:9,9 396:17 believer 386:6 benchmark 386:15 397:6 benchmarking 387:12 benchmarks 387:7 benefit 250:13 315:5 377:5,10 378:16 389:2 389:11,21
---	--	--	--

[benefit - bottom]

390:10,18,20	bias 147:7	bit 18:9 22:16	board's 55:11
405:11,15,20	148:9,17 149:6	40:8 58:20	bob 142:10
405:21 406:1	149:11,12,18	61:2 69:19	body 332:7,15
406:15,17,21	149:19,20	70:4 77:13	bold 308:1
benefits 49:5	150:3,5,9	81:8 110:9	315:9,10,12
best 12:21 13:1	151:18 152:19	120:20 128:3	boss 17:16
13:3 68:21	152:21 153:4,8	156:3 165:20	21:16
69:1,13 73:15	153:13 154:15	174:16 187:12	bottom 20:19
131:19 161:13	201:15 297:14	191:3 192:17	21:5 24:1,10
166:21 167:5	298:2,9,11,14	239:1,2 244:7	30:18 44:10
172:5 177:19	298:17,19,20	245:20 253:13	62:4,5 72:9
184:3 199:15	299:6 300:3	275:17 286:13	85:6 97:6
203:10,16	302:11	308:15 311:5	103:3,14 116:9
207:3 217:17	big 218:1 308:1	313:18 350:14	117:15 136:21
308:21 341:16	bigger 259:12	358:18 367:19	137:1,3 140:6
346:21 358:13	354:1 368:1	378:19 393:11	163:10,20
371:11 382:8	biggest 295:12	409:19	165:1 171:21
383:4	295:15 337:13	black 207:20	172:19 185:14
better 110:15	337:18	blair 32:4	185:17 186:3
145:9 152:11	bill 46:3	blank 418:16	187:16 191:12
183:2 211:2	bills 46:5	blended 353:2	194:9,16,17
212:13 216:18	binder 5:6 7:6	353:7	195:4,6,20
216:20 263:12	21:1,4 23:9	block 178:6	196:5,17
269:12 289:14	25:13,17,19	blood 94:13	204:12,15
319:8 329:12	39:5,13 56:12	109:7 325:16	205:4 243:1
343:10 378:20	58:11 205:14	326:8 335:21	255:20 257:18
386:7 404:12	231:4 329:10	blue 33:18	272:5 278:10
404:14,15	336:20 361:14	163:12	279:17 307:5
406:4	361:16	board 38:18	313:20 323:2
beyond 20:8	binder's 7:10	55:9,17 56:4,7	331:3 333:14
24:19 25:2	207:6 230:9	56:11,13,19	337:7 382:20
31:13 98:12	231:7	57:1,4,8,10,17	384:1 390:15
236:18	bindman	58:1,8 245:7	390:17 397:9
	408:21	396:3,10	397:12,18

[bottom - campione's]

400:3 bound 320:9 box 167:6 174:16 204:13 204:15 boy 328:7 break 14:10,14 27:2 70:1,12 71:1,12 155:4 155:5,10 229:9 229:12,18 239:2 282:21 283:7 308:15 323:19 356:15 362:8 412:9 breakdown 26:14 68:15 breaking 175:9 235:6 brick 241:14 brief 11:11 20:4 34:8 bring 72:12 73:1 74:3 broached 409:4 broad 270:6 387:15 broader 142:8 broke 156:1 brought 149:1 317:18 320:21 bs 109:14 110:3 111:7	bucket 181:20 254:5,6,9,20 buckets 98:20 109:13 110:2 budget 45:9 build 66:13 101:7 166:17 192:17 269:14 309:6 332:7 345:7 built 307:12 bullet 22:6 52:12 120:9,13 126:9 154:12 199:5,7 200:11 200:21 201:1,8 201:12 202:5 257:20 260:11 260:12 261:4 308:6 309:1 310:4 311:3,18 373:19 374:20 375:12 bullets 117:15 143:9 144:9 146:21 162:6 190:15 burden 122:18 123:5,7 152:13 240:15,20 burgraff 58:19 burns 44:21 business 32:16 259:5,7,8	395:18 buy 220:15 221:10 bypass 122:17 byproduct 212:9,10 385:13,16 c c 2:1 3:1 9:1 55:8 104:15 105:15 106:4 108:21 221:14 221:21 245:6 323:14,18 324:17 326:9 334:5 340:8 341:5,13,20 342:6 348:12 349:9 352:9,16 353:3,8,9,14 calculate 8:14 126:16 195:3,7 209:17 215:11 248:19 325:4 328:5 355:18 calculated 193:2 248:21 288:8 292:8 calculating 82:20 194:18 214:21 216:11 248:19 394:9	calculation 194:20 338:19 calculator 355:6 363:7,11 363:13 california 157:12 call 7:14 15:8 22:1,5 32:5,9 101:11 128:7 128:11 144:4 146:16 162:3 232:19 253:21 256:4,17 272:19 282:11 315:4 365:4 396:7 415:12 415:14 called 60:10 253:20 calls 262:17 campione 6:15 7:6,11 8:10 58:21 65:8 116:10 129:9 163:11,16 164:8,14 186:4 191:11 194:5 205:14 234:15 321:21 343:18 campione's 59:2 305:10 323:2
--	---	--	---

[capacities - characteristics]

capacities 386:14,21	326:12 339:19 371:16	339:19 369:16	182:15 184:14
capacity 61:10	category 97:7	certainty 146:7	184:18,19,20
152:5 158:8	203:2,4 205:4	146:18 154:1	204:3 207:6
208:20 285:6	278:11 281:18	156:16 157:1,3	208:15 209:3,4
capping 317:15	281:19 372:8	176:21 257:10	210:19 212:9
caps 317:12	378:2	certificate 4:11	214:7,11,15
capture 246:5	caused 127:14	4:12 418:1	215:6 232:10
captured 37:3	caution 351:3	certification	235:15 236:19
115:4 188:3	caveat 55:17	179:7	243:6 251:4
309:21 323:11	cc'ing 5:10 7:6	certified 1:17	274:4,5 294:7
365:8	30:21 205:14	1:18,19 6:9	303:21 307:16
car 321:6	ceiling 276:19	130:9 138:12	384:15,16
card 8:8 313:3	280:3	420:16	385:4 419:5
313:12,13	center 1:4 7:8	certify 417:2,7	changed 28:15
care 72:20	9:6 36:15	417:10 418:3	49:18,21 50:15
74:12 99:17	37:16 38:13	chain 31:6	50:18 63:1
150:1,10 151:9	59:13 61:9	184:7 185:18	65:18 81:11
278:20 288:8	95:9 217:9	challenges	108:14 208:9
325:20 330:18	219:21 380:16	117:10,14	292:19 293:4,6
335:18 365:13	400:15 420:3	150:9 199:12	294:8,9 296:2
392:1,18	centers 79:18	246:19 259:3	299:7,8,16
393:17 395:6	80:15 136:12	champions	303:8
398:16,20	175:19 364:10	59:12,17	changes 50:16
careful 302:18	365:2 392:17	chance 70:17	56:8 64:9,18
case 1:5 9:9	central 94:12	change 81:1	143:5 164:11
15:7 17:9 19:6	94:13 95:1	166:2,8,12,18	186:14 198:4,8
19:18 21:6	109:6 325:16	167:6 168:9,12	206:8 211:8
31:18 95:16,19	326:8 335:20	168:13 169:7,9	213:20 234:20
118:14 189:17	ceo 39:1,3	170:7 171:2,5	234:20 237:4
192:13 261:8	58:11	171:13,16,17	420:9
358:2	certain 41:21	171:20 173:8	changing 184:3
categories	59:16 90:10	175:4,6,6,12	257:13
261:9 266:19	222:11 271:16	177:15 181:5	characteristics
		182:8,8,9,12,13	288:14

[characterize - column]

characterize 240:15 246:6,8	claiming 19:14	250:10 251:3	392:20 393:3,7
chart 165:19,21	clarification 37:2 115:3	265:16 266:3	393:7,14 394:3
184:1,14,19,21	188:2 335:11	266:10 281:2	394:12 395:11
187:15 191:11	365:7	285:1 290:11	cms's 289:9
204:3,3 323:20	clarify 14:2	299:17 301:1	coaching 266:1
327:5 333:7	41:1 46:16	351:5 352:15	coffee 221:11
338:4 343:14	48:11 49:20	389:7 394:3	221:14,16,20
343:16 346:8	67:21 73:7	403:15 404:4	221:21 222:2
348:19 349:21	99:7 107:4	407:2,18	222:11
355:3	124:12,16	408:19	cohort 83:1
chatting 32:12	134:7 159:10	clearly 66:13	171:3,7,11
check 191:10	176:8 206:5	109:18 166:17	200:8 325:5
chicago 3:6	211:11 218:21	client 15:16	330:10
chicken 245:20	221:9 222:9	52:13 56:17	cohorts 82:21
chiming 221:16	226:7 227:4	63:17	126:14 293:12
choice 117:18	248:18	client's 55:9	coincidentally
180:20 293:16	clarifying	56:19	256:8,9
choices 72:20	368:21	clients 95:9	colleagues
choose 74:11	clark 3:5	clinical 264:5,5	32:12 360:20
153:9 235:3	clause 75:4	282:6	361:4
250:13 345:2	cleans 219:10	clinically 304:6	collected
choosing	223:18	close 132:19	244:10
111:15 121:2,9	clear 14:8,9	235:18 321:8	collecting
122:17 395:6	15:20 27:16	340:18 350:7	244:12 281:4
chose 97:5	51:8 75:13	closely 59:7	collective
227:8	78:9 88:12	closer 337:8	209:13 210:1
chosen 354:6,9	98:8 100:17	344:16	255:8 336:13
chsra 36:18	119:3 142:12	clues 257:11,12	colloquy 37:2
37:5 38:4,7	142:13 144:8	cms 64:19	115:3 188:2
city 245:3	150:13 181:16	79:18 84:10	365:7
civil 1:11	190:21 197:5	90:9 94:10	colon 135:9
clabsi 110:5	197:18 209:21	175:19 179:5,6	columbia 417:2
	228:5 249:17	180:9 194:1	column 166:2
		259:9,12 364:7	167:6 173:2

[column - completing]

323:21 352:14 comanaging 326:20 combination 65:3 270:5,11 354:13 combined 282:12 come 18:16 19:16 22:2,9 40:8 42:10 66:4 84:21 90:9 107:5 110:8 139:3 142:21 175:15 202:18 212:13 212:17 214:1 222:18 243:14 250:13 280:15 303:16 311:16 311:16 316:3 320:19 329:9 333:4 364:7,20 366:10 371:15 373:1 383:11 383:16 comes 57:13 84:20 97:1 102:4 125:2 173:2 213:15 214:5 245:4 279:10 390:19 comfortable 170:21	coming 32:1 98:14 176:2 232:18 293:21 295:17 297:2 299:11 comment 7:12 177:17 198:6 206:9,20 230:10 233:13 235:17 236:9 236:16 240:11 241:10 242:14 243:1 251:3 304:18 commented 233:16 comments 7:10 75:19 213:10 213:12 214:2 231:4 233:20 234:2 235:10 235:12,13,14 235:15,16 236:3 316:10 361:6 commercial 71:12 commission 49:10 417:18 commit 235:7 committing 203:7 commonly 151:8	communicate 21:10,15 communicated 176:14,18 285:20 communicates 179:16 225:15 communicating 56:10,12 communication 52:15,21 57:10 203:1 232:18 410:11,12,12 410:15,17 communicati... 16:4 52:13 communities 150:1 151:4 398:15,19 399:13 comparable 392:4,6 comparative 358:7 compare 261:15 393:17 compared 64:3 152:4,14 245:13 249:13 249:20 253:19 275:13 353:14 comparing 334:21 335:1	comparison 334:19 comparisons 323:17 compel 252:19 compelled 74:18 75:9 compensation 42:11 46:11,15 48:18 67:18 68:9 competition 391:2 competitors 392:10 complaints 258:14,17,19 complete 110:20 111:10 152:5 153:9 190:8 208:4,12 233:9 235:4 240:18 241:15 241:19 318:1 completed 27:8 28:11,16,18 167:13 299:12 completely 250:5 269:2 completeness 30:12 completing 122:19
---	---	---	--

[complied - consumer]

complied 10:9	190:5,10	confront 215:1	considerably
component	231:10 232:11	confrontation	190:7
111:13 267:15	244:11	215:5	consideration
268:9 399:15	concludes	confronting	123:6,8
components	416:5	214:15	considered
267:3 302:5	conclusion	confused 14:1	52:16 96:15,16
composite	176:2 292:14	101:6 181:5	98:17 262:14
52:17,19 54:20	333:4 383:11	confusing	310:10 393:15
64:17 65:4	concrete 217:1	313:18	411:6
90:4 225:1	274:6 402:19	conjunction	considering
244:17 267:2	concretely 95:4	382:19	372:18 382:18
287:16,21	397:19	connect 73:19	384:14
288:7 300:10	conduct 106:13	311:4	consistent 57:8
301:15 303:2	107:6	connected	88:9 90:6
392:12,12,15	conducted	187:7	108:16 188:10
computerized	112:1	connection	200:4 208:13
84:19 92:20	conducting	158:10	303:5
262:19 414:15	291:2	connotation	consortium
concept 203:17	conference	182:20	262:18
270:6	407:21	consensus	constant 303:5
conceptual	confidence	53:16,19 54:19	constrained
411:10	209:16 210:16	131:13	152:9
conceptually	212:6 215:10	consequence	construct 394:1
55:10 402:15	215:14,15	246:3,15	411:6,8
concern 150:2	216:7,8 219:16	consequences	constructs
153:7 183:10	219:19 220:10	308:1	394:11
193:5,7 245:11	222:5,20 223:1	consider	consultant
295:12,15,16	223:5,15,20	117:12 141:4	336:20
297:16	confident 224:9	188:9 192:6,14	consumer
concerned	262:20	394:18 395:5	72:13 73:2
252:4	confirm 28:2	408:9	74:5 88:19,20
concerns 18:17	137:17	considerable	89:6 220:9,17
21:20 145:6	conflicting 57:4	181:17 371:19	224:9 225:9,15
146:11 148:17		372:20	228:15

[consumers - correct]

consumers 74:10,16 75:5 101:20 176:15 220:12 244:16 389:3,5,16,20 390:9 399:15 cont 6:1 7:1 8:1 contact 31:6 32:10 58:20 179:7 contacts 58:13 contemplating 305:12 context 122:6 136:5 148:4,15 148:21 149:11 154:3 165:2,10 203:5 233:4 257:9,11,12 260:12 293:17 293:21 294:9 296:2 298:10 299:16,19 314:4 330:9 347:12 continental 34:20 continuation 7:9 231:2 continue 90:11 254:18 continued 3:1 71:2 155:11 158:20 229:19	283:8 356:16 362:9 continues 388:16 continuing 265:13 266:16 continuously 40:17 303:19 continuum 328:14 contract 5:13 17:20,21 37:18 37:18 38:7 40:18 41:13,19 43:8 44:18 47:7,7,16 49:17 50:12 63:6 65:12 67:15 313:8 contractor 43:15 56:17 393:20 contracts 41:15 47:9,20 48:5,7 48:12 65:18 contractual 38:5 41:8 control 136:12 conventional 32:14 conversation 19:21 20:4 25:21 31:19 134:4 172:10	172:16,18 202:21 251:9 257:2,3 308:20 347:11 384:9 387:10 408:7 conversations 26:2 32:3 121:12,20 122:3,4,8,10 124:1,2,4,7,18 127:17 172:20 187:8 244:15 318:4 convert 35:1 converted 30:1 249:1 copied 31:5 copies 418:15 copy 161:13 356:5 420:16 core 95:18 correct 16:12 19:2 20:21 22:18 24:3,12 24:16 25:15 26:20 29:4 31:1,2,12 33:8 33:17,20 34:2 34:5,7 35:9 36:12 37:7 38:8 39:15 40:15 41:3,10 42:5,7 43:6,11 44:1 45:7,15	45:19,20 46:6 46:7,19,20 47:1,3,18 48:10,21 49:1 49:17 50:20 51:9 54:11 57:15 61:4 62:10 65:10,21 66:5,16,21 73:9 77:2,3 80:2,8,19 81:15 83:8,13 83:15,16,21 84:2,11,12 85:18 86:17 87:21 88:2 93:1 94:5 95:20 96:10,12 98:2 99:1,3 100:1,2,13,15 101:10,12,17 101:19 106:8 106:12,19 112:19 117:16 117:21 120:1 120:12,14,19 125:15 126:1 126:10 127:1,2 127:4,12 128:1 129:18 135:1 138:15 139:12 140:4,8,13,18 141:1,12 142:2 142:17 147:4
---	--	--	--

[correct - court]

151:13 153:16	269:21 271:1,2	346:2,16,19	corroborate
156:6,12	271:18 277:3,4	348:21 349:5	408:14
160:10 161:1	278:17 279:6	350:19 351:13	cost 179:5
162:6,13	280:2 281:13	351:16 352:6	180:9
165:17 166:7	282:13,17	353:6 356:5	costa 8:12
167:18 168:7	286:15,21	357:16 361:8	329:17 330:14
168:15 170:11	287:1,4,7	361:12 364:4	costs 49:1
171:14,18	288:18 289:15	364:12,14,15	counsel 9:13
173:4,10,19	290:7,8,9,13,19	364:20 365:5	11:19 15:4,6,9
174:5,13 177:4	296:13,14	365:15,16	15:19 16:4,10
177:12 178:1	299:21 300:4	366:1,8 367:3	17:2,15 20:2,8
180:19 181:2	301:13,21	368:2 371:10	21:16 23:10
182:3 184:17	302:4,14,15	371:12 373:17	25:20 139:5
185:1,16	304:7,18 305:4	375:17,20	381:21 397:4
189:19 190:14	305:5,8 307:14	376:19 377:15	400:1,9 405:9
190:16 194:3	311:8,9,11	378:3,10,11	406:21 409:19
197:11 198:14	313:5,10 315:3	380:10 384:3	417:6,10
202:16 203:8	316:9 317:9	395:11 397:7	counseling 63:9
203:14,19	319:1 320:7,9	397:11 401:9	count 335:21
210:3 211:13	320:14 322:7	401:16 403:1,4	counting 336:5
212:20 218:17	323:21 324:3	404:2,4,5,16	country 351:7
219:17 220:6,7	325:13 327:9	407:8 409:21	couple 12:12
226:11,21	327:11,12	410:21 411:16	19:17 42:17
231:5,21 232:2	332:19 333:20	412:15,20	49:15 51:18
232:5 236:6	333:21 334:3,7	413:16 414:20	58:18 59:11
237:17 238:16	334:9,11 335:2	414:21 415:3,9	79:8 130:13
239:8,14,15	335:5 337:10	corrected	146:21 272:9
240:1 241:11	338:1 339:16	180:19	307:20 319:14
248:6,7 253:17	340:7,9,12,14	corrections	360:19 405:9
261:6 263:20	340:17,19	416:14 418:7	407:10 409:18
264:13,18	341:1,15	correctly 156:4	court 1:1 9:8
265:11 266:12	343:20 344:12	332:10 340:15	9:11 10:4,6,10
266:13 267:20	344:19 345:15	corresponding	10:15,19,21
268:6,18	345:18,20	376:16	11:2,4 12:13

[court - creation]

13:10 37:1	28:3 29:7,11	182:11 183:6	332:16 333:10
70:17 115:2	30:12,16 31:16	183:13,16,18	333:11 340:2
138:12 158:9	35:19 36:1	183:19 184:12	341:11 343:7
158:12,14	37:4 42:18	185:5,9 186:1	343:12,16,17
188:1 365:6	43:1 49:13,14	187:3 188:4	344:5,9 347:18
416:9,15	51:6 57:19	190:3 191:2,20	347:20 348:1,2
courtney 3:4	67:5 68:1,4,6	195:14,18	355:9,13
9:20 20:9 31:4	69:6,9,13,15,18	205:5,8,12,21	356:11 357:2
31:6 32:8	70:9,11,13,19	207:11,13	361:19 362:3
283:2 362:16	71:9 73:12	209:1 210:3,9	366:3 367:4
courtney.wood	76:4 78:15,19	211:13,17	368:4,18
3:8	81:4 84:6,8	217:2,5 221:3	369:12 370:15
cover 41:14	89:3,8 90:14	223:7,9 225:16	375:5,21 377:8
coverage 41:16	98:6 101:5	225:21 227:21	378:17 379:10
49:4	102:18 103:1	228:21 229:7	381:19 383:2
covered 84:11	112:7,10 113:2	229:13 230:3	383:14 385:7
318:20 320:13	113:6,15 114:1	230:15,18	387:20 390:2
320:20	115:5 121:17	234:6,10	391:19 392:5
covering 47:8	124:15,19	236:11 242:8	393:4 394:21
266:3	128:17,20	242:12 243:21	395:12 396:1
covers 41:21	133:2,5,7	244:3 252:14	396:21 397:2
42:6 182:6	134:5 136:18	255:15,18	398:12 414:8
covid 243:13	139:8,17 145:2	256:13,15	415:21 416:4
314:10	147:18,20	257:8 265:21	create 12:14
cpoe 92:19	148:19 155:4	266:8 271:21	267:1 270:21
187:18 253:15	155:16 157:18	272:3 274:9,10	386:7
261:7 262:1	158:11,13	277:21 279:11	created 56:4
415:16	159:3,18,20	280:18 282:20	190:7 199:12
crain 2:4 4:6,8	160:12,16	283:2,15 286:3	261:8 354:7
9:18,18 10:17	163:5,9 170:18	286:7 305:1	creates 391:2
10:20 11:1,5	172:11 173:16	306:20 307:3	creating 203:12
11:16,19 16:1	173:21 174:6	312:17 313:1	297:13
16:8,9 20:16	174:14 177:12	321:15,19	creation 75:14
23:19 25:3	177:13 179:13	329:21 330:3	

[credit - data]

credit 193:11 193:16 290:3 295:14 296:9 372:7 credits 296:10 creeping 118:19 190:11 crept 117:18 118:1 criteria 181:16 181:19 377:1 377:14,20 378:1,10 379:13 critical 150:15 150:17,18 330:18 crosswalk 261:12,13 271:1 crosswalks 261:8 262:13 263:6 264:1 265:14 266:17 269:1,4 crutcher 2:3 9:19 10:2 cs 109:14 110:3 111:7 culture 99:16 111:18 254:16 268:9 curious 297:8	current 18:21 64:8 80:20 83:4,5,10 88:7 88:16 105:16 106:18 117:11 120:17 122:16 124:13 145:11 194:11 199:10 199:20 202:7 208:3,10 209:14 260:13 263:17 303:11 306:4 324:5 363:12 384:7 404:12,15 407:3 415:6,8 currently 17:20 27:9 62:19 64:17 80:10,13 146:19 246:5 308:2 363:16 415:18 curtis 3:11 9:10 cut 209:7,13 211:9,12 267:6 336:3 cv 1:6 9:9 68:12 cycle 27:10 28:9,17,21 29:2 d d 9:1 104:15 105:15 106:4	109:1 110:6 221:14 222:1 323:14,18 324:17 326:15 333:14,20 337:8,14 340:4 341:4,13 347:9 348:12 349:9 352:9,16 353:3 353:14 401:1 damage 398:7 danforth 5:7 5:10 6:15 7:7 8:8,10 23:10 24:7 25:9 26:10 30:21 56:12 58:11 59:20 116:10 119:12,17 122:5 125:2 127:17 163:16 186:4 205:15 231:6 259:20 259:21 313:3 316:5 321:21 343:19 danforth's 58:18 191:21 data 39:20 79:20 80:12,14 80:15,19 82:5 82:6,14,16,17 82:19 83:19,20 83:20 84:9,10	84:13 91:6,11 92:12 93:11,15 93:17 94:2,4,6 94:8,10,15,20 94:21 95:2 96:7 101:2 102:8,9,10 111:16 120:17 154:5,6 178:14 179:20 191:19 193:20,21 194:1,2 195:6 199:21 208:4 208:11 209:16 211:2,3 212:7 214:20 215:2 215:10,10,14 215:15 216:7,9 219:16,19 222:20 223:2,5 223:15,20 239:6,10 240:5 240:7 244:10 244:12,13 253:3,5,7,9 254:10,13 255:9 257:15 258:4,6,15,19 258:21 259:9 259:12 260:9 260:15 261:2 261:21 262:12 262:15,18,20 264:2 269:16
---	--	--	---

[data - deleted]

269:19 270:10	day 20:4 26:10	120:3 121:13	defeat 247:10
270:19 288:7	31:20 32:7	121:21 122:1	defendant 1:8
289:3,6,8,14,19	46:1 141:3	123:12 124:3	3:2 9:21
290:17 291:5,7	156:14 161:14	125:1 142:13	362:17
292:7 293:10	162:21 253:15	208:18 214:1	defensive
300:10,12	253:20 347:7	248:15 249:5	210:17 211:8
301:15,17	365:14 368:9	250:10 254:9	211:12
302:12 303:3	373:16 417:13	254:17 285:19	defer 168:18
308:2,9 309:2	days 56:3,21	294:1 296:3	252:20
314:13 339:4	157:21 165:15	301:8 319:3,12	define 201:5
342:14 364:7,9	191:9,10	336:3 337:4	240:14 339:21
364:10,20	196:13 299:10	389:8 391:21	392:6
365:1,3 366:12	412:10	406:5	defined 27:9
368:7 384:19	daytime 330:8	decisions 90:9	276:13
391:15 412:6	331:6,10	224:14 285:3	definitely
412:11,12,15	dealing 289:2	301:4 303:6	328:19
412:15,18,19	289:14 297:7	305:15 319:9	definition 94:7
412:21 413:6	397:15	391:16	150:14 151:5,8
413:11,13,14	dear 405:7	deck 6:8 113:15	153:14,16,21
414:17 415:1,5	deaths 327:15	113:17 114:2	154:2,4 159:11
415:9,13,14,17	334:2,19 335:7	114:15 125:5	238:2,4,9
415:18	335:17 341:21	200:4	249:3 267:16
dataset 195:5	decade 388:4	declare 10:10	271:15 298:13
datasets 263:9	decades 388:4	declined 224:7	303:14 342:11
date 133:5	decent 22:16	227:13 381:5	degree 87:11
196:11 418:13	decide 86:11	401:19 405:2	87:13 269:13
dated 5:7 6:19	285:1,2 299:19	declining 403:8	335:12
8:15 196:14	decided 284:13	decreases	deincentivized
314:1 332:18	310:14	240:20	117:19
357:12 358:10	decides 224:13	deemed 300:21	delbanco 39:3
358:19	deciding 122:5	312:4	delete 200:12
dates 36:9	189:16	deena 8:12	201:7
davis 157:12	decision 23:1	329:16	deleted 200:21
	86:9 107:16		201:1,21

[deleting - different]

deleting 201:9	deponent 2:12	detail 18:13	die 104:14
delineates	4:12 418:1	154:7 384:12	106:3,19
45:12	deposed 12:8	detailed 142:10	326:10 347:9
delivered 84:5	17:17 18:5	details 15:14	348:12 349:9
delphi 52:21	deposition 1:10	128:6 281:16	352:9 353:13
53:11,14,15	1:16 9:5 12:16	determine	difference
delray 7:8 95:9	14:18,21 15:5	334:16	73:20 147:6
95:10,11,12	17:15 18:3	determined	148:6 149:5
96:1,9,19 97:2	29:14,15 33:6	179:3	152:3 154:14
97:13 217:9,12	163:11 416:6	detriment	169:1,2 201:14
218:1 219:1,18	416:19 420:4	250:6	226:2 305:11
219:21 222:14	depositions	develop 287:16	334:12,16
225:2 227:10	17:9	287:21 325:16	335:4 337:13
239:20 380:16	derived 304:17	326:9	340:4 341:6
400:1	derk 8:16 17:18	developed	differences
delray's 95:14	18:6,7 31:11	146:19 158:1	53:7 54:21
demonstrate	357:9	160:9 335:20	147:9 154:17
193:12,15	describe	developing	201:17 303:18
288:3,5	211:16 287:18	39:19,21	333:12 337:18
denominator	324:11	development	340:10
274:17 276:16	described	112:11 158:3	different 26:5,5
department	126:13	159:8,14	48:7 53:17
245:4	describes	develops 110:5	81:13,16,21
depending 26:6	287:20	deviation	82:7 95:8
66:8 290:12	description 5:5	245:14 294:12	117:12 118:17
349:4	6:5 7:5 8:5	294:18 295:1,5	141:6 151:2
depends 159:10	descriptions	295:6 305:17	153:18 158:6
221:2 303:14	219:3 226:17	deviations	167:16 171:12
depict 25:4	deserves 72:19	172:1	175:6 182:8
51:21	designation	dha 114:21	189:10,15,15
depiction 55:4	179:3	diagram	189:17 194:5
79:3 307:18	desire 250:11	411:15	199:2 211:2
359:5 360:1	desk 7:11 179:7	diametrically	214:14 222:7
	234:15	250:16	222:13 225:2,6

[different - district]

225:12 239:1	214:15,18	264:3 282:5	173:3,13 174:9
244:12 254:1	215:1,5 392:10	disclose 345:2,5	187:13 251:7
264:10 288:14	400:8	disclosure	257:9 319:7
293:7 299:13	direction 54:19	381:2,4 382:20	320:9 344:2
300:15,17	55:8,11 56:18	discount	372:21 408:18
302:10 303:18	57:1,4 58:3	325:21	discussions
306:10 311:2	117:13 165:13	discovery	15:15,15,18
318:16 323:16	214:9 318:5,10	133:1	31:11,13 197:1
332:11 339:18	318:13	discuss 22:19	262:3 374:13
340:1 341:4,20	directly 46:19	32:6 64:9	disease 136:12
342:16 350:17	48:16 180:12	112:17 316:21	disfavor 238:6
369:15 370:1	399:16 403:11	375:12 395:5	disincentive
372:3,4 378:10	director 35:11	396:16	190:7
386:20 394:7,7	36:10 37:15	discussed 23:4	disincentivized
394:10,11	38:1 39:18	24:19 25:5	193:8
399:17 402:15	45:4 409:1	31:10 78:2	dispensers
403:10 408:2	directors 55:9	125:16 138:14	279:14
408:20 410:6	55:18 56:19	145:5 164:15	display 325:14
411:6,8 413:5	57:2 396:3,10	203:17 204:19	383:4
differently	disadvantages	252:3 298:16	disregard
73:11 191:3	149:16	304:4 308:12	141:4
382:1	disagree 236:8	309:3,4 310:12	dissipate 54:12
difficult 131:14	237:3 243:4	320:16 326:7	distinction
188:21 245:15	265:5 267:7	366:14 374:17	96:14
difficulty	329:1 341:21	387:2	distinctly 165:7
158:19	disagreed	discussing	distinguish
dig 235:1 237:8	201:7	153:2 191:1	402:18
digestible	disagreement	248:10,11	distribution
244:18	301:9 306:12	discussion 11:7	216:15 295:2
diminished	disappointed	25:2 113:3	distributions
63:3 64:1,3	234:19	130:12 136:7	373:21
dip 127:8,14	discarded	138:19 139:4	district 1:1,1
direct 49:1	100:3 101:12	142:16 148:12	1:12 9:7,8
58:18 161:5	253:20 262:8	162:8 172:4	417:2

[divide - draft]

divide 335:14 336:5 division 1:2 9:9 361:20 dmm 1:6 9:9 doctors 98:4 397:19 398:1,3 document 5:8 5:15 20:17 23:16,20 24:2 24:21 27:14,16 28:5,6 29:5,16 29:19,21 30:2 30:7 33:6 43:2 43:4 54:18,21 56:16 71:14 72:5 78:16,20 82:11 83:18 85:5,15 90:21 96:13 98:14 100:17 101:20 102:2 103:2,7 104:2 105:18 113:1,7 128:14 130:16 132:21 136:3,15 137:8 139:18 140:7 141:5 148:1,14 157:6 160:18 162:12 163:4,6 168:20 176:19 182:5 184:9 185:10,15,20 195:20 197:9	205:17 206:7 206:10,14,16 207:1 210:7 211:14 224:19 224:20 229:4 230:10,19 231:16 233:13 234:12 242:19 255:13,19 257:6 260:9 265:6 271:4 272:4 273:12 283:18 285:7 286:13,16 288:16 307:5 312:18 314:17 324:13,14 338:3 343:9 344:6 347:15 354:16,18 355:15,17 356:2 357:7,21 407:12 411:19 413:19 documents 15:2 16:19,21 17:1 18:8,19 28:8 42:17 185:13 186:20 207:7 324:10 343:8 doing 26:7 28:12 34:19 53:9 60:18	63:4 69:20 90:4 107:8 108:11 169:4 175:4 184:15 188:16 219:21 232:21 233:3 238:19 244:8 253:2 276:13 297:17 304:21 327:18 369:18 369:19 372:19 dollar 50:12 domain 276:3,5 276:6,9,17,18 276:20 277:1,2 277:13,16 278:4,13 279:18,19 280:7,21 281:21 412:3 domains 90:6 276:13,15 281:3,6,18,19 303:3 394:7,7 410:6,19 domico 8:8 313:4,6 doors 151:3 dot 343:1 double 132:7 191:10 336:5 342:1,2,4 doubt 408:5	dr 2:12 7:14 9:5,16 11:17 15:12 20:17 23:20 36:2 38:12 43:2 71:10 73:8 78:20 103:2 113:7 114:3 133:8 134:16 136:10,11,20 137:1 139:18 156:11,14 157:7,8 158:5 158:7 159:7 160:2,17 161:21 162:1,9 177:7 184:6 185:10 190:18 195:19 207:14 217:6 230:4,19 231:20 232:1 234:12 242:14 256:5 257:2 283:16 286:8 287:5 299:3 313:2 321:20 328:18,19 330:14,14,14 357:3 362:16 397:3 408:21 416:6 420:4 draft 61:17,18 117:8 141:11 141:21 196:7
---	--	---	--

[draft - eliminate]

273:3,6 324:4 349:3,16 358:21 416:16 drafted 107:18 115:20 116:2 116:20 190:13 drafting 75:14 79:10 107:20 108:4 dramatic 183:1 183:2,7,14,14 183:18 drastic 170:7 173:7 175:4,6 175:12 182:8,9 182:12,13,15 182:19 204:3 drill 154:7 drive 388:10 390:13 driven 250:11 driving 119:1 354:4 drop 186:13 351:2,6 dropping 396:7 ds 109:14 110:3 111:7 due 109:15 158:18 193:17 323:10 324:19 352:2 duff 25:13	duly 417:5 dunn 2:3 9:18 10:2 dying 109:10 351:15 e e 1:13 2:1,1 3:1 3:1 9:1,1 e.g. 52:21 294:12 eager 342:9 earlier 31:10 31:20 54:2 68:3 83:12 88:4 103:15 156:14 168:16 198:13 199:2 253:15,20 268:7 286:14 305:9 311:19 347:6 361:1 362:19 365:14 366:8 371:8 373:5 378:8 380:5,20 381:10 384:5 385:12 386:12 386:19 403:15 earliest 260:19 early 15:8 39:6 55:19,20 56:3 56:21 64:5 82:2 106:9,11	157:21 286:19 288:2,4 299:9 393:18 earmarked 46:1 50:19 earned 35:7 easier 191:4 244:19,20 383:8 east 2:16 easy 72:13 73:2 74:4 188:7 edit 164:17 201:4 219:3 edited 206:10 232:9,13 361:14 editing 218:21 editor 86:8,8 editors 361:3 edits 197:18 198:1,11,13,16 199:7 203:16 203:16 207:6 230:10 361:17 educated 336:10 education 33:13 276:7 effect 235:10 331:9 397:10 400:2 effective 264:7 284:14	effectively 280:21 effort 41:14 51:3,3,5,7 107:9 189:3,8 189:13 efforts 46:4 50:17 68:13 123:11 243:11 351:8 egg 245:21 eight 356:21 362:6 eighth 328:3 either 32:3 39:17 52:14 77:5 93:18 98:17 121:21 132:21 170:4,5 171:10 181:21 197:6,7 213:4 223:10,11 235:19 251:7 278:1,2 349:3 359:6 405:5 electronic 414:12 element 118:4 elements 95:18 304:7 374:2 eligible 179:2 eliminate 170:8 170:17
---	--	--	--

[elser - estimate]

elser 3:3 9:20 20:3,7 25:13 31:11	284:6,8,8 313:2,18 316:16 321:3	246:17	equivalent 176:11 180:1
email 5:6,10 6:6,12,15,17,18 7:6,9,11,15 8:7 8:9,15 21:1,5,6 21:11 24:4,5 24:10,13,20 25:2,4,8,9 26:9 26:10 30:17 31:6,8,14 113:9,18 116:9 129:5,8 137:3 140:1,9,15 141:4,6 160:20 161:6,10 162:19 163:15 163:20 164:8 164:17,21 165:2,3,7 184:7 185:11 185:18 186:3 187:21 191:21 192:11 194:6 196:2,13,18 197:20 199:2 205:13,20 206:1,2 210:11 213:8 230:14 230:20 231:1,7 234:15 242:1 265:14 266:16 272:7 283:20	321:20 323:2 333:10 343:21 344:4 353:16 355:2,20 357:9 358:14,20 360:1 413:4 emails 20:6,9 196:5,6 305:10 emma 8:8 313:3,6,7 315:4 emphasize 109:20 empirical 119:19,21 120:2 193:16 193:18 265:12 266:15 301:12 empirically 127:19 369:21 employed 35:15 36:14 37:5,10,10 employee 18:21 employees 98:12 employer 36:16 encounter 82:5 encourage 209:15 212:8 212:12 222:21	encouraged 91:10 encouraging 249:19 endeavor 311:19 endorsed 60:17 ends 416:6 endurance 229:14 energy 354:7 engage 396:9 engineering 34:4,11 enjoyed 363:3 ensuing 291:11 ensure 207:18 ensuring 60:19 entails 60:13 entire 285:13 entirety 80:6 entities 392:16 entitled 115:15 entity 392:11 392:14 entity's 238:5,6 entry 84:19 92:20 262:19 414:15 environment 410:8 equate 352:9	202:8 211:3 220:3 379:12 era 243:13 erica 44:21 45:3 errata 4:13 418:8,15 419:1 420:10,12,13 error 238:4,4 238:10,12,21 267:15 269:13 271:15 352:3 errors 19:13 247:18 248:6 especially 243:13 esquire 2:4,5 2:15 3:4 essentially 66:20 263:5 278:9 established 182:14 327:20 estimate 68:21 69:1,13 104:13 108:5,20 109:14,17,18 109:20 138:9 157:2 238:3,9 240:8,9 295:4 328:10 329:9 329:12 341:9

[estimate - exhibit]

341:12,16,18	120:2,5 193:18	227:5 276:6	7:17,19 8:5,6,7
342:5,21 343:1	265:12 266:15	294:19 305:17	8:9,12,13,15
348:11 349:8	267:13,19	305:18 372:6	20:12,13,14
353:12 413:7	268:5 326:19	375:19 376:3	23:15,16,17
estimated	evolve 90:11	exceed 43:16	29:7,9,12,15
108:15 323:9	294:6	excel 8:13	30:13,14 35:19
323:13,16	evolved 82:16	355:14,18	35:20 42:19,20
325:9,11	82:20 83:2	356:6	51:11 71:4,14
327:15	88:11 291:15	excelled 397:16	78:2,16,17
estimates 106:2	292:20 293:7	excellent	102:19,20
278:8 342:16	303:7	241:16	113:3,4,19,20
estimating	evolving	except 263:21	115:19 116:3,5
326:3	291:20,21	exceptions	128:17,18
estimation	exact 59:3	257:20 261:5,7	129:4,5,5
238:15 239:9	154:1 162:3	exchanged 20:6	139:14,15
239:16,17	169:21 259:13	excited 321:12	154:12 160:13
240:2 271:10	342:11	exclude 260:13	160:14 163:7
271:13	exactly 25:20	290:15 346:14	163:11 177:3
et 1:4 4:3 5:3	54:7 77:7,16	346:17 351:4	185:6,7 195:15
6:3 7:3 8:3 9:6	79:12 128:11	352:21	195:16,19
419:3 420:3	132:2 167:10	excluding	196:7 204:6
evaluates 97:17	172:9 175:16	250:17 291:5	205:9,10 217:2
event 326:5	190:21 213:5	292:15 342:13	217:3 224:19
events 109:3,5	304:21 394:3	344:17	229:4 230:15
325:10	examination	exclusion 341:7	230:16 234:7,8
eventually	4:1,5 11:15	excuse 131:5	234:11 242:6,9
293:12	362:14 397:1	150:6 209:12	242:10 255:15
everybody 21:5	417:7	237:16	255:16 271:21
112:8	examined	exhibit 5:5,6,7	272:1 283:10
everybody's	417:5 418:4	5:8,10,12,13,15	283:18 286:4,5
35:18	example 64:5	5:17,19 6:5,6,8	306:21 307:1
evidence 60:21	94:10 95:10,11	6:9,11,12,15,17	312:18,19
75:3 90:13	109:6,21 142:8	6:18 7:5,6,8,9	321:16,17
119:19,21	200:14 225:20	7:11,12,14,15	329:21 330:1

[exhibit - f]

333:9 343:13 343:16 347:14 347:16,18 348:19 354:17 355:10,11 356:18 357:6 363:20,21 373:4 376:6,14 379:21 407:14 411:19 413:19 exhibits 5:1 6:1 7:1 8:1 exist 123:12 existence 176:6 existing 243:10 exists 80:8 168:5 experience 221:17 255:9 265:20 297:21 298:1 366:11 387:16 388:3 388:20 393:7 396:2,11 398:14 410:2 411:4,5,11,14 experienced 279:9 experiencing 152:14 expert 6:7,10 6:14 22:13,19 22:20,21 23:2 24:14,19 27:1	52:9,14 53:5 53:21 54:1,2 54:18 55:10 69:15 82:2,7 112:16 113:10 114:10 117:9 125:18 128:4 129:17 132:4,9 134:11,18 140:19 141:15 141:15 146:4,9 146:11 156:15 157:9,13,17 160:6 161:8 162:20 165:15 170:16 173:3 187:8 191:5 197:2 199:9 202:19 205:3 206:14 208:20 211:1 213:14 214:4,8,10 251:8 256:9 283:21 284:8 284:11 285:2,4 285:5,8,13,14 285:21 287:3,3 289:5 299:3 301:3 308:11 308:17 309:3 310:10 315:4 316:21 317:18 318:9 319:16 372:17 373:6	375:1,10 393:9 393:18 407:21 expertise 315:6 experts 39:20 91:7 202:6 287:15 expires 417:18 explain 62:13 108:17 126:3 232:10,20 233:3,6 269:3 316:4 335:12 340:18 349:20 377:10 388:8 393:11 explained 229:3 403:16 explains 27:15 28:7 29:21 222:16 400:3 explanation 92:9 178:8,9 178:18 232:9 383:5 explanatory 211:19 272:18 explication 228:5 explicit 173:20 319:17 372:21 408:8,9 explicitly 144:21 145:4 146:4 187:10	206:15 exploratory 15:8 explored 262:15 263:1 extends 98:12 extent 19:21 67:10 199:4 213:12 379:8 external 21:21 86:5,14 extreme 182:21 305:18 extremely 235:4 240:12 240:13,14 eye 378:20 f f 44:21 104:15 105:15 106:4 109:1 110:6 218:1 323:14 323:19 324:19 326:15 333:14 333:20 337:8 337:14 340:4 341:5,13 347:9 348:12 349:9 352:10,16 353:3,14 397:20 398:1,6 398:7,21,21
---	---	--	--

[face - feels]

face 150:10 153:12 231:17 351:18	141:11 144:3,6 149:2 157:13 159:13 167:19	408:16 409:9 411:14 412:13 415:16	father 18:1 19:5
facilities 115:1 199:6	191:6,7 201:6 203:9 221:4	fairly 152:2 275:21 276:2 279:5	favor 235:15 297:14 298:2 298:14
facing 88:19 117:10	223:13 236:8 241:6 246:6	faithful 142:15	favorable 117:18
fact 151:16 264:1,14	249:18 251:15 252:12,21	faithfully 92:7	favorite 35:18 238:5 254:12
factor 150:11	255:2 261:20	fall 7:18 105:19 105:21 243:5	feature 54:9
facts 268:13,16 301:10	263:4,16,16 270:2,12,13	284:3,10,15,17 303:12 384:15 385:3	federal 1:11,19 393:14 409:3
factual 19:13 346:13	274:3,9 276:1 277:11 279:16	falsely 235:2 237:11,20	fee 43:15 46:8
factually 19:15	280:9 282:2	familiar 51:17 51:18 71:18,19	feed 11:8 16:7
faculty 41:14 45:12,13 47:6 388:21	291:18,21 294:17 295:18 295:20,21	76:14 79:5,7 92:15,21 93:3 99:9,14,17 111:3 122:12 132:4,9 219:5 330:4,5,13,18 363:6 394:19	feedback 57:3 57:7,12 75:19 86:6 87:5,10 87:12,12 115:6 115:7 119:3 122:9 125:20
failed 377:1 406:10 407:5	296:3,4,5,7,21 301:11 302:16	famous 413:4	feel 14:2 56:21 86:13 123:10 164:16 170:21 183:7 184:7 220:10 224:9 252:1 253:21 257:3 262:20 296:3 306:7 308:12 309:10 331:15 353:17 385:4,9 418:7
failing 278:9	303:9 306:3,8	faq 110:11	feeling 385:17
fails 420:15	306:14 314:11	faqs 61:19	feels 253:15 282:15 296:1
failure 72:17 73:20,21 345:13	320:18 335:4 340:3 341:21 347:3 358:5 359:10 363:9,9 364:6 368:14 370:12 373:15 382:3 383:19 385:2 391:7 397:20 398:7 398:13 399:6,6 399:20 402:15 404:7 406:8	far 91:21 108:4 167:14 305:6 318:4 330:20 356:7	
failures 386:9		fast 294:2 299:13	
fair 13:1,7,8 14:3,4 16:4,5 49:13 56:3,6 62:21 65:7 80:7 88:6,8,13 92:2 93:16 94:1 98:13 112:13 125:3			

[fees - follows]

fees 43:12	164:15 222:1	237:2 240:18	flip 131:10
fell 83:2	244:18 343:9	242:1 251:6	331:16 359:4
felt 19:12 35:4	389:7	260:12 273:3	373:18 380:4
97:9 182:16,16	fine 70:11	274:1 282:11	flipping 65:13
201:1 259:1	77:13 87:17	294:10 308:3	360:8
262:4 351:18	137:7 229:13	310:9 313:20	floated 318:17
fewer 152:7	232:11 283:1	331:15 338:7	floor 280:16
246:3 281:18	309:7 362:4	348:18 354:19	florida 1:1,12
346:15,18	364:3	firsthand 123:1	9:8 95:9
351:20 352:1,4	finish 13:1,1	123:15,16	fluctuation
fifteen 204:7,8	78:9 117:4	fit 99:2	50:7,17
376:10	finished 107:21	five 81:15,21	focus 34:11
fifth 91:1	159:19	82:7,10 91:9	52:5 54:4 72:4
figure 255:14	firm 20:3	120:8 124:5	112:12 115:12
288:11	first 24:5 25:13	159:1 188:20	131:1 199:7
figured 36:9	39:13 43:13	229:16 279:21	315:8
file 141:6	44:20 46:13	281:3,6 289:18	focusing
355:18 358:3	50:4 53:17	290:15 291:4	333:17,17
filed 23:3,9	55:14 72:6	291:17 293:8	folio 32:19,21
files 154:5	73:11 75:4	319:4 347:18	folks 21:2 22:5
fill 64:21 66:6	79:15 83:11	356:11 364:8	26:7 44:12
208:3,11	89:9,9 91:1	366:6 367:2,21	58:13 94:21
filled 66:19	104:2 114:21	368:10 370:6,8	272:8 287:2
filling 377:19	117:17 120:9	370:10 401:14	follow 21:16
filter 57:11	126:15 140:15	410:10,14	107:9 143:18
final 7:17	141:21 142:9	413:5 414:4,7	149:3 178:12
232:19 284:2,9	147:14 158:4	fix 31:17 66:12	272:15 316:16
285:8 292:8	159:8 163:20	92:4 121:18	followed
319:21	171:2,7,10	147:10 154:18	260:20
finally 297:12	179:18 185:18	167:19 201:18	following 56:18
financially	186:3 188:8	387:21	373:11,16
235:6	193:3 196:6	flag 16:6	374:2 375:10
find 63:8 67:7	211:8 219:15	flat 46:8	follows 71:3
96:6 148:2	221:21 231:14		140:21 155:12

[follows - funded]

158:20 229:20 283:9 356:17 362:10 font 207:10 foregoing 418:4 foreign 325:6,7 forget 76:16 forgetting 387:5 forgive 41:17 278:19 forgot 182:2 307:16 form 27:20 31:15 42:10 50:21 57:18 67:20 73:6 76:3 89:2 90:1 98:5 101:3 121:16 124:11 126:6,8 132:21 134:2 144:19 157:15 170:14 172:7 173:15 173:18 174:4 174:12 182:10 186:19 190:2 190:19 191:17 205:1 206:11 208:16 211:10 221:1 223:6 225:18 227:19 228:17 236:10	243:19 252:13 274:7 277:14 279:3 280:11 304:19 324:5 331:19 339:20 341:10 349:3 349:16 366:3 367:4,16 368:3 368:18 369:12 369:13 370:15 375:5,21 377:7 377:8 378:17 378:18 379:10 381:19 383:1,2 383:13,14 385:6,7 387:20 389:4 390:2 391:18,19 392:5 393:4 394:20,21 395:12,21 396:1 398:9 399:12 formal 26:4 53:9 54:4 150:14 format 90:4 217:14 formation 80:5 formed 160:7 forms 84:9 318:16 fortunately 103:3,6	forty 42:3,3 forward 93:6 125:18 189:16 214:9 255:1 284:13 285:13 285:20 294:2 299:13 358:17 forwards 231:6 found 215:3 329:11 four 81:15,21 93:6,12,15 94:3 98:15 101:8 102:6 110:2 118:16 155:14 158:16 215:17 216:10 241:8 253:19 255:12 265:2 268:3 276:15 281:9 290:2 291:17 295:13 299:4 305:18 315:17 317:7 366:7,14 367:2 367:20 370:11 370:12 371:10 371:17 372:12 372:19 382:18 414:6 fourth 91:1 297:13 fraction 247:4	frame 90:7 106:15 168:3 framed 168:20 framework 215:18 framing 146:14 free 14:2 164:16 184:7 253:21 257:4 331:15 416:2 frequently 5:20 103:18 347:19 friday 314:20 friend 30:21 friends 405:8 fringe 49:4 front 23:7 65:13 130:9 226:5 286:8,9 286:10 313:2 354:18 fronts 258:19 fs 109:14 110:3 111:7 324:17 full 11:21 12:2 76:9 195:5 208:17 328:11 fully 143:17 224:11,18 328:9 fun 279:12 function 254:2 funded 152:11
---	---	--	---

[funding - go]

funding 42:6,8 43:18 151:2 further 45:9 136:2 165:13 169:18 290:20 350:20 382:5 397:1 415:21 417:7,10 future 47:16 52:17 54:19 55:1 125:10 240:18 359:2	gel 279:7,9 general 19:11 19:12 49:16 88:8 90:4 103:9 151:6 288:8 303:17 404:13 generally 36:5 36:13 41:11,17 47:5 50:6 51:17 53:6 60:13 67:10,19 73:10 76:5,14 79:5 81:20 82:8 83:19 86:1,18 93:2,5 95:13 108:17 123:9 126:3 135:21 142:3 151:1,4 171:7 217:7,14 219:2 233:4 234:2 284:6 287:18 291:10 296:19 314:8 316:17 324:10 397:15 getting 16:2 34:12 258:13 262:21 296:9,9 311:7 321:5,8 367:15 379:18 391:6 399:8 403:9	gibson 2:3 9:18 10:2 gibsondunn.c... 2:9,10 gist 217:19 give 10:12 13:15 19:10,19 23:5,6 35:17 44:12 48:16 97:10 167:11 174:19 193:10 213:12 215:4 219:19 221:4 222:6,10 223:20 227:5 234:6 243:17 270:16 277:11 290:2 295:13 324:9 331:3 343:8 372:7 410:9 given 58:3 68:7 71:13 97:7,10 97:15 182:1 267:13,19 306:5 353:16 357:5 418:5 gives 47:2 70:17 129:15 407:1 giving 103:2 144:10,16 203:18 210:16 222:2 265:10	266:11 359:14 378:15 379:12 glad 268:1 glitch 159:5 160:1 go 11:5 12:3,11 14:13 18:20 24:5,9 25:8 27:20,20 33:18 40:10 44:16 49:15 53:16 54:17 60:8 72:15 74:8 78:15 85:6 86:7 89:2 90:9 90:19,20,21 99:21 102:18 104:8 105:18 110:10,11 114:16 115:18 115:19 118:14 125:6,7 126:21 127:6 128:13 130:16 131:2,2 131:5 132:18 133:11 135:3,4 136:2,6,9 137:11 142:20 143:2,8 148:8 154:12 156:3 157:5,6,15 158:11,13 163:5,19,21 164:4 165:14
g			
g 9:1 gain 53:15 54:19 gained 63:3 gaining 63:20 gaming 135:15 gaps 64:21 354:1 garde 400:6 gas 218:9,12 gathered 402:4 gauge 213:12 218:9,12 gear 321:8 gears 32:18 33:12 41:4 69:19 70:8 112:7 321:4,6 321:7,8			

[go - good]

165:19 168:10	316:4 317:7	116:13 121:21	220:2 229:8,9
169:18 170:20	318:5 319:4,15	297:8 366:11	229:11 230:1,6
174:12,16	321:15 323:1	going 9:3 11:13	233:12 234:14
177:9 178:15	328:2 331:1	14:1,8 15:11	234:16 238:4
180:13 182:5	333:6,7 334:5	18:2,7,15	238:10 239:19
185:17 186:19	338:3 339:20	19:20 20:5	241:10 243:6
188:5 189:12	340:4,8,20	23:15 26:9	251:1,3 252:10
191:21 192:5	342:3 346:9	30:11,13 35:17	254:18,19
195:14 197:9	347:9 348:8	36:8 42:19	256:16 274:7
201:11 202:21	353:13 354:18	44:2,3,14 57:4	279:10 282:21
204:2,8 205:8	356:11 362:1,3	60:5 61:15	283:5,13
206:9 207:5,8	362:4 381:1	65:12 70:7,15	287:10 290:1
207:17 208:1	382:6 394:13	70:18 71:7	292:1 294:10
208:16 209:6	401:4 411:18	72:3 83:18	295:9 300:7
209:12 210:11	412:9 413:18	84:6 85:5	302:18 303:4
213:8 216:21	416:2,2,3	87:19 90:9,19	306:1 313:18
217:21 218:4,7	goal 215:6,7,11	93:5 96:17	321:4 327:19
218:20 219:15	216:7 219:14	102:15 108:2	332:14 341:19
221:1 225:18	219:15 222:21	112:7,8,12	343:1 346:8
230:6 236:10	247:10,12,12	114:15,15	347:2 348:19
236:18 239:5	249:12 250:6,7	117:7 119:20	354:15 356:13
240:11 242:8	308:13 309:11	119:21 120:4,7	356:21 360:14
260:11,12	309:18 310:1	122:14 125:5	361:3 362:6,12
268:11 273:2	311:2,7,10,21	137:8 139:2,9	364:1 366:3
273:18,18	312:1,4 384:18	141:10 142:19	368:1 369:2
277:14 278:13	384:20	148:12 152:2	376:2 390:16
280:11 287:10	goals 222:19	152:18,21	396:7 400:6
288:20 294:5	250:5,16 311:6	153:10 154:11	good 1:3 4:3
295:19 297:17	311:13 312:1,5	155:8 158:16	5:3 6:3 7:3 8:3
297:18 303:1	384:19	159:1,5 160:12	9:2,6 11:17,18
304:19 306:20	goes 24:19	162:19 183:20	13:3 29:8 70:1
307:21 308:5	43:20 50:20	190:6 192:6,14	70:13 112:8,9
310:4 313:19	51:4 59:6	198:19 199:5	116:15 129:1,2
314:17 315:17	65:19 85:16	201:11 205:8	164:1 186:10

[good - grounded]

207:14 213:12 229:8,10 283:2 301:19 332:4 335:18 362:21 363:1 369:1 370:19 378:21 399:8 416:1 419:3 420:3 gotten 54:9 258:8 governing 192:18 government 151:2 grab 28:8 328:21 grade 5:16,18 6:13 7:8,18 18:12 22:13,20 23:13 24:14 28:7 30:4 53:5 54:1,2 55:18 56:4,8 59:4 62:12,17 64:6 70:5 71:17 72:4,12 73:1 74:3,9,17 75:6 79:1,6,16 80:3 80:5,10,13,19 81:17 82:3 84:14 85:7 88:1,11,14,17 89:15 90:11 91:7,13 100:1	109:4,16 110:15,18 111:9 114:10 117:11 118:16 121:5 122:15 132:3,9 134:18 140:17,17 141:15 150:16 156:15 157:9 158:1 160:6,8 161:8 162:20 170:16 179:21 190:9 203:18 217:10 219:1 220:10 224:10 235:3 237:12 237:18,21 244:7 245:1,5 246:20 248:17 248:19 249:3 249:21 250:12 252:8,17 264:6 265:3 283:21 284:3,9,14 287:3 296:18 299:3,10 301:2 308:13 309:11 309:18 310:10 311:6,14 312:5 313:15 314:20 323:12 324:16 325:4 328:3 339:8 363:7,11 367:15 368:2	368:17 369:11 370:14,19 371:21 389:2,6 389:12 390:1 391:2 394:17 395:6 398:21 399:18 400:4,9 400:21 401:2 403:7 410:11 412:13 grade's 210:20 graded 91:9,18 99:6 100:20 102:1 243:7,18 389:21 grades 26:15 27:2,4 29:3 30:1 40:4 61:3 77:1,20 94:9 94:17 105:19 199:13 235:2 237:8 244:17 245:15 248:11 249:1 252:11 288:3,4 291:13 293:20 294:3,4 297:2 299:11 299:15 396:6,6 grading 5:9 390:7 391:8 graduated 33:19 34:3 grandfathered 255:2 263:5,10	grandfathering 282:11 grant 41:19 49:18,20 65:19 grants 41:15 47:5,8,20 48:5 48:7 65:14 66:4,6,19 67:1 67:11,17 68:3 68:8 granular 65:8 202:2 gray 316:4,9 grayer 315:10 great 14:16 36:7 72:1 148:7 159:4 175:2 245:8 369:7,7 370:11 405:6 greater 82:15 151:9 246:17 249:19,20 353:19 367:15 368:16 greatest 390:10 gross 277:12 ground 12:11 35:17 36:9 113:2 268:16 271:14 347:16 grounded 267:12,19 268:4,13
---	--	---	--

[grounding - healthcare]

grounding 327:6	344:21 345:1 345:21 346:21	278:16 279:5,7 279:8,14 281:2	happy 172:13 177:3 272:19
group 1:7 4:3 5:3,14 6:3 7:3 8:3 9:7,21 17:20 22:17 32:6,12 35:11 35:15 37:19 39:10 40:17,19 43:9 45:5 46:4 64:9 95:6 107:7,15 208:17 232:18 272:7,15 285:9 287:14 289:8 292:14 299:1 300:21 313:13 329:10 336:19 362:17 419:3 420:3	368:21 379:4 393:6 395:16 402:17 408:3 guessing 146:10 169:8 guidance 21:14 52:15 62:15 63:12,13,18,21 64:2,4,14,15,16 159:16 284:12 285:19 guide 256:16	281:5 282:3 317:5 339:7,11 372:5 376:8,15 377:19 378:7,9 406:10 407:6 415:17 417:13 handed 36:2,3 283:17 handling 416:10 hands 55:18 219:10 223:19 handwashing 97:18,21,21 218:5,9,12 219:4,18 222:14 226:18 239:21 240:3 376:3,5 380:10 380:15,17 382:21 hang 185:13 happen 13:19 happened 325:12 happening 64:18 250:8 314:9 318:4 326:5 happens 44:17 303:19	324:9 333:3 362:3 hard 218:8 243:14 harder 207:21 harm 337:18 391:10 hcahps 365:4 366:6,10 367:2 367:14,20,21 368:10,15 369:7,19,20 370:6,8,10,17 371:1 409:18 409:19 410:1,2 410:5,7,19 411:2 head 409:1 header 308:2 heads 13:7 19:19 health 36:15 37:17 38:14 49:5 84:17 157:11 200:15 241:13 245:3 354:8 396:9 healthcare 34:11,13 35:2 35:4 58:12 72:17 73:15 157:17 364:8
guess 19:16 61:15 62:21 69:9,11 94:7 124:2 149:10 165:12 169:6 203:1 238:9 242:18 246:11 251:6 273:2 275:10 282:3 298:10 305:6 306:1,12 310:12 329:15 329:19 336:10 337:12 344:15	h h 262:17 half 216:15 336:4 353:20 halfway 52:8 hand 7:15 10:7 92:21 95:13 96:1,9,20 97:9 97:14,14,17 98:4 187:18 220:1 223:3,16 230:5 253:16 254:6 270:15 270:17 271:5,7 271:9,12 272:12,17 273:7,14 274:11,18 275:19 276:1		

[healthcare - hospital]

386:7,10,11 388:11 390:13 390:14 409:2 hear 21:21 68:4 76:11 123:9,14 240:16 342:9 397:14 heard 57:11 240:16,21 241:2,3,8 258:12,13 259:15,18 285:18 329:15 386:14 387:1 395:4 hearing 122:13 heart 332:5 heavier 367:20 368:16 heavily 304:11 hedging 350:14 held 11:7 114:12 139:4 help 7:11 12:19 65:4 73:19 118:6 148:13 179:7 219:3 234:15 255:14 269:16,19 335:11 helped 38:16 159:16 231:9 231:15	helpful 85:4 117:9 118:7,14 147:16,19 236:12 242:7 255:11 257:5 272:20 324:10 389:7 391:21 helping 37:20 helps 383:5 387:6 hesitate 13:20 hesitating 186:21 hesitation 169:3 hh 316:15 hi 164:14 186:10 231:8 high 81:19 86:13 191:16 193:5,9 276:2 280:9 328:1 higher 97:12 109:10 238:11 264:6,21 345:14 350:13 378:2 398:19 highest 200:19 277:1 281:12 highlight 142:7 hilton 317:17 himeles 15:20 himms 262:17	histogram 64:7 historic 118:4 historical 27:10 83:11 120:16 167:1,7 168:6 179:20 215:20 254:2,9,21 255:3 264:1 265:19,19 270:4,5 282:11 282:14 312:17 327:19 403:2 415:13 historically 62:20 history 33:13 270:16 hit 342:21 hold 111:19 254:18 hole 230:8 holistic 65:7 371:5 home 18:1 357:4 honest 143:20 honestly 134:3 408:1 hope 74:17 75:8 155:19 191:4 hopkins 5:13 20:8 32:10 40:11 42:12	43:8,20 48:6 50:4,10 104:13 104:21 241:2 347:8 348:10 349:7 396:3,4 396:12,15 hospital 5:18 6:13 7:8,18 18:12 24:14 27:2,7,8,11,12 28:7,11,16 30:4 36:10 38:1 40:3 52:9 53:4 55:9 56:19 59:4,12 59:17 60:15,20 61:3,16 62:1 64:6,7 72:11 72:21 74:3,11 74:11,17 79:1 79:16,19 80:3 80:5,16 81:17 82:3,14,18 83:2 84:1,14 84:16 85:7 88:1,13,17 89:15 91:2,6 91:11 93:10,14 93:21 94:2 95:16 97:18 98:3 99:5 102:12,13 104:15,15 106:4,5 108:20
--	--	---	--

[hospital - hospitals]

108:21 109:3,8	246:20,21	377:13,18	382:14 383:10
109:9,16	248:20 254:4	378:1,14,15,15	383:10,12,21
110:15,16,18	254:11 255:8	379:15,16	384:1 390:12
110:19,20	260:20 261:15	380:16 381:4	398:8 404:10
111:8,9,10,16	261:19 268:4,7	382:7,19 383:4	405:1 413:7
117:11 119:7	269:7,9,11	383:12 386:3	hospitals 40:2
121:4 122:15	270:18 275:12	386:15 387:2,6	74:18 75:8
126:18 132:3,8	276:3 278:20	387:9,11 389:2	77:21 82:21
134:18 140:16	279:8 281:3	389:12 390:1	83:3 91:8,10
140:17 145:7	284:3,14	390:14,19,20	91:17 94:9,11
150:15,15,17	288:14 289:19	391:1 394:17	94:17,19 98:11
150:18 151:6	290:2 291:5,13	395:6 396:5	99:21 100:19
153:11,12,15	293:20 298:5	397:20 398:6	100:21 101:21
157:8 160:6	299:12 301:2	398:21 399:18	102:7 104:5,11
161:7 167:2,8	313:14 314:20	400:9 401:1,19	104:12,16,17
167:9 168:4	318:2 319:7,12	403:7 404:9	105:15 109:1
169:12,13	323:11 325:4	405:2 406:9,16	109:13 110:4,7
170:16 175:20	325:17 326:6	406:16 407:2,3	111:5,6,15
176:1 178:13	326:10,21	407:5 410:3,4	112:2,3 117:19
179:6,16,20	327:2,21 331:7	410:7,11	118:20 119:3
180:1,3,6,10,16	337:14,15	412:11 414:18	119:13 120:3
181:6 182:1	338:17 339:12	415:4	120:15 121:2,7
193:2,4 200:20	347:9 348:13	hospital's	121:8,12,20
208:5 213:6	348:13 349:10	93:11 97:8	122:3,5,10,13
215:1,19	349:10 353:14	104:4 120:16	123:9,14,17,18
216:13,17	353:15 363:7	179:3,5 193:19	124:1,2,8,18,21
217:10 219:10	364:9,21	218:13,16	126:7,11,13
223:2,15,18,20	365:10,19,19	253:4 261:17	127:9,14,17
224:6 225:2,5	366:12,15,19	267:13,19	132:1 133:16
225:10,15,16	367:13 368:1,6	268:5,13 271:9	134:1,8 143:12
225:17,20	368:15,17	271:12 300:11	144:11,17
227:6 239:5	369:7,9,11,16	300:20 301:16	145:12 147:6,9
241:2,15 243:8	370:5,14,17	348:5 368:19	148:16,18
244:6 245:5	371:14,17,21	380:7 382:8,11	149:1,16,19,20

[hospitals - huh]

150:2,3,7,9,19	244:9 245:9,13	328:4,9,13	282:21 304:2
151:9,12 152:1	245:16 246:3	338:16 339:3,5	hourly 46:8
152:4,5,8,10,10	247:5,7 250:13	339:8,11	hours 16:14
152:11,11,14	251:4 252:4,16	340:16,21	141:2 240:17
153:6,8 154:14	258:14,21	341:13,20	253:15 365:13
154:17,21	260:14 261:13	342:6,13 345:2	368:8
167:13,17,21	269:5,6,11	345:9 346:14	house 61:6
168:3 171:21	271:7,16	348:9,9,14,15	hsg 140:17
174:10 176:20	273:15 274:17	353:8,9 354:2	314:20
178:9,21 180:8	274:18 275:1	354:2,5,6,9,10	huge 128:21
181:11 186:12	275:14,21	371:18 372:7	huh 12:15
187:1,2 190:7	276:8,12,19	372:11,13	30:19 32:20
193:8,10 194:2	277:2,3,7,11,13	376:19,21,21	33:14 41:6
194:18,18,20	277:16,17	377:4,6 378:6	44:19 45:11,18
194:21 195:1,4	278:3,7 280:6	379:7,12,13,17	50:5 51:13
195:5 200:8,17	280:20 281:9	380:12 384:7	52:7,11 53:3
200:18,19	288:8 289:7,9	384:17 385:4,8	60:9 63:16,19
201:14,17	290:17 292:6	386:2,13,14,20	65:16 72:8,10
202:6,8 208:4	292:17 293:2	387:4,15	76:18,21 85:14
208:11 210:19	293:20 294:3	389:21 390:7	89:17 91:3,19
212:12,16	295:13,16,18	391:3,8 393:15	92:16 93:7,9
214:7,16	296:9 297:1,15	395:14,18	103:5,17
215:16,21	298:3,4,6,7,15	397:8,12 398:2	104:10 110:17
216:9,12,15	298:18 299:10	398:14,15,19	111:1 114:18
218:19 219:4,8	299:14,19	399:12 406:1	114:20 115:14
219:9 223:17	300:7,9,19	409:5 412:5	115:17 116:4,6
226:18 234:21	301:14 315:13	hospitalsafet...	118:11 125:9
235:2,5 237:4	315:18 317:10	400:11	127:7 129:6,10
237:11,15,16	317:20 320:5,8	hospitalsafet...	129:14,16
237:20 238:12	320:19 323:14	5:16,19 103:15	130:18 133:9
239:7 240:16	323:15,18	hospitalsafet...	135:5,7,10
240:17,19,21	324:20 325:5,6	71:18 76:12	140:18 143:4,7
241:4,18 243:7	325:7,10	hour 99:18	143:10,14
243:11,17	326:12,14,15	229:8,14	147:2 166:1,20

[huh - improved]

187:14 192:2 194:10 228:11 283:3 402:13 humankind 332:3 hurts 383:5 hygiene 7:16 92:21 95:13 96:1,9,20 97:9 97:14,17 98:4 187:18 220:1 223:3,16 253:16 254:6 270:15,17 271:5,7,9,12 272:12,17 273:7,14 274:12,18 275:19 276:1 281:2,5 282:4 317:5 372:5 376:8,15 377:19 378:7 406:10 407:6 415:17 hyperlink 85:13	icu 93:4 175:20 175:21 176:6 179:1,3,6,16 180:6,9,16 181:7,9,12 326:18,21 327:2,10,18 328:16 330:9 335:3,8,18 336:1 342:6 idea 82:3 131:21 144:16 197:16 202:7 205:3 215:18 215:20 216:18 245:9 281:17 315:20 316:14 317:3,12,18 320:1 402:1 403:5,21 404:17 ideas 82:8 identical 292:8 identification 20:15 23:18 29:10 30:15 35:21 42:21 71:5 78:18 102:21 113:5 113:21 128:19 139:16 160:15 163:8 185:8 195:17 205:11 217:4 230:17	234:9 242:11 255:17 272:2 283:11 286:6 307:2 312:20 321:18 330:2 355:12 356:19 identified 82:4 109:4 261:21 266:17 326:4 identify 9:13 86:5 195:6 identifying 153:5 ignore 254:19 ignored 82:15 100:5 260:21 ignoring 214:20 illinois 3:6 immediately 84:21 311:16 impact 47:11 47:13 248:15 267:1 328:11 328:14 367:15 368:16 369:6 369:10 370:13 390:8 impair 13:12 impetus 244:6 implement 169:8,9 219:9 223:17 243:6 251:4,12,18	implemented 92:3,6 318:3 328:10 implementing 91:21 200:16 implications 301:7 391:11 imply 279:18 implying 152:15 importance 270:6 410:17 important 111:13 147:5 154:13 201:13 224:13,14 264:16 265:11 266:12,20 267:8,9 268:9 282:15 304:7 impose 133:16 181:13 imposed 166:12 imposing 133:21 improve 86:7 209:16 212:6 215:9,15 216:8 384:19 386:16 387:7 390:20 improved 249:8 273:15
i			
iason 2:5 10:1 183:13 234:6 343:9 ic 93:3			

[improvement - incentivize]

improvement 123:11 243:11 351:7,19 387:15 390:17	190:6,10 192:19 197:3 199:10,20 200:16 208:3	impute 131:21 167:7 171:2 173:8 184:15 204:15 239:6	344:10,15,16 344:17 346:6 346:14,17 349:4 350:18
improvements 326:20 352:2 388:10 390:13	208:10 209:9 209:15 211:1 213:11 214:19	239:13,20 247:20 248:9 248:15 249:5,5	351:1,4 352:5 353:1,17 366:7 366:15,16
improving 264:8	225:3,6,11,20 238:2,7,10,14	250:10 255:10 266:16 282:16	367:2,20 369:9 370:7,11,12 371:9,18
imputation 27:3,13 30:8 77:15,19 78:3 78:12 81:10,14 81:16 90:15,16 93:13 95:19 112:12,17 115:7 116:16 117:13,18 118:1,3 120:16 124:8,12,13 125:10 126:6,7 126:9 127:10 127:15 128:5 143:5,13 145:11 150:11 151:15,19 152:19 153:1,2 153:4 158:4,6 159:8,11,12 164:11 165:14 166:8,19 167:1 168:13 175:14 177:15 179:2 186:7 187:8	239:4 243:5 247:18 248:6 249:9 250:9,18 250:20 254:20 257:13 258:18 260:19 263:11 263:13 265:13 267:15 268:20 269:13 271:15 284:13 291:16 293:7,15,16 294:1,6 296:21 303:7 304:17 304:20 305:11 306:2,11,16 308:8 309:1,4 312:3 315:15 316:21 317:19 318:15 319:4,5 319:6,10,20 320:17 384:6,9 384:16 385:13 402:20 412:17 413:5 415:1,19	294:11 305:4 316:15 317:4 319:7,8,13,13 412:6,16,21 413:12 imputed 27:15 93:6 94:3 96:15,19 98:15 100:2,3 101:8 102:5,6 106:18 117:17 118:21 144:18 145:8 215:17 216:10 253:14,19 255:13 262:8 264:2 265:2 266:21 268:3 268:15 269:17 269:19 270:3 270:11 271:11 282:4 304:3 310:16 338:14 338:18 339:9 340:16 341:7 342:10 344:2	372:12 374:14 376:4 377:15 402:1 404:13 412:6 414:2 imputes 263:18 275:19 imputing 194:7 202:7 204:19 212:11 238:11 238:19 260:9 263:8 267:7 270:10 278:7,8 292:8 293:9,11 293:13 294:16 309:17 310:5 310:10,21,21 372:18 374:14 379:5,6 412:13 412:18 413:13 inaccurate 183:7 271:17 incentive 119:2 incentivize 212:16 215:12

[incentivize - information]

310:6 311:1 384:20,20 incentivized 118:19 212:15 inception 241:14 incidence 109:2 325:5,9,11 327:14 inclined 221:6 221:13 include 135:12 201:2 267:2 344:2,10 346:5 350:18 352:21 353:4 368:10 384:2 410:11 included 50:11 62:16 88:10 109:3,16 139:6 164:16 222:12 299:2 325:4 363:11 410:10 410:14,20 includes 30:7 48:8 49:4 62:16 339:5 342:10 including 21:2 316:15 317:4 339:8 inclusion 52:16 341:7	incorporated 320:12 incorporating 371:21 incorrect 241:18 342:8 342:18,19 343:1,2 increase 215:12 246:14 increased 50:16 increases 109:11 275:5 increasing 249:12 increasingly 243:14 incredibly 142:10 independence 63:4,21 independent 135:18 137:5 138:18 173:1,4 280:14 368:19 independently 375:12 index 4:1 5:1 6:1 7:1 8:1 130:17 131:1,3 131:6,19 132:18 133:8 133:11,20	137:11,18 138:12,13,16 173:12,17 174:8 202:12 202:16 indicate 146:2 380:15 381:17 indicated 122:11 189:19 309:17 366:6 indicates 162:14 205:2 380:21 indicating 192:12 358:3 indication 144:9,15 indicator 276:12 404:12 404:15 individual 52:18 88:10 120:16 221:6 224:21,21 241:14 244:13 273:21 274:2 276:11 303:6 310:5 311:1 319:20 individually 332:1 individuals 26:5 86:5 397:15	industrial 34:4 34:10 industry 35:4 infection 94:14 325:16 326:9 335:21 infections 109:7 326:8 364:8 influence 248:14 399:1 influenced 208:5 influences 399:17 influencing 210:15 399:18 inform 84:18 269:17,19 information 23:11 27:10 31:7 72:12,14 72:18,19 73:1 73:16,18 74:4 78:1 79:19 80:11 84:17 90:13 94:18 97:8,11,15 102:12 111:17 111:19 175:18 176:1,9 181:10 215:19 216:12 219:20 220:2 220:13 222:3
---	--	--	---

[information - issues]

222:13 223:3 223:21 224:2,3 224:8,12,15 227:14 228:10 228:13 235:21 242:2 247:4,7 247:10,19 248:9 259:18 264:16 277:9 278:6 311:7,8 381:6,17 387:14 389:4 389:17,19 390:11,12 391:9,20 392:13,18 393:16,21 394:2,5 401:21 402:4 404:11 405:4 informed 72:20 345:1 391:16 infrastructure 278:14 initial 336:18 initially 82:13 291:12 initiatives 61:8 inpatient 245:18 246:13 339:14 410:3 input 159:16 284:12 285:19 315:6 361:5	inserted 94:12 198:8 insinuating 387:1 instance 65:17 287:5 instantiation 263:11 instill 222:4,20 223:1,14,19 institute 2:13 9:17 20:20 30:18 389:1 instruct 15:17 instructing 14:7 insurance 151:10 intended 94:9 94:18 394:4 intending 312:11 intensive 235:5 240:12 243:9,9 325:20 intensivist 328:1,1 330:8 331:7,10 intensivists 326:20 intent 94:15 141:18 318:12 384:15 385:19 385:21	interact 58:16 59:19 interest 35:2 interested 34:12 35:3 273:13 396:5 417:11 interesting 35:1 86:21 171:17 interlined 316:10 internal 64:12 240:19 internally 251:7 interpose 15:12 183:4 interpret 220:13,14 228:2 interpretation 145:14 interpreted 189:9 interprofessi... 331:8 interrupt 118:6 367:6 introduced 170:15 254:3 255:7 270:17 invest 354:6	investigator 37:19 41:12,18 invite 6:8 114:5 114:6 333:10 involve 52:20 involved 23:13 56:8,10 61:10 61:13 118:4 158:3,8 159:7 159:14 160:2,5 232:3 ips 93:3 175:5 175:12,14 176:20 177:10 177:14,20 178:5,21 179:2 182:6 184:4,15 184:20 188:11 253:16 261:8 262:1 331:18 338:8,14,18 339:4 344:15 415:16 isolation 371:3 issue 82:6 91:7 120:21 245:15 396:10 issued 29:3 32:7 233:14 issues 82:4 129:13 147:10 154:18 164:16 201:18
---	--	---	---

[issuing - know]

issuing 199:12 250:12 294:3 item 25:14 26:6 60:14 315:19 316:18,20 317:8,11 320:4 items 18:10 26:5 142:12 315:5 iteration 62:1 333:2 itogias 2:10	313:10 374:2,5 joshi 6:11,16 6:19 17:20 18:14 116:10 140:10 163:16 186:5 196:3 272:8 273:8 313:9 journal 7:20 85:8,12 86:4,8 88:15 89:16 286:11 330:17 330:19 361:2 journey 387:15 judge 343:3 judgment 301:18 july 32:5 40:19 41:2 417:19 june 7:16 8:15 272:12 357:12 358:10,19,20	keep 30:11 44:2 55:10 60:5 85:5 90:13,19 102:15 121:4 139:9 143:11 148:12 151:3 156:7 161:18 162:7 183:20 185:3 201:11 229:9 232:16 266:20 300:6 315:20 318:8 354:17 keeping 344:15 keeps 292:1 kelly 8:12 329:16 kentucky 400:17,18 405:8 kerr 1:16 9:12 417:1,16 key 12:12 82:18 267:3 kim 31:4 32:8 kim's 20:9 31:6 kind 386:15 knew 89:18 361:5 399:5 know 17:17 18:4,7,15 22:13 23:6,9 23:12 24:18 25:19,19 30:3	32:10 41:17 44:4,8 46:9 49:18 55:16 58:6 59:3 67:10,10 69:5 69:7 71:20 75:3 76:5,7,8,9 77:12 78:1,3,4 81:6 86:3 89:6 91:21 95:10 101:14 104:20 105:12 106:8 108:5 111:3 112:19 119:1 127:13,18,20 128:1,15 129:12 130:14 133:5 135:14 135:21 136:7 136:19 137:4 137:21 140:19 143:17 147:21 152:15 153:19 154:3,7 158:7 162:1 169:20 170:3,21 172:19,21 176:16,21 180:9 181:9,21 184:4 191:18 194:19,21 195:11 198:12 210:4,4 213:4 213:5 216:16
j			
j 45:16 january 36:11 jean 58:19 59:11 job 1:21 51:8 418:18 419:21 jogs 234:5 john 12:2 348:10 johns 5:13 20:8 32:10 40:11 42:12 43:8,20 50:4 104:12,21 241:2 347:8 349:7 396:3,4 396:11,15 joined 32:8 160:4 jordan 17:18 31:5,5,20 32:7	k kachalia 17:16 18:3 kahn 330:14 karen 22:1 kathy 148:21 149:7 151:21 152:12 katie 58:19 60:1		

[know - lawson]

216:19 217:14	362:19 364:1,3	I	law 417:5
220:13 225:7,9	369:6 370:1	I 3:4 131:2	lawson 2:15
225:12 226:3	371:13 373:13	I.a. 252:11	9:15,15 15:11
226:14 227:8	374:9 378:7	lack 97:7,15	16:16 27:20
228:2,15,19	379:3 380:20	176:9 214:16	31:15 49:12
229:5 231:10	386:11,12,19	224:8 227:14	50:21 57:18
233:8 237:9,14	391:4,11	228:10,12	67:3,20 68:2,5
238:8 240:13	392:11 394:16	240:7 253:5	69:3,7,11 70:7
244:15 246:8	395:1,17	289:13 381:6	70:10,12 73:6
251:1 258:7,10	398:10 399:2,9	381:16 401:21	76:3 81:2 84:5
258:13 259:9	399:11,11,12	405:4	89:2,5 90:1
259:13 260:1,2	399:17 400:18	lag 259:10,12	98:5 101:3
265:9,11 266:4	402:2,2,5,8	259:13	121:16 124:10
266:14 268:7	403:7,13 404:3	laid 27:14 82:7	124:16 134:2
274:4 277:9,17	404:5 406:6	landed 146:3,6	144:19 147:16
278:1,2 279:8	knowledge	293:13	148:10 155:6
280:8,13	85:20 92:5	landing 346:5	157:15 159:18
285:12 293:20	98:3,7 119:15	landslide 273:7	170:14 172:7
294:8 295:7,17	122:21 123:1,3	language 53:8	173:15,18
297:1,3 299:10	123:5 124:21	63:10,11,11	174:4,12
302:19 303:8	153:20 161:13	72:5 73:20	177:11 179:11
303:20 304:4	176:13 193:16	79:9 91:14	182:10 183:4
306:7 309:12	251:21 252:15	106:19 179:15	184:6 186:19
309:16 310:2	308:21 363:14	219:5 292:10	190:2,19
311:4 312:8	365:10,18	297:3	191:17 205:1
314:6,6 329:2	385:20 392:20	large 175:6	205:18 207:10
329:3,16	393:2 394:12	182:8 269:5	208:16 209:21
330:15,17,20	395:16	largely 270:3	211:10 221:1
331:14 339:21	known 300:10	larger 152:10	223:6,8 225:18
343:3,4,5	300:20 301:16	152:10	227:19 228:17
345:2 346:7,13	knows 343:10	latest 90:13	229:11 236:10
347:2 351:2		lauren 22:1	243:19 244:2
353:11 355:17			252:13 256:12
359:5,21			265:15,18

[lawson - leapfrog]

266:2 274:7	leading 6:6	71:17 72:11,21	232:4,18
277:14 279:3	26:5 113:9	74:3,17 76:16	234:15,21
280:11 283:1	367:5	79:16,19 80:3	237:5 243:5,17
304:19 331:19	leads 59:12	80:16 83:8	244:8,12 245:1
333:9 339:20	leah 25:12	84:14 85:7	245:2,18 246:2
341:10 343:15	58:11 329:10	88:13,17 89:14	246:19 249:11
344:4 347:21	336:19	91:11 93:11	249:18 251:3,8
367:16 368:3,5	leapfrog 1:7	94:1 95:6,12	251:12 252:1,3
369:13 377:7	4:3 5:3,14,15	95:21 96:8,19	252:12,16
378:18 383:1	6:3,17 7:3,11	97:4,5,5 98:19	253:2 254:4
383:13 385:6	7:15,17 8:3 9:7	100:18 101:1	255:7 258:3,15
391:18 394:20	9:21 17:19,21	102:9,11,13	258:20 261:9
395:21 398:9	18:12 19:18,19	107:7,15	261:14,18
414:6 416:3,9	23:10 27:3,8	110:16,20	262:2,12 263:6
416:12	28:6 32:6,12	111:16 112:3	263:7 264:1,15
lawsuit 18:4,9	35:11,14,15	119:4,6,11	266:17,18
18:16 22:19	36:10 37:10,11	121:1 122:11	269:6,11 270:9
23:2,8 31:5	37:19,21 38:1	125:14 138:2	270:17 272:8
32:13 242:4	38:5,7,15,18	140:12,16	272:11 273:7
lawyers 252:20	39:1,8,9 40:3	143:11 146:8	273:13,19
lay 114:19	40:17,18 41:5	146:10,15	274:19 275:18
406:8	41:8,15 42:6	153:16 158:8	276:2,13 279:4
lays 118:7	43:9 45:5 46:4	160:2,5 166:12	282:15 284:3
191:11 289:17	46:5,14 47:12	168:17 169:4	284:12 285:1,3
lcra 2:9	48:8 50:10	176:1,3,14,19	285:19 287:14
lead 26:2 41:19	51:2 52:2 55:5	180:3,10	287:20 289:8
41:19 286:20	55:15 57:10,14	181:11 185:11	290:5 291:11
322:16	58:2,4,14	189:15 199:11	291:12,15
leader 39:1	59:12,17,19	208:5,10,12,15	292:13,21
leaders 122:11	60:14,19,20	208:17,21	293:19 294:15
122:12 396:4	61:2,8 62:14	209:14 214:8	295:14 297:14
396:10	63:3,18,20	214:11 216:1	298:4,12,18
leadership	64:12 66:10	224:11 225:14	299:12 302:2
99:13 254:15	67:12 68:8	227:8 228:7	302:12,14

[leapfrog - line]

310:16 313:8	180:17 181:15	level 81:19	175:14 176:7
313:13 314:14	200:6,15 220:1	97:12,14	176:11,19
315:19 317:12	229:3 241:13	142:11 176:6	177:20 178:10
318:1,7,10	242:16 245:7	274:1 281:21	179:17 180:2
323:11 329:10	258:5 274:20	351:7,19	180:11 181:6,8
336:19 339:12	288:17 301:5	levels 345:6	181:14,19
346:5 347:7	302:19 303:9	liberty 350:2	182:1 184:4,15
350:1 352:18	303:10 345:3	352:18	188:10 192:6
353:17 357:19	345:10,14	license 258:6	192:15 204:16
362:17 364:9	388:5,14,17	258:10 259:16	204:19 215:16
364:21 365:11	389:2	270:19 314:5,7	216:10 220:4
366:12 371:14	leapfrog.org	licensees 154:6	228:16 238:18
371:17 372:18	76:17	licensing 260:5	238:20 239:14
373:21 379:5,6	learning 354:7	lifetime 397:16	239:20 267:5
379:11 384:14	leave 155:3	light 72:12 73:1	267:11 268:2
385:20 386:3	282:18	74:4	268:12 269:20
386:15 387:6,9	led 25:21 33:6	liked 202:7	271:6 290:8,10
387:17,19	213:21	likely 82:4	294:21 296:5,8
388:4 390:7	lee 2:4 9:18	104:14 106:3	296:8 298:5,6
391:8 392:4,10	11:19 132:20	106:19 162:10	339:6 371:20
392:19 394:9	left 40:9 99:6	186:13 280:9	372:13,19
394:16 395:4	166:2 287:11	341:9 345:3,4	376:4,11,12,15
397:5 399:1	339:1,2,7	347:6,8 348:11	377:14,21
407:1 408:9	340:5 341:4,8	349:8 350:8	378:4,14
412:5,6,10	342:1	352:9 353:13	379:18 380:10
414:17 419:3	legal 12:2	limitations	380:12 385:5
420:3	252:19 420:19	326:13	402:7 403:3,11
leapfrog's 5:18	legislation	limited 83:7,14	404:1 405:10
7:13 30:4	393:14	95:12 96:1	405:14 406:12
56:11 59:5	letter 30:1 74:9	97:6 131:3,16	406:14 407:1
75:14 77:19	91:7 244:17	131:21 132:4	line 18:2 94:13
78:12 79:1	245:1,5 249:1	132:10 138:3	109:6 111:2
93:10 94:1	249:3 252:17	144:11,17	131:10 133:12
103:16 180:7	389:6	173:8,13	133:15 135:8

[line - lookback]

148:2 178:12	40:8 44:14	335:13 342:14	137:10 142:6,7
202:18 208:1	51:11 52:6	346:10,10,13	146:21 148:6
218:8 268:11	54:3,14 61:2	346:18 348:13	156:7 169:13
315:10 325:16	66:13 69:19	348:18 350:21	177:1 178:5,14
326:8 328:3,6	70:4 77:13	351:20,20	178:16 187:10
331:3 335:20	81:8 110:9	352:1,2,4,4	187:15 188:7
395:17 397:6	120:20 128:3	355:6,6,19,19	196:5 197:20
405:11 406:17	143:16 156:3	357:14,19	197:21 204:5,8
419:5	165:20 166:17	358:6,7 359:15	209:6 216:21
lines 26:13	169:6 174:16	359:15 360:7,7	220:17 224:15
94:12 95:1	181:5 187:12	living 183:3	231:9 234:4,11
149:3 407:10	191:3 192:17	llp 1:13 2:3	260:8 271:20
link 16:7	201:2 218:8	local 1:12	279:17 288:6
111:20 129:11	239:1,2 244:7	74:11	288:13 290:20
linked 5:12	245:20 248:14	location 279:6	307:9 313:17
27:17 288:17	253:13 264:10	lodge 367:5	318:19 321:2
382:6 402:17	275:17 286:13	logic 213:21	323:1 324:7
linkedin 35:18	287:11 302:18	logistical 259:3	329:6,11 330:4
36:4	308:15 311:5	long 16:10,13	331:21 333:12
linking 326:19	313:17 322:15	28:10 47:11	333:13 337:7
list 60:10	350:1,14	157:19 158:7	338:4,4 340:20
156:11 413:5	352:18 367:19	160:1 229:8	343:7 346:9
listed 22:5	378:19 393:11	longer 208:6	347:14 350:20
304:20	396:21 400:6	212:11 241:17	352:12 358:6
listen 17:6	401:15 404:7	258:3	359:5 361:5
listening 363:3	409:19	look 21:4 24:1	369:10 371:4
literature	live 16:7	36:5 42:17	373:4,21 374:2
60:18 109:4	lives 8:11,11,14	43:12 44:14	379:21 383:9
326:4 327:19	8:14 104:16	51:10,11 56:16	394:18 395:10
332:7,15	105:10,10	60:7 71:20	400:1 401:4
345:15,17	108:15,16,20	105:18 107:7	408:14
399:12	109:15,19	109:2 113:17	lookback
little 13:4 18:8	322:6,6 323:10	116:3 129:4	167:14
23:5 33:13	323:13 326:3	133:14 136:4	

[looked - make]

looked 96:13 134:12 143:15 172:3 173:12 174:8 196:14 201:12 204:3 224:19 239:19 242:1 261:13 269:7 273:21 295:2 329:8 332:11 371:2 374:5 407:6	243:2 273:6,18 274:14 287:2 288:3 289:18 290:2 299:4 327:6	lots 117:19 262:16 332:3	176:5 198:1,11 198:13 244:10
looking 28:17 88:21 100:18 103:10 108:20 116:15 118:17 144:8 151:21 152:1 165:21 184:13 187:1 200:3 202:12 203:3,15 220:9 230:9 231:7 269:5 273:3 274:1 276:11 309:1 311:18 315:14 323:20 325:1 327:5 343:14 347:13 376:14 382:17 394:17 403:21 407:19 414:4	loop 132:19 235:18 los 245:3 lose 139:3 246:5 270:9 389:20 lost 8:11,14 96:6 105:10 108:16,20 109:15,19 110:13 158:9 262:12 322:6 323:10 326:3 335:13 342:14 346:10,13 351:21 352:1,2 352:4,5 355:6 355:19 357:19 358:7 359:15 360:7	loud 410:4 love 231:10 321:13 low 143:12 370:7 lower 83:3,6 110:4 171:10 189:1,18,20,21 193:4 212:18 235:3 237:12 237:18,21 281:19 295:5 326:14 lowest 97:14 132:13 135:13 136:1 138:4 143:12 172:4 172:10,16 192:20 203:2,4 223:2,16,20 276:16,18 277:12 281:1 290:11 374:1,8	246:2 285:19 294:1 305:15 337:5 367:13 418:8 madison 34:1 34:16,17 main 331:2 maintain 292:7 324:6 maintaining 298:14 majority 277:12 make 12:20 15:12,20 29:6 72:17,19 73:21 94:16 96:14 110:1 111:19 123:12 143:21 159:18 160:1 162:2 165:20 180:13 219:10 223:18 224:14 225:1 242:6 246:12 247:9 253:3,6 266:2 266:6,9 296:3 296:17 301:5 301:17 304:12 306:11 312:10 334:1 335:11 350:8 402:19
looks 24:13 26:13 141:2 143:8 175:2 184:13 188:20	lot 19:13 61:20 61:21 154:6 193:10 235:21 235:21 244:12 247:17 248:5 279:14 299:11 321:7,7 353:9 384:9 399:16	lump 324:17 lunch 139:5 155:5,10,19	
		m	
		m 262:17,17 made 90:5 108:7 134:10	

[make - mean]

418:15 maker 221:11 221:14,17,20 221:21 makers 222:2 222:11 makes 14:14,15 28:6 86:8 90:9 207:21 285:3 298:21 331:17 359:3 383:8 391:16 making 87:2 111:17 117:18 120:3 125:1 152:2 176:8 208:18 245:11 247:5 292:5,15 292:21 301:18 308:16 326:15 379:6 389:8 391:15,21 manage 52:9 60:10 managing 326:20 manifested 320:2 manifesting 320:2 manuscript 86:6 march 39:10 106:14 290:1	marginalized 150:1 mark 20:13 23:15 29:7 30:13 42:19 78:15 160:12 185:5 329:19 329:21 355:9 marked 20:14 23:17 29:9 30:14 35:20 42:20 71:4,13 78:17 102:20 113:4,20 128:18 139:15 160:14 163:7 185:7 195:16 205:10 217:3 230:16 234:8 242:10 255:16 272:1 283:10 283:17 286:5 307:1 312:19 321:17 330:1 355:11 356:18 357:5 markings 29:12 marks 11:12 70:14 71:6 155:7,13 158:15,21 229:15,21 283:4,12 356:12,20	362:5,11 marlene 1:16 9:12 12:19 117:6 417:1,16 marty 15:19 maryland 1:14 2:17 masters 34:3 match 372:13 matched 254:14 matches 384:1 material 383:17 math 328:3,7 340:20 matt 6:12,13 12:3 25:12 45:16 140:15 141:3 147:1,3 147:5 154:13 199:9 201:12 231:8 308:11 374:2 402:8 matter 9:6 21:10 161:5 193:17 252:19 304:6 362:18 matthew 1:11 2:12 4:2 5:2,12 6:2 7:2 8:2 9:5 9:16 12:2 416:6 418:11 419:2 420:4	maximum 279:19 mcdonald 148:21 mean 22:14 28:4 33:5 44:4 51:2 64:15 68:17 70:1 76:7 82:21 83:1 86:1 87:14 90:8 95:5 96:18 100:9 108:5 109:2 118:6,18 119:19 123:8 126:19 135:14 145:13 147:15 149:11 153:7 170:2 171:2,6 171:7,10,11 172:1,15 175:10 182:18 187:16 190:5 191:12,19 192:6,19,20,20 192:21 193:3 194:1,5,6,6,15 194:16,18 195:3,7 196:17 198:1 200:8 206:17 211:21 212:11,13,17 214:18,21 216:11 238:7
---	---	--	--

[mean - media]

244:2 245:14	186:18 194:4	79:17 82:16	334:12,21
246:11 261:12	213:18 214:6	88:10 90:5,8,8	335:1,13,14
264:6 265:6	measure 39:21	90:10,11 91:8	336:1,4 363:10
280:12 288:5	61:19 82:14,15	91:9,16,18	363:15 364:7
293:11,14	93:2 95:2 96:7	92:14 93:6,12	364:14,19
294:12,16,17	97:2 177:10	93:15 94:3	365:21 366:5,7
295:6 297:6	179:2 180:2	98:15,16,18,20	366:9 367:2,14
298:9 303:15	214:20 218:5	99:5,20 100:12	368:7,10,11,21
303:15 305:4	249:5,6 254:3	100:19 101:2,9	369:17 370:18
305:12,16	254:19 260:13	101:12,15,21	371:2,4,10,15
318:13,15	260:21,21	102:7 108:14	371:18 372:4
319:11 325:5	290:3,11,12,16	115:8 144:18	372:12,19
338:15 341:21	291:5 292:15	154:15 193:21	374:14 387:8
343:14 345:8	294:21 303:21	215:17 222:12	391:10 394:6
369:14 413:10	304:1 327:7	224:13 225:1	394:10,13
meaning 63:17	376:16 380:17	253:14,20	410:2 412:1
89:12 95:6	381:5 382:21	254:5 260:15	413:20 414:2
189:17 221:10	393:20 401:20	261:1 262:8,9	measuring
252:8 345:19	403:8 405:3	263:5,8,18	394:4
meaningful	410:1	264:3,12,17	mechanical
53:7 74:19	measured	265:1,2,11	331:9
75:10 189:14	238:5,6	266:12,16,21	mechanism
meaningfully	measurement	267:2,8,9	259:2 327:6
63:1 189:15,17	38:16 99:16	268:3 270:3,11	388:12
means 51:8	147:8 148:17	282:4,5 289:6	media 9:4
126:14,16	149:7 201:15	290:17 291:6,7	11:13 70:14
135:21 138:1	254:16	294:4 300:3	71:7 155:7,14
151:7 193:5,7	measurements	303:3 304:3	158:15 159:1
194:11,12	157:17 331:1	310:5 311:1	229:15 230:1
214:4 238:12	measures 39:21	315:14 317:1	283:4,13
260:18 281:6	52:16,19 60:16	320:5 323:12	356:12,21
305:9 325:12	60:19,21 62:16	325:3,17,18	362:5 399:16
meant 183:14	62:18 64:17,19	326:1,18 327:7	416:6
183:15,18	64:20 65:1,3	327:16 333:18	

[median - methodology]

median 293:11 293:14 294:11 305:16 318:15 medicaid 79:18 80:16 151:10 175:19 364:11 365:2 392:17 medical 1:3 7:8 9:6 86:2 95:9 109:15 179:1 217:9 219:21 323:10 352:3 380:16 400:14 419:3 420:3 medicare 79:18 80:15 175:19 364:10 365:2 392:17 medication 92:18 401:5 medications 13:12 medicine 104:13 330:18 348:10 349:7 396:3,4,12,15 medicines 410:12 meet 15:4,6 16:10 176:3 181:18 216:1 274:20 276:3,8 276:20 281:5 281:17,18	289:9 345:13 377:1,13 378:1 meeting 6:7,8,8 6:10,11,14 8:6 16:13 22:21 23:1,4 25:18 112:18,19 113:11 114:6,7 114:11,12 125:17 128:4 128:10,10 129:17 131:20 134:11 138:14 138:20 139:11 139:19 140:19 141:15,19 142:4 144:16 155:21 156:4 156:19,21 161:8,21 162:20 165:16 170:13,16 173:3 180:7,17 181:11 182:1 190:9 191:5 198:17 199:17 201:3 204:18 220:1 256:10 272:16 277:16 307:10,11 308:17 310:13 345:3,4,10 373:6,16 374:3 374:7,13	407:18,20 408:1,2,7,13,13 408:15 meetings 26:3 54:2 202:3 375:11 393:19 member 41:14 47:6 258:14 388:21 members 52:20 53:10 54:21 57:10 197:2 206:13 245:7 375:18 memory 28:12 28:14 36:9 68:18 77:11 78:7,8,10 81:2 81:3,5,20 87:7 87:14 133:20 137:7 162:11 177:6 198:19 234:5 235:19 235:20 241:5 408:4 410:13 mention 154:21 mentioned 57:9 90:3 94:21 132:16 139:10 146:1 147:1,5 154:13 162:1 201:12 202:19 215:9 252:11 291:15 297:16	308:11 349:18 358:1 378:9 mentions 257:17 merit 1:18 mess 84:3 messaging 183:8,10 met 15:1 82:2 112:16 156:14 156:18 162:1 181:17 263:2 275:2 277:2 362:20 379:13 meta 332:10 metadata 198:3 method 53:1,12 53:14,15 93:13 208:3,10 327:3 412:18 methodologi... 335:10 336:3 methodologies 81:16 128:5 208:19 306:2 methodology 5:9 7:18 18:11 18:12 27:14,14 27:16 28:5,7 29:20 30:8 56:9 62:15 77:15,20 78:12 80:8,21 81:11 81:14 83:4,5
--	---	---	--

[methodology - moment]

85:7 87:20,21	363:15 384:7	180:15 185:19	mistakes
88:7,14,17,18	384:15 385:3	205:18 344:4	109:15 323:11
89:1,1,15	402:20 403:8	minutes 139:10	misunderstan...
90:15 92:1,6,8	407:3 411:19	142:4 145:20	180:5
92:9 95:19	413:19 415:8	188:21	mobley 44:21
99:6 105:16	methods	mirrors 108:13	45:3
106:5,17,18	287:12 304:21	mischaracteri...	model 83:10
111:4 117:11	315:15 316:21	385:14	90:16 112:17
118:3 120:10	319:5	missed 379:15	115:7 135:12
124:8,13	metric 223:21	missing 82:5,6	143:5,13
125:11,13,16	335:9 338:5	91:8,17 94:6,8	145:11 158:4
149:19 150:6	metrics 216:10	94:8,15,20	159:8,11,15
150:12 151:19	mic'd 362:2	95:2 96:7,15	166:6 176:3
152:19 153:1,2	michigan 33:15	97:3 100:19	177:10 197:3
153:4 168:18	micro 201:2	101:21 102:5,8	199:11,20
176:18 177:16	middle 115:12	102:9 199:21	200:7,16
186:14 192:18	midway 104:8	208:4,11	222:20 239:4
194:8 206:8	military 115:1	257:15 260:20	244:11 245:1
208:15 214:11	199:6	267:3 289:2,7	304:17 306:16
219:15 224:19	mind 70:10	289:8,14,19	384:6,16
224:20 229:4	84:20,21	291:5 292:7,9	412:17 415:1
235:1 237:8	282:21 311:16	300:12 301:17	models 81:21
245:12 247:18	minimize 147:8	302:11 308:2,9	112:12 165:14
248:6 258:18	149:9 154:16	309:2 315:13	176:10 181:11
263:11,13,18	201:16	316:15 317:4	214:19 415:19
265:6 269:18	minimum	320:5 374:1	moderate
284:3,10,14	92:12 289:9	mission 387:18	166:12 168:13
285:1 286:17	minority	388:6,14,17	169:6,8 171:20
286:19 299:18	210:19	missy 21:21	modify 208:10
300:2 301:2,4	minus 52:1	31:3 58:11,18	209:14
302:3,13,17,21	80:10 294:12	59:20 119:12	moment 37:9
303:9,11,12,15	305:17	135:11 200:14	84:3 239:6
304:17 306:4,9	minute 96:5	259:20 314:19	256:14 342:17
324:7,11 360:9	177:14 180:4	317:3 320:10	

[monday - never]

monday 231:11	169:12 175:13	273:14 287:15	185:18 192:5
money 42:12	293:9,10	293:11	192:14 202:21
46:14 47:12	movement 87:1	nationally	210:14 213:13
month 197:17	moving 87:1	289:6 354:1	225:19 243:6
197:19 198:1	117:12 214:9	nationwide	251:4 263:12
281:5	291:18 317:18	241:20,21	281:4,5 324:13
morning 9:2	318:10	nature 37:14	334:15 340:20
11:17,18	multicenter	necessarily	371:4 384:10
mortality 109:5	330:10	75:4 87:2	390:16 416:15
110:1,5,7	multifold 215:7	94:18 98:11	needed 18:18
326:5,6,12,14	multiple 48:5	120:2 144:21	18:19 148:6
326:16,21	48:12 302:5	193:11 202:20	262:21 293:21
327:14,21	345:6	212:21 215:1	372:1 384:12
328:16 330:8	multiply	216:12 217:17	418:15
331:8,18	280:14 337:5	237:12 241:4	needs 14:12
333:13 337:15	n	250:5,16	181:16 293:17
337:20 338:16	n 2:1 3:1 9:1	268:21 278:4	371:5 393:14
341:13 342:6	name 9:10	319:19 332:15	412:21 413:14
344:3 345:14	11:19,21 12:2	369:18 378:7	negate 332:15
347:6	30:2,3 241:4	405:20 413:11	negative 132:7
mortar 241:14	337:1,4 358:3	necessary	319:18 390:8
motivate	362:16	210:21 213:11	406:6
200:17	named 15:9	418:8	net 148:16,18
mouth 100:9	417:3	need 13:6 14:11	149:1,16 150:3
move 51:10	names 12:4	21:15 27:19	150:7,9,13
65:15 93:6	20:9	28:1 41:14	151:6,18 152:1
126:5,11	narrow 53:18	63:21 72:15	152:4,4,8,14
142:11 189:16	national 52:13	108:8,8,9	153:5,8,11,12
206:17,18	54:18 55:10	113:16 123:11	153:15 154:21
244:21 254:10	60:18 64:19	129:12 136:2	neuro 179:1
284:13 285:20	79:17 83:1	142:13 153:14	never 93:21
286:3	214:21 216:11	163:3 172:8	122:2 132:21
moved 45:6	245:14,14	174:19 178:12	251:9 290:5
53:9 64:12		178:13 184:8	299:11 306:5

[never - number]

309:17 310:16 371:9 new 2:7,7 64:20 90:10 107:18 107:20 115:8 211:3 212:18 212:21 219:14 221:10 222:20 245:3 303:20 news 186:11 nice 155:19 nine 68:3 362:12 365:21 366:5 367:1 368:9,20 416:7 ninety 279:20 279:21 noble 243:2 nodding 13:7 non 152:4,7,14 noncomposite 392:12 nonimputed 346:6 nonparticipat... 77:20 95:16 99:21 111:5,6 120:3 132:1 133:16,21 144:17 167:8 167:17 174:10 176:20 215:16 216:9 225:10 237:16 268:4,5	271:7 338:16 339:5 406:16 412:5 nonperforming 277:7 nonprofit 151:12 nonrenewal 47:7 nonreporting 99:5 297:19 298:17,18 365:19 372:11 376:18,21 377:4 379:12 nonrepresent... 306:12 nonrepresenti... 237:15 nonresponding 369:9 378:6,13 378:15 nonsignificant 331:11 nonsubmission 402:10 nonsurvey 171:9 nonvoluntary 247:6 normal 141:20 216:14 north 3:5	notable 222:15 notarize 420:11 notary 1:19 417:1,17 note 140:6 178:21 201:2 207:7 209:9 232:8 309:14 312:7 358:16 416:14 420:9 noted 133:6 184:14 190:12 232:13 311:18 390:10 notes 6:11,13 7:14 8:6 23:7 29:8 61:19 108:7 128:10 129:12 139:19 140:19 141:10 141:11,16,19 142:9,20 143:3 144:5,15 145:1 154:11 156:5,7 161:2,7,10,13 162:8,19 172:4 196:7 197:11 198:21 199:1,1 203:12,15 205:2 256:1,4 256:17 257:1 263:12 307:11 307:12 309:21 311:20 373:6,8	373:10,12,13 373:13,14,16 374:15 407:11 407:17,19 408:5,14,21 notice 18:18 notified 20:5 noting 227:12 notion 204:19 320:19 nuance 303:18 309:21 nugget 34:8 number 5:5 6:5 7:5 8:5 11:13 21:1,9,18 43:13 44:6,15 48:16,17 50:3 50:18 51:11 66:2 70:15 71:7 90:21 109:14,18 120:8 125:6 143:3 155:8,14 158:16 159:1 174:19 175:9 179:4,7 229:16 230:1 246:12 274:11,17 277:2 279:17 280:5,6 283:5 283:13 288:21 290:2,15 291:4 293:8,9,10,13
--	---	---	--

[number - oh]

294:11 295:13 305:3,15,18 308:6 315:8,13 315:19 316:13 317:11 318:20 319:5,15 320:4 320:12,13,20 323:10,13 335:7,12 336:8 337:8 341:8,20 347:14 350:21 351:10,11 356:13,21 362:6,12 373:19,20 380:6,21 411:21 416:7 418:18 419:21 numbers 26:19 44:3,3,7,9,9 50:3,11 79:15 103:6 189:21 191:16 192:4 192:13 269:5 275:13 280:10 322:19 323:19 324:5,7 334:2 339:18 341:3 346:9,12 347:5 349:2,12 350:13 353:17 361:13 numerator 274:19	numerical 30:1 248:20,21,21 249:7 342:3 371:16 372:1,7 372:9 numerically 119:18 nurse 410:12 nurses 98:4 nursing 99:17 255:5 365:13 366:21 368:8,8 o o 9:1 o'clock 156:5 159:2 oath 13:9 object 14:6 15:11 27:20 31:15 50:21 57:18 67:20 73:6 76:3 89:2 90:1 98:5 101:3 121:16 124:10 132:20 134:2 144:19 157:15 170:14 172:7 173:15 173:18 174:4 174:12 182:10 186:19 190:2 190:19 191:17 205:1 208:16	211:10 221:1 223:6 225:18 227:19 228:17 236:10 243:19 252:13 274:7 277:14 279:3 280:11 304:19 331:19 339:20 341:10 347:3 366:3 367:16 368:3 369:12 369:13 377:7,8 378:18 383:1,2 383:13 385:6,7 391:18,19 393:4 394:20 394:21 395:12 395:21 398:9 objection 15:12 49:12 67:20 133:6 367:4,5 368:4,18 370:15 375:5 375:21 378:17 379:10 381:19 383:14 387:20 390:2 392:5 396:1 objections 266:1 objects 325:6,8 observation 301:12,14	observations 281:5 292:9 302:10 obviously 172:18 237:1 303:7 305:18 399:15 occasionally 13:19 occurred 127:9 199:16 occurring 335:18 odd 358:19 offer 243:6 251:4 offhand 67:9 221:5 280:8 office 22:2,9 offices 1:13 official 30:3 38:2,2 oh 11:1 29:13 44:11 70:19 86:21 110:14 122:13 125:7 135:6 137:15 142:21 183:13 183:15 198:3 209:10 245:8 248:3 306:11 321:12 325:15 328:7 332:5 343:8,14
---	---	--	--

[oh - okay]

373:15 387:6	66:17 67:8,14	126:3,12,17,20	167:11,19
414:9	67:16 68:14,14	127:20 128:2,8	168:8,19,21
okay 11:1,2	68:17,17 69:2	128:12,16	169:10,17,19
12:7,10 13:18	69:3,8,10,10,12	129:3,7,21	170:1,6,7,19
14:17 15:10	69:14,17,20	130:4,7,11,21	171:12,15,19
16:19 17:1,4,8	70:1,3 71:16	131:9 132:11	172:12 173:1,6
18:21 19:3	72:2 73:17	132:14,17	173:11 174:7
20:1,6,11	74:1,7 75:12	133:3,10,18,19	174:15 175:17
21:17 22:8,11	75:18 76:1	134:6,14,20	176:17 177:1
23:14 25:7	78:6,14 80:7	135:2,20	177:18 178:2,5
26:1,8,21 28:4	80:13,18 81:7	136:14 137:7	178:15 179:14
28:20 29:18	81:9,18 82:12	137:20 138:4,8	179:19 181:1,3
30:10 31:21	83:17 85:2,4	138:17 139:1,2	182:4,5,18
32:2,17 33:2,4	87:4,8 90:18	139:9,21 140:2	183:12,17,20
33:9,11 34:3	90:19 92:11	140:5,12,14	185:3,17 186:2
34:15 35:6,13	96:11 98:13	141:9,13 142:3	187:4,18
35:16 36:19	100:16 101:4	142:6,15,18	188:14,18,18
37:8,13 38:11	102:14,15	143:2,15,19	188:19,20
38:20 39:4,7	103:9,12,21	144:7 145:3,18	189:6 191:8,15
39:12,16 40:8	106:11,13,16	146:5,8,20	192:9,16 193:9
41:20 42:3,14	107:2,14,17	151:14 152:3	193:13 194:14
44:11,11 45:8	108:1 110:8,8	152:17 153:14	195:2,8,12,12
46:5,10 47:10	110:10 111:14	153:20 154:10	195:13,14,19
47:15,19 48:8	112:6,15 113:9	154:10 155:3,3	196:10,16,20
48:11,15 49:15	113:13 114:2,5	155:17 156:13	197:5,8 198:5
50:8,14 52:4	114:9,14	156:17,20	198:12,15,19
53:11 54:5,14	115:11 117:3	157:4,4 158:7	199:9,15,19
54:16 55:7,20	117:14,17	159:4,17 160:4	201:10 203:3,6
56:2,14 57:6	118:9,14	160:11,12	203:10,15,20
57:13 58:5	119:10 120:6	161:12,16	204:1,11,15
59:14,18 60:2	120:20 122:8	162:5,11,16,18	205:6,7,17
60:5,5 61:14	123:7,21 124:4	163:2,14 164:7	206:4,13,17
62:6,11 64:13	124:6,20 125:4	164:19 165:9	207:3,16 208:9
65:11 66:1,6,9	125:5,13,16,20	165:18 166:2	209:2,5,9,20

[okay - okay]

210:6,10 211:6	259:21 260:3,7	306:18,19	348:18 349:1,6
211:20 212:21	261:3 262:11	307:4,15 308:5	349:14,20
213:7 214:13	263:3,14	308:19 309:6	350:11,17
215:8,13	265:18 268:11	309:13,19	351:12,17,17
216:20 217:9	268:16,19	310:3 311:17	352:7 353:7,10
217:14,17	269:3 270:1,8	312:9,14,15,15	354:14,15
218:3 219:5,7	270:14,20,21	314:8,15,18	355:1,8 356:4
219:13 221:8	271:3,16,19	315:2,12 316:8	356:5,10,11
221:15,18,18	273:9,11,17	316:12 317:2,6	357:9 358:12
224:4 225:8	274:3 275:4,9	317:21 318:6	359:14,17,19
226:1,4,15	276:15,21	318:11,18	360:3,8,11
227:1,9 228:4	277:5 278:3,12	319:2 321:1,1	361:9,18 363:9
229:1,6,7	278:18 280:9	321:11,12,14	363:14,19
230:13 231:1	280:19 281:8	322:8,12,14,15	364:5,16
232:3 233:1,10	281:11,20	322:18,20,21	365:10,17
233:11 234:1,4	282:2,8,18,18	323:6 324:4,9	366:2,5,17
234:11,14	282:19 283:2	325:2 327:1,10	367:6,11 370:4
235:18 236:4,7	284:2,11,17,20	327:13,17	370:21 371:7
236:21 237:6	285:7,11,16	328:12,15,21	371:13 372:15
237:10 239:3,9	286:1,2,3,16,20	329:7,14,19	373:3,9,15
239:12,18	287:8 288:1,10	330:6,16,21	374:11,16,19
240:5,8,10,11	288:16,19	332:17 333:1,5	375:9,14,18
240:12,21	289:16 290:1	333:5,8 334:4	376:2 379:4
241:9 242:7,8	290:10,14	334:18 335:15	380:4,13,19
242:21 246:1	291:2,10,14	336:11,21	381:4,9,15
246:10,16	292:12,19,21	337:2,6,11,12	382:16 383:8
247:2,15	293:4 295:8,9	337:20 338:2,6	384:4 385:1,11
249:10 250:3	296:4,13,15	338:20 339:10	385:19 386:1
250:21 251:10	298:19,21,21	339:17 341:2	388:19 389:9
252:21 253:11	299:6 300:5,6	342:9,12,19,20	391:5,6,13
253:12 254:7	300:15,18	343:4,6,18,21	393:11 394:15
254:17 255:2	301:11 302:1	344:13 345:6	395:4,8 399:6
256:7,11 257:7	304:5 305:4,6	345:16,21	399:14,20,21
257:16 258:1	305:21 306:14	346:3,12,17,20	400:12,20

[okay - own]

401:3,10,13,15 403:20 404:17 405:6,13 407:9 408:11,16 409:9,14,17 410:4,9,16 411:1,12,17 412:17,21 413:3,13,17 414:5,11,12 415:15,20,21 old 120:10 258:21 259:9 317:16 319:15 older 87:20 211:2 once 29:1,2 59:16 72:1 190:20 219:20 240:12 371:2 one's 94:7 ones 236:17 270:4 354:11 354:11 398:3 ongoing 67:15 online 281:16 open 74:18 75:9 151:3 315:20 317:12 318:7,8,10 operate 178:21 179:6 180:9 operated 175:20,21	386:11 operationalized 83:9 294:20 operations 45:4 243:10 operative 303:13 opine 77:6 78:11 opining 77:14 78:11 opinion 237:2 369:5,10 399:3 399:4,7 opinions 315:21 opportunity 35:5 247:6 270:21 387:11 opposed 57:17 65:8 225:16 250:16 262:8 264:2 296:18 347:9 351:15 opposing 381:21 opt 243:7,17 251:5,7,10,12 251:18 252:1,4 opted 127:9 optimizes 210:19 option 188:9 241:12 243:7	243:17 251:5 295:13 320:17 373:2 options 158:6 263:1 305:19 319:6 394:18 413:5 order 84:19 92:20 143:1 262:19 414:15 organization 57:17 organizational 330:9 organizations 19:8 orient 164:1 original 208:2 254:20 262:7 originally 140:9 160:8 189:11 outcome 91:9 98:21 115:8 325:3,17 326:18 327:7 327:16 333:18 334:12,21 335:1,13,14 336:1,4 363:10 363:15 364:7 370:18 371:4 417:12	outcomes 241:16 outdated 259:1 outline 386:16 387:7 outlined 413:4 outlines 5:8 29:20 116:16 outputting 327:14 outside 17:1 21:15 243:10 265:13 266:17 overall 193:2 248:15,17,18 282:1 303:2 367:15 370:14 overhead 49:2 overlap 411:11 411:13 oversees 409:3 oversell 351:8 overtaken 247:12 overview 199:10 own 58:6,7 153:16 183:5 198:21 199:1,1 210:18 212:4 237:2 241:15 252:2 256:14 328:8 387:5 388:8 390:13
--	--	--	---

[ownership - paper]

ownership 309:14	115:13 116:7 116:13 131:2 131:10 133:14 135:4,6 136:6 136:9 145:19 148:9,11,11 149:3,21 163:21,21 164:1,4,5 165:20 174:19 177:9 178:3,15 178:15,19 179:8 184:1 191:13 192:1 196:6 197:21 204:9 206:11 207:6 217:6,10 217:21 218:4,7 218:9 220:10 223:16 226:5 226:16 227:7 229:2 234:16 257:18 273:3 288:20 292:2 297:8,11 307:21 308:3,3 308:5 309:8 316:5 323:1,3 323:20 331:15 347:21 348:3 354:19 364:2,4 373:18 376:15 380:4 400:3 413:18 414:3	414:10,10 418:16 419:5 pages 27:18 44:14 51:18 62:9 78:5 135:3 217:15 219:2 356:8 420:12 paid 42:12 43:15 46:19,21 48:16 50:4 palm 1:2 9:8 panel 6:7,10,14 22:13,20,21 23:2,8 24:19 27:1 52:9,14 52:19 53:5,10 54:1,3,18,21 55:10 82:2,7 112:16 113:11 117:10 125:19 129:17 134:11 140:19 141:15 141:15 146:4,9 146:11 156:15 160:7 161:8 162:20 165:16 170:16 173:3 187:8 191:5 197:2 199:10 202:6,19 205:3 206:14 208:2,9 208:14 211:1 214:8,10 251:8	256:9 283:21 284:8 285:2,5 285:8,13,14,21 287:3,3,15 289:5 291:4 301:3 308:11 308:17 309:3 310:10 315:4 316:21 317:18 318:9 319:16 372:17 373:6 373:20 374:17 375:1,10,18 393:10,18 407:21 panel's 114:11 284:12 panelists 24:14 128:5 132:4,9 134:19 157:9 213:14 214:4 299:3 375:11 panels 208:20 285:5 paper 33:3 105:4,6,8,9,10 105:13,14 106:17 107:19 107:21 108:6 217:18 286:21 287:18,20 295:11 297:3 302:2,16 303:21 304:18
p			
p 2:1,1 3:1,1 9:1 p.m. 25:10 114:7 155:15 158:17 159:2 164:9 174:17 186:5 192:1 229:17 230:2 283:6,14 356:14 357:1 362:7,13 416:8 416:19 pack 354:3 package 226:10 pad 33:3 page 4:5 5:5,20 6:5 7:5,8 8:5 12:12 24:9,10 27:5 29:6 43:13 44:2,6 44:15,17 50:4 51:11 52:5,8 60:8,8 63:13 74:9 76:12 77:5 79:9,11 79:14,14,15 84:11 90:21 91:1 102:17 103:6,18 104:6 105:7 110:14			

[paper - payment]

321:10 322:17 324:1 331:17 360:15,15,18 360:19 361:4 361:15,17 400:5 418:16 paragraph 53:2 63:14 72:6,6 73:5 79:16 85:6 91:2 96:12 104:9 207:17 209:7,13 210:14 213:16 289:17 290:21 292:1 297:11 297:12 300:7 302:6,9 348:8 paralegal 15:1 16:17 paramount 282:7 park 2:6 part 39:10 41:15 64:14 75:5,7,8 77:14 77:18 160:6 179:4 182:7 194:7,15 274:1 277:18,18 278:4 301:3 315:19 317:11 319:3,6,12 320:11 327:4	342:2 415:19 participants 166:14,16 participate 74:19 75:10 112:2 120:4 178:10 179:17 181:7 280:21 participated 406:9 participates 210:17 212:1 252:6 participating 167:21 275:12 275:14 339:3 participation 127:9 208:6 209:15 210:15 212:8 214:16 215:12 223:1 246:17,21 249:12,14,16 249:19 252:19 384:21 particular 77:5 217:12 263:21 375:7 particularly 52:5 parties 361:20 417:11 partner 15:19 17:21 19:4	partners 357:19 parts 231:8 pass 215:3 277:13 361:20 passed 276:17 279:19 280:6 passes 109:8 password 129:15 past 63:1 118:16 127:9 127:10,14 138:7 166:9,19 167:2,8 168:10 168:14 170:2 214:19 308:12 309:3 path 285:13 patient 7:20 65:4 85:8,12 88:15 89:12,16 99:18 104:4 109:2 110:5 219:11 223:19 224:12 245:10 253:4 267:1 270:7 282:6 286:11 287:15 304:7 326:5 348:5 351:7,9 365:13 366:10 368:9 386:16 387:7 389:1	390:19 391:9 392:16 394:12 396:11 410:2 410:18 411:3,4 411:7,11,13,14 patients 104:13 106:3 109:8 151:9 244:16 325:15,18,19 325:21 326:9 326:21 348:11 349:8 351:15 366:11 389:5 389:11 391:8 391:10,14 395:5,10 399:16 patrick 157:7,8 161:17 162:7 231:9,15 232:1 256:16 patterns 121:1 pause 10:17 11:11 124:3 222:6,10 paused 158:18 209:10 pay 46:14 47:12 paying 51:3,4,5 386:10 payment 43:12 43:19,20
---	--	--	---

[pays - performing]

pays 42:15	409:7	68:9 274:15,16	261:9 266:18
pediatric 179:1	pending 14:13	276:18,19	267:13,20
peer 85:7,19	people 73:19	325:14	268:5,8,14,17
86:1,2,11,16,20	104:3,3 210:16	percentages	269:8 271:9,12
88:7,14,18	228:2 233:4	26:16,18,19	271:14 277:8
89:15 90:16	336:14,15,16	perception	278:9,10
286:16 292:14	336:17 348:4	399:1	289:19 291:7
302:3,16,19,20	383:16 395:4	perceptions	292:6,16 293:1
303:11 306:4	395:19	398:18	293:11 296:19
306:16 360:15	perceived	perfect 364:5	300:11,20
360:17,18,21	157:16 397:17	376:13	301:16 339:4
361:2,7,10	percent 42:4	perfectly 87:17	368:20 371:6
389:14	45:16 48:19,20	perform 186:12	371:16 372:8
pen 33:3	66:3,3,15,18	269:10 275:13	372:10 378:2
penalization	67:2 68:13	277:10	381:5 387:12
385:13	195:6 245:17	performance	401:20 404:12
penalize 200:17	246:5,13 265:3	52:16 60:16	404:15 405:3
234:20 237:4	274:14 275:1,5	79:17 82:21	413:7
243:8 317:19	275:6,6 276:7	83:3,6 93:12	performances
319:12 384:16	276:8 277:3,8	94:2 97:7,9	118:18
penalized	277:15,18,19	117:20 132:13	performed 52:1
297:1 385:4	278:5 279:18	147:6,10 148:6	104:16 269:12
penalizes 384:7	280:16 281:9	149:5 154:14	269:12 323:15
penalizing	281:10 304:13	154:17 193:17	348:14 367:13
315:18 317:10	304:16,16	193:19 201:14	performer
320:8,19	306:3 325:15	201:17 202:7	216:13 319:8,9
penalties	327:21 336:8,9	203:2,4 205:4	369:1,1 390:15
300:11 301:17	337:5 339:14	212:14,19	397:13
302:11	350:7,16	213:1,3 216:17	performers
penalty 10:11	352:13,17	223:4 224:7	397:9
318:13,14	percentage	227:13 237:15	performing
319:18 384:18	42:1 48:17	238:1,3,15	97:12,13 138:4
385:18 408:8	49:9 50:19	239:16,17	143:12 145:7
408:10,19	65:18 67:18	240:3 253:4,6	145:11 153:9

[performing - polling]

176:6 212:13 261:18 370:6 379:8,9 period 17:19 37:6 55:21 94:12 112:13 146:17 196:21 235:17 259:13 263:6 404:11 periodic 52:13 periodically 71:21 perjury 10:11 person 1:10 32:4 141:20 240:17 407:20 408:6 personally 21:20 119:8 122:2 182:19 381:20 383:3 417:3 perspective 382:18 peruses 24:21 136:15 148:14 184:9 185:20 186:20 210:7 211:14 257:6 344:6 peter 134:16 135:8,11 143:9 143:11,18 190:21 231:9	231:15,20 ph.d. 34:6,8,10 35:7 38:12 phase 263:13 phone 32:4 phrase 131:18 137:21 138:6 138:13,19 182:9,15 191:3 202:15 203:3 phrased 168:20 physically 251:17,17 physician 92:20 93:4 157:11 262:19 326:18 327:11 327:18 328:16 330:8 331:7,10 335:3,8 336:2 337:15 342:6 410:11 414:15 physicians 397:15 pi 37:18,18 38:9 pick 95:11 97:4 223:10 picture 337:3 407:21 piece 58:8 64:11 305:13 400:5 418:16	pieces 224:15 315:9 pikeville 400:14,17,17 400:18 402:6 403:5,6,11 404:1,9,18 405:7 pikeville's 402:7 place 88:1 293:18 299:14 344:15 417:4 places 335:7 plaintiff 95:15 plaintiffs 1:5 1:15 2:2 9:19 10:2 11:20 plateauing 246:21 platform 7:13 242:16 play 23:5,5,6,6 368:1 playing 84:4 please 9:13 10:4,7 11:21 21:19 129:12 140:16 141:3 144:13 164:2 164:15,16 167:3 179:7 184:11 216:4 275:15 286:4	plus 52:1 point 21:8 63:20 96:5 108:7 114:6 122:9 126:8 130:2,5 135:12 136:8 152:18 152:21 156:18 167:20 180:1 203:17,21 224:17 258:5 268:7 279:21 282:9 285:18 296:1 297:21 297:21 298:1 299:5 303:1 316:14 317:17 318:17 328:5 347:6 373:19 374:21 397:4 407:16 pointed 213:10 226:9 points 96:20 142:14 244:13 244:14 256:21 323:9,16 375:12 policies 219:9 223:18 378:8 policy 97:18 241:13 polling 52:19 53:10 54:9
---	--	---	--

[poor - printout]

poor 145:11 180:20 241:5 368:15 369:1 371:1 poorly 145:7 367:14 popular 395:17 portion 41:13 41:21 47:8 51:3,5,7 78:11 131:6 139:6 156:8 236:15 306:5 328:14 377:19 posit 341:19 position 299:6 possibility 238:20 359:1 possible 79:12 115:8 132:15 236:4 237:14 237:19 247:8 247:11 251:11 251:17,17 281:1 289:18 319:5 361:16 374:1,7,9 416:18 possibly 141:18 237:17 post 243:13 245:5 252:16 potential 153:8 165:13 246:3	246:15 250:12 262:15 370:16 373:2 374:17 potentially 252:9 391:10 powerpoint 358:14 359:4,6 359:11,13 360:9 pptx 357:21 practice 87:3 99:9,14 161:9 366:20,20 368:7,8 practices 244:10 254:5,8 254:14 310:6 310:11,17,18 316:15 317:4 330:9 365:12 365:13 pratt 1:14 2:16 preceded 313:15 preceding 49:19 148:11 predict 189:1 preeti 6:11 17:20 140:10 140:11 154:12 197:18 272:8 273:8 313:10 preeti's 143:2	preface 128:15 137:2 prefer 232:17 244:16 preferred 232:16 prepare 14:18 14:20 15:5 17:2 416:13 prepared 133:4 359:7 373:14 prepublished 7:19 286:10 prescriber 84:19 present 3:10 41:2 55:16 presentation 226:2 357:15 358:19 359:2,6 359:12,13,14 360:5 presents 224:12 president 39:1 58:12 press 19:8,13 presumably 203:6 pretty 144:10 258:21 272:18 274:4 339:18 340:1 341:20 370:19	preventable 104:14 106:3 109:15 323:10 348:12 349:9 prevention 136:13 previous 141:4 141:6 303:1 previously 134:20 148:12 250:19 291:15 326:7 362:20 366:14 primarily 120:10 125:2 250:11 324:19 333:17 338:4 388:11 411:2 primary 26:7 58:13 61:5,7 151:10 162:3 306:8 364:9 365:1,2 366:12 414:17 prime 35:4 principal 37:18 41:12,18 388:21 print 7:20 286:11 printed 24:6 printout 5:17 78:21
--	--	---	---

[prior - providing]

prior 7:9 28:17 34:17 64:8 78:1 81:13 93:14,19 106:17 115:18 116:3 138:2 159:12 184:19 194:7 196:6 209:12 231:2,3 239:4,4,5 316:5 404:8 priorities 123:12 prioritize 123:11 150:10 prioritized 249:12,19 354:8 privilege 15:16 probably 48:6 54:13 60:1 72:15 88:4 105:19 116:1 127:16 144:5 236:2 276:9 280:16 296:7 335:17 345:5 349:19 353:20 411:10,13 problem 104:14 106:4 115:15 120:10 183:8 215:2 246:7 348:12	349:9 376:7 problems 72:16 73:15 116:16 procedure 1:12 proceedings 71:2 155:11 158:18,20 229:19 283:8 356:16 362:9 417:9 process 52:10 54:4 86:14 91:8,16,17 92:14 98:16,17 98:20 99:2,5 100:11,19 101:2,15,21 141:20 287:20 315:14 317:1 320:5 327:3,7 364:13,19 365:21 366:9 processes 240:19 produce 279:6 produced 20:19 24:2 30:17 43:4 44:13 133:1,2 140:7 160:18 185:15 189:11 236:1 255:19 272:4 307:5 357:6 358:16	359:21 product 222:3 products 220:18 221:7,7 professional 1:17 profile 5:12 36:4 profit 151:11 program 59:4 252:5,7 programs 60:18 64:19 285:4 project 46:4 promise 10:10 pronovost 134:16,17 135:8,11 136:20 190:18 231:20 328:18 328:19 332:9 337:21 345:19 proportion 66:10 proportionately 100:6 proportions 151:9 proposal 125:7 125:21 126:4,5 127:1 134:10 170:12,15 200:6 233:17	285:8 318:16 propose 167:7 214:1 proposed 125:10 128:5 134:12 143:5 145:16,21 146:4,6,10 167:13 168:11 206:8 213:20 214:7 234:20 243:5 proposes 135:3 proposing 133:15 144:10 174:10 316:18 316:20 protected 15:15 protects 391:17 protocols 331:9 provide 56:17 62:14 63:7,17 75:19 86:6,6 107:9 159:16 178:8 219:9 220:21 223:17 361:5 provided 145:16 199:9 251:10 361:16 provides 389:2 providing 264:11
--	---	---	--

[provision - question]

provision 274:11	punished 243:13	putting 31:3 40:1 169:11 203:2 206:7 213:20 219:18 273:13 392:11 392:15	190:18 191:6 191:12 192:20 194:16,17 195:4 196:17
proxy 262:1	pure 50:11	q	queried 241:3
psi90 91:9	purely 92:7		query 285:14
public 1:20 19:8 28:6 38:17 72:18,19 73:16 74:19 75:10 88:19 206:9,20 213:9 230:10 233:14 233:16 235:1 235:17 237:7 390:11 417:1 417:17	purports 103:10	qualifies 153:15	question 13:20 13:21 14:2,8 14:12,13 32:18 46:12 55:14 61:16 62:21 65:14 66:12 78:6,9 88:12 92:4 102:4 110:14 111:2 136:17 144:13 145:10,15,16 146:5,14,16 149:10 151:16 159:5,19 180:13 184:10 211:8 216:4 221:20 222:9 226:7 239:1 241:3 243:16 247:21 248:2 251:2,11,15,16 264:10 265:15 265:16 266:5 267:18 273:3 273:19,19,21 274:2,11,21 275:2,10,19 276:7 278:19
publication 7:20 286:11	purpose 70:6 72:7,11,21 74:2 187:5 200:15 273:11 384:16 385:20	qualify 345:1	
publicly 30:4 107:11 111:19 244:11 253:3 289:10 389:17 394:6 395:13	purposes 130:12 371:20 387:9	quality 40:2 72:18 73:16 74:19 75:9 86:13 123:11 150:3,10 157:17 222:3 243:10,11 244:9 247:3 262:5 387:15 388:11 389:1 389:17 390:11 390:18,21 392:18 398:16 398:19 409:2,3	
publish 108:2 392:17 393:14	pursuant 1:11 361:19	quantify 281:14 337:17	
published 85:8 88:3,15 89:16 106:2 322:11	push 213:15 214:5	quarter 265:3	
pull 26:21 99:12 329:5	pushback 214:7	quartile 135:13 136:1,21 137:1 137:4 143:12 171:21 172:4 172:10,16,19 187:12,16	
pulled 26:14 103:14 270:19	put 19:8 22:1 54:3 64:7 65:12 82:15 95:4 100:9 105:20 109:17 125:18 127:1 227:8 228:9 230:6 254:5,8 256:17 368:9 368:20 369:2 387:6 394:6 397:19		
pulling 147:18 242:2 245:16 414:12	puts 98:20 228:7,8 264:15		

[question - realtime]

281:7 282:3 302:8 306:1,15 320:8 329:8 337:13 346:5 347:2,4 348:4 360:14 369:15 370:2 373:12 381:11,13 386:17,21 387:5 390:3 402:14 403:10 405:10 406:7 406:10 412:4 414:14 questionable 292:5,16 293:1 295:10 296:16 297:9 302:10 351:4 questions 5:20 12:21 13:21 16:2 18:17 19:17 21:20 39:20 46:13 61:18 79:8 103:18 210:18 212:2 223:7,8 274:3 276:1,4 276:11 279:4 287:9 307:20 347:19 397:3,5 397:6 405:9 407:6 409:18	quick 137:10 158:14 199:10 229:12 256:17 412:4 quickly 26:14 74:10 380:1 quietness 410:7 quite 58:19 280:9 304:11 351:6 quote 270:18 r r 2:1,4 3:1 9:1 rabbit 230:8 raise 10:7 131:21 raised 144:16 145:6,15 146:15 405:10 raising 145:10 146:12 ran 374:6,8,9 range 249:3 290:11 305:19 350:15 352:17 379:14,17 ranged 42:2 rate 94:14 109:5,10 110:1 110:2,5,7 325:5,10,12 326:5,6,12,15 326:16 345:14	rates 109:2 rather 151:16 243:7 372:19 379:6,8 385:3 rating 208:18 220:20 222:11 252:5,7 328:16 337:20 389:6 392:3 393:15 394:13 395:14 ratings 58:12 208:18 220:18 244:17 245:2 285:4,4 389:11 392:21 393:3,8 395:11,17 396:16 rationale 267:5 reach 375:11 reaction 212:3 read 24:18 86:6 89:14 136:16 144:9 145:20 170:2 178:5 184:6,7 200:2 205:18 209:7 212:4,5 228:2 234:14,16 236:9,15,17,21 237:1 257:4 297:6 313:19 331:14 344:1,4 357:17 389:14 389:16 401:17	401:17 416:12 418:3 419:5 420:6,8 reader 381:1 383:9 reading 89:10 167:9 190:20 212:3 227:16 402:3 reads 232:10 ready 27:1 185:4,19 207:9 300:8 real 151:16 reality 110:3 353:18 realize 72:14 really 23:10 40:1 68:20 81:2 86:3 87:7 94:8,16,20 128:6 143:20 143:20 188:17 232:9 237:9 251:3 259:1 275:11 295:17 315:19 317:12 317:13,15 318:20 353:12 354:6 369:16 370:10,13 379:3 realtime 1:18 1:19 10:20
---	---	--	---

[realtime - record]

11:8 54:7	recall 38:21	406:12	234:12 307:7
70:18 248:4	63:10,11 65:20	received 18:18	308:17 335:17
rearticulate	67:6,7 79:10	57:3,7 111:7	359:11
261:20	81:20 84:14	125:20 140:3	recognized
reason 13:15	85:3 86:18	183:9,11	208:2
44:13 48:11	89:10 112:18	227:10 339:8	recognizing
79:2,4 97:5	115:20 128:4	380:16 401:1	341:18
104:21 105:3,5	128:11 130:1,4	receiving 18:8	recollection
119:2 120:17	134:16 135:16	19:20 20:5	25:16 77:4,14
140:2 145:4	138:8 146:7	32:11 180:2	80:20 81:7,12
195:8,10 198:9	156:1,4,13,20	206:6 377:4,5	116:19 131:20
201:9 225:14	157:1 197:1	377:9 385:4	137:5,6 138:18
226:1 262:7	198:16 200:21	recent 27:8,13	161:20 164:20
263:21 264:11	202:12 205:6	54:8 93:17	173:2,5 177:19
265:12,13	206:4,6,7,13	118:15 166:13	184:8 187:7
266:15,15,20	207:1,2 226:19	166:16 167:15	188:15 189:7
270:2 307:17	230:9,11	168:4 179:5	199:15 203:11
335:16 359:20	235:10,13,15	208:5,12	208:13 231:15
360:2 408:5	251:6 258:3	389:18,19	236:5 312:2
419:5	259:16 262:13	404:11	371:11 374:4
reasonable	279:1 295:9	recently 53:9	recommend
261:21 262:4	308:16 340:15	60:17 87:1	86:12 161:18
351:19	349:16 359:14	165:5 167:13	162:7
reasoning	372:16 374:21	255:7 329:11	recommendat...
213:11,13	375:3,15	recite 281:16	209:14 210:2
233:7	381:13 397:6,9	recognize	285:5
reasons 265:10	405:11 411:20	20:17 23:20	recommendat...
266:11 282:10	receive 47:14	43:2 71:14	62:15 86:7
299:1	72:20 91:12	78:20,21 103:7	recommended
recalibrate	150:1,15 178:9	113:7 139:18	291:4
260:14 290:16	181:8 241:17	139:19 140:1	recommending
recalibrating	298:8 365:12	152:13 185:10	192:14
291:6	372:14 377:20	205:17 206:1	record 9:3 11:7
	380:12 391:21	217:6 231:1	11:9,13 12:1

[record - relative]

27:13 37:3 70:15 71:8 115:4 133:6 139:7 155:6,8 155:14 158:13 158:16 159:1 188:3 229:16 230:1 266:10 283:5,14 284:21 356:13 357:1,18 362:1 362:6,12 365:8 401:18 404:20 407:18 416:3,4 416:7 417:9 418:5 recorded 1:10 9:5 12:17 129:17 417:8 recording 129:11 130:2 130:10 recordings 17:6 recross 361:21 396:21 red 218:12 332:4 redistributed 100:7,8 260:21 365:20 367:1 reduce 135:14 reduced 326:21	reduction 327:21 reevaluating 115:6 refer 21:19 44:3 95:2 96:7 105:6 131:16 149:12 150:5 363:17 376:6 386:14 reference 194:12 322:2 referenced 1:15 420:5 referencing 77:17 106:16 385:16 referred 89:18 105:10 referring 29:16 83:15 88:21 101:14 105:4,8 105:12 136:20 148:3 150:8 172:5 224:18 249:15 310:1 398:11 408:19 refers 26:18 45:19 53:12 76:19 231:20 232:1 309:12 309:16 348:19 refine 165:13 240:19	reflect 26:19 31:10 43:18 45:21 53:4,6 133:15 161:2 162:8,19 166:21 167:7 175:3,11 184:4 213:1,2 227:14 228:12 310:9 338:11 381:6 381:16 401:21 405:4 reflected 349:20 410:5 reflecting 338:12 reflection 271:8 reflective 302:13 311:2 353:18 reflects 110:19 111:9 161:4 216:18 224:8 274:15 323:21 324:2,4 339:1 339:3 reframe 73:11 refresh 25:16 81:7 115:21 116:19 157:5 161:20 172:9 184:8 188:15 231:14 374:4	refreshed 374:10 384:10 regard 19:4 59:8 156:14 238:17 393:2,7 regarding 11:7 15:6 77:15 78:12 139:5 374:13 regional 122:11 122:12 registered 1:17 1:18 regular 32:6,15 regulatory 243:10 252:18 rejected 86:12 297:13 299:3 relate 151:19 related 18:9 40:1 60:14 262:18 410:15 relates 264:7 410:18 411:2 relation 122:18 347:1 relationship 38:4,5 41:5,5,8 47:4 261:17 332:1,2,14 relative 62:17 100:5 240:13 245:12 303:4 323:17 387:12
---	---	--	---

[relatively - reporters]

relatively 65:5	146:18 148:5	301:3	247:12 250:14
release 19:13	162:3 165:1,2	remove 318:20	272:12,17
released 107:11	165:4,5,7,9,10	338:13,16,17	273:7,14
releases 19:8	165:10 175:13	338:18	275:21 277:18
relevance	175:16,17	repeat 136:17	289:7,10 298:4
264:5 282:6	187:2,5,13	144:13 164:2	298:7,7,12,12
relevant 262:18	197:4,6,7	167:3 184:10	299:20 310:6
reliable 60:21	204:2 206:15	216:3 248:2,3	311:1 315:18
relies 404:8	233:21 234:1	248:3 267:21	317:11 322:5
rely 395:19	235:11,14,16	302:8 377:16	354:11,12
relying 395:19	236:2 257:3,9	386:17 390:3	372:13 381:5
remain 106:10	260:4 262:16	406:19 412:8	386:2 401:19
270:3	263:15 308:18	rephrase 101:6	402:12 403:8
remainder	312:9,11 314:8	236:12,13	405:3 409:8
162:18	314:11,12,13	247:21 248:2	reported 93:21
remained	337:1,3 347:6	249:16 367:18	94:4 102:12
108:16 303:5	347:11,12	370:8	179:4 261:14
306:9 331:10	348:4,6 359:13	report 7:16	269:6 289:6
remaining 66:3	359:16 360:4	91:10 93:10	339:12 371:18
66:18 368:9	372:21 374:6,8	94:19 118:20	394:6
remains 88:9	374:12 375:2,6	120:17 121:2,2	reporter 1:17
90:6 337:13	384:8 385:14	121:3,5,9,13,21	1:18,18,19,19
remember 23:8	385:15 407:11	122:1,6,14	4:11 9:11 10:4
23:11 25:1,20	407:17,18,20	138:1,13,19	10:6,10,15,19
32:8 54:7 67:9	408:1,3,6,7,12	144:12,18	10:21 11:2,4
68:20 77:7	408:12,18,20	174:3 179:5	12:13 37:1
78:13 79:12	409:4,10,12,14	180:9,10 193:8	70:17 115:2
82:10 87:5,10	409:16 411:21	193:19 200:18	138:12 158:9
87:12,15 117:4	remembered	202:8,20	158:12,14
119:12 120:5	197:16	203:18 204:13	188:1 365:6
128:6,9 132:2	remembering	212:17,17	416:9,15
134:3,10,13	332:9	215:20 216:18	reporters 188:8
135:19 137:2	remind 99:11	220:3,5 224:7	193:3
144:6 145:17	117:9 140:10	227:13 246:4	

[reporting - results]

reporting 38:17 61:7 74:20 75:10 94:12 119:2 121:7 123:19 124:3 125:1 126:15 141:21 180:7,17 240:19 244:13 278:4 295:14 295:19 297:14 297:19 298:3 298:15 345:10 372:10 376:18 376:21 377:13 379:7 390:11 402:9 409:5,7	270:15 representing 2:2,12 3:2 9:10 138:11 224:1 301:1 represents 58:6 58:7 80:4 274:16 307:11 323:8 reputable 330:19 reputation 398:8,11,15 399:9,19 reputations 398:16 399:13 request 107:9 206:20 requested 20:9 50:10 86:10 272:17 require 252:16 413:11 required 91:12 requirements 274:21 289:9 requires 176:3 reread 297:5 rescinding 314:5 research 36:15 37:17 38:14 39:10 41:14 60:11 75:3	313:7 329:8 331:20 389:6 389:10,13,14 389:16 409:2 researcher 37:16 38:3 39:18 105:1 157:12 388:20 researchers 50:10 104:13 347:8 348:11 349:8 reserve 361:21 resource 152:9 243:8,9 resources 152:7 235:7 243:12,14 354:7 respect 15:13 56:8 62:12 111:4 121:14 125:1 258:17 331:17 335:3 respond 174:17 188:5 189:2 191:18 213:9 232:6 365:11 365:19 366:15 366:19 respondent 276:16 respondents 171:11	responding 246:13 275:1 277:3 377:6 378:15 379:18 responds 188:20 377:18 response 25:9 164:17 168:6 190:17 316:13 316:19 318:19 responses 214:2 257:17 257:19 261:9 261:15,17 266:18 274:18 responsibilities 39:17 responsible 39:19 responsive 180:12 rest 357:21 restart 223:10 223:12 restate 13:21 restaurant 245:2,5 252:10 252:11 result 335:18 342:6 374:7 385:3 resulted 403:9 results 28:19 95:14 127:10
--	---	---	--

[results - right]

127:15 189:10	236:1 262:20	24:2 30:11,18	140:21 141:11
289:10 331:2	286:17 292:14	34:1 35:8,11	142:11,12,16
332:12	302:3,17,20,20	36:13,19 39:8	143:6 144:12
retain 243:15	303:11 306:4,6	40:14 41:9	149:6,7,8,14
retained 63:7	306:16 360:16	43:5 44:10	153:15 155:1
63:17 325:7,8	360:17,18,19	46:21 47:2,17	156:11 165:16
retire 126:9,10	360:21 361:2,7	48:12,13 51:2	166:5,6 167:9
170:13 200:7	361:10 389:14	51:4 61:3 62:9	168:10,14
retired 64:20	reviewer	63:8 65:3 66:3	170:3,10 171:8
138:8	222:12	66:15,20 69:17	171:13 173:9
retiring 90:10	reviewers	74:8 76:13,15	173:13 174:3
return 420:12	86:11,20	76:15,18,20	174:11 177:6
reveal 15:17	reviewing	81:10,14 83:10	177:15,21
213:13	130:4 207:1	83:11,19 84:10	180:7,14,18
review 17:1,8	221:7 222:1	86:12 87:16,20	182:2,20 184:5
17:11 62:1	226:13,15	89:11,18 90:9	184:18 185:14
75:16,16,20	233:19 235:11	90:12 93:18	185:15 187:13
76:1 85:19	235:14 236:2	95:9,16,19	187:15 189:18
86:1,14 140:16	358:2 377:5	96:2,8,12,19	190:1,10,13,15
141:5 147:17	reviews 60:18	97:18 98:21	190:18 191:16
172:8 203:6	revise 142:1,6	99:2,6 100:4,7	192:20 193:6,9
206:14 219:3	206:14	100:12,14	194:1,6,8,17
220:12 224:12	revised 184:1	101:2,9,16	196:3,8,18
262:3 272:19	revision 75:14	102:15 103:16	199:17 201:21
273:9 333:2,3	revisions 86:10	105:16 110:2	202:13 203:13
361:3 416:14	197:11	114:11,19	203:18 204:13
reviewed 15:2	revoked 258:5	117:15,20	204:15,16,21
16:19,21 77:8	258:10	120:11,13,18	205:13 216:7
85:8 86:2,16	rewarding	121:15 122:1	217:10,15,19
88:7,14,18	145:11	123:15 125:14	218:1,5,13,14
89:15 90:16	rid 54:9	126:2 129:15	219:16 220:6
95:14 148:11	right 10:7	131:17 134:21	220:15 221:21
221:14 222:4	14:17 16:16	138:5,20	222:13 223:1
226:17,20	20:20 21:19	139:11 140:7	225:3 226:10

[right - rural]

226:10,13	294:15,18	369:15 371:3	rollout 296:20
227:2 228:15	295:1,18	371:16 373:7	rolls 282:1
230:19 231:4	296:11 297:17	377:2 378:5	romano 7:14
232:4,14	297:19 299:4,9	379:2,14	156:11,14
233:13,14,17	300:16,21	380:14,14	157:7,8 158:5
238:2,7 239:7	302:3,7,20,21	381:7 382:8,10	158:7 159:7
239:21 240:6,8	304:3,6,11	382:13 390:16	160:2 161:21
241:20 242:4	305:7 309:7	390:18 400:2,4	162:1,9 232:1
244:5 245:3,12	310:15 311:7	401:15 402:11	256:5 257:2
246:14,18	311:20 314:2	402:12,21	287:5 299:3
247:18 249:4	314:21 317:8	403:2,3,17	room 279:1
249:11 251:5	319:4,6,9,15	404:15,18	305:14,14
251:18 252:19	320:13 322:6,9	405:11 406:13	407:21
252:19 253:5	325:14 327:8	407:2,7 409:20	rough 416:16
253:16 255:20	328:17 332:2,6	412:10,19	416:17
256:5 259:6,10	332:20 333:13	413:1,10,15	round 40:9
261:5 263:19	333:14 334:6,8	414:2,10,15,18	53:18 64:8,8
264:12,20	334:18,20	414:19 415:2,5	168:14 170:2
265:7,9 267:12	335:4,19	rights 49:4	rounds 53:17
267:14 268:14	337:16,21	rise 46:11,12	118:16 166:9
268:17 269:1	338:5,13,20,21	risk 47:7	166:19 167:2,9
269:15 272:5	339:5,11,18	109:10	168:10 179:21
273:20 274:6	340:5,8,11,13	roginski 3:11	288:2,4 294:3
275:2,19	340:16 341:4,8	9:10	331:8
276:10 277:17	341:14 342:1	role 37:16	rudolph 38:10
278:1,5 279:19	342:21 343:19	38:15 39:5	38:12
279:21 281:1	344:3,11,18	52:1 59:2,10	rule 1:11,12
281:12 282:12	345:7,11 346:9	59:15 62:13,14	rules 12:11,13
282:20 286:2,8	346:15,18	63:2 75:13	420:14
286:14,18	348:1,20 349:4	79:10 218:21	running 11:4
287:6 288:17	350:18 353:9	226:12,15	187:5 188:16
289:14 290:6	356:8 357:3	233:19 368:1	runs 194:5
290:12,18	361:14 365:4	rolled 255:1	rural 151:1,4
292:3,19 293:8	366:17 368:13	293:19	

[s - saved]

s	80:10,13 81:17	249:21 253:4	410:11,18
s 2:1 3:1 9:1	82:3 84:14	262:5 264:6,8	411:9,11
262:17	85:7,9,12 88:1	264:8 267:1	412:13
safe 99:9,14	88:10,14,15,17	268:8,9,10	salary 42:15
112:3 150:2	89:13,15,16	270:7 282:7	47:2,4,14
254:5,8,14	90:11 91:6,11	283:21 284:3,9	48:20 50:15,16
310:6,10,17,18	91:13 104:4	284:14 286:12	50:18,19 51:4
316:15 317:4	105:19 109:3,3	287:3,15 288:7	65:19 66:15
365:12,12	109:16 110:15	288:9,13	samaritan 1:3
366:20,20	110:18,19	291:13 293:20	4:3 5:3 6:3 7:3
368:7,7 401:4	111:8,9,13,18	294:3 296:18	8:3 9:6 419:3
safer 104:12	111:21 114:10	297:2 299:2,10	420:3
218:19 219:4,8	117:11 118:16	299:14 301:2	sample 194:19
223:17 226:18	121:4 122:15	304:8 308:13	195:7 245:15
348:10 391:17	132:3,8 134:18	309:11,18	289:9 324:19
safest 74:11	140:16,17	310:9 311:6,14	sanitizer 279:2
safety 5:16,18	141:15 148:16	312:5 313:14	279:14 378:9
6:13 7:8,18,20	148:18 149:1	314:20 323:12	sanitizers
18:12 22:13,20	149:16 150:3,4	325:4 339:8	278:16 279:5
23:13 24:14	150:7,9,10,13	348:5 351:7,9	sara 2:15 9:15
28:7 30:4 40:2	150:13,16	354:9 368:2,17	15:9 142:10
40:4 52:9,17	151:5,15,18	369:11 370:14	416:2
53:5,21 54:2	152:1,4,4,7,14	370:19,19	satisfaction
54:20 55:9,18	153:5,8,11,12	371:21 382:7	411:3,7,14
56:4,8,19 59:4	153:15 154:21	386:16 387:8	saved 8:11,14
61:3 62:12,17	156:15 157:9	389:1,2,12,17	104:16 105:11
64:6,7 65:4	158:1 160:6,8	390:1,11,18,21	108:16 322:6
70:5 71:17	161:7 162:20	391:1,9 392:16	323:14 346:10
72:4,11,17	170:16 179:21	392:18 394:13	346:18 348:14
73:1,16 74:3	190:9 217:10	394:17 395:6	350:21 355:6
74:10,17,19	219:1 244:6,9	396:5,6,11	355:19 357:14
75:6,9 77:1,20	245:10 246:20	398:16 399:18	358:7 359:15
79:1,16 80:3,5	247:3,6,10,13	400:9 401:2	360:7
	247:19 248:8	403:7 409:3	

[saw - score]

saw 50:3 66:2	140:15 141:2	347:7 353:3	167:8 180:8,11
66:12 156:5	143:9 147:1	355:5 357:14	181:8 188:9
172:3,15 190:9	149:2,7 156:8	358:6 373:20	200:8 212:7,18
190:17 191:6	161:17 166:8	380:6,15 381:4	212:21 215:4
196:6,18 199:2	166:18 171:2	381:16 382:8	218:13,16
200:4 202:15	171:13,20	382:10,13	222:15,16
233:13 288:16	173:8 178:13	383:21 394:17	223:2,16,20
305:9 381:21	182:7 186:10	400:14 405:2	224:5,7 226:6
saying 101:13	187:16,18	414:14 415:1	226:10 227:2,3
106:18 135:16	188:21 194:11	scenario	227:6,11,14,17
144:4 152:12	194:16 200:14	187:10 252:3	228:6,12,14
192:10 198:13	204:15 206:19	370:17 374:18	238:19 239:7
224:4,6 227:16	210:12 211:21	scenarios 187:9	245:12 248:12
228:1 240:2	213:9 218:1,13	225:13 342:16	248:13,15,16
276:16 281:6	218:16,19	369:15 370:1	248:20,20,21
282:15 301:12	219:8 223:16	374:6	249:8,13
301:17,19	226:10 227:2	schedule 139:5	250:12,17,20
320:10 337:7	231:8,18	scheduled 23:1	267:2,8 268:15
345:16 351:14	232:19 234:16	32:5	271:11 277:12
352:8	243:4 251:3	science 34:4	278:7,8 281:1
says 21:8,9,18	256:4 257:20	scientist 38:13	282:1 287:16
25:12 36:10	260:13 261:4,7	scope 51:14,19	287:21 293:14
43:15 45:13,16	264:16 272:11	51:21 76:9	294:11,16
51:14 52:9,12	287:11,14	score 52:9,17	296:13 297:1
54:17,18 56:16	288:1 289:5	54:20 55:10	298:5,6,8
56:17 63:7,15	290:15,21	56:20 64:18	303:2 305:4,16
72:14 74:16	291:2 297:12	65:4 83:3,6	308:8 309:2
79:16 88:18	300:7 302:19	90:5 96:15,19	315:13 319:21
91:17 100:20	307:10 308:8	97:2,4,10	320:5 338:18
102:2 104:9,11	308:11 309:10	102:5,5,6	339:12 365:12
110:14,18	310:21 315:17	118:21 119:19	369:9 370:19
120:15 127:8	316:13,14	132:13 133:16	374:1,1 376:4
129:11 131:13	317:10 318:20	133:21 138:4	376:16,20
135:8,11,17	333:17,18	145:8,9 167:1	377:5,5,9

[score - see]

378:14 379:12	263:7,8 269:17	115:6 120:7,13	25:10,14 26:11
380:7,10 381:6	288:7,9,13	136:14 147:9	26:16 28:1
381:12,16	292:8 295:2	149:9 154:16	29:12,14 30:18
382:7,8,11,14	298:11 300:10	158:14 163:21	31:8 36:11
383:10,11,12	301:15 309:17	164:4 169:8	43:10,13,16
383:21 384:1	310:5,16,21	182:7 201:16	44:20,21 45:10
385:13 392:15	319:20 338:14	207:8,17	45:13,17 51:14
401:11,13,20	339:4,7 340:16	210:14 222:18	52:6,10 53:2
402:1,7,10	344:2,10,15,16	257:4 258:2	53:20 55:2,12
403:9,16	344:17 349:4	260:12 266:3	60:11 63:15,18
404:13 405:1,3	351:1,4 353:1	267:10 297:6	65:13,17 72:6
405:11 406:10	353:18 367:14	297:12 343:8	72:7 73:3
412:7,13,16	367:20,21	344:5 348:3	74:12,21 79:21
413:12	368:1,15 369:8	373:18 380:4	85:10,13 90:20
scored 406:14	370:6,7,8,10,11	secondary	91:4,14,17
scores 27:15	370:11,13,18	178:14 214:20	102:1,16 103:4
30:1 64:7	371:1 374:9	215:11 254:10	103:13,19
84:18 102:7,10	382:19,20	262:15 269:16	104:6,9,18
117:17 118:1	383:4 385:5	269:19 270:10	110:4,13,16,20
118:16,19	394:8,10	364:10 412:6	113:11 114:2,7
119:21 120:4	406:16	412:12,18,19	114:17 115:9
121:4 122:14	scoring 39:21	412:21 413:6	115:15 116:7
126:15 132:1	74:9 84:15	413:11,13,14	116:10,17
171:3 173:9	99:6 149:19	415:1,5,9,13,14	118:12 120:9
186:7,11,13,18	150:6 249:20	415:17,18	125:11 127:8
187:19 190:5	281:15 300:7,9	secondhand	127:11 129:8
190:10 200:19	300:19 301:14	123:3,5	130:17 131:3,6
204:16,20	407:3	section 116:16	131:8,14 133:8
209:17 212:11	second 10:18	274:19 289:2	133:12 135:8
215:11 224:21	11:6 22:13	289:13 297:7,7	137:11,14,15
238:11 244:17	24:17 29:21	see 16:7 17:14	137:16,17
248:10 249:1,4	59:21 63:14	20:19 21:2,6	138:16 141:7
250:10 255:10	74:9 79:15	21:12,19 22:3	142:20 143:3
258:20 262:1	83:14 91:1	24:4,6,7,11,15	143:13 145:19

[see - sense]

146:2 147:1,5 147:12 154:13 154:19 156:8 160:17,20 161:18 163:10 163:12,16 164:12,17 166:3,9,19 167:14 169:13 170:8 171:3,17 172:1 174:17 175:7 178:20 179:8,8,10,11 183:20,21,21 185:14 186:5,8 186:15 187:16 187:19 188:5 188:12 189:4 191:12 192:1,7 195:20 196:11 196:14 197:10 198:6 199:7,13 199:21 200:9 200:12 201:13 201:19 202:10 204:9 205:15 206:19 207:18 208:7 209:18 211:4 213:16 217:18,21 218:10 219:11 222:7 225:20 229:7 230:19 231:6,12 232:6	232:11 233:12 234:4,16 235:8 235:20 242:16 243:1 245:20 250:1,15 255:20 256:2,9 256:18 257:17 260:9,16 261:10 262:18 265:14 272:5,9 272:12,21 273:4 274:12 275:7 278:14 283:18,21 284:4,15,18 287:5,11,16 289:3,11,19 290:3,21 291:8 292:2,3,10,17 294:12 300:13 306:13 307:4 307:21 308:2,6 308:13 310:4,7 312:15 313:4 315:6,9,15 316:1,5,5 317:13 318:21 320:6,10 321:20 323:2,4 329:19 330:11 331:4,12 332:18 333:3 333:15,18 334:10 338:9	340:5 345:7 346:10,10 348:16 349:10 350:6 354:18 355:5,14 356:7 357:6,10,15 358:8 362:21 363:1 380:5 382:8 383:9 387:11 395:19 396:6 400:9,10 400:12,14,15 401:5,11 402:14,17 413:19 414:1 414:14 seeing 64:10 165:1,4,5 192:4 235:16 235:20 327:8 349:18 354:1 374:20 seek 74:11 395:6 seeking 389:5 seeks 37:1 115:2 188:1 365:6 seem 144:3 189:13 321:12 402:15 seemed 351:4 seems 145:10 275:20 331:3	344:1 408:14 seen 73:8 100:10 118:18 121:1 128:14 130:14 132:21 217:12 242:18 302:6 329:20 332:20,21 351:6,19 352:1 363:13 sees 237:3 selected 245:16 289:6 selecting 361:3 self 272:18 semantics 303:16 403:20 send 316:16 343:21 sending 161:9 164:20 165:7 191:11 196:7 senior 38:13 58:12 396:4 sensational 182:17,18,20 sense 14:14,15 19:11,12 24:17 49:16 50:2 57:1,21 103:9 108:1,3 119:13 119:14 143:21 148:7 186:21 222:19 256:21
--	---	---	---

[sense - significance]

280:5 298:21 312:10 329:9 359:3 361:7,11 361:12 390:17 410:9 sensitive 249:4 sensitivity 291:3 sent 15:3 114:6 140:3 165:11 197:18 199:3 256:20 316:16 358:20 sentence 63:14 72:7 73:11 85:20 89:10,12 147:15 148:1,4 179:18 209:13 210:1,2,5,15 211:12,16 212:4,5 237:2 288:1 292:2 331:2 sentences 236:17,21 237:1 sentiment 75:2 separate 84:17 113:18 317:8 separately 113:16 september 4:4 5:4 6:4 7:4 8:4 9:4 133:4	417:14 419:4 420:2 sequence 411:18 sequentially 358:17 serve 41:12 served 393:9 serves 177:6 services 56:16 56:18 60:10 79:18 80:16 157:11 175:19 364:11 365:2 392:17 session 16:20 17:2 set 55:8 56:18 57:1 60:6 92:12 139:2 142:19 163:4 181:15 185:3 195:13 205:7 216:2 233:11 253:12 265:8 267:10 286:2 306:19 312:16 321:3 360:12 373:8 394:10 394:11 405:7 417:4 setting 403:20 seven 100:14 101:2,18 109:7	283:13 326:9 356:13 364:21 366:12 407:15 seventh 328:2 seventy 42:3,4 281:9 several 171:21 378:10 shaking 13:6 share 23:2 73:16 86:9 111:15 119:11 202:6 212:14 213:21 shared 23:8,11 119:4,7 206:15 259:19 393:16 shares 179:6 sharing 389:4 she'll 416:13 sheet 418:8,15 419:1 420:10 shift 32:18 33:12 41:4 69:19 112:7 321:4 short 47:13 71:1 144:10 229:18 283:7 356:15 362:8 shorten 166:8 166:19 168:13 shorthand 1:17	shortly 15:9 shove 213:15 214:5 show 82:11 137:3 230:14 264:14 271:4 288:11 332:4,5 332:14 354:15 381:12 400:7 showed 225:5 showing 165:6 shown 264:7 404:19,21 405:1 shows 198:4,7 382:20 sic 9:9 115:13 234:19 256:5 287:15 357:20 side 59:5 287:11 292:3 338:5,20,21 339:1,2,5,7,11 342:1 sides 61:5 sign 416:12 420:6,11 signature 416:10,11 417:16 signed 44:21 420:17 significance 67:12 282:12
---	--	---	--

[significant - sort]

significant 66:9 67:13 72:16 73:14 267:1 270:8 304:3 306:3 334:14 351:2 369:6	slack 21:11 slash 338:8,11 338:12,13 339:3 slawson 2:19 slide 6:8 113:15 114:16 115:15 115:20 116:15 117:1,7,8 118:7 120:7 125:6,7,7 127:6,6 190:13 200:4 359:8 376:8 414:6,7	social 38:13 solicit 52:15 solid 90:6 solution 146:3 146:6,11,19 solutions 145:21 420:19 solve 115:16 116:17 somebody 203:17 204:19 227:16 307:12 somewhat 254:2 345:1 soon 416:17 sorry 10:17 11:6 16:16 29:13 60:6 61:12 113:16 117:5 130:19 132:6 135:6 142:21,21 152:20 158:9 164:3 175:4 179:8 183:13 183:17 184:20 189:12 207:11 209:10 221:9 242:13 256:13 284:17 343:14 350:5 380:1 387:5 404:4 411:5 414:9	sort 13:7 15:8 15:13 19:21 21:15 45:12 50:16,19 53:18 54:8 57:11 60:15,17 62:19 63:3 64:11 65:2 66:11 72:3 80:5 82:8 83:1 86:14 90:12 97:1 121:3,4 122:16 142:11,12 147:7 148:17 149:6,12,13,15 149:15 154:15 165:13 169:7 171:5 182:20 192:3 201:15 215:3 232:20 237:2 247:9 254:8,21 255:1 257:17 259:2 260:18 269:14 281:21 293:17 293:21 298:11 303:14 305:16 315:10 319:17 331:3 332:6 336:13 337:3 350:14 353:2 369:21 372:1 389:21 398:16 403:19 409:6
significantly 264:19 335:8 similar 110:7 122:9 202:2 221:7 349:19 392:19 394:9 simply 371:3 single 75:20 126:6,8 281:7 sitting 77:5 285:12 409:12 409:13 situation 237:3 245:21 293:18 379:11 situations 253:9 six 49:19 76:5 91:8,17 100:19 101:21 230:1 283:5 sixty 347:18 size 66:8 67:12 sizes 324:19 skills 328:7 skip 115:13 199:5 200:11	slides 116:14 134:12 slight 127:8,14 slightly 73:11 171:12 189:1 189:20 371:5 slippery 246:6 246:8 slope 246:7,9 328:3,5 small 94:9 150:19 151:4 166:8,18 167:6 168:9,11 169:9 171:16 207:10 207:11 242:13 247:4 324:19 smaller 53:18 94:11 340:10		

[sort - start]

409:12 410:17 413:6 sought 287:14 sound 394:19 sounded 211:7 211:12 sounds 13:3 112:19 177:4 210:16 212:1 264:17 319:2 source 80:14 83:20 154:8 221:2 269:19 364:9,10 365:1 365:3 366:13 387:14 395:10 412:12 413:14 414:17 415:1 sources 21:21 79:20 80:12,19 82:17,19 83:19 178:14 214:20 254:10 262:16 269:16 270:10 303:4 394:18 southern 1:1,12 9:8 space 320:21 spaeder 1:13 2:14 9:15 15:19 speak 20:2 56:11 58:8 61:6 75:5 76:9	77:9 86:4 92:1 121:8 122:20 152:6 193:16 220:14 264:9 328:20 363:12 385:8 386:13 386:20 396:2 398:1 speaking 42:8 266:1 303:12 372:16 374:21 395:18 specific 23:7 67:3,6 77:4,14 77:16 78:7,8 78:10 123:10 162:11 213:10 219:1 279:5 318:16 392:15 404:11 specifically 43:21 82:17 121:12,20 123:18 212:12 218:5 260:8 262:16 397:14 408:21 specifications 39:21 61:19 speculate 383:15 speculation 252:2	spent 22:16 spirit 108:13 spoke 17:17 25:17 31:4 375:3,6 spoken 375:15 spreadsheet 8:13 355:14 356:6 spring 26:14 27:4 40:7 177:11 401:1 srinivasan 136:10,11 137:1 staff 6:17 57:10 57:14 58:2,4,9 185:12 219:10 223:18 staffing 93:4 176:2,3,10 181:11 326:19 327:11,18 328:1,17 330:8 331:7,10 335:3 335:8 336:2 337:15 342:7 stamp 44:12 stand 106:20 106:21 213:14 214:4,8 standard 171:21 181:18 220:1 245:14	273:14,16 279:15 281:2,4 281:10,11 294:12,17 295:1,5,5 305:17 327:20 371:19 standards 180:7,18 181:15 216:1 261:19 262:6 276:2 345:3,10 345:14 standing 367:5 star 244:17 389:6,11 392:21 393:3,8 393:15 394:13 395:11,17 396:16 stark 192:4 start 12:12 14:17 17:19 20:12 34:12 39:7 40:6,19 42:18,18 47:5 62:21 72:15 91:16 104:2 113:13 116:15 136:9 139:13 142:21 147:21 148:10 163:20 185:17 197:14 206:1 236:21
--	---	--	---

[start - structural]

248:12 315:8 315:12 321:15 359:10 363:6 392:13 393:6 399:10 406:17 started 39:9 40:7 82:13 106:14 107:20 159:6 255:4 293:8 starting 72:6 91:2 273:2 287:10 322:16 331:3 333:14 starts 24:10 141:21 142:9 startup 296:17 state 9:14 11:21 151:16 288:15 404:20 stated 250:19 345:12 385:21 statement 55:15 56:6 74:14 88:13 91:20 111:11 111:12 119:16 125:3 127:19 189:9 199:16 237:7,13 241:16 308:16 340:21 353:16 statements 106:10	states 1:1 9:7 150:19 247:5 288:15 stating 301:10 statistical 334:15,16 statistically 334:13 stats 26:21 status 26:15 27:3 stay 135:13 271:8 332:5 410:3 stenographic... 417:8 step 27:6,6,7,12 28:9 83:11,14 93:13,16,17 95:19 118:5,15 118:17 120:10 120:13,15 121:14 122:1,1 122:6 126:7,9 126:10,11 127:10,15 143:13 161:18 162:7 166:9,15 166:18 167:6 168:2,9,17 169:5 170:8,13 170:17,20 171:1,6,9 174:11 175:5	175:12 177:20 179:2,12,14,18 182:6 186:7,11 186:18 192:19 194:7,11 200:3 200:4,7,7,16 209:9 225:3,5 225:10,10,16 225:17,20 227:6,11,18 228:8,9 243:5 267:4 271:7 341:12 382:5 403:2,2,6,12,12 404:1,2,6,6,7 404:14,18,18 405:5,5,14 415:4,10,11,12 stepping 61:2 141:14 251:6 258:2 steps 83:11 199:21 402:21 stewart 58:19 59:15 60:3,4 200:14 sticker 163:12 stickers 29:15 stipulate 367:6 stood 214:10 286:18 stopped 260:5 390:7 391:8	straight 192:19 192:20 strategic 63:8,9 63:12,18,21 64:2,3,14,15,16 stream 94:13 109:7 325:16 326:8 335:21 street 1:14 2:16 3:5 strengths 332:8 stretch 87:14 357:4 strike 46:12 97:19 100:21 152:19 203:11 205:6 210:3,4 247:15 258:8 347:1 364:18 395:8 strikes 358:18 strong 210:20 232:17 326:19 386:6 stronger 232:20 233:2 strongly 243:4 244:16 struck 210:1 structural 98:18,21 99:2 100:11 101:15 147:10 149:13 149:15,16
---	--	---	--

[structural - sure]

154:18 201:18 297:14 298:2,9 298:14,17,19 298:20 299:6 300:3 302:11 315:14 317:1 320:5 327:3 364:13,19 365:21 366:9 structure 303:2 303:17 306:8 structured 52:21 struggle 149:4 struggled 73:19 183:4 struggling 402:18 student 39:10 studied 89:7 220:12 studies 332:3 332:11 study 330:10 331:21 332:13 332:14 336:11 stuff 49:7 stuttering 151:17 sub 384:20 subject 161:5,6 164:11 186:7 284:2 357:14 409:4	submission 26:15 241:12 submit 86:4 178:13 200:17 202:9 234:21 237:4 404:9 submitted 7:12 93:14,19,19 168:4 169:13 175:21 242:15 274:18 submitting 200:19 215:2 243:8 subpoena 18:8 19:20 20:5 32:1 362:20 subpoenas 32:7 32:9,11 33:1,5 33:6 subsequent 162:20 subsequently 137:3 263:17 subset 53:18 187:1,2,6 194:21 222:2 245:16 281:17 substance 15:17 16:3 19:5 201:4 substantial 306:5 335:4	successes 386:8 suggest 145:21 277:6 suggested 52:18 133:20 187:9 190:18 317:3 suggesting 148:5 191:1 246:12 406:21 suggestion 319:16 suggestions 140:20 315:15 suggests 197:20 suite 1:14 2:16 3:5 summarize 360:7 393:21 394:2 summarizes 360:9 summary 80:4 201:3 389:4 393:16 394:4 super 190:21 supplemental 79:20 80:11,18 83:19,20 84:9 84:10,13 supplementary 82:17 supplied 20:10	supply 18:18 18:19 supplying 146:15 support 37:20 38:16 119:16 202:6 240:6 309:18 supported 205:3 308:12 309:10 supporting 75:4 313:14 supportive 312:4 supports 59:4 supposed 94:20 393:21 394:2 supposedly 245:8 sure 10:6,19 12:20 15:12 29:6 46:9 69:3 69:4 77:7 87:10 94:16 110:12 152:2 159:18 160:1 165:20 170:4,5 176:8 180:13 202:19 216:5,5 219:10 221:8 223:13,18 227:5 228:19 237:9 242:6
--	--	---	--

[sure - take]

266:2,6,9	112:3 118:20	274:19 275:2	394:13 396:10
296:17 297:4	120:18 121:5	275:12 279:4	systems 34:4,10
301:18 310:2	122:19 125:2	294:5 298:5	34:11 36:15
329:2,3 334:1	127:8,10,15	299:12,15	37:17 38:14
363:18 367:7	150:5 152:5	310:7 311:2	208:19 392:3
376:7 377:12	153:10 166:13	318:2 339:13	t
377:17 384:11	166:16 167:2,9	364:9,20,21	tab 102:18
384:13 386:18	167:14,15	365:11,20	128:13 139:13
390:6 391:5	168:4,6,10	366:11,12,15	163:6 195:14
392:8	169:14 176:1	371:14,17	205:8 242:8
surgery 59:13	178:11,13	377:18,20	286:4 306:20
61:9 325:19	180:3,10	384:20 386:3	312:18 321:16
surgical 179:1	181:16 186:12	386:15 387:6	347:17
surprise 351:14	190:8 193:8	387:10,11	table 31:1
surprised	200:18,20	397:5 402:9	164:15 165:1,8
132:3,8	202:9 208:5,6	404:9 406:9	194:9 323:3,6
survey 26:15	208:12 209:15	409:6 410:7	323:7,8 344:8
27:8,9,13 28:9	210:15,17	414:18	408:8
28:11,16,17,18	212:1 213:11	suzanne 39:3	tables 108:9
28:18 29:2	214:17 215:12	swear 10:4	125:6 288:12
36:10 38:1	234:21 235:4,4	swearing	tacks 49:9
39:20 40:2	235:7 237:5	114:21	take 14:10,14
59:12,13,17	241:12,15,19	switch 70:8	24:17 39:5
60:15,20 61:3	243:9,9,12	112:8	51:10 60:7
61:9,17,18	244:9 245:19	sworn 10:8,16	62:6 70:10
62:2,9 76:19	246:4 247:1	417:5	118:21 134:15
77:21 79:19	249:16,20	synthesized	136:4,14
80:17 82:18	250:14 252:8	332:12	146:21 147:3
84:17 91:12	254:4,11,13	system 72:17	148:8 153:1,4
93:11,14,18,19	255:8 259:14	73:15 74:9	155:4 172:13
94:1,5 97:20	261:14,15,18	200:15 241:13	177:1,3 178:5
98:9 102:13	261:19 262:4	354:8 386:8,10	178:16 185:19
110:16,20	269:7,7,10,11	386:11 388:11	195:5 205:18
111:10,16	270:18 273:19	390:13,14	

[take - test]

212:14 224:17 225:2 229:11 231:9,17 234:4 234:11 242:21 244:7 246:18 257:4 267:9 274:9 282:21 297:6 300:2 309:14 318:15 319:20 321:2 329:5 333:13 335:12,13 336:4 343:7 344:4,5 350:2 351:1 356:11 366:21 382:5 394:5 taken 1:11,16 9:5 77:10 319:15 takes 240:17 talk 18:6,11,13 18:14 19:5,18 21:6 22:12 32:9,15 33:12 41:4 70:4 82:3 83:18 92:14 93:5 102:16 104:1 110:13 112:11 119:7 123:17,18 128:3 133:6 148:9 149:21 162:16 163:3	253:13 257:12 321:10 322:19 talked 17:14,16 18:8,19 19:7 31:13 32:1 101:8,11 103:15 112:21 120:9 121:15 187:12 216:6 247:17 248:5 253:14 267:11 282:10 286:13 304:2,5,14 306:2 310:14 311:5,6,10 312:1,5 347:7 347:15 348:3 360:21 395:19 399:21 407:10 409:19 talking 43:19 55:21 58:9 76:12 85:20 93:8 117:14 136:21 148:16 149:18 151:19 155:21 224:17 230:4,7 249:7 256:21 271:4 297:19 322:8 339:15 354:11 355:2 356:6 365:14 366:8 366:20 371:8	378:8 380:5,20 381:10 398:3 413:20 talks 78:2 137:1 177:9 target 291:19 technical 158:19 159:4 159:21 393:9 393:18 technically 40:18 techniques 52:21 technology 84:17 262:17 teleconferences 52:14 tell 14:20 18:2 27:6 36:3 37:14 41:11 44:4 69:4 97:11 102:3 105:7 120:20 122:8 131:11 175:10,20 180:5 181:4,10 184:3 207:8 218:8 246:1 256:20 274:15 284:6 300:8 316:17 323:6 339:1 347:14 408:17 413:3	telling 224:3 403:13 tells 101:20 183:13 temporarily 209:10 ten 68:3 124:5 124:5 tenant 19:14 tend 150:1 395:18 tenor 343:21 344:1,7 tep 210:18 212:2 term 47:11,13 92:15 132:4,9 132:12 138:2 173:20 174:2 175:6 182:8 202:20 232:17 240:13 terms 19:14 47:8 59:5 64:9 86:9 98:19 150:3 189:15 215:10 326:3 333:4 337:18 361:2 397:16 test 28:14 36:9 68:18 81:2,3 81:20 137:7 229:14 265:9 328:8 329:9
---	--	--	--

[test - thinking]

334:15 369:14 369:21 410:13 testified 54:10 68:2 73:8 168:16 177:14 180:4 362:19 376:17 384:5 386:12,19 400:2 403:15 403:18 testify 13:13 387:18 405:16 testifying 13:10 384:8 397:10 testimony 10:11 13:16 18:5 179:15 204:12,18 238:14 271:5 271:11 349:17 363:3 385:15 405:13,18,19 416:14 418:5 420:8 testing 87:7 328:7 text 187:15 208:2 228:18 315:9 texting 21:11 thank 10:3,15 71:11 84:6 155:18,20 229:1 283:16	357:3 363:5 376:13 396:20 thanks 25:12 31:3 189:2 theirs 307:21 themes 142:8 theories 121:11 121:19 theory 341:3 413:14 thing 13:7 14:10,12 60:7 75:20 121:14 137:10 169:4 172:20 203:7 245:9 262:21 325:12 358:18 398:17 things 14:5 19:14 45:13 49:3 97:17,20 104:1 112:17 130:13 131:2 191:12 207:7 220:15 228:3 278:16 think 29:5 35:7 35:10 40:19 41:7 52:12 54:6 55:17 62:6 63:9 65:2 65:5 68:2,12 73:7,18,18 79:2,4 85:16	88:6,8,20 89:7 89:7,20 90:3 96:14 100:10 104:21 105:3 105:20,21 111:8,12,17,20 112:5,20 113:10,18 114:11 120:8 122:12 128:14 129:5 132:6 137:1 140:2 146:8,9 148:13 149:4,8,14,21 150:2 155:4 157:2 159:21 169:1 172:12 177:15 182:16 182:19 192:5 195:8,10 198:9 198:20 210:14 211:11 213:9 215:7,9 221:2 221:5 222:15 226:1 228:5,7 230:5 233:2,4 237:12 242:6 242:15 243:1 245:18 248:13 250:4,5,8 252:11 255:13 259:3 264:11 265:2,17,18,21 270:5 272:8,17	279:9 282:20 283:20 284:17 288:20 293:16 295:12 297:7 298:10 303:2 303:14 305:14 307:17 309:16 311:6,13 313:19 318:16 320:10 321:2 325:15 328:10 331:20,21 332:2,2 333:1 338:8 344:21 347:16 348:1 349:18 350:1 350:21 351:6,8 352:18 353:8 354:5,8 359:20 360:6,12 363:21 371:3 373:5,10 376:17 378:8 378:19 381:10 381:21 383:3,8 384:5 385:12 386:7 389:4 390:8 391:14 392:9 396:9,18 398:18 404:14 407:7,14 411:18 thinking 64:16 66:13 158:5
--	---	---	---

[thinking - today]

309:20 third 91:1 115:7 208:1 257:18 260:11 297:12 299:4 thomas 25:13 44:21 thought 61:14 117:9 192:13 232:19 233:1 245:8 351:3 thoughtful 284:12 thoughts 58:7,7 thread 6:6,18 113:9 196:2,18 231:1 313:3 three 16:14 26:13 47:6 61:10,11,13 66:8,19 67:1 67:17 71:7 86:5 99:4,4,20 101:11,14 114:19 143:8 155:8 162:7 241:8 253:19 254:4 255:11 262:7 263:4,18 264:2 266:16 270:3 281:14 282:10 288:12 293:13 294:11 305:2,3,15	319:5 323:8,16 366:16,19 368:7 373:19 373:20 383:4 414:1,1 thresholds 92:13 94:8,16 257:15 thursday 4:4 5:4 6:4 7:4 8:4 419:4 tie 111:18 ties 312:7 tilly 58:19 59:10,11 tim 197:14 time 11:9,14 12:20 14:3,6,6 14:11,11,11 15:4 17:18 22:16 38:9 39:2,3,8,14,18 40:3,16 41:13 42:1,1,4 45:4 45:17 46:6 49:17 50:15 51:8 55:20 62:6 65:18 67:21 69:20 70:15 71:8 84:15 88:1,11 89:9 90:7 106:15 112:8 118:3 124:9	131:20 155:9 155:15 156:3 157:19 158:16 159:2 162:2 166:6 171:3,7 171:9,10 188:8 192:18 193:3 194:13 213:21 229:16 230:2 235:4,5 240:12 240:18 244:7 246:18 254:17 258:3 262:13 266:4 273:15 275:15 283:5 283:14 293:17 297:21 298:1 299:5 300:19 301:10 303:5 303:21 312:4 313:8 314:4 321:9 323:9,16 332:6 338:7 354:6 356:14 357:1 361:20 362:7,13 377:16 390:4 404:11 409:1 416:7 417:4 420:15 timeframe 420:7 times 15:6 50:9 123:10 296:2	325:12 327:14 334:19 347:8 353:20 timing 107:16 112:20 162:3 198:10 314:6 314:13 title 35:12 37:14,21 38:2 38:2 59:3 307:16 330:7 358:6 titled 273:6 today 13:9,13 13:16 17:2 29:8 32:19 33:7 46:13 77:5,11 79:13 80:9,18 88:20 106:8 108:11 124:21 133:2 165:6 169:4 177:5,19 186:17 189:7 206:4 226:1 245:17 267:14 267:20 268:6 269:18 270:12 271:5 285:12 286:14 293:1,5 294:15 298:2 300:15,17 302:13,14,17 302:20 303:13
---	---	--	---

[today - truly]

304:21 309:1 311:5,19 350:12,13 353:11,12 363:2,3 375:15 384:10 388:17 402:21 today's 7:14 72:17 73:15 256:4,17 together 64:7 206:7 256:17 280:14 324:17 340:19 356:3 toggled 401:5 togias 2:5 10:1 10:1 11:3 16:6 183:15,17 347:17,19 told 21:4 259:21 387:4 toll 48:8 took 161:2 291:11 350:1 352:18 top 14:18 24:4 26:9 30:20 44:14,20 56:17 62:4,5 72:15 129:8 161:17 163:15 168:9 182:2 189:2 194:15 197:14 205:13 210:12	218:1,9 230:20 272:7 287:10 287:11 292:2 297:11 309:1 346:9 373:10 383:21 414:1 topic 112:21 114:21 151:20 286:4 320:19 320:20 375:7 topics 52:20 60:18 110:11 112:8 114:19 145:5 total 48:17 50:3 51:3 68:13,14 99:17 325:21 totally 70:8 touch 31:4 touching 219:11 223:19 touts 302:2 toward 87:1 219:21 towards 21:4 39:13 53:19 65:19 244:21 250:4,6 254:10 257:18 317:19 town 317:16 319:16 trace 81:20 track 198:8	tracked 207:6 tracking 119:18 tradeoff 250:1 train 98:4 trained 98:10 training 97:21 98:9,10,12 219:9 223:17 274:12 276:6 transcript 6:9 12:14 130:5,9 143:16 145:20 147:17 148:9 148:15 172:3,9 172:16 190:21 191:6 202:13 203:1 416:13 417:8 418:4 420:5,16 transcripts 17:9,11 transitioning 35:3 translate 260:18 325:11 372:1 translated 258:20 translates 169:20 transparency 111:13,21 117:20 122:17	386:6,7 388:12 transparent 87:2 111:17 216:1 224:11 224:18 233:6,8 268:8 320:1 391:15 transpire 107:3 107:4 treat 211:2 308:2 391:16 treated 152:2 treatment 115:1 199:6 trend 118:18 trends 349:19 trial 84:7 tripped 387:21 true 106:10 117:19 149:4,5 161:12 162:10 226:14,14 236:2 238:17 245:17 263:9 268:20,21 269:2 293:3 307:17 342:2 349:15 356:5 359:5,21 370:5 372:9 387:13 417:9 418:5 truly 213:14 214:4
---	---	---	--

[trust - under]

trust 220:20 221:4,6,13 trusted 361:5 truth 10:12,12 10:13 237:9 344:17 truthful 13:16 237:12 truthfully 13:13 68:20 try 64:21 142:3 142:7,11,12,15 148:2 162:16 trying 46:18 50:2,9 57:20 65:2 68:11,19 116:17 143:18 144:1 149:14 172:12 181:1 182:16 198:6 222:19 238:2,8 246:19 247:10 253:18 255:14 265:8 275:16 275:18 320:3 339:2 341:12 360:6 366:18 385:14 393:19 tuesday 231:11 tune 77:13 turns 186:12 tv 71:12 tweaked 207:8	twenty 401:14 407:15 twice 29:3 104:14 106:3 106:19 334:18 336:1 347:5 348:11 349:8 350:2,8 352:9 353:13,19 two 11:13 12:5 14:5 21:9 39:14 44:13 52:18 61:7 66:8,19 67:1 67:17 70:15 77:6 83:11 86:5 90:5 98:20 99:15 114:16 115:7 117:15 118:17 141:17 143:3,8 162:7 166:9,19 167:2,8 168:10 172:19 175:5 179:21 193:1,4 196:5 199:7,21 223:7,8 241:18 254:5 258:19 276:8 278:13 279:18 282:10 288:12 293:9 303:3 305:20 308:6 310:19 310:20 311:15	312:5 315:8,9 315:13,19 316:13 317:11 318:20 320:4 320:12,13,20 334:19 335:14 336:5,6 340:15 340:21 341:6 342:16 345:13 345:21 347:8 353:20 356:8 361:4 388:4 402:21 tx 420:13 tying 399:18 type 151:14 154:7 305:11 types 220:18 typical 68:15 typically 26:2 63:12 76:19 129:19 152:9	89:17 91:3,19 92:16 93:7,9 103:5,17 104:10 110:17 111:1 114:18 114:20 115:14 115:17 116:4,6 118:11 125:9 127:7 129:6,10 129:14,16 130:18 133:9 135:5,7,10 140:18 143:4,7 143:10,14 147:2 166:1,20 187:14 192:2 194:10 228:11 283:3 402:13 ultimate 222:11 224:10 ultimately 46:1 125:14 166:11 166:12 168:17 301:4 unable 162:2 unaware 86:19 unclear 148:3 169:6 under 10:11 13:9,12 63:14 105:15 166:18 168:11 179:12 179:18 184:20 192:18,19
		u	
		u.s. 247:8 uh 12:15 30:19 32:20 33:14 41:6 44:19 45:11,18 50:5 51:13 52:7,11 53:3 60:9 63:16,19 65:16 72:8,10 76:18 76:21 85:14	

[under - use]

227:11,18 304:20 348:3 373:19 382:6 415:4,10,11,12 undergraduate 33:16 underlying 164:16 394:1 404:10 undermine 223:4 224:5 331:16 underneath 226:17 understand 12:13,16 13:9 14:2 28:21 46:18 48:15 53:16 54:20 55:8 56:18 88:21 93:8 95:15,21 98:19 101:12 134:9 136:5 144:1 152:12 169:4 181:1 192:6,10 192:21 223:14 225:3 227:17 235:1 237:7 244:19,20 253:18 261:16 265:15 266:4,5 275:18 296:17 301:18 312:7,8	320:4 334:1 339:2 349:2 383:16 386:8 387:17,18 388:5 405:17 understanding 27:2 57:13,16 57:20,21 58:1 79:9 92:8 95:17 96:3 106:7 121:6,10 136:20 148:1 151:6 167:1,5 167:10,11,12 168:1 169:11 172:6,14 186:17 192:12 194:9,16 203:16 213:18 214:3,13 244:1 244:2,4 258:8 258:11 259:3 312:3 316:19 346:4 358:13 367:9 376:4 understands 15:13 266:6 understood 171:6 175:10 221:8 369:4 379:20 undetermined 213:2	unfair 322:15 unfavor 238:6 unintentional 308:1 unique 320:11 unit 9:4 11:13 70:15 71:7 155:8,14 158:16 159:1 229:16 230:1 283:5,13 325:20 356:13 356:21 362:6 362:12 416:6 united 1:1 9:7 150:19 247:5 288:15 universal 369:18 370:2 390:18 406:7 universally 98:11 university 5:14 32:10 33:15,21 38:3 40:12 42:12 43:9,20 46:3,5,21 47:2 47:12,17 49:9 157:12 unnatural 13:4 unreliable 94:17 unwieldy 66:12	update 105:11 107:8 108:8 114:21 189:14 259:2 322:8,10 324:2 361:12 361:13 updated 105:13 105:14 107:10 108:8 116:14 231:8 updates 7:17 86:10 284:2,9 284:13 updating 108:6 url 103:3,14 129:15 use 27:3 28:18 52:20 63:12 65:1 72:13 73:2 74:5,16 84:6,18 95:10 126:7 127:10 131:18 132:12 146:19 151:8 169:16 173:19 174:2 175:5 180:20 182:7 200:7 211:16 211:18 215:20 233:9 258:6 327:4 355:18 372:5 376:3 389:16 390:12 394:8 418:16
---	--	---	---

[used - walk]

used 27:10 80:19 81:15 106:1 121:4 122:15 126:15 132:13 138:2,6 202:20 208:3 208:11 209:17 239:5 258:15 284:14 287:21 291:12 324:7 344:21 363:15 372:3,10 412:16 420:16 user's 209:16 uses 27:3 79:17 80:3 153:17 302:14 using 60:20 75:6 80:11,13 80:15 82:17 84:14 110:2 120:15,16 127:14 143:13 154:8 175:4,11 178:14 190:6 194:12,20 199:11 212:7 214:20 215:11 253:2,5,7 260:14 263:6,9 288:7 290:17 291:3 326:11 326:18 386:9 388:11 412:11	412:12 413:6 415:18 usually 24:5 361:3 375:10 394:17 396:7 <tr> <td data-bbox="537 520 857 573" style="text-align: center;">v</td><td data-bbox="537 573 857 1900"> v 1:6 9:7 420:3 valid 60:20 208:6 293:15 validity 210:16 210:18,20 212:2 valuable 264:12 value 50:12,12 95:3,5,7 96:8,8 96:16 153:11 180:1 231:17 231:18 329:13 336:4 338:12 371:16 372:2 380:11 413:10 values 108:8 193:1,4 292:8 341:6,7 342:10 342:11 346:17 352:5 372:5,6 372:9,12 variation 292:7 326:13 varied 288:13 varies 68:11 </td></tr>	v	v 1:6 9:7 420:3 valid 60:20 208:6 293:15 validity 210:16 210:18,20 212:2 valuable 264:12 value 50:12,12 95:3,5,7 96:8,8 96:16 153:11 180:1 231:17 231:18 329:13 336:4 338:12 371:16 372:2 380:11 413:10 values 108:8 193:1,4 292:8 341:6,7 342:10 342:11 346:17 352:5 372:5,6 372:9,12 variation 292:7 326:13 varied 288:13 varies 68:11
v	v 1:6 9:7 420:3 valid 60:20 208:6 293:15 validity 210:16 210:18,20 212:2 valuable 264:12 value 50:12,12 95:3,5,7 96:8,8 96:16 153:11 180:1 231:17 231:18 329:13 336:4 338:12 371:16 372:2 380:11 413:10 values 108:8 193:1,4 292:8 341:6,7 342:10 342:11 346:17 352:5 372:5,6 372:9,12 variation 292:7 326:13 varied 288:13 varies 68:11		

 various 386:13 **venn** 411:15 **ventilation** 331:9 **verbally** 119:4 **verify** 359:8 420:8 **veritext** 9:11,12 420:12,19 **veritext.com.** 420:13 **versa** 117:6 **version** 43:10 88:5 116:14 142:20 143:2 356:1,1 363:12 414:13 **versions** 52:17 54:19 **versus** 171:7 182:1 297:19 340:13 341:19 352:16,16 407:1 **vice** 58:12 117:6 **video** 1:10 9:5 12:17 130:1 198:17 **videographer** 3:11 9:2,11 10:3 11:9,12 70:14 71:6 155:7,13 | 158:15,21 229:15,21 283:4,12 356:12,20 362:5,11 416:5 **videos** 17:4 **view** 203:21 285:16,18 292:21 296:1 334:14 346:20 354:4 371:5 384:14 **virginia** 407:11 **vis** 406:15,15 **visions** 55:1 **vogus** 197:14 **voluntarily** 91:10 **voluntary** 244:9 245:11 246:2,12,18 247:9 **vote** 344:14 **voting** 53:17 **vs** 419:3 | **w** | **w** 5:13 137:11 **wait** 60:6 135:6 142:21 380:1 **waiving** 416:10 **walk** 72:4 114:16 128:21 130:13,14 | |

[walk - we've]

166:16 171:1	154:12 155:5	362:1 363:4	213:4 215:4
197:13 313:18	156:3 163:5,19	367:4 373:4	216:17 228:14
322:12 352:10	165:19 175:3,5	379:21 383:15	235:19 237:19
walked 101:1	175:11 177:1	390:15 397:9	247:19 248:8
302:9	182:7 185:17	397:12,17,20	250:2,17
walking 170:21	197:9,13 199:6	398:5 400:8	261:16 267:6
315:5	200:11,18	401:4 405:17	278:1,2 292:3
wallace 330:14	203:6 204:5	407:17 408:17	292:5,15
want 12:11,19	207:5,7 209:6	411:18 412:4	329:12 343:4,5
13:21 14:17	210:4,4,11	413:18	348:14 360:21
16:3 20:12	213:8 216:21	wanted 37:21	371:15 374:5
22:12 24:18	217:21 218:4	136:19 137:4	379:4 385:15
28:15 33:12	218:20 223:14	152:13 189:16	396:9 399:3
41:4 49:15	229:9 230:14	189:21 203:13	406:7,9 417:11
51:11 52:5	242:21 253:13	209:11 212:6	ways 216:17
57:5,8 58:2	255:12 259:16	221:10 245:1	320:2 354:9
60:7 70:4,9	260:8 265:11	285:20	we've 11:1
72:3 73:7 79:8	266:2,5,9,14	wanting 244:21	28:15 53:9
82:5 85:5	267:17 270:9	wants 57:17	73:19 81:15
90:19 92:14	271:4,20	58:1 69:4	108:15,19
102:16 104:1,2	284:21 286:3	416:2	109:4 200:2
110:10,13	287:9 288:20	watch 17:4	247:17 248:5
111:18 112:11	297:6 308:5,15	198:17	266:4 267:11
113:13 115:12	313:17 315:8	watching 130:1	279:9 282:20
115:18 117:12	315:20 316:3	way 24:6 56:15	293:6 294:2
124:10 125:6	318:8 319:17	57:12 72:12	302:6,9 306:2
126:21 128:3	321:10,15	73:2 74:4 80:8	311:5,6,10
128:13 130:12	322:12,16,19	98:9 104:17	312:5 320:16
131:1,5,10	323:1 329:5	120:5 121:3	322:10 323:15
132:18,20	331:1,16 333:6	143:11 151:16	326:4 339:15
133:14 136:4	333:6,12	151:17 153:12	351:6 352:1,2
137:10 139:13	335:21 338:4	180:14 181:15	355:2 372:3
142:20 146:21	341:16 343:7	181:21 197:6,7	410:14
148:10 149:8	346:8 355:9	203:7 211:2,3	

[webpage - witness]

webpage 5:17 78:4 79:1,7 380:2 381:1,12 383:9	weighting 52:18 weights 62:17 100:5 260:14 261:1 264:6,21 290:16 291:6 303:4 365:20 367:1,19 394:8	willing 137:12 137:18,21 138:13,14,16 138:19 144:11 144:18 202:8 202:15,20 203:18 204:13 215:20,21 216:18 220:3,5	134:3 136:15 136:16 144:21 147:19 148:14 148:15 157:16 170:15 172:8 173:19 174:5 174:13 179:12 184:9,10 185:20,21 186:20,21 190:20 191:18 205:2,20 208:17 210:6,7 210:8 211:14 211:15 221:2 225:19 228:18 229:10 257:6,7 265:17 277:15 279:4 280:12 304:20 331:20 339:21 343:11 344:6,7 361:21 368:6,19 369:14 370:16 375:6 377:9 378:19 379:11 381:20 383:3 383:15 385:8 390:3 391:20 392:6 395:1,13 396:2,20 398:10 416:10 417:3,13 419:2 420:5,7,9,11,15
website 5:16,18 5:20 27:17 30:5 71:17,19 71:21 75:21 76:2,8,14,17 77:15,19 78:12 79:1,3,6 88:20 100:18 176:14 217:18 219:1 225:6,13 229:3 230:5,8 239:19 288:17 302:19 347:7,13 383:16 393:17 394:16 395:2 400:1,7,10,12 402:5,6	weird 375:14 welcome 71:10 155:17 went 33:15,21 34:6 230:7 344:8 399:21 400:1 wenthold 234:17 240:14 wenthold's 235:11 west 1:2 9:8 white 105:4,6,8 105:9,10,13,14 106:17 107:19 107:20 108:6 207:20 321:10 322:17 324:1 331:17 360:15 360:15,18 361:14,17 wide 326:21 327:2,21 wider 192:5 332:15	willingness 174:3,3 wilson 3:3 9:20 20:3,7 25:13 31:11 wilsonelser.c... 3:8 window 245:6 252:17 wine 332:4 wipe 97:14 wisconsin 33:21 34:16,17 38:3 40:10 wisdom 32:14 255:8 336:13 witness 4:2 5:2 6:2 7:2 8:2 9:16 10:5,9,14 10:16 24:21 25:1 28:1 51:2 69:8,10,12,14 69:17 73:9 81:3 89:6 90:3 101:4 124:17	

[wonder - yeah]

wonder 135:12 343:8 wondered 373:20 wondering 175:3 198:10 wood 3:4 4:7 5:11 9:20,20 14:6 30:21 32:4 132:20 133:3 225:15 283:3 362:1,15 362:16 365:9 366:4 367:7,8 367:17 368:12 369:3 370:3,20 375:8 376:1 377:11 379:1 379:19 382:2 383:7,18 385:10 387:21 388:2 390:5 392:2,7 393:5 395:3,15 396:13,18 416:15,17 wood's 20:3 word 63:8 100:10 109:17 131:3,5,6 137:11,17 138:14,16 174:9 180:20 180:21 182:12	182:13,19 183:2 191:6 197:9 204:20 211:15,18 233:8 289:14 344:21 words 27:6 100:9 149:14 169:11,21 181:4 183:3 228:7,8,9 388:9 work 26:15 32:6 37:20 38:2,2,13 41:16 46:2 50:11 51:14,21 53:4,6,19 54:18 59:7 61:20,21 86:15 108:9 157:21 183:3 187:21 195:3 217:15 221:18 250:4 285:4 319:19 336:18,19 397:20 398:6 409:3 worked 40:16 53:21 134:20 157:19 158:5 250:6 313:13 322:10	workforce 255:5 368:8 working 17:19 17:21 34:20 39:8,9,20 107:20 115:16 142:9 245:2 291:16 313:7 387:16 388:3 390:20 393:7 397:19 398:1 works 41:11 92:6 140:11,12 349:21 worksheet 179:4 world 86:2,3 306:13 worried 295:10 worries 207:9 worry 104:4 348:5 worse 269:12 275:13 277:7 worst 218:16 382:13 383:5 383:10,12 384:1 401:13 worth 189:2,8 189:13 wow 306:11 write 104:20 272:15 303:20 314:19	writes 164:14 316:5 writing 21:6,10 22:1 301:7 written 12:14 37:3 52:14 115:4 139:6 188:3 210:5 297:20 365:8 393:13 wrong 19:15 284:18 339:2 wrote 88:4 177:5 305:13
			y
			yeah 12:2 14:15 19:12 27:7 28:4 31:9 31:17,19 32:15 35:9 39:19 41:12 46:17 48:1,13,14 49:3,11 50:1 51:2 53:13 54:15,16 59:9 60:4,14 61:21 62:7,8,14 63:13 64:16 67:6 68:1,4,5 69:1,6,21 70:2 70:9,11,11,12 70:13,19 73:21 76:15,15,15,15

[yeah - à]

77:12,12,18	260:19 264:19	122:14 123:13	z
82:1,1,1 85:4	266:2 268:1	123:13,19,20	z 394:8
87:9,17 92:4	274:16,17	126:15 127:9	zendesk 7:13
93:21 99:8,13	275:16 280:12	168:1 169:14	242:16
99:14 100:9	288:6 291:18	170:3 328:20	zero 132:14,15
101:14 103:11	304:15 312:7	year's 404:8	132:18 133:8
104:3 105:20	312:15 314:12	years 40:13	133:16,21
107:7 111:15	320:3,21 321:3	48:5,6 49:19	134:8 144:11
113:1 114:4	326:6 333:8,10	54:8 55:5 56:7	144:17 174:9
116:3 121:1,18	336:9 338:15	62:20 63:1	174:11 290:2,5
122:13 128:1	341:2 343:16	64:1,5 67:12	295:14,18,21
135:18 136:6	344:5,7 347:20	76:6 77:8	296:7,10,11,12
136:19 137:16	348:1 350:1	81:16 87:9,9	296:13 305:19
140:2 144:14	352:11,11,19	124:5 232:4	371:9 372:18
147:18 148:7	353:4 354:21	240:18 291:11	373:1 374:1,9
155:20 157:16	355:4,7,18	299:13 303:19	378:20 379:5
166:15 167:4	356:1,8,9	320:18 372:4	406:3,4,13,17
167:12,19	358:18 359:3	yep 73:4 91:5	407:1,2,4
170:19 171:12	362:4 363:18	112:14 116:18	413:9
172:17 174:1	363:21 367:18	116:21 118:13	zeros 374:14
177:18 178:18	374:11 375:13	174:20 175:1	zoom 16:7 32:4
183:16 184:13	384:12 385:17	178:7 229:10	114:5 130:4
184:20 185:2	386:18 387:21	255:6 281:11	zuckerman
190:12 201:6	393:13 396:14	324:12 326:2	1:13 2:14 9:15
206:6,17	398:5 406:20	350:6,6 376:9	15:19
207:11 209:4	410:10 412:9	376:12 409:11	zuckerman.c...
220:8 221:10	year 29:1,2,3	yesterday 15:2	2:19
221:12 222:10	39:14 47:6	16:11,12	à
229:13 231:2,3	48:4,21 50:6,6	yields 345:14	à 406:15
231:17 236:14	68:7,11,11	york 2:7,7	
241:11 248:1,3	81:6 93:14,19	245:3	
251:15,20	93:20 114:11		
253:8,11 255:3	120:17 121:2,3		
256:13 259:19	121:3,5,7		

Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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EXHIBIT B

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION
CASE NO.: 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,
Plaintiffs,

vs.

THE LEAPFROG GROUP,
Defendants.

CONFIDENTIAL

VIDEO-RECORDED

DEPOSITION OF: KAREN VAN CAULIL

DATE: September 25, 2025

TIME: COMMENCED: 9:03 a.m.

CONCLUDED: 12:31 p.m.

TAKEN BY: Plaintiffs

PLACE: Wilson Elser Moskowitz Edelman & Dicker,
LLP

111 North Orange Avenue
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REPORTED BY: Mae Fisher, RMR, CRR

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1	I N D E X	
2	TESTIMONY OF KAREN VAN CAULIL	
3	DIRECT EXAMINATION BY MR. HVIDT	6
4	CERTIFICATE OF OATH	181
5	REPORTER'S DEPOSITION CERTIFICATE	182
6		
7	E X H I B I T S	
8	Exhibit 1 - Notice of Subpoena to Non-Party	15
9	Exhibit 2 - 41st Annual Meeting of the Board of	
10	Directors - March 4, 2025	29
11	Exhibit 3 - 2025 Regional Leader Communications	
12	Toolkit: Launching Leapfrog	
13	Surveys	53
14	Exhibit 4 - Final Draft LeapFrog Long Range	
15	Strategic Intent, Fiscal Year	
16	2026-2032, December 2024	72
17	Exhibit 5 - Leapfrog 101: Messaging & Common	
18	Objections	86
19	Exhibit 6 - Minutes - The Leapfrog Group	
20	Board of Directors - 6/11/2024	100
21	Exhibit 7 - e-mail chain and attachments	
22	LEAPFROG00326021-326022	102
23	Exhibit 8 - Minutes - The Leapfrog Group	
24	Board of Directors - 9/25/2024	106
25	Exhibit 9 - Letter	
	PBHN000018124-18126	120
	Exhibit 10 - e-mail chain	126
	Exhibit 11 - e-mail chain	131
	Exhibit 12 - Weekly Bulletin - 5/9/25	135
	Exhibit 13 - Leapfrog Group Board Meeting Agenda	
	6/25/25	138

1	Exhibit 14 - Slides	
	LEAPFROG00402156	141
2		
	Exhibit 15 - e-mail chain	150
3		
	Exhibit 16 - e-mail chain	158
4		
	Exhibit 17 - e-mail chain	159
5		
	Exhibit 18 - e-mail chain	164
6		
	Exhibit 19 - e-mail chain	166
7		
	Exhibit 20 - e-mail chain	
8	LEAPFROG00792177	168
9	Exhibit 21 - e-mail chain	172
10	Exhibit 22 - e-mail chain	176

P R O C E E D I N G S

THE VIDEOGRAPHER: Good morning. We are on the record at 9:03 a.m. on September 25, 2025.

Please note that the microphones are sensitive and may pick up whispering and private conversations. Please mute your phones at this time. Audio and video recording will continue to take place unless all parties agree to go off the record.

This is media unit number 1 of the video-recorded deposition of Karen van Caulil taken by counsel for plaintiff in the matter of Good Samaritan Medical Center, Inc., et al., versus The LeapFrog Group.

My name is Anthony Giagnacova and the court reporter is Mae Fisher, both representing Veritext Legal Solutions.

Counsel will now state their appearances and affiliations for the record beginning with the noticing attorney, after which the court reporter will swear in the witness.

MR. HVIDT: This is Scott Hvidt with Gibson Dunn for the plaintiffs.

MS. DABANKA: Elizabeth Dabanka with Gibson Dunn for the plaintiffs.

MR. BILLEK: Max Billek from Wilson Elser on

1 behalf of LeapFrog Group and I'm representing the
2 witness as well.

3 THE WITNESS: Hi, I'm Karen van Caulil with the
4 Florida Alliance for Healthcare Value.

5 THE COURT REPORTER: Can you raise your right
6 hand, please.

7 Do you solemnly swear or affirm that the
8 testimony you are about to give in this cause will be
9 the truth, the whole truth, and nothing but the truth?

10 THE WITNESS: Yes.

11 KAREN VAN CAULIL,
12 a witness herein, having been first duly sworn, was
13 examined, and testified as follows:

14 DIRECT EXAMINATION

15 BY MR. HVIDT:

16 Q. Good morning, Ms. Van Caulil.

17 A. It's Dr. van Caulil.

18 Q. Dr. van Caulil. Thank you.

19 A. It's okay.

20 Q. I was about to ask if that's how I should refer
21 to you.

22 A. Karen is fine.

23 Q. Karen is fine.

24 A. Yes.

25 Q. Okay. Could you please state your full name for

1 the record again?

2 A. Sure. It's Karen van Caulil.

3 Q. And do you understand that the court reporter is
4 taking down all the questions I ask and the answers that
5 you will be providing?

6 A. Yes.

7 Q. Have you been deposed before?

8 A. Yes. It's many years ago, I was trying to
9 remember how long, probably 30 years ago.

10 Q. And is that the only time you've been deposed?

11 A. Yes.

12 Q. And what type of matter was that?

13 A. It was in North Carolina. It was a certificate
14 of need-related matter.

15 Q. And I know it's been 30 years. But I'm just
16 going to go over a few ground rules for the deposition
17 to make her life easier today.

18 A. Okay.

19 Q. So because she's taking down a record, let's try
20 not to talk at the same time. I will try to allow you
21 to finish your answers completely before asking the next
22 question. I ask that you allow me to finish my question
23 before you begin your answer.

24 Do you understand that?

25 A. Yes, I do.

1 Q. And all the answers will need to be audible. So
2 no nodding of the heads or shaking heads so that she's
3 able to take down the actual words that you're answering
4 with.

5 A. Okay.

6 Q. And do you understand that you are testifying
7 under oath today?

8 A. Yes.

9 Q. And are you taking any medications or any
10 influence that would make it difficult for you to
11 understand questions or provide accurate answer?

12 A. No.

13 Q. If you don't understand one of my questions, and
14 that's very likely, please -- please ask to -- for me to
15 rephrase it and so -- because if you do not do so, we'll
16 assume -- the record will assume that you knew what I
17 was talking about.

18 A. Okay.

19 Q. From time to time, your counsel might object to a
20 question and so we will get into a cadence back and
21 forth, but please allow for a pregnant pause to allow
22 him to assert an objection if there's one that's needed.

23 A. I understand.

24 Q. And then please do speak up if you'd like a
25 break, need to go to the bathroom, need food, need

1 anything. But I'd just ask that we not take a break
2 during -- while a question is pending.

3 A. Okay.

4 Q. Thank you.

5 Dr. van Caulil, do you work?

6 A. Yes.

7 Q. Where do you work?

8 A. I work at the Florida Alliance for Healthcare
9 Value.

10 Q. And what do you do for them?

11 A. I'm the president and CEO.

12 Q. And what is included in your job responsibilities
13 as the president and CEO?

14 A. So we are a small nonprofit. We're a business
15 coalition on health. We're a 501(c)(3) research and
16 education organization.

17 We -- if you're familiar with business coalitions
18 on health, it's public and private sector employers who
19 come together in a learning community. The employers we
20 work with are typically self-funded, which means they're
21 paying the bills for healthcare and they have the
22 ability to flex their benefit design, do variations on
23 their network, their outreach, et cetera.

24 And so in my capacity as president and CEO, I'm
25 leading the organization in terms of, you know, the

1 projects and initiatives and the research that we
2 undertake. I have a board of directors and that's
3 composed of nine public and private sector employers.
4 So as far as, you know, board-related matters, that's in
5 my purview to work with the board.

6 I -- we work in policy as well, to make sure that
7 the employer voice is heard in Tallahassee and in D.C.
8 around health matters. Typically they haven't
9 participated on the healthcare policy and the employers
10 we work with are not healthcare businesses. They are
11 school districts and manufacturing companies and many
12 other industries. And so when they have worked in the
13 policy space, it's been around their core business. So
14 this is an area where if we see something that might
15 impact them favorably or not, we would be involved in
16 policy there.

17 I oversee my staff. I have a vice president. I
18 have a project and a program coordinator and an
19 administrative coordinator.

20 I'll stop there, if you have any further
21 questions.

22 Q. That's very helpful. So one item today, so if I
23 called it the Florida Alliance for Healthcare Values
24 today The Alliance?

25 A. Florida Alliance.

1 Q. Florida Alliance. Would that be what you'd
2 prefer for just --

3 A. Yeah, because there actually is a sister
4 organization called The Alliance in Wisconsin, so not to
5 confuse with them.

6 Q. Wonderful. Yeah, I want to just make sure that
7 we can come up with a terminology.

8 A. Florida Alliance works.

9 Q. Florida Alliance will be how we refer to it
10 today. Thank you for that.

11 A. Um-hmm.

12 Q. So as the name might suggest, for the Florida
13 Alliance, are all the employer members Florida
14 employers?

15 A. They -- it's a mix because there are some, like a
16 public school district. You know, all of their
17 employees, their plan members are in the state of
18 Florida. But there are companies that are members that
19 may have lives in other states or even globally. So
20 it's a mix.

21 Q. But do all --

22 A. But they all have at least -- I'm sorry, to
23 finish the thought -- they all have to have lives in
24 Florida.

25 Q. Wonderful. So like a company might have

1 employees in Florida and in California and they can be a
2 member of the Florida Alliance?

3 A. Yes. As long as they have lives in Florida.

4 Q. Understood. And so if the company only has
5 live -- only has employees or lives in California but
6 not any in Florida, they cannot be a member of the
7 Florida Alliance?

8 A. That's correct. Actually, I'd like to clarify
9 that. Not an employer member. So we have affiliate
10 members. And affiliate members are a mix of -- it's
11 hospitals and healthcare systems. It's solution
12 providers in healthcare, benefits consultants and they
13 typically are not headquartered in Florida. They may
14 have employees, but that's not a factor in that level of
15 membership. Sorry I wasn't clear on that.

16 Two -- two different levels. We also have a
17 healthcare advisory council and that's some hospitals
18 and healthcare systems, only a handful of those. We are
19 moving that category into affiliate so we only have the
20 two.

21 Q. And as a nonprofit with these multiple types of
22 members, is the organization focused on the benefit of
23 the employer members and then the affiliate members are
24 also in service of that mission? Is that a fair way to
25 refer to it?

1 A. Yes. I would say so. We're led by the
2 employers. It is a business coalition on health and the
3 affiliate members and the healthcare advisory council
4 members work with us on projects and initiatives. We
5 work in as multi-stakeholder way as possible. They
6 provide a lot of resources. They're also very
7 interested in what employers are doing and thinking and
8 challenged by, so it's an opportunity for them as well
9 to interact and to learn.

10 Q. And you mentioned that these employers are in a
11 variety of industries and they're not in the healthcare
12 industry, per se. Is there interest in healthcare
13 values related to their provision of health plans to
14 their employees?

15 A. I'm not understanding your question. This is the
16 employer members you're speaking about? Would you mind
17 repeating the question?

18 Q. Yeah. So your employer members are in a variety
19 of industries.

20 A. Right.

21 Q. Correct?

22 A. Correct.

23 Q. And they are members of the Florida Alliance for
24 Healthcare Values?

25 A. Yes.

1 Q. And their interest in healthcare values, is that
2 connected to their provision of health plans to their
3 employees?

4 A. Yes. I just want to clarify. You're saying
5 values, plural, it's not. You had that on the
6 deposition that way. It's Florida Alliance for
7 Healthcare Value. It's the cost and the quality
8 equation for value. So just want to clarify that.

9 Q. Thank you. And so --

10 A. So --

11 Q. So to go back to the question --

12 A. Yes.

13 Q. -- to make that clear.

14 A. Sorry.

15 Q. So the member -- the employer members of the
16 Florida Alliance for Healthcare Value, their interest in
17 healthcare, is that related to their provision of health
18 plans to their employees?

19 A. Yes. It is also related to educating their
20 workforce in the healthcare space. So it's not limited
21 to the provision of coverage. It is that culture of
22 health and well-being is also part of that.

23 Q. And that is -- what they're trying to do -- what
24 they're interested in there is not just providing a
25 health plan to their employees, but helping give their

1 employees information about the options they see in the
2 medical area to make the right healthcare decisions for
3 themselves; is that a fair way of saying it?

4 A. Some of the employers do that. I don't have
5 sight on all 80 of the employers and what they're
6 providing to their -- to their workforce, to their
7 employees. But some do that. And they do that through
8 different ways. They might have a vendor who works with
9 them in a -- you know, sort of a narrow network sort of
10 way. They might have direct contracts. You know,
11 there's different vendors who the employee can go in and
12 search on a provider and look at, you know, their
13 ratings from all different organizations. But they
14 don't all do that.

15 Q. I am handing you what's been marked as Exhibit 1
16 in your deposition.

17 (Exhibit No. 1 was marked for identification.)

18 BY MR. HVIDT:

19 Q. Have you seen this document before?

20 A. Yes.

21 Q. And what is this document?

22 A. This is the notice given to me that I'm having
23 this deposition today.

24 Q. You see this is the notice of the subpoena for a
25 non-party Karen van Caulil here at Wilson Elser --

1 A. Yes.

2 Q. -- in Orlando, Florida --

3 A. Yes.

4 Q. -- on September 25th?

5 A. Yes.

6 Q. I'd ask, just a reminder to let me finish --

7 A. Sorry.

8 Q. -- my question before answering. I know that I
9 can be foreshadowing sometimes of where I'm going but
10 just for the ease of the court reporter.

11 A. I apologize.

12 Q. No worries. Thank you.

13 And do you see what's called the case caption up
14 above, where it says Good Samaritan Medical Center, et
15 al., versus The LeapFrog Group?

16 A. Yes.

17 Q. Do you understand that you are being deposed in
18 that litigation?

19 A. Yes.

20 Q. And is Florida Alliance a party to that
21 litigation?

22 A. I don't believe that Florida Alliance is party.

23 Q. And are you a party to the litigation?

24 A. I don't believe I am.

25 Q. And do you have an understanding of what the

1 lawsuit is about?

2 A. Yes.

3 Q. And in your own words, what do you understand the
4 lawsuit to be about?

5 A. My understanding is that the five hospitals in
6 Palm Beach County that are part of Tenet Healthcare
7 wanted The LeapFrog Group to suppress their grades from
8 the spring hospital grade reporting. That the hospital
9 system has issue with the way the methodology generates
10 the grade. That's basic understanding.

11 Q. And do you have an understanding of what your
12 role may or may not be in the litigation?

13 A. I believe that my role is because the Florida
14 Alliance for Healthcare Value is the regional leader
15 organization, that there may be some interest by the
16 hospitals in that role that we serve.

17 Q. Did you prepare for your deposition today?

18 A. Yes.

19 Q. How did you prepare for your deposition?

20 A. I had a couple of meetings with my attorneys,
21 two. I looked at some of the e-mails that I knew that I
22 was involved with regarding LeapFrog in recent times. I
23 scanned our weekly bulletins, which is our major
24 communication with our employer members every week, just
25 to remind myself of what information we shared with them

1 over time. I thought about what questions you might be
2 asking me and thought about my responses.

3 So I will say that the regional leader
4 responsibilities in our organization fall to my vice
5 president, Ashley Tait-Dinger, so I don't attend
6 regional leader meetings. If I have over the years,
7 it's been minimal when she's unable to attend. So she
8 is the absolute main contact for regional leader
9 activities. So just to clarify that, that I don't have
10 -- you know, I don't sit in on regional leader meetings.
11 I don't review what they're -- what they're doing.
12 That's Ashley's role in the organization.

13 Q. Did you speak with Ashley before your deposition
14 today to prepare for it?

15 A. She had major surgery last Wednesday and is out
16 on medical leave so I did talk to her before she went
17 out. Just to, you know, clarify a few things that, you
18 know, I figured I should probably, you know, know. I
19 asked if anyone had reached out, you know, for example,
20 about the lawsuit that she may not have mentioned to me
21 and nobody had. Questions like that.

22 Q. And in preparing for your deposition, did you
23 review any documents outside the presence of counsel?

24 A. Are you asking did I look at documents on my own?

25 So I looked at -- well, I'm also trying to think

1 about the timing of getting the deposition, versus what
2 I might have seen prior to that time. So I -- I read
3 what was in the media, different articles that were
4 published in the spring. I read the LeapFrog response
5 to that. So those are things that I had done
6 previously.

7 Q. And in meeting -- you mentioned meeting with your
8 counsel in preparation for today's deposition. How long
9 were the meetings that you had with counsel?

10 A. I would say probably each of them was an hour,
11 hour and a half.

12 Q. And is -- are you or Florida Alliance paying for
13 your counsel's time in this matter?

14 A. No. LeapFrog is paying, as I understand.

15 Q. You could set that aside. We don't need that.

16 A. Where do I put it?

17 MR. BILLEK: You just turn it upside down.

18 BY MR. HVIDT:

19 Q. You can just turn it upside down.

20 MR. BILLEK: So it's not distracting.

21 THE WITNESS: Okay.

22 BY MR. HVIDT:

23 Q. I understand we don't have that much space.

24 Dr. van Caulil, did you attend college?

25 A. Yes.

1 Q. And where did you attend college?

2 A. My undergrad was at Duke University.

3 Q. And what was your degree in?

4 A. Bachelor of science in biology.

5 Q. And do you have any professional degrees?

6 A. I have a master's and I have a doctorate. But
7 when you say a professional degree, what would be an
8 example of a professional degree?

9 Q. Those would both be examples of professional
10 degrees.

11 A. Okay.

12 Q. What is your master's in?

13 A. Master of science in public health and health
14 policy and administration.

15 Q. And where did you earn that degree?

16 A. University of North Carolina at Chapel Hill.

17 Q. And you mentioned you had a doctorate. What is
18 your doctorate in?

19 A. I have a PhD in public affairs from the
20 University of Central Florida.

21 Q. And following receiving your degree, can you --
22 degrees, could you walk me through at a high level your
23 employment history?

24 A. Sure. So following graduation from college, I
25 was employed in Durham, North Carolina, with a company

1 called Medical Personnel Pool. And they were a home
2 health agency and supplemental staffing and I was a
3 coordinator. So that was for a couple years. And then
4 I worked at Duke hospital in the department of surgery
5 in between my undergrad and master's also, and then
6 while I was working on my master's, I was a research
7 assistant in the department of surgery.

8 After my master's, I did an administrative
9 residency at North Carolina Baptist Hospital, which is
10 in Winston-Salem. And from there, they hired me to work
11 in the department of clinical strategic planning, which
12 was a joint department between the hospital and the
13 school of medicine.

14 We moved from North Carolina to Florida and I
15 telecommuted, which was unusual back then, and stayed
16 with them for a couple of years and then worked on a
17 contract basis. I -- when I had my kids, I was a
18 consultant doing a lot of certificate of need work,
19 still for Baptist and some other clients.

20 Then I was hired in -- here in Orange County in
21 Orlando to develop and implement the system of care for
22 the uninsured here in Orange County. And -- so that
23 involved securing a federal grant to be able to bring
24 all the different stakeholders together to create that
25 system.

1 Then I was hired to be the executive director of
2 the Health Council of East Central Florida, which is a
3 regional health planning agency. So that's four
4 counties of Orange, Osceola, Seminole and Brevard, so
5 sort of Greater Orlando. And the University of Central
6 Florida College of Medicine recruited me away to be the
7 director of health planning to help build the medical
8 city here in Lake Nona.

9 And also in that position, I managed a big
10 federal grant to bring -- I think it was 1400 primary
11 care docs from paper charts to electronic health
12 records. And since then, I've been at the Florida
13 Alliance. Our legal name is actually Central Florida
14 Healthcare Coalition and the d/b/a is Florida Alliance.
15 We did a name change with the d/b/a probably six years
16 ago. It was Florida Healthcare Coalition and changed
17 the name in 2019.

18 I have been adjunct faculty at UCF, you know, in
19 that time period as well.

20 Q. Thank you. Impressive career.

21 Did you start the Florida Alliance when you
22 joined or did it exist before you got there?

23 A. The Central Florida Healthcare Coalition, the
24 legal name organization, started in 1984. So no, I did
25 not start it. I was in my senior year of college then.

1 So well before I got to Florida.

2 Q. And does the -- does Florida Alliance -- does it
3 have a relationship with any governmental entities?

4 A. So we have in our membership municipalities and
5 county governments. So in that capacity, yes.

6 Q. And is there any relationship between Florida
7 Alliance and our state regulator of hospitals?

8 A. The only relationship I think that would fit in
9 that category would be that I chair the Agency for
10 Healthcare Administration's -- it's a long name --
11 Advisory Council. State Consumer Health Information and
12 Policy Advisory Council. So that advisory council is in
13 statute to, you know, ensure that the state-reported
14 data, the regulator data is transparent and available to
15 consumers in a way that they can understand it.

16 Q. And is that -- you mentioned that you chair that
17 agency.

18 A. I currently, yeah.

19 Q. Is that a -- that sounds like it is a
20 relationship that you have. Is that correct?

21 A. Correct. That's why I was saying, the only thing
22 that really comes to mind, there's no contractual
23 relationship that we have with the state. So I don't
24 believe that there is anything beyond disclosing that I
25 have that role that I play on a volunteer basis.

1 Q. And does the Florida Alliance have any
2 relationship with any of the plaintiff hospitals in this
3 litigation?

4 A. No.

5 Q. Has the Florida Alliance ever communicated with
6 the plaintiff hospitals?

7 A. Ashley has sent letters requesting all of the
8 hospitals, including those, to fully participate,
9 encourage them to fully participate in the LeapFrog
10 hospital survey. She has signed off on those letters in
11 recent years. I signed off on them in the past. So I
12 think that's probably the only correspondence that we
13 ever had, and that is to basically say, we encourage you
14 to participate; we are all about transparency of
15 healthcare quality and costs and hope that you will
16 consider doing so and direct them to LeapFrog to take it
17 from there.

18 Q. And you mentioned LeapFrog. Do you understand
19 The LeapFrog Group is the defendant in this litigation?

20 A. Yes.

21 Q. And does the Florida Alliance have a relationship
22 with the defendant, LeapFrog Group?

23 A. The Florida Alliance is the regional leader
24 organization for the -- for Florida, for LeapFrog.

25 Q. And what is a regional leader organization for

1 LeapFrog?

2 A. So that's the vehicle that The LeapFrog Group
3 uses in, you know, in the markets, if you will. And I
4 don't know if they're -- they're not all necessarily at
5 a state level. It depends on the regional leader
6 organization that they work with. Some are, you know,
7 municipality level. Some might even be multistate.

8 And the regional leaders are the organizations
9 that, using the influence of employers and other
10 purchasers to encourage hospitals to be transparent
11 about patient safety and quality. So sending those
12 letters that I mentioned a few minutes ago is really
13 probably the most major aspect. I think -- I certainly
14 couldn't respond for what every regional leader
15 organization does. I think there's, you know, some
16 differentiation on the level of activity that they --
17 that they do.

18 For us, as regional leader, we make sure that our
19 employer members receive the reports that are generated
20 by The LeapFrog Group, that they're aware of the
21 websites for the survey and the grades, so they can go
22 there and use the information and the resources there.
23 We will also conduct meetings with hospitals with our
24 employers to talk about all different issues and
25 LeapFrog will often come up in those. So it's kind of

1 high level.

2 Q. You mentioned that part of being a regional
3 leader, the Florida Alliance makes sure that its
4 employer members are aware of the grades that LeapFrog
5 Group releases; is that correct?

6 A. Yes. Make them aware that they've been released
7 and then they can go and look for themselves in their
8 respective markets. What we'll do is, we have a weekly
9 bulletin that goes out almost every week of the year.
10 There are a couple weeks in the year that we don't do
11 it. And when the spring release and the fall release
12 comes out, we will do a synopsis that says, you know, we
13 had, you know, this many hospitals graded, this many
14 were A, B, C, D, F, have the link so that they can go to
15 the website. We will generate a press release that's
16 sort of high level, too. There were this many -- excuse
17 me -- hospitals in each of those grade levels. And,
18 also, if there were top hospitals -- and this is also
19 for ASCs. I shouldn't say it's just hospitals; it's
20 also the ambulatory surgery centers but direct them, you
21 know, for more information to go directly to LeapFrog to
22 get that information.

23 Q. And as part of the Florida Alliance's
24 relationship with The LeapFrog Group, you mentioned this
25 regional leader component, is part of the regional

1 leader component; is there a contract that governs that
2 relationship?

3 A. No.

4 Q. It's a volunteer relationship?

5 A. Yes.

6 Q. No money is exchanged, either direction, as part
7 of that relationship?

8 A. No money is exchanged. I do get reimbursed for
9 travel expenses if -- and so does Ashley, if we need to
10 leave Florida to go, you know, to a meeting. But that's
11 the only -- only exchange.

12 Q. And is there any other relationship between
13 Florida Alliance and The LeapFrog Group, other than the
14 regional leader relationship?

15 A. I serve on the board as an individual. No other
16 relationship beyond regional leader for the
17 organization. There is a data use agreement between
18 LeapFrog and the Florida Alliance, at least in the past,
19 we don't have a current data use agreement. So the last
20 year or so, LeapFrog has a new platform and a different
21 agreement came through and we've been back and forth
22 just trying to get clarification on the wording so we
23 don't have an active agreement. So right now, there's
24 nothing in force.

25 Q. To break that down a little bit, so you are

1 currently a member of the LeapFrog board of directors;
2 is that correct?

3 A. Yes.

4 Q. And your membership on the LeapFrog board of
5 directors is in the capacity -- in your individual
6 capacity; is that correct?

7 A. Yes.

8 Q. Your membership on the LeapFrog board of
9 directors is not something that's like the Florida
10 Alliance gets an automatic member on the LeapFrog board
11 of directors?

12 A. That's correct. It's because of my individual
13 experience and expertise and relationships with other
14 organizations. It's not -- it's not a Florida Alliance
15 board seat.

16 Q. Thank you. And then you mentioned the data use
17 agreement. What is the data that is at issue in that
18 agreement?

19 A. Well, Ashley knows all the details of that. I
20 would say at a kind of basic level, it would be the
21 hospital and ambulatory surgery grade data, survey data.
22 You know, I don't think there's anything else in there,
23 if you have the data use agreement and have access to
24 that data.

25 Q. And is there any fee that the Florida Alliance

1 pays The LeapFrog Group to get access to that data
2 pursuant to the data use agreements?

3 A. No.

4 MR. HVIDT: I am handing the witness what has
5 been marked as Exhibit 2.

6 (Exhibit No. 2 was marked for identification.)

7 MR. HVIDT: And Exhibit 2 was produced in this
8 litigation as FHA000045. The plaintiffs received this
9 production from the Florida Alliance on Tuesday night
10 and when we received it, the documents were identified
11 by code, like this Bates number, but they were not
12 Bates stamped.

13 Our vendor in uploading them yesterday did not
14 have time to apply the Bates stamping consistent with
15 the coding that Florida Alliance applied in the
16 document ID before we needed to print them for the
17 deposition today. So we are proceeding without Bates
18 stamped versions today for the Florida Alliance
19 productions.

20 And on the record, want to ask counsel for the
21 witness, who's also counsel for the defendant,
22 LeapFrog Group, if it's okay that we apply, insert a
23 Bates-copied version of the same document as soon as
24 one is available for purposes of the documents used
25 today that were produced by Florida Alliance?

1 MR. BILLEK: Of course.

2 THE WITNESS: May I ask what a Bates stamp is?

3 BY MR. HVIDT:

4 Q. Yes. A Bates stamp is a -- so you will see one
5 from a document produced by LeapFrog Group later. And
6 it is at the bottom right-hand corner of the document
7 and it simply is a coding where it's -- the code I read
8 in FHA0045, it would simply say that on that first page
9 and then the next page would go to 46.

10 A. Okay.

11 Q. And it's meant for evidentiary purposes so that
12 when we're talking about a document, we know that we're
13 all talking about the same thing.

14 MR. BILLEK: So it's like a page number that we
15 stamp on when we give it over.

16 THE WITNESS: Okay. Thank you.

17 BY MR. HVIDT:

18 Q. You're welcome.

19 A. So Bates must have been an important person, I
20 guess.

21 MR. BILLEK: Exactly.

22 THE WITNESS: At some point.

23 MR. HVIDT: I have handed the witness
24 Exhibit 2.

25 BY MR. HVIDT:

1 Q. Dr. van Caulil, have you seen this document
2 before?

3 A. Yes.

4 Q. And what is this document?

5 A. So this is the slide deck that was used for our
6 annual meeting of the board of directors in March. That
7 was our 41st annual board of directors meeting.

8 Q. And does the Florida Alliance have a process for
9 saving documents in the ordinary course of business?

10 A. Yes.

11 Q. And as far as you're aware, was this document
12 pulled from that process, that computer server that
13 saved this document in the ordinary course?

14 A. I was not involved in pulling the documents at
15 the request. So I don't know whether this came off of
16 our server or whether that was something that was just
17 directly turned over. Sorry, I don't. I don't know.

18 Q. Do you have any reason to doubt that this
19 document is an accurate reflection of the document that
20 was presented to the board of directors on March 4 of
21 2025?

22 A. Well, if I could just flip through quickly, I
23 could answer that question.

24 Q. Please go ahead.

25 A. Thank you.

1 THE VIDEOGRAPHER: The microphone.

2 THE WITNESS: I'm sorry. Didn't mean to do
3 that.

4 I don't have any reason to doubt that this
5 document is an accurate reflection of what was
6 presented.

7 BY MR. HVIDT:

8 Q. And was this document prepared in the ordinary
9 course of business?

10 A. Yes.

11 Q. And did you have a role in creating this
12 document?

13 A. Yes.

14 Q. And if you flip to page 2, do you see where it
15 says, Today's agenda?

16 A. Yes.

17 Q. And you see the first item on the agenda is a
18 call to order, welcome and overview?

19 A. Yes.

20 Q. And do you see your name there listed as the
21 president and CEO?

22 A. Yes.

23 Q. If we could flip to page 4 where the -- where the
24 title of the page is Florida Alliance Staff. Do you see
25 that?

1 A. Yes.

2 Q. And it lists your name there at the top.

3 Correct?

4 A. Yes.

5 Q. And then earlier today, you mentioned Ashley
6 Tait-Dinger. Do you recall that?

7 A. Yes.

8 Q. And is her name listed there as the vice
9 president?

10 A. Yes.

11 Q. And what is her role for Florida Alliance?

12 A. So as you can see, we're a small staff. In fact,
13 Jack Mahoney has subsequently retired, so it's just the
14 four of us. So if you're familiar with running a
15 nonprofit organization, everybody wears multiple hats to
16 be able to execute on the mission and actually be a
17 viable, sustainable organization.

18 Ashley's responsibilities are regional leader
19 responsibilities. She does our financial work and
20 compliance and insurance and sort of the business of
21 running the business, I would say. She is a very
22 technical person, so she does IT and data. So those are
23 her primary responsibilities. But if I'm unable to
24 attend a meeting or run a meeting, she could get called
25 on to do that.

1 I could say those are her primary
2 responsibilities. But -- and, as I said, as a small
3 organization, it's -- you know, other duties as
4 assigned. Happens pretty frequently, so...

5 Q. You mentioned one of Ashley's responsibilities is
6 as regional leader responsibilities. When you were
7 referring to regional leader responsibilities, those are
8 The LeapFrog Group regional leader responsibilities; is
9 that correct?

10 A. Yes.

11 Q. And looking at this list of the Florida Alliance
12 staff, below Ashley's name is Lisa Hain. Is that how
13 you pronounce it?

14 A. Yes.

15 Q. And what is Lisa Hain's role?

16 A. So she provides support to all of our team in
17 terms of scheduling meetings. She -- so she keeps my
18 calendar in particular. She facilitates the
19 correspondence between the board and the Florida
20 Alliance and with our members. She maintains the
21 website. She may, you know, at times work on the weekly
22 bulletin if I need her to look something up or find a
23 link. So she is administrative only. She's not project
24 management at all.

25 Q. And one of her roles you mentioned was

1 facilitating correspondence. Does she initiate
2 correspondence on behalf of Florida Alliance on her own
3 with members?

4 A. No.

5 Q. And so if she's sending a correspondence to a
6 Florida Alliance member, is that either because you or
7 Ashley directed her to do so?

8 A. Yes. Or on my behalf. So I should clarify to
9 say, you know, a lot of the letters that we do only need
10 to be updated or, you know, slightly amended. She'll
11 pull up out of the records the most recent version of a
12 document and do a preliminary updating or I'll direct
13 her or Ashley will direct her. Well, that same
14 correspondence needs to go to this party, you know, to
15 do that. So she doesn't do content-related generation
16 of a document.

17 Q. Understood. So she might send a document on --
18 an e-mail on your behalf; is that correct?

19 A. Yes. She will do that.

20 Q. Do -- consistent with that, does Lisa Hain -- or
21 Hain report to you?

22 A. Yes, she does.

23 Q. Does Ashley Tait-Dinger report to you?

24 A. Yes.

25 Q. If we could flip now to page 8. The title of the

1 page is Board of Directors 2025 to 2026.

2 A. Um-hmm.

3 Q. Please let me know when you're at that page.

4 A. I am.

5 Q. Is this the current Florida Alliance board of
6 directors?

7 A. Yes.

8 Q. And other than you listed there, are these
9 individuals all representatives from Florida employers?

10 A. Yes.

11 Q. And if you could, who is Kenneth Aldridge?

12 A. So he is the director of health services at Rosen
13 Hotels & Resorts. He also serves as our secretary and
14 treasurer on the board.

15 Q. And do you know -- do you know how many Florida
16 employees Rosen Hotels & Resorts has?

17 A. I don't have the actual number of employees, but
18 I think it's in the four to 5,000 range.

19 Q. And then can you tell me a little bit about Beth
20 Curran?

21 A. Yes. So she is the senior director of risk
22 management for Orange County Public Schools. She's also
23 the compliance officer on the board.

24 Q. And do you know how many employees approximately
25 Orange County Public Schools has?

1 A. Again, I don't have the number of employees. And
2 the reason that I don't, there's a couple reasons. We
3 have 80 employer members, so I don't have those numbers,
4 and they fluctuate. But sometimes that gets conflated
5 with covered lives in this world that we work in of
6 benefits. So I do know that Orange County Public
7 Schools probably has 32,000 covered lives. I think that
8 employee number is in the twenties. But that's just
9 ballpark.

10 Q. And the reason that covered lives might exceed
11 the number of employees is because some -- an employee
12 might have dependents that are included in the health
13 plan; is that correct?

14 A. Yes. And sometimes they have retirees.

15 Q. And so let's continue to use the phrase covered
16 lives moving forward as I try to communicate about this.
17 So going back to Rosen Hotels, do you have an
18 understanding of -- an estimate of how many covered
19 lives Rosen Hotels & Resorts has?

20 A. No. Let me explain why it would be better to
21 stick with an employee ballpark because our dues that
22 the members pay are on a sliding fee scale based on
23 their number of Florida employees.

24 I do know about Orange County Public Schools
25 covered lives because I've been in meetings where that

1 has come up. So I -- you know, again, I don't have
2 specifics on any of them, so I'm going to be giving you
3 my best guess as we go down -- down the line here.

4 Q. I appreciate that. Thank you. And it's possible
5 that the number of covered lives under Rosen
6 Hotels & Resorts exceeds the four to 5,000 estimate of
7 number of employees that it has; is that correct?

8 A. It's possible. I don't know if all of their --
9 they call them associates, their employees are eligible
10 for benefits in the hotel industry. There might be
11 part-time people not eligible. So I wouldn't say it's a
12 definite that -- it varies from industry to industry.
13 So I don't know the answer to that.

14 Q. Thank you.

15 And then can you tell me about Jair Espinosa?

16 A. Jair.

17 Q. Thank you.

18 A. Jair Espinosa is -- I don't know whether it's
19 benefits director or benefits manager at the City of
20 Miami. I honestly couldn't guess at this point how many
21 employees they have. They're not a very, very large
22 organization. So it's probably 2,000 if I were to
23 guess, but I don't feel comfortable guessing, so...

24 Q. And can you tell me about Sara Holtzman DeMarino?

25 A. Yes. So LYNX is Central Florida transit

1 authority. She is in a wellness, well-being position
2 there. I don't -- off the top of my head, I don't
3 know -- anticipating your next question on lives or
4 employees -- I don't -- I don't know.

5 Q. Appreciate that. Just for purposes of creating a
6 record, if we could -- I know that it's clear where I'm
7 going with my next question. But if -- just with your
8 counsel's permission, if we could stick with the
9 question asked and then to establish the record, that
10 would be helpful. I'll try to be as efficient as
11 possible.

12 A. Okay.

13 Q. And so to be clear, you do not know how many
14 employees or covered lives LYNX has; is that correct?

15 A. That's correct. I'm not comfortable guessing.

16 Q. And can you tell me a little bit about Dawn Hunt?

17 A. Sure. She leads benefits for MarineMax. They're
18 a national, if not global, company. But they are
19 headquartered here in Florida.

20 Q. And do you know how many Florida covered lives or
21 employees MarineMax has?

22 A. It's right around the 2,000 employee mark.

23 Q. And can you tell me about Stephanie Koch, Koch
24 (pronouncing)?

25 A. Koch.

1 Q. Koch. Third try.

2 A. Stephanie is the director of HR, human resources
3 for Hendry Marine Industries. She is the vice chair of
4 our board. And Hendry Marine has 400 employees.

5 Q. Can you tell me a little bit about Susan McBroom?

6 A. Susan is also the head of human resources in her
7 position at Patriot Rail. They are also a smaller
8 employer within Florida, probably three to 400 or a
9 couple -- I'll just say 300, ballpark, employees.

10 Q. And can you tell me about Rosa Novo and any
11 understanding of how many Florida employees or covered
12 lives Miami-Dade County Public Schools has?

13 A. Sure. So Rosa is our board chair. And her title
14 is administrative benefits director for the district.
15 They are the largest school district in the state of
16 Florida, third largest in the country. As far as
17 covered lives, it's in the 50,000 mark.

18 I don't have an updated number for the school
19 districts because this year there's been a loss of the
20 number of students and staff for a variety of reasons
21 across the state. So that's the most recent number that
22 I've heard.

23 Q. Thank you. And then lastly, can you tell me a
24 little bit about Mark Weinstein and any understanding of
25 how many Florida covered lives or employees ICUBA has?

1 A. Um-hmm. So Mark Weinstein is the CEO of ICUBA
2 and that is Independent Colleges and Universities
3 Benefits Association. They're a little bit different
4 than the other employer representatives on the board in
5 that they're a multiple-employer welfare arrangement.
6 And the short version of that is called a MEWA. So they
7 have, I believe, 25 private educational institutions
8 that come together in this MEWA to purchase healthcare
9 services. And they do that through ICUBA. I believe
10 there's about 15,000 employees in all of these different
11 private schools.

12 Q. And for the private educational institutions
13 within ICUBA, are those all Florida private
14 universities?

15 A. Yes. They're all located in Florida.

16 Q. Do you know if any of them are located in the
17 Palm Beach County area?

18 A. No. I don't know for sure. But it's possible.
19 They have schools in South Florida, Orlando and Tampa
20 predominantly. But I can't think of any that are
21 specifically in Palm Beach County. Nova Southeastern
22 University is one of their members, and I don't know
23 that they have a campus there.

24 Q. Thank you. Understanding that these were
25 estimates that you were able to provide here today, I've

1 been adding that all up, and so between Rosen
2 Hotels & Resorts, four to 5,000 employees; Orange County
3 Public Schools, 32,000 covered lives, the City of
4 Miami's estimated 2,000 employees; not knowing the
5 number with LYNX; the 2,000 MarineMax; the 400 employees
6 with Hendry Marine Industries; the three to 400 with
7 Patriot Rail; the approximately 50,000 with Miami-Dade
8 County schools, understanding that there's been some
9 changes within that; and the approximately 15,000 among
10 the 25 private educational institutions within ICUBA,
11 that adds up to just over 100,000 Florida employees
12 covered by the -- represented by the employers on your
13 board of directors; is that fair to say?

14 MR. BILLEK: Object to form.

15 You can answer. You can answer.

16 THE WITNESS: I -- we have a mix of employees
17 and covered lives in that calculation, so it's not all
18 apples and apples.

19 BY MR. HVIDT:

20 Q. Understanding that to be the case, do you --
21 understanding that there are some of those numbers that
22 are employees and some of those numbers that are covered
23 lives, if you add up the employees and the covered lives
24 as you've testified today where you've known those
25 numbers or estimated those numbers, do you -- is that

1 a -- adding those numbers all up, is that -- does that
2 sound right to you?

3 MR. BILLEK: Object to form.

4 You can answer.

5 THE WITNESS: Well, I didn't add them up. If
6 you added them up and that's the total that you got,
7 that sounds about right. I did not -- I don't have a
8 calculator in front of me and I didn't do a running
9 tally. It doesn't sound out of line.

10 BY MR. HVIDT:

11 Q. Flipping to page 13, where it says at the top,
12 2024 by the numbers, do you see that?

13 A. Yes.

14 Q. Do you see where it says that you have 87
15 employer members?

16 A. Yes. This was 20 -- from the 2024 annual report.
17 Yes.

18 Q. Do you know how many employer members you have
19 sitting here today?

20 A. It's just over 80. The difference between the 87
21 and the 82 is largely because there were banks that also
22 are another MEWA under the Florida Bankers Health
23 Consortium that merged or were taken over by other
24 banks, so it's attributed primarily to that.

25 Q. Do you know approximately how many Florida

1 covered lives are under that -- under your employer
2 membership?

3 A. We haven't done an update of that in a while and
4 need to. Over the years, it's been, you know, about
5 300,000, 400,000. What has complicated that calculation
6 is that sometimes the employers will send all of the
7 lives in all of their markets and all of their states
8 and will have to go back and forth on that. So I have
9 held back on publishing any number because I don't want
10 to have apples and oranges. And we've actually had
11 discussions about, well, should we -- should we ask
12 covered lives, rather than employees? Should we say
13 anywhere, not just Florida? So we haven't landed on a
14 final decision on that. But it is a significant number
15 of employees/lives that are represented by the 80-plus
16 employer members.

17 Q. And for your 80-plus employer members, do you
18 know how many employees are included within that?

19 A. No, that would be part of that update.

20 Q. So the answer as it relates to employees would be
21 similar to the -- the same as the answer you gave to the
22 question about how many covered lives there are within
23 the employer members; is that correct?

24 A. That's correct. I wish I had the specifics, but
25 it has -- seems like it should be a pretty

1 straightforward ask and answer, but it doesn't always
2 come back that way. So -- and as I mentioned
3 previously, some employers, based on the industry, not
4 every employee is eligible for benefits. Some have
5 dependents. Some have retirees. So that also
6 unfortunately complicates the calculation. So we -- we
7 try.

8 Q. Understanding that the number is difficult to
9 calculate, you mentioned earlier that the last estimate
10 you were aware of was around 300 to 400,000 Florida
11 covered lives; is that correct?

12 A. That's correct. But that's probably four or five
13 years ago.

14 Q. Do you think that that number has increased?

15 A. I think it's probably not vastly different for a
16 few reasons. I mean, we've had additional employer
17 members but also workforce size has also gone down in
18 some instances. So, you know, there are gains and
19 losses in different -- different members. So I feel
20 comfortable with that as a ballpark.

21 Q. If you could flip to the next page, do you see
22 where it says, Employer Members?

23 A. Yes.

24 Q. And then if you flip to the next page, does this
25 page represent the logos of the employer members that

1 granted you permission to use their logos on the page?

2 A. Yes.

3 Q. And then I believe that this page number I'm
4 going to flip to is towards the back of the document.
5 And so we'll take time to get there. But if you could
6 flip to the page that is 2025 Plan of Work.

7 A. Okay.

8 Q. It's page 38 of the PDF.

9 A. Oh, must have just passed it.

10 I have it.

11 Q. Thank you. Do you see where the top of the slide
12 reads, 2025 Plan of Work?

13 A. Yes.

14 Q. And is the plan of work a high-level summary of
15 the things that Florida Alliance is going to be doing in
16 the year 2025?

17 A. Yes. It's a high-level list of what we hope to
18 be able to work on. It is a mix of what we've secured,
19 if there's a grant, perhaps, project funding that we
20 might be seeking. So it basically covers the high-level
21 description of the projects.

22 Q. And if you look at the second bullet there, do
23 you see where it says, LeapFrog regional leader
24 activities/employer action reports?

25 A. Yes.

1 Q. And are the LeapFrog regional leader activities
2 consistent with those that we talked about earlier?

3 A. Yes.

4 Q. And what are employer action reports?

5 A. So we haven't been able to work on those yet
6 because we do not have a data use agreement. And that
7 is in LeapFrog's court right now and they've been busy
8 of late. And that would give us permission to create,
9 for the employers at their request, reports that could
10 use some of the LeapFrog survey and grade data alongside
11 other data. Fair price-related activities that you
12 could see later on the list.

13 And so in the back and forth on the data use
14 agreement, we're trying to get permission to show
15 LeapFrog results and, also, other -- other sources of
16 data. And that hasn't -- process has not been
17 completed. So we haven't done -- we haven't done that.
18 But that would be for the employers as they're figuring
19 out their changes they might have in networks and their
20 benefit design. A lot of them have been looking at
21 direct contracting. For example, you can see that also
22 on the list. They would ask us for information and we
23 haven't -- we haven't done an employer action report in
24 several -- several years. But the board members had
25 suggested that that would be useful.

1 Q. When was the last year that you did an employer
2 action report, if you can recall?

3 A. Well, that was one of the questions that I asked
4 Ashley because I couldn't recall and she said it's
5 probably January of 2020, she said, preCOVID.

6 Q. When you say that employers are looking into
7 direct contracting, what is direct contracting?

8 A. So they -- there's a bunch of different ways to
9 do direct contracting. But they could work with the
10 health plan, the carrier, the TPA, whatever phrase they
11 use who administrates their health plan to carve out a
12 particular center of excellence as an example. Or they
13 may hire a separate third-party administrator to have a
14 relationship, not just with a hospital, it could be with
15 independent physicians for specific services.

16 Oftentimes it is to, you know, get a better deal
17 on the cost that they're paying, but they want to make
18 sure that these are providers who are doing a good job,
19 have good outcomes. So they do their due diligence to
20 determine that that's an appropriate strategy for
21 driving value in their health plan.

22 We have members who might direct contract for
23 home health services, for infusion services. It's such
24 a variety.

25 Q. And one example of direct contracting that you

1 mentioned is if an employee wants to carve out a
2 particular center of excellence, did I get that right?

3 A. They may have a direct contract with a center of
4 excellence, yeah. It could be carved in, it could be
5 carved out.

6 Q. And does a center for excellence there refer to a
7 particular hospital or health system?

8 A. It could. But it could also be an outpatient.
9 It could be community oncologists. The term center of
10 excellence is used pretty -- pretty broadly. A lot of
11 health -- you know, healthcare systems say they're a
12 center of excellence for oncology or cardiac, so it
13 really does depend on what the organization is referring
14 to for themselves. But what the employers, when they
15 say a center of excellence, this is a provider who, from
16 their due diligence, has been able to have good
17 outcomes, has -- if applicable to LeapFrog in
18 particular, you know, they have done well in terms of
19 achieving, you know, in the survey results or the grade
20 results, but they certainly look at a lot of other --
21 other data.

22 So excellence has a lot wrapped into it. It's
23 price, it's quality, it's patient safety, it's equity.

24 So...

25 Q. And so it's possible -- some of them -- some of

1 your employer members are looking into direct
2 contracting; is that correct?

3 A. Yes.

4 Q. And one mechanism you can build into a direct
5 contract, if you're an employer, is you might get a
6 better deal by directing from a particular provider by
7 directing your employees to that provider; is that fair?

8 A. Yes. It usually has an element of a volume
9 expectation.

10 Q. And Florida Alliance is looking to create
11 employer action reports that use LeapFrog survey and
12 grading data to help facilitate its Florida members'
13 efforts into potentially direct contracting with
14 providers; is that correct?

15 A. Yes. That's one of the reasons that an employer
16 member would want that information.

17 Q. Thank you.

18 MR. HVIDT: We've been going about an hour.
19 Would you like to take a break, go off the record for
20 a minute?

21 THE WITNESS: I'm fine to keep going. It's up
22 to you.

23 MR. HVIDT: Are you okay?

24 THE COURT REPORTER: I'm fine, thanks.

25 MR. HVIDT: I'm happy to keep going if you're

1 okay. I just wanted to be mindful of that.

2 THE WITNESS: Thank you.

3 BY MR. HVIDT:

4 Q. You can set that document to the side.

5 A. Thank you.

6 Q. Earlier, we were talking about how Florida
7 Alliance is LeapFrog's regional leader; is that correct?

8 A. Yes.

9 Q. And do you understand what LeapFrog's goal is in
10 having regional leaders?

11 A. Yes. I think that the goal is to have boots on
12 the ground in the various states and regions of the
13 state who have relationships with employers and
14 healthcare purchasers to be able to reach out to the
15 hospitals they have relationships with and ambulatory
16 surgery centers, and they would be -- the regional
17 leader organizations would presumably be more familiar
18 with the market. And that helps LeapFrog with their
19 mission.

20 Q. Is one of the goals of LeapFrog's relationship
21 with the regional leaders to increase hospital
22 participation in the LeapFrog hospital survey?

23 A. Yes. Because, you know, our mission certainly
24 syncs with LeapFrog's mission to promote transparency.
25 And so having all of the hospitals, all of the

1 ambulatory surgery centers in the state fully respond to
2 their respective surveys would be the ultimate goal.

3 Q. You say that part of Florida Alliance's goal --
4 mission is to promote transparency. Is that correct?

5 A. Yes.

6 Q. Do you also ask for transparency from LeapFrog?

7 A. I don't know that we've explicitly had to ask
8 LeapFrog because they've been transparent about, you
9 know, how the -- you know, the hospitals and the
10 ambulatory surgery centers are asked to participate, the
11 process for submitting the data. They publish their
12 methodology. I won't speak for Ashley Tait-Dinger but
13 she's very active, I know from hearing from others on
14 the regional leader calls. If she has questions about
15 anything, she has never said that there was any pushback
16 or refusal to answer any questions she might have.

17 So I would say that, you know, our relationship
18 with LeapFrog has been, you know, very clear and any
19 questions, if we did have them, were always answered.
20 But, you know, methodology specifics would have to go to
21 the website and look at them specifically. I could not
22 tell you off the top of my head about the complexity of
23 that.

24 Q. I am handing you what's been marked as Exhibit 3
25 to your deposition.

1 (Exhibit No. 3 was marked for identification.)

2 BY MR. HVIDT:

3 Q. The -- Exhibit 3 has been produced in this
4 litigation as LEAPFROG00401485. And it is the 2025
5 regional leader communications toolkit launching
6 LeapFrog surveys.

7 Do you see that?

8 A. I do.

9 Q. Have you seen this document before?

10 A. I have not. If I could just flip through it,
11 there may be pieces of it I have seen. This would be a
12 document that would go to Ashley.

13 Yeah, this is not a document that would have been
14 sent to me personally. This would be the toolkit that
15 the representatives at the regional leader organizations
16 would use to -- I assume to guide the process. And
17 we've been involved with LeapFrog since 2002 as an
18 organization, and Ashley's worked on LeapFrog as her
19 responsibility -- she's probably been with the
20 organization 12 years, so I have full confidence in her,
21 in carrying out those duties.

22 Q. And Florida Alliance is one of LeapFrog's
23 regional leaders; is that correct?

24 A. Florida Alliance is the regional leader for
25 Florida for LeapFrog.

1 Q. And Ashley works for Florida Alliance; is that
2 correct?

3 A. That's correct. She's the vice president, as we
4 discussed earlier.

5 Q. And looking at this cover page to this document,
6 it is described as the communications toolkit for
7 regional leaders. Do you see that?

8 A. Yes.

9 Q. And if we go to the next page, you look down at
10 the last paragraph, see that the first sentence there,
11 do you see where it says, The 2025 communications
12 toolkit offers you instructions for launching the
13 LeapFrog Hospital survey and the LeapFrog ASC survey in
14 your region, focusing on the critical initial
15 communication you carry out, to encourage hospital and
16 ASC participation.

17 Do you see that?

18 A. Yes.

19 Q. Do you have any understanding whether Ashley and
20 Florida Alliance follows the communications toolkit that
21 LeapFrog provides?

22 A. I don't know if every item that's in here is
23 something that she does. I -- I don't know the answer.

24 Q. Do you know if she follows it generally?

25 A. I would have to assume, yes. There isn't -- as

1 we talked about earlier, there isn't a contract or an
2 agreement that says you will do this at this time in
3 this way. There's nothing like that. This is a
4 volunteer activity. And I believe I also said earlier
5 that my understanding is the regional leader
6 organizations do different levels of activity. I'm sure
7 it's a bandwidth issue with different organizations.
8 We're small, some are smaller than we are.

9 So I don't think this is a -- my best guess would
10 be that this is not a document that there's an
11 expectation that everybody is doing every single thing
12 in here. It's a guide.

13 Q. And would you agree that LeapFrog is providing
14 its regional leaders with this guide in hopes that they
15 follow it?

16 A. I'm sure they would like the regional leaders to
17 follow the guide.

18 MR. BILLEK: Just note my belated objection to
19 the form of the question.

20 BY MR. HVIDT:

21 Q. If you could flip to page 4 of this document,
22 which ends in 488 on the Bates stamp. Do you see where
23 it says, Step by step how to launch the LeapFrog
24 hospital survey and LeapFrog ASC survey in your market?

25 A. Yes.

1 Q. And then do you see that this slide, this page
2 and the next, provide a numerical list of recommended
3 action items to encourage participation in the survey?

4 A. From a quick scan, yes. But I haven't read all
5 of these to know what all those steps are.

6 Q. Understand. And then if you look at item 1, it
7 says, To get members and hospitals and ACSs excited
8 about the 2025 surveys.

9 Do you see that?

10 A. Yes.

11 Q. And then step 2 references, Personalizing
12 template letters asking hospitals to participate.

13 Do you see that?

14 A. Oh, down 2 -- yes. I see it now.

15 Q. And then if you look down to 4, it says, Send
16 hospitals letters by mail or e-mail no earlier than
17 March 30th but no later than April 30th.

18 A. Yes.

19 Q. And then if you go over to step 5, it says,
20 Follow up with those who have not responded.

21 Do you see that?

22 A. Yes.

23 Q. Is it fair to say that LeapFrog is encouraging
24 that regional leaders take multiple -- communicate
25 multiple times with hospitals or ACSs to encourage them

1 to participate in a given year?

2 A. Yes.

3 Q. Do you have any understanding from your role on
4 the LeapFrog board of directors that participation in
5 the surveys, the more there is, the better it is for
6 LeapFrog's finances?

7 MR. BILLEK: Object to form. You can answer.

8 THE WITNESS: The hospitals and ACSs do not pay
9 to participate in the survey. So answering it from my
10 role on the board, that's not a correct -- that's not
11 a correct question. There is not a financial line
12 item related to survey participation.

13 BY MR. HVIDT:

14 Q. So while the hospitals don't pay to participate
15 in the survey, does the increase in the number of
16 hospitals that participate in the survey impact the
17 licensing revenue that LeapFrog is able to achieve?

18 A. So I really don't know much about the licensing
19 revenue. I believe that's to be able to use the data.
20 Is that -- is that what the licensing revenue is that
21 you're referring to?

22 Q. The licensing that I was referring to there is
23 the licensing of the survey responses that hospitals
24 provide LeapFrog in participating in the survey.

25 But then moving on, do you have any understanding

1 whether the number of hospitals that participate in this
2 survey, if it increases, leads to a directional increase
3 in the number of accolades, subscriptions that LeapFrog
4 is able to get from hospitals?

5 A. So it would follow that the pool of potential
6 hospitals that could -- going back to your other
7 question -- pay to receive the results and/or pay the
8 accolade fee -- and I don't know how much either of
9 those are -- if that pool is greater, then I would agree
10 that that, you know, stands to be advantageous for
11 LeapFrog. That's not a discussion that I've been a
12 party to at any time. I wouldn't -- you know, I would
13 assume that makes sense. If there's more -- more
14 hospitals participating, then there's more hospitals who
15 might be interested in the data and might be interested
16 in participating in that accolade program.

17 Q. Flipping to slide -- page 7 of Exhibit 3, ending
18 in Bates number 491, do you see where it says, Best
19 practices used by regional leaders?

20 A. Yes.

21 Q. And the first item there bulleted under,
22 Launching the LeapFrog surveys in your community, do you
23 see where it says, Engage employers with purchasing
24 power to influence hospital decision-making based on
25 hospital survey participation?

1 A. Yes.

2 Q. Do you have an understanding why LeapFrog is
3 recommending that regional leaders engage employers with
4 purchasing power?

5 A. So all employers have purchasing power. It's
6 their second largest line item, healthcare is, and
7 hospital services are a significant portion of that.

8 So do I have an understanding why LeapFrog is
9 recommending engaging employers with purchasing power?
10 Well, my understanding, notwithstanding LeapFrog's
11 recommendation, is that all employers should be engaged,
12 you know, in speaking to, you know, the hospitals and
13 other providers in their markets about being transparent
14 with their price and their quality and their patient
15 safety.

16 And so I don't know how to answer the question on
17 any understanding why LeapFrog is recommending it. I
18 think it's broader than that. I think it's engage
19 employers across the board to be able to be more active
20 purchasers of healthcare, to insist upon transparency,
21 to be able to get their own data. This is not just an
22 issue that's with LeapFrog and the employers. They're
23 challenged by getting data from the PBMs, from the
24 health plans, their own data, if you will, their claims.

25 So one of the things that we do, not just as a

1 regional leader, but, you know, for our members, is to
2 get them to be more active. They do wield influence in
3 the market, especially, you know, if they're a
4 significant size. But collectively, through the Florida
5 Alliance, and you saw that we have smaller employer
6 members, can all sit down together and have a respectful
7 conversation with a hospital or a health plan or a PBM
8 and lay out expectations and hopes.

9 So, sorry I'm not answering directly, but I think
10 the premise of LeapFrog is to engage employers.
11 Employers started LeapFrog.

12 THE VIDEOGRAPHER: Counsel, can we take a small
13 break for the video change?

14 MR. HVIDT: Yeah.

15 MR. BILLEK: Absolutely.

16 THE VIDEOGRAPHER: We are off the record at
17 10:36 a.m.

18 (A brief recess was taken.)

19 THE VIDEOGRAPHER: We are on the record at
20 10:44 a.m.

21 BY MR. HVIDT:

22 Q. Counsel, are employers purchasers of healthcare?

23 A. You said counsel, so --

24 Q. Sorry. Strike that. Thank you.

25 MR. BILLEK: I'm happy to answer.

1 MR. HVIDT: Thank you, Counsel.

2 BY MR. HVIDT:

3 Q. Dr. van Caulil, are employers purchasers of
4 healthcare?

5 A. Yes.

6 Q. And do they purchase -- can they purchase that
7 healthcare from hospitals?

8 A. Yes.

9 Q. And so are employers directly and indirectly
10 customers of hospitals?

11 A. I've never heard the term customers used in that
12 exchange. They are paying the bill on behalf of their
13 plan members. So I guess -- I guess you could call that
14 a customer. Not familiar with using that term in our
15 world here.

16 Q. Looking down at the third bullet here back on
17 Exhibit 3 on page 7, do you see where it says, Meet with
18 local media?

19 A. Yes.

20 Q. And in that bullet, do you see the last sentence
21 there where it says, Encourage them to call attention to
22 the hospitals and ACSs that decline to respond to your
23 request for survey participation?

24 Do you see that?

25 A. Yes.

1 Q. What do you interpret that sentence to mean?

2 A. That the regional leaders, I guess, should
3 consider engaging with media to encourage full
4 participation in the survey. We don't do this. We
5 don't -- we don't work with the media on any kind of
6 issues on a regular basis.

7 Q. Can you flip to the next page, please. Do you
8 see where it says on page 8, on Bates number ending in
9 1492, Ideas for encouraging nonrespondents to the
10 LeapFrog surveys?

11 A. I see it.

12 Q. And do you see in the bolded underlined section
13 where it references, Common objections?

14 A. Yes.

15 Q. Have you ever encouraged hospitals -- you in your
16 individual capacity, encouraged hospitals to participate
17 in the LeapFrog hospital survey?

18 A. Me individually? No, not -- not as a rule. I
19 have been in meetings with hospitals that haven't --
20 well, let me rephrase. I'm sorry, I guess I have to
21 think this through, so strike what I said. So --

22 Q. Would you like me to reask the question?

23 A. Yeah. Please reask it. I thought of a couple of
24 instances that could probably be applicable.

25 Q. In your individual capacity, have you ever

1 encouraged hospitals to participate in the LeapFrog
2 hospital survey?

3 A. Yes. There was a period of time where the HCA
4 hospitals in Florida declined to respond. I think it
5 was in two -- two cycles. And there are 47 HCA
6 hospitals in the state, so that was a significant gap in
7 transparency for us because they had fully participated
8 for years and years and been very active in terms of
9 working with LeapFrog. And they declined to respond
10 because there were some new measures that were added a
11 few years ago, couple years ago.

12 And I did send letters to the CEOs of those
13 hospitals and asked them to please consider responding
14 to the survey again, that it was very important for the
15 Florida Alliance employer members for them to do so, and
16 if they needed to skip those questions, that would be up
17 to them. But please not to completely, you know,
18 nonrespond.

19 So in that individual capacity, yes. We had --
20 we had a meeting, I don't know, a year or more ago with
21 one of the hospitals in South Florida that either they
22 weren't responding at all or perhaps not fully. And in
23 that meeting, I said basically the same thing that I
24 just mentioned with HCA and that was that, you know, we
25 would encourage them -- you know, we -- we, on behalf of

1 the employer members, really want to promote
2 transparency.

3 So because I've not read this regional leader
4 book, you know, our encouraging in Florida as regional
5 leader is pretty much limited to issuing those letters
6 that I mentioned a while ago, you know, please respond,
7 and sending them to LeapFrog. I don't believe we do any
8 kind of follow-up if they haven't responded. We
9 certainly don't engage the media to call anybody out.
10 But we do have conversations in meetings with the
11 hospitals around LeapFrog participation.

12 Q. For the conversation with the hospital in South
13 Florida where they weren't responding to the survey, did
14 they provide to you a reason why they don't participate
15 in the survey?

16 A. Yes. And I think it was for certain questions.
17 I don't think it was for the entire survey. But I don't
18 recall exactly. But it boiled down to not enough
19 bandwidth in the staff, that it was a heavy lift for
20 them.

21 Q. And aside from the HCA dynamic and that one
22 Florida -- South Florida hospital, do you have any other
23 recollection sitting here today of your individual
24 encouragement of hospitals to participate in the survey?

25 A. Well, I signed the letters, you know, for many

1 years that would go to them. I haven't signed them in
2 the last couple of years. Nothing -- nothing else comes
3 to mind that would be me, Karen van Caulil, you know,
4 having a discussion or a letter.

5 Q. Does the Florida Alliance receive objections from
6 nonrespondents to the survey as to why they're not
7 responding? Now I'm asking the question not as to you
8 individually but the Florida Alliance in its reach-outs
9 to hospitals to encourage them to participate.

10 A. I'm rereading your question. Does the Florida
11 Alliance receive objections from nonrespondents to the
12 survey as to why they're not responding? I don't
13 understand the question.

14 Q. Does Florida Alliance when it reaches out to
15 hospitals to encourage them to participate, does the
16 Florida Alliance receive reasons from those hospitals as
17 to why they're not responding to the survey?

18 A. You know, I think that Ashley sends something
19 that's like your intention to participate or not. I --
20 I -- we don't ever talk about whether she gets anything
21 back because I think that the form says, you know, and
22 why not, if you're not. But I don't have direct
23 knowledge of that. But I think there is a vehicle for
24 receiving that information.

25 I can tell you that one instance comes to mind

1 when she had sent a letter to one of the hospitals that
2 was really obliterated in a hurricane up in the
3 Panhandle and somebody got back and said, we're closed,
4 you know, until we can get back up and running, so take
5 us off the list. So I think that's an extreme example,
6 but that one comes to mind. So that tells me there's a
7 vehicle for that communication.

8 Q. You can set that document to the side for now.

9 How did you first hear of the LeapFrog Group?

10 A. I think that I probably first heard about it when
11 I was interviewing for the position and wasn't familiar
12 with it. So that would have been 14-plus years ago,
13 probably during the interview process. That would be in
14 2011.

15 Q. And when you say you first heard about it when
16 you were interviewing for the position, that's the
17 position as the CEO and president of the Florida
18 Alliance; is that correct?

19 A. Correct. At the time called the Florida
20 Healthcare Coalition, yes.

21 Q. And --

22 MR. BILLEK: Central Florida.

23 THE WITNESS: Well, let me --

24 MR. BILLEK: Oh, no. I didn't mean to open up
25 a can of worms.

1 THE WITNESS: No, no, no. So just to clarify,
2 because it is confusing. So the legal name is Central
3 Florida Healthcare Coalition. We have the d/b/a of
4 Florida Healthcare Coalition and a d/b/a Florida
5 Alliance for Healthcare Value. When I joined the
6 organization, it was called the Florida Healthcare
7 Coalition.

8 MR. BILLEK: My apologies.

9 BY MR. HVIDT:

10 Q. Thank you.

11 You -- we talked earlier about how you are a
12 member of the board of directors of LeapFrog; is that
13 correct?

14 A. Correct.

15 Q. And when did you join the board?

16 A. September 2023.

17 Q. Were you invited to join the board?

18 A. Yes.

19 Q. Who were you invited by?

20 A. The nominating committee chair, and I can't
21 remember who it was at the time. And Leah.

22 Q. And who's Leah?

23 A. Leah Binder is the CEO of LeapFrog.

24 Q. Before you were invited in part by her to the
25 LeapFrog board, did you have a preexisting relationship

1 with her?

2 A. Yes. I've known Leah for probably the majority
3 of the time that I've been with the Florida Alliance.
4 We've served on committees and other boards together and
5 certainly knew of her from our work as a regional
6 leader. So I -- so I guess the shorter answer is, I
7 knew Leah. We have worked together.

8 Q. Were you aware whether there are any requirements
9 to be a board member of LeapFrog?

10 A. I serve on the nominating committee now. And the
11 way that board members are identified or potential board
12 members are identified is by looking at skill sets and
13 experience and expertise that would be helpful in having
14 strategic discussions about LeapFrog. So I'm not aware
15 of any specific requirements or qualifications, but I do
16 know that I was looked to as somebody who could
17 represent the employer healthcare purchaser voice.

18 Q. Are there any conflict of interest requirements?

19 A. I believe we sign a conflict of interest
20 disclosure form, yeah.

21 Q. Is there any requirement that the board donate to
22 The LeapFrog Group?

23 A. They have asked that we each contribute whatever
24 level, especially this year because of the 25th
25 anniversary, and they wanted to create like a board

1 match for donations.

2 Q. How often does the board of LeapFrog meet?

3 A. We have quarterly meetings.

4 Q. Are they all in person?

5 A. They have been two in person and two virtual, in
6 my two years.

7 Q. And what do you understand to be the duties and
8 responsibilities of a LeapFrog board member?

9 A. Well, certainly to attend the meetings and to
10 participate on a committee. I serve on the nominating
11 committee, as I mentioned. We -- you know, any board
12 member of any nonprofit, you know, has a fiduciary duty,
13 so certainly when the audited financial statements are
14 presented to us, we, you know, are seeking a clean audit
15 and can ask questions and have to vote to approve that
16 or not.

17 But primarily, it is the strategic direction of
18 LeapFrog and participating in those -- those
19 discussions.

20 Q. Does the LeapFrog board have any responsibilities
21 as it relates to the operations or management of
22 LeapFrog?

23 A. No. The operations and management people will
24 give updates. Leah will give an update on some of the
25 other staff on the status of operations, but they're not

1 action items.

2 Q. Has -- in your time on the LeapFrog board, since
3 September 2023, has the LeapFrog board ever disagreed
4 with the decisions of the LeapFrog executive team?

5 A. I don't think that we've, in the two years -- and
6 I haven't been at every board meeting. I missed one of
7 them because I had surgery like a day or so before. But
8 I don't think that there's ever been any kind of
9 disagreement with the team when they've brought things
10 forward. I would say that the members of the LeapFrog
11 board are all very smart, insightful people and they
12 might provide an alternate view or something to
13 consider. But I'm not aware of any disagreement with a
14 decision. People ask questions to, you know, understand
15 more deeply decisions that the LeapFrog staff have made
16 or the expert panel or whatever's being presented.

17 Q. In your time since you joined the board, what
18 kind of strategic decisions have been put forward to the
19 LeapFrog board for vote?

20 A. The only vote that I can think of in the two
21 years on a strategic decision has been how to conduct a
22 strategic planning process. Would it be to create a
23 committee, and that was a vote, and then they brought it
24 back recently to vote on it being a part of longer board
25 meetings. But an example of a strategy is to start

1 thinking about artificial intelligence and how that
2 might relate to the work that The LeapFrog Group does
3 and to bring in some experts to help navigate through
4 that because there wasn't anybody on the board that, you
5 know, would be really strong in that area.

6 Q. And so other than the vote on how to conduct a
7 strategic planning process, in your time on the LeapFrog
8 board of directors since September 2023, you can't
9 recall another time where the board was asked to vote on
10 a strategic decision as it relates to LeapFrog's
11 operations; is that correct?

12 A. I'm thinking right at the moment. I think we --
13 we don't really vote on operational matters. So I'm
14 going to say, to the best of my recollection, I can't
15 think of another time where we voted. The voting, vote
16 on minutes, as I said, vote on the audit, vote on having
17 a committee, those have been the primary votes that I
18 can recall.

19 Q. And would you consider LeapFrog's methodology for
20 how it grades hospitals to be part of those operational
21 matters that the LeapFrog board hasn't had a vote
22 regarding in your time on the LeapFrog board since
23 September 2023?

24 A. I -- I don't think we've voted on methodology in
25 that time. We've been informed about the methodology.

1 I can't recall a vote. We don't have that detail. In
2 fact, the last board meeting we had in June or somewhere
3 around that time, they did a 101 with the board to
4 educate anyone who is available to educate about
5 high-level methodology for the grade and the survey.
6 Because it's just not something that the board
7 deliberates.

8 MR. HVIDT: I'm handing the witness what's been
9 marked as Exhibit 4 in this deposition, which has been
10 produced in this litigation as LEAPFROG00378234.

11 (Exhibit No. 4 was marked for identification.)

12 BY MR. HVIDT:

13 Q. And it's a document titled, Final Draft LeapFrog
14 Long Range Strategic Intent, Fiscal Year 2026 to 2032,
15 December 2024.

16 Do you see that, Dr. van Caulil?

17 A. Yes, I do.

18 Q. And have you seen this document before?

19 A. I don't think I have. If it was presented to the
20 board on December 2024, that's the meeting that I
21 missed. I had surgery on December 13th and I think the
22 board meeting was the 16th up in Baltimore. I couldn't
23 travel for it.

24 Q. Understood. Thank you for clarifying that.

25 The item that I just want to point to,

1 understanding that you weren't there, when you're --
2 even if you aren't able to attend a board meeting, are
3 you e-mailed the packet of materials that are displayed
4 at the board meeting?

5 A. They send us materials in advance to review.
6 Sometimes they send things that weren't in the board
7 packet after. I don't -- I don't actually recall seeing
8 this. That doesn't --

9 Q. It's possible you may have received it but you
10 just haven't read it. Is that --

11 A. It's possible. It's possible that I received it.
12 I don't -- I don't remember seeing this.

13 I do know that the strategic planning committee
14 was working on something to react to.

15 Q. And looking there at objective 1, do you see
16 where it says, Scale of resources to the capacity needed
17 to make giant leaps for patient safety and stop
18 avoidable death and suffering?

19 A. Yes.

20 Q. Understanding that there has been, as you've
21 described earlier, movement in the strategic planning,
22 is scaling LeapFrog's resources one of the objectives in
23 LeapFrog's current strategic plan?

24 A. So there have been discussions about adding
25 additional staff because of workload, if that's what

1 scale resources to the capacity needed means. So that's
2 certainly been a discussion or at least an information
3 sharing to the board.

4 Q. And if you could flip to the next page where it
5 carries over to 235. Is it fair to say that this page
6 has about five bullets that are under that objective 1
7 that we just talked about?

8 A. Yes, I see it.

9 Q. And is the first bullet, Expand and diversify
10 revenue sources including funding through grants,
11 development, industry partnerships, data licensure?

12 A. Yes. That's the first bullet. Yes.

13 Q. You can set that document to the side for now.

14 We talked earlier about -- we mentioned
15 LeapFrog's hospital safety grade before. Can you tell
16 me in your own words what LeapFrog's hospital safety
17 grade is?

18 A. So two times a year, The LeapFrog Group publishes
19 A, B, C, D, F grades for hospitals and ambulatory
20 surgery centers also. I know you just asked about
21 hospital, but they're published at the same time. And
22 those are patient safety specific measures. It is, to
23 my understanding, a combination of publicly reported
24 data to CMS and, also, if the hospital responds to the
25 survey, there are some elements that get pulled into the

1 calculation of that grade.

2 Q. Do you have an understanding of how a hospital
3 who is -- who does not participate in the LeapFrog
4 hospital survey is grading?

5 A. They use publicly available data to generate a
6 grade.

7 Q. What is the publicly available data that they use
8 to generate a grade?

9 A. It's primarily CMS data.

10 Q. Do they use any other data to fill in for the
11 measures that are only -- that are not CMS-related data?

12 MR. BILLEK: Object to form.

13 You can answer.

14 THE WITNESS: Would you mind repeating the
15 question?

16 BY MR. HVIDT:

17 Q. Yes. So you mentioned that the LeapFrog Hospital
18 Safety Grade includes measures that are pulled from the
19 survey results that a hospital completes for the
20 LeapFrog Hospital Survey; is that correct?

21 A. Yes. I think there's a -- some subset of
22 questions that are from the survey.

23 Q. And if a hospital doesn't respond to the survey,
24 LeapFrog doesn't have data from that hospital for
25 those -- that subset of measures; is that correct?

1 A. That's correct.

2 Q. And do you have any understanding as to how
3 LeapFrog treats that subset of measures where the -- for
4 the hospitals that don't participate in the survey?

5 A. Yes. Certainly. That was something that was
6 explained to the board since I've been on the board
7 because that methodology changed last year, how they
8 imputed a score. And my understanding is that up until
9 the fall, if you didn't respond to the survey, you would
10 get the average or median score. And then for four
11 measures now, it's not that any longer. It's the lowest
12 possible score. So limited achievement for that
13 measure.

14 Q. You used the word impute -- imputed a score.
15 What does that mean?

16 A. That's the terminology that LeapFrog uses. So to
17 your earlier question, when they don't have it
18 available, this is how they fill that in.

19 Q. What does the word impute mean?

20 A. To calculate, to identify. I don't know the
21 dictionary definition. I would say in context it is how
22 they generate a score for that.

23 Q. How they generate a score for missing data; is
24 that correct?

25 A. Yes.

1 Q. And you mentioned that up until the fall, if you
2 didn't respond to the survey, you'd get an average or
3 median score. When you say the fall, are you referring
4 to up until fall of 2024?

5 A. I don't know specifics on this. I'm not involved
6 with the methodology. I've given you my understanding.
7 I don't know the exact time in 2024. I don't know when
8 it took effect.

9 Q. And you were a board member when the change took
10 effect; is that correct?

11 A. I was a board member when it was discussed. I
12 don't recall when it would take effect.

13 Q. And you mentioned that there are hospitals that
14 don't respond to the survey are now assigned the lowest
15 possible score; is that correct?

16 A. Limited achievement, I believe is what it's
17 actually called.

18 Q. And do you know on what basis LeapFrog assigns
19 nonparticipating hospitals the lowest possible score?

20 A. So they work with an expert panel to determine
21 the methodology and the basis for that change would have
22 been result of their deliberation and study of the issue
23 as to what the most appropriate proxy for nonresponse
24 would be.

25 Q. So is it your understanding that the LeapFrog

1 expert panel, in coming up with the lowest possible
2 score, was trying to identify the most approximate
3 estimate for what that score would have been had the
4 nonrespondent participated in the survey?

5 A. No. I don't think that's what they were trying
6 to do. They are assigning limited achievement of that
7 measure because they don't have data or information to
8 tell them what that hospital response would have been
9 should they have responded.

10 Q. So is it your understanding that the methodology
11 is not trying to estimate what the -- an accurate
12 estimate of what the nonresponding hospital would have
13 answered had it answered the survey?

14 A. I don't think that's the intent of the
15 methodology to try to come up with what the hospital
16 would have responded. They're asking the hospital to
17 respond to the question so that they can have accurate
18 information.

19 My recollection of conversations around this
20 change was that there were participating hospitals who
21 raised the issue of why would you give an average score
22 to somebody who's not responding, that might be a higher
23 score than somebody who is responding, that you need to
24 go back and come up with a different way.

25 And I can also tell you that over the years, I've

1 been in meetings, whether that's with the Florida
2 Hospital Association or some of these hospital meetings
3 where comments have been made, you know that hospitals
4 are gaming this with the survey by not responding to the
5 question because they'll get a better score if they
6 don't respond than if they provided their experience.

7 So I had heard that a few times. So I think that
8 probably was a factor in determining that providing an
9 average score was probably not fair to the hospitals
10 that do participate.

11 Q. And do -- strike that.

12 And so you -- the intent of the methodology is
13 not -- of the imputation methodology is not to assign
14 the nonresponding hospitals an accurate estimate of what
15 they would have answered had they answered the survey?
16 Is that correct?

17 MR. BILLEK: Object to form.

18 You can answer.

19 THE WITNESS: I want to say that I am not
20 involved in the methodology determination. And I
21 don't know what the intent was of the methodology
22 change. I -- I can't really answer that question
23 because it doesn't seem like it would even be possible
24 for those who work at LeapFrog to come up with an
25 answer that the hospital should be providing

1 themselves. They wouldn't have the data. They
2 wouldn't have the ability to come up with what they
3 could have provided themselves.

4 BY MR. HVIDT:

5 Q. So from your perspective as a LeapFrog board
6 member, you don't think it's possible for LeapFrog to
7 come up with an answer that would estimate what the
8 nonresponding hospitals would have achieved had they
9 participated in the LeapFrog survey; is that correct?

10 MR. BILLEK: Object to form.

11 THE WITNESS: I -- I don't know how they would
12 come up with an estimate when the simplest thing would
13 be for the hospital to answer that question for
14 themselves.

15 BY MR. HVIDT:

16 Q. So let me ask it again, because it's a yes-or-no
17 question.

18 So from your perspective as a LeapFrog board
19 member, you don't think it's possible for LeapFrog to
20 come up with an answer that would estimate what the
21 nonresponding hospitals would have achieved had they
22 participated in the LeapFrog survey; is that correct?

23 MR. BILLEK: Object to form.

24 THE WITNESS: I don't think this is a LeapFrog
25 board of directors' role since we don't talk about the

1 methodology and we don't hear about all of the
2 investigation and research and thinking and
3 deliberation on that. I would say as an individual, I
4 can't answer this as a LeapFrog board member. I would
5 say as an individual, I think it would be very
6 difficult to estimate what the nonresponding hospital
7 would have achieved on a measure and we'll say again,
8 the best way to come up with the most correct response
9 is for the hospital to provide that information
10 themselves.

11 BY MR. HVIDT:

12 Q. And isn't it the case that the -- by assigning
13 the hospital the lowest possible score, LeapFrog is not
14 trying to estimate what that hospital would have
15 achieved had it participated in the LeapFrog Hospital
16 Survey?

17 MR. BILLEK: Same objection.

18 THE WITNESS: I don't know what LeapFrog is
19 trying to achieve with the methodology because I
20 wasn't part of the discussions or have I heard about
21 the discussions to know what they were trying to
22 achieve.

23 BY MR. HVIDT:

24 Q. Is LeapFrog, by assigning the non -- by assigning
25 nonparticipating hospitals the lowest possible score for

1 the measures that LeapFrog does not have data on those
2 hospitals, is LeapFrog trying to encourage those
3 nonparticipating hospitals to participate in its survey?

4 A. I would think that as a hospital, if you know
5 you're performing better than that limited achievement
6 score, you would want to respond to that question so
7 that the public can see that you do care about patients'
8 safety and you are doing well on that measure.

9 So to answer your question, it could be that in
10 their deliberations about the change in the methodology,
11 that they hoped that nonparticipating hospitals would
12 answer for themselves. But I am not privy to that
13 discussion or whether that was part of their rationale
14 for this change.

15 Q. So as a LeapFrog board member, you are not privy
16 to whether the change in methodology as it relates to
17 nonparticipating hospitals, what the rationale was for
18 that change; is that correct?

19 A. I don't remember the exact discussion at the
20 meeting because it was a while ago and I think I was a
21 new board member trying to get my bearings, if you will,
22 on LeapFrog board responsibilities.

23 My recollection would be that the change was made
24 so that hospitals that are participating in the survey
25 who might be performing with limited achievement weren't

1 upset that hospitals that are not participating were
2 getting a higher score. That's my recollection of the
3 rationale. But I do know that when it was presented, it
4 was said to us that it was an extensive evaluation and
5 assessment and determination by the experts who were
6 convened to do that. And for us on the board,
7 collectively, we trust their expertise and their charge
8 to do that work.

9 So it wasn't a lengthy discussion. It was
10 information that was provided. But again, it's, you
11 know, easily a year ago.

12 Q. So when LeapFrog was updating the board about the
13 methodology change, it was said to the board that this
14 change followed a determination by the expert panel; is
15 that correct?

16 A. Yes.

17 Q. And did they discuss whether the expert panel
18 voted on this methodology change?

19 A. I don't recall that being part of the discussion.

20 Q. Did they discuss whether the expert panel
21 convened in a quorum regarding the proposed methodology
22 change that was actually implemented?

23 A. I don't know whether it was in a quorum. I don't
24 know that.

25 Q. So the LeapFrog executives didn't communicate to

1 you that the methodology change that they were going to
2 implement was not discussed with the full board at an
3 expert panel meeting?

4 A. No, I didn't say that. I said that I don't -- I
5 don't recall -- you know, I don't know whether it was a
6 quorum because I don't recall whether it was presented
7 that way.

8 Q. Understand and --

9 MR. BILLEK: And just note my objection to the
10 double negative you used. It made it confusing.

11 THE WITNESS: Yeah.

12 BY MR. HVIDT:

13 Q. Understand. I'm going to go back to that --

14 A. Okay. Sorry.

15 Q. -- because I was not trying to suggest that you
16 said that.

17 What I wanted to get an understanding of is when
18 the LeapFrog executives communicated about the
19 methodology change with the board, did they share with
20 the board that the methodology change that they were
21 proposing was not discussed with the full expert panel
22 at the April expert panel -- April 2024 expert panel
23 meeting?

24 A. I don't recall hearing that.

25 Q. So when --

1 A. I'm reading. I'm sorry. Let me read your
2 question again. Did they share with the board that the
3 methodology change that they were proposing was not
4 discussed with the full expert panel at the April expert
5 panel meeting?

6 I don't recall that level of specificity. It
7 could have been said. I don't -- I don't recall that.

8 Q. As a board member, would you have appreciated
9 knowing that the methodology proposal that was discussed
10 with the expert panel in April 2024 was different than
11 the methodology that the LeapFrog -- that LeapFrog ended
12 up implementing in the fall of 2024?

13 MR. BILLEK: Object to form.

14 THE WITNESS: I think that I would have wanted
15 to know what the difference was between the
16 recommendation and what was being implemented.

17 BY MR. HVIDT:

18 Q. Sitting here today, do you have any awareness
19 that the methodology change that was discussed at the
20 April 2024 expert panel meeting is different than the
21 LeapFrog methodology that it has had in place since the
22 fall of 2024?

23 A. I don't recall hearing that.

24 MR. HVIDT: Can we go off the record for a
25 moment? Thank you.

1 THE VIDEOGRAPHER: We are off the record at
2 11:33 a.m.

3 (A brief recess was taken.)

4 THE VIDEOGRAPHER: We are on the record at
5 11:37 a.m.

6 MR. HVIDT: Thank you.

7 BY MR. HVIDT:

8 Q. I'm handing you what's been marked as Exhibit 5.

9 (Exhibit No. 5 was marked for identification.)

10 BY MR. HVIDT:

11 Q. And Exhibit 5 has been produced in this
12 litigation by Florida Alliance as FHA0002072.

13 Do you see that, Dr. van Caulil?

14 A. Yes.

15 Q. And earlier today, we were talking about how the
16 LeapFrog staff presented to the LeapFrog board of
17 directors a LeapFrog 101. Do you remember that?

18 A. Yes. It wasn't part of a board meeting. It was
19 a separate meeting if people were available, and then
20 they sent the slides if you were unable to attend.

21 Q. And did you receive the slides?

22 A. Yes.

23 Q. Have you looked through them?

24 A. Yes.

25 Q. And the date of this set of slides is April 28,

1 2025. Do you see that?

2 A. Yes.

3 Q. And were you able to attend the meeting where
4 Leah Binder and Missy Danforth presented these?

5 A. No.

6 Q. And so is that why you were sent the slides
7 separately?

8 A. Yes. But they may have sent them to everybody,
9 whether you attended or not. I don't recall the e-mail
10 specifically.

11 Q. But you did not hear Leah Binder and Missy
12 Danforth walk through --

13 A. No, I --

14 Q. -- the slides in any way?

15 A. No, and I don't believe -- I'm sorry, I
16 interrupted -- no, and I don't believe they sent a
17 recording.

18 Q. Thank you. That was going to be my next
19 question.

20 And if -- you mentioned that you have read these
21 slides; is that correct?

22 A. I looked at them when I received them, yes.

23 Q. Okay. And if we can flip to slide 10. Do you
24 see where it says, Improving voluntary transparency?

25 A. Yes.

1 Q. Okay. And do you see where it says that
2 80 percent of hospitals voluntarily respond to
3 LeapFrog's annual survey?

4 A. Well, the wording is 80 -- Hospitals that
5 voluntarily respond to the annual LeapFrog survey
6 represent 80 percent of all acute care beds in the U.S.,
7 so that's specific to acute care beds.

8 Q. And so do you -- is that consistent with your
9 understanding that participation in LeapFrog's survey is
10 voluntary?

11 A. Yes.

12 Q. And if 80 percent of all acute care beds in the
13 United States are represented through hospitals that
14 participate, does that imply that there are 20 percent
15 of acute care beds in the U.S. that do not -- are in
16 hospitals who do not participate in the LeapFrog survey?

17 MR. BILLEK: Note my objection to form of the
18 question.

19 You can answer.

20 THE WITNESS: I don't know that you can say
21 20 percent of acute care beds. There are some
22 hospitals that don't qualify, if they're a specialty
23 hospital in some other determination. So if you
24 wouldn't mind repeating the question.

25 BY MR. HVIDT:

1 Q. Essentially the question is if -- 100 percent
2 minus 80 percent equals 20 percent; is that correct?

3 A. Yes, it is correct.

4 Q. Thank you.

5 A. So -- there's always caveats to everything, I'm
6 afraid.

7 Q. And you do not know whether or not the hospitals
8 that are excluded from that -- the hospital safety grade
9 are included in that calculation of 80 percent; is that
10 correct?

11 A. So this is a question about the survey. Can you
12 ask your question again, because I heard you say the
13 grade. So I just want to make sure I heard it
14 correctly.

15 Q. Yes. So you can strike that. It's not
16 significant.

17 A. Okay.

18 Q. We can -- let's flip over to the next slide,
19 please.

20 A. Okay.

21 Q. Do you see where it says at the top of slide 11,
22 Levers LeapFrog uses to gain survey participation?

23 A. Yes.

24 Q. And is this slide consistent with your
25 understanding that LeapFrog is trying to increase survey

1 participation?

2 A. LeapFrog -- yes. LeapFrog is trying to increase
3 survey participation because they'd like to see all the
4 hospitals in the country be transparent about their
5 quality and patient safety.

6 Q. And on this slide, does LeapFrog reference that a
7 lever that it can use to gain survey participation is
8 assigning nonparticipating hospitals the lowest score
9 for the imputed scores?

10 A. I'm waiting for the question to fully type out so
11 I can review it here. Does LeapFrog reference that a
12 lever that it can -- it's not showing on my screen.

13 Q. If you can -- if you can't understand my
14 question, then just ask me to repeat it again, because
15 looking back at the transcript, she's doing her best to
16 type it up but --

17 A. Yeah -- no, I --

18 Q. If we can just --

19 A. Please repeat the question.

20 Q. Yeah. On this slide, does LeapFrog reference
21 that one of the levers it uses to gain survey
22 participation is assigning nonparticipating hospitals
23 the lowest possible score for the imputing measures?

24 A. No, it doesn't include the limited achievement
25 score.

1 Q. And is this -- this is a slide deck that was sent
2 by LeapFrog staff to its board of directors to give it a
3 101 on the LeapFrog -- on LeapFrog's business; is that
4 correct?

5 A. Yes.

6 Q. And as the board, would you have appreciated that
7 LeapFrog staff be fully transparent of all the levers it
8 uses to gain survey participation in this slide?

9 A. I don't know that by leaving out the limited
10 achievement score for nonresponses would be something
11 that would be on a slide like this as a strategy.
12 Because I don't know, based on all the questions you
13 asked earlier and my responses, I don't know if that was
14 the intent of the expert panel or the staff in making
15 that decision to change the methodology.

16 So LeapFrog is transparent and I don't think by
17 leaving that out, they are not being transparent. It
18 says some measures included in the hospital safety
19 grade, so...

20 Q. And some measures being included in the hospital
21 safety grade is referencing to the notion that if you
22 participate in the LeapFrog survey, those answers get
23 used in the hospital safety grade; is that correct?

24 A. You're going to have to repeat that. I'm sorry.

25 Q. The reference to some measures included in the

1 hospital safety grade as a lever, LeapFrog uses to gain
2 survey participation, likely references the notion that
3 if you participate in the survey, those survey answers
4 go to measures that are included in your hospital safety
5 grade?

6 A. Survey participation in and of itself does not
7 mean you're going to get a better hospital safety grade,
8 but there are measures, yes, in the hospital survey that
9 are used in calculating the hospital safety grade if
10 you've responded to the survey.

11 Q. If you could flip to slide 25. I understand...

12 MR. BILLEK: Am I missing where these are
13 numbered or do you just mean the 25th page?

14 MR. HVIDT: 25th page on the PDF.
15 Unfortunately, it was produced to us without page
16 numbers.

17 MR. BILLEK: No, that's okay. When you said
18 slide 25, I thought you meant there was a number on
19 this slide somewhere that I couldn't see.

20 MR. HVIDT: The slide that is 25 is,
21 Differences Between LeapFrog Hospital Survey and
22 Safety Grade.

23 BY MR. HVIDT:

24 Q. Are you on that page?

25 A. I am now.

1 Q. Do you see where under LeapFrog Hospital Safety
2 Grade, it says, Grades are assigned via many sources?

3 A. Yes.

4 Q. The grades are assigned from LeapFrog from CMS
5 scores; is that part of the sources?

6 A. I don't know all the sources but I know CMS is
7 one of the sources.

8 Q. And do you know that LeapFrog Hospital Survey
9 answers are a source that goes into the grades?

10 A. Yes.

11 Q. Is there another source?

12 A. I don't know all the sources.

13 Q. Sitting here today, you can't think of another
14 source; is that correct?

15 A. That's correct.

16 Q. And if you could flip now to page 27, which is --
17 says, New safety grade imputation model.

18 Do you see that?

19 A. Yes.

20 Q. And then if you flip to the next page, slide 28,
21 it says, How LeapFrog calculates a grade for hospitals
22 that don't report to the survey, imputation.

23 Do you see that?

24 A. Yes.

25 Q. And in the first bullet on the left-hand side, it

1 reads, There's been a shift over time toward imputing
2 lowest level of performance when we don't have LeapFrog
3 Hospital Survey data.

4 Do you see that?

5 A. Yes.

6 Q. Does this slide explain why there's been a shift
7 toward imputing the lowest level of performance?

8 A. Only in that it's in line with the second bullet,
9 they're in line with recommendations from the national
10 expert panel and Johns Hopkins advisors. It doesn't --
11 I believe that's the answer.

12 Q. And that second bullet just references that the
13 change was made in line with recommendations. And that
14 bullet doesn't say why those recommendations were made;
15 is that correct?

16 A. That's correct. And again, I wasn't there for
17 the presentation for any additional, you know,
18 explanation or if anybody asked. And I don't have a
19 recording, so I don't know if it was addressed at the
20 time.

21 Q. And here, it says that the -- under that second
22 bullet that LeapFrog changed, quote, the way it
23 estimates performance.

24 Do you see that?

25 A. Yes.

1 Q. And so do you interpret this slide to mean that
2 LeapFrog was saying that the imputation process is
3 trying to estimate the performance of the nonperforming
4 hospitals?

5 MR. BILLEK: Object to form.

6 THE WITNESS: It says LeapFrog changed the way
7 it estimates performance for hospitals.

8 BY MR. HVIDT:

9 Q. So is that a yes?

10 A. Yes.

11 Q. You could flip to the next slide. Do you see
12 where it says, Common objections to LeapFrog?

13 A. Yes.

14 Q. And then if you flip again to the slide 31, the
15 slide after that, kind of banner change, says, Common
16 objections to LeapFrog concerns with the data.

17 Do you see that on slide 31?

18 A. There's two slides with that, so which one in
19 particular?

20 Q. We'll start with the first slide.

21 A. Okay. All right. Yes, I see it.

22 Q. The one where the first item on the left says,
23 LeapFrog data is self-reported. How can it be trusted?

24 Do you see that?

25 A. I do.

1 Q. And is it your understanding that this slide and
2 the next slide, LeapFrog is communicating common
3 objections that hospitals have provided for not
4 participating -- for reasons why they're not
5 participating in LeapFrog's hospital survey?

6 A. I don't know that if it's limited to not
7 participating. It could be that it's raised by a
8 hospital that has participated. So I wouldn't come to
9 the conclusion that it's just from those who have not.

10 Q. That's fair. These are objections to the
11 LeapFrog hospital safety grade that could be from
12 nonparticipating hospitals or could be from anyone. Is
13 that correct?

14 A. It doesn't say specifically, but I -- I would
15 have to guess it could be from anyone.

16 Q. Do you see there on slide 31 where the third box
17 says -- the blue box says, We have a poor safety grade
18 only because we do not participate in the LeapFrog
19 Hospital Survey.

20 Do you see that?

21 A. Yes.

22 Q. And so the inclusion of that quote on the slide
23 implies that that's a common objection that has been
24 raised to LeapFrog; would you agree with that?

25 A. Yes.

1 Q. And you see how in response, the last sentence
2 that's response below that says, Many hospitals that do
3 not report to LeapFrog earn As.

4 A. I see that.

5 Q. Do you have any understanding of the truth of
6 that statement?

7 A. I have seen but couldn't quote it directly a
8 number that LeapFrog has provided in recent months of
9 the number of hospitals who have As, Bs, Cs, Ds, Fs, who
10 don't participate in the survey.

11 Q. Would it surprise you to know that there's about
12 550 nonparticipating hospitals in this last grading
13 cycle that were given the lowest score through the
14 imputation methodology?

15 A. I would not be surprised or surprised. I don't
16 have a sense of how many. I don't know. I don't know
17 if that number is surprising or not.

18 Q. And of those 550 nonparticipating hospitals, do
19 you know that there are zero nonparticipating hospitals
20 in Florida who were given an A by LeapFrog in the spring
21 2025 cycle? Would that surprise you?

22 A. I don't have a reaction that's surprise or not
23 surprise. It's -- I didn't know that information,
24 though.

25 Q. And if the number of nonparticipating hospitals

1 that were given imputed lowest score for the four
2 measures, of the 550 across the country was only two,
3 would that, in your mind, be many hospitals?

4 MR. BILLEK: Object to form.

5 You can answer.

6 THE WITNESS: Could you repeat the question?

7 BY MR. HVIDT:

8 Q. Yeah. So in this document, the LeapFrog staff is
9 communicating to the board that many hospitals that do
10 not report to LeapFrog earn As. Do you see that?

11 A. I see that, yes.

12 Q. And in spring of 2025, the nonresponding
13 hospitals who were given a step 2 imputation that earned
14 an A was two of 550. Does that -- is two out of 550
15 many hospitals in your mind?

16 MR. BILLEK: Object to form.

17 THE WITNESS: I don't know that this response
18 here is limited to just one grade cycle. So could be
19 many hospitals over time that have not reported to
20 LeapFrog earn As.

21 BY MR. HVIDT:

22 Q. And did you know that in the fall of 2024, the
23 only other grading cycle that had this imputation
24 methodology, the numbers were the same?

25 MR. BILLEK: Object to form.

1 THE WITNESS: I hadn't heard that data.

2 BY MR. HVIDT:

3 Q. If that data is accurate, would you characterize
4 that data as being many hospitals?

5 A. Two hospitals in two hospitals is not many for
6 just those two cycles. I would assume that what they're
7 trying to say is that many hospitals over time have
8 received As.

9 Q. Before the methodology change, there could have
10 been nonresponding hospitals that got As, and that
11 statement could have been correct prior to the
12 methodology change; is that correct?

13 A. I think that's possible. I don't know the answer
14 to that, though.

15 Q. You can set that document to the side.

16 MR. BILLEK: That was 5?

17 MR. HVIDT: Yes. Thank you. And before I hand
18 the witness what has been marked as Exhibit 6, I want
19 to, on the record, note that there's a set of
20 documents that LeapFrog provided to plaintiff's
21 counsel on Sunday without Bates stamps. And when they
22 communicated that, they said that they would be
23 producing them later with Bates stamps. And we have
24 not yet received those versions.

25 And so there are a few documents we're going to

1 have to use today that do not yet have Bates stamps
2 but will have Bates stamps soon, consistent with how
3 we treated the Florida Alliance documents that were
4 produced, approximately 30 hours ago. Counsel, can we
5 get an agreement that we can insert the Bates-copied
6 version of this document in place of the
7 nonBates-copied version of this document when that's
8 provided by you?

9 MR. BILLEK: Of course.

10 MR. HVIDT: Thank you.

11 (Exhibit No. 6 was marked for identification.)

12 BY MR. HVIDT:

13 Q. I'm handing you what we've marked as Exhibit 6 to
14 your deposition. And I'll represent that Exhibit 6
15 appears to be LeapFrog group board of director minutes
16 from the June 11, 2024, board of directors meeting at
17 the Darcy Hotel, Washington, D.C. and Zoom.

18 Do you see that, Dr. van Caulil?

19 A. Yes.

20 Q. And do you see under the attendees your name
21 listed there on the third line?

22 A. I do.

23 Q. And is that correct? Did you attend this board
24 of directors meeting?

25 A. Yes. I can't recall whether it was in person or

1 Zoom, though.

2 Q. And is it part of LeapFrog's practices to prepare
3 minutes for board of directors meetings?

4 A. Yes.

5 Q. And when LeapFrog Group prepares minutes for
6 board of directors meetings, do they try to be truthful
7 and accurate as to the events that occurred during the
8 LeapFrog board of directors meetings?

9 A. Yes.

10 Q. And looking here at this document, do you have
11 any reason to doubt the authenticity or accuracy of the
12 minutes provided here?

13 A. No.

14 Q. And looking through this document, at this
15 meeting, was -- was the LeapFrog Group board of
16 directors asked to vote on whether the LeapFrog Group
17 should change its grading methodology for its hospital
18 safety grades?

19 A. I don't think that was an action taken. May I
20 look through the minutes?

21 Q. You may. Please look through the minutes and let
22 me know if that was an action taken at this meeting.

23 A. I don't see any actions taken on the grading
24 methodology.

25 Q. Do you see any reference in these minutes to

1 LeapFrog changing its imputation methodology to, instead
2 of trying to estimate the performance of
3 nonparticipating hospitals, to instead assign them the
4 lowest possible score for those measures that were
5 previously imputed?

6 A. I don't see an agenda item on the topic at all.

7 Q. Do you recall receiving a -- you can set that to
8 the side -- do you recall receiving a report from the
9 LeapFrog CEO at that June 2024 board of directors
10 meeting?

11 A. Leah typically does a verbal and written report.
12 I don't recall what was said.

13 Q. When you say written report, would she provide a
14 report in writing to the board of directors?

15 A. Yes. She does that. I don't know if that's
16 every time, but she'll write out her talking points.

17 MR. HVIDT: I'm handing the witness what has
18 been marked as Exhibit 7 in the Karen van Caulil
19 deposition which has been produced in this litigation
20 as LEAPFROG00326021. The cover page is an e-mail from
21 Leah Binder dated June 6, 2024, to Angela Hopkins re:
22 CEO report June 2024.

23 (Exhibit No. 7 was marked for identification.)

24 BY MR. HVIDT:

25 Q. Do you see that, Dr. van Caulil?

1 A. Yes.

2 Q. Do you see how there's an attachment there, CEO
3 report-June 2024?

4 A. I see -- it doesn't have a dash. It says
5 LeapFrog Group board of directors, CEO report, Leah
6 Binder, June 2024.

7 Q. In looking at the e-mail, do you see where Leah
8 says, Attached is the final?

9 A. Yes.

10 Q. And I also put it in the board packet. Little
11 correction there, I to in.

12 A. Okay.

13 Q. Do you see that?

14 A. Yes.

15 Q. So flipping to the attachment now, do you see in
16 that first section there where it says, The hospital
17 safety grade successful spring update?

18 A. Yes.

19 Q. Looking down to that second paragraph, can you
20 read that paragraph into the record for me, please?

21 A. We also published our planned updates to the
22 safety grade methodology slated for this fall. The
23 update dramatically lowers imputed scores for certain
24 measures for hospitals that decline to report to the
25 LeapFrog Hospital Survey. This follows a strong

1 recommendation from the expert panel. This should have
2 some impact on hospital reporting to the survey and will
3 strengthen the grade overall.

4 Q. Thank you.

5 And seeing that document in that line, does that
6 refresh your recollection of whether there was
7 discussion -- whether it was reported to the board that
8 there would be a methodology change at that June 2024
9 meeting?

10 A. Yes. I knew that it had been reported to us that
11 there was a change, but there wasn't board discussion or
12 a presentation of the methodology. So when Leah does a
13 report like this, this is essentially her talking points
14 during the meeting.

15 Q. Understood. So Leah may have said this or
16 something like this at the meeting. But you don't
17 recall there being any discussion after that was
18 referenced; is that correct?

19 A. I don't recall if there was discussion. There
20 could have been comments, but it wasn't a significant
21 discussion.

22 Q. And do you see where she says that, This follows
23 a strong recommendation from the expert panel?

24 A. I see that.

25 Q. Is that consistent with what you testified to

1 earlier that when The LeapFrog Group communicated this
2 change to you, they said that this came from a
3 recommendation from the expert panel?

4 A. Yes.

5 Q. And do you see where following that, she says,
6 This should have some impact on hospital reporting to
7 the survey?

8 A. Yes, I see that.

9 Q. And with that sentence, when she says, should
10 have some impact, do you think she is suggesting that
11 this change should increase hospital participation in
12 the LeapFrog Hospital Survey?

13 MR. BILLEK: Object to the form.

14 You can answer.

15 THE WITNESS: I -- I don't know what impact
16 that implies in that statement.

17 BY MR. HVIDT:

18 Q. And just to confirm, there was no board vote in
19 June 2024 on whether LeapFrog should change its safety
20 grade methodology in this regard; is that correct?

21 A. That's correct. We don't vote on the
22 methodology.

23 MR. HVIDT: Consistent with the last exhibit,
24 this is a document that was produced to us on Sunday
25 without Bates numbers with an indication that Bates

1 numbers versions would be following but haven't
2 followed yet. Are we in agreement that we can use
3 this document in the same regards?

4 MR. BILLEK: Of course.

5 MR. HVIDT: Thank you.

6 (Exhibit No. 8 was marked for identification.)

7 MR. HVIDT: I have handed the witness what will
8 be marked as Exhibit 8.

9 I'm so sorry.

10 MR. BILLEK: That's all right.

11 BY MR. HVIDT:

12 Q. Did I hand you two?

13 A. Oh, yes, actually. I'm sorry.

14 Q. Thank you.

15 MR. HVIDT: That may have been why I thought
16 that you already had one.

17 MR. BILLEK: That's all right. I don't want
18 anybody at Gibson Dunn to get fired over that
19 photocopying issue.

20 MR. HVIDT: We have handed the witness what is
21 titled at the top, Minutes, The LeapFrog Group Board
22 of Directors September 25, 2024, Zoom.

23 BY MR. HVIDT:

24 Q. Do you see that?

25 A. Yes.

1 Q. And do you see under attendees, your name is
2 listed?

3 A. Yes.

4 Q. And consistent with the exhibit two exhibits ago,
5 are minutes for LeapFrog Group board of directors
6 meetings prepared in the ordinary course of business?

7 A. Yes.

8 Q. Do you have any understanding to doubt or reason
9 to doubt the accuracy of the information in this
10 document?

11 A. No.

12 Q. And do you have an understanding of the time of
13 the year where LeapFrog's methodology is locked in for
14 how it's going to report for when -- how it's going to
15 report grades for the upcoming cycle?

16 A. No, I don't.

17 Q. And you're sitting there September 25, 2024, and
18 there's a grade cycle that's in the late fall and fourth
19 quarter of 2024; is that correct?

20 A. I don't know when they publish the fall scores,
21 but the last quarter sounds correct.

22 Q. And do you think that the LeapFrog methodology
23 that it was using for the fall of '24 would have been
24 locked in by this meeting?

25 A. I don't know.

1 Q. At this meeting, was there a vote on whether
2 LeapFrog should change its methodology for how it grades
3 nonparticipating hospitals?

4 A. No. We don't vote on methodology changes.

5 Q. And if you flip to the second-to-last page of the
6 minutes, the very bottom, do you see where it says,
7 Safety grade methodology change underlined?

8 A. Yes.

9 Q. And then carrying forward onto the last page, do
10 you see a description of the LeapFrog's safety grade
11 methodology change?

12 A. Yes.

13 Q. And do you see in that first sentence where it
14 says, LeapFrog uses an imputation model to be able to
15 grade hospitals even if they do not submit a LeapFrog
16 Hospital Survey?

17 A. Yes.

18 Q. Is it your understanding that if LeapFrog didn't
19 use an imputation model, it would not be able to grade
20 hospitals that do not submit a LeapFrog Hospital Survey?

21 MR. BILLEK: Object to form.

22 You can answer.

23 THE WITNESS: I -- I don't know if it would be
24 appropriate to have a different methodology for
25 nonresponding hospitals. So I think that using the

1 imputation model is so that they can use the same
2 approach for all hospitals. I'm not sure I'm
3 answering your question.

4 BY MR. HVIDT:

5 Q. Understanding, yeah, yeah --

6 A. Yeah.

7 Q. -- so I'll have a couple follow-ups on that.

8 A. Okay.

9 Q. The first question is, using the words in the
10 document?

11 A. Right.

12 Q. And so I'm just trying to get an understanding of
13 how that -- that sentence is structured. In there, it
14 says that LeapFrog uses an imputation model to be able
15 to grade hospitals even if they do not submit a LeapFrog
16 Hospital Survey.

17 Do you see that?

18 A. I do.

19 Q. And so would you take that sentence to mean that
20 if LeapFrog didn't use an imputation model, it would not
21 be able to grade hospitals if they did not submit the
22 LeapFrog Hospital Survey?

23 A. I read the sentence to say that's how -- the
24 imputation model is how they are able to grade
25 hospitals. I don't know that it says that without it,

1 they could not. I wouldn't take it that far in my
2 reading of that sentence.

3 Q. Okay. And you mentioned that you don't think it
4 would be appropriate to have a different methodology for
5 nonresponding hospitals. Is that correct?

6 A. That is not a fully formed thought. I was trying
7 to think as I was speaking how you would do that. So
8 I -- I probably should retract my comment because it's
9 not a fully formed thought. I'm trying to think out
10 loud in response to your question.

11 Q. Do you think that all hospitals should be graded
12 on the same methodology?

13 A. I think that it's complicated to answer that
14 question because if the hospitals don't participate and
15 you're missing a couple of items, you have to find
16 another way to put a value in.

17 Q. But if you're putting a value in, are you not --
18 are you grading them in a different methodology because
19 you don't have the data for those missing measures?

20 A. No. If your methodology states and it's publicly
21 available and the hospitals know that ahead of time,
22 this is the methodology, if you choose not to respond,
23 we're still grading you and this is how it will be
24 calculated. So it is the same methodology. It's not a
25 different methodology.

1 Q. Are nonresponding hospitals and responding
2 hospitals graded in the same manner?

3 A. I don't know how to interpret that question.
4 I -- I don't know what happens behind the development of
5 the grade. So I can't answer that question.

6 Q. Setting LeapFrog aside for the minute, if you are
7 grading hospitals, shouldn't you try to grade the
8 hospitals on the same measures?

9 MR. BILLEK: Object to form.
10 You can answer.

11 THE WITNESS: LeapFrog gives the opportunity
12 for every hospital to respond to the questions. And
13 they have in the methodology, we're doing this grade.
14 You should respond to the survey to ensure that your
15 achievement of that measure is reflected. In the
16 absence of that, here is the methodology that we use.

17 BY MR. HVIDT:

18 Q. And in that approach, is that approach clear to
19 those who use the LeapFrog grades to make their
20 decisions about where to receive healthcare?

21 MR. BILLEK: Object to form.

22 THE WITNESS: I can tell you that the Florida
23 Alliance in our role as regional leader makes sure
24 that the employers who are in our membership
25 understand that. LeapFrog has always been very

1 transparent on their website for the hospitals on the
2 methodology or the materials that are sent to them.

3 BY MR. HVIDT:

4 Q. Do you think that LeapFrog is clear that it is
5 penalizing nonresponding hospitals for not participating
6 in the survey?

7 A. I think LeapFrog is very clear that they'll give
8 limited achievement for that measure in the absence of
9 having any other information.

10 Q. And do you agree that giving limited achievement
11 to a hospital that doesn't participate in the LeapFrog
12 Hospital Survey is a penalty for not participating in
13 the LeapFrog Hospital Survey as it relates to the grade?

14 A. No. I don't see it has a penalty.

15 Q. What do you see it as?

16 A. I see it as the best possible guess, estimate,
17 proxy for that measure in the absence of having any
18 other information. Why would you say that there's been
19 a higher level of achievement when there's no evidence
20 to support that?

21 Q. And why would you say that there's a lower level
22 of achievement when there's no evidence to support that?

23 A. Because -- well, it says in the previous,
24 LeapFrog would look at their most recent scores from
25 four rounds, they're looking at the last two rounds. So

1 I don't know if there's some level of analysis. Again,
2 I've said it so many times, I don't know how the
3 methodology works. I don't know what happens behind the
4 scenes and why they came up with, after deliberation on
5 the expert panel, that putting limited achievement as
6 the appropriate way to fill in that gap, I had -- I've
7 not thought of that as a penalty. I've thought of that
8 as an opportunity for the hospital to provide the
9 information we want to see. We're about transparency
10 and if you know ahead of time what that methodology is
11 in fact, then that gives you every opportunity to put
12 the answer in that reflects your achievement.

13 Q. Again, why would you say that a lower level
14 achievement score is appropriate for a nonresponding
15 hospital when there's no evidence to support that?

16 MR. BILLEK: Object to form.

17 THE WITNESS: I think it's more appropriate to
18 give that level than it is to assume that they've had
19 a higher level of achievement.

20 BY MR. HVIDT:

21 Q. But when you're giving a lower -- lowest level of
22 achievement, aren't you also -- are you assuming that
23 they wouldn't -- that they would get the lowest level?

24 A. I'm not making any assumptions. I don't
25 understand your question.

1 Q. By assigning the lowest level of achievement to
2 nonparticipating hospitals, for the imputed measures,
3 LeapFrog is not trying to estimate their performance had
4 they responded to the survey; is that correct?

5 A. You showed me a document that had wording that
6 said this is how LeapFrog is estimating their
7 performance, a few minutes ago -- a few documents ago.

8 Q. I showed you a document that showed that the
9 LeapFrog staff communicated to the board that they're
10 trying to estimate --

11 A. Correct.

12 Q. -- the -- that they're trying to estimate the --
13 what the nonparticipating hospital would have achieved
14 by assigning them a lowest score; is that correct?

15 A. The document that we looked at said that they're
16 trying to estimate what the nonparticipating hospital
17 would have achieved, but I don't remember it saying by
18 assigning the lowest score. I don't remember seeing
19 that tag on to the statement.

20 Q. And when the LeapFrog staff communicated to the
21 board of directors that they were trying to estimate how
22 the hospital would have performed had it participated in
23 the LeapFrog survey by assigning the lowest possible
24 score, did you take them as being truthful in that?

25 A. I don't remember the specific discussion. I know

1 it's written like this. I didn't have any reason to
2 think that I wasn't being told the truth.

3 Q. Looking back at the minutes, if we go down -- I
4 think it's probably like eight lines down, do you see
5 where it says, This means hospitals?

6 A. I see that.

7 Q. Sentence reads, This means hospitals that have
8 not reported their performance to LeapFrog will have a
9 lower score for the imputed measures.

10 Do you see that?

11 A. Yes.

12 Q. And so by that sentence, LeapFrog staff was
13 updating the LeapFrog board that nonparticipating
14 hospitals would automatically have a lower score for the
15 imputed measures.

16 Is that correct?

17 A. Yes.

18 Q. And then it goes on to say that, These measures
19 are CPOE, BCMA, IPS and hand hygiene.

20 Do you see that?

21 A. Yes.

22 Q. The next sentence says, Hospitals can still get
23 an A if they fall into this category but it does make it
24 harder.

25 Do you see that?

1 A. Yes.

2 Q. And so is the LeapFrog staff communicating to the
3 board that it will be harder for a nonparticipating
4 hospital to receive an A simply by virtue of not
5 participating in the LeapFrog Hospital Survey?

6 MR. BILLEK: Object to form.

7 You can answer.

8 THE WITNESS: I don't know that that full
9 sentence that you said, by -- simply by virtue of not
10 participating, is -- is accurate. They're saying that
11 hospitals can still get an A if they do extremely well
12 in the publicly reported data. They're not going to
13 get that mid-level response without providing their
14 own -- their own data.

15 BY MR. HVIDT:

16 Q. And here, the LeapFrog staff is communicating to
17 the board that it will be harder for nonparticipating
18 hospitals to get an A if they don't participate in the
19 LeapFrog survey and are given an imputed limited
20 achievement score; is that correct?

21 MR. BILLEK: Object to form.

22 You can answer.

23 THE WITNESS: Yes.

24 BY MR. HVIDT:

25 Q. And as I mentioned earlier, it would be harder to

1 get an A -- it has proven to be harder to be getting an
2 A if you're a nonparticipating hospital in the LeapFrog
3 survey. Only two of 550 such hospitals got one in the
4 spring of 2025; is that fair to say that that's harder?

5 MR. BILLEK: Object to form.

6 You can answer.

7 THE WITNESS: What were the numbers prior to
8 that time? I don't know the answer.

9 BY MR. HVIDT:

10 Q. Over 100.

11 MR. BILLEK: Object to form.

12 You can answer.

13 THE WITNESS: So over 100 in the cycles before
14 got As who were a nonrespondent and it went down to
15 two? Okay. And the question was?

16 BY MR. HVIDT:

17 Q. Does that show that it has proven to be harder
18 for nonparticipating hospitals to get an A?

19 A. Yes. I don't know that -- with a caveat. I
20 don't know the detail of the 98 or however, you know,
21 100, whatever number you said. Now I don't remember.
22 200, 100. Hospitals, whether they performed poorly on a
23 CMS measures. I don't know that it's because of those
24 four measures that were imputed. So I would have to
25 revise my answer to say, certainly going from 100 to two

1 shows that there's something happening to reduce the
2 number of As. It could be a combination. It could be a
3 combination of issues.

4 Q. So assigning them the lowest score is likely a
5 contributing factor in --

6 A. I would -- I would say it could be a contributing
7 factor. I don't know that it is the only factor.

8 Q. And again, it is proven harder for a
9 nonparticipating hospital to get an A as there's no
10 Florida nonparticipating hospitals who got an A in the
11 spring of 2025 grading cycle; is that correct?

12 A. Is the question -- the question is it harder for
13 Florida than anyone else, you're saying, or you're just
14 saying has it proven that it's harder?

15 Q. Does the fact that there are no Florida
16 nonparticipating hospitals who got an A in the spring
17 2025 grading cycle confirm that the LeapFrog staff was
18 communicating to the board that this methodology change
19 will make it harder for nonparticipating hospitals to
20 get an A?

21 A. Yes.

22 MR. HVIDT: I have a subject change and it's
23 12:30. Do we want to go off the record?

24 THE WITNESS: Whatever you want to do.

25 MR. BILLEK: Do you want to take a break for

1 lunch or something?

2 MR. HVIDT: Yeah, I'm happy for it to be a
3 brief lunch but I do think we have around two hours
4 remaining.

5 THE COURT REPORTER: Do you want to go off the
6 record?

7 MR. HVIDT: Yeah. Sorry.

8 THE VIDEOGRAPHER: We are off the record at
9 12:31 p.m.

10 (Luncheon recess was taken.)

11 THE VIDEOGRAPHER: We are on the record at
12 12:59 p.m.

13 MR. HVIDT: Thank you.

14 BY MR. HVIDT:

15 Q. Earlier this morning, we talked about Florida
16 Alliance's role as a regional leader for The LeapFrog
17 Group; is that correct?

18 A. Yes.

19 Q. And you talked about how as part of that role,
20 Florida Alliance will send letters to hospitals to
21 encourage their participation in the LeapFrog Hospital
22 Survey; is that correct?

23 A. Yes.

24 Q. And has Florida Alliance sent letters to the
25 plaintiff hospitals in 2025 encouraging them to

1 participate in the LeapFrog Hospital Survey?

2 A. I don't know for sure.

3 Q. Does Florida Alliance have a practice of sending
4 letters to all hospitals in its region to encourage them
5 to participate in the LeapFrog Hospital Survey?

6 A. So Ashley, who I've mentioned, our VP, is in
7 charge of making that determination. I mentioned that
8 sort of extreme answer -- excuse me -- example of a
9 hospital that might be damaged and, you know, not
10 operational or not fully operational. So she does go
11 through, you know, who would be eligible. And the goal
12 is to send, you know, to every -- every eligible acute
13 hospital. So in general, you know, and the different --
14 the different categories.

15 So the shorter answer is, the practice is to send
16 to all applicable hospitals because there are some that
17 are not applicable.

18 Q. Thank you.

19 MR. HVIDT: I'm handing the witness what has
20 been marked as Exhibit 9 in this deposition.

21 (Exhibit No. 9 was marked for identification.)

22 THE WITNESS: Okay.

23 MR. HVIDT: Which has been produced in this
24 litigation as PBHN000018124. It is dated
25 April 23, 2025.

1 Counsel, do you see that date? I'm sorry.

2 Strike that.

3 BY MR. HVIDT:

4 Q. Dr. van Caulil, do you see that date?

5 A. I do.

6 Q. And what is Exhibit 9?

7 A. So this is a letter to -- I don't know if I'm
8 pronouncing his first name correctly -- Jerad Hanlon at
9 West Boca Medical Center and it has that item on the
10 intent to submit. Looks like it's a partial letter. It
11 looks like it's missing the signature page on it. So it
12 doesn't look like a full letter, actually, because if we
13 were to send it, it would be signed. So it's a letter
14 that looks like it's not complete. So I don't know
15 whether -- do you have the remainder of it? Okay.

16 Q. This is the document that was received by --

17 A. Okay.

18 Q. -- Jerad Hanlon at West Boca Medical Center.

19 A. Okay.

20 Q. And produced in the way that he sent it to us or
21 was kept in ordinary course of business. And so looking
22 at the top of the letter, do you see the Florida
23 Alliance for Healthcare Value logo?

24 A. Yes.

25 Q. Do you have any reason to doubt that Florida

1 Alliance sent a letter to West Boca Medical Center?

2 A. I don't have any doubts, but I -- I would say the
3 letter is not -- it's not complete. It's not -- it's
4 missing at least one page.

5 Q. And aside from lacking a signature --

6 A. I don't know the reason why. I'm sorry. I can't
7 speculate as to why. But I know that, you know --

8 Q. Aside from the fact that you're not seeing a
9 signature on this document, do you have any other reason
10 to question that the -- that the substance of the
11 document is inaccurate in any way?

12 A. No, I don't.

13 Q. And is this letter consistent with the letters
14 that Florida Alliance sends to hospitals in Florida to
15 encourage them to participate in the LeapFrog Hospital
16 Survey?

17 A. So I have already mentioned that it is not a
18 complete letter, I don't think. I -- when I've seen
19 copies of the letters, Ashley is signing them and
20 there's more specific information that would be included
21 from my quick perusal of it. So it is not consistent,
22 then, in that somewhere along the way, part of it is
23 missing, I think.

24 Q. Looking at the first page, is the first page of
25 the letter consistent with the first page of the letters

1 that Florida Alliance typically sends to Florida
2 Hospitals to encourage them to participate in the
3 LeapFrog Hospital Survey?

4 A. Yes. I believe so. But the letters come from
5 Ashley Tait-Dinger, so I don't have, you know, exact
6 wording known for the letter. But it looks consistent
7 with what I've seen in the past.

8 Q. Does Ashley Tait-Dinger report to you?

9 A. Yes, she does.

10 Q. Would you -- do you review the templates of the
11 letters before you approve of the template being
12 personalized for the Florida Hospitals?

13 A. No. If she's signing the letter, I may or may
14 not have seen -- seen it. The template comes from
15 LeapFrog and is updated with, I guess, local information
16 if -- if needed.

17 Q. And -- but the nature of this was produced by
18 West Boca Medical Center, do you have any reason to
19 dispute that they received this document?

20 A. No.

21 Q. And in looking at this first page of the letter,
22 do you -- is it fair to say that the letter is trying to
23 encourage West Boca to participate in the LeapFrog
24 Hospital Survey?

25 A. Yes.

1 Q. And it includes a form on the next page asking
2 for its intent to participate or not. Do you see that?

3 A. Yes. And that's what I had mentioned earlier
4 this morning, trying to recall what that looked like,
5 yeah.

6 Q. Absolutely. And there's a comment box where we
7 talked about how there's --

8 A. Correct.

9 Q. -- you might explain why you do not wish to
10 participate?

11 A. Yes.

12 Q. And in looking at this letter, and that's
13 represented in Exhibit 9, do you see any reference to
14 how LeapFrog will assign a low score to the hospital for
15 imputed measures if it doesn't participate in the
16 LeapFrog Hospital Survey?

17 A. No. And again, for the record, wherever along
18 the way there -- there is an aspect of this letter that
19 I'm pretty sure is missing, which would direct the
20 recipient with any questions to LeapFrog to their
21 website for reporting. That's what I believe is missing
22 from this letter.

23 Q. Are you aware whether Florida Alliance produced a
24 copy of this letter in its production?

25 A. I am not.

1 Q. Are you aware whether this document would have
2 been responsive to the subpoena sent to Florida
3 Alliance?

4 A. It should have been. At the time period, yes, it
5 should have been.

6 Q. And do you have any understanding as to why it
7 wasn't produced?

8 A. No. I don't know that it wasn't produced.

9 Q. When did you become aware of the lawsuit that was
10 filed by plaintiff hospitals for the -- that the
11 deposition that you're taking is within?

12 A. I was at our annual conference on May 1st and I
13 think I got an e-mail from Leah that day. I remember
14 seeing -- seeing it then. I think that there were some
15 conversations maybe earlier than that that it might
16 happen. Yeah. Late April or so.

17 Q. So you were informed in late April or so that
18 there might be a litigation; is that correct?

19 A. I think that sounds like the time period. Yes.

20 Q. And how were you informed?

21 A. I don't remember specifically whether it was in a
22 meeting or reading something that said that there had
23 been conversations between the hospitals and LeapFrog
24 about not displaying the grade and when LeapFrog said
25 we're going to display the grade, the information that I

1 got was we could expect a lawsuit as a result.

2 Q. And would that have come in the capacity as a
3 board member?

4 A. I don't recall.

5 Q. Were -- when you had that communication, were you
6 asked to do anything before the lawsuit was filed by
7 LeapFrog?

8 A. Only if any calls or e-mails or letters were
9 directed to us, to send them to Leah or Karen, whoever
10 at LeapFrog, and also not to speak to the media.

11 MR. HVIDT: I am handing the witness what's
12 been marked as Exhibit 10 in this deposition.

13 (Exhibit No. 10 was marked for identification.)

14 MR. BILLEK: Thanks.

15 MR. HVIDT: Exhibit 10's Bates number will be
16 FHA0002804. It was produced in this litigation by
17 Florida Alliance.

18 BY MR. HVIDT:

19 Q. Dr. van Caulil, do you see the document that I've
20 handed you?

21 A. Yes.

22 Q. Do you see that the top e-mail is an e-mail from
23 Chris Skisak to Leah Binder, regional leaders of
24 LeapFrog, board members of LeapFrog, with copy to Missy
25 Danforth, Karen Jupiter and Lauren Bailey regarding

1 spring safety grade lawsuit?

2 A. Yes.

3 Q. And you mentioned earlier that you received an
4 e-mail from Leah Binder on May 1, 2025, regarding the
5 lawsuit. Is that correct?

6 A. Yes. As I said, we had our annual conference
7 that day and I looked at my phone and saw the e-mail.

8 Q. And looking down at the e-mail from Leah Binder,
9 do you see where she cites the hospitals involved in the
10 lawsuit?

11 A. Yes.

12 Q. Do you see next to the hospitals involved in the
13 lawsuit, she puts their spring grade. Do you see that?

14 A. I do.

15 Q. And in your own words, how would you characterize
16 Leah Binder's e-mail to the regional leaders and the
17 board members here?

18 A. So she's certainly alerting the board and the
19 regional leaders to the fact that there's a lawsuit
20 that's been filed. And that they're going to do what it
21 takes to defend LeapFrog's position. She -- I'm just
22 looking down -- yes, she did attach the statement that
23 she had put together. That was the other document that
24 I had seen at or around that same time. And also to
25 please, you know, let people know that if they had any

1 questions, who to refer to.

2 Q. And do you see Chris Skisak's response above?

3 A. Chris Skisak, yes. He's my counterpart at the
4 Houston Business Coalition on Health, yes, I see it.

5 Q. So is he a regional leader?

6 A. The Houston Business Coalition on Health is a
7 regional leader, yes.

8 Q. Is he a member of the board of LeapFrog?

9 A. No.

10 Q. Do you see the second sentence of his e-mail, he
11 writes, In this case, the grades are doing what we all
12 hope - steer patients away from unsafe hospitals to more
13 safe ones, close quote.

14 A. Yes, I see that.

15 Q. Do you agree with him?

16 A. I wouldn't characterize the situation that way.

17 Q. Do you agree that a low LeapFrog grade steers
18 patients away from those hospitals?

19 A. I think it can. I think that patients take in a
20 lot of information in seeking hospital care. Oftentimes
21 they're going at the request -- at the recommendation of
22 their physician. I don't know that they're looking at
23 the -- at the grades. But it certainly could, if
24 somebody was aware of the hospital safety grades, give
25 them pause and to investigate further.

1 Q. And is one of the reasons why LeapFrog publishes
2 safety grades to influence consumer decisions about what
3 hospitals they should get their care at?

4 A. I wouldn't use the word influence. LeapFrog does
5 this to promote transparency so that consumers and
6 employers, purchasers of health services, have
7 information about patient safety performance. And they
8 are free to look at the methodology and the approach and
9 make their own decision about whether they agree with it
10 and should take that grade under consideration.

11 Q. Do you understand that LeapFrog's own documents
12 notes that one of the reasons for their hospital safety
13 grades is to influence consumer hospital decisions?

14 A. I haven't seen that written.

15 Q. In going back to Chris's e-mail, he references
16 steering patients away from unsafe hospitals.

17 Do you see that?

18 A. I do.

19 Q. And so is he connecting unsafe hospitals with the
20 letter grades D and F?

21 A. I don't know what Chris is doing.

22 Q. Would you characterize an F and D grade to be an
23 unsafe hospital?

24 A. I always look at the whole picture: The hospital
25 survey information, the safety grade information, when

1 we're -- when I'm personally seeking care, elderly
2 mother, and look at the history. So I'm a different
3 person than the general community, I will give that.
4 But I think it's part of a story and should be looked
5 at, you know, alongside other -- other sources.

6 Q. And that part of the story can impact decisions
7 made about where to receive healthcare --

8 A. Yes.

9 Q. -- is that correct?

10 A. Yes.

11 Q. And when you say that it's always good to look at
12 the whole picture, would you consider part of the whole
13 picture to include whether or not that hospital
14 participated in the LeapFrog survey?

15 A. For me personally, yes.

16 Q. Do you think that that's something that the
17 general consumer of the LeapFrog grade understands?

18 A. I don't know.

19 Q. You can set that to the side for the moment.

20 After receiving notice from Leah Binder of the
21 lawsuit, did you then notify your board at Florida
22 Alliance?

23 A. Yes.

24 Q. And going back to our discussion this morning,
25 your board, other than yourself, are representatives

1 from Florida employers; is that correct?

2 A. Yes, that's correct.

3 MR. HVIDT: I'm handing the witness what's been
4 marked as Exhibit 11 in the van Caulil deposition. It
5 was produced by the Florida Alliance as FHA0001995.

6 (Exhibit No. 11 was marked for identification.)

7 MR. HVIDT: Momentarily going back to
8 Exhibit 10. Exhibit 10 was produced by the Florida
9 Alliance as FHA0001739.

10 BY MR. HVIDT:

11 Q. Dr. van Caulil, do you see Exhibit 11 as an
12 e-mail chain regarding lawsuit against LeapFrog from
13 hospitals in Palm Beach County by and among you and your
14 board and Ashley Tait-Dinger in May of 2025?

15 A. Yes.

16 Q. And if you could go down to your original e-mail
17 dated May 6, 2025, on the third-to-last page.

18 A. Okay.

19 Q. Do you see your e-mail there to your board with
20 copy to Ashley that initiates this chain?

21 A. Yes.

22 Q. And included in your e-mail to your board of
23 Florida employers, you included the same lists of the
24 plaintiff hospitals that Leah Binder included in her
25 e-mail, along with the LeapFrog spring 2025 grade for

1 the hospitals.

2 Do you see that?

3 A. Yes.

4 Q. And so when you send an e-mail to your board, you
5 expect them to hopefully read the e-mail; is that
6 correct?

7 A. Yes.

8 Q. And your board, as we walked through in a
9 back-of-the-napkin manner, might have an employee or
10 covered lives number in Florida around 100,000; is that
11 fair?

12 A. Yes. We came to that earlier.

13 Q. And here in this e-mail, you are alerting them to
14 the plaintiff hospitals with their LeapFrog spring 2025
15 grade next to them; do you see that?

16 A. Yes.

17 Q. And if you flip to the next page, do you see the
18 paragraph beginning, I asked what protection?

19 A. Yes.

20 Q. Farther down, you write in that paragraph, We
21 have not sent these hospital CEOs the requests to
22 complete this survey as it would likely fan the flames.

23 Do you see that?

24 A. Yes, I do see that.

25 Q. What do you mean by that?

1 A. So as it says also earlier in the letter, I did
2 have a call with the LeapFrog attorney a few days before
3 that and felt that it would upset the CEOs to receive
4 those letters. And now Leah had wanted us to go ahead
5 and to send those letters and -- after this time of
6 this -- after this was sent. And we waited and I had
7 forgotten -- I had forgotten there was a period of time
8 in there where we didn't want to do that. So then the
9 letters were eventually sent, because of the later
10 sentence there, Business as usual, not to change course.

11 Q. Understood. And so there was a decision
12 initially to not send the hospital CEOs a request to
13 complete the LeapFrog Hospital Survey?

14 A. Yes.

15 Q. And later, there was a change?

16 A. Yes.

17 Q. And LeapFrog -- and Florida Alliance did send
18 letters to the plaintiff hospitals asking them to
19 participate in the LeapFrog survey?

20 A. Yes.

21 MR. BILLEK: Scott, when you have a second, I
22 just need a two-second break for an urgent matter I
23 have to deal with. I'm sorry to interrupt you and I'm
24 not trying to jam up your -- so whenever you get a
25 minute.

1 MR. HVIDT: Totally understand. Mind if we
2 quickly finish this document? We're pretty close.

3 MR. BILLEK: Of course. Finish your topic.
4 Thank you.

5 BY MR. HVIDT:

6 Q. At the time of this e-mail, it wasn't yet clear
7 whether LeapFrog's counsel would be your counsel; is
8 that correct?

9 A. That's correct.

10 MR. HVIDT: I can pause there for you to go
11 deal with your matter.

12 MR. BILLEK: Thank you.

13 MR. HVIDT: We can go off the record.

14 THE VIDEOGRAPHER: We're off the record at 1:25
15 p.m.

16 (A brief recess was taken.)

17 THE VIDEOGRAPHER: We are on the record at 1:31
18 p.m.

19 BY MR. HVIDT:

20 Q. Looking back at the page in Exhibit 12 that we're
21 looking at --

22 A. I think we're looking at 11.

23 Q. We're looking at Exhibit 11, the page we're still
24 at, in the following paragraph that begins, We also
25 decided.

1 Do you see that?

2 A. Yes.

3 Q. In this paragraph, is it fair to say that you are
4 contemplating whether to include reference to this
5 lawsuit in the weekly bulletin sent to the Florida
6 employer members that you have? And if so, what amount
7 of information?

8 A. Yes. I was asking the board if we should alert
9 the employer members because you showed earlier, you
10 know, our members are displayed, you know, publicly, in
11 case they were contacted by the media or anyone so they
12 would know ahead of time and they would know who to
13 direct their questions to. I wasn't sure what to do. I
14 was asking for board guidance on that.

15 Q. And ultimately, you -- the decision was made to
16 include a reference in the weekly bulletin to the
17 lawsuit; is that correct?

18 A. Yes. The board members wanted us to do that.

19 Q. Handing you what's been marked as Exhibit 12 in
20 the van Caulil deposition.

21 (Exhibit No. 12 was marked for identification.)

22 BY MR. HVIDT:

23 Q. Which was produced in this litigation by Florida
24 Alliance as FHA0000001.

25 Do you see Exhibit 12 before you, Dr. van Caulil?

1 A. Yes.

2 Q. And what is Exhibit 12?

3 A. So I mentioned earlier in the deposition that we
4 communicate with our employer members via a weekly
5 bulletin. And this is the one that went out on May 9th.

6 Q. And so this weekly bulletin that went out on
7 May 9th was distributed to all of the Florida employer
8 members of the Florida Alliance for Healthcare Value; is
9 that correct?

10 A. Yes. Each of the employer members would have
11 received this via e-mail on that day.

12 Q. And earlier, we discussed that the employer
13 members of the Florida Alliance for Healthcare Value
14 represented approximately three to 400,000 Florida
15 employees or covered lives a few years ago and that
16 might be a fair approximation of where it sits today; is
17 that correct?

18 A. Yes.

19 Q. And if you flip through this document, which
20 hopefully has page numbers, to page 7. Do you see where
21 there's a blue banner that says, The LeapFrog Group?

22 A. Yes.

23 Q. And if you scroll down to the bottom of that
24 section, do you see where it says, As you may have
25 heard, a lawsuit has been filed against The LeapFrog

1 Group on behalf of five hospitals in Palm Beach County,
2 requesting that The LeapFrog Group suppress their grades
3 on the safety score website.

4 A. Yes.

5 Q. And then you go on to say if they have questions
6 or inquiries, to direct them to Karen Jupiter at The
7 LeapFrog Group; do you see that?

8 A. Yes.

9 Q. Are weekly bulletins prepared in the ordinary
10 course of Florida Alliance business?

11 A. Yes.

12 Q. You can set that to the side.

13 MR. HVIDT: Can we go off the record
14 momentarily?

15 THE VIDEOGRAPHER: We are off the record at
16 1:37 p.m.

17 (A brief recess was taken.)

18 THE VIDEOGRAPHER: We are back on the record at
19 1:39 p.m.

20 MR. HVIDT: Thank you.

21 BY MR. HVIDT:

22 Q. Dr. van Caulil, did you attend a board meeting in
23 June of this year for The LeapFrog Group?

24 A. Yes. I wasn't able to attend for the full time,
25 but I was there for a good portion of the meeting.

1 Q. And during that board meeting, was there a report
2 on the lawsuit?

3 A. I don't recall. I assume you're looking for the
4 minutes or agenda from it, so if I could refresh my
5 memory. Sorry the jump to conclusions, but --

6 Q. That one was helpful.

7 A. Yeah.

8 MR. HVIDT: And so I'm handing the witness
9 what's been marked as Exhibit 13 in the van Caulil
10 deposition, which is a document that was produced by
11 The LeapFrog Group on Sunday without Bates numbers and
12 we haven't yet received the Bates-copied version.

13 I'll note on the record an item for all the
14 documents produced by LeapFrog Group on Sunday that
15 don't have Bates numbers, that LeapFrog Group asks
16 that they be confidential, and so we'll have the
17 transcript be confidential while those portions are
18 designated as confidential moving forward.

19 Is that okay with you, Counsel?

20 (Exhibit No. 13 was marked for identification.)

21 MR. BILLEK: Yes.

22 BY MR. HVIDT:

23 Q. And, Dr. van Caulil, do you see that the top of
24 this document says, LeapFrog Group board meeting agenda?

25 A. Yes.

1 Q. And do you see the date of it is June 25, 2025?

2 A. Yes.

3 Q. And there's a location in person and a board
4 meeting Zoom link. Do you see that?

5 A. Yes.

6 Q. And is it the practice of The LeapFrog Group to
7 not memorialize and approve minutes at the subsequent
8 board meeting?

9 A. Yes. The practice is you would receive the
10 minutes from this June meeting at the September meeting.

11 Q. So it is the case that here, before the September
12 board meeting occurred, there would not have been
13 minutes at this meeting yet approved; is that correct?

14 A. That's correct. We have not received a draft
15 minutes or a board packet yet.

16 Q. And looking down at the agenda items, do you see
17 where it says five rows down, Executive session?

18 A. Yes.

19 Q. And then it says the -- in the discussion, The
20 board will meet in the executive session with counsel
21 and Leah and three members of the management team to be
22 briefed on a confidential legal matter.

23 Do you see that?

24 A. I do.

25 Q. As part of that discussion, do you recall there

1 being a PR message delivered to the board?

2 A. No, I don't recall. Public relations PR you're
3 saying?

4 Q. Correct.

5 A. No.

6 Q. Do you recall Lauren Bailey communicating --

7 A. Oh, Lauren did a presentation. Okay. I guess I
8 wouldn't have called that PR. But yes. Lauren did a
9 presentation.

10 Q. What would you call that presentation that Lauren
11 did?

12 A. Communications.

13 Q. Do you recall when Lauren gave that presentation
14 that there was a slide deck accompanying that
15 presentation?

16 A. Yes. There were slides, yes.

17 Q. And did the slides follow along with oral
18 communication that she gave to the board?

19 A. Yes.

20 Q. You can set that one to the side.

21 MR. HVIDT: I'm handing Dr. van Caulil a
22 document that's been marked as Exhibit 14, which was
23 produced in this litigation by LeapFrog as
24 LEAPFROG00402156, as previously marked as Bailey
25 Exhibit 42.

1 (Exhibit No. 14 was marked for identification.)

2 BY MR. HVIDT:

3 Q. Do you see that, Dr. van Caulil?

4 A. Yes, I do.

5 Q. And flipping through the document, and please
6 take your time, could you let us know if the message on
7 the page is consistent with what you recall being orally
8 communicated by Lauren Bailey at the board meeting?

9 A. Yes.

10 Q. Looking in the document, Exhibit 14, do you see
11 under slide 2 where it says, Slide 2?

12 A. Yes.

13 Q. Do you see where Lauren says, quote, We will make
14 it painful for Tenet by drawing further attention to
15 their very poor performance with strategic media
16 coverage and local and national press?

17 A. Yes.

18 Q. Is that consistent with the message that Lauren
19 gave to the board at the June 2025 board meeting?

20 A. To the best of my recollection, yes.

21 Q. Do you see down in that first page where it says,
22 Slide 7, and then there's three sub-bullets there?

23 A. Yes.

24 Q. And there's a bold part where he says, They say
25 we are weaponizing fear, distorting facts and misleading

1 the public.

2 Do you see that?

3 A. I do.

4 Q. And her response is, Our methodology is
5 100 percent transparent and completely unbiased.

6 Do you see that?

7 A. I do.

8 Q. Do you believe that the LeapFrog methodology is
9 completely unbiased?

10 A. I do.

11 Q. Do you have an understanding that the LeapFrog
12 safety grade expert panel does not agree that it's
13 completely unbiased?

14 A. No.

15 Q. Flipping over to the next page, do you see where
16 there's a reference to Slide 9?

17 A. Yes.

18 Q. And then three sub-bullets down, it says quote,
19 We also like to focus on the poor performance of these
20 hospitals earning a D and F.

21 Do you see that?

22 A. Yes.

23 Q. And so in this communication, is LeapFrog
24 equating a D and F to the poor performance of the
25 hospitals?

1 A. Is that a question?

2 Q. Yes. The question was, in this communication, is
3 LeapFrog staff equating to the board poor performance to
4 the hospitals receiving a D and an F?

5 A. Yes.

6 Q. And so when someone is communicating that the
7 hospitals received a D and an F, that's consistent with
8 trying to communicate that they are poor-performing
9 hospitals; is that correct?

10 A. Poor performing on the hospital safety grade,
11 yes.

12 Q. Looking at slides 10 and 11, Lauren references
13 how they've garnered 18 original stories about the
14 lawsuit.

15 Do you see that?

16 A. I do.

17 Q. When you heard the word -- or garnered, a similar
18 message, did you interpret that to mean that The
19 LeapFrog Group was taking efforts to put the lawsuit
20 into the press?

21 MR. BILLEK: Object to form.

22 You can answer.

23 THE WITNESS: I -- when I was hearing the
24 presentation, my interpretation was that both sides
25 were engaging the media heavily to get their story

1 across.

2 BY MR. HVIDT:

3 Q. You also mentioned earlier today that you had
4 read some references about the lawsuit in the press
5 before; is that correct?

6 A. Yes.

7 Q. And had you read about the Palm Beach Post
8 articles?

9 A. I -- I couldn't say specifically.

10 Q. Okay.

11 A. Sorry.

12 Q. Is it fair to say that there was local Florida
13 press about the lawsuit that highlighted the hospital's
14 D and F grades?

15 A. So it's an interesting question because I had to
16 look for it, you know, to Google, if you will, to be
17 able to pull up the articles. I didn't see anything in
18 the normal course of my engaging with the news media,
19 and I had board members and other people who knew about
20 this say, I haven't heard a thing. I haven't heard
21 anything. I haven't seen anything. I have a board
22 member who lives in Palm Beach County, I have other
23 employer members down there that said, I haven't seen
24 anything.

25 So while there was local Florida press about the

1 lawsuit, I don't know that it was pervasive. And I
2 don't know that it all had the grades in it, depending
3 on which side of the issue, plaintiff or the defendant,
4 were telling the story. So I just thought that was
5 interesting that most people in my circle hadn't seen or
6 heard anything about it. And that surprised me.

7 Q. In today's news cycles, there's a lot of news
8 happening. Is that fair to say?

9 A. Yes, there's a lot of news happening.

10 Q. And often when you -- we're no longer in the days
11 where we got a morning paper and that's a primary way
12 where we got the morning -- got the news; is that right?

13 A. Yes.

14 Q. And we're no longer in a day where there's three,
15 four nightly news stations that you tune into to get the
16 news for the day --

17 A. Yes.

18 Q. -- is that correct?

19 A. Yes, unfortunately that's the case.

20 Q. I agree that's unfortunate.

21 And so the fact that you need to search for news
22 that you're looking for doesn't mean that people aren't
23 consuming it?

24 A. Correct. But my point is that the people who I
25 thought would have heard about it hadn't, quote, seen

1 anything, their words, on it. If you go back to the
2 discussion we had about the board and what should we do
3 and say, I was concerned that, you know, they would read
4 about it in the media before hearing it from us and they
5 know we're a regional leader, we'd be associated in some
6 way.

7 Q. And I'll come back to that momentarily.

8 When you have those conversations with them, did
9 you fill them in about the lawsuit?

10 A. No.

11 Q. Flipping to the last page of this document before
12 we set it aside. Do you see in the second-to-last
13 paragraph, Lauren mentions your name. Do you see that?

14 A. I do.

15 Q. And what is Lauren referring to there?

16 A. So in July, I'm going to say mid July, the Bruce
17 Bradley fellows, are you familiar with that program in
18 LeapFrog? It's a fellowship that they have. They were
19 coming down to Florida, specifically to Orlando,
20 specifically to AdventHealth, to have their educational
21 session and such. And Leah had asked -- well, actually,
22 Joe Berger, who runs the regional leader program, asked
23 Ashley, my vice president, if she would attend that
24 meeting, Leah would be there, Jill would be there, the
25 fellows would be there, AdventHealth was going to do a

1 big presentation on their patient safety.

2 Ashley was unable to come for medical reasons.
3 She lives in the state of Washington right now. So I
4 was to attend. And so Leah said to me, or somebody on
5 her staff said Leah has had a conversation with the CEO
6 of Jupiter Medical Center. She was thanking them for
7 their straight As. And in the course of the
8 conversation mentioned the Florida Alliance and the CEO
9 is not familiar with your organization. And Leah
10 thought it might be a good opportunity when she's in
11 Florida to go down to Jupiter Medical Center, learn from
12 them what they've done to be able to achieve straight As
13 and have me and an employer member or two come along to
14 talk about the Florida Alliance.

15 And so I said that, you know, I would -- I would
16 be able to do that. And I had a couple of employer
17 members who are willing to attend. I -- my intent in
18 the meeting for us was to be able to educate about the
19 Florida Alliance. We do a lot, a lot more than
20 LeapFrog. It's a very small percent of the work that we
21 do. And hospital CEOs like to meet with employers in an
22 area and use it as that opportunity, not to, you know,
23 really get into any kind of LeapFrog discussion.

24 The meeting was subsequently canceled. Leah did
25 not come to Florida at all. She had -- I believe it was

1 her brother having surgery and so she reached out to me
2 and said that the meeting was canceled. I could go
3 ahead if I wanted to and meet with them. But as this
4 lawsuit was progressing, I was not really feeling
5 comfortable with going down to Palm Beach and having my
6 employers brought into the mix in case anything had come
7 up about the lawsuit.

8 So I was fine with the meeting being canceled.
9 We had no prep calls. I never rescheduled and there's
10 been nothing further.

11 Q. You mentioned that your intent behind the meeting
12 was to connect your employer members to a CEO who wasn't
13 aware of the Florida Alliance.

14 A. That's correct.

15 Q. What -- thank you.

16 A. Sorry.

17 Q. What was -- what was communicated to you from
18 LeapFrog as to what their intent was for the meeting?

19 MR. BILLEK: Just note my objection.

20 You can answer.

21 THE WITNESS: Leah told me and then also in
22 this meeting, the board meeting, that it was to
23 highlight and spotlight and congratulate Jupiter
24 Medical Center on their achievement. I learned that
25 they were setting up media interviews, and I did say

1 that we would not be participating in anything like
2 that.

3 BY MR. HVIDT:

4 Q. Did LeapFrog communicate to you that they were
5 trying to keep LeapFrog in the news in Palm Beach
6 County?

7 A. I don't remember them saying it that way and that
8 that would be a way to do that, so no.

9 Q. Did LeapFrog communicate to you that they were
10 trying to portray Jupiter in contrast to plaintiff
11 hospitals in the media and with employers?

12 A. I would say yes.

13 Q. And in one of the -- and in trying to contrast
14 Jupiter Medical Center with the plaintiff hospitals, did
15 LeapFrog want to contrast Jupiter's A LeapFrog grade
16 with plaintiff hospital's D and F LeapFrog grades?

17 MR. BILLEK: Object to form.

18 You can answer.

19 THE WITNESS: I don't know what their plan was
20 for that. The gist of the message was, here's a
21 straight A hospital in an area where we have several
22 hospitals who haven't achieved that level of success
23 with our grading. So what are you doing differently
24 and innovatively around patient safety and quality
25 that we can learn from and perhaps share?

1 BY MR. HVIDT:

2 Q. You can set that document to the side.

3 A. The pile's getting a little smaller.

4 Q. That, it is.

5 A. It's getting higher over here.

6 Q. Did the Florida Alliance reach out to its -- some
7 of its members to see if they would be willing to
8 participate in the meeting with Jupiter Medical Center?

9 A. Yes, I did.

10 MR. HVIDT: I've handed the witness what has
11 been produced in this litigation by Florida Alliance
12 as FHA0000907.

13 (Exhibit No. 15 was marked for identification.)

14 THE WITNESS: Yes.

15 BY MR. HVIDT:

16 Q. Do you see Exhibit 15 in front of you?

17 A. I do.

18 Q. And what is Exhibit 15?

19 A. So this is an e-mail that Lisa Hain sent to check
20 in with Nancy Bolton, who is the benefits person at Palm
21 Beach schools, to see if she's available to attend that
22 meeting at Jupiter Medical Center. We already had Susan
23 McBroom, who we talked about earlier today, at Patriot
24 Rail, who had said that she would attend. And she sent
25 that on July 1st. I was in Europe at the time.

1 Q. And earlier today, we talked about Lisa Hain's
2 role with Florida Alliance. Do you recall that?

3 A. Yes.

4 Q. And you said that she performs an administrative
5 role and will coordinate communication. Is that fair?

6 A. I wouldn't say she coordinates communication.
7 She supports us in our communication effort.

8 Q. And so when -- before we presented you with
9 Exhibit 15, you mentioned that you sent a message to
10 some of your Florida employer members about
11 participating in the meeting with Jupiter Medical
12 Center. Do you recall that?

13 A. Yes.

14 Q. And so when Lisa is the actual sender of this
15 e-mail, did you direct her to send this e-mail?

16 A. So I don't recall that. As I said, I was on
17 vacation. I was in Scandinavia at the time. And I
18 think that I sent e-mails before I left, which would
19 have been -- I think I left June 28th for vacation. And
20 then when either I wasn't hearing from people or they
21 couldn't respond, it could be that Ashley worked with
22 her on this. I don't recall whether I would have
23 e-mailed while I was away. So, I'm sorry, I don't
24 recall. But it was due to the fact that I was -- I was
25 out of pocket.

1 Q. Would either you or Ashley have been the one
2 to -- directed the communication that Lisa Hain sent
3 here?

4 A. Yes.

5 Q. And the substance of the message from Lisa Hain,
6 is that a substance that would have been communicated
7 for her to send by either you or Ashley?

8 A. Yes.

9 Q. And in the message, you're reaching out to Palm
10 Beach schools and Nancy Bolton specifically. Why are
11 you reaching out to Palm Beach schools?

12 A. Because the meeting was going to be in Palm Beach
13 County.

14 Q. And would the meeting being in Palm Beach County
15 also relate to the notion that Jupiter is in Palm Beach
16 County?

17 A. Yes.

18 Q. And would the nature of the meeting in Palm Beach
19 County relate to that the five plaintiff hospitals are
20 in Palm Beach County?

21 A. I would say much less than -- than the issue that
22 Jupiter Medical Center is in Palm Beach County. As I
23 said a few minutes ago, my intent for the meeting was to
24 get to know the CEO, and I presume other team members,
25 who would come so that we could educate them about the

1 Florida Alliance and see where there were opportunities
2 to collaborate.

3 Q. You didn't initiate the meeting request, it
4 wasn't your idea --

5 A. No.

6 Q. -- to come up with the idea for the meeting; is
7 that correct?

8 A. That's correct.

9 Q. Was it LeapFrog's idea to have that meeting?

10 A. I don't know whose idea it was. I don't know
11 whether it came from Jupiter Medical Center or
12 originated from LeapFrog. I don't know.

13 Q. And in this message that was sent, do you see --
14 can you read into the record the last sentence of that
15 main paragraph of the e-mail?

16 A. The purpose of the meeting is to recognize and
17 thank Jupiter Medical Center for the straight As they
18 received as part of the spring LeapFrog Hospital Safety
19 Grades when there are five other hospitals in the county
20 with Ds and Fs.

21 Q. Thank you.

22 And when it references that there are five other
23 counties -- five other hospitals in the county with Ds
24 and Fs, is that a reference to the plaintiff hospitals?

25 A. Yes.

1 Q. Why did Florida Alliance feel a need to include
2 reference to the notion that there are five other
3 hospitals in the county with Ds and Fs?

4 A. I don't recall.

5 Q. And is Palm Beach schools an employer of a decent
6 amount of covered lives in Palm Beach County?

7 A. Yes.

8 Q. And in connecting Palm Beach schools with Jupiter
9 Medical Center, is there a goal to direct Palm Beach
10 schools to have their employees go to Jupiter Medical
11 Center over the five plaintiff hospitals?

12 A. No.

13 Q. Is it a possibility that upon being informed that
14 Jupiter Medical Center gets straight As, in comparison
15 to five hospitals in Palm Beach County that get Ds and
16 Fs from LeapFrog, that Nancy Bolton might direct her
17 employees to go to Jupiter Medical Center instead of the
18 five plaintiff hospitals?

19 A. I don't know whether Nancy Bolton or her
20 leadership would do that.

21 Q. Is it a possibility that upon being informed that
22 Jupiter Medical Center gets straight As, in comparison
23 to five hospitals in Palm Beach County that gets Ds and
24 Fs from LeapFrog, that Nancy Bolton might direct her
25 employees to go to Jupiter Medical Center instead of

1 five plaintiff hospitals?

2 MR. BILLEK: Object to the form of the
3 question.

4 You can answer.

5 THE WITNESS: I don't know if it's a
6 possibility. I don't know if it's a possibility
7 because I don't know what their plan states or their
8 benefit design or their contracts. So I don't know if
9 it's a possibility.

10 BY MR. HVIDT:

11 Q. Is that the intent that LeapFrog had behind this
12 meeting, in juxtaposing Jupiter with plaintiff
13 hospitals?

14 MR. BILLEK: Object to form.

15 You can answer.

16 THE WITNESS: I don't know what the intent was
17 of LeapFrog beyond what I said which was to highlight
18 their -- Jupiter Medical Center's straight As and to
19 give us an opportunity to introduce ourselves.

20 BY MR. HVIDT:

21 Q. But when you were at a board meeting in June of
22 2025, did Lauren Bailey communicate to the board and
23 yourself that LeapFrog wanted to make it painful for
24 Tenet?

25 A. Yes. That was stated.

1 Q. So is it possible that the effort to set up a
2 meeting with Jupiter Medical Center and Florida
3 employers highlighting Jupiter Medical Center's LeapFrog
4 straight As with plaintiff hospitals' Ds and Fs, that
5 that was one of the ways that LeapFrog was trying to
6 make it painful for Tenet?

7 MR. BILLEK: Object to form.

8 THE WITNESS: I don't recall that I make that
9 connection. If LeapFrog wants to highlight a
10 high-performing hospital and give us an opportunity to
11 create a relationship with a hospital, a health system
12 or whoever, who we haven't had the opportunity to work
13 with, I don't translate that to being pain for the
14 other hospitals.

15 BY MR. HVIDT:

16 Q. But LeapFrog's communicated to you that that was
17 their intent behind this meeting; is that correct?

18 A. That was not my intent for the meeting.

19 Q. But did LeapFrog communicate to you that that was
20 their intent for the meeting?

21 MR. BILLEK: Just note my objection to the
22 form.

23 THE WITNESS: No, they did not communicate to
24 me that the intent for the Jupiter meeting was to
25 cause any harm or pain to the five hospitals. It was

1 to spotlight, thank Jupiter Medical Center because
2 you're in a county where not everybody is able to
3 achieve that high level of grade consistently. What
4 is it that you are doing that is innovative and
5 effective that we can learn from? I mean, they're
6 also a 501(c)(3) organization just like the Florida
7 Alliance. And these types of meetings can put a
8 spotlight on things that can be shared broadly.

9 So to me, when it was posed as an opportunity,
10 that's what I saw could happen at the meeting.
11 However, we never had the meeting.

12 BY MR. HVIDT:

13 Q. You never had the meeting but you did have
14 reach-outs to Florida employers, correct?

15 A. I reached out. My staff reached out to Florida
16 employers who live or work in Palm Beach County to see
17 if they were interested in meeting at the hospital.

18 Q. And in those correspondences, you noted that five
19 of the hospitals in Palm Beach County have Ds and Fs, in
20 comparison to Jupiter Medical Center's As; is that
21 correct?

22 A. Yes. That's correct.

23 Q. And -- let's look at another one of those
24 correspondence.

25 Did Nancy Bolton respond to this outreach, do you

1 recall?

2 A. I don't recall. She -- if she did respond, she
3 couldn't make it.

4 MR. HVIDT: I'm handing the witness what's been
5 marked as Exhibit 16, which was produced by Florida
6 Alliance as --

7 THE WITNESS: Oh, okay.

8 (Exhibit No. 16 was marked for identification.)

9 MR. HVIDT: -- FHA0000913, which is the e-mail
10 chain, Re: Join Karen at Jupiter Medical Center
11 July 16th between Lisa Hain and Karen van Caulil at
12 the top.

13 BY MR. HVIDT:

14 Q. Do you see that?

15 A. Yes.

16 Q. And if you flip down to the second page, do you
17 see the response from Nancy Bolton there in the middle?

18 A. Yes, I see it now that she was unable to make the
19 meeting.

20 Q. But in responding to the e-mail, is it fair to
21 say that she had received and consumed the e-mail that
22 was sent to her?

23 MR. BILLEK: Object to form.

24 THE WITNESS: Nancy responded to Lisa's e-mail
25 on July 1st saying she had a school board meeting that

1 day and unable to attend. So I would interpret that
2 as her having read Lisa's e-mail.

3 MR. HVIDT: Thank you.

4 And I'm now handing the witness what's been
5 marked as Exhibit 17, which was produced in this
6 litigation by Florida Alliance as FHA0002804.

7 (Exhibit No. 17 was marked for identification.)

8 MR. HVIDT: Exhibit 17 at the top is an e-mail
9 chain between Ashley Tait-Dinger, Karen van Caulil
10 regarding, Join Karen at Jupiter Medical Center July
11 16, 1:00 p.m. to 3:00 p.m.

12 BY MR. HVIDT:

13 Q. Do you see that?

14 A. Yes.

15 Q. If you flip back to your -- origin of this
16 e-mail, do you see on July 1, 2025, Lisa Hain e-mailed
17 Rosa Novo? Do you see that?

18 A. Yes.

19 Q. And Rosa Novo is the chair of the Florida
20 Alliance board; is that correct?

21 A. Yes.

22 Q. And in this message that was sent, does this
23 message mirror what we looked at in Exhibit 15?

24 A. Yes.

25 Q. And there in that sentence, at the end of that

1 main paragraph, Florida Alliance references Jupiter
2 Medical Center's straight As and then says, When there
3 are five hospitals in a county with Ds and Fs.

4 Do you see that?

5 A. Yes.

6 Q. And Rosa Novo works with Miami-Dade schools; is
7 that correct?

8 A. Correct.

9 Q. And how many covered lives or employees do you
10 recall they had?

11 A. Yeah. That was like 45 or 50,000, I believe I
12 said at the time.

13 Q. And in this message, Florida Alliance is
14 communicating to Rosa that plaintiff hospitals have Ds
15 and Fs and is contrasting that with Jupiter Medical
16 Center's straight As; is that correct?

17 A. I'm sorry? Could you say that again? I was --

18 Q. Yeah. Going back to the original e-mail. In
19 this message, Florida Alliance is communicating to Rosa
20 Novo that plaintiff hospitals have Ds and Fs and is
21 contrasting that with Jupiter Medical Center's straight
22 As.

23 Is that correct?

24 A. So the e-mail does not say it's the plaintiff
25 hospitals. It just says there are five other hospitals

1 in the county with Ds and Fs. That doesn't make any
2 reference to the five hospitals or that they are the
3 ones that are -- that have filed a lawsuit.

4 Q. It doesn't refer to them by name; is that
5 correct?

6 A. That's correct.

7 Q. But are the five -- is the intent here behind
8 Florida Alliance's communication to five other hospitals
9 in the county with Ds and Fs are the five plaintiff
10 hospitals?

11 A. It is referencing the five -- that there are five
12 other hospitals in the county with Ds and Fs. That's
13 what it says. But it does not call them out and it does
14 not point out that it's those five that happen to be in
15 the lawsuit.

16 Q. And -- but it does reference that there are five
17 other hospitals in the county with Ds and Fs?

18 A. Yes, it does.

19 Q. And is LeapFrog's intent in setting up this
20 meeting to contrast an A grade hospital with D and F
21 grade hospitals?

22 A. I don't know if it's LeapFrog's intent at the
23 time to do that.

24 Q. And Rosa responds saying she can't attend; is
25 that correct?

1 A. Correct.

2 Q. And then Lisa updates you that Rosa is not able
3 to attend; is that right?

4 A. That's correct. Which I felt was unfortunate
5 because of her being board chair.

6 Q. And you ask -- excuse me, strike that.

7 Lisa then references to you on July 4th that
8 there's no word from MAPEI. Do you see that?

9 A. Yes.

10 Q. What is MAPEI?

11 A. So that's another employer member down in the
12 same area. I can't remember what language it's an
13 acronym for but maybe Italian, the different letters.
14 They're like a manufacturing industrial glues and
15 adhesives and such, so...

16 Q. Do you have any -- are they in the Palm Beach
17 County area?

18 A. Yes.

19 Q. Do you have any understanding of how many covered
20 lives or employees they have?

21 A. I would say less than 1,000.

22 Q. And then moving forward, you write to Ashley on
23 July 4th, I hate to even suggest this but should I see
24 if FPL would like to attend?

25 You see that?

1 A. Yes.

2 Q. What's FPL?

3 A. Florida Power & Light. They're not a member of
4 the Florida Alliance.

5 Q. Okay. And then --

6 A. I wanted to keep it to employer members, but knew
7 that they were located in the county as their
8 headquarters.

9 Q. And after discussion of that idea, you suggest
10 maybe Melissa Miller; do you see that on the first page?

11 A. Yes.

12 Q. Who's Melissa Miller?

13 A. So she is with -- or had been with Florida
14 Power & Light. I was just clarifying to Ashley that I
15 was not thinking of this other person, Michael, who we
16 had been working with. Melissa had served as our board
17 vice chair and was in a different position at FPL. I
18 didn't take it further than that.

19 Q. There was no reach-out to --

20 A. No.

21 Q. -- Melissa Miller?

22 A. No. Stopped right there, yes.

23 Q. How many -- do you recall how many employer
24 members you reached out to about attending this meeting?

25 A. Rosa and Nancy, Elissa from MAPEI, Marcia from

1 Lennar, Susan McBroom from Patriot Rail. I think that's
2 it.

3 Q. I'm handing you what's been marked as Exhibit 18
4 to this deposition. And Exhibit 18 was produced by
5 Florida Alliance as FHA0000921.

6 (Exhibit No. 18 was marked for identification.)

7 BY MR. HVIDT:

8 Q. And it is an e-mail from Lisa Hain to Elissa
9 Cadovius?

10 A. Cadovius.

11 Q. And Barbara Ramos regarding, Join Karen at
12 Jupiter Medical Center July 16, 1:00 p.m. to 3:00 p.m.

13 Do you see that?

14 A. Yes.

15 Q. And is the substance of this message to Elissa
16 and Barbara consistent with the message that was
17 conveyed to Rosa Novo and Nancy Bolton in Exhibit 17 and
18 15 respectively?

19 A. Yes.

20 Q. And in this message, again, it references Jupiter
21 Medical Center's straight As from the LeapFrog Hospital
22 Safety Grade when there are five other hospitals in the
23 county with Ds and Fs.

24 Do you see that?

25 A. Yes.

1 Q. You can set that to the side. Thank you.

2 You mentioned Lennar. Did I say it right?

3 A. Lennar Homes, yes.

4 Q. Lennar Homes?

5 A. Yes.

6 Q. Do you have an understanding of how many covered
7 lives Lennar Homes has?

8 A. That's one of the employer members who gives like
9 national, international numbers. And I don't know that
10 I have offhand Florida, I would say it's maybe 2,000 in
11 Florida.

12 Q. You also mentioned Patriot Rail, and a
13 representative of Patriot Rail sits on your board; is
14 that correct?

15 A. Yes.

16 Q. And earlier we talked about how they might have a
17 few hundred Florida employees or covered lives; is that
18 correct?

19 A. Correct.

20 Q. And why -- why, again, were you targeting -- or
21 do all those Florida employers you were talking about
22 have a presence in Palm Beach County?

23 A. All of them except for Patriot Rail. Susan
24 McBroom lives in Palm Beach County. If they have lives
25 in Palm Beach County, it's a very small number.

1 Q. Patriot Rail might be a little bit further south
2 in Florida?

3 A. No, out of Jacksonville predominantly.

4 Q. Oh, Jacksonville.

5 A. Its short rail, railroad, I don't really know
6 what that really means, but that's what I've been told.

7 Q. Don't they connect to the big ones?

8 A. I think so.

9 Q. And did you ever reach out to Florida bankers
10 regarding the meeting as well?

11 A. I guess I might have, yeah. I -- I don't
12 remember if we did or not. They do have banks in South
13 Florida. As I mentioned, there are multiple employer
14 welfare arrangements as well with many, many banks.

15 MR. HVIDT: And I've handed the witness what's
16 been marked as Exhibit 19 to this deposition, which
17 was produced by Florida Alliance as FHA0001749 and is
18 a May 8, 2025, e-mail from Ashley Tait-Dinger to Lisa
19 Hain regarding contacts.

20 (Exhibit No. 19 was marked for identification.)

21 BY MR. HVIDT:

22 Q. Do you see that?

23 A. Yes.

24 Q. And then Ashley Tait-Dinger writes, Can you send
25 me the main contacts' e-mails for the following?

1 Do you see that?

2 A. Yes.

3 Q. And then lists Palm Beach - Nancy Bolton. Do you
4 see that?

5 A. Yes.

6 Q. And then it notes Lennar - not sure who this is?

7 A. Yes.

8 Q. And then it says MAPEI - not sure who this is?

9 And then it says Banker - Adella.

10 Do you see that?

11 A. Yes.

12 Q. And then do you see where she writes, I need to
13 contact them about the LeapFrog lawsuit?

14 A. Yes, I see that.

15 Q. Do you have an understanding of whether Florida
16 Alliance contacted each of those Florida employer
17 members of Florida Alliance about the LeapFrog lawsuit?

18 A. No, I don't.

19 Q. And are these communications that we've been
20 looking at the contacts' e-mails that Ashley Tait-Dinger
21 was looking for those contact information for?

22 A. Are you asking about for the Jupiter meeting?

23 Q. Yes.

24 A. No, I don't think so. I don't think that the
25 invitation to the Jupiter meeting was till weeks after

1 that, probably in -- probably in June.

2 Q. Did you ask Ashley Tait-Dinger to reach out to
3 those Florida employer members about the lawsuit?

4 A. I don't recall doing that. We talked earlier
5 about the dialogue with the board on how to inform the
6 members and it could be that this didn't happen and it
7 deferred to the weekly bulletin correspondence. I'm not
8 familiar with this e-mail.

9 Q. I'm handing you what's been marked as Exhibit 20
10 to the van Caulil deposition, which is produced in this
11 litigation as LEAPFROG00792177.

12 At the top of the document is an e-mail chain
13 between Lauren Bailey, Karen van Caulil, Leah Binder,
14 Angela Hopkins, Karen Jupiter, regarding Jupiter Medical
15 Center.

16 Do you see that, Dr. van Caulil?

17 (Exhibit No. 20 was marked for identification.)

18 THE WITNESS: Yes.

19 BY MR. HVIDT:

20 Q. If we could walk this back to the original e-mail
21 in this chain on Bates number ending 2180.

22 A. Yes.

23 Q. The e-mail on this chain that started it was from
24 Leah Binder; is that correct?

25 A. Yes.

1 Q. And it's dated May 28th. Do you see that?

2 A. Yes.

3 Q. And she writes, You may recall we spoke about
4 planning a visit of you and some of your members and me
5 to Jupiter Medical Center, one of the straight A
6 hospitals.

7 Do you see that?

8 A. Yes.

9 Q. Do you recall when you spoke with Leah Binder
10 about planning a visit between you and her and some of
11 the Florida Alliance members to Jupiter Medical Center
12 that predated May 28, 2025?

13 A. I think that we spoke just before that, only
14 maybe days before. I don't recall the exact date. She
15 called me and asked me if I would be interested. It was
16 a very short conversation.

17 Q. And she writes that the CEO of Jupiter Medical
18 Center is excited about the visit and is interested in
19 setting up this meeting; is that correct?

20 A. That's what it says.

21 Q. And forwarding along in this e-mail to the page
22 number ending 2178, do you see your e-mail dated
23 June 16, 2025?

24 A. Yes.

25 Q. And you wrote that you have an enthusiastic yes

1 from Susan McBroom, the director of human resources at
2 Patriot Rail.

3 Do you see that?

4 A. Yes.

5 Q. And you also referenced the -- you're waiting to
6 hear back from Nancy Bolton at Palm Beach schools.

7 Do you see that?

8 A. Correct. Yes.

9 Q. And then carrying forward, you respond that
10 Shannon Chamberlain from Lennar Homes is also attending.
11 Do you see that, on June 19th?

12 A. Yes.

13 Q. And so is it correct that before the meeting was
14 canceled, you had a commitment to attend the meeting
15 from two of your Florida employer members; is that
16 correct?

17 A. That's correct.

18 Q. And those were Lennar Homes and Patriot Rail?

19 A. Correct.

20 Q. And in response to your e-mail, Lauren Bailey
21 responds the next day, I'm going to reach out to their
22 PR team today to kick off planning.

23 Do you see that?

24 A. Yes.

25 Q. Did you interpret the their PR team to be Jupiter

1 Medical Center's PR team?

2 A. Yes.

3 Q. And you had mentioned that you did not intend to
4 participate in the PR component; is that correct?

5 A. That's correct.

6 Q. Did your intention of not participating in the PR
7 component stop -- was that communicated before June 20,
8 2025?

9 A. I communicated that from the outset. As soon as
10 I heard that there was going to be any level of media,
11 it might have been at the board meeting the first time I
12 heard that. I said that I would not participate nor put
13 my employers in a position like that. And Leah said she
14 understood.

15 Q. And LeapFrog intended to continue with the PR
16 effort, even if it didn't include the Florida members in
17 that PR component?

18 A. I don't know if they were going to continue
19 without us. I just made it clear that we were not
20 participating.

21 Q. If you had communicated to Leah at the board
22 meeting earlier in June that you had intended not to
23 have your members participate in the LeapFrog -- in the
24 PR effort regarding the meeting and on June 20, 2025,
25 Lauren Bailey's communicating a plan to reach out to

1 Jupiter Medical Center's PR team today to kick off
2 planning, does that indicate that LeapFrog was --
3 continued to go ahead with PR planning for the meeting
4 with Jupiter Medical Center even after you communicated
5 your intent not to participate in such PR planning?

6 A. It looks like that was Lauren's plan. I don't
7 know if she went ahead and did that, but it looks like
8 that's her plan.

9 MR. HVIDT: I'm handing the witness what's been
10 marked as Exhibit 21 to the van Caulil deposition.
11 The exhibit was produced in this litigation as
12 FHA0002195. And the top e-mail is from Karen van
13 Caulil to Ashley Tait-Dinger regarding Jupiter Medical
14 Center dated May 28, 2025.

15 (Exhibit No. 21 was marked for identification.)

16 BY MR. HVIDT:

17 Q. Do you see that?

18 A. Yes.

19 Q. Was this e-mail sent in the ordinary course of
20 business?

21 A. Yes.

22 Q. And if you flip to the e-mail that originated
23 this chain, do you see the e-mail that was in a prior
24 exhibit that we looked at from Leah Binder to you
25 regarding this Jupiter Medical Center meeting?

1 A. Yes.

2 Q. And again, she references a conversation that she
3 had with you predating this May 28, 2025, e-mail; is
4 that correct?

5 A. Yes.

6 Q. And you forwarded that e-mail to Ashley
7 Tait-Dinger on May 28, 2025, on the second page.

8 Do you see that?

9 A. Yes.

10 Q. And then Ashley Tait-Dinger replies, I thought
11 the meeting was with AdventHealth in June.

12 Do you see that?

13 A. Yes.

14 Q. And you write back on May 28, 2025. Can you read
15 in the record your e-mail?

16 A. Yes. This is something different. Leah wants to
17 highlight Jupiter Medical Center's A safety grade
18 because of the lawsuit and poor performing hospitals in
19 Palm Beach County.

20 Q. Does reading this e-mail refresh your
21 recollection that Leah communicated to you that she
22 wants to highlight Jupiter Medical Center's A safety
23 grade because of the lawsuit and poor performing
24 hospitals in Palm Beach?

25 A. Well, I hadn't recalled that I had said that in

1 an e-mail, so obviously my statements earlier, I need to
2 amend. She must have said at some point to me that that
3 was her intent. And I hadn't remembered that. Because
4 subsequent discussions were about when we had the
5 follow-up call was to really highlight their straight A
6 performance.

7 Q. And so before your e-mail on May 28, 2025, you're
8 communicating that when Leah spoke with you, she
9 communicated to you that she wanted to highlight Jupiter
10 Medical Center's A safety grade because of the lawsuit
11 and poor performing hospitals in Palm Beach County; is
12 that correct?

13 A. I don't recall the exact conversation, but I
14 don't see myself writing that sentence if I didn't feel
15 that at the time.

16 Q. And you mentioned earlier that you recalled that
17 the conversation you had with her was shortly before the
18 May 28th e-mail from her to you that starts this chain;
19 is that correct?

20 A. Yes. I don't remember the exact date. It was a
21 brief conversation and it was supposed to have a more
22 detailed follow-up which never happened. There was a
23 planning meeting set, and I think on the Jupiter end
24 they had to reschedule it so it never was rescheduled.

25 Q. And you didn't think that the meeting was a good

1 idea from the outset; is that correct?

2 A. No. It's not entirely correct. Initially, I
3 thought it would be a good opportunity to be able to
4 meet the Jupiter Medical Center CEO and his leadership
5 team and as the days and weeks progressed and I
6 discussed this with Ashley, we thought that it probably
7 would be best not to do it while the lawsuit was going
8 on, that it probably made more sense to wait until a
9 later date and hope that we could reengage.

10 Q. And why would having a meeting with Jupiter
11 Medical Center highlighting its A LeapFrog grade not be
12 a good idea while the lawsuit was pending?

13 MR. BILLEK: Object to form.

14 You can answer that again.

15 THE WITNESS: So, you know, you can't control
16 where a conversation is going to go before you have
17 it. And as Ashley and I continued to talk about it,
18 it just made sense to stick with what we were saying
19 to everybody else, which was to, you know, kind of
20 stay out of any kind of discussions about the matters
21 of the lawsuit. And in case it came up, didn't want
22 to put my employers in that position.

23 BY MR. HVIDT:

24 Q. I'm handing you what's been marked as Exhibit 22
25 in the van Caulil deposition, which was produced in this

1 litigation as FHA0002516.

2 (Exhibit No. 22 was marked for identification.)

3 BY MR. HVIDT:

4 Q. It is an e-mail chain between -- at the top
5 between Ashley Tait-Dinger and Karen van Caulil dated
6 July 7, 2025, Re: Visit to Jupiter Medical Center.

7 Do you see that?

8 A. Yes.

9 Q. And if you'd go to the original e-mail in this
10 chain on the last page, let me know when you're there.

11 A. I'm here.

12 Q. And so did you get an e-mail from Leah Binder on
13 July 7, 2025, Re: Visit to Jupiter Medical Center?

14 A. Yes.

15 Q. And in the second sentence of the e-mail, does
16 Leah Binder tell you -- or strike that.

17 The first sentence of the e-mail, Leah Binder
18 informs you that she's not going to be able to make the
19 trip to Florida. Do you see that?

20 A. Yes.

21 Q. And the second sentence references what we talked
22 about earlier as relates to her brother needing surgery.

23 Do you see that?

24 A. Yes.

25 Q. And then what's the third sentence say, if you

1 could read that into the record, please?

2 A. In addition, the timing is not right for me to be
3 in Florida in terms of some legal issues.

4 Q. Do you have an understanding of what she was
5 referencing there?

6 A. No, not specifically.

7 Q. Were you aware that as of July 7th, LeapFrog was
8 maintaining that the court that is housing this
9 litigation didn't have jurisdiction over the LeapFrog
10 Group?

11 A. No, I'm not aware.

12 Q. Were you aware that at this time, the LeapFrog
13 Group was claiming that it didn't direct business into
14 Florida?

15 A. I'm not understanding directing business into
16 Florida. No, I'm not aware of that.

17 Q. And then forwarding on in the e-mail chain,
18 there's an e-mail from Ashley Tait-Dinger to you and
19 potentially to Lisa Hain, but it's not clear whether
20 she's on it or not, on July 7th at 9:35 p.m., that
21 begins on the first page and then goes on to the second.

22 Do you see that?

23 A. Yes.

24 Q. She says, Just to you. So this has actually
25 removed Lisa Hain. Does that make sense?

1 A. Yes.

2 Q. And she writes, Leah e-mailed me too. Shocking
3 counsel did not think this was good timing...but let us
4 do it...oh, I thought we were covered under your
5 insurance...if you were told not to, why would we be
6 allowed?

7 Do you see that?

8 A. Yes.

9 Q. What did you interpret her to mean?

10 A. I didn't understand her e-mail. I was still out
11 of the country at the time. And Ashley will send
12 e-mails that are a little hard to follow with stream of
13 consciousness. My interpretation of it was we all came
14 to the same conclusion, that the meeting should not
15 proceed.

16 Q. And you responded, quote, I am relieved it is
17 canceled.

18 Do you see that?

19 A. Yes.

20 Q. And can you explain why you were relieved it is
21 canceled?

22 A. I think I've already answered that. I didn't
23 want to put my employer members in a difficult position
24 when I was also hearing about media and what might
25 happen at the meeting. I just thought it would be best.

1 And Leah offered. She said if you want to go
2 ahead with the meeting without me, you can do that. But
3 I, as I said, was like, let's reschedule for a later
4 time.

5 Q. And Ashley Tait-Dinger replied, Yes, me too, I
6 thought the whole thing was a bad idea.

7 Do you see that?

8 A. I do see that.

9 Q. Do you agree with her?

10 MR. BILLEK: Object to form.

11 You can answer.

12 THE WITNESS: I had already said I was fine
13 with it being canceled.

14 MR. HVIDT: If we could go off record for a
15 minute.

16 MR. BILLEK: Sure.

17 THE VIDEOGRAPHER: We are off the record at
18 2:46 p.m.

19 (A brief recess was taken.)

20 THE VIDEOGRAPHER: We are on the record at 2:55
21 p.m.

22 MR. HVIDT: Counsel for plaintiffs rest and
23 reserve.

24 MR. BILLEK: I have nothing further. I don't
25 have anything at all.

1 THE VIDEOGRAPHER: This concludes the
2 deposition. We are off the video record at 2:55 p.m.

3 MR. BILLEK: We will order in the same speed
4 and information that plaintiff orders.

5 (The deposition was concluded at 2:55 p.m.)
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CERTIFICATE OF OATH

STATE OF FLORIDA)

COUNTY OF ORANGE)

I, MAE FISHER, Registered Merit Reporter,
Certified Realtime Reporter and Notary Public, State of
Florida, certify that KAREN VAN CAULIL personally
appeared before me on September 25, 2025, and was duly
sworn/affirmed.

WITNESS my hand and official seal this 29th day
of September, 2025.



MAE FISHER, RMR, CRR

Notary Public - State of Florida

Commission HH 443649

Expires: January 8, 2028

Personally known _____

OR Produced Identification X _____

Type of Identification Produced Driver's license

1 TRANSCRIPT CERTIFICATE
2 STATE OF FLORIDA)
 COUNTY OF ORANGE)
3
4 I, MAE FISHER, Registered Merit Reporter,
 Certified Realtime Reporter and Notary Public, State of
5 Florida, certify that I was authorized to and did
 stenographically report the deposition of Karen van
6 Caulil; that a review of the transcript was not
 requested; and the foregoing transcript, pages 5 through
7 180, is a true record of my stenographic notes.
8 I FURTHER CERTIFY that I am not a relative,
 employee, attorney, or counsel of any of the parties,
9 nor am I a relative or employee of any of the parties'
 attorney or counsel connected with the action, nor am I
10 financially interested in the action.

11
12 DATED this 29th day of September, 2025, at
13 Orlando, Orange County, Florida.

14
15
16 

17
18 _____
19 MAE FISHER, Notary Public
20 State of Florida
21
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25

Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog Group
Karen Van Caulil (#7586376)

E R R A T A S H E E T

PAGE_____ LINE_____ CHANGE_____

REASON_____

PAGE_____ LINE_____ CHANGE_____

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REASON_____

PAGE_____ LINE_____ CHANGE_____

REASON_____

Karen Van Caulil

Date

1 Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog Group
2 Karen Van Caulil (#7586376)

3 ACKNOWLEDGEMENT OF DEPONENT

4 I, Karen Van Caulil, do hereby declare that I
5 have read the foregoing transcript, I have made any
6 corrections, additions, or changes I deemed necessary as
7 noted above to be appended hereto, and that the same is
8 a true, correct and complete transcript of the testimony
9 given by me.

10
11 _____
12 Karen Van Caulil

_____ Date

13 *If notary is required

14 SUBSCRIBED AND SWORN TO BEFORE ME THIS

15 _____ DAY OF _____, 20____.

16
17
18 _____
19 NOTARY PUBLIC
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[& - 2024]

&	10:44 60:20	15 3:7 4:2	1:37 137:16
& 1:18 2:2,6,11 3:14 36:13,16 37:19 38:6 42:2 163:3,14	11 3:22 89:21 100:16 131:4,6 131:11 134:22 134:23 143:12 182:11	150:13,16,18 151:9 159:23 164:18 182:15 15,000 41:10 42:9	1:39 137:19 1st 125:12 150:25 158:25
0	111 1:19	150 4:2	2
07940 2:12	11:33 86:2	158 4:3	2 3:8 29:5,6,7 30:24 32:14 56:11,14 98:13 141:11,11 182:2
1	11:37 86:5	159 4:4	2,000 38:22 39:22 42:4,5 165:10
1 3:7 5:9 15:15 15:17 56:6 73:15 74:6 127:4 159:16 182:1	12 3:23 53:20 134:20 135:19 135:21,25 136:2 182:12	16 4:3 158:5,8 159:11 164:12 169:23 182:16	20 4:7 43:16 88:14,21 89:2 168:9,17 171:7 171:24 182:20 184:15
1,000 162:21	120 3:20	164 4:5	200 2:7 117:22
10 3:21 87:23 126:12,13 131:8,8 143:12 182:10	1200 1:19	166 4:6	2001 2:3
10's 126:15	126 3:21	168 4:8	2002 53:17
100 3:16 89:1 117:10,13,21 117:22,25 142:5	12:30 118:23	16th 72:22 158:11	2011 66:14
100,000 42:11 132:10	12:31 1:16 119:9	17 4:4 159:5,7 159:8 164:17 182:17	2019 22:17
101 3:14 72:3 86:17 91:3	12:59 119:12	172 4:9	2020 48:5
10166-0193 2:7	13 3:24 43:11 138:9,20 182:13	176 4:10	2023 67:16 70:3 71:8,23
102 3:17	131 3:22	18 4:5 143:13 164:3,4,6 182:18	2024 3:13 43:12,16 72:15 72:20 77:4,7 84:22 85:10,12 85:20,22 98:22 100:16 102:9 102:21,22
106 3:19	135 3:23	180 182:7	
10:36 60:17	138 3:25	181 3:4	
	13th 72:21	182 3:5	
	14 4:1 66:12 140:22 141:1 141:10 182:14	19 4:6 166:16 166:20 182:19	
	1400 22:10	1984 22:24	
	141 4:1	19th 170:11	
	1492 62:9	1:00 159:11 164:12	

[2024 - 72]

103:3,6 104:8 105:19 106:22 107:17,19 2025 1:14 3:9 3:10 5:3 31:21 36:1 46:6,12 46:16 53:4 54:11 56:8 87:1 97:21 98:12 117:4 118:11,17 119:25 120:25 127:4 131:14 131:17,25 132:14 139:1 141:19 155:22 159:16 166:18 169:12,23 171:8,24 172:14 173:3,7 173:14 174:7 176:6,13 181:8 181:12 182:11 2026 36:1 72:14 2026-2032 3:13 2028 181:17 2032 72:14 21 4:9 172:10 172:15 182:21 2100 2:3 212 2:8 214 2:4	2178 169:22 2180 168:21 22 4:10 175:24 176:2 182:22 22714 181:15 182:16 23 120:25 182:23 235 74:5 24 107:23 182:24 25 1:14 5:3 41:7 42:10 92:11,18,20 106:22 107:17 139:1 181:8 182:25,25 25th 16:4 68:24 92:13,14 27 93:16 28 86:25 93:20 169:12 172:14 173:3,7,14 174:7 28th 151:19 169:1 174:18 29 3:9 29th 181:11 182:11 2:46 179:18	58:17 61:17 157:6 182:3 30 7:9,15 100:4 300 40:9 45:10 300,000 44:5 30th 56:17,17 31 95:14,17 96:16 32,000 37:7 42:3 32801 1:20 351-4000 2:8 38 46:8 3:00 159:11 164:12	4th 162:7,23 5 5 3:14 56:19 86:8,9,11 99:16 182:5,6 5,000 36:18 38:6 42:2 5/9/25 3:23 50,000 40:17 42:7 160:11 501 9:15 157:6 53 3:11 550 97:12,18 98:2,14,14 117:3
		4	6
		4 3:9,12 31:20 32:23 55:21 56:15 72:9,11 182:4 400 40:4,8 42:5 42:6 400,000 44:5 45:10 136:14 41st 3:8 31:7 42 140:25 443649 181:17 45 160:11 46 30:9 47 63:5 488 55:22 491 58:18	6 3:3,15 99:18 100:11,13,14 102:21 131:17 182:6 6/11/2024 3:16 6/25/25 3:25 624-0800 2:12 698-3317 2:4
			7
			7 2:11 3:17 58:17 61:17 102:18,23 136:20 141:22 176:6,13 182:7 72 3:13
	3		
	3 3:10 9:15 52:24 53:1,3		

[75201 - adhesives]

75201 2:4	86:5	99:3 101:7	60:2 63:8
7586376 183:2	ability 9:22	116:10	activities 18:9
184:2	80:2	achieve 57:17	46:24 47:1,11
7th 177:7,20	able 8:3 21:23	81:19,22	activity 25:16
8	33:16 41:25	147:12 157:3	55:4,6
8 3:18 35:25	46:18 47:5	achieved 80:8	actual 8:3
62:8 106:6,8	49:16 51:14	80:21 81:7,15	36:17 151:14
166:18 181:17	57:17,19 58:4	114:13,17	actually 11:3
182:8	59:19,21 73:2	149:22	12:8 22:13
80 15:5 37:3	87:3 108:14,19	achievement	33:16 44:10
43:20 44:15,17	109:14,21,24	76:12 77:16	73:7 77:17
88:2,4,6,12	137:24 144:17	78:6 82:5,25	83:22 106:13
89:2,9	147:12,16,18	90:24 91:10	121:12 146:21
80526 1:3	157:2 162:2	111:15 112:8	177:24
82 43:21	175:3 176:18	112:10,19,22	acute 88:6,7,12
86 3:14	above 16:14	113:5,12,14,19	88:15,21
87 43:14,20	128:2 184:7	113:22 114:1	120:12
9	absence 111:16	116:20 148:24	add 42:23 43:5
9 3:20 120:20	112:8,17	achieving	added 43:6
120:21 121:6	absolute 18:8	49:19	63:10
124:13 142:16	absolutely	acknowledge...	adding 42:1
182:9	60:15 124:6	184:3	43:1 73:24
9/25/2024 3:19	access 28:23	acronym	addition 177:2
973 2:12	29:1	162:13	additional
98 117:20	accolade 58:8	acss 56:7,25	45:16 73:25
9:03 1:15 5:3	58:16	57:8 61:22	94:17
9:25 1:3	accolades 58:3	action 46:24	additions 184:6
9:35 177:20	accompanying	47:4,23 48:2	addressed
9th 136:5,7	140:14	50:11 56:3	94:19
a	accuracy	70:1 101:19,22	adds 42:11
a.m. 1:15 5:3	101:11 107:9	182:9,10	adella 167:9
60:17,20 86:2	accurate 8:11	actions 101:23	adhesives
	31:19 32:5	active 27:23	162:15
	78:11,17 79:14	52:13 59:19	

[adjunct - anniversary]

adjunct 22:18	agenda 3:24	aldridge 36:11	136:13 137:10
administrates 48:11	32:15,17 102:6	alert 135:8	147:8,14,19
administration 20:14	138:4,24	alerting 127:18	148:13 150:6
administratio... 23:10	139:16	132:13	150:11 151:2
administrative 10:19 21:8	ago 7:8,9 22:16	alliance 6:4 9:8	153:1 154:1
34:23 40:14	25:12 45:13	10:23,24,25	157:7 158:6
151:4	63:11,11,20	11:1,4,8,9,13	159:6,20 160:1
administrator 48:13	64:6 66:12	12:2,7 13:23	160:13,19
advance 73:5	82:20 83:11	14:6,16 16:20	163:4 164:5
advantageous 58:10	100:4 107:4	16:22 17:14	166:17 167:16
adventhealth 146:20,25	114:7,7 136:15	19:12 22:13,14	167:17 169:11
173:11	152:23	22:21 23:2,7	alliance's 26:23
advisors 94:10	agree 5:8 55:13	24:1,5,21,23	52:3 119:16
advisory 12:17	58:9 96:24	26:3 27:13,18	161:8
13:3 23:11,12	112:10 128:15	28:10,14,25	allow 7:20,22
23:12	128:17 129:9	29:9,15,18,25	8:21,21
affairs 20:19	142:12 145:20	31:8 32:24	allowed 178:6
affiliate 12:9	179:9	33:11 34:11,20	alongside 47:10
12:10,19,23	agreement	35:2,6 36:5	130:5
13:3	27:17,19,21,23	46:15 50:10	alternate 70:12
affiliations 5:18	28:17,18,23	51:7 53:22,24	ambulatory
affirm 6:7	47:6,14 55:2	54:1,20 60:5	26:20 28:21
affirmed 181:9	100:5 106:2	63:15 65:5,8	51:15 52:1,10
afraid 89:6	agreements	65:11,14,16	74:19
agency 21:2	29:2	66:18 67:5	amend 174:2
22:3 23:9,17	ahead 31:24	68:3 86:12	amended 35:10
	110:21 113:10	100:3 111:23	amount 135:6
	133:4 135:12	119:20,24	154:6
	148:3 172:3,7	120:3 121:23	analysis 113:1
	179:2	122:1,14 123:1	angela 102:21
	al 1:6 5:12	124:23 125:3	168:14
	16:15 183:1	126:17 130:22	anniversary
	184:1	131:5,9 133:17	68:25
		135:24 136:8	

[annual - asking]

annual 3:8 31:6 31:7 43:16 88:3,5 125:12 127:6 answer 7:23 8:11 31:23 38:13 42:15,15 43:4 44:20,21 45:1 52:16 54:23 57:7 59:16 60:25 68:6 75:13 79:18,22,25 80:7,13,20 81:4 82:9,12 88:19 94:11 98:5 99:13 105:14 108:22 110:13 111:5 111:10 113:12 116:7,22 117:6 117:8,12,25 120:8,15 143:22 148:20 149:18 155:4 155:15 175:14 179:11 answered 52:19 78:13,13 79:15,15 178:22 answering 8:3 16:8 57:9 60:9 109:3	answers 7:4,21 8:1 91:22 92:3 93:9 anthony 5:14 anticipating 39:3 anybody 64:9 71:4 94:18 106:18 apologies 67:8 apologize 16:11 appearances 5:17 appeared 181:8 appears 100:15 appended 184:7 apples 42:18,18 44:10 applicable 49:17 62:24 120:16,17 applied 29:15 apply 29:14,22 appreciate 38:4 39:5 appreciated 85:8 91:6 approach 109:2 111:18 111:18 129:8 appropriate 48:20 77:23 108:24 110:4	113:6,14,17 approve 69:15 123:11 139:7 approved 139:13 approximate 78:2 approximately 36:24 42:7,9 43:25 100:4 136:14 approximation 136:16 april 56:17 84:22,22 85:4 85:10,20 86:25 120:25 125:16 125:17 area 10:14 15:2 41:17 71:5 147:22 149:21 162:12,17 arrangement 41:5 arrangements 166:14 articles 19:3 144:8,17 artificial 71:1 asc 54:13,16 55:24 ascs 26:19 ashley 18:5,13 24:7 27:9	28:19 33:5 35:7,13,23 48:4 52:12 53:12 54:1,19 65:18 120:6 122:19 123:5,8 131:14,20 146:23 147:2 151:21 152:1,7 159:9 162:22 163:14 166:18 166:24 167:20 168:2 172:13 173:6,10 175:6 175:17 176:5 177:18 178:11 179:5 ashley's 18:12 33:18 34:5,12 53:18 aside 19:15 64:21 111:6 122:5,8 146:12 asked 18:19 39:9 48:3 52:10 63:13 68:23 71:9 74:20 91:13 94:18 101:16 126:6 132:18 146:21,22 169:15 asking 7:21 18:2,24 56:12
---	---	---	--

[asking - baltimore]

65:7 78:16 124:1 133:18 135:8,14 167:22 asks 138:15 aspect 25:13 124:18 assert 8:22 assessment 83:5 assign 79:13 102:3 124:14 assigned 34:4 77:14 93:2,4 assigning 78:6 81:12,24,24 90:8,22 114:1 114:14,18,23 118:4 assigns 77:18 assistant 21:7 associated 146:5 associates 38:9 association 41:3 79:2 assume 8:16,16 53:16 54:25 58:13 99:6 113:18 138:3 assuming 113:22 assumptions 113:24	attach 127:22 attached 103:8 attachment 103:2,15 attachments 3:17 attend 18:5,7 19:24 20:1 33:24 69:9 73:2 86:20 87:3 100:23 137:22,24 146:23 147:4 147:17 150:21 150:24 159:1 161:24 162:3 162:24 170:14 attended 87:9 attendees 100:20 107:1 attending 163:24 170:10 attention 61:21 141:14 attorney 5:19 133:2 182:8,9 attorneys 17:20 attributed 43:24 audible 8:1 audio 5:6 audit 69:14 71:16	audited 69:13 authenticity 101:11 authority 39:1 authorized 182:5 automatic 28:10 automatically 115:14 available 23:14 29:24 72:4 75:5,7 76:18 86:19 110:21 150:21 avenue 1:19 2:3 2:7 average 76:10 77:2 78:21 79:9 avoidable 73:18 aware 25:20 26:4,6 31:11 45:10 68:8,14 70:13 124:23 125:1,9 128:24 148:13 177:7 177:11,12,16 awareness 85:18	b b 3:6 22:14,15 26:14 67:3,4 74:19 bachelor 20:4 back 8:20 14:11 21:15 27:21 37:17 44:8,9 45:2 46:4 47:13 58:6 61:16 65:21 66:3,4 70:24 78:24 84:13 90:15 115:3 129:15 130:24 131:7 132:9 134:20 137:18 146:1,7 159:15 160:18 168:20 170:6 173:14 bad 179:6 bailey 126:25 140:6,24 141:8 155:22 168:13 170:20 bailey's 171:25 ballpark 37:9 37:21 40:9 45:20 baltimore 72:22
--	--	--	---

[bandwidth - bit]

bandwidth 55:7 64:19	bcma 115:19	123:4 124:21	75:12 79:17
banker 167:9	beach 1:2 17:6	142:8 147:25	80:10,23 81:17
bankers 43:22	41:17,21	160:11	84:9 85:13
166:9	131:13 137:1	benefit 9:22	88:17 92:12,17
banks 43:21,24	144:7,22 148:5	12:22 47:20	95:5 98:4,16
166:12,14	149:5 150:21	155:8	98:25 99:16
banner 95:15	152:10,11,12	benefits 12:12	100:9 105:13
136:21	152:14,15,18	37:6 38:10,19	106:4,10,17
baptist 21:9,19	152:20,22	38:19 39:17	108:21 111:9
barbara 164:11	154:5,6,8,9,15	40:14 41:3	111:21 113:16
164:16	154:23 157:16	45:4 150:20	116:6,21 117:5
based 37:22	157:19 162:16	berger 146:22	117:11 118:25
45:3 58:24	165:22,24,25	best 38:3 55:9	126:14 133:21
91:12	167:3 170:6	58:18 71:14	134:3,12
basic 17:10	173:19,24	81:8 90:15	138:21 143:21
28:20	174:11	112:16 141:20	148:19 149:17
basically 24:13	bearings 82:21	175:7 178:25	155:2,14 156:7
46:20 63:23	beds 88:6,7,12	beth 36:19	156:21 158:23
basis 21:17	88:15,21	better 37:20	175:13 179:10
23:25 62:6	beginning 5:18	48:16 50:6	179:16,24
77:18,21	132:18	57:5 79:5 82:5	180:3
bates 29:11,12	begins 134:24	92:7	bills 9:21
29:14,17,23	177:21	beyond 23:24	binder 67:23
30:2,4,19	behalf 6:1 35:2	27:16 155:17	87:4,11 102:21
55:22 58:18	35:8,18 61:12	big 22:9 147:1	103:6 126:23
62:8 99:21,23	63:25 137:1	166:7	127:4,8 130:20
100:1,2,5	belated 55:18	bill 61:12	131:24 168:13
105:25,25	believe 16:22	billek 2:10 5:25	168:24 169:9
126:15 138:11	16:24 17:13	5:25 19:17,20	172:24 176:12
138:12,15	23:24 41:7,9	30:1,14,21	176:16,17
168:21	46:3 55:4	42:14 43:3	binder's 127:16
bathroom 8:25	57:19 64:7	55:18 57:7	biology 20:4
	68:19 77:16	60:15,25 66:22	bit 27:25 36:19
	87:15,16 94:11	66:24 67:8	39:16 40:5,24

[bit - cadovius]

41:3 166:1 blue 96:17 136:21 board 3:8,16 3:19,24 10:2,4 10:5 27:15 28:1,4,8,10,15 31:6,7,20 34:19 36:1,5 36:14,23 40:4 40:13 41:4 42:13 47:24 57:4,10 59:19 67:12,15,17,25 68:9,11,11,21 68:25 69:2,8 69:11,20 70:2 70:3,6,11,17,19 70:24 71:4,8,9 71:21,22 72:2 72:3,6,20,22 73:2,4,6 74:3 76:6,6 77:9,11 80:5,18,25 81:4 82:15,21 82:22 83:6,12 83:13 84:2,19 84:20 85:2,8 86:16,18 91:2 91:6 98:9 100:15,16,23 101:3,6,8,15 102:9,14 103:5 103:10 104:7	104:11 105:18 106:21 107:5 114:9,21 115:13 116:3 116:17 118:18 126:3,24 127:17,18 128:8 130:21 130:25 131:14 131:19,22 132:4,8 135:8 135:14,18 137:22 138:1 138:24 139:3,8 139:12,15,20 140:1,18 141:8 141:19,19 143:3 144:19 144:21 146:2 148:22 155:21 155:22 158:25 159:20 162:5 163:16 165:13 168:5 171:11 171:21 boards 68:4 boca 121:9,18 122:1 123:18 123:23 boiled 64:18 bold 141:24 bolded 62:12 bolton 150:20 152:10 154:16	154:19,24 157:25 158:17 164:17 167:3 170:6 book 64:4 boots 51:11 bottom 30:6 108:6 136:23 box 96:16,17 124:6 bradley 146:17 break 8:25 9:1 27:25 50:19 60:13 118:25 133:22 brevard 22:4 brief 60:18 86:3 119:3 134:16 137:17 174:21 179:19 briefed 139:22 bring 21:23 22:10 71:3 broader 59:18 broadly 49:10 157:8 brother 148:1 176:22 brought 70:9 70:23 148:6 bruce 146:16 bs 97:9 build 22:7 50:4	bullet 46:22 61:16,20 74:9 74:12 93:25 94:8,12,14,22 bulleted 58:21 bulletin 3:23 26:9 34:22 135:5,16 136:5 136:6 168:7 bulletins 17:23 137:9 bullets 74:6 141:22 142:18 bunch 48:8 business 9:14 9:17 10:13 13:2 31:9 32:9 33:20,21 91:3 107:6 121:21 128:4,6 133:10 137:10 172:20 177:13,15 businesses 10:10 busy 47:7 c c 2:1 5:1 9:15 26:14 74:19 157:6 cadence 8:20 cadovius 164:9 164:10
--	--	--	--

[calculate - certainly]

calculate 45:9 76:20	62:16,25 63:19 73:16 74:1	15:25 19:24 31:1 61:3 65:3	158:10 159:10 164:12 168:15
calculated 110:24	126:2	72:16 86:13	169:5,11,18
calculates 93:21	caption 16:13	100:18 102:18	172:4,14,25
calculating 92:9	cardiac 49:12	102:25 121:4	175:4,11 176:6
calculation 42:17 44:5	care 21:21	126:19 131:4	176:13 183:1
45:6 75:1 89:9	22:11 82:7	131:11 135:20	184:1
calculator 43:8	88:6,7,12,15,21	135:25 137:22	center's 155:18
calendar 34:18	128:20 129:3	138:9,23	156:3 157:20
california 12:1	130:1	140:21 141:3	160:2,16,21
12:5	career 22:20	158:11 159:9	164:21 171:1
call 32:18 38:9	carolina 7:13	168:10,13,16	172:1 173:17
61:13,21 64:9	20:16,25 21:9	172:10,13	173:22 174:10
133:2 140:10	21:14	175:25 176:5	centers 26:20
161:13 174:5	carrier 48:10	181:7 182:6	51:16 52:1,10
called 10:23	carries 74:5	183:2,24 184:2	74:20
11:4 16:13	carry 54:15	184:4,12	central 20:20
21:1 33:24	carrying 53:21	cause 6:8	22:2,5,13,23
41:6 66:19	108:9 170:9	156:25	38:25 66:22
67:6 77:17	carve 48:11	caveat 117:19	67:2
140:8 169:15	49:1	caveats 89:5	ceo 9:11,13,24
calls 52:14	carved 49:4,5	center 1:6 5:12	32:21 41:1
126:8 148:9	case 1:3 16:13	16:14 48:12	66:17 67:23
campus 41:23	42:20 81:12	49:2,3,6,9,12	102:9,22 103:2
canceled 147:24 148:2,8	128:11 135:11	49:15 121:9,18	103:5 147:5,8
170:14 178:17	139:11 145:19	122:1 123:18	148:12 152:24
178:21 179:13	148:6 175:21	147:6,11	169:17 175:4
capacity 9:24	categories 120:14	148:24 149:14	ceos 63:12
23:5 28:5,6	category 12:19	150:8,22	132:21 133:3
	23:9 115:23	151:12 152:22	133:12 147:21
	caulil 1:13 3:2	153:11,17	certain 64:16
	5:10 6:3,11,16	154:9,11,14,17	103:23
	6:17,18 7:2 9:5	154:22,25	certainly 25:13
		156:2 157:1	49:20 51:23

[certainly - comment]

64:9 68:5 69:9 69:13 74:2 76:5 117:25 127:18 128:23 certificate 3:4,5 7:13 21:18 181:1 182:1 certified 181:6 182:4 certify 181:7 182:5,8 cetera 9:23 chain 3:17,21 3:22 4:2,3,4,5,6 4:7,9,10 131:12,20 158:10 159:9 168:12,21,23 172:23 174:18 176:4,10 177:17 chair 23:9,16 40:3,13 67:20 159:19 162:5 163:17 challenged 13:8 59:23 chamberlain 170:10 change 22:15 60:13 77:9,21 78:20 79:22 82:10,14,16,18 82:23 83:13,14	83:18,22 84:1 84:19,20 85:3 85:19 91:15 94:13 95:15 99:9,12 101:17 104:8,11 105:2 105:11,19 108:2,7,11 118:18,22 133:10,15 183:4,7,10,13 183:16,19 changed 22:16 76:7 94:22 95:6 changes 42:9 47:19 108:4 184:6 changing 102:1 chapel 20:16 characterize 99:3 127:15 128:16 129:22 charge 83:7 120:7 charts 22:11 check 150:19 choose 110:22 chris 126:23 128:2,3 129:21 chris's 129:15 circle 145:5 cites 127:9	city 22:8 38:19 42:3 claiming 177:13 claims 59:24 clarification 27:22 clarify 12:8 14:4,8 18:9,17 35:8 67:1 clarifying 72:24 163:14 clean 69:14 clear 12:15 14:13 39:6,13 52:18 111:18 112:4,7 134:6 171:19 177:19 clients 21:19 clinical 21:11 close 128:13 134:2 closed 66:3 cms 74:24 75:9 75:11 93:4,6 117:23 coalition 9:15 13:2 22:14,16 22:23 66:20 67:3,4,7 128:4 128:6 coalitions 9:17 code 29:11 30:7	coding 29:15 30:7 collaborate 153:2 collectively 60:4 83:7 college 19:24 20:1,24 22:6 22:25 colleges 41:2 combination 74:23 118:2,3 come 9:19 11:7 25:25 38:1 41:8 45:2 78:15,24 79:24 80:2,7,12,20 81:8 96:8 123:4 126:2 146:7 147:2,13 147:25 148:6 152:25 153:6 comes 23:22 26:12 65:2,25 66:6 123:14 comfortable 38:23 39:15 45:20 148:5 coming 78:1 146:19 commenced 1:15 comment 110:8 124:6
--	---	---	---

[comments - consistent]

comments 79:3 104:20	160:19 171:25 174:8	completes 75:19	confidential 1:12 138:16,17
commission 181:17	communication 17:24 54:15	complexity 52:22	138:18 139:22
commitment 170:14	66:7 126:5	compliance 33:20 36:23	confirm 105:18
committee 67:20 68:10	140:18 142:23	complicated 44:5 110:13	118:17
69:10,11 70:23	143:2 151:5,6	complicates 45:6	conflated 37:4
71:17 73:13	151:7 152:2	component 26:25 27:1	conflict 68:18
committees 68:4	161:8	171:4,7,17	68:19
common 3:14	communicati... 3:10 53:5 54:6	composed 10:3	confuse 11:5
62:13 95:12,15	54:11,20	computer 31:12	confusing 67:2
96:2,23	140:12 167:19	concerned 146:3	84:10
communicate 37:16 56:24	community 9:19 49:9	concerns 95:16	congratulate 148:23
83:25 136:4	58:22 130:3	concluded 1:16	connect 148:12
143:8 149:4,9	companies 10:11 11:18	180:5	166:7
155:22 156:19	company 11:25	concludes 180:1	connected 14:2
156:23	12:4 20:25	conclusion 96:9	182:9
communicated 24:5 84:18	39:18	178:14	connecting 129:19 154:8
99:22 105:1	comparison 154:14,22	conclusions 138:5	connection 156:9
114:9,20 141:8	157:20	conduct 25:23	consciousness 178:13
148:17 152:6	complete 121:14 122:3	70:21 71:6	consider 24:16
156:16 171:7,9	122:18 132:22	conference 125:12 127:6	62:3 63:13
171:21 172:4	133:13 184:8	confidence 53:20	70:13 71:19
173:21 174:9	completed 47:17		130:12
communicating 96:2 98:9	completely 7:21 63:17		consideration 129:10
116:2,16	142:5,9,13		consistent 29:14 35:20
118:18 140:6			47:2 88:8
143:6 160:14			89:24 100:2
			104:25 105:23

[consistent - correction]

107:4 122:13 122:21,25 123:6 141:7,18 143:7 164:16 consistently 157:3 consortium 43:23 consultant 21:18 consultants 12:12 consumed 158:21 consumer 23:11 129:2,13 130:17 consumers 23:15 129:5 consuming 145:23 contact 18:8 167:13,21 contacted 135:11 167:16 contacts 166:19 166:25 167:20 contemplating 135:4 content 35:15 context 76:21 continue 5:7 37:15 171:15 171:18	continued 172:3 175:17 contract 21:17 27:1 48:22 49:3 50:5 55:1 contracting 47:21 48:7,7,9 48:25 50:2,13 contracts 15:10 155:8 contractual 23:22 contrast 149:10 149:13,15 161:20 contrasting 160:15,21 contribute 68:23 contributing 118:5,6 control 175:15 convened 83:6 83:21 conversation 60:7 64:12 147:5,8 169:16 173:2 174:13 174:17,21 175:16 conversations 5:5 64:10 78:19 125:15 125:23 146:8	conveyed 164:17 coordinate 151:5 coordinates 151:6 coordinator 10:18,19 21:3 copied 29:23 100:5,7 138:12 copies 122:19 copy 124:24 126:24 131:20 core 10:13 corner 30:6 correct 12:8 13:21,22 23:20 23:21 26:5 28:2,6,12 33:3 34:9 35:18 37:13 38:7 39:14,15 44:23 44:24 45:11,12 50:2,14 51:7 52:4 53:23 54:2,3 57:10 57:11 66:18,19 67:13,14 71:11 75:20,25 76:1 76:24 77:10,15 79:16 80:9,22 81:8 82:18 83:15 87:21 89:2,3,10 91:4	91:23 93:14,15 94:15,16 96:13 99:11,12 100:23 104:18 105:20,21 107:19,21 110:5 114:4,11 114:14 115:16 116:20 118:11 119:17,22 124:8 125:18 127:5 130:9 131:1,2 132:6 134:8,9 135:17 136:9,17 139:13,14 140:4 143:9 144:5 145:18 145:24 148:14 153:7,8 156:17 157:14,21,22 159:20 160:7,8 160:16,23 161:5,6,25 162:1,4 165:14 165:18,19 168:24 169:19 170:8,13,16,17 170:19 171:4,5 173:4 174:12 174:19 175:1,2 184:8 correction 103:11
---	---	--	--

[corrections - danforth]

corrections 184:6 correctly 89:14 121:8 corresponden... 24:12 34:19 35:1,2,5,14 157:24 168:7 corresponden... 157:18 cost 14:7 48:17 costs 24:15 council 12:17 13:3 22:2 23:11,12,12 counsel 2:9,14 5:11,17 8:19 18:23 19:8,9 29:20,21 60:12 60:22,23 61:1 99:21 100:4 121:1 134:7,7 138:19 139:20 178:3 179:22 182:8,9 counsel's 19:13 39:8 counterpart 128:3 counties 22:4 153:23 country 40:16 90:4 98:2 178:11	county 17:6 21:20,22 23:5 36:22,25 37:6 37:24 40:12 41:17,21 42:2 42:8 131:13 137:1 144:22 149:6 152:13 152:14,16,19 152:20,22 153:19,23 154:3,6,15,23 157:2,16,19 160:3 161:1,9 161:12,17 162:17 163:7 164:23 165:22 165:24,25 173:19 174:11 181:3 182:2,12 couple 17:20 21:3,16 26:10 37:2 40:9 62:23 63:11 65:2 109:7 110:15 147:16 course 30:1 31:9,13 32:9 100:9 106:4 107:6 121:21 133:10 134:3 137:10 144:18 147:7 172:19	court 1:1 5:14 5:19 6:5 7:3 16:10 47:7 50:24 119:5 177:8 cover 54:5 102:20 coverage 14:21 141:16 covered 37:5,7 37:10,15,18,25 38:5 39:14,20 40:11,17,25 42:3,12,17,22 42:23 44:1,12 44:22 45:11 132:10 136:15 154:6 160:9 162:19 165:6 165:17 178:4 covers 46:20 cpoe 115:19 create 21:24 47:8 50:10 68:25 70:22 156:11 creating 32:11 39:5 critical 54:14 crr 1:21 181:16 crutcher 2:2,6 cs 97:9 culture 14:21	curran 36:20 current 27:19 36:5 73:23 currently 23:18 28:1 customer 61:14 customers 61:10,11 cv 1:3 cycle 97:13,21 98:18,23 107:15,18 118:11,17 cycles 63:5 99:6 117:13 145:7
d			
d 3:1 5:1 22:14 22:15 26:14 67:3,4 74:19 129:20,22 142:20,24 143:4,7 144:14 149:16 161:20 d.c. 10:7 100:17 dabanka 2:6 5:23,23 dade 40:12 42:7 160:6 dallas 2:4 damaged 120:9 danforth 87:4 87:12 126:25			

[darcy - development]

darcy 100:17	170:21 181:11	defendants	17:17,19 18:13
dash 103:4	182:11 184:15	1:10 2:14	18:22 19:1,8
data 23:14,14	days 133:2	deferred 168:7	29:17 52:25
27:17,19 28:16	145:10 169:14	definite 38:12	72:9 100:14
28:17,21,21,23	175:5	definition	102:19 120:20
28:24 29:1,2	deal 48:16 50:6	76:21	125:11 126:12
33:22 47:6,10	133:23 134:11	degree 20:3,7,8	131:4 135:20
47:11,13,16	death 73:18	20:15,21	136:3 138:10
49:21 50:12	december 3:13	degrees 20:5,10	164:4 166:16
52:11 57:19	72:15,20,21	20:22	168:10 172:10
58:15 59:21,23	decent 154:5	deliberates	175:25 180:2,5
59:24 74:11,24	decided 134:25	72:7	182:5
75:5,7,9,10,11	decision 44:14	deliberation	described 54:6
75:24 76:23	58:24 70:14,21	77:22 81:3	73:21
78:7 80:1 82:1	71:10 91:15	113:4	description
94:3 95:16,23	129:9 133:11	deliberations	46:21 108:10
99:1,3,4	135:15	82:10	design 9:22
110:19 116:12	decisions 15:2	delivered 140:1	47:20 155:8
116:14	70:4,15,18	demarino	designated
date 1:14 86:25	111:20 129:2	38:24	138:18
121:1,4 139:1	129:13 130:6	department	detail 72:1
169:14 174:20	deck 31:5 91:1	21:4,7,11,12	117:20
175:9 183:24	140:14	depend 49:13	detailed 174:22
184:12	declare 184:4	dependents	details 28:19
dated 102:21	decline 61:22	37:12 45:5	determination
120:24 131:17	103:24	depending	79:20 83:5,14
169:1,22	declined 63:4,9	145:2	88:23 120:7
172:14 176:5	deemed 184:6	depends 25:5	determine
182:11	deeply 70:15	deponent 184:3	48:20 77:20
dawn 39:16	defend 127:21	deposed 7:7,10	determining
day 70:7	defendant	16:17	79:8
125:13 127:7	24:19,22 29:21	deposition 1:13	develop 21:21
136:11 145:14	145:3	3:5 5:10 7:16	development
145:16 159:1		14:6 15:16,23	74:11 111:4

[dialogue - document]

dialogue 168:5	131:14 159:9	28:1,5,9,11	discussions
dicker 1:18	166:18,24	31:6,7,20 36:1	44:11 68:14
2:11	167:20 168:2	36:6 42:13	69:19 73:24
dictionary	172:13 173:7	57:4 67:12	81:20,21 174:4
76:21	173:10 176:5	71:8 80:25	175:20
difference	177:18 179:5	86:17 91:2	display 125:25
43:20 85:15	direct 3:3 6:14	100:16,24	displayed 73:3
differences	15:10 24:16	101:3,6,8,16	135:10
92:21	26:20 35:12,13	102:9,14 103:5	displaying
different 12:16	47:21 48:7,7,9	106:22 107:5	125:24
15:8,11,13	48:22,25 49:3	114:21	dispute 123:19
19:3 21:24	50:1,4,13	disagreed 70:3	distorting
25:24 27:20	65:22 124:19	disagreement	141:25
41:3,10 45:15	135:13 137:6	70:9,13	distracting
45:19,19 48:8	151:15 154:9	disclosing	19:20
55:6,7 78:24	154:16,24	23:24	distributed
85:10,20	177:13	disclosure	136:7
108:24 110:4	directed 35:7	68:20	district 1:1,1
110:18,25	126:9 152:2	discuss 83:17	11:16 40:14,15
120:13,14	directing 50:6	83:20	districts 10:11
130:2 162:13	50:7 177:15	discussed 54:4	40:19
163:17 173:16	direction 27:6	77:11 84:2,21	diversify 74:9
differentiation	69:17	85:4,9,19	division 1:2
25:16	directional	136:12 175:6	dmm 1:3
differently	58:2	discussion	docs 22:11
149:23	directly 26:21	58:11 65:4	doctorate 20:6
difficult 8:10	31:17 60:9	74:2 82:13,19	20:17,18
45:8 81:6	61:9 97:7	83:9,19 104:7	document
178:23	director 22:1,7	104:11,17,19	15:19,21 29:16
diligence 48:19	36:12,21 38:19	104:21 114:25	29:23 30:5,6
49:16	40:2,14 100:15	130:24 139:19	30:12 31:1,4
dinger 18:5	170:1	139:25 146:2	31:11,13,19,19
33:6 35:23	directors 3:9	147:23 163:9	32:5,8,12
52:12 123:5,8	3:16,19 10:2		35:12,16,17

[document - ease]

46:4 51:4 53:9 53:12,13 54:5 55:10,21 66:8 72:13,18 74:13 98:8 99:15 100:6,7 101:10 101:14 104:5 105:24 106:3 107:10 109:10 114:5,8,15 121:16 122:9 122:11 123:19 125:1 126:19 127:23 134:2 136:19 138:10 138:24 140:22 141:5,10 146:11 150:2 168:12 documents 18:23,24 29:10 29:24 31:9,14 99:20,25 100:3 114:7 129:11 138:14 doing 13:7 18:11 21:18 24:16 46:15 48:18 55:11 82:8 90:15 111:13 128:11 129:21 149:23 157:4 168:4	donate 68:21 donations 69:1 double 84:10 doubt 31:18 32:4 101:11 107:8,9 121:25 doubts 122:2 dr 6:17,18 9:5 19:24 31:1 61:3 72:16 86:13 100:18 102:25 121:4 126:19 131:11 135:25 137:22 138:23 140:21 141:3 168:16 draft 3:12 72:13 139:14 dramatically 103:23 drawing 141:14 driver's 181:22 driving 48:21 ds 97:9 153:20 153:23 154:3 154:15,23 156:4 157:19 160:3,14,20 161:1,9,12,17 164:23 due 48:19 49:16 151:24	dues 37:21 duke 20:2 21:4 duly 6:12 181:8 dunn 2:2,6 5:22 5:24 106:18 durham 20:25 duties 34:3 53:21 69:7 duty 69:12 dynamic 64:21 e e 2:1,1 3:1,6,17 3:21,22 4:2,3,4 4:5,6,7,9,10 5:1 5:1 17:21 35:18 56:16 73:3 87:9 102:20 103:7 125:13 126:8 126:22,22 127:4,7,8,16 128:10 129:15 131:12,16,19 131:22,25 132:4,5,13 134:6 136:11 150:19 151:15 151:15,18,23 153:15 158:9 158:20,21,24 159:2,8,16,16 160:18,24 164:8 166:18	166:25 167:20 168:8,12,20,23 169:21,22 170:20 172:12 172:19,22,23 173:3,6,15,20 174:1,7,18 176:4,9,12,15 176:17 177:17 177:18 178:2 178:10,12 183:3,3,3 earlier 33:5 45:9 47:2 51:6 54:4 55:1,4 56:16 67:11 73:21 74:14 76:17 86:15 91:13 105:1 116:25 119:15 124:3 125:15 127:3 132:12 133:1 135:9 136:3,12 144:3 150:23 151:1 165:16 168:4 171:22 174:1 174:16 176:22 earn 20:15 97:3 98:10,20 earned 98:13 earning 142:20 ease 16:10
--	---	--	--

[easier - enthusiastic]

easier 7:17	elissa 163:25	26:4 37:3 40:8	149:11 156:3
easily 83:11	164:8,15	41:4,5 43:15	157:14,16
east 22:2	elizabeth 2:6	43:18 44:1,16	165:21 171:13
edabanka 2:8	5:23	44:17,23 45:16	175:22
edelman 1:18	elser 1:18 2:11	45:22,25 46:24	employment
2:11	5:25 15:25	47:4,23 48:1	20:23
educate 72:4,4	employed	50:1,5,11,15	encourage 24:9
147:18 152:25	20:25	60:5 63:15	24:13 25:10
educating	employee 15:11	64:1 68:17	54:15 56:3,25
14:19	37:8,11,21	135:6,9 136:4	61:21 62:3
education 9:16	39:22 45:4	136:7,10,12	63:25 65:9,15
educational	49:1 132:9	144:23 147:13	82:2 119:21
41:7,12 42:10	182:8,9	147:16 148:12	120:4 122:15
146:20	employees	151:10 154:5	123:2,23
effect 77:8,10	11:17 12:1,5	162:11 163:6	encouraged
77:12	12:14 13:14	163:23 165:8	62:15,16 63:1
effective 157:5	14:3,18,25	166:13 167:16	encouragement
efficient 39:10	15:1,7 36:16	168:3 170:15	64:24
effort 151:7	36:17,24 37:1	178:23	encouraging
156:1 171:16	37:11,23 38:7	employers 9:18	56:23 62:9
171:24	38:9,21 39:4	9:19 10:3,9	64:4 119:25
efforts 50:13	39:14,21 40:4	11:14 13:2,7	ended 85:11
143:19	40:9,11,25	13:10 15:4,5	ends 55:22
eight 115:4	41:10 42:2,4,5	25:9,24 36:9	engage 58:23
either 27:6 35:6	42:11,16,22,23	42:12 44:6	59:3,18 60:10
58:8 63:21	44:12,15,18,20	45:3 47:9,18	64:9
151:20 152:1,7	50:7 136:15	48:6 49:14	engaged 59:11
elderly 130:1	154:10,17,25	51:13 58:23	engaging 59:9
electronic	160:9 162:20	59:3,5,9,11,19	62:3 143:25
22:11	165:17	59:22 60:10,11	144:18
element 50:8	employer 10:7	60:22 61:3,9	ensure 23:13
elements 74:25	11:13 12:9,23	111:24 129:6	111:14
eligible 38:9,11	13:16,18 14:15	131:1,23	enthusiastic
45:4 120:11,12	17:24 25:19	147:21 148:6	169:25

[entire - expert]

entire 64:17	europe 150:25	except 165:23	134:20,23
entirely 175:2	evaluation 83:4	exchange 27:11	135:19,21,25
entities 23:3	events 101:7	61:12	136:2 138:9,20
equals 89:2	eventually	exchanged 27:6	140:22,25
equating	133:9	27:8	141:1,10
142:24 143:3	everybody	excited 56:7	150:13,16,18
equation 14:8	33:15 55:11	169:18	151:9 158:5,8
equity 49:23	87:8 157:2	excluded 89:8	159:5,7,8,23
especially 60:3	175:19	excuse 26:16	164:3,4,6,17
68:24	evidence	120:8 162:6	166:16,20
espinosa 38:15	112:19,22	execute 33:16	168:9,17
38:18	113:15	executive 22:1	172:10,11,15
esquire 2:2,6	evidentiary	70:4 139:17,20	172:24 175:24
2:10	30:11	executives	176:2
essentially 89:1	exact 77:7	83:25 84:18	exhibits 107:4
104:13	82:19 123:5	exhibit 3:7,8,10	exist 22:22
establish 39:9	169:14 174:13	3:12,14,15,17	expand 74:9
estimate 37:18	174:20	3:18,20,21,22	expect 126:1
38:6 45:9 78:3	exactly 30:21	3:23,24 4:1,2,3	132:5
78:11,12 79:14	64:18	4:4,5,6,7,9,10	expectation
80:7,12,20	examination	15:15,17 29:5	50:9 55:11
81:6,14 95:3	3:3 6:14	29:6,7 30:24	expectations
102:2 112:16	examined 6:13	52:24 53:1,3	60:8
114:3,10,12,16	example 18:19	58:17 61:17	expenses 27:9
114:21	20:8 47:21	72:9,11 86:8,9	experience
estimated 42:4	48:12,25 66:5	86:11 99:18	28:13 68:13
42:25	70:25 120:8	100:11,13,14	79:6
estimates 41:25	examples 20:9	102:18,23	expert 70:16
94:23 95:7	exceed 37:10	105:23 106:6,8	77:20 78:1
estimating	exceeds 38:6	107:4 120:20	83:14,17,20
114:6	excellence	120:21 121:6	84:3,21,22,22
et 1:6 5:12 9:23	48:12 49:2,4,6	124:13 126:12	85:4,4,10,20
16:14 183:1	49:10,12,15,22	126:13,15	91:14 94:10
184:1		131:4,6,8,8,11	104:1,23 105:3

[expert - first]

113:5 142:12 expertise 28:13 68:13 83:7 experts 71:3 83:5 expires 181:17 explain 37:20 94:6 124:9 178:20 explained 76:6 explanation 94:18 explicitly 52:7 extensive 83:4 extreme 66:5 120:8 extremely 116:11	factor 12:14 79:8 118:5,7,7 facts 141:25 faculty 22:18 fair 12:24 15:3 42:13 47:11 50:7 56:23 74:5 79:9 96:10 117:4 123:22 132:11 135:3 136:16 144:12 145:8 151:5 158:20 fall 18:4 26:11 76:9 77:1,3,4 85:12,22 98:22 103:22 107:18 107:20,23 115:23 familiar 9:17 33:14 51:17 61:14 66:11 146:17 147:9 168:8 fan 132:22 far 10:4 31:11 40:16 110:1 farms 2:11 farther 132:20 favorably 10:15 fear 141:25 federal 21:23 22:10	fee 28:25 37:22 58:8 feel 38:23 45:19 154:1 174:14 feeling 148:4 fellows 146:17 146:25 fellowship 146:18 felt 133:3 162:4 pha0000001 135:24 pha000045 29:8 pha0000907 150:12 pha0000913 158:9 pha0000921 164:5 pha0001739 131:9 pha0001749 166:17 pha0001995 131:5 pha0002072 86:12 pha0002195 172:12 pha0002516 176:1 pha0002804 126:16 159:6	pha0045 30:8 fiduciary 69:12 figured 18:18 figuring 47:18 filed 125:10 126:6 127:20 136:25 161:3 fill 75:10 76:18 113:6 146:9 final 3:12 44:14 72:13 103:8 finances 57:6 financial 33:19 57:11 69:13 financially 182:10 find 34:22 110:15 fine 6:22,23 50:21,24 148:8 179:12 finish 7:21,22 11:23 16:6 134:2,3 fired 106:18 first 6:12 30:8 32:17 54:10 58:21 66:9,10 66:15 74:9,12 93:25 95:20,22 103:16 108:13 109:9 121:8 122:24,24,25 123:21 141:21
f			
f 26:14 74:19 129:20,22 142:20,24 143:4,7 144:14 149:16 161:20 facilitate 50:12 facilitates 34:18 facilitating 35:1 fact 33:12 72:2 113:11 118:15 122:8 127:19 145:21 151:24			

[first - forgotten]

163:10 171:11 176:17 177:21 fiscal 3:12 72:14 fisher 1:21 5:15 181:5,16 182:4 182:17 fit 23:8 five 17:5 45:12 74:6 137:1 139:17 152:19 153:19,22,23 154:2,11,15,18 154:23 155:1 156:25 157:18 160:3,25 161:2 161:7,8,9,11,11 161:14,16 164:22 flames 132:22 flex 9:22 flip 31:22 32:14 32:23 35:25 45:21,24 46:4 46:6 53:10 55:21 62:7 74:4 87:23 89:18 92:11 93:16,20 95:11 95:14 108:5 132:17 136:19 158:16 159:15 172:22	flipping 43:11 58:17 103:15 141:5 142:15 146:11 florida 1:1,20 6:4 9:8 10:23 10:25 11:1,8,9 11:12,13,18,24 12:1,2,3,6,7,13 13:23 14:6,16 16:2,20,22 17:13 19:12 20:20 21:14 22:2,6,12,13,14 22:16,21,23 23:1,2,6 24:1,5 24:21,23,24 26:3,23 27:10 27:13,18 28:9 28:14,25 29:9 29:15,18,25 31:8 32:24 33:11 34:11,19 35:2,6 36:5,9 36:15 37:23 38:25 39:19,20 40:8,11,16,25 41:13,15,19 42:11 43:22,25 44:13 45:10 46:15 50:10,12 51:6 52:3 53:22,24,25 54:1,20 60:4	63:4,15,21 64:4,13,22,22 65:5,8,10,14,16 66:17,19,22 67:3,4,4,6 68:3 79:1 86:12 97:20 100:3 111:22 118:10 118:13,15 119:15,20,24 120:3 121:22 121:25 122:14 122:14 123:1,1 123:12 124:23 125:2 126:17 130:21 131:1,5 131:8,23 132:10 133:17 135:5,23 136:7 136:8,13,14 137:10 144:12 144:25 146:19 147:8,11,14,19 147:25 148:13 150:6,11 151:2 151:10 153:1 154:1 156:2 157:6,14,15 158:5 159:6,19 160:1,13,19 161:8 163:3,4 163:13 164:5 165:10,11,17 165:21 166:2,9	166:13,17 167:15,16,17 168:3 169:11 170:15 171:16 176:19 177:3 177:14,16 181:2,7,16 182:2,5,12,18 fluctuate 37:4 focus 142:19 focused 12:22 focusing 54:14 follow 55:15,17 56:20 58:5 64:8 109:7 140:17 174:5 174:22 178:12 followed 83:14 106:2 following 20:21 20:24 105:5 106:1 134:24 166:25 follows 6:13 54:20,24 103:25 104:22 food 8:25 force 27:24 foregoing 182:6 184:5 foreshadowing 16:9 forgotten 133:7 133:7
--	--	--	---

[form - go]

form 42:14 43:3 55:19 57:7 65:21 68:20 75:12 79:17 80:10,23 85:13 88:17 95:5 98:4,16 98:25 105:13 108:21 111:9 111:21 113:16 116:6,21 117:5 117:11 124:1 143:21 149:17 155:2,14 156:7 156:22 158:23 175:13 179:10 formed 110:6,9 forth 8:21 27:21 44:8 47:13 forward 37:16 70:10,18 108:9 138:18 162:22 170:9 forwarded 173:6 forwarding 169:21 177:17 four 22:3 33:14 36:18 38:6 42:2 45:12 76:10 98:1 112:25 117:24 145:15	fourth 107:18 fpl 162:24 163:2,17 free 129:8 frequently 34:4 front 43:8 150:16 fs 97:9 153:20 153:24 154:3 154:16,24 156:4 157:19 160:3,15,20 161:1,9,12,17 164:23 full 6:25 53:20 62:3 84:2,21 85:4 116:8 121:12 137:24 fully 24:8,9 52:1 63:7,22 90:10 91:7 110:6,9 120:10 funded 9:20 funding 46:19 74:10 further 10:20 128:25 141:14 148:10 163:18 166:1 179:24 182:8	gain 89:22 90:7 90:21 91:8 92:1 gains 45:18 gaming 79:4 gap 63:6 113:6 garnered 143:13,17 general 120:13 130:3,17 generally 54:24 generate 26:15 75:5,8 76:22 76:23 generated 25:19 generates 17:9 generation 35:15 getting 19:1 59:23 83:2 117:1 150:3,5 giagnacova 5:14 giant 73:17 gibson 2:2,6 5:21,23 106:18 gibsondunn.c... 2:5,8 giralda 2:11 gist 149:20 give 6:8 14:25 30:15 47:8 69:24,24 78:21	91:2 112:7 113:18 128:24 130:3 155:19 156:10 given 15:22 57:1 77:6 97:13,20 98:1 98:13 116:19 184:9 gives 111:11 113:11 165:8 giving 38:2 112:10 113:21 global 39:18 globally 11:19 glues 162:14 go 5:8 7:16 8:25 14:11 15:11 25:21 26:7,14,21 27:10 30:9 31:24 35:14 38:3 44:8 50:19 52:20 53:12 54:9 56:19 65:1 78:24 84:13 85:24 92:4 115:3 118:23 119:5 120:10 131:16 133:4 134:10,13 137:5,13 146:1 147:11 148:2
	g		
	g 5:1		

[go - hain]

154:10,17,25 172:3 175:16 176:9 179:1,14 goal 51:9,11 52:2,3 120:11 154:9 goals 51:20 goes 26:9 93:9 115:18 177:21 going 7:16 16:9 37:17 38:2 39:7 46:4,15 50:18,21,25 58:6 71:14 84:1,13 87:18 91:24 92:7 99:25 107:14 107:14 116:12 117:25 125:25 127:20 128:21 129:15 130:24 131:7 146:16 146:25 148:5 152:12 160:18 170:21 171:10 171:18 175:7 175:16 176:18 good 1:5 5:2,11 6:16 16:14 48:18,19 49:16 130:11 137:25 147:10 174:25 175:3,12 178:3 183:1 184:1	google 144:16 governmental 23:3 governments 23:5 governs 27:1 grade 17:8,10 26:17 28:21 47:10 49:19 72:5 74:15,17 75:1,6,8,18 89:8,13 91:19 91:21,23 92:1 92:5,7,9,22 93:2,17,21 96:11,17 98:18 103:17,22 104:3 105:20 107:18 108:7 108:10,15,19 109:15,21,24 111:5,7,13 112:13 125:24 125:25 127:1 127:13 128:17 129:10,22,25 130:17 131:25 132:15 142:12 143:10 149:15 157:3 161:20 161:21 164:22 173:17,23 174:10 175:11	graded 26:13 110:11 111:2 grades 17:7 25:21 26:4 71:20 74:19 93:2,4,9 101:18 107:15 108:2 111:19 128:11,23,24 129:2,13,20 137:2 144:14 145:2 149:16 153:19 grading 50:12 75:4 97:12 98:23 101:17 101:23 110:18 110:23 111:7 118:11,17 149:23 graduation 20:24 grant 21:23 22:10 46:19 granted 46:1 grants 74:10 greater 22:5 58:9 ground 7:16 51:12 group 1:9 3:15 3:18,24 5:13 6:1 16:15 17:7 24:19,22 25:2	25:20 26:5,24 27:13 29:1,22 30:5 34:8 66:9 68:22 71:2 74:18 100:15 101:5,15,16 103:5 105:1 106:21 107:5 119:17 136:21 137:1,2,7,23 138:11,14,15 138:24 139:6 143:19 177:10 177:13 183:1 184:1 guess 30:20 38:3,20,23 55:9 61:13,13 62:2,20 68:6 96:15 112:16 123:15 140:7 166:11 guessing 38:23 39:15 guidance 135:14 guide 53:16 55:12,14,17
			h
			h 3:6 183:3 hain 34:12 35:20,21 150:19 152:2,5

[hain - hmm]

158:11 159:16 164:8 166:19 177:19,25 hain's 34:15 151:1 half 19:11 hand 6:6 30:6 93:25 99:17 106:12 115:19 181:11 handed 30:23 106:7,20 126:20 150:10 166:15 handful 12:18 handing 15:15 29:4 52:24 72:8 86:8 100:13 102:17 120:19 126:11 131:3 135:19 138:8 140:21 158:4 159:4 164:3 168:9 172:9 175:24 hanlon 121:8 121:18 happen 125:16 157:10 161:14 168:6 178:25 happened 174:22 happening 118:1 145:8,9	happens 34:4 111:4 113:3 happy 50:25 60:25 119:2 hard 178:12 harder 115:24 116:3,17,25 117:1,4,17 118:8,12,14,19 harm 156:25 hate 162:23 hats 33:15 hca 63:3,5,24 64:21 head 39:2 40:6 52:22 headquartered 12:13 39:19 headquarters 163:8 heads 8:2,2 health 9:15,18 10:8 13:2,13 14:2,17,22,25 20:13,13 21:2 22:2,3,7,11 23:11 36:12 37:12 43:22 48:10,11,21,23 49:7,11 59:24 60:7 128:4,6 129:6 156:11 healthcare 6:4 9:8,21 10:9,10	10:23 12:11,12 12:17,18 13:3 13:11,12,24 14:1,7,16,17,20 15:2 17:6,14 22:14,16,23 23:10 24:15 41:8 49:11 51:14 59:6,20 60:22 61:4,7 66:20 67:3,4,5 67:6 68:17 111:20 121:23 130:7 136:8,13 hear 66:9 81:1 87:11 170:6 heard 10:7 40:22 61:11 66:10,15 79:7 81:20 89:12,13 99:1 136:25 143:17 144:20 144:20 145:6 145:25 171:10 171:12 hearing 52:13 84:24 85:23 143:23 146:4 151:20 178:24 heavily 143:25 heavy 64:19 held 44:9 help 22:7 50:12 71:3	helpful 10:22 39:10 68:13 138:6 helping 14:25 helps 51:18 hendry 40:3,4 42:6 hereto 184:7 hh 181:17 hi 6:3 high 20:22 26:1 26:16 46:14,17 46:20 72:5 156:10 157:3 higher 78:22 83:2 112:19 113:19 150:5 highlight 148:23 155:17 156:9 173:17 173:22 174:5,9 highlighted 144:13 highlighting 156:3 175:11 hill 20:16 hire 48:13 hired 21:10,20 22:1 history 20:23 130:2 hmm 11:11 36:2 41:1
--	---	--	---

[holtzman - hotels]

holtzman 38:24	89:8 91:18,20	25:10,23 26:13	117:3,18,22
home 21:1	91:23 92:1,4,7	26:17,18,19	118:10,16,19
48:23	92:8,9,21 93:1	51:15,25 52:9	119:20,25
homes 165:3,4	93:8 94:3 96:5	56:7,12,16,25	120:4,16
165:7 170:10	96:8,11,19	57:8,14,16,23	122:14 123:2
170:18	101:17 103:16	58:1,4,6,14,14	123:12 125:10
honestly 38:20	103:25 104:2	59:12 61:7,10	125:23 127:9
hope 24:15	105:6,11,12	61:22 62:15,16	127:12 128:12
46:17 128:12	108:16,20	62:19 63:1,4,6	128:18 129:3
175:9	109:16,22	63:13,21 64:11	129:16,19
hoped 82:11	111:12 112:11	64:24 65:9,15	131:13,24
hopefully 132:5	112:12,13	65:16 66:1	132:1,14
136:20	113:8,15	71:20 74:19	133:18 137:1
hopes 55:14	114:13,16,22	76:4 77:13,19	142:20,25
60:8	116:4,5 117:2	78:20 79:3,9	143:4,7,9
hopkins 94:10	118:9 119:21	79:14 80:8,21	149:11,14,22
102:21 168:14	120:1,5,9,13	81:25 82:2,3	152:19 153:19
hospital 17:8,8	122:15 123:3	82:11,17,24	153:23,24
21:4,9,12	123:24 124:14	83:1 88:2,4,13	154:3,11,15,18
24:10 28:21	124:16 128:20	88:16,22 89:7	154:23 155:1
48:14 49:7	128:24 129:12	90:4,8,22	155:13 156:4
51:21,22 54:13	129:13,23,24	93:21 95:4,7	156:14,25
54:15 55:24	130:13 132:21	96:3,12 97:2,9	157:19 160:3
58:24,25 59:7	133:12,13	97:12,18,19,25	160:14,20,25
60:7 62:17	143:10 147:21	98:3,9,13,15,19	160:25 161:2,8
63:2 64:12,22	149:21 153:18	99:4,5,5,7,10	161:10,12,17
74:15,16,21,24	156:10,11	102:3 103:24	161:21 164:22
75:2,4,17,19,20	157:17 161:20	108:3,15,20,25	169:6 173:18
75:23,24 78:8	164:21	109:2,15,21,25	173:24 174:11
78:12,15,16	hospital's	110:5,11,14,21	hotel 38:10
79:2,2,25	144:13 149:16	111:1,2,7,8	100:17
80:13 81:6,9	hospitals 12:11	112:1,5 114:2	hotels 36:13,16
81:13,14,15	12:17 17:5,16	115:5,7,14,22	37:17,19 38:6
82:4 88:23	23:7 24:2,6,8	116:11,18	42:2

[hour - included]

hour 19:10,11 50:18	102:24 105:17 105:23 106:5,7	42:10	imply 88:14
hours 100:4 119:3	106:11,15,20 106:23 109:4	idea 153:4,6,9 153:10 163:9 175:1,12 179:6	important 30:19 63:14
housing 177:8	111:17 112:3	ideas 62:9	impressive 22:20
houston 128:4 128:6	113:20 116:15 116:24 117:9	identification 15:17 29:6 53:1 72:11	improving 87:24
hr 40:2	117:16 118:22	86:9 100:11 102:23 106:6 120:21 126:13	imputation 79:13 93:17,22 95:2 97:14 98:13,23 102:1 108:14,19 109:1,14,20,24
human 40:2,6 170:1	119:2,7,13,14 120:19,23 121:3 126:11 126:15,18 131:3,7,10 134:1,5,10,13 134:19 135:22 137:13,20,21 138:8,22 140:21 141:2 144:2 149:3 150:1,10,15 155:10,20 156:15 157:12 158:4,9,13 159:3,8,12 164:7 166:15 166:21 168:19 172:9,16 175:23 176:3 179:14,22	131:6 135:21 138:20 141:1 150:13 158:8 159:7 164:6 166:20 168:17 172:15 176:2 181:21,22	impute 76:14 76:19
hundred 165:17		identified 29:10 68:11,12	imputed 76:8 76:14 90:9 98:1 102:5 103:23 114:2 115:9,15 116:19 117:24 124:15
hunt 39:16		identify 76:20 78:2	imputing 90:23 94:1,7
hurricane 66:2		impact 10:15 57:16 104:2 105:6,10,15 130:6	inaccurate 122:11
hvidt 2:2 3:3 5:21,21 6:15 15:18 19:18,22 29:4,7 30:3,17 30:23,25 32:7 42:19 43:10 50:18,23,25 51:3 53:2 55:20 57:13 60:14,21 61:1 61:2 67:9 72:8 72:12 75:16 80:4,15 81:11 81:23 84:12 85:17,24 86:6 86:7,10 88:25 92:14,20,23 95:8 98:7,21 99:2,17 100:10 100:12 102:17	hygiene 115:19	implement 21:21 84:2 implemented 83:22 85:16 implementing 85:12 implies 96:23 105:16	include 90:24 130:13 135:4 135:16 154:1 171:16
	i		included 9:12 37:12 44:18 89:9 91:18,20 91:25 92:4
	icuba 40:25 41:1,9,13		

[included - introduce]

122:20 131:22 131:23,24 includes 75:18 124:1 including 24:8 74:10 inclusion 96:22 increase 51:21 57:15 58:2 89:25 90:2 105:11 increased 45:14 increases 58:2 independent 41:2 48:15 indicate 172:2 indication 105:25 indirectly 61:9 individual 27:15 28:5,12 62:16,25 63:19 64:23 81:3,5 individually 62:18 65:8 individuals 36:9 industrial 162:14 industries 10:12 13:11,19 40:3 42:6	industry 13:12 38:10,12,12 45:3 74:11 influence 8:10 25:9 58:24 60:2 129:2,4 129:13 inform 168:5 information 15:1 17:25 23:11 25:22 26:21,22 47:22 50:16 65:24 74:2 78:7,18 81:9 83:10 97:23 107:9 112:9,18 113:9 122:20 123:15 125:25 128:20 129:7,25,25 135:7 167:21 180:4 informed 71:25 125:17,20 154:13,21 informs 176:18 infusion 48:23 initial 54:14 initially 133:12 175:2 initiate 35:1 153:3 initiates 131:20	initiatives 10:1 13:4 innovative 157:4 innovatively 149:24 inquiries 137:6 insert 29:22 100:5 insightful 70:11 insist 59:20 instance 65:25 instances 45:18 62:24 institutions 41:7,12 42:10 instructions 54:12 insurance 33:20 178:5 intelligence 71:1 intend 171:3 intended 171:15,22 intent 3:12 72:14 78:14 79:12,21 91:14 121:10 124:2 147:17 148:11 148:18 152:23 155:11,16 156:17,18,20	156:24 161:7 161:19,22 172:5 174:3 intention 65:19 171:6 interact 13:9 interest 13:12 14:1,16 17:15 68:18,19 interested 13:7 14:24 58:15,15 157:17 169:15 169:18 182:10 interesting 144:15 145:5 international 165:9 interpret 62:1 95:1 111:3 143:18 159:1 170:25 178:9 interpretation 143:24 178:13 interrupt 133:23 interrupted 87:16 interview 66:13 interviewing 66:11,16 interviews 148:25 introduce 155:19
---	--	--	--

[investigate - knew]

investigate 128:25 investigation 81:2 invitation 167:25 invited 67:17 67:19,24 involved 10:15 17:22 21:23 31:14 53:17 77:5 79:20 127:9,12 ips 115:19 issue 17:9 28:17 55:7 59:22 77:22 78:21 106:19 145:3 152:21 issues 25:24 62:6 118:3 177:3 issuing 64:5 italian 162:13 item 10:22 32:17 54:22 56:6 57:12 58:21 59:6 72:25 95:22 102:6 121:9 138:13 items 56:3 70:1 110:15 139:16	j	105:19 137:23 139:1,10 141:19 151:19 155:21 168:1 169:23 170:11 171:7,22,24 173:11 jupiter 126:25 137:6 147:6,11 148:23 149:10 149:14 150:8 150:22 151:11 152:15,22 153:11,17 154:8,10,14,17 154:22,25 155:12,18 156:2,3,24 157:1,20 158:10 159:10 160:1,15,21 164:12,20 167:22,25 168:14,14 169:5,11,17 170:25 172:1,4 172:13,25 173:17,22 174:9,23 175:4 175:10 176:6 176:13 jupiter's 149:15	jurisdiction 177:9 juxtaposing 155:12
	jack 33:13 jacksonville 166:3,4 jair 38:15,16 38:18 jam 133:24 january 48:5 181:17 jerad 121:8,18 jersey 2:12 jill 146:24 job 9:12 48:18 joe 146:22 johns 94:10 join 67:15,17 158:10 159:10 164:11 joined 22:22 67:5 70:17 joint 21:12 july 146:16,16 150:25 158:11 158:25 159:10 159:16 162:7 162:23 164:12 176:6,13 177:7 177:20 jump 138:5 june 72:2 100:16 102:9 102:21,22 103:3,6 104:8	k karen 1:13 3:2 5:10 6:3,11,22 6:23 7:2 15:25 65:3 102:18 126:9,25 137:6 158:10,11 159:9,10 164:11 168:13 168:14 172:12 176:5 181:7 182:5 183:2,24 184:2,4,12 keep 50:21,25 149:5 163:6 keeps 34:17 kenneth 36:11 kept 121:21 kick 170:22 172:1 kids 21:17 kind 25:25 28:20 62:5 64:8 70:8,18 95:15 147:23 175:19,20 knew 8:16 17:21 68:5,7 104:10 144:19	

[knew - leader]

163:6	74:20 76:20	152:24 153:10	launch 55:23
know 7:15 9:25	77:5,7,7,18	153:10,12	launching 3:10
10:4 11:16	79:3,21 80:11	154:19 155:5,6	53:5 54:12
15:9,10,12	81:18,21 82:4	155:7,8,16	58:22
16:8 18:10,17	83:3,11,23,24	161:22 165:9	lauren 126:25
18:18,18,18,19	84:5,5 85:15	166:5 171:18	140:6,7,8,10,13
22:18 23:13	88:20 89:7	172:7 175:15	141:8,13,18
25:3,4,6,15	91:9,12,13	175:19 176:10	143:12 146:13
26:12,13,21	93:6,6,8,12	knowing 42:4	146:15 155:22
27:10 28:22	94:17,19 96:6	85:9	168:13 170:20
30:12 31:15,17	97:11,16,16,19	knowledge	171:25
34:3,21 35:9	97:23 98:17,22	65:23	lauren's 172:6
35:10,14 36:3	99:13 101:22	known 42:24	lawsuit 17:1,4
36:15,15,24	102:15 105:15	68:2 123:6	18:20 125:9
37:6,24 38:1,8	107:20,25	181:20	126:1,6 127:1
38:13,18 39:3	108:23 109:25	knows 28:19	127:5,10,13,19
39:4,6,13,20	110:21 111:3,4	koch 39:23,23	130:21 131:12
41:16,18,22	113:1,2,3,10	39:25 40:1	135:5,17
43:18,25 44:4	114:25 116:8	I	136:25 138:2
44:18 45:18	117:8,19,20,20	lacking 122:5	143:14,19
48:16 49:11,18	117:23 118:7	lake 22:8	144:4,13 145:1
49:19 51:23	120:2,9,11,12	landed 44:13	146:9 148:4,7
52:7,9,9,13,17	120:13 121:7	language	161:3,15
52:18,20 54:22	121:14 122:6,7	162:12	167:13,17
54:23,24 56:5	122:7 123:5	large 38:21	168:3 173:18
57:18 58:8,10	125:8 127:25	largely 43:21	173:23 174:10
58:12 59:12,12	127:25 128:22	largest 40:15	175:7,12,21
59:16 60:1,3	129:21 130:5	40:16 59:6	lay 60:8
63:17,20,24,25	130:18 135:10	lastly 40:23	leader 3:10
64:4,6,25 65:3	135:10,12,12	late 47:8	17:14 18:3,6,8
65:18,21 66:4	141:6 144:16	107:18 125:16	18:10 24:23,25
68:16 69:11,12	145:1,2 146:3	125:17	25:5,14,18
69:14 70:14	146:5 147:15		26:3,25 27:1
71:5 73:13	147:22 149:19		27:14,16 33:18

[leader - leapfrog]

34:6,7,8 46:23	171:13,21	69:18,20,22	108:20 109:14
47:1 51:7,17	172:24 173:16	70:2,3,4,10,15	109:15,20,22
52:14 53:5,15	173:21 174:8	70:19 71:2,7	111:6,11,19,25
53:24 55:5	176:12,16,17	71:21,22 72:13	112:4,7,11,13
60:1 64:3,5	178:2 179:1	74:18 75:3,17	112:24 114:3,6
68:6 111:23	leapfrog 1:9	75:20,24 76:3	114:9,20,23
119:16 128:5,7	3:10,12,14,15	76:16 77:18,25	115:8,12,13
146:5,22	3:18,24 5:12	79:24 80:5,6,9	116:2,5,16,19
leaders 25:8	6:1 16:15 17:7	80:18,19,22,24	117:2 118:17
51:10,21 53:23	17:22 19:4,14	81:4,13,15,18	119:16,21
54:7 55:14,16	24:9,16,18,19	81:24 82:1,2	120:1,5 122:15
56:24 58:19	24:22,24 25:1	82:15,22 83:12	123:3,15,23
59:3 62:2	25:2,20,25	83:25 84:18	124:14,16,20
126:23 127:16	26:4,21,24	85:11,11,21	125:23,24
127:19	27:13,18,20	86:16,16,17	126:7,10,24,24
leadership	28:1,4,8,10	88:5,16 89:22	128:8,17 129:1
154:20 175:4	29:1,22 30:5	89:25 90:2,2,6	129:4 130:14
leading 9:25	34:8 46:23	90:11,20 91:2	130:17 131:12
leads 39:17	47:1,10,15	91:3,7,16,22	131:25 132:14
58:2	49:17 50:11	92:1,21 93:1,4	133:2,13,17,19
leah 67:21,22	51:18,22 52:6	93:8,21 94:2	136:21,25
67:23 68:2,7	52:8,18 53:6	94:22 95:2,6	137:2,7,23
69:24 87:4,11	53:17,18,25	95:12,16,23	138:11,14,15
102:11,21	54:13,13,21	96:2,11,18,24	138:24 139:6
103:5,7 104:12	55:13,23,24	97:3,8,20 98:8	140:23 142:8
104:15 125:13	56:23 57:4,17	98:10,20 99:20	142:11,23
126:9,23 127:4	57:24 58:3,11	100:15 101:5,8	143:3,19
127:8,16	58:22 59:2,8	101:15,16	146:18 147:20
130:20 131:24	59:17,22 60:10	102:1,9 103:5	147:23 148:18
133:4 139:21	60:11 62:10,17	103:25 105:1	149:4,5,9,15,15
146:21,24	63:1,9 64:7,11	105:12,19	149:16 153:12
147:4,5,9,24	66:9 67:12,23	106:21 107:5	153:18 154:16
148:21 168:13	67:25 68:9,14	107:22 108:2	154:24 155:11
168:24 169:9	68:22 69:2,8	108:14,15,18	155:17,23

[leapfrog - litigation]

156:3,5,9,19	157:5	162:13	113:5 116:19
164:21 167:13	learned 148:24	level 12:14	line 38:3 43:9
167:17 171:15	learning 9:19	20:22 25:5,7	57:11 59:6
171:23 172:2	leave 18:16	25:16 26:1,16	94:8,9,13
175:11 177:7,9	27:10	28:20 46:14,17	100:21 104:5
177:12 183:1	leaving 91:9,17	46:20 68:24	183:4,7,10,13
184:1	led 13:1	72:5 85:6 94:2	183:16,19
leapfrog's 47:7	left 93:25 95:22	94:7 112:19,21	lines 115:4
51:7,9,20,24	151:18,19	113:1,13,18,19	link 26:14
53:22 57:6	legal 5:16	113:21,23	34:23 139:4
59:10 71:10,19	22:13,24 67:2	114:1 116:13	lisa 34:12,15
73:22,23 74:15	139:22 177:3	149:22 157:3	35:20 150:19
74:16 88:3,9	lengthy 83:9	171:10	151:1,14 152:2
91:3 96:5	lennar 164:1	levels 12:16	152:5 158:11
101:2 107:13	165:2,3,4,7	26:17 55:6	159:16 162:2,7
108:10 127:21	167:6 170:10	lever 90:7,12	164:8 166:18
129:11 134:7	170:18	92:1	177:19,25
153:9 156:16	letter 3:20 65:4	levers 89:22	lisa's 158:24
161:19,22	66:1 121:7,10	90:21 91:7	159:2
leapfrog0032...	121:12,13,22	license 181:22	list 34:11 46:17
102:20	122:1,3,13,18	licensing 57:17	47:12,22 56:2
leapfrog0032...	122:25 123:6	57:18,20,22,23	66:5
3:17	123:13,21,22	licensure 74:11	listed 32:20
leapfrog0037...	124:12,18,22	life 7:17	33:8 36:8
72:10	124:24 129:20	lift 64:19	100:21 107:2
leapfrog0040...	133:1	light 163:3,14	lists 33:2
53:4	letters 24:7,10	likely 8:14 92:2	131:23 167:3
leapfrog0040...	25:12 35:9	118:4 132:22	litigation 16:18
4:1 140:24	56:12,16 63:12	limited 14:20	16:21,23 17:12
leapfrog0079...	64:5,25 119:20	64:5 76:12	24:3,19 29:8
4:8 168:11	119:24 120:4	77:16 78:6	53:4 72:10
leaps 73:17	122:13,19,25	82:5,25 90:24	86:12 102:19
learn 13:9	123:4,11 126:8	91:9 96:6	120:24 125:18
147:11 149:25	133:4,5,9,18	98:18 112:8,10	126:16 135:23

[litigation - mail]

140:23 150:11 159:6 168:11 172:11 176:1 177:9 little 27:25 36:19 39:16 40:5,24 41:3 103:10 150:3 166:1 178:12 live 12:5 157:16 lives 11:19,23 12:3,5 37:5,7 37:10,16,19,25 38:5 39:3,14 39:20 40:12,17 40:25 42:3,17 42:23,23 44:1 44:7,12,15,22 45:11 132:10 136:15 144:22 147:3 154:6 160:9 162:20 165:7,17,24,24 llp 1:18 2:2,6 2:11 local 61:18 123:15 141:16 144:12,25 located 41:15 41:16 163:7 location 139:3 locked 107:13 107:24	logo 121:23 logos 45:25 46:1 long 3:12 7:9 12:3 19:8 23:10 72:14 longer 70:24 76:11 145:10 145:14 look 15:12 18:24 26:7 34:22 46:22 49:20 52:21 54:9 56:6,15 101:20,21 112:24 121:12 129:8,24 130:2 130:11 144:16 157:23 looked 17:21 18:25 68:16 86:23 87:22 114:15 124:4 127:7 130:4 159:23 172:24 looking 34:11 47:20 48:6 50:1,10 54:5 61:16 68:12 73:15 90:15 101:10,14 103:7,19 112:25 115:3 121:21 122:24	123:21 124:12 127:8,22 128:22 134:20 134:21,22,23 138:3 139:16 141:10 143:12 145:22 167:20 167:21 looks 121:10,11 121:14 123:6 172:6,7 loss 40:19 losses 45:19 lot 13:6 21:18 35:9 47:20 49:10,20,22 128:20 145:7,9 147:19,19 loud 110:10 low 124:14 128:17 lower 112:21 113:13,21 115:9,14 lowers 103:23 lowest 76:11 77:14,19 78:1 81:13,25 90:8 90:23 94:2,7 97:13 98:1 102:4 113:21 113:23 114:1 114:14,18,23 118:4	lunch 119:1,3 luncheon 119:10 lynx 38:25 39:14 42:5 m made 70:15 79:3 82:23 84:10 94:13,14 130:7 135:15 171:19 175:8 175:18 184:5 madison 2:12 mae 1:21 5:15 181:5,16 182:4 182:17 mahoney 33:13 mail 3:17,21,22 4:2,3,4,5,6,7,9 4:10 35:18 56:16,16 87:9 102:20 103:7 125:13 126:22 126:22 127:4,7 127:8,16 128:10 129:15 131:12,16,19 131:22,25 132:4,5,13 134:6 136:11 150:19 151:15 151:15 153:15 158:9,20,21,24
--	--	---	---

[mail - measures]

159:2,8,16 160:18,24 164:8 166:18 168:8,12,20,23 169:21,22 170:20 172:12 172:19,22,23 173:3,6,15,20 174:1,7,18 176:4,9,12,15 176:17 177:17 177:18 178:10 mailed 73:3 151:23 159:16 178:2 mails 17:21 126:8 151:18 166:25 167:20 178:12 main 18:8 153:15 160:1 166:25 maintaining 177:8 maintains 34:20 major 17:23 18:15 25:13 majority 68:2 make 7:17 8:10 10:6 11:6 14:13 15:2 25:18 26:6 48:17 73:17	89:13 111:19 115:23 118:19 129:9 141:13 155:23 156:6,8 158:3,18 161:1 176:18 177:25 makes 26:3 58:13 111:23 making 58:24 91:14 113:24 120:7 managed 22:9 management 34:24 36:22 69:21,23 139:21 manager 38:19 manner 111:2 132:9 manufacturing 10:11 162:14 mapei 162:8,10 163:25 167:8 march 3:9 31:6 31:20 56:17 marcia 163:25 marine 40:3,4 42:6 marinemax 39:17,21 42:5 mark 39:22 40:17,24 41:1 marked 15:15 15:17 29:5,6	52:24 53:1 72:9,11 86:8,9 99:18 100:11 100:13 102:18 102:23 106:6,8 120:20,21 126:12,13 131:4,6 135:19 135:21 138:9 138:20 140:22 140:24 141:1 150:13 158:5,8 159:5,7 164:3 164:6 166:16 166:20 168:9 168:17 172:10 172:15 175:24 176:2 market 51:18 55:24 60:3 markets 25:3 26:8 44:7 59:13 master 20:13 master's 20:6 20:12 21:5,6,8 match 69:1 materials 73:3 73:5 112:2 matter 5:11 7:12,14 19:13 133:22 134:11 139:22	matters 10:4,8 71:13,21 175:20 max 5:25 max.billek 2:13 maxwell 2:10 mcbroom 40:5 150:23 164:1 165:24 170:1 mean 32:2 45:16 62:1 66:24 76:15,19 92:7,13 95:1 109:19 132:25 143:18 145:22 157:5 178:9 means 9:20 74:1 115:5,7 166:6 meant 30:11 92:18 measure 76:13 78:7 81:7 82:8 111:15 112:8 112:17 measures 63:10 74:22 75:11,18 75:25 76:3,11 82:1 90:23 91:18,20,25 92:4,8 98:2 102:4 103:24 110:19 111:8 114:2 115:9,15
--	---	---	--

[measures - members]

115:18 117:23 117:24 124:15 mechanism 50:4 media 5:9 19:3 61:18 62:3,5 64:9 126:10 135:11 141:15 143:25 144:18 146:4 148:25 149:11 171:10 178:24 median 76:10 77:3 medical 1:5 5:12 15:2 16:14 18:16 21:1 22:7 121:9,18 122:1 123:18 147:2,6 147:11 148:24 149:14 150:8 150:22 151:11 152:22 153:11 153:17 154:9 154:10,14,17 154:22,25 155:18 156:2,3 157:1,20 158:10 159:10 160:2,15,21 164:12,21 168:14 169:5 169:11,17	171:1 172:1,4 172:13,25 173:17,22 174:10 175:4 175:11 176:6 176:13 183:1 184:1 medications 8:9 medicine 21:13 22:6 meet 61:17 69:2 139:20 147:21 148:3 175:4 meeting 3:8,24 19:7,7 27:10 31:6,7 33:24 33:24 63:20,23 70:6 72:2,20 72:22 73:2,4 82:20 84:3,23 85:5,20 86:18 86:19 87:3 100:16,24 101:15,22 102:10 104:9 104:14,16 107:24 108:1 125:22 137:22 137:25 138:1 138:24 139:4,8 139:10,10,12 139:13 141:8	141:19 146:24 147:18,24 148:2,8,11,18 148:22,22 150:8,22 151:11 152:12 152:14,18,23 153:3,6,9,16 155:12,21 156:2,17,18,20 156:24 157:10 157:11,13,17 158:19,25 161:20 163:24 166:10 167:22 167:25 169:19 170:13,14 171:11,22,24 172:3,25 173:11 174:23 174:25 175:10 178:14,25 179:2 meetings 17:20 18:6,10 19:9 25:23 34:17 37:25 62:19 64:10 69:3,9 70:25 79:1,2 101:3,6,8 107:6 157:7 melissa 163:10 163:12,16,21	member 12:2,6 12:9 14:15 28:1,10 35:6 50:16 67:12 68:9 69:8,12 77:9,11 80:6 80:19 81:4 82:15,21 85:8 126:3 128:8 144:22 147:13 162:11 163:3 members 11:13 11:17,18 12:10 12:10,22,23,23 13:3,4,16,18,23 14:15 17:24 25:19 26:4 34:20 35:3 37:3,22 41:22 43:15,18 44:16 44:17,23 45:17 45:19,22,25 47:24 48:22 50:1,12 56:7 60:1,6 61:13 63:15 64:1 68:11,12 70:10 126:24 127:17 135:6,9,10,18 136:4,8,10,13 139:21 144:19 144:23 147:17 148:12 150:7 151:10 152:24
---	--	--	---

[members - money]

163:6,24 165:8 167:17 168:3,6 169:4,11 170:15 171:16 171:23 178:23 membership 12:15 23:4 28:4,8 44:2 111:24 memorialize 139:7 memory 138:5 mentioned 13:10 18:20 19:7 20:17 23:16 24:18 25:12 26:2,24 28:16 33:5 34:5,25 45:2,9 49:1 63:24 64:6 69:11 74:14 75:17 77:1,13 87:20 110:3 116:25 120:6,7 122:17 124:3 127:3 136:3 144:3 147:8 148:11 151:9 165:2,12 166:13 171:3 174:16 mentions 146:13	merged 43:23 merit 181:5 182:4 message 140:1 141:6,18 143:18 149:20 151:9 152:5,9 153:13 159:22 159:23 160:13 160:19 164:15 164:16,20 messaging 3:14 methodology 17:9 52:12,20 71:19,24,25 72:5 76:7 77:6 77:21 78:10,15 79:12,13,20,21 81:1,19 82:10 82:16 83:13,18 83:21 84:1,19 84:20 85:3,9 85:11,19,21 91:15 97:14 98:24 99:9,12 101:17,24 102:1 103:22 104:8,12 105:20,22 107:13,22 108:2,4,7,11,24 110:4,12,18,20 110:22,24,25 111:13,16	112:2 113:3,10 118:18 129:8 142:4,8 mewa 41:6,8 43:22 miami 38:20 40:12 42:7 160:6 miami's 42:4 michael 163:15 microphone 32:1 microphones 5:4 mid 116:13 146:16 middle 158:17 miller 163:10 163:12,21 mind 13:16 23:22 65:3,25 66:6 75:14 88:24 98:3,15 134:1 mindful 51:1 minimal 18:7 minus 89:2 minute 50:20 111:6 133:25 179:15 minutes 3:15 3:18 25:12 71:16 100:15 101:3,5,12,20	101:21,25 106:21 107:5 108:6 114:7 115:3 138:4 139:7,10,13,15 152:23 mirror 159:23 misleading 141:25 missed 70:6 72:21 missing 76:23 92:12 110:15 110:19 121:11 122:4,23 124:19,21 mission 12:24 33:16 51:19,23 51:24 52:4 missy 87:4,11 126:24 mix 11:15,20 12:10 42:16 46:18 148:6 model 93:17 108:14,19 109:1,14,20,24 moment 71:12 85:25 130:19 momentarily 131:7 137:14 146:7 money 27:6,8
--	---	---	--

[months - notary]

months 97:8	121:8 146:13	needing 176:22	114:2,13,16
morning 5:2	161:4	needs 35:14	115:13 116:3
6:16 119:15	nancy 150:20	negative 84:10	116:17 117:2
124:4 130:24	152:10 154:16	network 9:23	117:18 118:9
145:11,12	154:19,24	15:9	118:10,16,19
moskowitz	157:25 158:17	networks 47:19	nonperforming
1:18 2:11	158:24 163:25	never 52:15	95:3
mother 130:2	164:17 167:3	61:11 148:9	nonprofit 9:14
moved 21:14	170:6	157:11,13	12:21 33:15
movement	napkin 132:9	174:22,24	69:12
73:21	narrow 15:9	new 2:7,7,12	nonrespond
moving 12:19	national 39:18	27:20 63:10	63:18
37:16 57:25	94:9 141:16	82:21 93:17	nonrespondent
138:18 162:22	165:9	news 144:18	78:4 117:14
multi 13:5	nature 123:17	145:7,7,9,12,15	nonresponde...
multiple 12:21	152:18	145:16,21	62:9 65:6,11
33:15 41:5	navigate 71:3	149:5	nonresponding
56:24,25	necessarily	night 29:9	78:12 79:14
166:13	25:4	nightly 145:15	80:8,21 81:6
multistate 25:7	necessary	nine 10:3	98:12 99:10
municipalities	184:6	nodding 8:2	108:25 110:5
23:4	need 7:14 8:1	nominating	111:1 112:5
municipality	8:25,25,25	67:20 68:10	113:14
25:7	19:15 21:18	69:10	nonresponse
mute 5:6	27:9 34:22	non 3:7 15:25	77:23
n	35:9 44:4	81:24	nonresponses
n 2:1 3:1 5:1	78:23 133:22	nona 22:8	91:10
name 5:14 6:25	145:21 154:1	nonbates 100:7	normal 144:18
11:12 22:13,15	167:12 174:1	nonparticipat...	north 1:19 7:13
22:17,24 23:10	needed 8:22	77:19 81:25	20:16,25 21:9
32:20 33:2,8	29:16 63:16	82:3,11,17	21:14
34:12 67:2	73:16 74:1	90:8,22 96:12	notary 181:6
100:20 107:1	123:16	97:12,18,19,25	181:16 182:4
		102:3 108:3	182:17 184:13

[notary - opportunity]

184:19 note 5:4 55:18 84:9 88:17 99:19 138:13 148:19 156:21 noted 157:18 184:7 notes 129:12 167:6 182:7 notice 3:7 15:22,24 130:20 noticing 5:19 notify 130:21 notion 91:21 92:2 152:15 154:2 notwithstandi... 59:10 nova 41:21 novo 40:10 159:17,19 160:6,20 164:17 number 5:9 29:11 30:14 36:17 37:1,8 37:11,23 38:5 38:7 40:18,20 40:21 42:5 44:9,14 45:8 45:14 46:3 57:15 58:1,3 58:18 62:8	92:18 97:8,9 97:17,25 117:21 118:2 126:15 132:10 165:25 168:21 169:22 numbered 92:13 numbers 37:3 42:21,22,25,25 43:1,12 92:16 98:24 105:25 106:1 117:7 136:20 138:11 138:15 165:9 numerical 56:2 o o 5:1 oath 3:4 8:7 181:1 object 8:19 42:14 43:3 57:7 75:12 79:17 80:10,23 85:13 95:5 98:4,16,25 105:13 108:21 111:9,21 113:16 116:6 116:21 117:5 117:11 143:21 149:17 155:2 155:14 156:7	158:23 175:13 179:10 objection 8:22 55:18 81:17 84:9 88:17 96:23 148:19 156:21 objections 3:14 62:13 65:5,11 95:12,16 96:3 96:10 objective 73:15 74:6 objectives 73:22 obliterated 66:2 obviously 174:1 occurred 101:7 139:12 offered 179:1 offers 54:12 offhand 165:10 officer 36:23 official 181:11 oftentimes 48:16 128:20 oh 46:9 56:14 66:24 106:13 140:7 158:7 166:4 178:4 okay 6:19,25 7:18 8:5,18 9:3	19:21 20:11 29:22 30:10,16 39:12 46:7 50:23 51:1 84:14 87:23 88:1 89:17,20 92:17 95:21 103:12 109:8 110:3 117:15 120:22 121:15 121:17,19 131:18 138:19 140:7 144:10 158:7 163:5 oncologists 49:9 oncology 49:12 ones 128:13 161:3 166:7 open 66:24 operational 71:13,20 120:10,10 operations 69:21,23,25 71:11 opportunities 153:1 opportunity 13:8 111:11 113:8,11 147:10,22 155:19 156:10 156:12 157:9
---	---	---	---

[opportunity - park]

175:3 options 15:1 oral 140:17 orally 141:7 orange 1:19 21:20,22 22:4 36:22,25 37:6 37:24 42:2 181:3 182:2,12 oranges 44:10 order 32:18 180:3 orders 180:4 ordinary 31:9 31:13 32:8 107:6 121:21 137:9 172:19 organization 9:16,25 11:4 12:22 17:15 18:4,12 22:24 24:24,25 25:6 25:15 27:17 33:15,17 34:3 38:22 49:13 53:18,20 67:6 147:9 157:6 organizations 15:13 25:8 28:14 51:17 53:15 55:6,7 origin 159:15 original 131:16 143:13 160:18	168:20 176:9 originated 153:12 172:22 orlando 1:20 16:2 21:21 22:5 41:19 146:19 182:12 osceola 22:4 outcomes 48:19 49:17 outpatient 49:8 outreach 9:23 157:25 outs 65:8 157:14 outset 171:9 175:1 outside 18:23 overall 104:3 oversee 10:17 overview 32:18 own 17:3 18:24 35:2 59:21,24 74:16 116:14 116:14 127:15 129:9,11 p p 2:1,1 5:1 p.m. 1:16 119:9 119:12 134:15 134:18 137:16 137:19 159:11 159:11 164:12	164:12 177:20 179:18,21 180:2,5 packet 73:3,7 103:10 139:15 page 30:8,9,14 32:14,23,24 35:25 36:1,3 43:11 45:21,24 45:25 46:1,3,6 46:8 54:5,9 55:21 56:1 58:17 61:17 62:7,8 74:4,5 92:13,14,15,24 93:16,20 102:20 108:5,9 121:11 122:4 122:24,24,25 123:21 124:1 131:17 132:17 134:20,23 136:20,20 141:7,21 142:15 146:11 158:16 163:10 169:21 173:7 176:10 177:21 183:4,7,10,13 183:16,19 pages 182:6 pain 156:13,25 painful 141:14 155:23 156:6	palm 1:2 17:6 41:17,21 131:13 137:1 144:7,22 148:5 149:5 150:20 152:9,11,12,14 152:15,18,20 152:22 154:5,6 154:8,9,15,23 157:16,19 162:16 165:22 165:24,25 167:3 170:6 173:19,24 174:11 panel 70:16 77:20 78:1 83:14,17,20 84:3,21,22,22 85:4,5,10,20 91:14 94:10 104:1,23 105:3 113:5 142:12 panhandle 66:3 paper 22:11 145:11 paragraph 54:10 103:19 103:20 132:18 132:20 134:24 135:3 146:13 153:15 160:1 park 2:7
--	---	---	---

[part - permission]

part 14:22 17:6 26:2,23,25 27:6 38:11 44:19 52:3 67:24 70:24 71:20 81:20 82:13 83:19 86:18 93:5 101:2 119:19 122:22 130:4,6 130:12 139:25 141:24 153:18 partial 121:10 participate 24:8,9,14 52:10 56:12 57:1,9,14,16 58:1 62:16 63:1 64:14,24 65:9,15,19 69:10 75:3 76:4 79:10 82:3 88:14,16 91:22 92:3 96:18 97:10 110:14 112:11 116:18 120:1,5 122:15 123:2 123:23 124:2 124:10,15 133:19 150:8 171:4,12,23 172:5	participated 10:9 63:7 78:4 80:9,22 81:15 96:8 114:22 130:14 participating 57:24 58:14,16 69:18 78:20 82:24 83:1 96:4,5,7 112:5 112:12 116:5 116:10 149:1 151:11 171:6 171:20 participation 51:22 54:16 56:3 57:4,12 58:25 61:23 62:4 64:11 88:9 89:22 90:1,3,7,22 91:8 92:2,6 105:11 119:21 particular 34:18 48:12 49:2,7,18 50:6 95:19 parties 5:8 182:8,9 partnerships 74:11 party 3:7 15:25 16:20,22,23 35:14 48:13	58:12 passed 46:9 past 24:11 27:18 123:7 patient 25:11 49:23 59:14 73:17 74:22 90:5 129:7 147:1 149:24 patients 82:7 128:12,18,19 129:16 patriot 40:7 42:7 150:23 164:1 165:12 165:13,23 166:1 170:2,18 pause 8:21 128:25 134:10 pay 37:22 57:8 57:14 58:7,7 paying 9:21 19:12,14 48:17 61:12 pays 29:1 pbhn000018... 120:24 pbhn000018... 3:20 pbm 60:7 pbms 59:23 pdf 46:8 92:14 penalizing 112:5	penalty 112:12 112:14 113:7 pending 9:2 175:12 people 38:11 69:23 70:11,14 86:19 127:25 144:19 145:5 145:22,24 151:20 percent 88:2,6 88:12,14,21 89:1,2,2,9 142:5 147:20 performance 94:2,7,23 95:3 95:7 102:2 114:3,7 115:8 129:7 141:15 142:19,24 143:3 174:6 performed 114:22 117:22 performing 82:5,25 143:8 143:10 156:10 173:18,23 174:11 performs 151:4 period 22:19 63:3 125:4,19 133:7 permission 39:8 46:1 47:8
--	--	--	---

[permission - power]

47:14	pieces 53:11	172:5 174:23	poorly 117:22
person 30:19	pile's 150:3	plans 13:13	portion 59:7
33:22 69:4,5	place 1:18 5:7	14:2,18 59:24	137:25
100:25 130:3	85:21 100:6	platform 27:20	portions
139:3 150:20	plaintiff 2:9	play 23:25	138:17
163:15	5:11 24:2,6	please 5:4,6 6:6	portray 149:10
personalized	119:25 125:10	6:25 8:14,14	posed 157:9
123:12	131:24 132:14	8:21,24 31:24	position 22:9
personalizing	133:18 145:3	36:3 62:7,23	39:1 40:7
56:11	149:10,14,16	63:13,17 64:6	66:11,16,17
personally	152:19 153:24	89:19 90:19	127:21 163:17
53:14 130:1,15	154:11,18	101:21 103:20	171:13 175:22
181:7,20	155:1,12 156:4	127:25 141:5	178:23
personnel 21:1	160:14,20,24	177:1	possibility
perspective	161:9 180:4	plural 14:5	154:13,21
80:5,18	plaintiff's	plus 44:15,17	155:6,6,9
perusal 122:21	99:20	66:12	possible 13:5
pervasive	plaintiffs 1:7	pocket 151:25	38:4,8 39:11
145:1	1:17 5:22,24	point 30:22	41:18 49:25
phd 20:19	29:8 179:22	38:20 72:25	73:9,11,11
phone 127:7	plan 11:17	145:24 161:14	76:12 77:15,19
phones 5:6	14:25 37:13	174:2	78:1 79:23
photocopying	46:6,12,14	points 102:16	80:6,19 81:13
106:19	48:10,11,21	104:13	81:25 90:23
phrase 37:15	60:7 61:13	policy 10:6,9	99:13 102:4
48:10	73:23 149:19	10:13,16 20:14	112:16 114:23
physician	155:7 171:25	23:12	156:1
128:22	172:6,8	pool 21:1 58:5	post 144:7
physicians	planned 103:21	58:9	potential 58:5
48:15	planning 21:11	poor 96:17	68:11
pick 5:5	22:3,7 70:22	141:15 142:19	potentially
picture 129:24	71:7 73:13,21	142:24 143:3,8	50:13 177:19
130:12,13	169:4,10	143:10 173:18	power 58:24
	170:22 172:2,3	173:23 174:11	59:4,5,9 163:3

[power - progressed]

163:14 pr 140:1,2,8 170:22,25 171:1,4,6,15,17 171:24 172:1,3 172:5 practice 120:3 120:15 139:6,9 practices 58:19 101:2 precovid 48:5 predated 169:12 predating 173:3 predominantly 41:20 166:3 preexisting 67:25 prefer 11:2 pregnant 8:21 preliminary 35:12 premise 60:10 prep 148:9 preparation 19:8 prepare 17:17 17:19 18:14 101:2 prepared 32:8 107:6 137:9 prepares 101:5	preparing 18:22 presence 18:23 165:22 presentation 94:17 104:12 140:7,9,10,13 140:15 143:24 147:1 presented 31:20 32:6 69:14 70:16 72:19 83:3 84:6 86:16 87:4 151:8 president 9:11 9:13,24 10:17 18:5 32:21 33:9 54:3 66:17 146:23 press 26:15 141:16 143:20 144:4,13,25 presumably 51:17 presume 152:24 pretty 34:4 44:25 49:10,10 64:5 124:19 134:2 previous 112:23	previously 19:6 45:3 102:5 140:24 price 47:11 49:23 59:14 primarily 43:24 69:17 75:9 primary 22:10 33:23 34:1 71:17 145:11 print 29:16 prior 19:2 99:11 117:7 172:23 private 5:5 9:18 10:3 41:7 41:11,12,13 42:10 privy 82:12,15 probably 7:9 18:18 19:10 22:15 24:12 25:13 37:7 38:22 40:8 45:12,15 48:5 53:19 62:24 66:10,13 68:2 79:8,9 110:8 115:4 168:1,1 175:6,8 proceed 178:15 proceeding 29:17	process 31:8,12 47:16 52:11 53:16 66:13 70:22 71:7 95:2 produced 29:7 29:25 30:5 53:3 72:10 86:11 92:15 100:4 102:19 105:24 120:23 121:20 123:17 124:23 125:7,8 126:16 131:5,8 135:23 138:10 138:14 140:23 150:11 158:5 159:5 164:4 166:17 168:10 172:11 175:25 181:21,22 producing 99:23 production 29:9 124:24 productions 29:19 professional 20:5,7,8,9 program 10:18 58:16 146:17 146:22 progressed 175:5
--	---	--	--

[progressing - question]

progressing 148:4 project 10:18 34:23 46:19 projects 10:1 13:4 46:21 promote 51:24 52:4 64:1 129:5 pronounce 34:13 pronouncing 39:24 121:8 proposal 85:9 proposed 83:21 proposing 84:21 85:3 protection 132:18 proven 117:1 117:17 118:8 118:14 provide 8:11 13:6 41:25 56:2 57:24 64:14 70:12 81:9 102:13 113:8 provided 79:6 80:3 83:10 96:3 97:8 99:20 100:8 101:12	provider 15:12 49:15 50:6,7 providers 12:12 48:18 50:14 59:13 provides 34:16 54:21 providing 7:5 14:24 15:6 55:13 79:8,25 116:13 provision 13:13 14:2,17,21 proxy 77:23 112:17 public 9:18 10:3 11:16 20:13,19 36:22 36:25 37:6,24 40:12 42:3 82:7 140:2 142:1 181:6,16 182:4,17 184:19 publicly 74:23 75:5,7 110:20 116:12 135:10 publish 52:11 107:20 published 19:4 74:21 103:21 publishes 74:18 129:1	publishing 44:9 pull 35:11 144:17 pulled 31:12 74:25 75:18 pulling 31:14 purchase 41:8 61:6,6 purchaser 68:17 purchasers 25:10 51:14 59:20 60:22 61:3 129:6 purchasing 58:23 59:4,5,9 purpose 153:16 purposes 29:24 30:11 39:5 pursuant 29:2 purview 10:5 pushback 52:15 put 19:16 70:18 103:10 110:16 113:11 127:23 143:19 157:7 171:12 175:22 178:23 puts 127:13 putting 110:17 113:5	q qualifications 68:15 qualify 88:22 quality 14:7 24:15 25:11 49:23 59:14 90:5 149:24 quarter 107:19 107:21 quarterly 69:3 question 7:22 7:22 8:20 9:2 13:15,17 14:11 16:8 31:23 39:3,7,9 44:22 55:19 57:11 58:7 59:16 62:22 65:7,10 65:13 75:15 76:17 78:17 79:5,22 80:13 80:17 82:6,9 85:2 87:19 88:18,24 89:1 89:11,12 90:10 90:14,19 98:6 109:3,9 110:10 110:14 111:3,5 113:25 117:15 118:12,12 122:10 143:1,2 144:15 155:3
--	---	---	---

[questions - recess]

questions 7:4 8:11,13 10:21 18:1,21 48:3 52:14,16,19 63:16 64:16 69:15 70:14 75:22 91:12 111:12 124:20 128:1 135:13 137:5 quick 56:4 122:21 quickly 31:22 134:2 quorum 83:21 83:23 84:6 quote 94:22 96:22 97:7 128:13 141:13 142:18 145:25 178:16	ramos 164:11 range 3:12 36:18 72:14 rather 44:12 ratings 15:13 rational 82:13 82:17 83:3 reach 51:14 65:8 150:6 157:14 163:19 166:9 168:2 170:21 171:25 reached 18:19 148:1 157:15 157:15 163:24 reaches 65:14 reaching 152:9 152:11 react 73:14 reaction 97:22 read 19:2,4 30:7 56:4 64:3 73:10 85:1 87:20 103:20 109:23 132:5 144:4,7 146:3 153:14 159:2 173:14 177:1 184:5 reading 85:1 110:2 125:22 173:20 reads 46:12 94:1 115:7	really 23:22 25:12 49:13 57:18 64:1 66:2 71:5,13 79:22 147:23 148:4 166:5,6 174:5 realtime 181:6 182:4 reask 62:22,23 reason 31:18 32:4 37:2,10 64:14 101:11 107:8 115:1 121:25 122:6,9 123:18 183:6,9 183:12,15,18 183:21 reasons 37:2 40:20 45:16 50:15 65:16 96:4 129:1,12 147:2 recall 33:6 48:2 48:4 64:18 71:9,18 72:1 73:7 77:12 83:19 84:5,6 84:24 85:6,7 85:23 87:9 100:25 102:7,8 102:12 104:17 104:19 124:4 126:4 138:3	139:25 140:2,6 140:13 141:7 151:2,12,16,22 151:24 154:4 156:8 158:1,2 160:10 163:23 168:4 169:3,9 169:14 174:13 recalled 173:25 174:16 receive 25:19 58:7 65:5,11 65:16 86:21 111:20 116:4 130:7 133:3 139:9 received 29:8 29:10 73:9,11 87:22 99:8,24 121:16 123:19 127:3 136:11 138:12 139:14 143:7 153:18 158:21 receiving 20:21 65:24 102:7,8 130:20 143:4 recent 17:22 24:11 35:11 40:21 97:8 112:24 recently 70:24 recess 60:18 86:3 119:10
r			
r 2:1 5:1 183:3 183:3 rail 40:7 42:7 150:24 164:1 165:12,13,23 166:1,5 170:2 170:18 railroad 166:5 raise 6:5 raised 78:21 96:7,24			

[recess - relationship]

134:16 137:17 179:19 recipient 124:20 recognize 153:16 recollection 64:23 71:14 78:19 82:23 83:2 104:6 141:20 173:21 recommenda... 59:11 85:16 104:1,23 105:3 128:21 recommenda... 94:9,13,14 recommended 56:2 recommending 59:3,9,17 record 5:3,8,18 7:1,19 8:16 29:20 39:6,9 50:19 60:16,19 85:24 86:1,4 99:19 103:20 118:23 119:6,8 119:11 124:17 134:13,14,17 137:13,15,18 138:13 153:14 173:15 177:1 179:14,17,20	180:2 182:7 recorded 1:13 5:10 recording 5:7 87:17 94:19 records 22:12 35:11 recruited 22:6 reduce 118:1 reengage 175:9 refer 6:20 11:9 12:25 49:6 128:1 161:4 reference 90:6 90:11,20 91:25 101:25 124:13 135:4,16 142:16 153:24 154:2 161:2,16 referenced 104:18 170:5 references 56:11 62:13 92:2 94:12 129:15 143:12 144:4 153:22 160:1 162:7 164:20 173:2 176:21 referencing 91:21 161:11 177:5 referring 34:7 49:13 57:21,22	77:3 146:15 reflected 111:15 reflection 31:19 32:5 reflects 113:12 refresh 104:6 138:4 173:20 refusal 52:16 regard 105:20 regarding 17:22 71:22 83:21 126:25 127:4 131:12 159:10 164:11 166:10,19 168:14 171:24 172:13,25 regards 106:3 region 54:14 120:4 regional 3:10 17:14 18:3,6,8 18:10 22:3 24:23,25 25:5 25:8,14,18 26:2,25,25 27:14,16 33:18 34:6,7,8 46:23 47:1 51:7,10 51:16,21 52:14 53:5,15,23,24 54:7 55:5,14 55:16 56:24	58:19 59:3 60:1 62:2 64:3 64:4 68:5 111:23 119:16 126:23 127:16 127:19 128:5,7 146:5,22 regions 51:12 registered 181:5 182:4 regular 62:6 regulator 23:7 23:14 reimbursed 27:8 relate 71:2 152:15,19 related 7:14 10:4 13:13 14:17,19 35:15 47:11 57:12 75:11 relates 44:20 69:21 71:10 82:16 112:13 176:22 relations 140:2 relationship 23:3,6,8,20,23 24:2,21 26:24 27:2,4,7,12,14 27:16 48:14 51:20 52:17 67:25 156:11
---	---	--	--

[relationships - responding]

relationships 28:13 51:13,15	replied 179:5	representatives 36:9 41:4	reserve 179:23
relative 182:8,9	replies 173:10	53:15 130:25	residency 21:9
release 26:11	report 35:21,23	represented 42:12 44:15	resorts 36:13
26:11,15	43:16 47:23	88:13 124:13	36:16 37:19
released 26:6	48:2 93:22	136:14	38:6 42:2
releases 26:5	97:3 98:10	representing 5:15 6:1	resources 13:6
relieved 178:16	102:8,11,13,14	request 31:15	25:22 40:2,6
178:20	102:22 103:3,5	47:9 61:23	73:16,22 74:1
remainder	103:24 104:13	128:21 133:12	170:1
121:15	107:14,15	153:3	respectful 60:6
remaining	123:8 138:1	requested 182:6	respective 26:8
119:4	182:5	requesting 24:7	52:2
remember 7:9	reported 1:21	137:2	respectively 164:18
67:21 73:12	23:13 74:23	requests 132:21	respond 25:14
82:19 86:17	95:23 98:19	required 184:13	52:1 61:22
114:17,18,25	104:7,10 115:8	requirement 68:21	63:4,9 64:6
117:21 125:13	116:12	requirements 68:8,15,18	75:23 76:9
125:21 149:7	reporter 5:15	rereading 65:10	77:2,14 78:17
162:12 166:12	5:19 6:5 7:3	reschedule 174:24 179:3	79:6 82:6 88:2
174:20	16:10 50:24	rescheduled 148:9 174:24	88:5 110:22
remembered	119:5 181:5,6	research 9:15	111:12,14
174:3	182:4,4	10:1 21:6 81:2	151:21 157:25
remind 17:25	reporter's 3:5		158:2 170:9
reminder 16:6	reporting 17:8		responded 56:20 64:8
removed	104:2 105:6		78:9,16 92:10
177:25	124:21		114:4 158:24
repeat 90:14,19	reports 25:19		178:16
91:24 98:6	46:24 47:4,9		responding 63:13,22 64:13
repeating	50:11		65:7,12,17
13:17 75:14	represent 45:25 68:17		78:22,23 79:4
88:24	88:6 100:14		111:1 158:20
rephrase 8:15	representative 165:13		
62:20			

[responds - says]

responds 74:24 161:24 170:21	182:6	rows 139:17	samaritan 1:5
response 19:4 78:8 81:8 97:1 97:2 98:17 110:10 116:13 128:2 142:4 158:17 170:20	revise 117:25	rule 62:18	5:11 16:14
responses 18:2 57:23 91:13	right 6:5 13:20 15:2 27:23 30:6 39:22 43:2,7 47:7 49:2 71:12 95:21 106:10 106:17 109:11	rules 7:16	183:1 184:1
responsibilities 9:12 18:4 33:18,19,23 34:2,5,6,7,8 69:8,20 82:22	145:12 147:3 162:3 163:22 165:2 177:2	run 33:24	sara 38:24
responsibility 53:19	risk 36:21	running 33:14 33:21 43:8 66:4	saved 31:13
responsive 125:2	rmr 1:21 181:16	runs 146:22	saving 31:9
rest 179:22	role 17:12,13 17:16 18:12 23:25 32:11 33:11 34:15 57:3,10 80:25 111:23 119:16 119:19 151:2,5	s	saw 60:5 127:7 157:10
result 77:22 126:1	roles 34:25	s 2:1 3:6 5:1 183:3	saying 14:4 15:3 23:21 95:2 114:17 116:10 118:13 118:14 140:3 149:7 158:25 161:24 175:18
results 47:15 49:19,20 58:7 75:19	rosa 40:10,13 159:17,19 160:6,14,19 161:24 162:2 163:25 164:17	safe 128:13	says 16:14 26:12 32:15 43:11,14 45:22 46:23 54:11 55:2,23 56:7 56:15,19 58:18 58:23 61:17,21 62:8 65:21 73:16 87:24 88:1 89:21 91:18 93:2,17 93:21 94:21 95:6,12,15,22 96:17,17 97:2 103:4,8,16 104:22 105:5,9 108:6,14 109:14,25 112:23 115:5
retired 33:13	rosen 36:12,16 37:17,19 38:5 42:1	safety 25:11 49:23 59:15 73:17 74:15,16 74:22 75:18 82:8 89:8 90:5 91:18,21,23 92:1,4,7,9,22 93:1,17 96:11 96:17 101:18 103:17,22 105:19 108:7 108:10 127:1 128:24 129:2,7 129:12,25 137:3 142:12 143:10 147:1 149:24 153:18 164:22 173:17 173:22 174:10	
retirees 37:14 45:5	ross 2:3	saalem 21:10	
retract 110:8	rounds 112:25 112:25		
revenue 57:17 57:19,20 74:10			
review 18:11 18:23 73:5 90:11 123:10			

[says - see]

115:22 133:1 136:21,24 138:24 139:17 139:19 141:11 141:13,21,24 142:18 160:2 160:25 161:13 167:8,9 169:20 177:24 scale 37:22 73:16 74:1 scaling 73:22 scan 56:4 scandinavia 151:17 scanned 17:23 scenes 113:4 scheduling 34:17 school 10:11 11:16 21:13 40:15,18 158:25 schools 36:22 36:25 37:7,24 40:12 41:11,19 42:3,8 150:21 152:10,11 154:5,8,10 160:6 170:6 science 20:4,13 score 76:8,10 76:12,14,22,23 77:3,15,19	78:2,3,21,23 79:5,9 81:13 81:25 82:6 83:2 90:8,23 90:25 91:10 97:13 98:1 102:4 113:14 114:14,18,24 115:9,14 116:20 118:4 124:14 137:3 scores 90:9 93:5 103:23 107:20 112:24 scott 2:2 5:21 133:21 screen 90:12 scroll 136:23 se 13:12 seal 181:11 search 15:12 145:21 seat 28:15 second 46:22 59:6 94:8,12 94:21 103:19 108:5 128:10 133:21,22 146:12 158:16 173:7 176:15 176:21 177:21 secretary 36:13 section 62:12 103:16 136:24	sector 9:18 10:3 secured 46:18 securing 21:23 see 10:14 15:1 15:24 16:13 30:4 32:14,17 32:20,24 33:12 43:12,14 45:21 46:11,23 47:12 47:21 53:7 54:7,10,11,17 55:22 56:1,9 56:13,14,21 58:18,23 61:17 61:20,24 62:8 62:11,12 72:16 73:15 74:8 82:7 86:13 87:1,24 88:1 89:21 90:3 92:19 93:1,18 93:23 94:4,24 95:11,17,21,24 96:16,20 97:1 97:4 98:10,11 100:18,20 101:23,25 102:6,25 103:2 103:4,7,13,15 104:22,24 105:5,8 106:24 107:1 108:6,10 108:13 109:17	112:14,15,16 113:9 115:4,6 115:10,20,25 121:1,4,22 124:2,13 126:19,22 127:9,12,13 128:2,4,10,14 129:17 131:11 131:19 132:2 132:15,17,23 132:24 135:1 135:25 136:20 136:24 137:7 138:23 139:1,4 139:16,23 141:3,10,13,21 142:2,6,15,21 143:15 144:17 146:12,13 150:7,16,21 153:1,13 157:16 158:14 158:17,18 159:13,16,17 160:4 162:8,23 162:25 163:10 164:13,24 166:22 167:1,4 167:10,12,14 168:16 169:1,7 169:22 170:3,7 170:11,23 172:17,23
---	---	--	---

[see - side]

173:8,12 174:14 176:7 176:19,23 177:22 178:7 178:18 179:7,8 seeing 73:7,12 104:5 114:18 122:8 125:14 125:14 seeking 46:20 69:14 128:20 130:1 seem 79:23 seems 44:25 seen 15:19 19:2 31:1 53:9,11 72:18 97:7 122:18 123:7 123:14,14 127:24 129:14 144:21,23 145:5,25 self 9:20 95:23 seminole 22:4 send 35:17 44:6 56:15 63:12 73:5,6 119:20 120:12,15 121:13 126:9 132:4 133:5,12 133:17 151:15 152:7 166:24 178:11	sender 151:14 sending 25:11 35:5 64:7 120:3 sends 65:18 122:14 123:1 senior 22:25 36:21 sense 58:13 97:16 175:8,18 177:25 sensitive 5:4 sent 24:7 53:14 66:1 86:20 87:6,8,16 91:1 112:2 119:24 121:20 122:1 125:2 132:21 133:6,9 135:5 150:19,24 151:9,18 152:2 153:13 158:22 159:22 172:19 sentence 54:10 61:20 62:1 97:1 105:9 108:13 109:13 109:19,23 110:2 115:7,12 115:22 116:9 128:10 133:10 153:14 159:25 174:14 176:15 176:17,21,25	separate 48:13 86:19 separately 87:7 september 1:14 5:3 16:4 67:16 70:3 71:8,23 106:22 107:17 139:10,11 181:8,12 182:11 serve 17:16 27:15 68:10 69:10 served 68:4 163:16 server 31:12,16 serves 36:13 service 12:24 services 36:12 41:9 48:15,23 48:23 59:7 129:6 session 139:17 139:20 146:21 set 19:15 51:4 66:8 74:13 86:25 99:15,19 102:7 130:19 137:12 140:20 146:12 150:2 156:1 165:1 174:23 sets 68:12	setting 111:6 148:25 161:19 169:19 several 47:24 47:24 149:21 shaking 8:2 shannon 170:10 share 84:19 85:2 149:25 shared 17:25 157:8 sharing 74:3 she'll 35:10 102:16 shift 94:1,6 shocking 178:2 short 41:6 166:5 169:16 shorter 68:6 120:15 shortly 174:17 show 47:14 117:17 showed 114:5,8 114:8 135:9 showing 90:12 shows 118:1 shvidt 2:5 side 51:4 66:8 74:13 93:25 99:15 102:8 130:19 137:12 140:20 145:3
---	--	---	---

[side - spotlight]

150:2 165:1 sides 143:24 sight 15:5 sign 68:19 signature 121:11 122:5,9 181:15 182:16 signed 24:10,11 64:25 65:1 121:13 significant 44:14 59:7 60:4 63:6 89:16 104:20 signing 122:19 123:13 similar 44:21 143:17 simplest 80:12 simply 30:7,8 116:4,9 single 55:11 sister 11:3 sit 18:10 60:6 sits 136:16 165:13 sitting 43:19 64:23 85:18 93:13 107:17 situation 128:16 six 22:15 size 45:17 60:4	skill 68:12 skip 63:16 skisak 126:23 128:3 skisak's 128:2 slated 103:22 slide 31:5 46:11 56:1 58:17 87:23 89:18,21 89:24 90:6,20 91:1,8,11 92:11,18,19,20 93:20 94:6 95:1,11,14,15 95:17,20 96:1 96:2,16,22 140:14 141:11 141:11,22 142:16 slides 4:1 86:20 86:21,25 87:6 87:14,21 95:18 140:16,17 143:12 sliding 37:22 slightly 35:10 small 9:14 33:12 34:2 55:8 60:12 147:20 165:25 smaller 40:7 55:8 60:5 150:3	smart 70:11 solemnly 6:7 solution 12:11 solutions 5:16 somebody 66:3 68:16 78:22,23 128:24 147:4 soon 29:23 100:2 171:9 sorry 11:22 12:15 14:14 16:7 31:17 32:2 60:9,24 62:20 84:14 85:1 87:15 91:24 106:9,13 119:7 121:1 122:6 133:23 138:5 144:11 148:16 151:23 160:17 sort 15:9,9 22:5 26:16 33:20 120:8 sound 43:2,9 sounds 23:19 43:7 107:21 125:19 source 93:9,11 93:14 sources 47:15 74:10 93:2,5,6 93:7,12 130:5	south 41:19 63:21 64:12,22 166:1,12 southeastern 41:21 southern 1:1 space 10:13 14:20 19:23 speak 8:24 18:13 52:12 126:10 speaking 13:16 59:12 110:7 specialty 88:22 specific 48:15 68:15 74:22 88:7 114:25 122:20 specifically 41:21 52:21 87:10 96:14 125:21 144:9 146:19,20 152:10 177:6 specificity 85:6 specifics 38:2 44:24 52:20 77:5 speculate 122:7 speed 180:3 spoke 169:3,9 169:13 174:8 spotlight 148:23 157:1,8
---	--	---	---

[spring - substance]

spring 17:8 19:4 26:11 97:20 98:12 103:17 117:4 118:11,16 127:1,13 131:25 132:14 153:18 staff 10:17 32:24 33:12 34:12 40:20 64:19 69:25 70:15 73:25 86:16 91:2,7 91:14 98:8 114:9,20 115:12 116:2 116:16 118:17 143:3 147:5 157:15 staffing 21:2 stakeholder 13:5 stakeholders 21:24 stamp 30:2,4 30:15 55:22 stamped 29:12 29:18 stamping 29:14 stamps 99:21 99:23 100:1,2 stands 58:10	start 22:21,25 70:25 95:20 started 22:24 60:11 168:23 starts 174:18 state 5:17 6:25 11:17 23:7,11 23:13,23 25:5 40:15,21 51:13 52:1 63:6 147:3 181:2,6 181:16 182:2,4 182:18 stated 155:25 statement 97:6 99:11 105:16 114:19 127:22 statements 69:13 174:1 states 1:1 11:19 44:7 51:12 88:13 110:20 155:7 stations 145:15 status 69:25 statute 23:13 stay 175:20 stayed 21:15 steer 128:12 steering 129:16 steers 128:17 stenographic 182:7	stenographic... 182:5 step 55:23,23 56:11,19 98:13 stephanie 39:23 40:2 steps 56:5 stick 37:21 39:8 175:18 stop 10:20 73:17 171:7 stopped 163:22 stories 143:13 story 130:4,6 143:25 145:4 straight 147:7 147:12 149:21 153:17 154:14 154:22 155:18 156:4 160:2,16 160:21 164:21 169:5 174:5 straightforward 45:1 strategic 3:12 21:11 68:14 69:17 70:18,21 70:22 71:7,10 72:14 73:13,21 73:23 141:15 strategy 48:20 70:25 91:11 stream 178:12	strengthen 104:3 strike 60:24 62:21 79:11 89:15 121:2 162:6 176:16 strong 71:5 103:25 104:23 structured 109:13 students 40:20 study 77:22 sub 141:22 142:18 subject 118:22 submit 108:15 108:20 109:15 109:21 121:10 submitting 52:11 subpoena 3:7 15:24 125:2 subscribed 184:14 subscriptions 58:3 subsequent 139:7 174:4 subsequently 33:13 147:24 subset 75:21,25 76:3 substance 122:10 152:5,6
---	--	---	--

[substance - taken]

164:15 success 149:22 successful 103:17 suffering 73:18 suggest 11:12 84:15 162:23 163:9 suggested 47:25 suggesting 105:10 suite 1:19 2:3 summary 46:14 sunday 99:21 105:24 138:11 138:14 supplemental 21:2 support 34:16 112:20,22 113:15 supports 151:7 supposed 174:21 suppress 17:7 137:2 sure 7:2 10:6 11:6 20:24 25:18 26:3 39:17 40:13 41:18 48:18 55:6,16 89:13 109:2 111:23	120:2 124:19 135:13 167:6,8 179:16 surgery 18:15 21:4,7 26:20 28:21 51:16 52:1,10 70:7 72:21 74:20 148:1 176:22 surprise 97:11 97:21,22,23 surprised 97:15,15 145:6 surprising 97:17 survey 24:10 25:21 28:21 47:10 49:19 50:11 51:22 54:13,13 55:24 55:24 56:3 57:9,12,15,16 57:23,24 58:2 58:25 61:23 62:4,17 63:2 63:14 64:13,15 64:17,24 65:6 65:12,17 72:5 74:25 75:4,19 75:20,22,23 76:4,9 77:2,14 78:4,13 79:4 79:15 80:9,22 81:16 82:3,24	88:3,5,9,16 89:11,22,25 90:3,7,21 91:8 91:22 92:2,3,3 92:6,8,10,21 93:8,22 94:3 96:5,19 97:10 103:25 104:2 105:7,12 108:16,20 109:16,22 111:14 112:6 112:12,13 114:4,23 116:5 116:19 117:3 119:22 120:1,5 122:16 123:3 123:24 124:16 129:25 130:14 132:22 133:13 133:19 surveys 3:11 52:2 53:6 56:8 57:5 58:22 62:10 susan 40:5,6 150:22 164:1 165:23 170:1 sustainable 33:17 swear 5:20 6:7 sworn 6:12 181:9 184:14	syncs 51:24 synopsis 26:12 system 17:9 21:21,25 49:7 156:11 systems 12:11 12:18 49:11 t t 3:6 183:3,3 tag 114:19 tait 18:5 33:6 35:23 52:12 123:5,8 131:14 159:9 166:18 166:24 167:20 168:2 172:13 173:7,10 176:5 177:18 179:5 take 5:7 8:3 9:1 24:16 46:5 50:19 56:24 60:12 66:4 77:12 109:19 110:1 114:24 118:25 128:19 129:10 141:6 163:18 taken 1:17 5:10 43:23 60:18 86:3 101:19,22 101:23 119:10 134:16 137:17 179:19
--	---	---	---

[takes - thought]

takes 127:21	74:15 78:8,25	85:25 86:6	75:21 78:5,14
talk 7:20 18:16	111:22 176:16	87:18 89:4	79:7 80:6,19
25:24 65:20	telling 145:4	99:17 100:10	80:24 81:5
80:25 147:14	tells 66:6	104:4 106:5,14	82:4,20 85:14
175:17	template 56:12	119:13 120:18	91:16 93:13
talked 47:2	123:11,14	134:4,12	99:13 101:19
55:1 67:11	templates	137:20 148:15	105:10 107:22
74:7,14 119:15	123:10	153:17,21	108:25 110:3,7
119:19 124:7	tenet 17:6	157:1 159:3	110:9,11,13
150:23 151:1	141:14 155:24	165:1	112:4,7 113:17
165:16 168:4	156:6	thanking 147:6	115:2,4 119:3
176:21	term 49:9	thanks 50:24	122:18,23
talking 8:17	61:11,14	126:14	125:13,14,19
30:12,13 51:6	terminology	thing 23:21	128:19,19
86:15 102:16	11:7 76:16	30:13 55:11	130:4,16
104:13 165:21	terms 9:25	63:23 80:12	134:22 151:18
tallahassee	34:17 49:18	144:20 179:6	151:19 164:1
10:7	63:8 177:3	things 18:17	166:8 167:24
tally 43:9	testified 6:13	19:5 46:15	167:24 169:13
tampa 41:19	42:24 104:25	59:25 70:9	174:23,25
targeting	testifying 8:6	73:6 157:8	178:3,22
165:20	testimony 3:2	think 18:25	thinking 13:7
team 34:16	6:8 184:8	22:10 23:8	71:1,12 81:2
70:4,9 139:21	texas 2:4	24:12 25:13,15	163:15
152:24 170:22	thank 6:18 9:4	28:22 36:18	third 40:1,16
170:25 171:1	11:10 14:9	37:7 41:20	48:13 61:16
172:1 175:5	16:12 22:20	45:14,15 51:11	96:16 100:21
technical 33:22	28:16 30:16	55:9 59:18,18	131:17 176:25
telecommuted	31:25 38:4,14	60:9 62:21	thought 11:23
21:15	38:17 40:23	63:4 64:16,17	18:1,2 62:23
tell 36:19 38:15	41:24 46:11	65:18,21,23	92:18 106:15
38:24 39:16,23	50:17 51:2,5	66:5,10 70:5,8	110:6,9 113:7
40:5,10,23	60:24 61:1	70:20 71:12,15	113:7 145:4,25
52:22 65:25	67:10 72:24	71:24 72:19,21	147:10 173:10

[thought - tuesday]

175:3,6 178:4 178:25 179:6 three 40:8 42:6 136:14 139:21 141:22 142:18 145:14 till 167:25 time 1:15 5:6 7:10,20 8:19 8:19 18:1 19:2 19:13 22:19 29:14 38:11 46:5 55:2 58:12 63:3 66:19 67:21 68:3 70:2,17 71:7,9,15,22,25 72:3 74:21 77:7 94:1,20 98:19 99:7 102:16 107:12 110:21 113:10 117:8 125:4,19 127:24 133:5,7 134:6 135:12 137:24 141:6 150:25 151:17 160:12 161:23 171:11 174:15 177:12 178:11 179:4 times 17:22 34:21 56:25 74:18 79:7	113:2 timing 19:1 177:2 178:3 title 32:24 35:25 40:13 titled 72:13 106:21 today 7:17 8:7 10:22,24 11:10 15:23 17:17 18:14 29:17,18 29:25 33:5 41:25 42:24 43:19 64:23 85:18 86:15 93:13 100:1 136:16 144:3 150:23 151:1 170:22 172:1 today's 19:8 32:15 145:7 together 9:19 21:24 41:8 60:6 68:4,7 127:23 told 115:2 148:21 166:6 178:5 took 77:8,9 toolkit 3:10 53:5,14 54:6 54:12,20 top 26:18 33:2 39:2 43:11	46:11 52:22 89:21 106:21 121:22 126:22 138:23 158:12 159:8 168:12 172:12 176:4 topic 102:6 134:3 total 43:6 totally 134:1 toward 94:1,7 towards 46:4 tpa 48:10 transcript 90:15 138:17 182:1,6,6 184:5,8 transit 38:25 translate 156:13 transparency 24:14 51:24 52:4,6 59:20 63:7 64:2 87:24 113:9 129:5 transparent 23:14 25:10 52:8 59:13 90:4 91:7,16 91:17 112:1 142:5 travel 27:9 72:23	treasurer 36:14 treated 100:3 treats 76:3 trip 176:19 true 182:7 184:8 trust 83:7 trusted 95:23 truth 6:9,9,9 97:5 115:2 truthful 101:6 114:24 try 7:19,20 37:16 39:10 40:1 45:7 78:15 101:6 111:7 trying 7:8 14:23 18:25 27:22 47:14 78:2,5,11 81:14,19,21 82:2,21 84:15 89:25 90:2 95:3 99:7 102:2 109:12 110:6,9 114:3 114:10,12,16 114:21 123:22 124:4 133:24 143:8 149:5,10 149:13 156:5 tuesday 29:9
--	---	--	--

[tune - use]

tune 145:15	159:1	59:10,17 73:1	unsafe 128:12
turn 19:17,19	unbiased 142:5	73:20 74:23	129:16,19,23
turned 31:17	142:9,13	75:2 76:2,8	unusual 21:15
twenties 37:8	under 8:7 38:5	77:6,25 78:10	upcoming
two 12:16,16	43:22 44:1,1	84:17 88:9	107:15
12:20 17:21	58:21 74:6	89:25 96:1	update 44:3,19
63:5,5 69:5,5,6	93:1 94:21	97:5 107:8,12	69:24 103:17
70:5,20 74:18	100:20 107:1	108:18 109:5	103:23
95:18 98:2,14	129:10 141:11	109:12 125:6	updated 35:10
98:14 99:5,5,6	178:4	142:11 162:19	40:18 123:15
106:12 107:4	undergrad	165:6 167:15	updates 69:24
112:25 117:3	20:2 21:5	177:4,15	103:21 162:2
117:15,25	underlined	understands	updating 35:12
119:3 133:22	62:12 108:7	130:17	83:12 115:13
147:13 170:15	understand 7:3	understood	uploading
type 7:12 90:10	7:24 8:6,11,13	12:4 35:17	29:13
90:16 181:22	8:23 16:17	72:24 104:15	ups 109:7
types 12:21	17:3 19:14,23	133:11 171:14	upset 83:1
157:7	23:15 24:18	undertake 10:2	133:3
typically 9:20	51:9 56:6	unfortunate	upside 19:17
10:8 12:13	65:13 69:7	145:20 162:4	19:19
102:11 123:1	70:14 84:8,13	unfortunately	urgent 133:22
u	90:13 92:11	45:6 92:15	use 25:22 27:17
u.s. 88:6,15	111:25 113:25	145:19	27:19 28:16,23
ucf 22:18	129:11 134:1	uninsured	29:2 37:15
ultimate 52:2	178:10	21:22	46:1 47:6,10
ultimately	understanding	unit 5:9	47:13 48:11
135:15	13:15 16:25	united 1:1	50:11 53:16
um 11:11 36:2	17:5,10,11	88:13	57:19 75:5,7
41:1	37:18 40:11,24	universities	75:10 90:7
unable 18:7	41:24 42:8,20	41:2,14	100:1 106:2
33:23 86:20	42:21 45:8	university 20:2	108:19 109:1
147:2 158:18	54:19 55:5	20:16,20 22:5	109:20 111:16
	57:3,25 59:2,8	41:22	111:19 129:4

[use - want]

147:22 used 29:24 31:5 49:10 58:19 61:11 76:14 84:10 91:23 92:9 useful 47:25 uses 25:3 76:16 89:22 90:21 91:8 92:1 108:14 109:14 using 25:9 61:14 107:23 108:25 109:9 usual 133:10 usually 50:8	31:1 61:3 65:3 72:16 86:13 100:18 102:18 102:25 121:4 126:19 131:4 131:11 135:20 135:25 137:22 138:9,23 140:21 141:3 158:11 159:9 168:10,13,16 172:10,12 175:25 176:5 181:7 182:5 183:2,24 184:2 184:4,12	versions 29:18 99:24 106:1 versus 5:12 16:15 19:1 viable 33:17 vice 10:17 18:4 33:8 40:3 54:3 146:23 163:17 video 1:13 5:6 5:10 60:13 180:2 videographer 5:2 32:1 60:12 60:16,19 86:1 86:4 119:8,11 134:14,17 137:15,18 179:17,20 180:1 view 70:12 virtual 69:5 virtue 116:4,9 visit 169:4,10 169:18 176:6 176:13 voice 10:7 68:17 volume 50:8 voluntarily 88:2,5 voluntary 87:24 88:10 volunteer 23:25 27:4	55:4 vote 69:15 70:19,20,23,24 71:6,9,13,15,16 71:16,21 72:1 101:16 105:18 105:21 108:1,4 voted 71:15,24 83:18 votes 71:17 voting 71:15 vp 120:6 vs 1:8
v	variations 9:22 varies 38:12 variety 13:11 13:18 40:20 48:24 various 51:12 vastly 45:15 vehicle 25:2 65:23 66:7 vendor 15:8 29:13 vendors 15:11 verbal 102:11 veritext 5:15 version 29:23 35:11 41:6 100:6,7 138:12		w
v 183:1 184:1 vacation 151:17,19 value 6:4 9:9 14:7,8,16 17:14 48:21 67:5 110:16,17 121:23 136:8 136:13 values 10:23 13:13,24 14:1 14:5 van 1:13 3:2 5:10 6:3,11,16 6:17,18 7:2 9:5 15:25 19:24			wait 175:8 waited 133:6 waiting 90:10 170:5 walk 20:22 87:12 168:20 walked 132:8 want 11:6 14:4 14:8 29:20 44:9 48:17 50:16 64:1 72:25 79:19 82:6 89:13 99:18 106:17 113:9 118:23 118:24,25 119:5 133:8 149:15 175:21 178:23 179:1

[wanted - worked]

wanted 17:7 51:1 68:25 84:17 85:14 133:4 135:18 148:3 155:23 163:6 174:9 wants 49:1 156:9 173:16 173:22 washington 100:17 147:3 way 12:24 13:5 14:6 15:3,10 17:9 23:15 45:2 55:3 68:11 78:24 81:8 84:7 87:14 94:22 95:6 110:16 113:6 121:20 122:11,22 124:18 128:16 145:11 146:6 149:7,8 ways 15:8 48:8 156:5 we've 27:21 44:10 45:16 46:18 50:18 52:7 53:17 68:4 70:5 71:24,25 100:13 167:19	weaponizing 141:25 wears 33:15 website 26:15 34:21 52:21 112:1 124:21 137:3 websites 25:21 wednesday 18:15 week 17:24 26:9 weekly 3:23 17:23 26:8 34:21 135:5,16 136:4,6 137:9 168:7 weeks 26:10 167:25 175:5 weinstein 40:24 41:1 welcome 30:18 32:18 welfare 41:5 166:14 wellness 39:1 went 18:16 117:14 136:5,6 172:7 west 1:2 121:9 121:18 122:1 123:18,23 whatever's 70:16	whispering 5:5 wield 60:2 willing 147:17 150:7 wilson 1:18 2:11 5:25 15:25 wilsonelser.c... 2:13 winston 21:10 wisconsin 11:4 wish 44:24 124:9 witness 5:20 6:2,3,10,12 19:21 29:4,21 30:2,16,22,23 32:2 42:16 43:5 50:21 51:2 57:8 66:23 67:1 72:8 75:14 79:19 80:11,24 81:18 84:11 85:14 88:20 95:6 98:6,17 99:1,18 102:17 105:15 106:7 106:20 108:23 111:11,22 113:17 116:8 116:23 117:7 117:13 118:24 120:19,22	126:11 131:3 138:8 143:23 148:21 149:19 150:10,14 155:5,16 156:8 156:23 158:4,7 158:24 159:4 166:15 168:18 172:9 175:15 179:12 181:11 wonderful 11:6 11:25 word 76:14,19 129:4 143:17 162:8 wording 27:22 88:4 114:5 123:6 words 8:3 17:3 74:16 109:9 127:15 146:1 work 9:5,7,8,20 10:5,6,10 13:4 13:5 21:10,18 25:6 33:19 34:21 37:5 46:6,12,14,18 47:5 48:9 62:5 68:5 71:2 77:20 79:24 83:8 147:20 156:12 157:16 worked 10:12 21:4,16 53:18
---	---	---	--

[worked - zoom]

68:7 151:21	y	z
workforce	yeah 11:3,6	zero 97:19
14:20 15:6	13:18 23:18	zoom 100:17
45:17	49:4 53:13	101:1 106:22
working 21:6	60:14 62:23	139:4
63:9 73:14	68:20 84:11	
163:16	90:17,20 98:8	
workload	109:5,5,6	
73:25	119:2,7 124:5	
works 11:8	125:16 138:7	
15:8 54:1	160:11,18	
113:3 160:6	166:11	
world 37:5	year 3:12 22:25	
61:15	26:9,10 27:20	
worms 66:25	40:19 46:16	
worries 16:12	48:1 57:1	
wrapped 49:22	63:20 68:24	
write 102:16	72:14 74:18	
132:20 162:22	76:7 83:11	
173:14	107:13 137:23	
writes 128:11	years 7:8,9,15	
166:24 167:12	18:6 21:3,16	
169:3,17 178:2	22:15 24:11	
writing 102:14	44:4 45:13	
174:14	47:24 53:20	
written 102:11	63:8,8,11,11	
102:13 115:1	65:1,2 66:12	
129:14	69:6 70:5,21	
wrote 169:25	78:25 136:15	
x	yesterday	
x 3:1,6 181:21	29:13	
	york 2:7,7	

Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted

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