

1 paid a lesser amount of money than you did on this
 2 particular claim?
 3 A. Yes, we would have.
 4 Q. Do you pay your claims based on your belief
 5 that the information contained on the claims that are
 6 submitted to you is accurate?
 7 A. Yes, we do.
 8 Q. If you found that the information was
 9 inaccurate or fraudulently placed on those forms would
 10 your company pay the claim or do something about it?
 11 A. We would do something about it.
 12 Q. Now I will note on the very bottom of this
 13 form, and I think we're talking about boxes 32 and 33,
 14 do you see those?
 15 A. Yes.
 16 Q. In those boxes we have some designations
 17 of, it says service facility under 32, and what is that,
 18 service facility?
 19 A. That's where the service actually took
 20 place. It's the facility in which the service took
 21 place.
 22 Q. And it says Endoscopy Center of S. Nevada
 23 LLC?
 24 A. Yes.
 25 Q. 700 Shadow Lane?

1 Q. Does that payment pertain to the claim form
 2 that we had seen earlier?
 3 A. Yes, it does.
 4 Q. And you said that the actual paid amount
 5 for this claim was \$131.20, right?
 6 A. Yes, it was.
 7 Q. So that's money that actually left your
 8 company and went to the Endoscopy Center?
 9 A. That's correct.
 10 Q. The \$560 does that correlate with how much
 11 was actually billed?
 12 A. That's correct.
 13 Q. And what is the reason why there is a
 14 difference between those two numbers?
 15 A. Because our contracted rate, we have a, we
 16 had a contracted rate with Endoscopy Center that paid
 17 \$16.40 per unit per 15 minutes during that time period.
 18 Q. Okay. So it would have been an increase if
 19 there would have been more units and a decrease if there
 20 had been fewer?
 21 A. Correct.
 22 Q. Because you have a contracted rate it's
 23 less money than you actually have to pay than what they
 24 submit?
 25 A. Correct.

1 A. Yes.
 2 Q. In Las Vegas?
 3 A. Yes.
 4 Q. Is that where the bill came from?
 5 A. Yes.
 6 Q. Now under the next one where it says
 7 billing provider there is a name over there.
 8 A. Yes.
 9 Q. And it has a designation of CRNA. Do you
 10 see that?
 11 A. Yes.
 12 Q. What name is designated there?
 13 A. Mathahs.
 14 Q. First name?
 15 A. Keith.
 16 Q. So is that the provider on this form?
 17 A. That's the anesthesiologist that performed,
 18 that provided the service.
 19 Q. Now I want to flip to that explanation of
 20 benefits portion which I think you said was on page 2.
 21 A. Two.
 22 Q. Of Exhibit 35. And explain that for the
 23 Grand Jury. Again does that have Mr. Meana's name on
 24 it?
 25 A. Yes.

1 Q. Is the \$560, is that a three unit charge?
 2 Was that your experience that it was a three unit charge
 3 from, I mean time charge from the Endoscopy Center?
 4 A. Yes.
 5 Q. Did every claim that you had come in that
 6 was in the three unit charge range have a dollar figure
 7 of \$560?
 8 A. I'm not sure.
 9 Q. The ones that you have looked at.
 10 A. Yes, the ones I reviewed all had the \$560
 11 billed amount for three time units.
 12 Q. Fair enough. Now I know that we have gone
 13 through what we just did on this particular patient. I
 14 want to move to the next one which is Gwendolyn Martin I
 15 believe you said; is that correct?
 16 A. Yes.
 17 Q. I'm going to hand you what has been marked
 18 as Grand Jury Exhibit Number 34. Flip through that
 19 again and do the same thing, tell me if you recognize
 20 the forms that are there and what they are.
 21 A. Yes, I do.
 22 Q. What are they?
 23 A. Again it's the HCVA 1500 with billed
 24 charges for endoscopy services.
 25 Q. Okay. And are there two separate groups

1 being the HCVA 1500 form and then an explanation of
2 benefits saying what you actually paid?

3 A. Yes.

4 Q. Are they all for the same patient Gwendolyn
5 Martin?

6 A. They're all for the same patient. There's
7 two HCVA 1500s for two separate services on two separate
8 dates of service.

9 Q. Fair enough. Showing the first page of
10 Grand Jury Exhibit Number 34, and I know we've gone
11 through the exhibit, I'll go through it quickly. Does
12 it show on the form the name of the patient?

13 A. Yes.

14 Q. We're looking at the 1500 HCVA form; is
15 that correct?

16 A. Yes, we are.

17 Q. And then if we go down does it show the
18 procedure date?

19 A. Yes, 9/20/07.

20 Q. So according to this form the procedure
21 occurred on 9/20 of '07?

22 A. Yes.

23 Q. Still an endoscopy procedure?

24 A. Yes.

25 Q. The point I want to get to on this

1 particular form, the amount being charged is I think
2 \$560 according to this?

3 A. Yes.

4 Q. And the number of minutes billed is 31
5 minutes?

6 A. Yes.

7 Q. Endoscopy Center of Southern Nevada still?

8 A. Yes.

9 Q. And Mr. Lakeman being the anesthesia
10 person?

11 A. Yes.

12 Q. Now on that particular form, going to page
13 3 of the exhibit, does page 3 relate to the actual,
14 what's called the explanation of benefits form showing
15 the amount paid by your company for this claim?

16 A. Yes, it does.

17 Q. And how much was paid on that particular
18 claim?

19 A. \$304.

20 Q. Even?

21 A. Yes.

22 Q. So \$304. And the charged amount was how
23 much?

24 A. Five hundred sixty.

25 Q. Now I notice between the first product we

1 looked at on Miss, I think it was Miss Meana's form, or
2 excuse me, Rudolfo Meana's form and this one that there
3 are difference in what you paid based on the same billed
4 charge.

5 A. Correct.

6 Q. Can you explain that?

7 A. Mr. Meana's was, is a senior and his
8 contracted rate was \$16.40. The commercial -- this
9 member --

10 Q. Per unit you mean?

11 A. Per unit. This member is a commercial
12 member so they're a working employed member with
13 commercial insurance and that rate is \$38, was \$38 per
14 unit at that time.

15 Q. So it was much higher?

16 A. It was much higher.

17 Q. So is that why there is a difference
18 between how much you have to pay?

19 A. That's why there's a difference in payment.
20 So the units are the same, eight units, but multiplied
21 by a different contracted rate.

22 Q. Fair enough. And if you could, if you
23 could let me finish my question before --

24 A. I'm sorry.

25 Q. -- you answer that would help the court

1 reporter taking down what's being said.

2 A. Certainly.

3 Q. Now I want to move to page 4 of Exhibit 34
4 which is the, I think another one of these HCVA claim
5 forms; is that correct?

6 A. Yes, it is.

7 Q. It still has Miss Martin's name on it?

8 A. Yes.

9 Q. If we move down we see that it looks like
10 this was a claim on the following day, the 21st of
11 September of 2007; is that correct?

12 A. Yes, it is.

13 Q. Now I notice that the number here under
14 section D on box, under the box, large box 24 --

15 A. Yes.

16 Q. -- has a different procedure type code. Is
17 that still an endoscopy procedure?

18 A. Yes, it is.

19 Q. Is that an upper or lower or do you know?

20 A. I'm not sure.

21 Q. But clearly there were two different
22 endoscopy type procedures?

23 A. Yes.

24 Q. If we move across we see the billed amount
25 is still \$560?

1 A. Yes.
 2 Q. And the minutes that were submitted to your
 3 company on this particular claim were 32?
 4 A. Yes.
 5 Q. The CRNA at the bottom in box 33 is I
 6 believe Keith Mathahs; correct?
 7 A. Yes.
 8 Q. And then box 32, this was a claim that came
 9 from the Endoscopy Center?
 10 A. Yes.
 11 Q. Move to I believe it's page 6 of the
 12 exhibit which is titled explanation of benefits. Do you
 13 see that?
 14 A. Yes.
 15 Q. What is the date for this particular, the
 16 procedure related to this payment of claim?
 17 A. 9/21/07.
 18 Q. Does that refer to the HCVA form we just
 19 saw a moment again?
 20 A. Yes, it does.
 21 Q. Same patient's name?
 22 A. Yes.
 23 Q. Dollar amount that was billed?
 24 A. \$560.
 25 Q. The amount paid?

1 BY A JUROR:
 2 Q. Miss Myers, there is a commercial product
 3 and a senior product?
 4 A. Yes.
 5 Q. On the senior product is Medicare billed
 6 for a portion of that as well?
 7 A. No. What Secure Horizons Pacific Care
 8 senior product is a Medicare managed, Medicare advantage
 9 product. So Medicare subcontracts to other HMO
 10 insurance companies to provide health care to their
 11 members. So Medicare relinquishes their billing rights
 12 to the insurance company that they have contracted,
 13 subcontracted with.
 14 Q. Thank you.
 15 A. Does that --
 16 THE FOREPERSON: Any further questions?
 17 BY A JUROR:
 18 Q. If there was a patient without insurance of
 19 any sort would that patient pay the full \$560.
 20 A. Yes.
 21 Q. No discounts to the patient?
 22 A. Well, that actually is a provider question.
 23 I'm not, I'm only speaking as an insurance company.
 24 Q. But you have paid claims for the full
 25 amount?

1 A. \$304.
 2 Q. So if I understand you correctly this
 3 patient had procedures on the 20th and the 21st and that
 4 on those two days the amount of anesthesia billed was
 5 the same; correct?
 6 A. Yes.
 7 Q. The amount of payment for each procedure
 8 was the same?
 9 A. Yes.
 10 Q. If the person had had a, let's say just on
 11 the 21st for example had had both the upper and the
 12 lower endoscopy done at the same time, would there have
 13 been one anesthesia charge or two?
 14 A. One. One base unit charge.
 15 Q. But not two separate?
 16 A. Not two separate base units.
 17 Q. And then the time for doing both would have
 18 been certainly added together; correct?
 19 A. Correct.
 20 Q. Are those the only two patients that you
 21 reviewed in relation to this particular case?
 22 A. Yes.
 23 MR. STAUDAHER: I have nothing further for
 24 this witness.
 25 THE FOREPERSON: Are there any questions?

1 A. They have insurance, if I receive their
 2 claim they have insurance.
 3 Q. They have insurance. I see.
 4 A. And they are contracted with us.
 5 Q. I understand. Thank you.
 6 A. To provide that.
 7 BY A JUROR:
 8 Q. Does your billing company or your insurance
 9 company require anesthesia records or any other medical
 10 records be submitted with the HCVA or do you request
 11 those only on a case that you may need them?
 12 A. Only a case that they're required. One of
 13 the other items on the form is actually the time. Above
 14 the area there is a time.
 15 MR. STAUDAHER: And so that we're clear on
 16 this I'm going to hand her back both of the exhibits. I
 17 don't know if she needs to refer to both. But if you
 18 would tell us which one you're looking at.
 19 THE WITNESS: I'm looking at Rudolfo Meana.
 20 MR. STAUDAHER: So that for the record is
 21 Grand Jury Exhibit Number 35 and she's referring to the
 22 first page of the exhibit.
 23 THE WITNESS: And above the procedure code
 24 there actually is a time entered and this one is 10:30
 25 to 11:03.

MR. STAUDAHER: And I'll display that to the Grand Jury so that we can make sure we see what you're referring to. And I'll zoom in on it actually.

So can you say that once again now that this is displayed for the Grand Jury.

THE WITNESS: Yes. So when we receive the claim we see the 10:30 to 11:03 and that equates to the 33 minutes and as long as that is on the form and it's our contracted provider and there is no reason to have an indication that it's not accurate that is what is paid on.

A JUROR: Thank you.

THE FOREPERSON: Any further questions?

MR. STAUDAHER: I now have a follow-up question to that.

THE FOREPERSON: Okay.

BY MR. STAUDAHER:

Q. Related to that particular item that you just designated, is that also present on Grand Jury Exhibit Number 34?

A. Yes, it is.

Q. I'm going to place that up there so that the Grand Jury can see that as well.

So there is a specific time frame listed; is that correct?

A. That's correct. This procedure took place between 12:20 and 12:51.

Q. And this is the procedure I believe on the 20th; correct?

A. Yes.

Q. And the other one which you mentioned was 10:30 to 11:03 was on the 21st?

A. Correct.

Q. And that was Grand Jury Exhibit Number 35; correct?

THE FOREPERSON: Yes.

MR. STAUDAHER: One second, I'm not done.

Q. With relation to that, did your company require that the actual minute time or the time designated for the anesthesia be submitted along with the bills?

A. Yes.

Q. That was something specific to Pacific Care?

A. That was something specific to our processing of the claim, yes.

Q. So if other insurance companies had that or didn't have that you wouldn't really know?

A. I wouldn't know.

Q. It was just something that your company

required?

A. That's correct.

MR. STAUDAHER: Okay.

BY A JUROR:

Q. Did you have anyone audit those time factors to see if there was any overlap?

A. No, we did not.

THE FOREPERSON: Any further questions? None?

A JUROR: I have one.

THE FOREPERSON: Okay.

BY A JUROR:

Q. I kind of was confused on the contracted rates that you had. When you said you had it with Dr. Desai, so you guys agreed that this is the amount that you're going to pay for this, that's what it meant?

A. Correct.

Q. Okay. So different people, different insurers do different rates with different doctors?

A. Correct.

Q. That's what it meant?

A. Correct, different insurance companies have different payment methodologies and contracts with providers.

Q. Okay.

BY MR. STAUDAHER:

Q. I'm sorry, I have one additional follow-up. I just want to be clear on this. I showed you, and I just want to go, we're looking currently on the screen at Exhibit 35, is that correct? And let me go to that section. We're looking at box 24, section or column D. Correct?

A. Yes.

Q. The number designations on that are 10.30 to 11.03?

A. Yes.

Q. And this is Rudolfo Meana; correct?

A. Yes.

Q. And the 21st --

A. Yes.

Q. -- of September of 2007?

A. Yes.

Q. Now on Gwendolyn Martin, I think I showed you -- and this is Exhibit Number 34.

A. Yes.

Q. First page, Gwendolyn Martin, I'll zoom back out so we can see where we're at here. 9/20 of 07?

A. Yes.

Q. And the time that you're talking about is 12:20 to 12:51?

1 A. Yes.
 2 Q. Now page 4 of that exhibit, and I'll show
 3 it to you here, it's still Gwendolyn Martin; correct?
 4 A. Yes.
 5 Q. And the date is 9/21 of '07?
 6 A. Yes.
 7 Q. And there are specific times listed there.
 8 What are they?
 9 A. This is 13:15 to 13:47, that is 1:15 to
 10 1:47.
 11 Q. Now one question. When you receive these
 12 claims in --
 13 A. Yes.
 14 Q. -- if you received a series of claims, I
 15 assume if you had a lot of Pacific Care patients or
 16 Secure Horizon patients who came into a facility on a
 17 day for a number of procedures, and since you're having
 18 specific times placed on those forms as a requirement,
 19 do you ever look at those to see if there is any problem
 20 with them, if they overlap, anything like that?
 21 A. Normally they're processed on an individual
 22 basis.
 23 Q. But if somebody had a couple of forms in
 24 front of them --
 25 A. Yes.

1 Q. -- and they look at them and for example
 2 we're looking at the time range of 1315 to 1347 --
 3 A. Yes.
 4 Q. -- if someone had a form the next form over
 5 that says 1330 to 13 whatever, same claim, same company,
 6 would that raise a red flag?
 7 A. Yes, it would.
 8 MR. STAUDAHER: I have nothing further?
 9 THE FOREPERSON: Are there any further
 10 questions?
 11 BY A JUROR:
 12 Q. Yeah, I do have one.
 13 All right. Based on what Mike said here it
 14 would raise a question, I understand. But you wouldn't
 15 necessarily handle both claims though, would you? I
 16 mean there might be another person sitting down the
 17 aisle from you or something.
 18 A. That's correct. I have, there are multiple
 19 claims examiners so two claims for the same time period
 20 could be processed by two individual people. We were a
 21 manual claim shop meaning that we, a person data entered
 22 the information from the HCVA into the computer system
 23 and it could have been two different people.
 24 Q. Yeah. So you wouldn't, based on that you
 25 may never catch the overlap?

1 A. That's correct, unless a red flag had been
 2 raised and we proceeded to investigate.
 3 Q. Okay.
 4 THE FOREPERSON: Any further questions?
 5 None?
 6 By law, these proceedings are secret and
 7 you are prohibited from disclosing to anyone anything
 8 that has transpired before us, including evidence and
 9 statements presented to the Grand Jury, any event
 10 occurring or statement made in the presence of the Grand
 11 Jury, and information obtained by the Grand Jury.
 12 Failure to comply with this admonition is a
 13 gross misdemeanor punishable by a year in the Clark
 14 County Detention Center and a \$2,000 fine. In addition,
 15 you may be held in contempt of court punishable by an
 16 additional \$500 fine and 25 days in the Clark County
 17 Detention Center.
 18 Do you understand this admonition?
 19 THE WITNESS: I do.
 20 THE FOREPERSON: Thank you. You can be
 21 excused.
 22 MR. STAUDAHER: And ladies and gentlemen, I
 23 was a little remiss at the beginning. Before I bring in
 24 the next witness I just want to reiterate the fact that
 25 I know there are a couple of Grand Jurors missing this

1 morning, we still have 12 to proceed on, but I want to
 2 reiterate that before you deliberate, if you were absent
 3 from any of these proceedings you must read the
 4 transcripts of any portion or the entirety of any
 5 presentation that you have not been present for. Do I
 6 have general acknowledgment that you will do that in
 7 this particular case?
 8 THE FOREPERSON: Yes.
 9 MR. STAUDAHER: I don't see anybody saying
 10 otherwise on the record. Is that true, Madam Foreman?
 11 THE FOREPERSON: Yes.
 12 MR. STAUDAHER: With that I'll bring in the
 13 next witness.
 14 THE FOREPERSON: Please raise your right
 15 hand.
 16 You do solemnly swear the testimony you are
 17 about to give upon the investigation now pending before
 18 this Grand Jury shall be the truth, the whole truth, and
 19 nothing but the truth, so help you God?
 20 THE WITNESS: Yes.
 21 THE FOREPERSON: Thank you. You may be
 22 seated.
 23 You are advised that you are here today to
 24 give testimony in the investigation pertaining to the
 25 offenses of performance of act in reckless disregard of

1 persons or property, criminal neglect of patients,
2 insurance fraud, obtaining money under false pretenses,
3 and racketeering, involving Dipak Kantilal Desai, Ronald
4 Ernest Lakeman and Keith H. Mathahs.

5 Do you understand this advisement?

6 THE WITNESS: Yes.

7 THE FOREPERSON: Please state both your
8 first and last names and spell them for the record.

9 THE WITNESS: Corrine Spaeth. First name
10 spelled C-O-R-R-I-N-E, last name Spaeth, S-P-A-E-T-H.

11 THE FOREPERSON: Thank you.

12 MR. STAUDAHER: And ladies and gentlemen of
13 the Grand Jury, the testimony of this witness will
14 pertain to the racketeering charges as I've said before,
15 28, 29, 58 and 59, but in addition to that specifically
16 they will relate to Counts 13, 22, 43 and 52, as well as
17 Counts 17, 26, 47 and 56.

18 CORRINE SPAETH,

19 having been first duly sworn by the Foreperson of the
20 Grand Jury to testify to the truth, the whole truth,
21 and nothing but the truth, testified as follows:

22 EXAMINATION

23 BY MR. STAUDAHER:

24 Q. Miss Spaeth, what do you do for a living?

1 A. I'm the director of the claims department
2 for Sierra Health Services.

3 Q. And Sierra Health Services, do they go by
4 other names as well?

5 A. Yes, they sell different products. Health
6 Plan of Nevada, Sierra Health and Life Insurance
7 Company, and we have, we're recently purchased by United
8 Health Care.

9 Q. So you're associated with them as well?

10 A. Yes.

11 Q. So if you have a claim coming in from one
12 of those different entities or to one of those entities
13 like HPN or Sierra Health it would still come to your
14 company?

15 A. Yes, it would.

16 Q. Can you explain to us what happens when a
17 claim comes in and -- is it a certain type of form for
18 example?

19 A. Differences between the two companies?

20 Q. No. I'm talking about in general when a
21 claim comes in does it come in on a certain type of
22 form?

23 A. Yes. In-patient claims come in UB forms
24 and physician forms come in on HCVA 1500 forms.

25 Q. I'm going to specifically be asking you

1 about some HCVA 1500 forms. But if I understand you
2 correctly that's where the claim comes from a provider
3 to your company and then you pay on those claims?

4 A. Yes, we do. And yes, it does.

5 Q. Now when you pay on the claims is that kind
6 of the revenue cycle from your organization, you're the
7 insurance company that insures, you get the claim, you
8 look at it, you decide what your contracted amount is or
9 whatever and you pay on it?

10 A. Yes, and the member benefits as well.

11 Q. Got it.

12 I'm going to direct your attention to two
13 specific patients, specifically Carole Grueskin and
14 Stacy Hutchison. Were they patients with HPN at the
15 time?

16 A. They were our members, yes.

17 Q. And did you receive claims from them on
18 the, both of them, on the 21st of September of 2007?

19 A. Dates of service were September 21, 2007.

20 Q. Is that what I said?

21 A. I thought you said received. I'm sorry.

22 Q. I'm sorry, dates of service. That's what I
23 meant.

24 I'm going to hand you a couple of packets
25 of information here. I'm going to start off with the

1 first one which has been marked as Grand Jury
2 Exhibit 37. It bears the name of Stacy Hutchison and
3 I'm going to ask you some questions about that if I
4 could.

5 Now if you would flip through that and tell
6 me if you recognize the documents and tell me generally
7 what they are.

8 A. Yes, I do recognize these documents. The
9 first two pages are claim forms for Stacy Hutchison, one
10 is for date of service 9/21 and one is for 9/28. They
11 are each from CRNA, who is a registered, certified nurse
12 anesthetist, and it is a charge for him performing
13 anesthesia for her services on these dates at the
14 Endoscopy Center.

15 Q. Okay. And the other pages, what are those?

16 A. Those are the EOB that we generate after we
17 make the payment that are mailed back to the patients.

18 Q. What is an EOB?

19 A. It's an explanation of benefits.

20 Q. Is that the actual explanation to the
21 patient of what you actually paid to the provider?

22 A. Yes, it is. And what they would owe if
23 they owe anything.

24 Q. I'm going to display this for the Grand
25 Jury. And they have been through these forms, ma'am,

1 and I know you're familiar with them too so I'm just
 2 going to kind of run through the form.
 3 Is this in fact, this is the first page of
 4 Grand Jury Exhibit Number 37, is this what you just
 5 designated as the 1500 claim form?
 6 A. Yes, it is.
 7 Q. Whose name is on the form?
 8 A. Stacy Hutchison.
 9 Q. I'm going to move down the form to I
 10 believe it's box 24, that column or that row going
 11 across, do you see that?
 12 A. Yes, I do.
 13 Q. Date of service is?
 14 A. 9/21/2007.
 15 Q. I'm looking at box D. Does that have a
 16 procedure code in it?
 17 A. Yes.
 18 Q. What kind of code is that?
 19 A. It's an anesthesia procedure code.
 20 Q. For a?
 21 A. For a colonoscopy.
 22 Q. If we move across to the charge for that,
 23 how much was billed to your company for that service?
 24 A. \$560.
 25 Q. And what was the number of minutes or

1 whatever that are were listed there?
 2 A. The number of minutes for this procedure
 3 that he billed us for were 31 minutes.
 4 Q. Does that, do those numbers vary, I mean
 5 charges and minutes and so forth vary on typical charges
 6 that come in for procedures?
 7 A. Yes, they can vary.
 8 Q. Moving to the bottom, box 30, what is the
 9 entity that submitted this claim form to you?
 10 A. Endoscopy -- well, Ron Lakenan is the
 11 entity that submitted it. And he performed it at the
 12 Endoscopy Center of Southern Nevada.
 13 Q. Is that located at a particular address
 14 indicated on that form?
 15 A. Yes.
 16 Q. What is it?
 17 A. 700 Shadow Lane.
 18 Q. Here in Las Vegas?
 19 A. Yes, here in Las Vegas.
 20 Q. So if I understand you correctly that's the
 21 form that you get?
 22 A. Yes, it is.
 23 Q. Okay. Now on page 2 of this document still
 24 says, it's still another one of these HCVA 1500 forms?
 25 A. Yes, it is.

1 Q. For Stacy Hutchison?
 2 A. Yes.
 3 Q. We go down to that same line in box 24, it
 4 says date of service on this particular one was 9/28 of
 5 '07; is that right?
 6 A. Yes, it is.
 7 Q. Same type of procedure, an endoscopy type
 8 procedure?
 9 A. It's an endoscopy type procedure, yes.
 10 Q. Under the billed amount the charge that was
 11 submitted to you?
 12 A. \$560.
 13 Q. Now here I note that instead of 31 minutes
 14 it appears to be 32 minutes; is that correct?
 15 A. Yes, it is.
 16 Q. Is that what you refer to as sometimes
 17 variation in the amount of time that is submitted to
 18 you?
 19 A. Yes.
 20 Q. If somebody submitted a lower bill to you,
 21 for example like two minutes, would typically the amount
 22 billed under section F be charged at a lower amount?
 23 Would that typically show up as a billed amount which
 24 would be lower?
 25 A. It should be because if it's a ten minute

1 or two minute procedure then yes the dollar should be
 2 lower.
 3 Q. Okay. Now on the bottom, and I know that
 4 the CRNA here is Linda Hubbard I think you designated
 5 box 33; correct?
 6 A. Yes.
 7 Q. Does it still come from the Endoscopy
 8 Center of Southern Nevada?
 9 A. Yes, it does.
 10 Q. Now moving to what you described as the
 11 explanation of benefits form for the procedure for Stacy
 12 Hutchison on I think it's the 21st. And I'll zoom in on
 13 that a little bit because I know it's hard to read.
 14 Is that the procedure -- based on the
 15 explanation of benefits the payment for that procedure
 16 on the 21st?
 17 A. Yes. No, that's the bill charge
 18 highlighted there, \$560. And if you go over --
 19 Q. Under the column indicating, and it's hard
 20 to read but it says description, what is described
 21 there?
 22 A. Anesthesia intestinal endoscopy.
 23 Q. Now I'm going to take you down to the lower
 24 right hand corner of the section where the billing
 25 occurs. Do you see a dollar amount there?

1 A. Yes.
 2 Q. What is that dollar amount?
 3 A. Are you speaking of the very last column?
 4 Q. Yes.
 5 A. That is the allowed amount, the amount we
 6 paid on this particular claim which is \$90.
 7 Q. I want to talk about that for just a
 8 minute. Now \$90 as you say the amount you actually
 9 paid; correct?
 10 A. Yes.
 11 Q. Now before we go any further with that I
 12 want to go to the next page which is another EOB form I
 13 think; correct?
 14 A. Yes, it is.
 15 Q. And the date on this one is the 28th of
 16 2007?
 17 A. Yes.
 18 Q. Description?
 19 A. Anesthesia upper gastrointestinal.
 20 Q. Same dollar amount billed?
 21 A. Same dollar amount billed.
 22 Q. But you pay the same amount; is that
 23 correct?
 24 A. Yes, we did.
 25 Q. Still \$90?

1 Q. But is it important to get accurate
 2 information?
 3 A. Absolutely.
 4 Q. In some respects does, at the end of a -- I
 5 assume that you, you said the contracted amount or
 6 something along those lines; is that right?
 7 A. Yes, it's a contracted amount.
 8 Q. I know you're probably not involved in the
 9 actual contract negotiations; is that right?
 10 A. No, I'm not.
 11 Q. But is it your understanding or do you have
 12 knowledge of the fact that what a provider basically
 13 eventually says is what work they had to put in over a
 14 period of years or over a period of a year for certain
 15 services, that that might factor into what they contract
 16 out later on for how much you pay them?
 17 A. Absolutely, the history of claims is looked
 18 at to renegotiate contracts.
 19 Q. So when you say history of claims, is that
 20 stuff that is, or information that is contained on the
 21 1500 claim form itself?
 22 A. Yes, it is.
 23 Q. So if somebody was doing a procedure for
 24 example that was only taking two minutes but they kept
 25 submitting bills for 30 or 31 or 32 minutes or something

1 A. Yes.
 2 Q. In the payment, I know that the amount that
 3 was submitted to you was for either 32 or I think it
 4 was --
 5 A. Thirty-one.
 6 Q. Thirty-one minutes, 31 or 32 minutes, and
 7 the billed amount was 560 on both of those, but you paid
 8 the same amount on both; is that correct?
 9 A. Yes, it is.
 10 Q. If they had billed, or if they had billed
 11 out, I don't know, \$120 for ten minutes of anesthesia
 12 time, how much would you have paid?
 13 A. We would have still paid \$90.
 14 Q. So are you telling us that you paid a flat
 15 amount of \$90 regardless of what was billed to you?
 16 A. Yes, we did.
 17 Q. So did it matter how many minutes were
 18 placed in the boxes?
 19 A. It still matters but it wouldn't have in
 20 regard to the payment out the door it would not have
 21 changed it.
 22 Q. So the dollar amount coming back to the
 23 Endoscopy Center would not have changed regardless of
 24 what they put in?
 25 A. Correct.

1 along those lines, when it came to negotiate would that
 2 go into, be a factor, at least considered in whether or
 3 not to raise the reimbursement or lower the
 4 reimbursement?
 5 A. Yes, it would.
 6 Q. Okay. Now beside those two, or that
 7 patient, was there another one that you dealt with
 8 beside Miss or Mr. Hutchison?
 9 A. Yes, there is a third.
 10 Q. And who was that?
 11 A. It's -- I need to pull this name out. It's
 12 Carole Grueskin.
 13 Q. I'm showing you is what is marked as Grand
 14 Jury Exhibit 36. Just flip through both pages of it and
 15 tell me if you recognize what's there.
 16 A. Yes, I do.
 17 Q. What is that document?
 18 A. It is the claim form again on a HCVA 1500,
 19 it is the explanation of benefits that we generate at
 20 the time of making the payment.
 21 Q. Okay.
 22 A. And this one looks a little bit different
 23 because this is one of our Senior Dimension members, the
 24 explanation of benefits.
 25 Q. Got it. And I'll ask you about that in

1 just a second.

2 So I'm going to display this for the Grand

3 Jury. This is the first page of Grand Jury Exhibit

4 Number 36. Again you said it was a HCVA 1500 form?

5 A. Yes, it is.

6 Q. It mentions Carole Grueskin as being the

7 patient?

8 A. Yes.

9 Q. Slide down again to box 24, the first line

10 across, do you see that?

11 A. Yes, I do.

12 Q. Date?

13 A. 9/21/2007.

14 Q. Under the type of procedure?

15 A. It's the anesthesia procedure code 00810,

16 colonoscopy.

17 Q. And then if we move across, the dollar

18 amount charged in the minutes, can you tell us what

19 those are?

20 A. The charges are \$560 once again and 31

21 minutes in time that he's stating that he provided for

22 the procedure.

23 Q. And then on the bottom?

24 A. Again the claim is from Ron Lakeman, CRNA,

25 and he performed it at the Endoscopy Center of Southern

1 Q. So the amount that would have been paid on

2 this claim would have been \$90?

3 A. Had the member had no responsibility, yes,

4 but the member has a \$20 responsibility.

5 Q. So the date on this is still the 21st?

6 A. Yes, it is.

7 Q. Of September of 2007?

8 A. Yes, it is.

9 Q. The amount billed?

10 A. Is 560.

11 Q. But the amount paid is only?

12 A. \$70.

13 MR. STAUDAHER: I have nothing further of

14 this witness.

15 THE FOREPERSON: Are there any questions

16 from the jury? None?

17 By law, these proceedings are secret and

18 you are prohibited from disclosing to anyone anything

19 that has transpired before us, including evidence and

20 statements presented to the Grand Jury, any event

21 occurring or statement made in the presence of the Grand

22 Jury, and information obtained by the Grand Jury.

23 Failure to comply with this admonition is a

24 gross misdemeanor punishable by a year in the Clark

25 County Detention Center and a \$2,000 fine. In addition,

1 Nevada.

2 Q. 700 Shadow Lane, Las Vegas?

3 A. Yes.

4 Q. Moving to page 2, this is the one you said

5 had a little bit different look to it as far as the

6 explanation of benefits.

7 A. It does, yes. It's a CMS requirement that

8 the font sizes be larger, et cetera, so we have to

9 revise the EOB somewhat for this membership.

10 Q. What is CMS?

11 A. Centers for Medicare and Medicaid Services.

12 Q. And do you know why they want the font size

13 bigger on those forms?

14 A. I believe just so the, it's just easier for

15 the members to read.

16 Q. And is this group typically an elderly type

17 person?

18 A. Yes, it is.

19 Q. As far as the payment, I notice there's a

20 difference in the amount. You told us earlier that it

21 was \$90 that you paid on these flat fee kind of

22 services.

23 A. Yes. And this is still \$90 in allowable

24 but the member had a cost sharing of \$20 or a \$20 co-

25 payment.

1 you may be held in contempt of court punishable by an

2 additional \$500 fine and 25 days in the Clark County

3 Detention Center.

4 Do you understand this admonition?

5 THE WITNESS: I do.

6 THE FOREPERSON: Thank you. You can be

7 excused now.

8 Ten minute break. We'd like to call a ten

9 minute break.

10 MR. STAUDAHER: We could. If it would be

11 possible if I could just put on the next witness who

12 will be a relatively short witness and then take a ten

13 minute break. If that would be okay.

14 THE FOREPERSON: Okay.

15 (At this time, Juror Yolanda Parker enters

16 the proceedings.)

17 THE FOREPERSON: Please raise your right

18 hand.

19 You do solemnly swear the testimony you are

20 about to give upon the investigation now pending before

21 this Grand Jury shall be the truth, the whole truth, and

22 nothing but the truth, so help you God?

23 THE WITNESS: I do.

24 THE FOREPERSON: Thank you. You may be

25 seated. Over by the microphone.

1 You are advised that you are here today to
2 give testimony in the investigation pertaining to the
3 offenses of performance of act in reckless disregard of
4 persons or property, criminal neglect of patients,
5 insurance fraud, obtaining money under false pretenses,
6 and racketeering, involving Dipak Kantilal Desai, Ronald
7 Ernest Lakeman and Keith H. Mathahs.

8 Do you understand this advisement?

9 THE WITNESS: Yes.

10 THE FOREPERSON: Okay. Please state your
11 first and last names spelling both for the record.

12 THE WITNESS: Patricia Gonzalez.

13 P-A-T-R-I-C-I-A, Gonzalez, G-O-N-Z-A-L-E-Z.

14 THE FOREPERSON: Thank you.

15 PATRICIA GONZALEZ,

16 having been first duly sworn by the Foreperson of the
17 Grand Jury to testify to the truth, the whole truth,
18 and nothing but the truth, testified as follows:

19
20 EXAMINATION

21
22 BY MR. STAUDAHER:

23 Q. Miss Gonzalez, what do you do for a living?

24 A. I do contracting for Blue Cross Blue
25 Shield. I'm the director of network management.

1 Q. In your job at Blue Cross Blue Shield do
2 you deal or have access to claim forms, payment, BOB
3 forms and things like that?

4 A. Yes.

5 Q. And just as we go forward on this if you
6 can let me finish my question before you answer that
7 will help the court reporter because she's taking down
8 the words and it's difficult for her to take it down if
9 we're talking over each other.

10 A. I understand.

11 Q. In that process of doing that work I assume
12 you see that kind of form, you look at the claims,
13 things like that; is that right?

14 A. Correct.

15 Q. I'm going to direct your attention to three
16 specific patients and ask if they are associated in any
17 way with your insurance company Blue Cross Blue Shield
18 as far as members? The first one being Patty Aspinwall.

19 A. Yes.

20 Q. The second being Kenneth Rubino.

21 A. Yes.

22 Q. And the third being Sharrieff Ziyad.

23 A. Yes.

24 Q. I'm going to start off with Sharrieff Ziyad
25 and ask you some questions about him and some claims

1 that pertain to him. Is that okay?

2 A. Yes.

3 Q. Showing you what has been previously marked
4 as Grand Jury Exhibit Number 31. It's a three page
5 document. Just flip through that if you would and tell
6 me if you recognize the forms that are contained in that
7 exhibit.

8 A. Yes.

9 Q. Now I will display those momentarily here
10 but before we do that I wanted to ask you a couple of
11 things. The first page of that exhibit is a certain
12 type of form. What do you call that form?

13 A. HCVA 1500.

14 Q. Is that typically the type of information
15 that, or claim type information that is submitted to
16 your company for payment for services rendered to a
17 member?

18 A. Yes.

19 Q. And you said Mr. Ziyad was a member of Blue
20 Cross Blue Shield; is that right?

21 A. Yes.

22 Q. This first page of the exhibit that's being
23 displayed before the Grand Jury right now, is that the
24 form that was submitted for Sharrieff Ziyad on the date
25 in question?

1 A. Yes.

2 Q. And if we go down a little bit we can see
3 the date I believe on box 24, line 1, do you see that?

4 A. Yes.

5 Q. What is the date that the service was
6 rendered on this particular procedure?

7 A. 7/25 of '07.

8 Q. Okay. And if we go across to column D
9 there is a procedure code listed there. Do you know
10 what that's for?

11 A. Yes.

12 Q. And what is that?

13 A. Colonoscopy.

14 Q. The anesthesia for it a I assume?

15 A. Yes, the anesthesia for a colonoscopy.

16 Q. If we move across to column F there is a
17 dollar amount listed. What is that dollar amount?

18 A. \$560.

19 Q. And as far as the dollar amount is
20 concerned, what is that? Is that how much is actually
21 submitted by the entity to your insurance company for
22 billing purposes?

23 A. That is correct.

24 Q. The charge so to speak?

25 A. Yes, the billed charges.

1 Q. I note that on the next column there is a
 2 number 8; is that correct?
 3 A. Correct.
 4 Q. Typically on procedures that are done, the
 5 anesthesia portion of procedures, do they get billed out
 6 in minutes or in units?
 7 A. In minutes.
 8 Q. And do you know what the difference is
 9 between minutes and units?
 10 A. Yes.
 11 Q. Go ahead.
 12 A. Every 15 minutes equals one unit.
 13 Q. As far as a base number of units do you
 14 start off with, for an endoscopy type procedure is there
 15 a base that you start with?
 16 A. Yes.
 17 Q. What is the base?
 18 A. Five.
 19 Q. The base of five and then additional time
 20 would then be added to that base of five in the term of
 21 increments of 15 minutes; is that correct?
 22 A. That is correct.
 23 Q. So if there was eight units billed would
 24 that be three units on top of the base?
 25 A. Yes.

1 and then we'll come back to the other one because I
 2 think it's a little bit easier to read. This is really
 3 small. I'll try to zoom in a little bit.
 4 First of all what are we looking at? What
 5 form is this?
 6 A. This is the explanation of payment.
 7 Q. And I'm going to, I just zoomed into the
 8 portion of the line which is entitled anesthesia which
 9 is the top line of the two, the next line down is
 10 totals. Do you see what it said we paid at the top of
 11 that column?
 12 A. Yes.
 13 Q. Is that what you actually paid on this
 14 particular claim?
 15 A. Yes.
 16 Q. What is the dollar amount that you paid?
 17 A. \$206.82.
 18 Q. And that's on a charge of \$560 for what
 19 appears to be eight units; is that correct?
 20 A. Correct.
 21 Q. Now I'm going to flip back to the preceding
 22 page, a little bit easier to read. Does it have the
 23 same information on it?
 24 A. Yes.
 25 Q. On the left hand side of the column it says

1 Q. For a total of eight?
 2 A. Correct.
 3 Q. We see the number 8 in that designation.
 4 Do you know if that was submitted as eight units or
 5 minutes? I'm not asking how you interpret it at this
 6 point but how you believe it was submitted based on the
 7 dollar amount you see billed for it.
 8 A. Right, eight units.
 9 Q. Looking at the bottom of the screen, I
 10 think we're on boxes, both in box 32 and 33, there are
 11 providers and locations of service; is that correct?
 12 A. That is correct.
 13 Q. And who are, who is designated as the
 14 provider who performed the service?
 15 A. On box 33 Ron Lickman (sic).
 16 Q. Lakeman?
 17 A. Yes.
 18 Q. And the location where the service took
 19 place?
 20 A. The Endoscopy Center of Southern Nevada.
 21 Q. Is that on 700 Shadow Lane in Las Vegas?
 22 A. Yes, that is correct.
 23 Q. And I'm going to turn to the next page.
 24 Actually the next two pages have I think similar
 25 information on them. I'll turn to the last page 3 first

1 anesthesia under description?
 2 A. Correct.
 3 Q. Billed charge is 560?
 4 A. Yes.
 5 Q. And it says service paid is \$206.82?
 6 A. Correct.
 7 Q. Is that what you actually paid for the
 8 anesthesia billed to you at 560 on this particular
 9 patient?
 10 A. Yes.
 11 Q. I'm going to show you some others in just a
 12 moment but one of the things I wanted to ask you is
 13 this. If you received a payment, your company, if you
 14 received a billed amount minute wise for services, for
 15 anesthesia that were let's say the 31 minutes, you said
 16 already that that would be considered eight units; is
 17 that correct?
 18 A. Yes, that is correct.
 19 Q. If you had a claim come in that say was 22
 20 minutes, how many units would that be?
 21 A. Seven.
 22 Q. Would you pay a lesser amount on that claim
 23 than you would on a 31 minute submitted bill?
 24 A. Yes.
 25 Q. Would that relate to the fact that you're

1 paying on seven units versus eight units?
 2 A. Correct.
 3 Q. If a charge came in that was at 12 minutes
 4 how many units would you pay on in that instance?
 5 A. Six.
 6 Q. Would that charge, the amount paid be less
 7 than it would for either the 22 minute or the 31 minute
 8 charge?
 9 A. Correct.
 10 Q. So if in fact information is put on one of
 11 these forms which indicates a higher number of minutes
 12 than was actually done in the procedure would that
 13 translate into a larger charge if it went into the next
 14 unit area?
 15 A. Yes.
 16 Q. Would that be something that your company
 17 would just go ahead and pay anyway and not care about?
 18 A. We would pay the amount that's on the
 19 claim. If a member came in and said they weren't, you
 20 know, there that long, at that time we would ask for
 21 medical records to validate the time.
 22 Q. Okay. So you would do something if it was
 23 called to your attention that there was a problem?
 24 A. Yes.
 25 Q. If you learned that a claim came in that

1 was say at 31 minutes and it was in fact only 12 minutes
 2 but they were billing at that higher amount, would
 3 somebody investigate that?
 4 A. Yes.
 5 Q. I assume you don't want to pay more money
 6 than you have to for procedures; correct?
 7 A. Correct.
 8 Q. I'm going to show you -- and is it the same
 9 for all claims?
 10 A. Yes.
 11 Q. I'm going to show you the next exhibit
 12 which is marked as Grand Jury Exhibit Number 32 and have
 13 you -- this is for I believe Kenneth Rubino. Would you
 14 flip through that set of documents and just tell me if
 15 you recognize them.
 16 A. Yes.
 17 Q. I'm going to display these for the Grand
 18 Jury.
 19 This is the first page of this eight page
 20 exhibit. And is this that 1500 HCVA form that you
 21 mentioned earlier?
 22 A. That is correct.
 23 Q. Under box 2 does it have a designation for
 24 the patient?
 25 A. Yes.

1 Q. And that patient is who?
 2 A. Kevin (sic) Rubino.
 3 Q. And moving down to box 24, that line, do
 4 you see it?
 5 A. Yes.
 6 Q. First line. What is the date of the
 7 service?
 8 A. 9/21/07.
 9 Q. Is this has a procedure code of 00810 under
 10 column D?
 11 A. Yes.
 12 Q. Is that -- what is that?
 13 A. The anesthesia for colonoscopy.
 14 Q. Is there a difference between the codes for
 15 colonoscopies versus upper endoscopies?
 16 A. The code itself is different, the base is
 17 the same.
 18 Q. Okay. So it's still five unit base for
 19 each procedure?
 20 A. Yes.
 21 Q. In this particular instance I see, if we
 22 move over to column F, that the charge is the same,
 23 \$560. Do you see that?
 24 A. Yes.
 25 Q. But in this case it looks like there is a

1 three instead of the eight. Do you think that is
 2 designating minutes instead of units?
 3 A. Yes.
 4 Q. If we move to the bottom of this page,
 5 boxes 32 and 33, who is the provider and where was the
 6 service provided?
 7 A. Provider on box 33 is Kenneth, or Keith
 8 Mathias, or I'm sorry, Mathans, M-A-T-H-A-N-S, and
 9 Endoscopy Center of Southern Nevada is where the
 10 procedure was provided.
 11 Q. 700 Shadow Lane?
 12 A. Yes.
 13 Q. And I think you said M-A-T-H-A-N-S. Is it
 14 M-A-T-H-A-H-S? And I'll show you the actual exhibit.
 15 A. Yes, it is.
 16 Q. I just wanted to make sure we had that
 17 accurate.
 18 I'm going to move to the very last page
 19 which I believe would be page 8 of the exhibit and I'll
 20 display that to the Grand Jury.
 21 I'm zoom back out a little bit so we can
 22 see what we're looking at.
 23 Can you tell us what this is?
 24 A. Our explanation of payment.
 25 Q. Okay. I will zoom in on -- well, can you

1 tell us how much the charge was again? If this is the
2 explanation of payment for the previous HCVA form that
3 we saw.

4 A. Yes.

5 Q. Same date, same procedure code, same dollar
6 amount charged, that kind of thing?

7 A. That is correct.

8 Q. Does it show how much you actually paid on
9 the claim?

10 A. Yes.

11 Q. How much did you pay on the claim?

12 A. \$245.12.

13 Q. Is that the portion at the very end of
14 this?

15 A. Yes.

16 Q. So the 245.12 is for, is it based on a
17 charge of 560?

18 A. It's based on 32 minutes.

19 Q. But again the billed amount of 560; is that
20 right?

21 A. Yes.

22 Q. So that was the actual amount paid back to
23 the Endoscopy Center?

24 A. Yes.

25 Q. Again if the billed amount, billed minute

1 amount would have been less would there have been less
2 money paid to the company?

3 A. Yes.

4 Q. Now I noticed when I'm looking between the
5 two of these that between, for example Kenneth Rubino's
6 which is Exhibit Number 32, and Ziyad Sharrieff's which
7 is Exhibit 31, that although the charge was the same for
8 the same type of procedure the dollar amount paid was
9 different. Do you know why?

10 A. Yes. Because the eight was interpreted as
11 minutes and it would have been paid as six units, not
12 eight.

13 Q. So even though the charge is the same you
14 actually paid out less on that particular claim; is that
15 right?

16 A. Correct.

17 Q. As far as the, so there is no difference in
18 their actual coverage, just in how it was interpreted in
19 your company at the time?

20 A. Correct.

21 Q. Now let's look to the last one which is
22 Patty Aspinwall. I think you haven't looked at this one
23 yet. This is Grand Jury Exhibit Number 33. Just look
24 through that and tell me if that is recognizable to you
25 and what those documents are.

1 A. Yes.

2 Q. What are these documents?

3 A. It's the HCVA 1500. We were a secondary
4 payer so it's the primary explanation of payment and our
5 explanation of payment.

6 Q. Okay. Now when you say you're the
7 secondary payer, can you explain that to us?

8 A. The member has two insurance companies and
9 based on the insurance company they decide who is
10 primary and who is secondary. The primary would pay
11 first. As the secondary payer we pay the member's
12 responsibility.

13 Q. Do you get some form from the primary
14 insurer saying what they paid on this claim so you know
15 what to pay yourself?

16 A. The provider submits that information with
17 the claim.

18 Q. So let's go through this briefly here.
19 Moving to, looking at the first page of Exhibit
20 Number 33, is this, again is this that HCVA 1500 claim
21 form?

22 A. That is correct.

23 Q. Under box 2 the patient's name?

24 A. Patty Aspinwall.

25 Q. Aspinwall?

1 A. Aspinwall.

2 Q. And then moving down to box 24, line 1, do
3 you see that?

4 A. Yes.

5 Q. In that particular instance do you see the
6 date on that?

7 A. Yes, 9/21/07.

8 Q. Procedure date?

9 A. Yes.

10 Q. And if we move over we see that there is a
11 procedure charge or procedure code; is that right?

12 A. Correct.

13 Q. Now above that I actually see that there's
14 some, of that procedure code do you see that there's a
15 time listed here?

16 A. Correct.

17 Q. Is that the time that relates to what is
18 designated over on box I believe it's G which designates
19 the number of minutes?

20 A. Yes, correct.

21 Q. So they actually put in when the procedure
22 started and stopped?

23 A. Correct.

24 Q. As far as the charges, the charged amount
25 is how much?

1 A. \$560.
 2 Q. And the minutes here in this case are?
 3 A. Thirty-one.
 4 Q. Who is the provider?
 5 A. Ron Lakeman.
 6 Q. And the procedure was done at?
 7 A. Endoscopy Center of Southern Nevada at 700
 8 Shadow Lane.
 9 Q. In Las Vegas?
 10 A. In Las Vegas.
 11 Q. Now the next page I'm going to skip by for
 12 just a moment. We'll come back to that. It's a small
 13 one and I think it just shows what some of the other
 14 information later on in the exhibit. Is that correct?
 15 A. Correct.
 16 Q. I'm going to go to page 3 though which is,
 17 it appears to be some sort of explanation of benefits
 18 from another company; is that correct?
 19 A. That is correct.
 20 Q. Up at the upper right hand corner of that
 21 page and even at the top left hand corner it mentioned a
 22 different type of insurance company. What is that
 23 insurance company?
 24 A. That would be the primary, United Health
 25 Care.

1 A. No, that's what United Health Care paid.
 2 Q. So the primary paid that amount on the
 3 claim?
 4 A. Correct.
 5 Q. Now the portion over here that says patient
 6 responsibility \$62.48, is that what you would pay, the
 7 whole amount?
 8 A. Yes.
 9 Q. You would pay on that whole amount rather?
 10 A. Yes.
 11 Q. Did you pay a full amount of \$62 on that
 12 claim?
 13 A. No.
 14 Q. Okay. So let's go to the very last page
 15 which I believe is page 8 of the exhibit and I'm going
 16 to zoom out so you can see what form we're talking about
 17 here. Are you familiar with that form?
 18 A. Yes.
 19 Q. What is that?
 20 A. That is the explanation of payment from
 21 Anthem Blue Cross Blue Shield.
 22 Q. Okay. Now patient's name same, date of
 23 service same, that kind of stuff?
 24 A. Correct.
 25 Q. Do you see where it says total billed under

1 Q. And the primary, are they the ones -- did
 2 you get this form as part of the claim that came to you?
 3 A. Yes.
 4 Q. Is that so that you knew exactly what they
 5 had paid so you could know what you were going to have
 6 to pay?
 7 A. Yes.
 8 Q. So in this particular instance, I'm going
 9 to zoom down here to under where it says service detail,
 10 do you see that?
 11 A. Yes.
 12 Q. Patient's name listed; correct?
 13 A. Correct.
 14 Q. And I assume this form goes with that HCVA
 15 form we saw earlier?
 16 A. Correct.
 17 Q. Date of procedure?
 18 A. 9/21/07.
 19 Q. Amount charged, billed?
 20 A. \$560.
 21 Q. Moving across. Now it says paid to
 22 provider. Do you see that column?
 23 A. Yes.
 24 Q. It looks like there is an amount of
 25 \$249.92. Is that what you paid?

1 the patient's name?
 2 A. Yes.
 3 Q. Is that amount -- what is that amount?
 4 A. \$560.
 5 Q. Now I'm going to go to the line, the first
 6 line that, or row that goes across. Do you see that?
 7 A. Yes.
 8 Q. Under type of service here, do you see
 9 that?
 10 A. Yes.
 11 Q. What is it?
 12 A. Anesthesia.
 13 Q. Total billed?
 14 A. Five hundred and sixty.
 15 Q. Now if we move over to the one that says
 16 other amount, is that that \$249.92 amount, is that what
 17 the primary paid?
 18 A. That is correct.
 19 Q. If we move to the last column which says
 20 payment amount, what dollar amount is listed there?
 21 A. Payment amount is 56.48.
 22 Q. Is that what your company actually paid on
 23 this claim?
 24 A. Yes.
 25 Q. So United Health Care pays theirs, you pay

1 yours for a total combined?
 2 A. Correct.
 3 Q. And is the patient responsible for any
 4 remaining balance?
 5 A. No.
 6 Q. So that's just what was paid on the claim
 7 at that point?
 8 A. Yes.
 9 Q. Again if this had come in and the amount
 10 had been, the billing amount had been less minutes or
 11 whatever, would you have paid less on the claim?
 12 A. Yes.
 13 Q. As evidenced by that first one we saw where
 14 there was actually, you paid it out of eight minutes
 15 because it said eight, even though you think that's
 16 units; is that correct?
 17 A. Correct.
 18 Q. As far as this particular one, the amount
 19 that was paid out for the claim is different obviously
 20 than the previous two that you've looked at. Is that
 21 because there was a primary insurer involved as well?
 22 A. That is correct.
 23 Q. So if the primary insurer had not been
 24 involved and it would have been your company would you
 25 have paid a higher amount on that claim?

1 Q. I guess you're losing me here somewhere.
 2 BY MR. STAUDAHNER:
 3 Q. Let me ask a couple of clarifying
 4 questions.
 5 When we looked at the forms, the charges
 6 were the same for all of them.
 7 A. Yes.
 8 Q. Every claim that came through, \$560.
 9 A. Correct.
 10 Q. With the exception of one claim that had an
 11 eight on it.
 12 A. Yes.
 13 Q. All the charges were above 30 minutes;
 14 correct?
 15 A. Yes.
 16 Q. On the one claim that had an eight
 17 designated the charge was still \$560?
 18 A. Yes.
 19 Q. Which was the same as the previous ones
 20 that had been submitted at 31 plus minutes?
 21 A. Yes.
 22 Q. If the provider makes a mistake and puts
 23 down the number of units which 31, 32, 33 minutes would
 24 be; correct?
 25 A. Yes.

1 A. Yes.
 2 Q. Do you know how much you would have paid
 3 out on the base claim if the primary insurer would not
 4 have been there?
 5 A. Yes.
 6 Q. What would you have paid out? If you know.
 7 A. We would have paid 245.12.
 8 MR. STAUDAHNER: I have nothing further of
 9 this witness.
 10 THE FOREPERSON: Are there any questions?
 11 Yes.
 12 BY A JUROR:
 13 Q. Who determines on a claim form whether it's
 14 minutes or units, who determines that?
 15 A. The providers for anesthesia are told on
 16 our provider manual to bill it as minutes.
 17 Q. Okay. Did I see two different, one up
 18 there for minutes and one for units, right?
 19 A. Yes.
 20 Q. For the same procedure or different
 21 procedure?
 22 A. Same procedure. Two different claims.
 23 Q. Understand. But not to your company
 24 though, right?
 25 A. Yes.

1 Q. If they put down eight units instead,
 2 because you have an agreement with them to put down
 3 minutes you'll pay them a lower amount based on the
 4 minutes there?
 5 A. Correct.
 6 Q. So they make a mistake, you're not going to
 7 pay them more because you say look, we told you minutes,
 8 you put down eight, I don't care if it's units or not,
 9 that's what we're billing you at is eight minutes; is
 10 that correct?
 11 A. Correct.
 12 MR. STAUDAHNER: Does that help?
 13 BY A JUROR:
 14 Q. Did someone then make a mistake in putting
 15 down units versus minutes?
 16 MR. STAUDAHNER: I'm going to ask her not --
 17 that would be speculation at this point. We don't know
 18 what the billing person who submitted the form actually
 19 did and I think that goes beyond the scope of what her
 20 testimony could be.
 21 BY THE FOREPERSON:
 22 Q. I have a question.
 23 A. Uh-huh.
 24 Q. Was Ron Lakeman the CRNA for Rubino and
 25 Ziyad?

1 A. You mentioned for Rubino?
 2 Q. Uh-huh.
 3 A. For Rubino it was Keith Mathahs.
 4 Q. And for the other gentleman or woman Ziyad.
 5 I might be saying the name wrong.
 6 A. Ron Lakeman.
 7 THE FOREPERSON: Thank you.
 8 Are there any further questions? None?
 9 Yes.
 10 BY A JUROR:
 11 Q. Yes. Can we look at that form again and
 12 see the box that says units minutes. Is it described in
 13 the block, is it units or units/minutes or -- just for
 14 clarification.
 15 MR. STAUDAHER: Based on the Grand Juror's
 16 question I'm going to display Exhibit Number 31, the
 17 first page of that exhibit which is the HCVA form. I
 18 will zoom in on it so we can see what's being talked
 19 about here.
 20 A JUROR: Days or units.
 21 A JUROR: Okay. So it's listed as days or
 22 units.
 23 MR. STAUDAHER: That's correct. But I'll
 24 ask a follow-up question.
 25 Q. But it was your agreement with the

1 providers that they would put in that box not just the
 2 units but the minutes?
 3 A. Correct.
 4 Q. And that's what you would bill at?
 5 A. Correct.
 6 Q. Every bill that you saw come through that
 7 you have reviewed which was written in minutes being
 8 greater than 30, meaning 31, 32, 33 minutes for all the
 9 claims, whether they are these claims or others
 10 pertaining to the Endoscopy Center, were they all billed
 11 out at a \$560 charge?
 12 A. Correct.
 13 Q. Would that \$560 charge translate into eight
 14 units of anesthesia, five for the base and three for the
 15 time period?
 16 A. Yes.
 17 MR. STAUDAHER: Okay. Does that help?
 18 A JUROR: Yes, sir. Thank you.
 19 THE FOREPERSON: Are there any further
 20 questions? None?
 21 By law, these proceedings are secret and
 22 you are prohibited from disclosing to anyone anything
 23 that has transpired before us, including evidence and
 24 statements presented to the Grand Jury, any event
 25 occurring or statement made in the presence of the Grand

1 Jury, and information obtained by the Grand Jury.
 2 Failure to comply with this admonition is a
 3 gross misdemeanor punishable by a year in the Clark
 4 County Detention Center and a \$2,000 fine. In addition,
 5 you may be held in contempt of court punishable by an
 6 additional \$500 fine and 25 days in the Clark County
 7 Detention Center.
 8 Do you understand this admonition?
 9 THE WITNESS: Yes.
 10 THE FOREPERSON: Thank you. You may be
 11 excused.
 12 THE WITNESS: Thank you.
 13 THE FOREPERSON: You're welcome.
 14 MR. STAUDAHER: And we can go off the
 15 record so you can take your break.
 16 THE FOREPERSON: Okay. Fifteen minutes.
 17 (Recess.)
 18 MR. STAUDAHER: Ladies and gentlemen of the
 19 Grand Jury, we're back from your break. I want to put
 20 on the record that prior to the last witness, or from
 21 the witness testifying about I think it was Gwendolyn,
 22 Carole Grueskin rather, we had one of the Grand Jurors
 23 return to the Grand Jury proceeding. I just need to, as
 24 I've told the Grand Jurors in the past, to make sure
 25 that although you were not present for the first portion

1 of the presentation today that you acknowledge at least
 2 that you will review the transcripts of that portion
 3 that you missed before deliberating in this case.
 4 A JUROR: Yes.
 5 MR. STAUDAHER: Okay. And also I asked the
 6 other Grand Jurors at the beginning of this proceeding
 7 but I did not ask you if in the interim between the last
 8 presentation and this presentation if there's been
 9 anything that's happened, any testimony that you've
 10 heard in this particular case that has caused you to no
 11 longer be able to be unbiased. Is there a problem with
 12 that at this time?
 13 A JUROR: No.
 14 MR. STAUDAHER: So you can listen to the
 15 evidence presented, render a verdict, not a verdict, but
 16 deliberate in this particular case based on just that
 17 evidence and applying it to the law given to you?
 18 A JUROR: Yes.
 19 MR. STAUDAHER: Thank you.
 20 With that we'll continue.
 21 THE FOREPERSON: Please raise your right
 22 hand.
 23 You do solemnly swear the testimony you are
 24 about to give upon the investigation now pending before
 25 this Grand Jury shall be the truth, the whole truth, and

1 nothing but the truth, so help you God?
 2 THE WITNESS: I do.
 3 THE FOREPERSON: Please be seated.
 4 THE WITNESS: Thank you.
 5 THE FOREPERSON: You are advised that you
 6 are here today to give testimony in the investigation
 7 pertaining to the offenses of performance of act in
 8 reckless disregard of persons or property, criminal
 9 neglect of patients, insurance fraud, obtaining money
 10 under false pretenses, and racketeering, involving Dipak
 11 Kantilal Desai, Ronald Ernest Lakeman and Keith H.
 12 Mathahs.

13 Do you understand this advisement?
 14 THE WITNESS: Yes.
 15 THE FOREPERSON: Can you please state your
 16 first and last names and spell them for the record.
 17 THE WITNESS: My first name is Nancy,
 18 N-A-N-C-Y, my last name is Sampson, S-A-M-P-S-O-N.
 19 THE FOREPERSON: Thank you.

20
 21 NANCY SAMPSON,
 22 having been first duly sworn by the Foreperson of the
 23 Grand Jury to testify to the truth, the whole truth,
 24 and nothing but the truth, testified as follows:
 25

1 this case; is that correct?
 2 A. That's correct.
 3 Q. Now I know that since you're no longer
 4 working at Metro you don't have a job at Metro so I'm
 5 going to ask you during the time that you were
 6 investigating what was your position?
 7 A. I was an analyst and my focus was as a
 8 financial analyst.
 9 Q. And when you say financial analyst I assume
 10 you look at bank records, things like that?
 11 A. Yes.
 12 Q. Do you look at other things too as part of
 13 the analysis you do in typical cases?
 14 A. I generally look at all the documents, all
 15 the evidence, I go through the interviews the detectives
 16 do, I prepare association charts, I will schedule out
 17 bank records and track money.
 18 Q. Are you present for things like search
 19 warrants and things like that as well?
 20 A. Yes, I've been on a number of search
 21 warrants and I was on this search warrant.
 22 Q. So there was a search warrant done in this
 23 case?
 24 A. Yes, that's correct.
 25 Q. Before we get to that let's do a little bit

EXAMINATION

1
 2
 3 BY MR. STAUDAHNER:

4 Q. Miss Sampson, I'm going to take you back in
 5 time a little bit to an investigation regarding the
 6 Endoscopy Center of Southern Nevada. Were you involved
 7 in that in some way?

8 A. Yes, I was.

9 Q. What time frame were you working in that
 10 capacity as an investigator on this particular case?

11 A. I was working at Las Vegas Metropolitan
 12 Police Department, this case happened in the beginning
 13 of 2008, so when it was made public and I got involved
 14 with it shortly after it was made public.

15 Q. How long did you continue on with the case?

16 A. Until we submitted it to the District
 17 Attorney's Office in November of last year.

18 Q. Now you are no longer working for Metro; is
 19 that correct?

20 A. That's correct.

21 Q. And the reason -- did you retire, quit,
 22 what happened?

23 A. I retired in January.

24 Q. Prior to that time though you were actively
 25 involved in the investigation and analysis done in the

1 more background.

2 So you do that kind of work. What kind of
 3 training or background do you have in that?

4 A. I was a, I have a Bachelor of Science
 5 Degree in Criminal Justice from Arizona State
 6 University. I worked as a commissioned peace officer
 7 for the Arizona State Attorney General's Office. I was
 8 in that position for nine years when I got the position
 9 at Metro. The position I had at Metro, it started as a
 10 financial investigator which is a civilian position and
 11 after awhile it was reclassified to analyst which was an
 12 appointed position with Metro and I was in that position
 13 until I retired in January.

14 Q. Okay. So I assume you've been involved in
 15 other cases beside just this one then over your time?

16 A. Oh yes.

17 Q. Now let's get into this particular case.
 18 How was it that you became involved with it in the first
 19 place?

20 A. I was assigned to the public integrity unit
 21 in the criminal intelligence section at Metro. Brian
 22 Labus and the health district did a briefing to law
 23 enforcement, I was not at that briefing, it was on my
 24 day off, and when I came back to work on Tuesday we were
 25 preparing to do a search warrant and the case was

1 assigned to the public integrity section.

2 Q. So really it sounds like the case started
3 after it was initially brought to Metro with a search
4 warrant then?

5 A. Yes.

6 Q. So let's go to the search warrant
7 situation. Do you know where it took place?

8 A. We had several locations. I was at two of
9 the locations. I was at the search warrant on Shadow
10 Lane, 700 Shadow Lane, and also at the location on
11 Tenaya.

12 Q. So were there others as well?

13 A. Yes.

14 Q. Where were all the search warrants served?

15 A. There was, I think there was six. So there
16 was the Shadow Lane, the one on Burnham, one on Lake
17 Mead, one on Tenaya and one on Rainbow. That's five.

18 Q. Now you mentioned the two. Let's talk
19 about the Shadow Lane one. You said you were present
20 for that one; correct?

21 A. Yes, I was at Shadow Lane.

22 Q. Tell us about that. What did you do as
23 part of the search warrant execution?

24 A. Once they had secured, the officers had
25 secured the location, the business had been shutdown so

1 there was no one there, we had to get into the office
2 and once they secured it then I was assigned by the lead
3 detective Robert Whiteley to inventory the documents
4 that were taken and put an inventory in all of the
5 packaging. So I did that. I also went up to the fourth
6 floor to those offices up there and looked at some
7 records that they had found up there and then I was in
8 the clinic side of the location also.

9 Q. Okay. Before we get too far into what all
10 you found or did at the search warrant locations I'm
11 going to show you what has been previously marked as
12 Grand Jury Exhibit Number 38. It looks like a series of
13 diagrams and so forth. Can you tell us what those are?

14 A. These are diagrams that are made at the
15 time of the search warrant to identify the locations
16 that we were at. So the cover sheet, the first sheet is
17 700 Shadow Lane which is the map of the clinic.

18 Q. And the next page?

19 A. Next one is 700 Shadow Lane, Suite 470,
20 which are their business offices which were upstairs.

21 Q. And you went to those offices you said?

22 A. I did.

23 Q. And then the next page?

24 A. 3150 North Tenaya Way.

25 Q. And I assume -- have you seen all of these

1 documents before?

2 A. Yes.

3 Q. And the next page?

4 A. 4275 Burnham Avenue.

5 Q. Next page?

6 A. 4275 Burnham Avenue.

7 Q. Next page?

8 A. 2610 West Horizon Ridge Parkway.

9 Q. Next page?

10 A. 1815 East Lake Mead.

11 Q. And last page? Actually the second to the
12 last. I'm sorry.

13 A. 5915 South Rainbow.

14 Q. And last page?

15 A. Last one is 700 Shadow Lane and this is the
16 doctors' offices location.

17 Q. So if I understand you correctly the first
18 two pages and the very last page pertain to 700 Shadow
19 Lane?

20 A. Yes.

21 Q. You didn't draw any of these maps; is that
22 correct?

23 A. No.

24 Q. When I say maps they're really diagrams.

25 A. That's correct.

1 Q. The diagrams that are here though to the
2 best of your knowledge, you've been at these facilities;
3 correct?

4 A. I've been at two of them, yes.

5 Q. Which ones again?

6 A. I was at Shadow Lane and the Tenaya.

7 Q. But you've seen these at least submitted as
8 part of the diagrams for the other facilities as well?

9 A. Yes.

10 Q. I'm not going to ask you questions about
11 the other facilities right now. I'm primarily focused
12 with you on the 700 Shadow Lane.

13 A. Okay.

14 Q. And the three maps pertaining to that. You
15 were in those locations?

16 A. That is correct.

17 Q. Do they fairly and accurately, when I say
18 accurately, they're not to scale I assume; is that
19 correct?

20 A. That's correct.

21 Q. They show the location of the rooms and how
22 they're laid out in comparison to each other?

23 A. Yes.

24 Q. I'm going to show you the first page here.
25 And this is the first page of Grand Jury Exhibit

1 Number 38. I want to get the whole thing on and then we
2 can zoom in on it a little bit later.

3 What are we looking at here?

4 A. This is the clinic where the procedures
5 were performed.

6 Q. I'm going to stand over here as we go
7 through it.

8 I note here that on the top portion of this
9 that there's an area where there's a waiting room. Do
10 you know where the front entrance was to the building
11 based on this?

12 A. The front entrance to this location was a
13 hallway that was just on the other side of that first
14 row of offices. So the front door was into the waiting
15 room.

16 Q. So this area right here at the top right
17 hand portion of the screen?

18 A. Yes.

19 Q. So this is not from the outside of the
20 building in, it's from a hallway on the inside of the
21 building?

22 A. Yes.

23 Q. So you enter the suite area or this area,
24 the patient area so to speak from the waiting room and
25 then come into the rest of the facility based on that?

1 A. Yes.

2 Q. As far as your involvement here, I notice
3 that there is a procedure room 1 and a procedure room 2
4 listed; is that correct?

5 A. That's correct.

6 Q. And also a patient area and a pre-op room;
7 is that correct?

8 A. Yes.

9 Q. All those rooms exist, they look like they
10 kind of match the map in the area you were at when you
11 examined them?

12 A. Yes. Some of the -- I didn't go into the
13 pre-op room or the restroom at this end. I was mainly
14 working with the records that were being taken and the
15 other evidence in the other areas.

16 Q. Okay. As far as the patient procedure
17 rooms do those later factor into some of the analysis
18 that you did?

19 A. Yes.

20 Q. And what I mean by that is that there were
21 in fact two procedure rooms and how they were oriented,
22 things like that.

23 A. That's correct.

24 Q. Beside that particular diagram you
25 mentioned that there was another one. I think that was

1 the second page of this exhibit which again is Exhibit
2 38, nine page exhibit. What are we looking at here?

3 A. These are the business offices that were on
4 the fourth floor.

5 Q. So you went up to the fourth floor. Did
6 you gain records or do things up there as well?

7 A. I was asked to look at some records up
8 there. Detectives were searching those offices and
9 securing the evidence. I didn't get into all of the
10 offices. I couldn't even tell you which offices I got
11 into.

12 Q. Where were these records that they asked
13 you to look at?

14 A. They were either in office 5 or office 6.

15 Q. So down here in the lower right, or left
16 hand corner rather of this screen?

17 A. Yes. And I believe I was in office either
18 7 or 8.

19 Q. As well?

20 A. Yes.

21 Q. What were you asked to do? What kind of
22 records did they want you to come up and take a look at?

23 A. They were, I believe they were contracts,
24 they were some business records. I looked at them
25 quickly. I knew we were taking them so I didn't really

1 study anything.

2 Q. Were there any patient files up there?

3 A. There might have been, I didn't see any.

4 Q. You said there was another location you
5 went to as well; is that correct?

6 A. Yes.

7 Q. I think that was on the last page of
8 Exhibit 38. I'm turning to that now.

9 I'll zoom back out a bit.

10 And what are we looking at here?

11 A. This is the doctors' offices at 700 Shadow
12 Lane. This is where the doctors had their offices, the
13 patients were seen, and then there was a connection
14 between the waiting room here and the waiting room on
15 the clinic side, you could walk back and forth.

16 Q. So this is located on the same floor --

17 A. Yes.

18 Q. -- as the very first picture that we saw?

19 A. That's correct.

20 Q. But a separate complete area?

21 A. Yes.

22 Q. Now I see that on this particular diagram
23 that there are exam rooms listed, as well as restrooms,
24 lots of exam rooms; is that correct?

25 A. Yes.

1 Q. And check-out areas. Was this the medical
2 side of things?

3 A. This was the medical side where they had
4 the patient files, the doctors all had offices and they
5 did, and they had the exam rooms, yes.

6 Q. And I notice in the lower right hand corner
7 of that screen there is a room designated as Dipak
8 Desai's office.

9 A. Yes, that's correct.

10 Q. And on the opposite side, the left corner,
11 left lower corner of that diagram is Clifford Carroll's
12 office.

13 A. Yes.

14 Q. And then there is one in between them.

15 A. Yes.

16 Q. Up at the very top of the screen, not the
17 waiting room, there's a large two room with a connector
18 between the two called records room I think; is that
19 correct?

20 A. Yes, that's correct.

21 Q. I'm going to talk about this area for a
22 minute. Did you do anything, find anything in this
23 area, look at any records?

24 A. All of these exam rooms and the doctors'
25 offices were searched. There were patient records found

1 in all of those. So I was in exam room 10. Next to
2 that is a storage room that was full of boxed records
3 that were older, we took all of those. I don't believe
4 there were any records in exam rooms 5, 6, 7, 8 and 9 on
5 the side. We took records from Clifford Carroll's
6 office, from office 3, from Dipak Desai's office, Dr.
7 Carrera's office. There were some patient files around
8 the nurses stations and then the main patient file area
9 was where the records room is and the check-out area.

10 Q. At any time in any of these locations did
11 you come across patient files that were of interest to
12 you?

13 A. In the clinic side they had boxes of -- let
14 me explain how the patient files were set up.

15 Q. Okay.

16 A. In this room they had patient files.

17 Q. In which room? There is a whole bunch of
18 them.

19 A. In this particular area where the doctors'
20 offices were.

21 Q. So the medical side, we're talking about
22 the last page of Exhibit 38.

23 A. Right. Mainly the check-out area and the
24 records room, they had patient files that were on
25 shelves, they were alphabetical for the most part and

1 they were in manila colored file folders and we call
2 those the patient files.

3 Q. Right.

4 A. Okay. Then there were files everywhere.
5 There were files in the doctors' offices, there were
6 files in the nurses station, there were files in the
7 check-out area, there were patient files everywhere in
8 this area.

9 Then on the clinic side they had --

10 Q. When you say clinic you're referring to
11 where the endoscopy procedures are done?

12 A. Yes, where the procedures were done.

13 Q. Okay.

14 A. They had more patient files that were in
15 green manila, green file folders, and we called those
16 the procedure files in order to differentiate when we
17 talked about these, where the files were located, and
18 they contained different information.

19 Q. So there was a difference between the
20 procedure file and the patient file?

21 A. That's correct.

22 Q. Now the patient file contained what, what
23 kind of stuff was in there?

24 A. The patient file had information the
25 patients would give when they signed in, their insurance

1 information, their addresses, their contact information,
2 it would have copies of reports from the procedure
3 files, it would have the doctor's notes. What I would
4 consider a typical patient file.

5 Q. And then the procedure file itself, what
6 was in there?

7 A. The procedure files had the reports from
8 the procedures, they had the anesthesia records, they
9 had the information when the patient checked in at the
10 reception area.

11 Q. Now obviously you find these in two
12 different locations then?

13 A. Yes.

14 Q. So did the procedure files primarily remain
15 on what you called the clinic side where the procedures
16 were done or did they intermix?

17 A. They were intermixed and they were also
18 intermixed at the other location I was at on Tenaya.

19 Q. Okay. Now that's what the files generally
20 look like and where they were; correct?

21 A. Right.

22 Q. When you were going through the search
23 process did you ever locate a grouping of files of
24 patients that were of interest to you?

25 A. There was a post office box, a United

1 States Post Office I believe, and there were the patient
2 files that had been identified by the health department
3 as the victims in this case.

4 Q. Now let's talk about that. Is that
5 location anywhere on these diagrams that you --

6 A. It would be on the clinic side.

7 Q. Let's go back to that one. Referring back
8 to page 1 then of Exhibit 38. What area are you talking
9 about?

10 A. I didn't find them. I believe they were
11 located in a file room reception area.

12 Q. Did you see them at some point?

13 A. I did see them at some point.

14 Q. You didn't find them initially but then did
15 you did see them together?

16 A. Right. There were some other of the victim
17 files, we called them victims, located in Dr. Carroll's
18 office on the other side.

19 Q. Okay. So two different locations where
20 these were grouped?

21 A. Yes.

22 Q. So you find -- and these were all patient
23 files essentially or procedure files that were related
24 to --

25 A. They were both.

1 Q. They were both. To what the CDC or what
2 the health district had been focusing on as far as
3 patients go?

4 A. The patients they had identified from
5 September 21st and July 25th.

6 Q. They were all kind of grouped together in
7 those two locations?

8 A. Yes.

9 Q. Did you recover those items, not you
10 specifically necessarily, but did the police recover
11 those items?

12 A. We recovered all of the patient files from
13 those two areas.

14 Q. And it was up to you to sort of document
15 and categorize all this information?

16 A. I focused on the patient files that were
17 our victims from the 21st, all of the patients from
18 September 21st and all of the patients from July 25th.

19 Q. So not just the ones focused on as
20 potential victims being infected but all of the patients
21 period?

22 A. For those two days, yes.

23 Q. Now beside the things you just mentioned
24 did you do anything else related to the search warrant
25 execution or recovery of records or anything like that?

1 A. After all the evidence was at our office I
2 went through all of the evidence. I went through it
3 looking for business records, bank records, anything
4 related to any of our patients that had been identified
5 as victims.

6 Q. And did you generate any kind of analyzes
7 or reports or anything like that as a result of doing
8 that work?

9 A. I did, I generated several.

10 Q. Okay. Why don't we just kind of walk
11 through them. What were some of the reports or some of
12 the things that you looked at and generated?

13 A. I started with the patient files because we
14 were trying to get a handle on the sequence.

15 Q. When you say the sequence what are you
16 talking about?

17 A. Of what patients were seen first and second
18 and how long the procedures lasted, who was involved in
19 their procedures.

20 Q. And did you put that in some sort of form
21 so you could look at it or compare between patients?

22 A. I did, I put them in an Excel spreadsheet.

23 Q. I'm showing you what has been marked as
24 Grand Jury Exhibit 43, I know that this is going to be
25 difficult for the Grand Jury, it's in the spreadsheet

1 form but we'll make it available and the Grand Jury can
2 look at it at any time.

3 But can you tell us what this item is?

4 A. This is how I compiled the information from
5 the patient procedure files.

6 Q. What date does this information come from?

7 A. This is July 25, 2007.

8 Q. So tell us what we're kind of looking at
9 here. First of all is this all the patients listed for
10 that day?

11 A. This is all of the patients listed for that
12 day. One of the files was missing was Bruce Young so
13 his information is just -- I couldn't find it.

14 Q. So he was a patient listed for the day but
15 you couldn't find the information?

16 A. Right.

17 Q. Okay.

18 A. I got the names of all the patients for the
19 day from their endoscopy logs which were maintained at
20 the, on the clinic side. The endoscopy logs are big
21 books, they're about this big and --

22 Q. And for the record she's measuring it looks
23 like about two feet by, what, one and a half feet,
24 something like that?

25 A. Yeah, one foot. They were too big to copy

1 so I had to work off the originals. They had all of the
2 patients listed, it was handwritten by name for the
3 dates, and they had assigned them patient number and
4 this number was also the number on the procedure files.

5 Q. And you're referring to the right hand
6 column; is that correct?

7 A. Well, the second column in, the patient
8 file number column.

9 Q. We're talking moving from right to left on
10 this spreadsheet; is that correct?

11 A. Moving from left to right.

12 Q. Excuse me. I'm turned around, left to
13 right. Sorry.

14 A. Yes.

15 Q. My perspective, not yours.

16 Go ahead.

17 A. I took the information out of the patient,
18 the procedure files which included an anesthesia record
19 and that's the first record that is summarized here.
20 There was also a chart where they noted the procedure
21 time, when it started.

22 Q. As you go across as you're mentioning
23 things if you'd just give us what the column heading is
24 you're referring to.

25 A. All of the anesthesia records are

1 summarized off of, where it says medicine, chart
2 procedure start time, chart procedure end time, and then
3 I calculated using Excel the minutes for the procedure.

4 Q. And why did you do that?

5 A. Because we saw a pattern and we had been
6 told that they --

7 Q. First of all at this point I don't want to
8 get into anything that you were told by someone else.
9 But based on information you had received in your
10 investigation you focused in certain areas; correct?

11 A. Right.

12 Q. You focused on those areas. Did you see
13 the pattern that you were looking for?

14 A. Yes. Excel is a spreadsheet that will
15 calculate, it adds and subtracts and so I put in a
16 formula to calculate the time when the procedure started
17 and when it ended, and they were all 30 to 33 minutes on
18 the average for all the rooms I averaged. The one room
19 was 30 minutes, the other room was 31 minutes.

20 Q. Now you said there was a difference in
21 rooms. There were different times for different rooms?

22 A. When I, the first time I did this I, we
23 tried to figure out what rooms the different patients
24 were in.

25 Q. Okay.

1 A. And I sorted it by doctor, I sorted it by
2 CRNA, I sorted it by time, and nothing worked because it
3 was, we could not determine what room the patients were
4 in. And then we received information from the Board of
5 Medical Examiners that there was a computer glitch in
6 the reports that were generated, they were generated by
7 a computer. And the glitch actually is this blue
8 column. Those are the report times, the start times and
9 the end times, and that's what this was finally sorted
10 on were those report times. The glitch was in one of
11 the procedure rooms the computer had the wrong date and
12 so we were able to go back through and put all of the
13 rooms, designate all of the rooms that had that glitch
14 as room 1 or room 2.

15 Q. So you could separate them out based on
16 that information?

17 A. Yes.

18 Q. Did you in fact see the computer glitch
19 that you'd been given some information about?

20 A. Yes.

21 Q. So did they pretty much divide up the rooms
22 when you did that?

23 A. Yes.

24 Q. I'm going to look at one thing here before
25 I ask you another question.

1 Now on this particular diagram I note on,
2 where you did your minute calculation, I note that
3 virtually all of them are either 31 or 32 minutes; is
4 that correct?

5 A. That's correct.

6 Q. With the exception of one patient, Carolyn
7 Clark, who is listed at 30 minutes, and a patient named
8 Katie Lawson who is listed at 14 minutes; is that
9 correct?

10 A. Yes.

11 Q. And so the rest of them are either 31
12 minutes or higher?

13 A. Right. That was from the anesthesia logs.

14 Q. And it shows that a total of 65 patients
15 were done that day?

16 A. Yes.

17 Q. Is that right?

18 A. Yes.

19 Q. And does the first top portion of the
20 chart, does that correspond to one room and the bottom
21 portion to another room? Or how did you designate that?

22 A. Uhm, you know what, I have to look at this.

23 Q. Let me put it up here, maybe make it a
24 little easier. Well I don't know if it's easier or not.
25 I'll just let you take care of it.

1 A. It doesn't work with bifocals.
 2 On this particular day, the 25th, the
 3 computer glitch wasn't, it didn't apply to this day, it
 4 applied to the other one. And so these are sorted by
 5 CRNA.

6 Q. Okay. In this particular diagram, this
 7 exhibit, you don't have them sorted by that computer
 8 glitch?

9 A. That's correct, it didn't show up on the
 10 reports. The reports had the right date for both rooms.

11 Q. So at this point we don't know which room
 12 is which?

13 A. Right.

14 Q. Now were you ever able to sort out which
 15 room was which for this date, the 25th?

16 A. No.

17 Q. As far as the breaking up then you only
 18 have two, or how many different CRNAs do you have for
 19 that day?

20 A. We had two CRNAs.

21 Q. Was it your understanding based on the
 22 review of the records that they primarily stayed in one
 23 room for the majority of the day?

24 A. Yes.

25 Q. So when you sort them by the nurse

1 anesthetist does that generally group them according to
 2 what your analysis was and record review as to the room
 3 that they were in?

4 A. Pretty much.

5 Q. Now with the exception of I assume they
 6 take breaks and so forth?

7 A. That's what we were told, yes.

8 Q. Again I want to stay away from things you
 9 were told specifically, just things that you did in your
 10 investigation. And anything you mention that you were
 11 told I'm admonishing the Grand Jury is not offered for
 12 the truth of the matter, just to show how she got to the
 13 next step in her investigation.

14 So let's move forward. So what else did
 15 you do in this particular situation with this exhibit?

16 A. In this particular day we had one victim,
 17 his name was Michael Washington, and the genetic testing
 18 had been done by CDC and they identified the source and
 19 the source was Sharrieff Ziyad.

20 Q. So on this diagram Sharrieff Ziyad is
 21 listed here and I think that that is line or patient
 22 number what?

23 A. Patient number 35.

24 Q. Patient 35.

25 A. Uh-huh.

1 Q. Do we see that the infected patient Michael
 2 Washington follows him in time?

3 A. Yes.

4 Q. And in fact he is the same anesthesiologist
 5 or, not anesthesiologist but nurse anesthetist as the
 6 one that performed both of those procedures; is that
 7 correct?

8 A. That's correct.

9 Q. What about the doctor involved, did that
 10 change?

11 A. The doctor was Dr. Desai on both of them.

12 Q. Now beside that information pertaining to
 13 this diagram, I mean you were able to at least sort this
 14 as best you could by the times, you said that all of
 15 these times varied depending on what you would look at,
 16 whether it was I think it was procedure time, machine
 17 time, all of that stuff. Is that correct?

18 A. Right. I took the times from the procedure
 19 files, from the anesthetist log which is the first
 20 columns here, the chart, the medicine, the chart
 21 procedure start time, procedure end time, and then I
 22 added them up.

23 Q. Is that the green column?

24 A. That's the green column. The green column
 25 is my addition on all of those.

1 The next column is what kind of procedure
 2 it was. If it was an endoscopy those were E, if it was
 3 a colonoscopy those were C. The doctor was from the
 4 report and the signatures. The nurse was also from the
 5 report and the signatures. They had the GI tech so
 6 those were all listed on the reports.

7 Q. So each one of these entities has its own
 8 time?

9 A. Well, these were the people, these were the
 10 players that were on that procedure.

11 Q. I see. Okay.

12 A. Then the different logs started with the
 13 times. So the nurse filled out a log, in that she noted
 14 the procedure start time and end time, and I calculated
 15 the minutes from that. I took what scope they had used
 16 because that was written on there, on the file. They
 17 had a place where they put what time the physician was
 18 at the bedside so I took that time. What time they were
 19 discharged, I took that time. I calculated the time
 20 from that. Then the nurse who signed off on it, on that
 21 discharge. Then we had monitor tapes, one was from a
 22 heart monitor and one was from another monitor, so I
 23 have tape reading 1 and tape reading 2, and I took those
 24 times, and then I have the report time and that's what
 25 this is sorted on, the CRNA and the report time. And

1 then I have what time it ended and then how long it
 2 took.
 3 Q. Okay. So that was how you ended up sorting
 4 this?
 5 A. Right.
 6 Q. Did you ever have a feel for how accurate
 7 the times were that you were looking at, whether they be
 8 the taped time or machine time or the doctor's time or
 9 the nurse's time or the procedure time or whatever?
 10 A. Well, in order to try to make sense of that
 11 and to figure out the order everything happened in I
 12 sorted this spreadsheet on all of the times and they
 13 were different, it just didn't, it didn't match. So
 14 when we got the information about the report time that's
 15 what I went with for the sorts.
 16 Q. I note on this particular diagram that
 17 there, beside Ziyad Sharrieff which is line or row 35,
 18 and Michael Washington which is line, or rather row 39,
 19 you have Ziyad Sharrieff in it appears to be sort of
 20 orange-ish?
 21 A. That's correct.
 22 Q. And Michael Washington who is the infected
 23 patient who is designated in green?
 24 A. Yes.
 25 Q. There are some other lines up here that are

1 also in orange. What relationship do those have?
 2 A. On the anesthetist log they would note if a
 3 patient had a disease and so those are the ones that
 4 were designated on the anesthetist log as having
 5 Hepatitis C.
 6 Q. So on that particular day we have four
 7 patients that are Hepatitis C positive at the facility?
 8 A. That they knew of, yes.
 9 Q. When you say anesthetist form do you mean
 10 the anesthesia record?
 11 A. The anesthesia log is what they called it.
 12 Q. Okay. So one of the persons that had been
 13 designated that day as being Hepatitis C positive was in
 14 fact I think Ziyad Sharrieff?
 15 A. Yes.
 16 Q. And then Michael Washington follows Ziyad
 17 Sharrieff after it looks like three patients?
 18 A. Yes.
 19 Q. Now beside the information here, I mean one
 20 of the columns I want to go back to is this column
 21 designated anesthesia minutes calculated from the
 22 records. And you designate that off of chart procedure
 23 start time, chart procedure end time?
 24 A. That's correct.
 25 Q. Do those times come from the anesthesia

1 record?
 2 A. Yes.
 3 Q. So all of the ones designated as 31, 32
 4 minutes and so forth down that line come from that
 5 document?
 6 A. Yes, they noted the start time and the end
 7 time.
 8 Q. Did you ever add up all that time to see
 9 how much it added up to?
 10 A. How many minutes in the day?
 11 Q. Yes.
 12 A. No, I never did.
 13 Q. Did it look like it was possible?
 14 A. No.
 15 Q. Okay. As far as the 25th did you do any
 16 other analysis other than what you talked about thus far
 17 related to that?
 18 A. On the 25th?
 19 No.
 20 Q. Okay. You said that you moved, you also
 21 looked at the same types of information for the 21st of
 22 September of 2007; is that correct?
 23 A. Correct.
 24 Q. I'm going to go ahead and change out the
 25 exhibit right now.

1 And I will lay this out here, this exhibit,
 2 which is again Exhibit 43, it will be available, it's an
 3 admitted exhibit now and it's available for the Grand
 4 Jury for review and I'll lay it out on the table.
 5 Okay. Showing you what has been marked as
 6 Grand Jury Exhibit Number 42, what are we looking at
 7 here?
 8 A. This is the spreadsheet for September 21st.
 9 All of the information was taken from the patient
 10 procedure files. Same columns as on the 25th. I
 11 started with the anesthesia chart, I moved across taking
 12 all the information. This is the day that had the
 13 computer glitch so we were able to identify the patients
 14 that were in one room and the patients that were in the
 15 second room.
 16 Q. Was there more than two CRNAs on that day?
 17 A. I don't think so.
 18 Q. Or were there rather.
 19 A. No. We had Keith Mathahs and Ronald
 20 Lakeman.
 21 Q. The only two CRNAs on that day?
 22 A. Yes.
 23 Q. So when you sort them in this particular
 24 instance, although you've got your blue line here under
 25 report procedure start time, are these sorted by that or

1 not?

2 A. Yes. They're sorted by the room and the

3 time.

4 Q. So is the top grouping one room and the

5 bottom grouping another room?

6 A. That is correct.

7 Q. On this particular spreadsheet we have

8 colored rows.

9 A. Yes.

10 Q. Can you tell us what the colors indicate?

11 A. The orange are the hepatitis, the people

12 that were identified with hepatitis off the anesthesia

13 logs.

14 Q. So we have two for that day; is that

15 correct?

16 A. Yes.

17 Q. One appears at the end of the day and I

18 believe that is who?

19 A. Trina Smith.

20 Q. And one is at the very top of the day and

21 that is who?

22 A. Kenneth Rubino.

23 Q. So Kenneth Rubino. Did he have any

24 significance to any of the other patients later on?

25 A. He was shown to be the source patient

1 these the ones that are genetically matched?

2 A. Yes, those are genetically matched.

3 Q. Now you have designated these in two

4 separate rooms; correct?

5 A. That's correct.

6 Q. I note that there are, there is a source

7 patient on the top half and then it appears to be

8 infected patients below that person.

9 A. Yes.

10 Q. And those infected patients are whom? Do

11 you want to read off -- I'm talking about the ones in

12 green.

13 A. Rudolfo Meana, Sonia Orellana, Gwendolyn

14 Martin.

15 Q. Let's stop there. Those are the ones in

16 the one room where the source patient was?

17 A. Right.

18 Q. We also have three patients listed in the

19 other room as well?

20 A. Right.

21 Q. And who are they?

22 A. Stacy Hutchison, Patty Aspinwall and Carole

23 Gneskin.

24 Q. Now was there any indication based on your

25 review of things and all of the analysis that you did as

1 through the genetic testing.

2 Q. So the patients that follow after Kenneth

3 Rubino are the infected patients?

4 A. That's correct.

5 Q. That turn up positive that is.

6 A. That's correct.

7 Q. What is the yellow designation?

8 A. There were two patients who showed up with

9 Hepatitis C but there was not enough genetic material to

10 show the source of their infection.

11 Q. When you say enough genetic material, the

12 CDC couldn't make a match or they didn't have the

13 resources to be able to do so on those patients?

14 A. My understanding is the hepatitis virus

15 mutates and it adapts to the host, the person that it's

16 in, so it changes, and there wasn't enough, whether it

17 was too long in time or whatever reason I don't know,

18 but those two people they were not able to genetically

19 link to the source.

20 Q. But we see that one of those persons

21 directly follows Mr. Rubino; correct?

22 A. That's correct.

23 Q. Now what are the green lines?

24 A. Green lines are the infected patients.

25 Q. And when you say infected patients are

1 to any cross movement of any personnel or any supplies

2 or anything from one room to the other during the day?

3 A. Well, we really struggled with this because

4 it was very difficult to try to figure out how it

5 happened. Once we were able to separate the two rooms

6 we looked at the times. So Kenneth Rubino started -- I

7 can't tell what time that is. His procedure started at

8 9:50 in the morning and it was over at 10 o'clock and

9 Stacy Hutchison who was in the other room started at

10 9:52 and she was finished at 10:06.

11 Q. According to the records anyway?

12 A. According to the computer-generated report.

13 Those were the times I went off of to do this. So we

14 have the CRNA for Kenneth Rubino was Keith Mathahs and

15 the CRNA for Stacy Hutchison was Ronald Lakeman. The

16 next patient after Stacy Hutchison in the second room

17 was Renate Blemings and Renate Blemings records show

18 that Keith Mathahs was her CRNA. So what we have is

19 Keith Mathahs starting up here.

20 Q. When you say up here you're designating in

21 one room at the top; correct?

22 A. In the first room and ending up in the

23 second room right after Stacy Hutchison.

24 Q. So right about that time then somewhere

25 according to the records he at least moves over to that

1 room?

2 A. Right.

3 Q. And I wouldn't want you to speculate as to

4 how, what he brought with him or didn't bring with him

5 or whatever, but at least we have the CRNA, if I

6 understand you correctly, we have the CRNA where the

7 source patient originates and infected patients after

8 that in that same room?

9 A. Yes.

10 Q. And then we have around the time that the

11 infection start in the second room we have evidence that

12 shows that Mr. Mathahs is the CRNA that moves to that

13 room at least for a period of time?

14 A. That's correct.

15 Q. Now was there any indication that he in

16 fact had been involved in any way with Stacy Hutchison's

17 procedure?

18 A. Not according to the records. And the

19 records that I used were the ones that were generated

20 and signed off on in the procedure files.

21 Q. But you said not according to the records.

22 Did you have any other source of information that led

23 you to a different conclusion?

24 A. One of the depositions I read in the civil

25 litigation that's going on.

1 Q. Is that correct?

2 A. Yes.

3 Q. So we at least have movement and infections

4 follow from thereon after?

5 A. Yes.

6 Q. And if I need to leave this up here I can.

7 But I'm talking about the exhibit again, Exhibit 42 if

8 you still need to refer to that.

9 But the patients that follow in that room,

10 the second room, those patients, the anesthesiologist or

11 the anesthesia person, the nurse anesthetist at least of

12 record for those three procedures was who?

13 A. Ronald Lakenan.

14 Q. So Mr. Mathahs at least according to the

15 records had returned back to his room at some point?

16 A. Yes, but he shows up again.

17 Q. Go ahead.

18 A. We were told that they covered each other

19 for lunch.

20 Q. Okay. And again that's not offered for the

21 truth of the matter.

22 Based on that information did you see

23 anything that reflected that kind of thing in the

24 records that you reviewed?

25 A. Well, Keith Mathahs is in this room, in

1 Q. And I don't want to get into specifics

2 about what other people said, but were you able to

3 follow-up on any information based on any deposition

4 that you read?

5 A. Well, the information that I got made this

6 a little clearer for me.

7 Q. Okay.

8 A. The person that was deposed said that when

9 they started the computer-generated report they had a

10 drop down list and they would click off who was in the

11 room and I noticed on some of these reports that the

12 person that was listed on the report was not the person

13 who signed off.

14 Q. And ladies and gentlemen of the Grand Jury,

15 that information is not offered for the truth of the

16 matter and I would ask you not to consider that hearsay

17 statement in your deliberation, just for why this

18 individual, this particular witness was analyzing the

19 things as she did in this particular case.

20 That being said, did you, you obviously had

21 indication that at least right at the time that Stacy

22 Hutchison's procedure is either finished or sometime

23 within the procedure that Mr. Mathahs moves from the

24 room he was in to the second procedure room?

25 A. Yes.

1 room 1 until noon, about noon, 11:57, when Ronald

2 Lakeman took this procedure and then Keith Mathahs is

3 back. And then in the other room Keith Mathahs shows up

4 for this procedure after Stacy Hutchin -- Renate

5 Blenkins at 10:13, then he comes back again at 11:34.

6 Q. Did that look like it was around a lunch

7 break then?

8 A. That's what it looked like to me.

9 Q. So the prior time when he's actually moved

10 over to that room you don't know why he came over?

11 A. No.

12 Q. And he's only over there for one recorded

13 procedure; is that right?

14 A. Yes.

15 Q. And that procedure immediately follows

16 Stacy Hutchison's procedure?

17 A. Yes.

18 Q. So you don't know if he came in there

19 before Stacy Hutchison or during the procedure at all?

20 A. No.

21 Q. Any other information related to this

22 exhibit?

23 A. On my comments, the last column, I call it

24 comment, and that's what I use for myself to make notes

25 or to notice something that is interesting. So we have

1 where I would say that in this case Linda McGreevy was
2 listed on the report as the nurse but Karen Richvalsky
3 off on it. So --

4 Q. And could you spell Richvalsky?

5 A. R-I-C-H-V-A-L-S-K-Y, Karen.

6 So that was another discrepancy that I
7 tried to note on the spreadsheets where the names didn't
8 quite match up with the signatures.

9 Q. So if I understand you correctly, and just
10 so I can reiterate, that sometimes signatures and who
11 was supposed to be in the room didn't match up; is that
12 what you're saying?

13 A. Yes.

14 Q. And you saw that also around the time that
15 Mr. Mathahs moves to the room with Stacy Hutchison or
16 not?

17 A. I don't remember. I know he was on Renate
18 Blenings' report. Or on her procedure file. I don't
19 remember if he was on the report or not.

20 Q. Okay. Now let's move on. So you do all
21 that analysis work, you lay it all out, that's part of
22 those exhibits that you've got, what is the next thing
23 you do as far as analysis goes in the case?

24 A. We tried to see from the procedure files if
25 there was another way this infection could have been

1 transmitted and it could have possibly been in the, when
2 they had the heplock administered to them.

3 Q. So somebody had raised that issue to you
4 and I assume that meant you went back and tried to find
5 any evidence to support it; correct?

6 A. That's correct.

7 Q. What did you do to try to either look at
8 that problem and support it or discount it?

9 A. Well, I went back to the patient, the
10 procedure files, and I noted who had signed off as the
11 heplock nurse, the person who had inserted the heplock.

12 Q. And are you all hearing this by the way? I
13 mean can you hear what she's saying?

14 Try to speak up a little bit into the
15 microphone.

16 A. Okay. The procedure file shows Lynette
17 Campbell was the heplock nurse for Kenneth Rubino.

18 Q. What day are we talking about first of all?

19 A. We're talking about September 21st, this
20 day. So Lynette Campbell was --

21 Q. And before we go any further, I can see
22 you're referring to a document.

23 A. Yes.

24 Q. Is that correct?

25 This is Grand Jury Exhibit Number 39. What

1 is this document first of all?

2 A. This is an association chart that I
3 prepared using software we have at Metro called Analyst
4 Notebook.

5 Q. Did you take this information in preparing
6 this particular exhibit based on the information you had
7 gotten in your investigation?

8 A. Yes.

9 Q. I'm going to go ahead and display that up
10 here --

11 A. Oh, good.

12 Q. -- for the Grand Jury. And then you can
13 tell us about it as we go through it and if you need me
14 to zoom in on a particular section let me know.

15 A. Okay.

16 Q. Right now I'm zooming out so we have the
17 entirety of the document showing. And if you can tell
18 us kind of what we're looking at.

19 A. Okay. This room is room 1 and this room is
20 room 2.

21 Q. And just for the record she's referring to
22 the designations of those things on the document.

23 A. Right. So based on the sort from the
24 reports we have these people who were these victims and
25 the source Kenneth Rubino who were in procedure room 1.

1 Q. And for the record she referred to all of
2 the persons along the top portion of the screen going
3 from left to right.

4 A. And then we have the people who were in the
5 other procedure room, Stacy Hutchison, Patty Aspinwall
6 and Carole Grueskin.

7 Q. And they are designated on the bottom of
8 the screen for the record.

9 A. In the center I have Lynette Campbell who
10 was the heplock nurse, she's the person who initialed
11 off that she had given, inserted the heplock into them
12 before the procedure and she did the heplock for Kenneth
13 Rubino, Rudolfo Meana, Sonia Orellana, Gwendolyn Martin
14 and Nguyen -- I don't know how to pronounce his name,
15 it's Vietnamese, he was one of our yellow that we didn't
16 have the genetic matches for.

17 Q. And when you say yellow are you referring
18 to the yellow marking --

19 A. Yes.

20 Q. -- on the spreadsheet on Exhibit --
21 whatever it is.

22 A. Then we had Jeff Krueger who was,
23 administered the heplock for Stacy Hutchison, Lakota
24 Quannah, and he signed off on those.

25 In the interviews that detectives conducted

1 Patty Aspinwall identified Jeff Krueger, she described
 2 him as the person who had given her the heplock.
 3 Q. But you also have a line in that diagram
 4 going to Miss Campbell as well; is that right?
 5 A. Right.
 6 Q. Why is that?
 7 A. Well, she signed off on it on the records.
 8 Patty Aspinwall described Jeff Krueger.
 9 Q. So tell us what -- I mean I see what you've
 10 just described, but how does this, what does this mean?
 11 A. This was to try to show that the same
 12 person had given all of the heplocks and that didn't
 13 happen because we have Jeff Krueger who signed off on
 14 two of them and was identified on a third. It also
 15 brought into my mind whether the records were correct or
 16 not.
 17 Q. Okay. So at least on this date we have for
 18 sure Stacy Hutchison who was not administered a heplock
 19 by Miss Campbell; correct?
 20 A. That's correct.
 21 Q. And actually the CRNA Jeff Krueger, not
 22 CRNA, the nurse rather, Jeff Krueger, was the one who
 23 administered that heplock?
 24 A. That's correct.
 25 Q. And then Miss Campbell seems to be tied at

1 least to the remainder and possibly Miss Aspinwall?
 2 A. That's correct.
 3 Q. You can sit down again if you would.
 4 Now let's talk about this related to the
 5 25th. Did you look at that issue possibly for the 25th
 6 of July of 2007 as well?
 7 A. Yes, we did.
 8 Q. Did you find that there had been a
 9 commonality between either Mr. Krueger or Miss Campbell
 10 related to that particular procedure date?
 11 A. No. On that procedure date the records
 12 show that the CRNA administered the heplock to the
 13 source patient Sharrieff Ziyad and somebody else
 14 administered Michael Washington.
 15 Q. So two different people administered the
 16 heplock?
 17 A. Right.
 18 Q. But the key thing here I want to make sure
 19 I'm clear on is that the source patient for the 25th was
 20 actually, had his heplock put in by the CRNA who did his
 21 procedure?
 22 A. That is correct.
 23 Q. Go ahead. Anything else about that?
 24 A. No.
 25 Q. So based on that did you have any

1 indication that there was overlap, there was some person
 2 who was common between, or persons who were common
 3 between all of these people?
 4 A. Well, there wasn't one person who was
 5 common between all of them, no.
 6 Q. And in fact on the 25th there was, it
 7 sounds like Mr., not Mr. Washington -- who is the source
 8 patient?
 9 A. Ziyad.
 10 Q. Ziyad Sharrieff was the individual who
 11 didn't even go to the procedure room, he just went, or
 12 not the procedure room, to the pre-op room, he went
 13 straight to the procedure room?
 14 A. That is correct.
 15 Q. Now what was the next thing you did in your
 16 analysis or the next portion you went to?
 17 A. I did a financial analysis to track the
 18 money that Doctors Desai, Carrol and Carrera received in
 19 2007.
 20 Q. Now when you say financial analysis what do
 21 you mean?
 22 A. I took, I went through the evidence that we
 23 had taken in the search warrant and I identified the
 24 bank accounts that they had and in the bank accounts
 25 summaries they also had listed all of the checks and who

1 they were paid to, so I took the accounts that had
 2 payments to the doctors and I got a Grand Jury subpoena
 3 for those bank records from the bank and I scheduled
 4 those out to try to determine how much the doctors had
 5 received in income for 2007.
 6 Q. What was the purpose of that? Were you
 7 trying to find out who was the main player or the minor
 8 players or what?
 9 A. Well that, to verify who the main player
 10 was. Also to see if there was a financial incentive for
 11 this infection.
 12 Q. Okay. And you're looking at a document
 13 here, it's marked as Grand Jury Exhibit Number 40, and
 14 what is this document?
 15 A. This is the summary page of my analysis
 16 with all of the bank records. So I show that for 2007
 17 Dr. Dipak Desai received \$6,809,003.74.
 18 Q. What about the other two doctors that you
 19 mentioned?
 20 A. Dr. Clifford Carrol received \$1,967,446.17.
 21 Q. And what about Dr. Carrera?
 22 A. Dr. Carrera received \$1,403,010.64.
 23 Q. So if I have it correct it looks like Dipak
 24 Desai made the lion's share of the money?
 25 A. That's correct.

1 Q. Now the next page, page 3 of the exhibit,
2 the bottom, there is also some numbers listed there is
3 are there not?

4 A. Yes.

5 Q. What are those?

6 A. These were amounts that came from one of
7 the bank accounts. When we took the records in the
8 search warrant one of the file folders said CRNA and it
9 was a bank account with Wells Fargo.

10 Q. So it was listed, its title was CRNA?

11 A. The handwritten title on the folder was
12 CRNA. The bank account's name was not CRNA.

13 Q. What was the bank account's name?

14 A. I don't remember.

15 Q. But it was different?

16 A. Yes.

17 Q. Do you know who had control of that
18 account?

19 A. Dr. Desai.

20 Q. Can you tell us what you found in that
21 account? Are we talking about just one year or more
22 years than that?

23 A. We're just talking about 2007. I looked at
24 this file folder at the first because I thought it would
25 show bonuses or payments made to the nurse anesthetist,

1 the CRNAs, and in fact there were no payments to the
2 nurse anesthetists, there were only payments to doctors.
3 So I pulled out these three doctors because they were
4 involved in our infections and it shows that Dr. Desai
5 received \$250,000 from that account, Dr. Carrol received
6 125,000 from that account, and Dr. Carrera received
7 25,000 from that account.

8 Q. But based on what you said earlier it would
9 have been Dr. Desai that would have made the
10 disbursements; is that correct?

11 A. That's correct.

12 Q. So he was the one who controlled the
13 account?

14 A. That's correct.

15 Q. Now beside that analysis what else did you
16 do?

17 A. We had allegations that they had reused
18 supplies, propofol, so I took all of their medical
19 supplies on those categories and I looked at the vendors
20 who had provided the propofol, the bite blocks and the
21 syringes and I did an analysis to see if they had
22 ordered enough supplies to provide a vial per person
23 without reusing it, adequate number of syringes and
24 adequate number of bite blocks.

25 Q. And just, you have a document in front of

1 you, it's quite large, but it is Grand Jury Exhibit
2 Number 41. So if you need to refer to that at any time
3 just let us know you're doing it. It's here available
4 to you and it is available to the Grand Jury as well.

5 So is that a summary report of that
6 particular analysis?

7 A. Yes.

8 Q. And tell us what it is you found related to
9 each one of those categories you mentioned.

10 A. Okay. I started with trying to determine
11 how many patients had been seen in 2006 and 2007 and the
12 reason I included 2006 was to see if they had an
13 existing inventory of supplies. So I counted the number
14 of patients in the endoscopy log book and we had the
15 registers for both the Burnham clinic and the Shadow
16 Lane clinic.

17 Q. Before you go on I just want to make sure,
18 you say you're using the endoscopy log books which is
19 the record from the business itself; correct?

20 A. The big book, yes.

21 Q. And that was information contained in the
22 search warrant?

23 A. That's right. And then we also served a
24 Grand Jury subpoena on the custodian for the Endoscopy
25 Center to get the ones we hadn't gotten in the search

1 warrant from the Burnham clinic, so we had all of the
2 endoscopy registers.

3 Q. And then beside that what other records did
4 you look at in tabulating and coming up with the
5 information that you're about to testify to?

6 A. I used the vendor files from the search
7 warrant, identified all of the vendors that provided the
8 propofol, the syringes and the bite blocks, and we
9 subpoenaed those records from the vendors to make sure
10 that I had all of the information. And then I was
11 worried that I had, I might miss a vendor so we
12 subpoenaed that information also from the custodian of
13 records for the Endoscopy Center so that I would make
14 sure I had all of the vendors.

15 Q. After you did all that did you have a
16 compilation of all the records you were aware of that
17 were related to what you're discussing?

18 A. Yes, I did.

19 Q. Okay. Go ahead.

20 A. Okay. In 2006 there was no existing
21 inventory for the bite blocks or the propofol or the
22 syringes. So in 2007 they had 7,521 endoscopy
23 procedures where they would have used bite blocks and
24 they --

25 Q. And let me make sure I'm clear on that.

1 You know there is a difference between a colonoscopy and
2 an upper endoscopy; correct?

3 A. Correct.

4 Q. In a colonoscopy they don't use a bite
5 block.

6 A. That's correct.

7 Q. On an upper endoscopy they do.

8 A. Yes.

9 Q. I assume you know that's to supposedly
10 protect a patient's teeth or protect the scope or both
11 or something along those lines?

12 A. That's correct.

13 Q. When you did your analysis, when you say
14 procedures that would have required a bite block, are
15 you talking about strictly upper endoscopy procedures?

16 A. Yes.

17 Q. Okay. Go ahead.

18 A. And I identified those by counting them in
19 the endoscopy logs. So there were 7,521 upper endoscopy
20 procedures and they ordered 3,250 bite blocks. So based
21 on those numbers I did a ratio of the procedures to the
22 bite blocks and it was two to one, two procedures for
23 every bite block.

24 Q. Go on.

25 A. I did the same for propofol logs. They

1 used propofol as the anesthetic for the procedures and
2 the CRNAs or nurses signed out the propofol logs every
3 day. The propofol vials, excuse me, every day.

4 Q. And before you get to that I want to ask
5 you if during your analysis and research you ever looked
6 into how propofol is distributed, the size, the amount
7 of container, or the size in the various containers that
8 were available at least for purchase.

9 A. We did. I did some research on the
10 internet, I looked up AstraZeneca and I got their
11 information for propofol, they were the manufacturers.

12 Q. Do you know what it comes in size wise?

13 A. They come in 10-milliliter vials,
14 20-milliliter vials and 50-milliliter vials.

15 Q. Are you aware of any larger quantity, up to
16 100CC?

17 A. I'm not.

18 Q. At the Endoscopy Center specifically did
19 you look at what they had or what they were using at any
20 of the centers but specifically the Shadow Lane center?

21 A. Yes, they ordered 20-milliliter and
22 50 milliliter vials.

23 Q. Generally through all the facilities or
24 just the one?

25 A. For both the facilities.

1 Q. And there were just two facilities that did
2 endoscopy procedures primarily?

3 A. There was a third one, it was the one on
4 Rainbow, it opened in late 2007 after our infections.

5 Q. And then it closed?

6 A. Yes.

7 Q. Go ahead.

8 A. The propofol logs were the sign out logs
9 for the vials of propofol that the CRNAs used every day
10 and they wrote how many they checked out and how many
11 they returned so I was able to calculate how many vials
12 they had used for the day.

13 Q. Okay.

14 A. The logs that I used were the 50-milliliter
15 logs and after I prepared this report I went back and I
16 found the 20 milliliter vials that they had also checked
17 out.

18 Q. So this report just deals with the 50 but
19 you've also looked into the 20 as well?

20 A. Yes, and I have an addendum report that
21 isn't here.

22 Q. Okay. But you do know the information from
23 the addendum report?

24 A. Yes, I do.

25 Q. Okay.

1 A. So the ratio of patients to propofol vials
2 for July 25th was three to one. So they had one vial of
3 propofol they used for every three patients. And the
4 ratio of patients to vials for September 21st was also
5 three to one.

6 Q. Now what about the 20-milliliter
7 containers?

8 A. Twenty milliliter containers on the 21st,
9 they checked out two which did not impact the ratio
10 significantly, and they didn't check out any on the
11 25th.

12 Q. Okay. So let's talk about the total number
13 of patients and the total number of vials on those two
14 days.

15 A. Okay.

16 Q. And just for the record she's referring to
17 page 9 designated as DA-endoscopy bates number 5211.

18 A. So on July 25th they had 65 patients. Two
19 of those patients had two procedures so they had 67
20 procedures. But when I did my analysis I just used the
21 number of patients because there should, the vials were
22 for single use, one patient only. Ronald Lakeman signed
23 out five vials and did not return any. Then he signed
24 out 20 vials and returned five. So the total number of
25 vials they used that day was 20. So the ratio of

1 patients to vials for July 25th was 3.25 patients to one
2 vial.

3 Q. So if I understand you correctly 20 vials
4 total that were used or just checked out?

5 A. They were checked out and I'm assuming that
6 they were used.

7 Q. So 20 checked out that didn't get returned?

8 A. Right.

9 Q. And they had 65 patients that day?

10 A. That's correct.

11 Q. Let's move to the 21st.

12 A. Okay. On the 21st they had 63 patients and
13 they had 64 procedures, one patient had both procedures.
14 So I counted 63 patients. CRNA Keith Mathahs signed out
15 18 vials and returned none. CRNA Mathahs signed out 20
16 vials and returned 14. So the total number of vials
17 signed out was 24. So the ratio of patients to vials
18 for this day was 2.62 to one. And then if you include
19 the other two vials that are in the addendum report it
20 doesn't change it significantly, it's still around
21 three.

22 Q. So it was actually a total of 26 vials that
23 were checked out then?

24 A. Yes.

25 Q. Including those two 20 ml ones?

1 patients and all the vials ordered by both clinics?

2 A. That's correct.

3 Q. Okay. Go on.

4 A. I also looked at the syringes to see,
5 because we had allegations that they reused syringes, so
6 I took both clinics once again for this because they
7 shared medical supplies. So on the two days in 2007
8 when they spread the infection I counted the number of
9 injections off of the anesthesia logs that they used and
10 there were --

11 Q. When you say injections you would mean
12 drawing up a syringe from a bottle, injecting that,
13 discarding that syringe and then drawing up from
14 possibly the same bottle with a new syringe for another
15 injection; is that right?

16 A. Well, I counted the number of injections
17 that they had listed on the, the CRNAs had listed on
18 their anesthesia logs.

19 Q. Okay. That's fine.

20 A. So I did that in order to get a ratio for
21 the number of injections that they should have had.

22 Just a minute. Let me make sure this is
23 the right page.

24 Okay.

25 Q. And just for the record we're referring to

1 A. Right.

2 Q. And there was a total of 63 patients?

3 A. Yes.

4 Q. Those are the ones you looked at for those
5 two days; correct?

6 A. That's correct.

7 Q. Did you do any analysis for any other
8 propofol use on any other days or in general?

9 A. I looked at the propofol in general to see
10 if they had ordered enough propofol vials for the number
11 of patients that they saw. In 2007 there were 23,576
12 patients seen at both clinics. We had information that
13 they shared medical supplies between the two clinics so
14 I included both sets of numbers in this analysis. They
15 ordered 11,844 vials of propofol and that would be both
16 the 50-milliliter and the 20-milliliter, and so that's
17 the ratio of patients to vials is two to one. They had
18 two patients for every vial of propofol that they
19 ordered.

20 Q. Okay. And that's giving at least the
21 benefit of two clinics seeing patients?

22 A. Right.

23 Q. Is that correct?

24 A. That's correct.

25 Q. Okay. And then just combining all the

1 page 13 of the document designated as DA-endoscopy bates
2 number 5215.

3 A. I took the number of injections, I counted
4 the number of injections that all of the patients
5 received on both of those two days. On July 25th there
6 were 123 injections and there were 65 patients. So I
7 took that and averaged it to 1.9 injections for that
8 day. On September 21st there were 63 patients and 185
9 injections so on that day the average was 2.93. And I
10 took an average of both of those averages and I got
11 1.92, or 2. -- I'm sorry, 2.425. So every patient
12 should have received 2.4 injections for their
13 procedures.

14 Then I took how many patients Burnham
15 had --

16 Q. Referring to page 14, DA-endoscopy 5216.

17 A. -- and for 2007 they had 8,619 patients,
18 they ordered 18,900 syringes, so the ratio of patients
19 to syringes was one patient to 2.19. My developed ratio
20 was one patient to 2.4. So the Burnham clinic was
21 close, close to the ratio that I had developed as to how
22 many injections were actually given.

23 The Shadow clinic, they had 14,957 patients
24 and they ordered 17,100 syringes, so their actual ratio
25 was one patient to 1.14 syringe. So they weren't even

1 close to the developed ratio I had.

2 Q. When you talked about syringes were you
3 talking about all types of syringes ordered by the
4 clinic?

5 A. I'm talking about the 100C syringes that --

6 Q. Were typically used?

7 A. -- were typically used for the injection,
8 injecting propofol.

9 Q. Okay. Anything else regarding that
10 analysis?

11 A. I don't think so. I looked at 2008 to see
12 if the ordering changed after they were notified by the
13 health district and in 2008 they ordered more bite
14 blocks. In 2008 they ordered 1400 bite blocks for five
15 weeks. Or for six weeks.

16 Q. And how many patients during that time if
17 you know?

18 A. I didn't count them.

19 Q. Okay.

20 A. And in 2007 they ordered, for the entire
21 year they ordered 3,250. So they ordered significantly
22 more bite blocks in 2008 than they did in 2007.

23 The propofol logs show that 38 vials, in
24 2008 38 vials were checked out for 34 patients, which
25 meant the ratio of patient to propofol vials was one

1 patient to every 1.1 vial. So they started ordering
2 more than they had in 2007. And that also followed
3 through for the number of vials that they ordered. They
4 ordered 3,125 vials of propofol and they had ordered
5 11,844 for the entire year of 2007. So the average
6 number of vials ordered per week in 2007 was 228, the
7 number of vials ordered for the six weeks in 2008 was
8 approximately 521 per week.

9 Q. So at least double?

10 A. Double, yes. And the same thing happened
11 for the syringes. The orders in 2008 changed, for the
12 period in five or six weeks in 2008 they ordered 5200
13 syringes and they ordered 36,000 for the entire year in
14 2007.

15 Q. So their average per week, did you do that
16 too?

17 A. I did. Number of syringes ordered per week
18 in 2007 was approximately 692, number of syringes
19 ordered per week for five weeks in 2008 was
20 approximately 1,040.

21 Q. Now beside the analysis of those three
22 items that you've described was there anything else of
23 significance contained in this report?

24 A. I don't believe there was.

25 Q. Now beside that analysis and the financial

1 one and the spreadsheets, things like that that you did,
2 what else, if anything, did you do in this case?

3 A. I went through all of the evidence, I went
4 through all of the interviews and indexed them by
5 topics.

6 Q. Did you do any further analysis work of any
7 type?

8 A. No, these were the two that I focused on.

9 Q. Okay. And when you say two, you're talking
10 about the financial analysis and the medical supplies
11 analysis?

12 A. That's correct.

13 Q. You also did the actual patient records
14 analysis too?

15 A. Yes, I did.

16 MR. STAUDAHNER: I have nothing further for
17 this witness.

18 THE FOREPERSON: Are there any questions
19 from the Grand Jury?

20 We'll start over here with Bob.

21 BY A JUROR:

22 Q. In 2008 when they realized they were under
23 investigation and they ordered more vials of propofol,
24 what size did they order, the 20 or the 50?

25 A. They ordered the 20. They sent back all of

1 the 50 that they had.

2 THE FOREPERSON: Okay. On this side, Lisa.
3 BY A JUROR:

4 Q. And when you developed your ratios of
5 patients to supplies, you know, the bite blocks, the
6 propofol and the syringes, did you take into account
7 beginning inventory of 2007 of these supplies and ending
8 inventory in 2007?

9 A. There was no beginning inventory because I
10 looked at 2006 and they didn't order enough of any of
11 the supplies to have any inventory left over.

12 Q. Did you take into account beginning
13 inventory in 2006 to see if they ordered enough? I mean
14 because they could have had a significant amount
15 beginning of 2006 to where they didn't need to order as
16 much in 2007.

17 A. They could have. And there was one period
18 where they ordered in 2006 a significant number of
19 propofol vials, but they didn't, they wouldn't have
20 lasted until 2007.

21 Q. Were there -- this was a partner, do you
22 know what type of entity this was? Was it a partnership
23 or a corporation?

24 A. There were several agreements that changed
25 over the years so some of the partners and --

1 partnership is kind of loose.
 2 Q. Okay. I guess --
 3 A. Some of the partners were early on and they
 4 continued through, like I think Dr. Carrol had started
 5 early on, but as partners dropped off those agreements
 6 changed.
 7 Q. What I'm trying to get at was there a
 8 balance sheet where you could go in and see where they
 9 had taken an inventory, did you look at a balance sheet?
 10 A. An inventory of what?
 11 Q. Well, a balance sheet for the, for whatever
 12 this entity was, did they take a physical inventory at
 13 the end of the year that you looked at?
 14 A. I didn't see one.
 15 Q. They didn't have a balance sheet that they
 16 published for the partners or --
 17 A. No. One of the doctors that we
 18 interviewed, I was present for, he described it that
 19 they were employees, the other doctors were employees
 20 and Desai, Dr. Desai determined how much they would be
 21 paid and how much they would get from the CRNA account.
 22 Q. Okay. So bottom line --
 23 MR. STAUDAHNER: And again, ladies and
 24 gentlemen, I'm going to admonish you about that
 25 statement. I want you to disregard that particular

1 was one patient for every 2.4 syringes and the number of
 2 syringes that they used at Shadow wasn't even close to
 3 what it should have been.
 4 Does that answer your question?
 5 Q. I'm not a math person. It just sounds like
 6 numbers to me. I was hoping it would be more like if
 7 you could give me an answer of they issued so many
 8 syringes per person or they didn't.
 9 A. They, at Burnham they used 2.19 syringes
 10 per patient.
 11 Q. Is that good or bad?
 12 A. Well --
 13 MR. STAUDAHNER: And she can't make a
 14 qualification on that. She's just here to give you the
 15 information based on the analysis she did so I would ask
 16 her not to answer that particular question. Just
 17 telling you how many of whatever was used on the
 18 patients that were at the clinic when she did the
 19 analysis.
 20 BY A JUROR:
 21 Q. Okay. What's average amount of injections
 22 does one patient normally get?
 23 A. Well, that varied because the propofol was
 24 given according to their size and the duration of the
 25 procedure.

1 statement for your deliberation. It's a hearsay
 2 statement.
 3 BY A JUROR:
 4 Q. So there was no inventory that we could
 5 look at to say beginning or ending for the calendar
 6 years?
 7 A. I didn't find one in going through the
 8 records.
 9 Q. Thank you.
 10 A. You're welcome.
 11 THE FOREPERSON: Shelley.
 12 BY A JUROR:
 13 Q. You said in 2007 that, referring to the
 14 syringes, that, you gave the two numbers of 1.4 and then
 15 1. I think it was 9, and you said that the numbers
 16 didn't match, but by what percentage ratio though?
 17 A. I developed a ratio based on these, the two
 18 days that I had scheduled out, I counted all the
 19 injections, and that ratio was one patient and 2.4
 20 syringes. Then I took the number of syringes and the
 21 number of patients at the Burnham clinic and that ratio
 22 was one patient for 2.19 syringes. And then I applied
 23 the same developed ratio that I had to the number of
 24 patients and syringes at Shadow and that ratio was one
 25 patient for every 1.14 syringe. So my developed ratio

1 Q. Okay.
 2 THE FOREPERSON: Are there any further
 3 questions?
 4 Yes, Lisa.
 5 BY A JUROR:
 6 Q. Perhaps you can answer this, perhaps you
 7 can't. But we know that they would have needed at least
 8 two syringes for their heplock, one for the saline and
 9 one for the propofol; correct?
 10 A. That's correct.
 11 Q. Okay. So they, so --
 12 BY MR. STAUDAHNER:
 13 Q. With the distinction -- I think I need to
 14 add and clarify -- when I asked the witness about the
 15 size of the syringe I believe that the size for the
 16 syringe that was used for injection of the drug propofol
 17 may have been different than for the injection of the
 18 flushes. Is that correct?
 19 A. That's correct.
 20 Q. So they would have been two different types
 21 of syringes. You only looked at the 100C syringes which
 22 were typically used for the injection of the propofol
 23 drug alone?
 24 A. That's correct.
 25 Q. So there were other syringes used in the

1 practice, 500C syringes and smaller syringes and things
2 like that?

3 A. That's right.

4 Q. You didn't look at any of those?

5 A. No.

6 MR. STAUDAHNER: Okay.

7 THE FOREPERSON: Are there any further
8 questions? Yes.

9 BY A JUROR:

10 Q. All the analysis you done were only, was
11 only on 25 July and on September 21st, right? There was
12 no, you didn't randomly pick another date and run an
13 analysis as a baseline to correlate these two?

14 A. Not of a complete day, but I did do some
15 additional work on information that we got from the
16 health district. They provided us a list of the
17 patients that had responded to a questionnaire that said
18 that they were infected. I put those on a spreadsheet,
19 I was looking for another cluster date and I found I
20 think three dates where there were two patients infected
21 on two of those dates and three patients infected on a
22 third.

23 MR. STAUDAHNER: And again I'm going to
24 admonish the Grand Jury at this time there is not
25 evidence that they were infected at the clinic on those

1 days but just patients that reported infection had
2 procedures on those dates.

3 Is that correct?

4 THE WITNESS: That's correct.

5 THE FOREPERSON: Yes.

6 BY A JUROR:

7 Q. How did you know that they only used the 10
8 ml for the propofol or that they only used 10 ml for the
9 propofol injections?

10 A. In the interviews that detectives conducted
11 with the CRNAs.

12 Q. Okay.

13 BY MR. STAUDAHNER:

14 Q. And one last question I have related to the
15 one that the Grand Juror asked. Typically if you had a
16 large inventory, let's say you had box, case after case
17 of propofol on January 1st of 2006, would you expect
18 to normally see ordering of propofol on a regular basis
19 with a large inventory in place?

20 A. Yes.

21 Q. Yes?

22 A. Well, no, not with a large inventory in
23 place. And I did look at those ordering records and I
24 noticed that one large order in 2006, but they had
25 continued ordering propofol all along.

1 Q. So there wasn't like January of that year
2 that they didn't have to order any propofol because they
3 had so much left over from the year before?

4 A. No.

5 Q. So they kept ordering in January and
6 February and March and April, all the months?

7 A. Yes.

8 Q. And then one month along there mid year
9 they ordered actually larger amount than they had even
10 on different months before and after that?

11 A. That's correct.

12 Q. Okay. But by the time they got to the end
13 of the year the amount they had ordered throughout the
14 whole year I think you said was not enough to do what
15 they needed to do?

16 A. Right.

17 Q. If they had used one per patient?

18 A. That's right.

19 THE FOREPERSON: Any further questions?
20 None?

21 THE WITNESS: I'd like to add one thing.
22 The standard I used on this was one patient, one vial, a
23 syringe per injection, one syringe per injection. So I
24 used that standard care, medical practice, to apply to
25 this ratio also.

1 BY MR. STAUDAHNER:

2 Q. Was that what you were at least operating
3 on as accepted aseptic technique for handling drugs in
4 the way they were used in that type of practice?

5 A. Yes.

6 Q. So every time the vial is entered it should
7 have been entered with a new syringe, that's why if they
8 had a second injection of the drug you would have
9 attributed that to a new syringe?

10 A. That's correct.

11 THE FOREPERSON: Any further comment?

12 Questions? Okay.

13 By law, these proceedings are secret and
14 you are prohibited from disclosing to anyone anything
15 that has transpired before us, including evidence and
16 statements presented to the Grand Jury, any event
17 occurring or statement made in the presence of the Grand
18 Jury, and information obtained by the Grand Jury.

19 Failure to comply with this admonition is a
20 gross misdemeanor punishable by a year in the Clark
21 County Detention Center and a \$2,000 fine. In addition,
22 you may be held in contempt of court punishable by an
23 additional \$500 fine and 25 days in the Clark County
24 Detention Center.

25 Do you understand this admonition?

1 THE WITNESS: Yes, I do.
 2 THE FOREPERSON: Thank you. You may be
 3 excused.
 4 THE WITNESS: Thank you.
 5 THE FOREPERSON: You're welcome.
 6 MR. STAUDAHER: One second ladies and
 7 gentlemen.
 8 Ladies and gentlemen, that concludes it.
 9 Thank you for coming over. I will have one witness
 10 after -- they are going to present that case. So it's
 11 probably going to be about two hours for them to present
 12 it, I believe they're coming back at 1:30 or
 13 thereabouts. I know we went over a little bit so I'll
 14 let you decide when you want to come back. I know it's
 15 an important case for them. They anticipate two hours.
 16 I have one witness who is relatively short like the
 17 morning witness after that so we should be finished
 18 relatively early. So I know they'll be back here at
 19 1:30.
 20 (Recess.)
 21 (Juror Agnes Parker exits the proceedings.)
 22 MR. STAUDAHER: Ladies and gentlemen of the
 23 Grand Jury, we're back in case 09BGJ049A-C, Dipak
 24 Kantilal Desai, Ronald Ernest Lakeman, Keith H. Mathahs,
 25 State versus those individuals. We have one additional

1 witness to provide to you after you had your break
 2 earlier today. I'll call that witness in now.
 3 THE FOREPERSON: Please raise your right
 4 hand. Thank you.
 5 You do solemnly swear the testimony you are
 6 about to give upon the investigation now pending before
 7 this Grand Jury shall be the truth, the whole truth, and
 8 nothing but the truth, so help you God?
 9 THE WITNESS: Yes, ma'am.
 10 THE FOREPERSON: Thank you. You may be
 11 seated.
 12 THE WITNESS: Thank you.
 13 THE FOREPERSON: You are advised that you
 14 are here today to give testimony in the investigation
 15 pertaining to the offenses of performance of act in
 16 reckless disregard of persons or property, criminal
 17 neglect of patients, insurance fraud, obtaining money
 18 under false pretenses, and racketeering, involving Dipak
 19 Kantilal Desai, Ronald Ernest Lakeman and Keith H.
 20 Mathahs.
 21 Do you understand this advisement?
 22 THE WITNESS: Yes, ma'am.
 23 THE FOREPERSON: Could you please state
 24 both your first and last names spelling them for the
 25 record.

1 THE WITNESS: First name is Joanne,
 2 J-O-A-N-N-E, last name Sams, S-A-M-S.
 3 THE FOREPERSON: Thank you.
 4 THE WITNESS: You're welcome.
 5 JOANNE SAMS,
 6 having been first duly sworn by the Foreperson of the
 7 Grand Jury to testify to the truth, the whole truth,
 8 and nothing but the truth, testified as follows:
 9
 10 EXAMINATION
 11
 12 BY MR. STAUDAHER:
 13 Q. Miss Sams, what do you do for a living?
 14 A. I'm a certified coder for the Veterans
 15 Administration.
 16 Q. What do you do as a coder for them?
 17 A. What I do is I take medical documentation
 18 and I turn it into codes for billing and for reporting
 19 purposes.
 20 Q. Okay. In that process do you receive forms
 21 called HCVA 1500 forms from different providers?
 22 A. Yes, sir.
 23 Q. Do you take the information off that form
 24 and then base -- I assume that's a claim coming in;
 25 correct?

1 A. Yes, sir.
 2 Q. Do you then formulate what you would
 3 reimburse based off that claim?
 4 A. That's correct.
 5 Q. And then go through the process of actually
 6 paying out the vendor?
 7 A. And validating that the codes are verified
 8 by the documentation submitted.
 9 Q. Okay. I'm going to show you what has been
 10 marked as Grand Jury Exhibit Number 44, ask you to just
 11 flip through that document and tell me if you recognize
 12 it.
 13 A. Yes, I do recognize this.
 14 Q. Look at all the pages. I think there are
 15 five or six pages.
 16 A. Yes.
 17 Q. Five page document.
 18 A. Yes, sir.
 19 Q. What is this document, ma'am?
 20 A. This is a sample of a HCVA 1500 form.
 21 Q. Page 1.
 22 A. Page 1. Page 2 is a payment history for a
 23 veteran.
 24 Q. And who is that veteran?
 25 A. Michael Washington.

1 Third page is the operative report for a
2 procedure performed on Michael at the endoscopic center.
3 The fourth page is a spreadsheet that I created that
4 provides a description of services and definitions of
5 what the modifiers on the claim form and the time
6 indicated on the claim form as well. The fifth page is
7 an overview, it's an expanded view of the claims history
8 from page 3.

9 Q. Okay. So the first page, this HCVA form is
10 not filled out; is that correct?

11 A. That's correct.

12 Q. In this particular case were you able to
13 find the actual form that was submitted on that claim?

14 A. No, we were not.

15 Q. Do you normally get claim forms like this?

16 A. Yes, we do.

17 Q. Now you had said that the succeeding pages
18 of this exhibit though contain information that's in
19 your computers that was basically inputted from that
20 information form?

21 A. That's correct, yes.

22 Q. Is that correct?

23 A. Yes, sir.

24 Q. So even though you don't have the actual
25 HCVA form you have the information that was inputted

1 from the form?

2 A. Absolutely, that's correct.

3 Q. Have you gone back and looked at this
4 information to see if it conformed or if it matched this
5 operative report that was provided as well?

6 A. Yes, I have.

7 Q. Does it?

8 A. Yes, it does, it does match.

9 Q. I notice on page 3 of this document there
10 is an operative report from the Endoscopy Center of
11 Southern Nevada; is that correct?

12 A. Yes.

13 Q. I'll show it to you right here. And again
14 we're still looking for the record at Exhibit 44.

15 Is that a requirement from the Veterans
16 Administration that they provide an operative report of
17 the procedure done and the dates and times and all that
18 stuff associated with it?

19 A. Yes, it's for continuity of care and to
20 validate that the services were in fact rendered to a
21 particular patient, yes.

22 Q. Who was the information pertaining to on
23 that particular form?

24 A. This is for the patient Michael Washington.

25 Q. Who was the doctor who actually performed

1 the procedure?

2 A. Dr. Desai.

3 Q. Dipak Desai?

4 A. Dipak Desai, yes.

5 Q. Who was the individual who performed the
6 anesthesia services?

7 A. Anesthesia was provided by Ronald Lakeman,
8 CRNA.

9 Q. What procedure was performed?

10 A. A colonoscopy.

11 Q. What was the procedure date?

12 A. 7/25/2007.

13 Q. Now beside that information on the
14 operative report, you mentioned on page 4 that this was
15 information pertaining to this specific claim; is that
16 correct?

17 A. That's correct.

18 Q. What information is on that page?

19 A. The CPT code which is the procedure code,
20 the description of that code, the modifiers that the
21 provider billed us with the anesthesia time and the
22 units billed.

23 Q. Okay. I'm going to display this for the
24 Grand Jury so that we know what we're talking about as
25 we follow along.

1 I'm going to go back to page -- we'll start
2 off with page 1. And this is just, I think you said
3 just the blank --

4 A. It's the sample form, yes, sir.

5 Q. Page 2. And I note that up in the left
6 hand corner, upper left hand corner is Michael
7 Washington's name; is that correct?

8 A. That's correct.

9 Q. What is the information on this form
10 showing us?

11 A. It is showing us, the first entry is the
12 surgical center that they billed for the services, for
13 the use of their facility, vendor identified as
14 Endoscopic Center of Southern Nevada. The second entry
15 is the vendor, the Gastroenterology Center, it is an
16 office call, the date of service is 2/1/08.

17 Q. And I think what I'd like to do is move
18 down to the actual date for the procedure.

19 A. The 7/25?

20 Q. Yes, the 7/25 date.

21 A. The highlighted 7/25/07 is the, 00810 is
22 the anesthesia code.

23 Q. For what?

24 A. For the colonoscopy performed on that day.

25 Q. Let's move to the next page. I know you've

1 already testified to it but I just want you to highlight
2 the portions that we specifically discussed. This is
3 the operative report is it not?

4 A. Yes, sir.

5 Q. And it shows the Endoscopy Center of
6 Southern Nevada, 700 Shadow Lane?

7 A. That's correct. Michael Washington as the
8 patient, it shows your procedure date of 7/24/07.

9 Q. 7/24?

10 A. 7/25, I'm sorry, '07. It shows the
11 attending physician is Dr. Dipak Desai and the
12 medication used and their findings of the procedure.

13 Q. Now one other thing I wanted to point out
14 to you. Under the indications does it also have, or the
15 providers, does it also have CRNA Ronald Lakeman's name?

16 A. Yes, sir.

17 Q. Beside that type of anesthesia --

18 A. Is the propofol.

19 Q. What does that mean exactly?

20 A. That was the type of medication, the
21 anesthesia, that they administered to the patient.

22 Q. Okay. Next page which I just want to make
23 sure we have is page 1, 2, 3, 4 I believe, this is the
24 spreadsheet information that you said came from this
25 particular claim?

1 A. That's correct.

2 Q. And tell us what we're looking at here
3 specifically.

4 A. Okay. What I did is I took the procedure
5 codes from the previous page and I just did a
6 description showing what the procedure was, as a lower
7 intestinal endoscopic procedure, the modifiers that were
8 billed and the total units billed being eight, the total
9 anesthesia time as 31 minutes for a total of three
10 units.

11 Q. So explain the difference between three
12 units versus the total eight being billed.

13 A. Okay. The anesthesia code, the anesthesia
14 services comes with a base code, base unit value of
15 five, it's in the very first block, I identified that as
16 five, that is added to the times units.

17 Q. So if the base is five and the time is
18 three that would be a total of eight?

19 A. Total of eight. And that's what they
20 billed us for was a total of eight units.

21 Q. And the total time they billed you for was?

22 A. Thirty-one minutes.

23 Q. Let's go to the last page of this exhibit
24 and we'll start at the top. There's a lot of stuff here
25 so why don't you walk us through what we're looking at

1 just generally and I would like you to focus on just
2 that procedure date at this point.

3 A. Okay. Again this is the claims history for
4 Michael Washington with the date of service of
5 7/25/2007, the anesthesia, the 00810, showing the P3
6 modifier, the -- what I did was I expanded that view to
7 show the procedure code, the amount that the Veterans
8 Administration paid --

9 Q. So if I understand you correctly this
10 number 4 listed in the middle of the page refers back to
11 this number 4 here?

12 A. That's correct.

13 Q. Is that correct?

14 A. That's correct.

15 Q. And that's the date of 7/25/07?

16 A. Correct.

17 Q. And then down below --

18 A. It gives you more detail to that particular
19 line.

20 Q. So you just expand out number 4?

21 A. That's correct.

22 Q. Let's talk about that for a moment. On
23 number 4 walk us through what we're looking at.

24 A. Okay. What it's showing you is the amount
25 that was paid to the provider, it shows the amount of

1 units that was paid, total number of eight, it shows you
2 the anesthesia time as 31 minutes and any of the
3 modifiers, the QZ, the QS and the P3 modifiers that were
4 also billed.

5 Q. What are those?

6 A. Those identify that it was monitored
7 anesthesia care, that it was provided by, services
8 performed by a CRNA, and that the patient has a systemic
9 disease, he's categorized as having a severe systemic
10 disease.

11 Q. Okay. Let's talk about the top. It says
12 service provided, that's 00810?

13 A. That's correct.

14 Q. Is that a colonoscopy?

15 A. That's --

16 Q. Or anesthesia for a colonoscopy?

17 A. Anesthesia code for colonoscopy, yes.

18 Q. Got it. And below that it says amount
19 paid. What does that mean? Is that the actual dollar
20 amount paid to the clinic?

21 A. That's correct.

22 Q. And how much is that?

23 A. That's a hundred dollars.

24 Q. Now if we move over where it says, on the
25 right hand side of that expanded section, it says amount

1 claimed. Do you see that?
 2 A. Yes, sir.
 3 Q. It also has another number there. What is
 4 that number?
 5 A. That is also a hundred dollars.
 6 Q. Is that what was actually claimed on this?
 7 A. That's right, they billed a hundred dollars
 8 and they were paid a hundred dollars.
 9 Q. Now if we go down to the bottom we see it
 10 says units paid and it has a number there.
 11 A. Yes, sir.
 12 Q. What is that?
 13 A. That is the number 8.
 14 Q. And anesthesia time?
 15 A. Was 31 minutes.
 16 Q. So even though the amount billed was a
 17 hundred dollars and the amount claimed was a hundred
 18 dollars, this 30, I just want to be clear, this
 19 anesthesia time of 31 minutes and the units that they
 20 claimed were eight, were actually, that's the
 21 information that was contained in the form that was
 22 submitted to you for payment?
 23 A. That's correct, uh-huh.
 24 Q. So if this was an incorrect amount, if it
 25 really wasn't 31 minutes, that would be something that

1 would be incorrect on the form that was submitted to
 2 you?
 3 A. That's correct, yes.
 4 Q. Now did you have anything else to do with
 5 this particular claim or work or are you just providing
 6 this information to us today?
 7 A. That's it, uh-huh.
 8 MR. STAUDAHER: I have nothing further for
 9 this witness.
 10 THE FOREPERSON: Are there any questions
 11 from the jury?
 12 There are none.
 13 By law, these proceedings are secret and
 14 you are prohibited from disclosing to anyone anything
 15 that has transpired before us, including evidence and
 16 statements presented to the Grand Jury, any event
 17 occurring or statement made in the presence of the Grand
 18 Jury, and information obtained by the Grand Jury.
 19 Failure to comply with this admonition is a
 20 gross misdemeanor punishable by a year in the Clark
 21 County Detention Center and a \$2,000 fine. In addition,
 22 you may be held in contempt of court punishable by an
 23 additional \$500 fine and 25 days in the Clark County
 24 Detention Center.
 25 Do you understand this admonition?

1 THE WITNESS: Yes, ma'am.
 2 THE FOREPERSON: Thank you. You may be
 3 excused.
 4 THE WITNESS: Thank you very much.
 5 MR. STAUDAHER: One second ladies and
 6 gentlemen.
 7 Ladies and gentlemen of the Grand Jury,
 8 that concludes the testimony in this particular case
 9 today. We are not going to submit it for deliberation
 10 at this time. We have at least one more presentation to
 11 make. So I will submit it to you at another date but at
 12 this point we'll conclude testimony. Thank you.
 13 (Proceedings adjourned, to reconvene
 14 At a later, undetermined time.)
 15 --oo00--
 16
 17
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 25

REPORTER'S CERTIFICATE

1
 2
 3 STATE OF NEVADA)
 4) Ss
 5 COUNTY OF CLARK)
 6
 7 I, Danette L. Antonacci, C.C.R. 222, do
 8 hereby certify that I took down in Shorthand (Stenotype)
 9 all of the proceedings had in the before-entitled matter
 10 at the time and place indicated and thereafter said
 11 shorthand notes were transcribed at and under my
 12 direction and supervision and that the foregoing
 13 transcript constitutes a full, true, and accurate record
 14 of the proceedings had.
 15 Dated at Las Vegas, Nevada,
 16 May 15, 2010.
 17 *Danette L. Antonacci*
 18 Danette L. Antonacci, C.C.R. 222
 19
 20
 21
 22
 23
 24
 25

AFFIRMATION

Pursuant to NRS 239B.030

The undersigned does hereby affirm that the
preceding TRANSCRIPT filed in GRAND JURY CASE NUMBER
09BGJ049ABC:

☒ Does not contain the social security number of any
person,

-OR-

☐ Contains the social security number of a person as
required by:

A. A specific state or federal law, to-
wit: NRS 656.250.

-OR-

B. For the administration of a public program
or for an application for a federal or
state grant.


Signature5-15-10
Date

Danette L. Antonacci
Print Name

Official Court Reporter
Title

RA 000461

\$	12 [4] 16/12 36/1 61/3 62/1	44/12 44/16 51/5 98/5 98/17
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\$1,967,446.17 [1] 128/20	125,000 [1] 130/6	136/4 136/8 137/11 137/12
\$120 [1] 46/11	12:20 [1] 32/25	140/8 149/11
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\$16.40 [2] 19/17 23/8	12:51 [2] 30/2 32/25	61/7
\$2,000 [5] 35/14 51/25 79/4	13 [3] 34/5 37/16 140/1	222 [3] 1/25 168/6 168/17
152/21 166/21	1315 [1] 34/2	228 [1] 142/6
\$20 [3] 50/24 50/24 51/4	1330 [1] 34/5	23 [1] 8/9
\$206.82 [2] 59/17 60/5	1347 [1] 34/2	23,576 [1] 138/11
\$245.12 [1] 65/12	13:15 [1] 33/9	239B.030 [1] 169/2
\$249.92 [2] 70/25 72/16	13:47 [1] 33/9	24 [11] 13/7 24/14 32/6
\$250,000 [1] 130/5	14 [4] 8/9 104/8 137/16	41/10 43/3 49/9 56/3 63/3
\$304 [3] 22/19 22/22 26/1	140/16	68/2 137/17 161/9
\$38 [2] 23/13 23/13	14,957 [1] 140/23	245.12 [2] 65/16 74/7
\$500 [5] 35/16 52/2 79/6	1400 [1] 141/14	25 [11] 35/16 52/2 56/7 79/6
152/23 166/23	15 [7] 15/7 15/12 15/12	100/7 149/11 152/23 160/19
\$560 [24] 12/17 14/3 19/10	19/17 57/12 57/21 168/15	160/20 161/10 166/23
20/1 20/7 20/10 22/2 24/25	1500 [19] 11/14 12/22 12/24	25,000 [1] 130/7
25/24 27/19 41/24 43/12	20/23 21/1 21/14 38/24 39/1	25th [16] 98/5 98/18 105/2
44/18 49/20 56/18 59/18	41/5 42/24 47/21 48/18 49/4	105/15 111/15 111/18 112/10
63/23 69/1 70/20 72/4 75/8	55/13 62/20 67/3 67/20	126/5 126/5 126/19 127/6
75/17 78/11 78/13	155/21 156/20	136/2 136/11 136/18 137/1
\$6,809,003.74 [1] 128/17	1500s [1] 21/7	140/5
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\$90 [8] 45/6 45/8 45/25	18,900 [1] 140/18	28 [4] 8/13 37/15 40/10 43/4
46/13 46/15 50/21 50/23 51/2	1815 [1] 87/10	28th [1] 45/15
,	185 [1] 140/8	29 [6] 1/16 2/1 5/1 8/13
'07 [5] 21/21 33/5 43/5 56/7	1:15 to [1] 33/9	16/3 37/15
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63/9 160/21 163/5 164/12	147/1	104/7 165/18
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32/22 63/8 68/7 70/18 160/21	2.62 [1] 137/18	47/25 49/20 55/4 60/15 60/23
161/8 163/15	2.93 [1] 140/9	61/7 62/1 66/7 75/20 75/23
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09BGJ049ABC [2] 1/9 169/5	136/24 136/25 137/3 137/7	165/15 165/19 165/25
1	137/15 143/24 143/25	3150 [1] 86/24
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1.1 [1] 142/1	20 ml [1] 137/25	25/8 43/14 46/3 46/6 47/25
1.14 [2] 140/25 146/25	20-milliliter [4] 134/14	58/10 62/12 64/5 65/18 66/6
1.4 [1] 146/14	134/21 136/6 138/16	75/23 78/8 104/3 111/3
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1.92 [1] 140/11	132/20 144/10 144/13 144/15	15/14 15/23 17/13 25/5 29/8
10 [4] 94/1 150/7 150/8	144/18 150/17 150/24	44/5 58/10 58/15 64/5 64/7
169/18	2007 [37] 10/19 11/19 24/11	66/23 67/20 75/23 78/8
10 o'clock [1] 116/8	32/16 39/18 39/19 41/14	102/17
10-milliliter [1] 134/13	45/16 49/13 51/7 100/7	34 [6] 20/18 21/10 24/3
10.30 [1] 32/9	111/22 126/6 127/19 128/5	29/20 32/19 141/24
100CC [1] 134/16	128/16 129/23 131/11 132/22	35 [8] 11/1 18/22 28/21 30/9
10:06 [1] 116/10	135/4 138/11 139/7 140/17	32/5 106/23 106/24 109/17
10:07 [1] 2/9	141/20 141/22 142/2 142/5	36 [2] 48/14 49/4
10:13 [1] 120/5	142/6 142/14 142/18 144/7	36,000 [1] 142/13
10:30 [3] 28/24 29/7 30/7	144/8 144/16 144/20 146/13	37 [2] 40/2 41/4
10CC [2] 141/5 148/21	159/12 163/5	38 [8] 86/12 89/1 91/2 92/8
11,844 [2] 138/15 142/5	2008 [11] 82/13 141/11	94/22 97/8 141/23 141/24
11.03 [1] 32/10	141/13 141/14 141/22 141/24	39 [2] 109/18 122/25
11:03 [2] 28/25 29/7	142/7 142/11 142/12 142/19	3:35 [1] 2/8
11:03 was [1] 30/7	143/22	4
11:34 [1] 120/5	2010 [4] 1/16 2/1 5/1 168/15	40 [1] 128/13
11:57 [1] 120/1	20th [2] 26/3 30/4	41 [1] 131/2
	21 [3] 33/5 39/19 40/10	42 [2] 112/6 119/7
	21st [23] 10/19 11/18 24/10	4275 [2] 87/4 87/6
	26/3 26/11 30/7 32/14 39/18	43 [3] 37/16 99/24 112/2

RA 000462

4	105/14 107/13 112/13 114/13 114/18 116/5 118/2 135/11 157/12 about [66] above [4] 28/13 28/23 68/13 75/13 absent [1] 36/2 Absolutely [3] 47/3 47/17 158/2 accepted [1] 152/3 access [1] 54/2 according [10] 21/20 22/2 106/1 116/11 116/12 116/25 117/18 117/21 119/14 147/24 account [10] 129/9 129/18 129/21 130/5 130/6 130/7 130/13 144/6 144/12 145/21 account's [2] 129/12 129/13 accounts [4] 127/24 127/24 128/1 129/7 accurate [6] 17/6 29/10 47/1 64/17 109/6 168/12 accurately [3] 5/6 88/17 88/18 acknowledge [1] 80/1 acknowledgment [1] 36/6 across [13] 14/11 24/24 41/11 41/22 49/10 49/17 56/8 56/16 70/21 72/6 94/11 101/22 112/11 act [5] 7/16 36/25 53/3 81/7 154/15 actively [1] 82/24 actual [15] 16/20 19/4 22/13 30/14 40/20 47/9 64/14 65/22 66/18 140/24 143/13 157/13 157/24 160/18 164/19 actually [38] 11/25 12/13 14/4 17/19 19/7 19/11 19/23 21/2 27/22 28/13 28/24 29/3 40/21 45/8 56/20 58/24 59/13 60/7 61/12 65/8 66/14 68/13 68/21 72/22 73/14 76/18 87/11 103/7 120/9 125/21 126/20 137/22 140/22 151/9 156/5 158/25 165/6 165/20 adapts [1] 114/15 add [3] 111/8 148/14 151/21 added [5] 26/18 57/20 107/22 111/9 162/16 addendum [3] 135/20 135/23 137/19 addition [9] 8/11 15/11 35/14 37/15 51/25 79/4 107/25 152/21 166/21 additional [10] 15/25 32/2 35/16 52/2 57/19 79/6 149/15 152/23 153/25 166/23 address [4] 5/19 5/21 6/3 42/13 addresses [1] 96/1 adds [1] 102/15 adequate [2] 130/23 130/24 adjourned [1] 167/13 adjudication [1] 10/4 administered [8] 122/2 124/23 125/18 125/23 126/12 126/14 126/15 161/21 administration [5] 4/18 155/15 158/16 163/8 169/15 administrator [1] 9/2 admitted [1] 112/3	admonish [2] 145/24 149/24 admonishing [1] 106/11 admonition [10] 35/12 35/18 51/23 52/4 79/2 79/8 152/19 152/25 166/19 166/25 advantage [1] 27/8 advised [5] 7/14 36/23 53/1 81/5 154/13 advisement [5] 7/21 37/5 53/8 81/13 154/21 affirm [1] 169/4 AFFIRMATION [1] 169/1 AFORESAID [1] 1/4 after [23] 5/21 11/24 40/16 82/14 84/11 85/3 99/1 110/17 114/2 116/16 116/23 117/7 119/4 120/4 132/15 135/4 135/15 141/12 150/16 151/10 153/10 153/17 154/1 again [31] 14/20 18/23 20/19 20/23 25/19 29/4 48/18 49/4 49/9 49/20 49/24 65/1 65/19 65/25 67/20 73/9 77/11 88/5 91/1 106/8 112/2 119/7 119/16 119/20 120/5 126/3 139/6 145/23 149/23 158/13 163/3 AGNES [2] 2/8 153/21 agreed [1] 31/15 agreement [2] 76/2 77/25 agreements [2] 144/24 145/5 ahead [11] 7/3 57/11 61/17 101/16 111/24 119/17 123/9 126/23 132/19 133/17 135/7 aisle [1] 34/17 ALICE [1] 2/12 all [89] allegations [2] 130/17 139/5 allowable [1] 50/23 allowed [1] 45/5 alone [1] 148/23 along [8] 30/15 47/6 48/1 124/2 133/11 150/25 151/8 159/25 alphabetical [1] 94/25 already [2] 60/16 161/1 also [34] 2/19 29/19 80/5 85/10 86/5 86/8 90/6 96/17 101/4 101/20 108/4 110/1 111/20 115/18 121/14 125/3 125/14 127/25 128/10 129/2 131/23 132/12 135/16 135/19 136/4 139/4 142/2 143/13 151/25 161/14 161/15 164/4 165/3 165/5 although [3] 66/7 79/25 112/24 always [1] 15/14 amount [94] amounts [1] 129/6 analysis [32] 4/14 82/25 83/13 90/17 106/2 111/16 115/25 121/21 121/23 127/16 127/17 127/20 128/15 130/15 130/21 131/6 133/13 134/5 136/20 138/7 138/14 141/10 142/21 142/25 143/6 143/10 143/11 143/14 147/15 147/19 149/10 149/13 analyst [5] 83/7 83/8 83/9 84/11 123/3 analyzes [1] 99/6
44 [3] 8/9 156/10 158/14		
45 [1] 15/13		
47 [1] 37/17		
470 [1] 86/19		
48 [1] 8/10		
5		
5-15-10 [1] 169/18		
50 [3] 135/18 143/24 144/1		
50 milliliter [1] 134/22		
50-milliliter [3] 134/14 135/14 138/16		
50CC [1] 149/1		
52 [1] 37/16		
5200 [1] 142/12		
521 [1] 142/8		
5211 [1] 136/17		
5215 [1] 140/2		
5216 [1] 140/16		
53 [1] 8/10		
56 [1] 37/17		
56.48 [1] 72/21		
560 [6] 46/7 51/10 60/3 60/8 65/17 65/19		
57 [1] 8/10		
58 [2] 8/13 37/15		
59 [2] 8/14 37/15		
5915 [1] 87/13		
6		
63 [4] 137/12 137/14 138/2 140/8		
64 [1] 137/13		
65 [4] 104/14 136/18 137/9 140/6		
656.250 [1] 169/13		
67 [1] 136/19		
692 [1] 142/18		
7		
7,521 [2] 132/22 133/19		
7/24 [1] 161/9		
7/24/07 [1] 161/8		
7/25 [4] 56/7 160/19 160/20 161/10		
7/25/07 [2] 160/21 163/15		
7/25/2007 [2] 159/12 163/5		
700 [14] 17/25 42/17 50/2 58/21 64/11 69/7 85/10 86/17 86/19 87/15 87/18 88/12 92/11 161/6		
8		
8,619 [1] 140/17		
9		
9/20 [2] 21/21 32/22		
9/20/07 [1] 21/19		
9/21 [2] 33/5 40/10		
9/21/07 [5] 13/13 25/17 63/8 68/7 70/18		
9/21/2007 [2] 41/14 49/13		
9/28 [2] 40/10 43/4		
9:19 [1] 1/17		
9:50 in [1] 116/8		
9:52 and [1] 116/10		
A		
a.m [2] 1/17 2/9		
ability [1] 5/7		
able [11] 80/11 103/12		

RA 000463

RA 000463

<p>A</p> <p>analyzing [1] 118/18</p> <p>anesthesia [54] 15/4 15/6 15/23 22/9 26/4 26/13 28/9 30/15 40/13 41/19 44/22 45/19 46/11 49/15 56/14 56/15 57/5 59/8 60/1 60/8 60/15 63/13 72/12 74/15 78/14 96/8 101/18 101/25 104/13 110/10 110/11 110/21 110/25 112/11 113/12 119/11 139/9 139/18 159/6 159/7 159/21 160/22 161/17 161/21 162/9 162/13 162/13 163/5 164/2 164/7 164/16 164/17 165/14 165/19</p> <p>anesthesiologist [5] 15/17 18/17 107/4 107/5 119/10</p> <p>anesthetic [1] 134/1</p> <p>anesthetist [9] 40/12 106/1 107/5 107/19 110/2 110/4 110/9 119/11 129/25</p> <p>anesthetists [1] 130/2</p> <p>ANNE [1] 2/15</p> <p>another [20] 12/6 24/4 34/16 42/24 45/12 48/7 69/18 90/25 92/4 103/25 104/21 108/22 113/5 121/6 121/25 139/14 149/12 149/19 165/3 167/11</p> <p>answer [6] 23/25 54/6 147/4 147/7 147/16 148/6</p> <p>answered [1] 7/1</p> <p>Anthem [1] 71/21</p> <p>anticipate [1] 153/15</p> <p>Antonacci [5] 1/25 5/4 168/6 168/17 169/21</p> <p>any [83]</p> <p>anybody [1] 36/9</p> <p>anyone [6] 31/5 35/7 51/18 78/22 152/14 166/14</p> <p>anything [25] 6/5 33/20 35/7 40/23 51/18 78/22 80/9 92/1 93/22 93/22 98/24 98/25 99/3 99/7 102/8 106/10 116/2 119/23 126/23 141/9 142/22 143/2 152/14 166/4 166/14</p> <p>anyway [2] 61/17 116/11</p> <p>anywhere [1] 97/5</p> <p>appeared [1] 5/11</p> <p>appears [6] 43/14 59/19 69/17 109/19 113/17 115/7</p> <p>application [1] 169/15</p> <p>applied [2] 105/4 146/22</p> <p>apply [2] 105/3 151/24</p> <p>applying [2] 6/7 80/17</p> <p>appointed [1] 84/12</p> <p>approximately [3] 142/8 142/18 142/20</p> <p>April [4] 1/16 2/1 5/1 151/6</p> <p>are [141]</p> <p>area [22] 5/10 28/14 61/14 89/9 89/16 89/23 89/23 89/24 90/6 90/10 92/20 93/21 93/23 94/8 94/9 94/19 94/23 95/7 95/8 96/10 97/8 97/11</p> <p>areas [5] 90/15 93/1 98/13 102/10 102/12</p> <p>Arizona [2] 84/5 84/7</p> <p>around [6] 94/7 101/12 117/10 120/6 121/14 137/20</p> <p>Arrives [1] 2/9</p>	<p>as [153]</p> <p>aseptic [1] 152/3</p> <p>ask [23] 9/18 11/3 11/7 12/20 14/11 40/3 48/25 54/16 54/25 55/10 60/12 61/20 75/3 76/16 77/24 80/7 83/5 88/10 103/25 118/16 134/4 147/15 156/10</p> <p>asked [7] 6/1 80/5 91/7 91/12 91/21 148/14 150/15</p> <p>asking [2] 38/25 58/5</p> <p>Aspinall [1] 67/24</p> <p>ASPINWALL [10] 4/7 54/18 66/22 67/25 68/1 115/22 124/5 125/1 125/8 126/1</p> <p>assigned [5] 15/9 84/20 85/1 86/2 101/3</p> <p>Assistant [1] 2/5</p> <p>associated [4] 12/19 38/9 54/16 158/18</p> <p>association [3] 4/13 83/16 123/2</p> <p>assume [14] 33/15 47/5 54/11 56/14 62/5 70/14 83/9 84/14 86/25 88/18 106/5 122/4 133/9 155/24</p> <p>assuming [1] 137/5</p> <p>AstraZeneca [1] 134/10</p> <p>at [212]</p> <p>attending [1] 161/11</p> <p>attention [5] 9/17 10/9 39/12 54/15 61/23</p> <p>Attorney [2] 2/20 84/7</p> <p>Attorney's [1] 82/17</p> <p>attributed [1] 152/9</p> <p>audit [1] 31/5</p> <p>available [6] 100/1 112/2 112/3 131/3 131/4 134/8</p> <p>Avenue [2] 87/4 87/6</p> <p>average [6] 102/18 140/9 140/10 142/5 142/15 147/21</p> <p>averaged [2] 102/18 140/7</p> <p>averages [1] 140/10</p> <p>aware [2] 132/16 134/15</p> <p>away [1] 106/8</p> <p>awhile [1] 84/11</p> <p>B</p> <p>Bachelor [1] 84/4</p> <p>back [34] 10/7 14/18 28/16 32/22 40/17 46/22 59/1 59/21 64/21 65/22 69/12 79/19 82/4 84/24 92/9 92/15 97/7 97/7 103/12 110/20 119/15 120/3 120/5 122/4 122/9 135/15 143/25 153/12 153/14 153/18 153/23 158/3 160/1 163/10</p> <p>background [2] 84/1 84/3</p> <p>bad [1] 147/11</p> <p>balance [5] 73/4 145/8 145/9 145/11 145/15</p> <p>bank [12] 83/10 83/17 99/3 127/24 127/24 128/3 128/3 128/16 129/7 129/9 129/12 129/13</p> <p>base [23] 15/7 15/9 15/10 15/16 15/18 15/24 16/15 26/14 26/16 57/13 57/15 57/17 57/19 57/20 57/24 63/16 63/18 74/3 78/14 155/24 162/14 162/14 162/17</p> <p>based [30] 5/24 15/15 17/4</p>	<p>23/3 34/13 34/24 44/14 58/6 65/16 65/18 67/9 76/3 77/15 80/16 89/11 89/25 102/9 103/15 105/21 115/24 118/3 119/22 123/6 123/23 126/25 130/8 133/20 146/17 147/15 156/3</p> <p>baseline [1] 149/13</p> <p>basically [2] 47/12 157/19</p> <p>basis [2] 33/22 150/18</p> <p>bates [2] 136/17 140/1</p> <p>be [78]</p> <p>bears [1] 40/2</p> <p>became [1] 84/18</p> <p>because [28] 16/14 19/15 19/22 43/25 44/13 48/23 54/7 59/1 66/10 73/15 73/21 76/2 76/7 99/13 102/5 103/2 108/16 116/3 125/13 129/24 130/3 136/21 139/5 139/6 144/9 144/14 147/23 151/2</p> <p>bedside [1] 108/18</p> <p>been [69]</p> <p>before [36] 1/4 5/18 7/8 8/5 8/8 9/18 23/23 35/8 35/23 36/2 36/17 37/14 45/11 51/19 52/20 54/6 55/10 55/23 78/23 80/3 80/24 83/25 86/9 87/1 103/24 120/19 122/21 124/12 131/17 134/4 151/3 151/10 152/15 154/6 166/15 168/8</p> <p>before-entitled [1] 168/8</p> <p>beginning [8] 35/23 80/6 82/12 144/7 144/9 144/12 144/15 146/5</p> <p>being [22] 6/4 6/6 6/14 8/24 13/3 21/1 22/1 22/9 24/1 49/6 54/18 54/20 54/22 55/22 77/18 78/7 90/14 98/20 110/13 118/20 162/8 162/12</p> <p>belief [1] 17/4</p> <p>believe [26] 10/11 13/6 13/14 13/24 20/15 25/6 25/11 30/3 41/10 50/14 56/3 58/6 62/13 64/19 68/18 71/15 91/17 91/23 94/3 97/1 97/10 113/18 142/24 148/15 153/12 161/23</p> <p>below [4] 13/9 115/8 163/17 164/18</p> <p>benefit [1] 138/21</p> <p>benefits [13] 12/9 18/20 21/2 22/14 25/12 39/10 40/19 44/11 44/15 48/19 48/24 50/6 69/17</p> <p>beside [14] 48/6 48/8 84/15 90/24 98/23 107/12 109/17 110/19 130/15 132/3 142/21 142/25 159/13 161/17</p> <p>best [3] 5/7 88/2 107/14</p> <p>between [23] 5/22 19/14 22/25 23/18 30/2 38/19 57/9 63/14 66/4 66/5 80/7 92/14 93/14 93/18 95/19 99/21 126/9 127/2 127/3 127/5 133/1 138/13 162/11</p> <p>beyond [1] 76/19</p> <p>BIANCA [1] 2/10</p> <p>bias [1] 5/21</p> <p>biases [1] 5/23</p> <p>bifocals [1] 105/1</p> <p>big [4] 100/20 100/21 100/25 131/20</p>
---	--	--

RA 000464

<p>B</p> <p>bigger [1] 50/13</p> <p>bill [9] 12/14 15/22 18/4 43/20 44/17 60/23 74/16 78/4 78/6</p> <p>billed [50] 14/3 15/4 16/5 16/7 19/11 20/11 20/23 22/4 23/3 24/24 25/23 26/4 27/5 41/23 42/3 43/10 43/22 43/23 45/20 45/21 46/7 46/10 46/10 46/15 51/9 56/25 57/5 57/23 58/7 60/3 60/8 60/14 65/19 65/25 65/25 70/19 71/25 72/13 78/10 159/21 159/22 160/12 162/8 162/8 162/12 162/20 162/21 164/4 165/7 165/16</p> <p>billing [10] 18/7 27/11 28/8 44/24 56/22 62/2 73/10 76/9 76/18 155/18</p> <p>bills [2] 30/16 47/25</p> <p>bit [14] 44/13 48/22 50/5 56/2 59/2 59/3 59/22 64/21 82/5 83/25 89/2 92/9 122/14 153/13</p> <p>bite [14] 130/20 130/24 132/8 132/21 132/23 133/4 133/14 133/20 133/22 133/23 141/13 141/14 141/22 144/5</p> <p>blank [1] 160/3</p> <p>Blēmings [3] 116/17 116/17 120/5</p> <p>Blēmings' [1] 121/18</p> <p>block [5] 77/13 133/5 133/14 133/23 162/15</p> <p>blocks [11] 130/20 130/24 132/8 132/21 132/23 133/20 133/22 141/14 141/14 141/22 144/5</p> <p>blue [12] 53/24 53/24 54/1 54/1 54/17 54/17 55/19 55/20 71/21 71/21 103/7 112/24</p> <p>blurry [1] 14/16</p> <p>Board [1] 103/4</p> <p>BOB [2] 2/11 143/20</p> <p>bonuses [1] 129/25</p> <p>book [2] 131/14 131/20</p> <p>books [2] 100/21 131/18</p> <p>both [31] 7/24 9/8 26/11 26/17 28/16 28/17 34/15 37/7 39/18 46/7 46/8 48/14 53/11 58/10 97/25 98/1 105/10 107/6 107/11 131/15 133/10 134/25 137/13 138/12 138/14 138/15 139/1 139/6 140/5 140/10 154/24</p> <p>bottle [2] 139/12 139/14</p> <p>bottom [13] 17/12 25/5 42/8 44/3 49/23 58/9 64/4 104/20 113/5 124/7 129/2 145/22 165/9</p> <p>box [25] 24/14 24/14 24/14 25/5 25/8 32/6 41/10 41/15 42/8 43/3 44/5 49/9 56/3 58/10 58/15 62/23 63/3 64/7 67/23 68/2 68/18 77/12 78/1 96/25 150/16</p> <p>boxed [1] 94/2</p> <p>boxes [6] 17/13 17/16 46/18 58/10 64/5 94/13</p> <p>break [7] 52/8 52/9 52/13</p>	<p>79/15 79/19 120/7 154/1</p> <p>breaking [1] 105/17</p> <p>breaks [1] 106/6</p> <p>Brian [1] 84/21</p> <p>briefing [2] 84/22 84/23</p> <p>briefly [1] 67/18</p> <p>bring [3] 35/23 36/12 117/4</p> <p>brought [3] 85/3 117/4 125/15</p> <p>Bruce [1] 100/12</p> <p>building [3] 89/10 89/20 89/21</p> <p>bunch [1] 94/17</p> <p>burden [1] 6/2</p> <p>Burnham [9] 85/16 87/4 87/6 131/15 132/1 140/14 140/20 146/21 147/9</p> <p>business [6] 85/25 86/20 91/3 91/24 99/3 131/19</p> <p>but [83]</p> <p>C</p> <p>C-O-R-R-I-N-E [1] 37/10</p> <p>C.C.R [3] 1/25 168/6 168/17</p> <p>calculate [3] 102/15 102/16 135/11</p> <p>calculated [4] 102/3 108/14 108/19 110/21</p> <p>calculation [1] 104/2</p> <p>calendar [1] 146/5</p> <p>call [6] 52/8 55/12 95/1 120/23 154/2 160/16</p> <p>called [12] 9/10 9/12 9/14 22/14 61/23 93/18 95/15 96/15 97/17 110/11 123/3 155/21</p> <p>came [16] 6/5 14/4 18/4 25/8 33/16 48/1 61/3 61/19 61/25 70/2 75/8 84/24 120/10 120/18 129/6 161/24</p> <p>CAMP [1] 2/6</p> <p>Campbell [7] 122/17 122/20 124/9 125/4 125/19 125/25 126/9</p> <p>can [39] 7/1 9/9 23/6 29/2 29/4 29/23 32/22 35/20 38/16 42/7 49/18 52/6 54/6 56/2 64/21 64/23 64/25 67/7 71/16 77/11 77/18 79/14 79/15 80/14 81/15 86/13 89/2 100/1 100/3 113/10 119/6 121/10 122/13 122/21 123/12 123/17 126/3 129/20 148/6</p> <p>can't [4] 14/16 116/7 147/13 148/7</p> <p>canvassed [1] 5/10</p> <p>capacity [1] 82/10</p> <p>care [21] 9/1 9/3 9/4 9/6 9/11 9/15 9/16 27/7 27/10 30/19 33/15 38/8 61/17 69/25 71/1 72/25 76/8 104/25 151/24 158/19 164/7</p> <p>CAROLE [7] 4/10 39/13 48/12 49/6 79/22 115/22 124/6</p> <p>Carolyn [1] 104/6</p> <p>Carrera [4] 127/18 128/21 128/22 130/6</p> <p>Carrera's [1] 94/7</p> <p>Carrol [4] 127/18 128/20 130/5 145/4</p> <p>Carrol's [3] 93/11 94/5 97/17</p> <p>case [33] 5/14 6/2 6/21 26/21 28/11 28/12 36/7 63/25</p>	<p>69/2 80/3 80/10 80/16 82/10 82/12 82/15 83/1 83/23 84/17 84/25 85/2 97/3 118/19 121/1 121/23 143/2 150/16 150/16 153/10 153/15 153/23 157/12 167/8 169/4</p> <p>cases [2] 83/13 84/15</p> <p>catch [1] 34/25</p> <p>categories [2] 130/19 131/9</p> <p>categorize [1] 98/15</p> <p>categorized [1] 164/9</p> <p>caused [1] 80/10</p> <p>CDC [3] 98/1 106/18 114/12</p> <p>center [39] 14/5 17/22 19/8 19/16 20/3 22/7 25/9 35/14 35/17 40/14 42/12 44/8 46/23 49/25 51/25 52/3 58/20 64/9 65/23 69/7 78/10 79/4 79/7 82/6 124/9 131/25 132/13 134/18 134/20 152/21 152/24 157/2 158/10 160/12 160/14 160/15 161/5 166/21 166/24</p> <p>centers [2] 50/11 134/20</p> <p>certain [5] 38/17 38/21 47/14 55/11 102/10</p> <p>certainly [2] 24/2 26/18</p> <p>CERTIFICATE [1] 168/1</p> <p>certified [2] 40/11 155/14</p> <p>certify [1] 168/7</p> <p>cetera [1] 50/8</p> <p>chance [1] 10/20</p> <p>change [4] 6/12 107/10 111/24 137/20</p> <p>changed [6] 46/21 46/23 141/12 142/11 144/24 145/6</p> <p>changes [1] 114/16</p> <p>charge [29] 14/7 14/7 20/1 20/2 20/3 20/6 23/4 26/13 26/14 40/12 41/22 43/10 44/17 56/24 59/18 60/3 61/3 61/6 61/8 61/13 63/22 65/1 65/17 66/7 66/13 68/11 75/17 78/11 78/13</p> <p>charged [7] 22/1 22/22 43/22 49/18 65/6 68/24 70/19</p> <p>charges [13] 6/2 6/8 6/16 13/24 20/24 37/14 42/5 42/5 49/20 56/25 68/24 75/5 75/13</p> <p>chart [11] 4/13 101/20 102/1 102/2 104/20 107/20 107/20 110/22 110/23 112/11 123/2</p> <p>charts [1] 83/16</p> <p>check [5] 93/1 94/9 94/23 95/7 136/10</p> <p>check-out [4] 93/1 94/9 94/23 95/7</p> <p>checked [9] 96/9 135/10 135/16 136/9 137/4 137/5 137/7 137/23 141/24</p> <p>checks [1] 127/25</p> <p>CHRISTINE [1] 2/7</p> <p>civil [1] 117/24</p> <p>civilian [1] 84/10</p> <p>claim [98]</p> <p>claimed [4] 165/1 165/6 165/17 165/20</p> <p>claims [30] 9/3 9/7 9/20 9/21 10/2 10/3 11/15 17/4 17/5 27/24 33/12 33/14 34/15 34/19 34/19 38/1 38/23 39/3 39/5 39/17 47/17 47/19 54/12 54/25 62/9 74/22 78/9 78/9</p>
---	--	---

<p>C</p> <p>claims... [2] 157/7 163/3 clarification [1] 77/14 clarify [1] 148/14 clarifying [1] 75/3 CLARK [13] 1/2 35/13 35/16 51/24 52/2 79/3 79/6 104/7 152/20 152/23 166/20 166/23 168/4 clear [5] 28/15 32/3 126/19 132/25 165/18 clearer [1] 118/6 clearly [1] 24/21 click [1] 118/10 Clifford [3] 93/11 94/5 128/20 clinic [20] 86/8 86/17 89/4 92/15 94/13 95/9 95/10 96/15 97/6 100/20 131/15 131/16 132/1 140/20 140/23 141/4 146/21 147/18 149/25 164/20 clinics [5] 138/12 138/13 138/21 139/1 139/6 close [4] 140/21 140/21 141/1 147/2 closed [1] 135/5 cloud [1] 5/24 cluster [1] 149/19 CMS [2] 50/7 50/10 co [1] 50/24 code [21] 15/8 24/16 28/23 41/16 41/18 41/19 49/15 56/9 63/9 63/16 65/5 68/11 68/14 159/19 159/19 159/20 160/22 162/13 162/14 163/7 164/17 coder [2] 155/14 155/16 codes [4] 63/14 155/18 156/7 162/5 colonoscopies [1] 63/15 colonoscopy [13] 41/21 49/16 56/13 56/15 63/13 108/3 133/1 133/4 159/10 160/24 164/14 164/16 164/17 colored [2] 95/1 113/8 colors [1] 113/10 column [24] 32/6 41/10 44/19 45/3 56/8 56/16 57/1 59/11 59/25 63/10 63/22 70/22 72/19 101/6 101/7 101/8 101/23 103/8 107/23 107/24 107/24 108/1 110/20 120/23 columns [3] 107/20 110/20 112/10 combined [1] 73/1 combining [1] 138/25 come [21] 9/25 20/5 38/13 38/21 38/23 38/24 42/6 44/7 59/1 60/19 69/12 73/9 78/6 89/25 91/22 94/11 100/6 110/25 111/4 134/13 153/14 comes [7] 15/5 38/17 38/21 39/2 120/5 134/12 162/14 coming [6] 38/11 46/22 132/4 153/9 153/12 155/24 comment [2] 120/24 152/11 comments [1] 120/23 commercial [7] 9/8 9/9 9/11 23/8 23/11 23/13 27/2 commissioned [1] 84/6 common [3] 127/2 127/2 127/5 commonality [1] 126/9</p>	<p>companies [5] 27/10 30/22 31/22 38/19 67/8 company [40] 9/5 9/7 9/19 9/24 10/15 10/21 11/21 11/21 15/20 16/21 17/10 19/8 22/15 25/3 27/12 27/23 28/8 28/9 30/13 30/25 34/5 38/7 38/14 39/3 39/7 41/23 54/17 55/16 56/21 60/13 61/16 66/2 66/19 67/9 69/18 69/22 69/23 72/22 73/24 74/23 compare [1] 99/21 comparison [1] 88/22 compilation [1] 132/16 compiled [1] 100/4 complaint [1] 8/6 complete [2] 92/20 149/14 completely [1] 6/6 comply [5] 35/12 51/23 79/2 152/19 166/19 computer [11] 10/4 34/22 103/5 103/7 103/11 103/18 105/3 105/7 112/13 116/12 118/9 computer-generated [2] 116/12 118/9 computers [1] 157/19 concerned [1] 56/20 conclude [1] 167/12 concludes [2] 153/8 167/8 conclusion [1] 117/23 conducted [2] 124/25 150/10 conformed [1] 158/4 confused [1] 31/13 connection [1] 92/13 connector [1] 93/17 consensus [1] 6/12 consider [2] 96/4 118/16 considered [2] 48/2 60/16 constituted [1] 8/15 constitutes [1] 168/12 contact [1] 96/1 contain [2] 157/18 169/8 contained [9] 16/19 17/5 47/20 55/6 95/18 95/22 131/21 142/23 165/21 container [1] 134/7 containers [3] 134/7 136/7 136/8 Contains [1] 169/11 contempt [5] 35/15 52/1 79/5 152/22 166/22 continuation [1] 5/14 continue [3] 7/4 80/20 82/15 continued [2] 145/4 150/25 continuity [1] 158/19 contract [2] 47/9 47/15 contracted [13] 15/19 19/15 19/16 19/22 23/8 23/21 27/12 28/4 29/9 31/13 39/8 47/5 47/7 contracting [1] 53/24 contracts [3] 31/23 47/18 91/23 control [1] 129/17 controlled [1] 130/12 conversely [1] 16/24 copies [2] 6/19 96/2 copy [2] 10/2 100/25 corner [9] 44/24 69/20 69/21 91/16 93/6 93/10 93/11 160/6 160/6</p>	<p>corporation [1] 144/23 correct [200] correctly [9] 15/21 26/2 39/2 42/20 87/17 117/6 121/9 137/3 163/9 correlate [2] 19/10 149/13 correspond [1] 104/20 Corrine [2] 37/9 37/18 cost [1] 50/24 could [24] 7/23 23/22 23/23 34/20 34/23 40/4 52/10 52/11 70/5 76/20 92/15 99/21 103/3 103/15 107/14 121/4 121/25 122/1 144/14 144/17 145/8 146/4 147/7 154/23 couldn't [47] 91/10 100/13 100/15 114/12 count [1] 141/18 counted [6] 131/13 137/14 139/8 139/16 140/3 146/18 counting [1] 133/18 counts [6] 8/9 8/12 8/13 8/13 37/16 37/17 COUNTY [12] 1/2 35/14 35/16 51/25 52/2 79/4 79/6 152/21 152/23 166/21 166/23 168/4 couple [6] 9/18 33/23 35/25 39/24 55/10 75/3 court [10] 1/1 1/5 23/25 35/15 52/1 54/7 79/5 152/22 166/22 169/23 cover [1] 86/16 coverage [1] 66/18 covered [1] 119/18 CPT [1] 159/19 created [1] 157/3 criminal [8] 7/17 8/6 37/1 53/4 81/8 84/5 84/21 154/16 CRNA [29] 18/9 25/5 40/11 44/4 49/24 76/24 103/2 105/5 108/25 116/14 116/15 116/18 117/5 117/6 117/12 125/21 125/22 126/12 126/20 129/8 129/10 129/12 129/12 137/14 137/15 145/21 159/8 161/15 164/8 CRNAs [9] 105/18 105/20 112/16 112/21 130/1 134/2 135/9 139/17 150/11 cross [6] 53/24 54/1 54/17 55/20 71/21 116/1 currently [2] 8/15 32/4 custodian [2] 131/24 132/12 cycle [1] 39/6</p> <p>D</p> <p>DA [3] 136/17 140/1 140/16 DA-endoscopy [3] 136/17 140/1 140/16 Danette [5] 1/25 5/4 168/6 168/17 169/21 data [1] 34/21 date [41] 10/3 11/18 13/10 13/12 21/18 25/15 33/5 40/10 41/13 43/4 45/15 49/12 51/5 55/24 56/3 56/5 63/6 65/5 68/6 68/8 70/17 71/22 100/6 103/11 105/10 105/15 125/17 126/10 126/11 149/12 149/19 159/11 160/16 160/18 160/20 161/8 163/2 163/4 163/15 167/11 169/19</p>
--	--	--

D		
<p>Dated [1] 168/14</p> <p>dates [9] 21/8 39/19 39/22 40/13 101/3 149/20 149/21 150/2 158/17</p> <p>day [37] 10/20 24/10 33/17 84/24 100/10 100/12 100/14 100/19 104/15 105/2 105/3 105/19 105/23 106/16 110/6 110/13 111/10 112/12 112/16 112/21 113/14 113/17 113/20 116/2 122/18 122/20 134/3 134/3 135/9 135/12 136/25 137/9 137/18 140/8 140/9 149/14 160/24</p> <p>days [17] 14/12 26/4 35/16 52/2 77/20 77/21 79/6 98/22 136/14 138/5 138/8 139/7 140/5 146/18 150/1 152/23 166/23</p> <p>deal [1] 54/2</p> <p>dealing [1] 10/15</p> <p>deals [1] 135/18</p> <p>dealt [2] 10/15 48/7</p> <p>decide [3] 39/8 67/9 153/14</p> <p>decision [1] 5/25</p> <p>decrease [1] 19/19</p> <p>Defendants [1] 1/11</p> <p>definitions [1] 157/4</p> <p>Degree [1] 84/5</p> <p>deliberate [2] 36/2 80/16</p> <p>deliberating [1] 80/3</p> <p>deliberation [3] 118/17 146/1 167/9</p> <p>department [3] 38/1 82/12 97/2</p> <p>depending [1] 107/15</p> <p>deposed [1] 118/8</p> <p>deposition [1] 118/3</p> <p>depositions [1] 117/24</p> <p>Deputy [2] 2/4 2/20</p> <p>DESAI [22] 1/10 5/16 7/19 31/15 37/3 53/6 81/11 107/11 127/18 128/17 128/24 129/19 130/4 130/9 145/20 145/20 153/24 154/19 159/2 159/3 159/4 161/11</p> <p>Desai's [2] 93/8 94/6</p> <p>described [8] 44/10 44/20 77/12 125/1 125/8 125/10 142/22 145/18</p> <p>description [6] 44/20 45/18 60/1 157/4 159/20 162/6</p> <p>designate [5] 13/19 14/22 103/13 104/21 110/22</p> <p>designated [18] 18/12 29/19 30/15 41/5 44/4 58/13 68/18 75/17 93/7 109/23 110/4 110/13 110/21 111/3 115/3 124/7 136/17 140/1</p> <p>designates [2] 13/2 68/18</p> <p>designating [2] 64/2 116/20</p> <p>designation [7] 12/24 13/14 14/14 18/9 58/3 62/23 114/7</p> <p>designations [3] 17/16 32/9 123/22</p> <p>detail [2] 70/9 163/18</p> <p>detective [1] 86/3</p> <p>detectives [4] 83/15 91/8 124/25 150/10</p> <p>Detention [10] 35/14 35/17</p>	<p>51/25 52/3 79/4 79/7 152/21 152/24 166/21 166/24</p> <p>determine [3] 103/3 128/4 131/10</p> <p>determined [1] 145/20</p> <p>determines [2] 74/13 74/14</p> <p>developed [9] 5/23 6/5 140/19 140/21 141/1 144/4 146/17 146/23 146/25</p> <p>diagram [9] 90/24 92/22 93/11 104/1 105/6 106/20 107/13 109/16 125/3</p> <p>diagrams [7] 4/12 86/13 86/14 87/24 88/1 88/8 97/5</p> <p>did [122]</p> <p>didn't [33] 30/23 87/21 90/12 91/9 91/25 92/3 97/10 97/14 105/3 105/9 109/13 109/13 114/12 117/4 121/7 121/11 124/15 125/12 127/11 136/10 137/7 141/18 144/10 144/15 144/19 145/14 145/15 146/7 146/16 147/8 149/4 149/12 151/2</p> <p>difference [12] 19/14 23/3 23/17 23/19 50/20 57/8 63/14 66/17 95/19 102/20 133/1 162/11</p> <p>Differences [1] 38/19</p> <p>different [37] 23/21 24/16 24/21 31/18 31/18 31/19 31/19 31/22 31/23 34/23 38/5 38/12 48/22 50/5 63/16 66/9 69/22 73/19 74/17 74/20 74/22 95/18 96/12 97/19 102/21 102/21 102/23 105/18 108/12 109/13 117/23 126/15 129/15 148/17 148/20 151/10 155/21</p> <p>differentiate [1] 95/16</p> <p>difficult [4] 14/21 54/8 99/25 116/4</p> <p>Dimension [1] 48/23</p> <p>DIPAK [15] 1/10 5/15 7/19 37/3 53/6 81/10 93/7 94/6 128/17 128/23 153/23 154/18 159/3 159/4 161/11</p> <p>direct [5] 10/9 10/18 14/18 39/12 54/15</p> <p>directing [1] 9/17</p> <p>direction [1] 168/11</p> <p>directly [1] 114/21</p> <p>director [3] 9/1 38/1 53/25</p> <p>disbursements [1] 130/10</p> <p>discarding [1] 139/13</p> <p>discharge [1] 108/21</p> <p>discharged [1] 108/19</p> <p>disclosing [5] 35/7 51/18 78/22 152/14 166/14</p> <p>discount [1] 122/8</p> <p>discounts [1] 27/21</p> <p>discrepancy [1] 121/6</p> <p>discussed [1] 161/2</p> <p>discussing [1] 132/17</p> <p>disease [3] 110/3 164/9 164/10</p> <p>display [11] 12/20 14/20 29/1 40/24 49/2 55/9 62/17 64/20 77/16 123/9 159/23</p> <p>displayed [2] 29/5 55/23</p> <p>disregard [6] 7/16 36/25 53/3 81/8 145/25 154/16</p>	<p>distinction [1] 148/13</p> <p>distributed [1] 134/6</p> <p>district [8] 1/1 1/5 2/20 82/16 84/22 98/2 141/13 149/16</p> <p>divide [1] 103/21</p> <p>do [151]</p> <p>doctor [5] 103/1 107/9 107/11 108/3 158/25</p> <p>doctor's [2] 96/3 109/8</p> <p>doctors [11] 31/19 92/12 93/4 127/18 128/2 128/4 128/18 130/2 130/3 145/17 145/19</p> <p>doctors' [5] 87/16 92/11 93/24 94/19 95/5</p> <p>document [25] 11/1 11/2 11/9 11/10 12/7 12/19 14/17 14/18 42/23 48/17 55/5 98/14 111/5 122/22 123/1 123/17 123/22 128/12 128/14 130/25 140/1 156/11 156/17 156/19 158/9</p> <p>documentation [2] 155/17 156/8</p> <p>documents [13] 4/9 4/18 10/24 11/12 12/3 40/6 40/8 62/14 66/25 67/2 83/14 86/3 87/1</p> <p>does [50] 6/4 9/19 9/23 9/24 9/25 13/18 14/22 15/17 18/23 19/1 19/3 19/10 21/11 21/17 22/13 22/16 25/18 25/20 27/15 28/8 38/21 39/4 41/15 42/4 44/7 44/9 47/4 50/7 59/22 62/23 65/8 76/12 78/17 100/6 104/19 104/20 106/1 125/10 125/10 147/4 147/22 158/7 158/8 158/8 161/14 161/15 161/19 164/19 169/4 169/8</p> <p>doesn't [2] 105/1 137/20</p> <p>doing [5] 26/17 47/23 54/11 99/7 131/3</p> <p>dollar [19] 13/25 20/6 25/23 44/1 44/25 45/2 45/20 45/21 46/22 49/17 56/17 56/17 56/19 58/7 59/16 65/5 66/8 72/20 164/19</p> <p>dollars [6] 164/23 165/5 165/7 165/8 165/17 165/18</p> <p>don't [27] 28/17 36/9 46/11 62/5 76/8 76/17 83/4 94/3 99/10 102/7 104/24 105/7 105/11 112/17 114/17 118/1 120/10 120/18 121/17 121/18 124/14 129/14 133/4 141/11 142/24 157/24 162/25</p> <p>done [14] 26/12 30/12 57/4 61/12 69/6 82/25 83/22 95/11 95/12 96/16 104/15 106/18 149/10 158/17</p> <p>door [2] 46/20 89/14</p> <p>double [2] 142/9 142/10</p> <p>down [30] 6/1 13/5 21/17 24/1 24/9 34/16 41/9 43/3 44/23 49/9 54/7 54/8 56/2 59/9 63/3 68/2 70/9 75/23 76/1 76/2 76/8 76/15 91/15 111/4 118/10 126/3 160/18 163/17 165/9 168/7</p> <p>Dr [17] 31/14 94/6 97/17 107/11 128/17 128/20 128/21 128/22 129/19 130/4 130/5 130/6 130/9 145/4 145/20</p>

RA 000467

D Dr... [2] 159/2 161/11 draw [1] 87/21 drawing [2] 139/12 139/13 drop [1] 118/10 dropped [1] 145/5 drug [3] 148/16 148/23 152/8 drugs [1] 152/3 duly [6] 5/5 8/17 37/19 53/16 81/22 155/6 duration [1] 147/24 during [7] 11/2 19/17 83/5 116/2 120/19 134/5 141/16	152/7 enters [1] 52/15 entire [3] 141/20 142/5 142/13 entirety [2] 36/4 123/17 entities [3] 38/12 38/12 108/7 entitled [2] 59/8 168/8 entity [5] 42/9 42/11 56/21 144/22 145/12 entrance [2] 89/10 89/12 entry [2] 160/11 160/14 EOB [5] 40/16 40/18 45/12 50/9 54/2 equal [2] 15/7 15/15 equals [1] 57/12 equates [1] 29/7 ERNEST [8] 1/10 5/16 7/20 37/4 53/7 81/11 153/24 154/19 essentially [1] 97/23 et [1] 50/8 even [11] 22/20 66/13 69/21 73/15 91/10 127/11 140/25 147/2 151/9 157/24 165/16 event [5] 35/9 51/20 78/24 152/16 166/16 eventually [1] 47/13 ever [6] 33/19 96/23 105/14 109/6 111/8 134/5 every [18] 5/20 15/8 15/12 20/5 57/12 75/8 78/6 133/23 134/2 134/3 135/9 136/3 138/18 140/11 142/1 146/25 147/1 152/6 everything [1] 109/11 everywhere [2] 95/4 95/7 evidence [17] 35/8 51/19 78/23 80/15 80/17 83/15 90/15 91/9 99/1 99/2 117/11 122/5 127/22 143/3 149/25 152/15 166/15 evidenced [1] 73/13 exactly [2] 70/4 161/19 exam [6] 92/23 92/24 93/5 93/24 94/1 94/4 EXAMINATION [5] 8/21 37/22 53/20 82/1 155/10 examined [2] 3/2 90/11 examiners [2] 34/19 103/5 example [6] 26/11 34/1 38/18 43/21 47/24 66/5 Excel [3] 99/22 102/3 102/14 exception [3] 75/10 104/6 106/5 excuse [3] 23/2 101/12 134/3 excused [5] 35/21 52/7 79/11 153/3 167/3 execution [2] 85/23 98/25 exhibit [69] Exhibit 34 [1] 24/3 Exhibit 35 [2] 18/22 32/5 Exhibit 36 [1] 48/14 Exhibit 37 [1] 40/2 Exhibit 38 [2] 92/8 94/22 Exhibit 43 [1] 99/24 Exhibit 44 [1] 158/14 exhibits [4] 4/1 4/3 28/16 121/22 exist [1] 90/9 existing [2] 131/13 132/20 exits [1] 153/21	expand [1] 163/20 expanded [3] 157/7 163/6 164/25 expect [1] 150/17 experience [1] 20/2 explain [6] 18/22 23/6 38/16 67/7 94/14 162/11 explanation [19] 12/8 18/19 21/1 22/14 25/12 40/19 40/20 44/11 44/15 48/19 48/24 50/6 59/6 64/24 65/2 67/4 67/5 69/17 71/20
E E-L-A-I-N-E [1] 8/1 each [10] 5/20 6/3 26/7 40/11 54/9 63/19 88/22 108/7 119/18 131/9 earlier [6] 19/2 50/20 62/21 70/15 130/8 154/2 early [3] 145/3 145/5 153/18 easier [5] 50/14 59/2 59/22 104/24 104/24 East [1] 87/10 eight [31] 15/18 15/25 16/10 16/11 23/20 57/23 58/1 58/4 58/8 59/19 60/16 61/1 62/19 64/1 66/10 66/12 73/14 73/15 75/11 75/16 76/1 76/8 76/9 78/13 162/8 162/12 162/18 162/19 162/20 164/1 165/20 EIGHTH [1] 1/1 either [9] 46/3 61/7 91/14 91/17 104/3 104/11 118/22 122/7 126/9 Elaine [2] 8/1 8/16 elderly [1] 50/16 else [10] 98/24 102/8 106/14 126/13 126/23 130/15 141/9 142/22 143/2 166/4 employed [1] 23/12 employees [2] 145/19 145/19 end [14] 6/17 13/23 47/4 65/13 90/13 102/2 103/9 107/21 108/14 110/23 111/6 113/17 145/13 151/12 ended [3] 102/17 109/1 109/3 ending [3] 116/22 144/7 146/5 endoscopic [3] 157/2 160/14 162/7 endoscopies [1] 63/15 endoscopy [51] 13/20 13/21 17/22 19/8 19/16 20/3 20/24 21/23 22/7 24/17 24/22 25/9 26/12 40/14 42/10 42/12 43/7 43/9 44/7 44/22 46/23 49/25 57/14 58/20 64/9 65/23 69/7 78/10 82/6 95/11 100/19 100/20 108/2 131/14 131/18 131/24 132/2 132/13 132/22 133/2 133/7 133/15 133/19 133/19 134/18 135/2 136/17 140/1 140/16 158/10 161/5 enforcement [1] 84/23 enough [12] 11/5 20/12 21/9 23/22 114/9 114/11 114/16 130/22 138/10 144/10 144/13 151/14 enter [1] 89/23 entered [4] 28/24 34/21 152/6		F facilities [6] 88/2 88/8 88/11 134/23 134/25 135/1 facility [7] 17/17 17/18 17/20 33/16 89/25 110/7 160/13 fact [15] 9/15 35/24 41/3 47/12 60/25 61/10 62/1 90/21 103/18 107/4 110/14 117/16 127/6 130/1 158/20 factor [3] 47/15 48/2 90/17 factors [1] 31/6 facts [1] 6/7 Failure [5] 35/12 51/23 79/2 152/19 166/19 fair [5] 11/5 16/18 20/12 21/9 23/22 fairly [1] 88/17 faithfully [1] 5/5 false [5] 7/18 37/2 53/5 81/10 154/18 familiar [2] 41/1 71/17 far [18] 6/21 10/15 50/5 50/19 54/18 56/19 57/13 66/17 68/24 73/18 86/9 90/2 90/16 98/2 105/17 111/15 111/16 121/23 Fargo [1] 129/9 February [1] 151/6 federal [2] 169/12 169/15 fee [1] 50/21 feel [1] 109/6 feet [2] 100/23 100/23 fewer [1] 19/20 Fifteen [1] 79/16 fifth [1] 157/6 figure [4] 20/6 102/23 109/11 116/4 file [16] 94/8 95/1 95/15 95/20 95/20 95/22 95/24 96/4 96/5 97/11 101/8 108/16 121/18 122/16 129/8 129/24 filed [1] 169/4 files [38] 92/2 93/4 94/7 94/11 94/14 94/16 94/24 95/2 95/4 95/5 95/6 95/6 95/7 95/14 95/16 95/17 96/3 96/7 96/14 96/19 96/23 97/2 97/17 97/23 97/23 98/12 98/16 99/13 100/5 100/12 101/4 101/18 107/19 112/10 117/20 121/24 122/10 132/6 filled [2] 108/13 157/10 finally [1] 103/9 financial [8] 83/8 83/9 84/10 127/17 127/20 128/10 142/25 143/10 find [12] 93/22 96/11 97/10 97/14 97/22 100/13 100/15

RA 000468

F find... [5] 122/4 126/8 128/7 146/7 157/13 findings [1] 161/12 fine [12] 14/17 35/14 35/16 51/25 52/2 79/4 79/6 139/19 152/21 152/23 166/21 166/23 finish [2] 23/23 54/6 finished [3] 116/10 118/22 153/17 first [59] five [23] 15/10 15/10 15/16 15/24 16/14 22/24 57/18 57/19 57/20 63/18 72/14 78/14 85/17 136/23 136/24 141/14 142/12 142/19 156/15 156/17 162/15 162/16 162/17 flag [2] 34/6 35/1 flat [2] 46/14 50/21 flip [9] 11/8 18/19 20/18 40/5 48/14 55/5 59/21 62/14 156/11 floor [4] 86/6 91/4 91/5 92/16 flushes [1] 148/18 focus [2] 83/7 163/1 focused [6] 88/11 98/16 98/19 102/10 102/12 143/8 focusing [1] 98/2 folder [2] 129/11 129/24 folders [3] 95/1 95/15 129/8 follow [9] 6/19 29/14 32/2 77/24 114/2 118/3 119/4 119/9 159/25 follow-up [4] 29/14 32/2 77/24 118/3 followed [1] 142/2 following [2] 5/6 24/10 follows [9] 8/19 37/21 53/18 81/24 107/2 110/16 114/21 120/15 155/8 font [2] 50/8 50/12 foot [1] 100/25 foregoing [1] 168/11 Foreman [1] 36/10 Foreperson [7] 2/3 2/4 8/17 37/19 53/16 81/22 155/6 form [78] forms [27] 4/5 4/6 4/7 4/8 4/10 4/11 17/9 20/20 24/5 33/18 33/23 38/23 38/24 38/24 39/1 40/9 40/25 42/24 50/13 54/2 54/3 55/6 61/11 75/5 155/20 155/21 157/15 formula [1] 102/16 formulate [1] 156/2 forth [7] 9/20 13/10 42/5 86/13 92/15 106/6 111/4 forward [2] 54/5 106/14 found [8] 17/8 86/7 86/10 93/25 129/20 131/8 135/16 149/19 four [1] 110/6 fourth [4] 86/5 91/4 91/5 157/3 frame [2] 29/24 82/9 fraud [5] 7/18 37/2 53/5 81/9 154/17 fraudulent [1] 16/19 fraudulently [1] 17/9 front [5] 33/24 89/10 89/12	89/14 130/25 full [5] 27/19 27/24 71/11 94/2 168/12 further [20] 26/23 27/16 29/13 31/8 34/8 34/9 35/4 45/11 51/13 74/8 77/8 78/19 122/21 143/6 143/16 148/2 149/7 151/19 152/11 166/8 G G-O-N-Z-A-L-E-Z [1] 53/13 gain [1] 91/6 Gastroenterology [1] 160/15 gastrointestinal [1] 45/19 gave [1] 146/14 general [5] 6/11 36/6 38/20 138/8 138/9 General's [1] 84/7 generally [7] 11/8 40/6 83/14 96/19 106/1 134/23 163/1 generate [3] 40/16 48/19 99/6 generated [7] 99/9 99/12 103/6 103/6 116/12 117/19 118/9 genetic [5] 106/17 114/1 114/9 114/11 124/16 genetically [3] 114/18 115/1 115/2 gentleman [1] 77/4 gentlemen [12] 5/13 8/4 35/22 37/12 79/18 118/14 145/24 153/7 153/8 153/22 167/6 167/7 get [27] 8/5 9/25 12/23 21/25 39/7 42/21 47/1 57/5 67/13 70/2 83/25 84/17 86/1 86/9 89/1 91/9 99/14 102/8 118/1 131/25 134/4 137/7 139/20 145/7 145/21 147/22 157/15 GI [1] 108/5 give [14] 7/8 7/15 36/17 36/24 52/20 53/2 80/24 81/6 95/25 101/23 147/7 147/14 154/6 154/14 given [7] 80/17 103/19 124/11 125/2 125/12 140/22 147/24 gives [1] 163/18 giving [1] 138/20 glitch [8] 103/5 103/7 103/10 103/13 103/18 105/3 105/8 112/13 go [49] 7/3 21/11 21/17 32/4 32/5 38/3 43/3 44/18 45/11 45/12 48/2 54/5 56/2 56/8 57/11 61/17 67/18 69/16 71/14 72/5 79/14 83/15 85/6 89/6 90/12 97/7 98/3 101/16 101/22 103/12 110/20 111/24 119/17 122/21 123/9 123/13 126/23 127/11 131/17 132/19 133/17 133/24 135/7 139/3 145/8 156/5 160/1 162/23 165/9 God [5] 7/10 36/19 52/22 81/1 154/8 goes [4] 70/14 72/6 76/19 121/23 going [67] gone [3] 20/12 21/10 158/3 Gonzalez [4] 53/12 53/13	53/15 53/23 good [2] 123/11 147/11 got [18] 13/18 39/11 48/25 82/13 84/8 91/10 100/18 106/12 109/14 112/24 118/5 121/22 128/2 134/10 140/10 149/15 151/12 164/18 gotten [2] 123/7 131/25 GRAND [91] grant [1] 169/16 greater [2] 12/14 78/8 green [9] 95/15 95/15 107/23 107/24 107/24 109/23 114/23 114/24 115/12 gross [5] 35/13 51/24 79/3 152/20 166/20 group [2] 50/16 106/1 grouped [2] 97/20 98/6 grouping [3] 96/23 113/4 113/5 groups [1] 20/25 GRUESKIN [7] 4/10 39/13 48/12 49/6 79/22 115/23 124/6 guess [3] 11/10 75/1 145/2 guys [1] 31/15 GWENDOLYN [10] 4/8 8/11 20/14 21/4 32/18 32/21 33/3 79/21 115/13 124/13 H had [159] hadn't [1] 131/25 half [2] 100/23 115/7 hallway [2] 89/13 89/20 hand [20] 7/6 11/7 20/17 28/16 36/15 39/24 44/24 52/18 59/25 69/20 69/21 80/22 89/17 91/16 93/6 101/5 154/4 160/6 160/6 164/25 Handling [1] 14/18 handle [2] 34/15 99/14 handling [1] 152/3 handwritten [2] 101/2 129/11 happen [1] 125/13 happened [6] 80/9 82/12 82/22 109/11 116/5 142/10 happens [1] 38/16 harbor [1] 5/23 hard [3] 10/2 44/13 44/19 has [30] 5/10 6/2 6/5 6/12 6/13 6/15 6/25 18/9 20/17 24/7 24/16 35/8 40/1 51/4 51/19 55/3 63/9 67/8 78/23 80/10 86/11 99/23 108/7 112/5 152/15 156/9 164/8 165/3 165/10 166/15 have [175] haven't [1] 66/22 having [9] 5/5 8/17 33/17 37/19 53/16 81/22 110/4 155/6 164/9 HCVA [26] 11/14 12/24 20/23 21/1 21/7 21/14 24/4 25/18 28/10 34/22 38/24 39/1 42/24 48/18 49/4 55/13 62/20 65/2 67/3 67/20 70/14 77/17 155/21 156/20 157/9 157/25 he [25] 42/3 42/11 49/21 49/25 100/14 107/4 113/23 113/25 116/25 117/4 117/15 118/24 119/16 120/5 120/10 120/18 121/17 121/19 124/15
---	---	--

RA 000469

<p>H</p> <p>he... [6] 124/24 127/11 127/12 130/12 136/23 145/18 he's [4] 49/21 120/9 120/12 164/9 heading [1] 101/23 health [17] 9/1 15/20 27/10 38/2 38/3 38/5 38/6 38/8 38/13 69/24 71/1 72/25 84/22 97/2 98/2 141/13 149/16 hear [1] 122/13 heard [1] 80/10 hearing [1] 122/12 hearsay [2] 118/16 146/1 heart [1] 108/22 held [5] 35/15 52/1 79/5 152/22 166/22 help [9] 7/10 23/25 36/19 52/22 54/7 76/12 78/17 81/1 154/8 hepatitis [7] 110/5 110/7 110/13 113/11 113/12 114/9 114/14 heplock [15] 122/2 122/11 122/11 122/17 124/10 124/11 124/12 124/23 125/2 125/18 125/23 126/12 126/16 126/20 148/8 heplocks [1] 125/12 her [11] 5/7 28/16 40/13 54/8 76/16 76/19 106/13 116/18 121/18 125/2 147/16 here [62] hereby [2] 168/7 169/4 higher [6] 23/15 23/16 61/11 62/2 73/25 104/12 highlight [1] 161/1 highlighted [2] 44/18 160/21 him [7] 40/12 54/25 55/1 107/2 117/4 117/4 125/2 his [8] 23/7 100/13 106/17 116/7 119/15 124/14 126/20 126/20 history [5] 47/17 47/19 156/22 157/7 163/3 HMO [4] 9/6 9/6 9/7 27/9 hoping [1] 147/6 Horizon [5] 9/13 9/14 10/11 33/16 87/8 Horizons [1] 27/7 host [1] 114/15 hours [2] 153/11 153/15 how [63] HPN [2] 38/13 39/14 Hubbard [1] 44/4 huh [5] 76/23 77/2 106/25 165/23 166/7 hundred [8] 22/24 72/14 164/23 165/5 165/7 165/8 165/17 165/17 Hutchin [1] 120/4 HUTCHISON [18] 4/11 39/14 40/2 40/9 41/8 43/1 44/12 48/8 115/22 116/9 116/15 116/16 116/23 120/19 121/15 124/5 124/23 125/18 Hutchison's [3] 117/16 118/22 120/16</p> <p>I</p> <p>I'd [2] 151/21 160/17 I'll [21] 14/17 14/20 21/11</p>	<p>29/1 29/3 32/21 33/2 36/12 44/12 48/25 58/25 59/3 64/14 64/19 77/23 92/9 104/25 112/4 153/13 154/2 158/13 I'm [94] I've [4] 37/14 79/24 83/20 88/4 identified [13] 4/3 97/2 98/4 99/4 106/18 113/12 125/1 125/14 127/23 132/7 133/18 160/13 162/15 identify [4] 11/4 86/15 112/13 164/6 if [132] immediately [1] 120/15 impact [1] 136/9 IMPANELED [1] 1/4 impartiality [1] 5/25 important [2] 47/1 153/15 in [354] In-patient [1] 38/23 inaccurate [1] 17/9 incentive [1] 128/10 include [1] 137/18 included [3] 101/18 131/12 138/14 includes [1] 15/16 including [6] 35/8 51/19 78/23 137/25 152/15 166/15 income [1] 128/5 incorrect [2] 165/24 166/1 increase [1] 19/18 increased [1] 16/19 increment [1] 15/10 increments [1] 57/21 INDEX [2] 3/1 4/1 indexed [1] 143/4 indicate [1] 113/10 indicated [3] 42/14 157/6 168/9 indicates [1] 61/11 indicating [1] 44/19 indication [5] 29/10 115/24 117/15 118/21 127/1 indications [1] 161/14 Indictment [3] 5/12 8/7 8/14 individual [6] 10/12 33/21 34/20 118/18 127/10 159/5 individuals [2] 10/14 153/25 infected [13] 98/20 107/1 109/22 114/3 114/24 114/25 115/8 115/10 117/7 149/18 149/20 149/21 149/25 infection [6] 114/10 117/11 121/25 128/11 139/8 150/1 infections [3] 119/3 130/4 135/4 information [71] initialed [1] 124/10 initially [3] 12/16 85/3 97/14 injecting [2] 139/12 141/8 injection [8] 139/15 141/7 148/16 148/17 148/22 151/23 151/23 152/8 injections [14] 139/9 139/11 139/16 139/21 140/3 140/4 140/6 140/7 140/9 140/12 140/22 146/19 147/21 150/9 inputted [2] 157/19 157/25 inserted [2] 122/11 124/11 inside [1] 89/20</p>	<p>instance [5] 61/4 63/21 68/5 70/8 112/24 instances [1] 10/10 instead [6] 16/9 16/11 43/13 64/1 64/2 76/1 INSTRUCTIONS [1] 4/4 insurance [29] 7/18 9/4 9/7 12/23 15/20 23/13 27/10 27/12 27/18 27/23 28/1 28/2 28/3 28/8 30/22 31/22 37/2 38/6 39/7 53/5 54/17 56/21 67/8 67/9 69/22 69/23 81/9 95/25 154/17 insurer [4] 67/14 73/21 73/23 74/3 insurers [1] 31/19 insures [1] 39/7 integrity [2] 84/20 85/1 intelligence [1] 84/21 Intent [1] 5/11 interest [2] 94/11 96/24 interesting [1] 120/25 interim [1] 80/7 intermix [1] 96/16 intermixed [2] 96/17 96/18 internet [1] 134/10 interpret [1] 58/5 interpreted [2] 66/10 66/18 interviewed [1] 145/18 interviews [4] 83/15 124/25 143/4 150/10 intestinal [2] 44/22 162/7 into [28] 6/5 33/16 34/22 47/15 48/2 59/7 61/13 61/13 78/13 84/17 86/1 86/9 89/14 89/25 90/12 90/17 91/9 91/11 102/8 118/1 122/14 124/11 125/15 134/6 135/19 144/6 144/12 155/18 inventory [16] 86/3 86/4 131/13 132/21 144/7 144/8 144/9 144/11 144/13 145/9 145/10 145/12 146/4 150/16 150/19 150/22 investigate [2] 35/2 62/3 investigating [1] 83/6 investigation [17] 7/8 7/15 36/17 36/24 52/20 53/2 80/24 81/6 82/5 82/25 102/10 106/10 106/13 123/7 143/23 154/6 154/14 investigator [2] 82/10 84/10 involved [12] 47/8 73/21 73/24 82/6 82/13 82/25 84/14 84/18 99/18 107/9 117/16 130/4 involvement [1] 90/2 involving [6] 7/19 10/10 37/3 53/6 81/10 154/18 is [487] ish [1] 109/20 isn't [1] 135/21 issue [4] 5/21 6/3 122/3 126/5 issued [1] 147/7 issues [1] 6/21 it [310] it's [66] item [2] 29/18 100/3 items [4] 28/13 98/9 98/11 142/22 its [3] 6/2 108/7 129/10</p>
--	--	---

RA 000470

I	L	Lickman [1] 58/15 Life [1] 38/6 like [42] 7/1 13/6 14/23 15/16 24/9 33/20 38/13 43/21 52/8 54/3 54/13 63/25 70/24 83/10 83/18 83/19 85/2 86/12 90/9 90/22 96/20 98/25 99/7 100/23 100/24 110/17 111/13 120/6 120/8 127/7 128/23 143/1 145/4 147/5 147/6 149/2 151/1 151/21 153/16 157/15 160/17 163/1 Linda [2] 44/4 121/1 line [19] 43/3 49/9 56/3 59/8 59/9 59/9 63/3 63/6 68/2 72/5 72/6 106/21 109/17 109/18 111/4 112/24 125/3 145/22 163/19 lines [6] 47/6 48/1 109/25 114/23 114/24 133/11 link [1] 114/19 lion's [1] 128/24 LISA [3] 2/6 144/2 148/4 list [2] 118/10 149/16 listed [28] 29/24 33/7 42/1 56/9 56/17 68/15 70/12 72/20 77/21 90/4 92/23 100/9 100/11 100/14 101/2 104/7 104/8 106/21 108/6 115/18 118/12 121/2 127/25 129/2 129/10 139/17 139/17 163/10 listen [1] 80/14 listening [1] 6/7 litigation [1] 117/25 little [17] 14/21 35/23 44/13 48/22 50/5 56/2 59/2 59/3 59/22 64/21 82/5 83/25 89/2 104/24 118/6 122/14 153/13 living [4] 8/25 37/25 53/23 155/13 LLC [1] 17/23 locate [1] 96/23 located [5] 42/13 92/16 95/17 97/11 97/17 location [10] 58/18 85/10 85/25 86/8 87/16 88/21 89/12 92/4 96/18 97/5 locations [10] 58/11 85/8 85/9 86/10 86/15 88/15 94/10 96/12 97/19 98/7 log [7] 107/19 108/13 110/2 110/4 110/11 131/14 131/18 logs [15] 100/19 100/20 104/13 108/12 113/13 133/19 133/25 134/2 135/8 135/8 135/14 135/15 139/9 139/18 141/23 long [6] 29/8 61/20 82/15 99/18 109/1 114/17 longer [3] 80/11 82/18 83/3 look [34] 33/19 34/1 39/8 50/5 54/12 66/21 66/23 76/7 77/11 83/10 83/12 83/14 90/9 91/7 91/13 91/22 93/23 96/20 99/21 100/2 103/24 104/22 107/15 111/13 120/6 122/7 126/5 132/4 134/19 145/9 146/5 149/4 150/23 156/14 looked [25] 20/9 23/1 47/17 66/22 73/20 75/5 86/6 91/24 99/12 111/21 116/6 120/8 129/23 130/19 134/5 134/10
itself [5] 11/9 47/21 63/16 96/5 131/19 J J-O-A-N-N-E [1] 155/2 January [5] 82/23 84/13 150/17 151/1 151/5 January 1st [1] 150/17 Jeff [6] 124/22 125/1 125/8 125/13 125/21 125/22 Joanna [2] 155/1 155/5 job [2] 54/1 83/4 JOSEPH [1] 2/4 judgment [1] 5/24 JUDICIAL [1] 1/1 July [9] 98/5 98/18 100/7 126/6 136/2 136/18 137/1 140/5 149/11 July 25 [1] 100/7 July 25th [6] 98/5 98/18 136/2 136/18 137/1 140/5 Juror [4] 6/4 52/15 150/15 153/21 Juror's [1] 77/15 JURORS [5] 2/1 35/25 79/22 79/24 80/6 jury [85] just [80] Justice [1] 84/5	Labus [1] 84/22 ladies [12] 5/13 8/4 35/22 37/12 79/18 118/14 145/23 153/6 153/8 153/22 167/5 167/7 laid [1] 88/22 Lake [2] 85/16 87/10 LAKEMAN [21] 1/10 5/16 7/20 22/9 37/4 42/10 49/24 53/7 58/16 69/5 76/24 77/6 81/11 112/20 116/15 119/13 120/2 136/22 153/24 154/19 159/7 Lakeman's [1] 161/15 Lakota [1] 124/23 Lane [21] 17/25 42/17 50/2 58/21 64/11 69/8 85/10 85/10 85/16 85/19 85/21 86/17 86/19 87/15 87/19 88/6 88/12 92/12 131/16 134/20 161/6 large [7] 24/14 93/17 131/1 150/16 150/19 150/22 150/24 larger [4] 50/8 61/13 134/15 151/9 Las [11] 1/15 5/1 18/2 42/18 42/19 50/2 58/21 69/9 69/10 82/11 168/14 last [28] 5/22 7/24 37/8 37/10 45/3 53/11 58/25 64/18 66/21 71/14 72/19 79/20 80/7 81/16 81/18 82/17 87/11 87/12 87/14 87/15 87/18 92/7 94/22 120/23 150/14 154/24 155/2 162/23 lasted [2] 99/18 144/20 late [1] 135/4 later [6] 47/16 69/14 89/2 90/17 113/24 167/14 law [12] 6/15 6/17 6/18 6/22 35/6 51/17 78/21 80/17 84/22 152/13 166/13 169/12 Lawson [1] 104/8 lay [3] 112/1 112/4 121/21 lead [1] 86/2 learned [1] 61/25 least [19] 48/2 80/1 88/7 107/13 116/25 117/5 117/13 118/21 119/3 119/11 119/14 125/17 126/1 134/8 138/20 142/9 148/7 152/2 167/10 leave [1] 119/6 Leaves [1] 2/8 led [1] 117/22 left [14] 19/7 59/25 69/21 91/15 93/10 93/11 101/9 101/11 101/12 124/3 144/11 151/3 160/5 160/6 less [7] 19/23 61/6 66/1 66/1 66/14 73/10 73/11 lesser [2] 17/1 60/22 let [15] 5/9 9/18 15/21 23/23 32/5 54/6 75/3 94/13 104/23 104/25 123/14 131/3 132/25 139/22 153/14 let's [26] 10/10 11/13 14/25 16/3 26/10 60/15 66/21 67/18 71/14 83/25 84/17 85/6 85/18 97/4 97/7 106/14 115/15 121/20 126/4 136/12 137/11 150/16 160/25 162/23 163/22 164/11	Lickman [1] 58/15 Life [1] 38/6 like [42] 7/1 13/6 14/23 15/16 24/9 33/20 38/13 43/21 52/8 54/3 54/13 63/25 70/24 83/10 83/18 83/19 85/2 86/12 90/9 90/22 96/20 98/25 99/7 100/23 100/24 110/17 111/13 120/6 120/8 127/7 128/23 143/1 145/4 147/5 147/6 149/2 151/1 151/21 153/16 157/15 160/17 163/1 Linda [2] 44/4 121/1 line [19] 43/3 49/9 56/3 59/8 59/9 59/9 63/3 63/6 68/2 72/5 72/6 106/21 109/17 109/18 111/4 112/24 125/3 145/22 163/19 lines [6] 47/6 48/1 109/25 114/23 114/24 133/11 link [1] 114/19 lion's [1] 128/24 LISA [3] 2/6 144/2 148/4 list [2] 118/10 149/16 listed [28] 29/24 33/7 42/1 56/9 56/17 68/15 70/12 72/20 77/21 90/4 92/23 100/9 100/11 100/14 101/2 104/7 104/8 106/21 108/6 115/18 118/12 121/2 127/25 129/2 129/10 139/17 139/17 163/10 listen [1] 80/14 listening [1] 6/7 litigation [1] 117/25 little [17] 14/21 35/23 44/13 48/22 50/5 56/2 59/2 59/3 59/22 64/21 82/5 83/25 89/2 104/24 118/6 122/14 153/13 living [4] 8/25 37/25 53/23 155/13 LLC [1] 17/23 locate [1] 96/23 located [5] 42/13 92/16 95/17 97/11 97/17 location [10] 58/18 85/10 85/25 86/8 87/16 88/21 89/12 92/4 96/18 97/5 locations [10] 58/11 85/8 85/9 86/10 86/15 88/15 94/10 96/12 97/19 98/7 log [7] 107/19 108/13 110/2 110/4 110/11 131/14 131/18 logs [15] 100/19 100/20 104/13 108/12 113/13 133/19 133/25 134/2 135/8 135/8 135/14 135/15 139/9 139/18 141/23 long [6] 29/8 61/20 82/15 99/18 109/1 114/17 longer [3] 80/11 82/18 83/3 look [34] 33/19 34/1 39/8 50/5 54/12 66/21 66/23 76/7 77/11 83/10 83/12 83/14 90/9 91/7 91/13 91/22 93/23 96/20 99/21 100/2 103/24 104/22 107/15 111/13 120/6 122/7 126/5 132/4 134/19 145/9 146/5 149/4 150/23 156/14 looked [25] 20/9 23/1 47/17 66/22 73/20 75/5 86/6 91/24 99/12 111/21 116/6 120/8 129/23 130/19 134/5 134/10

RA 000471

L looked... [9] 135/19 138/4 138/9 139/4 141/11 144/10 145/13 148/21 158/3 looking [29] 12/21 15/22 21/14 28/18 28/19 32/4 32/6 34/2 41/15 58/9 59/4 64/22 66/4 67/19 89/3 91/2 92/10 99/3 100/8 102/13 109/7 112/6 123/18 128/12 149/19 158/14 162/2 162/25 163/23 looks [9] 13/6 24/9 48/22 63/25 70/24 86/12 100/22 110/17 128/23 loose [1] 145/1 losing [1] 75/1 lot [2] 33/15 162/24 lots [1] 92/24 lower [14] 13/21 24/19 26/12 43/20 43/22 43/24 44/2 44/23 48/3 76/3 91/15 93/6 93/11 162/6 lunch [2] 119/19 120/6 Lynette [3] 122/16 122/20 124/9 LYONAI [1] 2/7	124/13 Martin's [1] 24/7 match [7] 90/10 109/13 114/12 121/8 121/11 146/16 158/8 matched [3] 115/1 115/2 158/4 matches [1] 124/16 material [2] 114/9 114/11 math [1] 147/5 MATHAHS [24] 1/10 5/17 7/20 18/13 25/6 37/4 53/7 77/3 81/12 112/19 116/14 116/18 116/19 117/12 118/23 119/14 119/25 120/2 120/3 121/15 137/14 137/15 153/24 154/20 Mathias [1] 64/8 Mathias [1] 64/8 matter [5] 46/17 106/12 118/16 119/21 168/8 matters [1] 46/19 may [16] 7/12 28/11 34/25 35/15 36/21 52/1 52/24 79/5 79/10 148/17 152/22 153/2 154/10 166/22 167/2 168/15 maybe [1] 104/23 McGreevy [1] 121/1 me [29] 9/18 11/9 15/21 20/19 23/2 23/23 32/5 40/6 40/6 48/15 54/6 55/6 62/14 66/24 75/1 75/3 94/14 101/12 104/23 118/6 120/8 123/13 123/14 132/25 134/3 139/22 147/6 147/7 156/11 Mead [2] 85/17 87/10 mean [17] 9/23 20/3 23/10 34/16 42/4 90/20 107/13 110/9 110/19 122/13 125/9 125/10 127/21 139/11 144/13 161/19 164/19 MEANA [9] 4/9 8/11 10/12 13/2 15/22 28/19 32/12 115/13 124/13 Meana's [4] 18/23 23/1 23/2 23/7 meaning [3] 16/20 34/21 78/8 meant [5] 31/16 31/21 39/23 122/4 141/25 measuring [1] 100/22 Medicaid [1] 50/11 medical [12] 28/9 61/21 93/1 93/3 94/21 103/5 130/18 138/13 139/7 143/10 151/24 155/17 Medicare [6] 27/5 27/8 27/8 27/9 27/11 50/11 medication [2] 161/12 161/20 medicine [2] 102/1 107/20 member [12] 23/9 23/11 23/12 23/12 39/10 50/24 51/3 51/4 55/17 55/19 61/19 67/8 member's [1] 67/11 members [5] 27/11 39/16 48/23 50/15 54/18 membership [1] 50/9 mention [1] 106/10 mentioned [10] 30/6 62/21 69/21 77/1 85/18 90/25 98/23 128/19 131/9 159/14 mentioning [1] 101/22 mentions [1] 49/6 net [1] 6/2 methodologies [1] 31/23	Metro [9] 82/18 83/4 83/4 84/9 84/9 84/12 84/21 85/3 123/3 Metropolitan [1] 82/11 MICHAEL [14] 2/13 2/19 106/17 107/1 109/18 109/22 110/16 126/14 156/25 157/2 158/24 160/6 161/7 163/4 microphone [2] 52/25 122/15 mid [1] 151/8 middle [1] 163/10 might [5] 34/16 47/15 77/5 92/3 132/11 Mike [1] 34/13 milliliter [11] 134/13 134/14 134/14 134/21 134/22 135/14 135/16 136/6 136/8 138/16 138/16 mind [2] 6/6 125/15 minor [1] 128/7 minute [17] 14/23 14/25 30/14 43/25 44/1 45/8 52/8 52/9 52/13 60/14 60/23 61/7 61/7 65/25 93/22 104/2 139/22 minutes [91] misdeemeanor [5] 35/13 51/24 79/3 152/20 166/20 miss [15] 23/1 23/1 24/7 27/2 37/25 48/8 53/23 82/4 125/4 125/19 125/25 126/1 126/9 132/11 155/13 miss a [1] 132/11 Miss Aspinwall [1] 126/1 Miss Campbell [4] 125/4 125/19 125/25 126/9 Miss Martin's [1] 24/7 Miss Meana's [1] 23/1 Miss Myers [1] 27/2 Miss Sampson [1] 82/4 Miss Sams [1] 155/13 Miss Spaeth [1] 37/25 missed [1] 80/3 missing [2] 35/25 100/12 mistake [3] 75/22 76/6 76/14 ml [3] 137/25 150/8 150/8 modifier [1] 163/6 modifiers [5] 157/5 159/20 162/7 164/3 164/3 moment [5] 12/19 25/19 60/12 69/12 163/22 momentarily [1] 55/9 money [15] 7/18 12/10 16/22 17/1 19/7 19/23 37/2 53/5 62/5 66/2 81/9 83/17 127/18 128/24 154/17 monitor [3] 108/21 108/22 108/22 monitored [1] 164/6 month [1] 151/8 months [2] 151/6 151/10 more [17] 9/18 16/20 16/21 19/19 62/5 76/7 84/1 95/14 112/16 129/21 141/13 141/22 142/2 143/23 147/6 163/18 167/10 morning [3] 36/1 116/8 153/17 most [1] 94/25 move [23] 13/5 13/23 20/14 24/3 24/9 24/24 25/11 41/9 41/22 49/17 56/16 63/22 64/4 64/18 68/10 72/15 72/19 106/14 121/20 137/11 160/17
--	---	--

M

move... [2] 160/25 164/24
 moved [3] 111/20 112/11
 120/9
 movement [2] 116/1 119/3
 moves [4] 116/25 117/12
 118/23 121/15
 moving [9] 42/8 44/10 50/4
 63/3 67/19 68/2 70/21 101/9
 101/11
 Mr [1] 127/7
 Mr. [12] 18/23 22/9 23/7
 48/8 55/19 114/21 117/12
 118/23 119/14 121/15 126/9
 127/7
 Mr. Hutchison [1] 48/8
 Mr. Krueger [1] 126/9
 Mr. Lakeman [1] 22/9
 Mr. Mathahs [4] 117/12 118/23
 119/14 121/15
 Mr. Meana's [2] 18/23 23/7
 Mr. Rubino [1] 114/21
 Mr. Washington [1] 127/7
 Mr. Ziyad [1] 55/19
 much [27] 12/10 14/2 19/10
 22/17 22/23 23/15 23/16
 23/18 41/23 46/12 47/16
 56/20 65/1 65/8 65/11 68/25
 74/2 103/21 106/4 111/9
 128/4 144/16 145/20 145/21
 151/3 164/22 167/4
 multiple [1] 34/18
 multiplied [2] 15/19 23/20
 must [1] 36/3
 mutates [1] 114/15
 my [16] 23/23 54/6 81/17
 81/18 83/7 84/23 101/15
 107/25 114/14 120/23 125/15
 128/15 136/20 140/19 146/25
 168/10
 Myers [3] 8/1 8/16 27/2
 myself [1] 120/24

N

N-A-N-C-Y [1] 81/18
 name [32] 10/12 11/14 13/1
 18/7 18/12 18/14 18/23 21/12
 24/7 25/21 37/9 37/10 40/2
 41/7 48/11 67/23 70/12 71/22
 72/1 77/5 81/17 81/18 101/2
 106/17 124/14 129/12 129/13
 155/1 155/2 160/7 161/15
 169/21
 named [1] 104/7
 names [8] 7/24 37/8 38/4
 53/11 81/16 100/18 121/7
 154/24
 Nancy [2] 81/17 81/21
 necessarily [2] 34/15 98/10
 need [9] 28/11 48/11 79/23
 119/6 119/8 123/13 131/2
 144/15 148/13
 needed [2] 148/7 151/15
 needs [1] 28/17
 neglect [5] 7/17 37/1 53/4
 81/9 154/17
 negotiate [1] 48/1
 negotiations [1] 47/9
 network [1] 53/25
 NEVADA [20] 1/2 1/7 1/15 5/1
 5/15 17/22 22/7 38/6 42/12
 44/8 50/1 58/20 64/9 69/7

82/6 158/11 160/14 161/6
 168/3 168/14
 never [2] 34/25 111/12
 new [4] 5/23 139/14 152/7
 152/9
 next [32] 14/10 18/6 20/14
 34/4 35/24 36/13 45/12 52/11
 57/1 58/23 58/24 59/9 61/13
 62/11 69/11 86/18 86/19
 86/23 87/3 87/5 87/7 87/9
 94/1 106/13 108/1 116/16
 121/22 127/15 127/16 129/1
 160/25 161/22
 Nguyen [1] 124/14
 nine [3] 16/7 84/8 91/2
 no [48] 1/9 1/25 5/10 6/9
 6/10 6/12 6/18 6/23 7/2 27/7
 27/21 29/9 31/7 38/20 44/17
 47/10 51/3 66/17 71/1 71/13
 73/5 80/10 80/13 82/18 83/3
 86/1 87/23 105/16 111/12
 111/14 111/19 112/19 120/11
 120/20 126/11 126/24 127/5
 130/1 132/20 143/8 144/9
 145/17 146/4 149/5 149/12
 150/22 151/4 157/14
 none [8] 31/9 35/5 51/16
 77/8 78/20 137/15 151/20
 166/12
 noon [2] 120/1 120/1
 normally [4] 33/21 147/22
 150/18 157/15
 North [1] 86/24
 not [74]
 note [11] 17/12 43/13 57/1
 89/8 104/1 104/2 109/16
 110/2 115/6 121/7 160/5
 Notebook [1] 123/4
 noted [4] 101/20 108/13
 111/6 122/10
 notes [3] 96/3 120/24 168/10
 nothing [17] 7/10 8/19 26/23
 34/8 36/19 37/21 51/13 52/22
 53/18 74/8 81/1 81/24 103/2
 143/16 154/8 155/8 166/8
 notice [8] 5/11 22/25 24/13
 50/19 90/2 93/6 120/25 158/9
 noticed [3] 66/4 118/11
 150/24
 notified [1] 141/12
 November [1] 82/17
 now [97]
 NRS [2] 169/2 169/13
 number [86]
 number 2 [1] 13/1
 Number 31 [1] 77/16
 Number 32 [1] 66/6
 Number 33 [2] 66/23 67/20
 Number 34 [3] 21/10 29/20
 32/19
 Number 37 [1] 41/4
 Number 38 [1] 89/1
 number 4 [3] 163/10 163/11
 163/23
 Number 41 [1] 131/2
 Number 42 [1] 112/6
 number 5211 [1] 136/17
 number 5215 [1] 140/2
 numbers [8] 19/14 42/4 129/2
 133/21 138/14 146/14 146/15
 147/6
 nurse [14] 40/11 105/25

107/5 108/4 108/13 108/20
 119/11 121/2 122/11 122/17
 124/10 125/22 129/25 130/2
 nurse's [1] 109/9
 nurses [3] 94/8 95/6 134/2

O

o'clock [1] 116/8
 obtained [5] 35/11 51/22 79/1
 152/18 166/18
 obtaining [5] 7/18 37/2 53/5
 81/9 154/17
 obviously [3] 73/19 96/11
 118/20
 occurred [2] 5/22 21/21
 occurring [5] 35/10 51/21
 78/25 152/17 166/17
 occurs [1] 44/25
 off [28] 10/11 11/13 39/25
 54/24 57/14 79/14 84/24
 101/1 102/1 108/20 110/22
 113/12 115/11 116/13 117/20
 118/10 118/13 121/3 122/10
 124/11 124/24 125/7 125/13
 139/9 145/5 155/23 156/3
 160/2
 offenes [5] 7/16 36/25 53/3
 81/7 154/15
 offered [3] 106/11 118/15
 119/20
 office [19] 9/24 14/7 82/17
 84/7 86/1 91/14 91/14 91/17
 93/8 93/12 94/6 94/6 94/6
 94/7 96/25 97/1 97/18 99/1
 160/16
 officer [1] 84/6
 officers [1] 85/24
 offices [15] 86/6 86/20 86/21
 87/16 89/14 91/3 91/8 91/10
 91/10 92/11 92/12 93/4 93/25
 94/20 95/5
 Official [1] 169/23
 Oh [2] 84/16 123/11
 okay [95]
 older [1] 94/3
 on [316]
 once [7] 14/20 29/4 49/20
 85/24 86/2 116/5 139/6
 one [150]
 ones [15] 20/9 20/10 70/1
 75/19 88/5 98/19 110/3 111/3
 115/1 115/11 115/15 117/19
 131/25 137/25 138/4
 only [17] 26/20 27/23 28/11
 28/12 47/24 51/11 62/1
 105/17 112/21 120/12 130/2
 136/22 148/21 149/10 149/11
 150/7 150/8
 ooOoo [1] 167/15
 op [3] 90/6 90/13 127/12
 opened [1] 135/4
 operating [1] 152/2
 operations [1] 9/1
 operative [6] 157/1 158/5
 158/10 158/16 159/14 161/3
 opposite [1] 93/10
 or [171]
 orange [3] 109/20 110/1
 113/11
 orange-ish [1] 109/20
 order [9] 95/16 109/10
 109/11 139/20 143/24 144/10

<p>O</p> <p>order... [3] 144/15 150/24 151/2</p> <p>ordered [30] 130/22 133/20 134/21 138/10 138/15 138/19 139/1 140/18 140/24 141/3 141/13 141/14 141/20 141/21 141/21 142/3 142/4 142/4 142/6 142/7 142/12 142/13 142/17 142/19 143/23 143/25 144/13 144/18 151/9 151/13</p> <p>ordering [6] 141/12 142/1 150/18 150/23 150/25 151/5</p> <p>orders [1] 142/11</p> <p>Orellana [2] 115/13 124/13</p> <p>organization [1] 39/6</p> <p>oriented [1] 90/21</p> <p>originally [1] 10/7</p> <p>originals [1] 101/1</p> <p>originates [1] 117/7</p> <p>other [48] 12/3 27/9 28/9 28/13 30/6 30/22 38/4 40/15 54/9 59/1 69/13 72/16 77/4 80/6 83/12 84/15 88/8 88/11 88/22 89/13 90/15 90/15 96/18 97/16 97/18 102/19 105/4 109/25 111/16 111/16 113/24 115/19 116/2 116/9 117/22 118/2 119/18 120/3 120/21 124/5 128/18 132/3 137/19 138/7 138/8 145/19 148/25 161/13</p> <p>others [3] 60/11 78/9 85/12</p> <p>otherwise [1] 36/10</p> <p>our [14] 19/15 29/9 30/20 39/16 48/23 64/24 67/4 74/16 98/17 99/1 99/4 124/15 130/4 135/4</p> <p>out [57]</p> <p>outside [1] 89/19</p> <p>over [26] 18/7 34/4 44/18 47/13 47/14 52/25 54/9 63/22 68/10 68/18 71/5 72/15 84/15 89/6 116/8 116/25 120/10 120/10 120/12 143/20 144/11 144/25 151/3 153/9 153/13 164/24</p> <p>overlap [4] 31/6 33/20 34/25 127/1</p> <p>overview [1] 157/7</p> <p>owe [2] 40/22 40/23</p> <p>own [1] 108/7</p>	<p>particular [60]</p> <p>partner [1] 144/21</p> <p>partners [5] 9/2 144/25 145/3 145/5 145/16</p> <p>partnership [2] 144/22 145/1</p> <p>party [1] 9/2</p> <p>past [1] 79/24</p> <p>patient [91]</p> <p>patient's [6] 25/21 67/23 70/12 71/22 72/1 133/10</p> <p>patients [88]</p> <p>Patricia [2] 53/12 53/15</p> <p>pattern [2] 102/5 102/13</p> <p>PATTY [8] 4/7 54/18 66/22 67/24 115/22 124/5 125/1 125/8</p> <p>pay [35] 9/3 9/6 9/21 10/6 10/6 15/5 16/21 16/21 17/4 17/10 19/23 23/18 27/19 31/16 39/3 39/5 39/9 45/22 47/16 60/22 61/4 61/17 61/18 62/5 65/11 67/10 67/11 67/15 70/6 71/6 71/9 71/11 72/25 76/3 76/7</p> <p>payer [3] 67/4 67/7 67/11</p> <p>paying [2] 61/1 156/6</p> <p>payment [28] 10/16 11/25 12/4 19/1 23/19 25/16 26/7 31/23 40/17 44/15 46/2 46/20 48/20 50/19 50/25 54/2 55/16 59/6 60/13 64/24 65/2 67/4 67/5 71/20 72/20 72/21 156/22 165/22</p> <p>payments [4] 128/2 129/25 130/1 130/2</p> <p>pays [2] 10/4 72/25</p> <p>peace [1] 84/6</p> <p>pending [5] 7/8 36/17 52/20 80/24 154/6</p> <p>people [11] 31/18 34/20 34/23 108/9 113/11 114/18 118/2 123/24 124/4 126/15 127/3</p> <p>per [17] 15/19 19/17 19/17 23/10 23/11 23/13 130/22 142/6 142/8 142/15 142/17 142/19 147/8 147/10 151/17 151/23 151/23</p> <p>percentage [1] 146/16</p> <p>performance [5] 7/16 36/25 53/3 81/7 154/15</p> <p>prepared [12] 18/17 42/11 49/25 58/14 89/5 107/6 157/2 158/25 159/5 159/9 160/24 164/8</p> <p>performing [1] 40/12</p> <p>perhaps [2] 148/6 148/6</p> <p>period [10] 10/19 19/17 34/19 47/14 47/14 78/15 98/21 117/13 142/12 144/17</p> <p>person [24] 10/24 22/10 26/10 34/16 34/21 50/17 76/18 114/15 115/8 118/8 118/12 118/12 119/11 122/11 124/10 125/2 125/12 127/1 127/4 130/22 147/5 147/8 169/8 169/11</p> <p>personnel [1] 116/1</p> <p>persons [9] 7/17 37/1 53/4 81/8 110/12 114/20 124/2 127/2 154/16</p> <p>perspective [1] 101/15</p> <p>pertain [5] 8/9 19/1 37/14</p>	<p>55/1 87/18</p> <p>pertaining [12] 6/16 7/15 10/21 36/24 53/2 78/10 81/7 88/14 107/12 154/15 158/22 159/15</p> <p>physical [1] 145/12</p> <p>physician [3] 38/24 108/17 161/11</p> <p>pick [1] 149/12</p> <p>picture [1] 92/18</p> <p>place [11] 17/20 17/21 29/22 30/1 58/19 84/19 85/7 108/17 150/19 150/23 168/9</p> <p>placed [3] 17/9 33/18 46/18</p> <p>Plaintiff [1] 1/8</p> <p>plan [2] 15/17 38/6</p> <p>player [2] 128/7 128/9</p> <p>players [2] 108/10 128/8</p> <p>please [11] 7/5 7/24 36/14 37/7 52/17 53/10 80/21 81/3 81/15 154/3 154/23</p> <p>plus [2] 15/24 75/20</p> <p>point [12] 21/25 58/6 73/7 76/17 97/12 97/13 102/7 105/11 119/15 161/13 163/2 167/12</p> <p>police [2] 82/12 98/10</p> <p>portion [17] 13/25 14/12 18/20 27/6 36/4 57/5 59/8 65/13 71/5 79/25 80/2 89/8 89/17 104/19 104/21 124/2 127/16</p> <p>portions [1] 161/2</p> <p>position [7] 83/6 84/8 84/8 84/9 84/10 84/12 84/12</p> <p>positive [3] 110/7 110/13 114/5</p> <p>possible [2] 52/11 111/13</p> <p>possibly [4] 122/1 126/1 126/5 139/14</p> <p>post [2] 96/25 97/1</p> <p>potential [2] 5/21 98/20</p> <p>practice [3] 149/1 151/24 152/4</p> <p>pre [3] 90/6 90/13 127/12</p> <p>pre-op [3] 90/6 90/13 127/12</p> <p>preceding [2] 59/21 169/4</p> <p>predicate [1] 9/19</p> <p>preliminary [1] 15/17</p> <p>prepare [1] 83/16</p> <p>prepared [2] 123/3 135/15</p> <p>preparing [2] 84/25 123/5</p> <p>presence [5] 35/10 51/21 78/25 152/17 166/17</p> <p>present [11] 2/1 2/19 6/5 29/19 36/5 79/25 83/18 85/19 145/18 153/10 153/11</p> <p>presentation [5] 36/5 80/1 80/8 80/8 167/10</p> <p>presentations [2] 5/19 6/13</p> <p>presented [8] 6/8 6/17 35/9 51/20 78/24 80/15 152/16 166/16</p> <p>pretenses [5] 7/18 37/2 53/5 81/10 154/18</p> <p>pretty [2] 103/21 106/4</p> <p>prevent [1] 6/6</p> <p>previous [6] 5/18 6/13 65/2 73/20 75/19 162/5</p> <p>previously [2] 55/3 86/11</p> <p>primarily [4] 88/11 96/14 105/22 135/2</p>
<p>P</p> <p>P-A-T-R-I-C-I-A [1] 53/13</p> <p>p.m [1] 2/8</p> <p>P3 [2] 163/5 164/3</p> <p>Pacific [9] 9/3 9/4 9/6 9/11 9/15 9/16 27/7 30/18 33/15</p> <p>packaging [1] 86/5</p> <p>packets [1] 39/24</p> <p>page [82]</p> <p>pages [8] 40/9 40/15 48/14 58/24 87/18 156/14 156/15 157/17</p> <p>paid [66]</p> <p>PAM [1] 2/3</p> <p>PARKER [4] 2/8 2/9 52/15 153/21</p> <p>Parkway [1] 87/8</p> <p>part [6] 70/2 83/12 85/23 88/8 94/25 121/21</p>		<p>RA 000474</p>

P	pull [1] 48/11 pulled [1] 130/3 punishable [10] 35/13 35/15 51/24 52/1 79/3 79/5 152/20 152/22 166/20 166/22 purchase [1] 134/8 purchased [1] 38/7 purpose [1] 128/6 purposes [2] 56/22 155/19 Pursuant [1] 169/2 put [21] 10/3 14/18 46/24 47/13 52/11 61/10 68/21 76/1 76/2 76/8 78/1 79/19 86/4 99/20 99/22 102/15 103/12 104/23 108/17 126/20 149/18 puts [1] 75/22 putting [1] 76/14	33/14 39/21 60/13 60/14 102/9 103/4 127/18 128/5 128/17 128/20 128/22 130/5 130/5 130/6 140/5 140/12 recently [1] 38/7 reception [2] 96/10 97/11 Recess [2] 79/17 153/20 reckless [5] 7/16 36/25 53/3 81/8 154/16 reclassified [1] 84/11 recognizable [1] 66/24 recognize [9] 11/9 20/19 40/6 40/8 48/15 55/6 62/15 156/1 156/13 reconvene [1] 167/13 record [25] 5/9 7/25 28/20 36/10 37/8 53/11 79/15 79/20 81/16 100/22 101/18 101/19 106/2 110/10 111/1 119/12 123/21 124/1 124/8 131/19 136/16 139/25 154/25 158/14 168/12 recorded [1] 120/12 records [48] 28/9 28/10 61/21 83/10 83/17 86/7 90/14 91/6 91/7 91/12 91/22 91/24 93/18 93/23 93/25 94/2 94/4 94/5 94/9 94/24 96/8 98/25 99/3 99/3 101/25 105/22 110/22 116/11 116/17 116/25 117/18 117/19 117/21 119/15 119/24 125/7 125/15 126/11 128/3 128/16 129/7 132/3 132/9 132/13 132/16 143/13 146/8 150/23 recover [2] 98/9 98/10 recovered [1] 98/12 recovery [1] 98/25 red [2] 34/6 35/1 refer [6] 8/6 25/18 28/17 43/16 119/8 131/2 referred [2] 8/12 124/1 referring [17] 11/2 11/3 11/5 12/6 28/21 29/3 95/10 97/7 101/5 101/24 122/22 123/21 124/17 136/16 139/25 140/16 146/13 refers [1] 163/10 reflect [1] 5/9 reflected [1] 119/23 regard [1] 46/20 regarding [11] 4/5 4/6 4/7 4/8 4/10 6/15 6/22 9/19 10/19 82/5 141/9 regardless [2] 46/15 46/23 registered [1] 40/11 registers [2] 131/15 132/2 regular [1] 150/18 reimburse [1] 156/3 reimbursement [2] 48/3 48/4 reiterate [3] 35/24 36/2 121/10 relate [3] 22/13 37/16 60/25 related [13] 10/24 25/16 29/18 97/23 98/24 99/4 111/17 120/21 126/4 126/10 131/8 132/17 150/14 relates [1] 68/17 RELATING [2] 4/9 4/11 relation [2] 26/21 30/13 relationship [1] 110/1 relatively [3] 52/12 153/16
primary [11] 67/4 67/10 67/10 67/13 69/24 70/1 71/2 72/17 73/21 73/23 74/3 Print [1] 169/21 prior [3] 79/20 82/24 120/9 probably [2] 47/8 153/11 problem [4] 33/19 61/23 80/11 122/8 procedure [120] procedures [30] 24/22 26/3 33/17 42/6 57/4 57/5 62/6 89/4 95/11 95/12 96/8 96/15 99/18 99/19 107/6 119/12 132/23 133/14 133/15 133/20 133/21 133/22 134/1 135/2 136/19 136/20 137/13 137/13 140/13 150/2 proceed [1] 36/1 proceeded [1] 35/2 proceeding [2] 79/23 80/6 proceedings [13] 1/21 5/7 35/6 36/3 51/17 52/16 78/21 152/13 153/21 166/13 167/13 168/8 168/13 process [6] 10/2 11/22 54/11 96/23 155/20 156/5 processed [4] 9/25 11/24 33/21 34/20 processing [1] 30/21 product [9] 9/8 9/9 10/11 22/25 27/2 27/3 27/5 27/8 27/9 products [2] 9/7 38/5 professional [1] 11/15 program [1] 169/15 prohibited [5] 35/7 51/18 78/22 152/14 166/14 pronounce [1] 124/14 property [5] 7/17 37/1 53/4 81/8 154/16 propofol [37] 130/18 130/20 132/8 132/21 133/25 134/1 134/2 134/3 134/6 134/11 135/8 135/9 136/1 136/3 138/8 138/9 138/10 138/15 138/18 141/8 141/23 141/25 142/4 143/23 144/6 144/19 147/23 148/9 148/16 148/22 150/8 150/9 150/17 150/18 150/25 151/2 161/18 protect [2] 133/10 133/10 provide [5] 27/10 28/6 130/22 154/1 158/16 provided [11] 18/18 49/21 64/6 64/10 130/20 132/7 149/16 158/5 159/7 164/7 164/12 provider [19] 10/1 10/7 18/7 18/16 27/22 29/9 39/2 40/21 47/12 58/14 64/5 64/7 67/16 69/4 70/22 74/16 75/22 159/21 163/25 providers [7] 11/15 31/24 58/11 74/15 78/1 155/21 161/15 provides [1] 157/4 providing [1] 166/5 public [5] 82/13 82/14 84/20 85/1 169/15 published [1] 145/16	Q QS [1] 164/3 qualification [1] 147/14 Quannah [1] 124/24 quantity [1] 134/15 question [16] 6/18 8/10 23/23 27/22 29/15 33/11 34/14 54/6 55/25 76/22 77/16 77/24 103/25 147/4 147/16 150/14 questionnaire [1] 149/17 questions [24] 6/14 6/21 6/24 9/19 26/25 27/16 29/13 31/8 34/10 35/4 40/3 51/15 54/25 74/10 75/4 77/8 78/20 88/10 143/18 148/3 149/8 151/19 152/12 166/10 quickly [2] 21/11 91/25 quit [1] 82/21 quite [2] 121/8 131/1 QZ [1] 164/3 R R-I-C-H-V-A-L-S-K-Y [1] 121/5 racketeering [7] 7/19 8/12 37/3 37/14 53/6 81/10 154/18 Rainbow [3] 85/17 87/13 135/4 raise [8] 7/5 34/6 34/14 36/14 48/3 52/17 80/21 154/3 raised [2] 35/2 122/3 randomly [1] 149/12 range [2] 20/6 34/2 rate [7] 15/19 19/15 19/16 19/22 23/8 23/13 23/21 rates [2] 31/14 31/19 rather [7] 8/7 71/9 79/22 91/16 109/18 112/18 125/22 ratio [22] 133/21 136/1 136/4 136/9 136/25 137/17 138/17 139/20 140/18 140/19 140/21 140/24 141/1 141/25 146/16 146/17 146/19 146/21 146/23 146/24 146/25 151/25 ratios [1] 144/4 read [10] 14/22 36/3 44/13 44/20 50/15 59/2 59/22 115/11 117/24 118/4 reading [2] 108/23 108/23 realized [1] 143/22 really [7] 30/23 59/2 85/2 87/24 91/25 116/3 165/25 reason [5] 19/13 29/9 82/21 114/17 131/12 receive [6] 10/2 28/1 29/6 33/11 39/17 155/20 received [18] 11/21 16/24	

RA 000475

RA 000475

<p>R</p> <p>relatively... [1] 153/18</p> <p>relinquishes [1] 27/11</p> <p>remain [1] 96/14</p> <p>remainder [1] 126/1</p> <p>remaining [1] 73/4</p> <p>remember [3] 121/17 121/19 129/14</p> <p>remiss [1] 35/23</p> <p>Renate [4] 116/17 116/17 120/4 121/17</p> <p>render [1] 80/15</p> <p>rendered [3] 55/16 56/6 158/20</p> <p>rendering [1] 5/25</p> <p>renegotiate [1] 47/18</p> <p>report [28] 4/15 103/8 103/10 108/4 108/5 108/24 108/25 109/14 112/25 116/12 118/9 118/12 121/2 121/18 121/19 131/5 135/15 135/18 135/20 135/23 137/19 142/23 157/1 158/5 158/10 158/16 159/14 161/3</p> <p>reported [2] 1/25 150/1</p> <p>reporter [3] 24/1 54/7 169/23</p> <p>REPORTER'S [2] 1/21 168/1</p> <p>reporting [1] 155/18</p> <p>reports [10] 96/2 96/7 99/7 99/11 103/6 105/10 105/10 108/6 118/11 123/24</p> <p>request [2] 2/19 28/10</p> <p>require [2] 28/9 30/14</p> <p>required [4] 28/12 31/1 133/14 169/11</p> <p>requirement [3] 33/18 50/7 158/15</p> <p>research [2] 134/5 134/9</p> <p>resources [1] 114/13</p> <p>respects [1] 47/4</p> <p>responded [1] 149/17</p> <p>response [1] 5/11</p> <p>responsibility [4] 51/3 51/4 67/12 71/6</p> <p>responsible [1] 73/3</p> <p>rest [2] 89/25 104/11</p> <p>restroom [1] 90/13</p> <p>restrooms [1] 92/23</p> <p>result [1] 99/7</p> <p>retire [1] 82/21</p> <p>retired [2] 82/23 84/13</p> <p>return [2] 79/23 136/23</p> <p>returned [6] 119/15 135/11 136/24 137/7 137/15 137/16</p> <p>reused [2] 130/17 139/5</p> <p>reusing [1] 130/23</p> <p>revenue [1] 39/6</p> <p>review [6] 10/20 80/2 105/22 106/2 112/4 115/25</p> <p>reviewed [4] 20/10 26/21 78/7 119/24</p> <p>revise [1] 50/9</p> <p>revisit [1] 6/17</p> <p>Richvalsky [2] 121/2 121/4</p> <p>Ridge [1] 87/8</p> <p>right [71]</p> <p>rights [1] 27/11</p> <p>road [1] 6/1</p> <p>ROBERSON [1] 2/10</p> <p>Robert [1] 86/3</p> <p>Ron [6] 42/10 49/24 58/15</p>	<p>69/5 76/24 77/6</p> <p>RONALD [15] 1/10 5/16 7/19 37/3 53/6 81/11 112/19 116/15 119/13 120/1 136/22 153/24 154/19 159/7 161/15</p> <p>room [70]</p> <p>rooms [20] 88/21 90/9 90/17 90/21 92/23 92/24 93/5 93/24 94/4 102/18 102/21 102/21 102/23 103/11 103/13 103/13 103/21 105/10 115/4 116/5</p> <p>ROSE [1] 2/11</p> <p>rounded [1] 15/14</p> <p>row [5] 41/10 72/6 89/14 109/17 109/18</p> <p>rows [1] 113/8</p> <p>RUBINO [16] 4/6 54/20 62/13 63/2 76/24 77/1 77/3 113/22 113/23 114/3 114/21 116/6 116/14 122/17 123/25 124/13</p> <p>Rubino's [1] 66/5</p> <p>Rudolfo [9] 8/11 10/12 13/2 15/22 23/2 28/19 32/12 115/13 124/13</p> <p>run [2] 41/2 149/12</p> <p>S</p> <p>S-A-M-P-S-O-N [1] 81/18</p> <p>S-A-M-S [1] 155/2</p> <p>S-P-A-E-T-H [1] 37/10</p> <p>said [43] 5/18 6/4 6/14 8/24 16/25 18/20 19/4 20/15 24/1 31/14 34/13 37/14 39/20 39/21 47/5 49/4 50/4 55/19 59/10 60/15 61/19 64/13 73/15 85/19 86/21 92/4 102/20 107/14 111/20 117/21 118/2 118/8 118/20 129/8 130/8 146/13 146/15 149/17 151/14 157/17 160/2 161/24 168/9</p> <p>SALAMANOUPOULUS [1] 2/5</p> <p>saline [1] 148/8</p> <p>same [44] 20/19 21/4 21/6 23/3 23/20 25/21 26/5 26/8 26/12 34/5 34/5 34/19 43/3 43/7 45/20 45/21 45/22 46/8 59/23 62/8 63/17 63/22 65/5 65/5 65/5 66/7 66/8 66/13 71/22 71/23 74/20 74/22 75/6 75/19 92/16 107/4 111/21 112/10 117/8 125/11 133/25 139/14 142/10 146/23</p> <p>sample [2] 156/20 160/4</p> <p>Sampson [3] 81/18 81/21 82/4</p> <p>Sams [3] 155/2 155/5 155/13</p> <p>saw [9] 25/19 65/3 70/15 73/13 78/6 92/18 102/5 121/14 138/11</p> <p>say [30] 9/20 16/3 16/18 26/10 29/4 45/8 47/19 60/15 60/19 62/1 67/6 76/7 83/9 87/24 88/17 95/10 99/15 110/9 114/11 114/25 116/20 121/1 124/17 127/20 131/18 133/13 139/11 143/9 146/5 150/16</p> <p>saying [6] 21/2 36/9 67/14 77/5 121/12 122/13</p> <p>says [26] 12/22 14/11 15/23 17/17 17/22 18/6 34/5 42/24 43/4 44/20 47/13 59/25 60/5</p>	<p>70/9 70/21 71/5 71/25 72/15 72/19 77/12 102/1 164/11 164/18 164/24 164/25 165/10</p> <p>scale [1] 88/18</p> <p>schedule [1] 83/16</p> <p>scheduled [2] 128/3 146/18</p> <p>Science [1] 84/4</p> <p>scope [3] 76/19 108/15 133/10</p> <p>screen [8] 32/4 58/9 89/17 91/16 93/7 93/16 124/2 124/8</p> <p>search [19] 83/18 83/20 83/21 83/22 84/25 85/3 85/6 85/9 85/14 85/23 86/10 86/15 96/22 98/24 127/23 129/8 131/22 131/25 132/6</p> <p>searched [1] 93/25</p> <p>searching [1] 91/8</p> <p>seated [5] 7/13 36/22 52/25 81/3 154/11</p> <p>second [17] 30/12 49/1 54/20 87/11 91/1 99/17 101/7 112/15 116/16 116/23 117/11 118/24 119/10 152/8 153/6 160/14 167/5</p> <p>secondary [4] 67/3 67/7 67/10 67/11</p> <p>secret [5] 35/6 51/17 78/21 152/13 166/13</p> <p>Secretary [1] 2/5</p> <p>section [14] 13/6 13/6 13/15 13/24 14/11 24/14 32/6 32/6 43/22 44/24 84/21 85/1 123/14 164/25</p> <p>Secure [5] 9/13 9/14 10/11 27/7 33/16</p> <p>secured [3] 85/24 85/25 86/2</p> <p>securing [1] 91/9</p> <p>security [2] 169/8 169/11</p> <p>see [73]</p> <p>seeing [1] 138/21</p> <p>Seek [1] 5/11</p> <p>seems [1] 125/25</p> <p>seen [7] 19/2 86/25 88/7 92/13 99/17 131/11 138/12</p> <p>sell [1] 38/5</p> <p>senior [7] 9/8 9/12 23/7 27/3 27/5 27/8 48/23</p> <p>sense [1] 109/10</p> <p>sent [2] 10/7 143/25</p> <p>separate [9] 20/25 21/7 21/7 26/15 26/16 92/20 103/15 115/4 116/5</p> <p>September [15] 10/19 11/18 24/11 32/16 39/18 39/19 51/7 98/5 98/18 111/22 112/8 122/19 136/4 140/8 149/11</p> <p>September 21 [1] 39/19</p> <p>September 21st [7] 10/19 98/5 98/18 122/19 136/4 140/8 149/11</p> <p>sequence [2] 99/14 99/15</p> <p>series [4] 11/9 11/12 33/14 86/12</p> <p>served [2] 85/14 131/23</p> <p>service [27] 13/10 13/12 17/17 17/18 17/19 17/20 18/18 21/8 39/19 39/22 40/10 41/13 41/23 43/4 56/5 58/11 58/14 58/18 60/5 63/7 64/6 70/9 71/23 72/8 160/16 163/4 164/12</p>
--	---	--

RA 000476

S	97/18 100/20 144/2 164/25 Sierra [4] 38/2 38/3 38/6 38/13 sign [1] 135/8 Signature [1] 169/19 signatures [4] 108/4 108/5 121/8 121/10 signed [14] 95/25 108/20 117/20 118/13 122/10 124/24 125/7 125/13 134/2 136/22 136/23 137/14 137/15 137/17 significance [2] 113/24 142/23 significant [2] 144/14 144/18 significantly [3] 136/10 137/20 141/21 signifies [2] 14/24 15/8 similar [1] 58/24 since [2] 33/17 83/3 single [1] 136/22 sir [11] 9/22 78/18 155/22 156/1 156/18 157/23 160/4 161/4 161/16 165/2 165/11 sit [1] 126/3 sitting [2] 9/23 34/16 situation [2] 85/7 106/15 six [9] 11/1 16/14 61/5 66/11 85/15 141/15 142/7 142/12 156/15 six-page [1] 11/1 sixty [2] 22/24 72/14 size [8] 50/12 134/6 134/7 134/12 143/24 147/24 148/15 148/15 sizes [1] 50/8 skip [1] 69/11 Slide [1] 49/9 small [2] 59/3 69/12 smaller [1] 149/1 Smith [1] 113/19 so [254] social [2] 169/8 169/11 software [1] 123/3 solemnly [5] 7/7 36/16 52/19 80/23 154/5 some [37] 10/23 12/21 14/22 17/16 39/1 40/3 47/4 54/25 54/25 60/11 67/13 68/14 69/13 69/17 82/7 86/6 90/12 90/17 91/7 91/24 94/7 97/12 97/13 97/16 99/11 99/11 99/20 103/19 109/25 118/11 119/15 127/1 129/2 134/9 144/25 145/3 149/14 somebody [6] 33/23 43/20 47/23 62/3 122/3 126/13 someone [3] 34/4 76/14 102/8 something [16] 9/14 14/23 17/10 17/11 30/18 30/20 30/25 34/17 47/6 47/25 61/16 61/22 100/24 120/25 133/11 165/25 sometime [1] 118/22 sometimes [2] 43/16 121/10 somewhat [1] 50/9 somewhere [2] 75/1 116/24 Sonia [2] 115/13 124/13 sorry [10] 14/16 23/24 32/2 39/21 39/22 64/8 87/12 101/13 140/11 161/10 sort [11] 14/22 27/19 69/17 98/14 99/20 105/14 105/25	107/13 109/19 112/23 123/23 sorted [10] 103/1 103/1 103/2 103/9 105/4 105/7 108/25 109/12 112/25 113/2 sorting [1] 109/3 sorts [1] 109/15 sounds [3] 85/2 127/7 147/5 source [13] 106/18 106/19 113/25 114/10 114/19 115/6 115/16 117/7 117/22 123/25 126/13 126/19 127/7 South [1] 87/13 Southern [11] 22/7 42/12 44/8 49/25 58/20 64/9 69/7 82/6 158/11 160/14 161/6 Spaeth [4] 37/9 37/10 37/18 37/25 speak [3] 56/24 89/24 122/14 speaking [2] 27/23 45/3 specific [12] 10/10 11/3 13/21 29/24 30/18 30/20 33/7 33/18 39/13 54/16 159/15 169/12 specifically [13] 8/9 10/18 10/24 14/10 37/15 38/25 39/13 98/10 106/9 134/18 134/20 161/2 162/3 specifics [2] 12/21 118/1 speculate [1] 117/3 speculation [1] 76/17 spell [4] 7/24 37/8 81/16 121/4 spelled [1] 37/10 spelling [2] 53/11 154/24 spread [1] 139/8 spreadsheet [13] 4/16 4/17 99/22 99/25 101/10 102/14 109/12 112/8 113/7 124/20 149/18 157/3 161/24 spreadsheets [2] 121/7 143/1 Ss [1] 168/3 STACY [21] 4/11 39/14 40/2 40/9 41/8 43/1 44/11 115/22 116/9 116/15 116/16 116/23 117/16 118/21 120/4 120/16 120/19 121/15 124/5 124/23 125/18 stamp [1] 10/3 stand [1] 89/6 standard [2] 151/22 151/24 start [17] 10/10 11/13 39/25 54/24 57/14 57/15 102/2 103/8 107/21 108/14 110/23 111/6 112/25 117/11 143/20 160/1 162/24 started [16] 8/5 68/22 84/9 85/2 99/13 101/21 102/16 108/12 112/11 116/6 116/7 116/9 118/9 131/10 142/1 145/4 starting [1] 116/19 state [14] 1/7 5/15 6/2 7/24 37/7 53/10 81/15 84/5 84/7 153/25 154/23 168/3 169/12 169/16 statement [9] 35/10 51/21 78/25 118/17 145/25 146/1 146/2 152/17 166/17 statements [5] 35/9 51/20 78/24 152/16 166/16 States [1] 97/1 stating [1] 49/21
----------	--	--

RA 000477

<p>S</p> <p>station [1] 95/6 stations [1] 94/8 statutes [1] 6/19 Staudaher [1] 2/19 stay [1] 106/8 stayed [1] 105/22 Stenotype [1] 168/7 step [1] 106/13 still [21] 21/23 22/7 24/7 24/17 24/25 33/3 36/1 38/13 42/23 42/24 44/7 45/25 46/13 46/19 50/23 51/5 63/18 75/17 119/8 137/20 158/14 stop [1] 115/15 stopped [1] 68/22 storage [1] 94/2 straight [1] 127/13 strictly [1] 133/15 struggled [1] 116/3 study [1] 92/1 stuff [6] 47/20 71/23 95/23 107/17 158/18 162/24 subcontracted [1] 27/13 subcontracts [1] 27/9 submit [4] 11/15 19/24 167/9 167/11 submits [2] 10/1 67/16 submitted [30] 11/17 12/1 12/13 12/16 16/2 16/18 17/6 25/2 28/10 30/15 42/9 42/11 43/11 43/17 43/20 46/3 55/15 55/24 56/21 58/4 58/6 60/23 75/20 76/18 82/16 88/7 156/8 157/13 165/22 166/1 submitting [1] 47/25 subpoena [2] 128/2 131/24 subpoenaed [2] 132/9 132/12 subtracts [1] 102/15 succeeding [1] 157/17 suite [2] 86/19 89/23 summaries [1] 127/25 summarized [2] 101/19 102/1 summary [4] 4/14 4/15 128/15 131/5 supervision [1] 168/11 supplies [11] 116/1 130/18 130/19 130/22 131/13 138/13 139/7 143/10 144/5 144/7 144/11 support [2] 122/5 122/8 supposed [1] 121/11 supposedly [1] 133/9 sure [15] 5/20 6/18 20/8 24/20 29/2 64/16 79/24 125/18 126/18 131/17 132/9 132/14 132/25 139/22 161/23 surgical [1] 160/12 swear [5] 7/7 36/16 52/19 80/23 154/5 sworn [6] 5/5 8/17 37/19 53/16 81/22 155/6 syringe [11] 139/12 139/13 139/14 140/25 146/25 148/15 148/16 151/23 151/23 152/7 152/9 syringes [32] 130/21 130/23 132/8 132/22 139/4 139/5 140/18 140/19 140/24 141/2 141/3 141/5 142/11 142/13 142/17 142/18 144/6 146/14</p>	<p>146/20 146/20 146/22 146/24 147/1 147/2 147/8 147/9 148/8 148/21 148/21 148/25 149/1 149/1 system [2] 10/4 34/22 systemic [2] 164/8 164/9 SZURAN [1] 2/12</p> <p>T</p> <p>table [1] 112/4 tabulating [1] 132/4 take [17] 9/20 10/3 12/18 44/23 52/12 54/8 79/15 82/4 91/22 104/25 106/6 123/5 144/6 144/12 145/12 155/17 155/23 taken [6] 1/15 86/4 90/14 112/9 127/23 145/9 taking [5] 24/1 47/24 54/7 91/25 112/11 talk [9] 14/25 45/7 85/18 93/21 97/4 126/4 136/12 163/22 164/11 talked [4] 77/18 95/17 111/16 141/2 talking [21] 13/9 17/13 32/24 38/20 54/9 71/16 94/21 97/8 99/16 101/9 115/11 119/7 122/18 122/19 129/21 129/23 133/15 141/3 141/5 143/9 159/24 tape [2] 108/23 108/23 taped [1] 109/8 tapes [1] 108/21 tech [1] 108/5 technique [1] 152/3 teeth [1] 133/10 tell [27] 9/9 11/8 20/19 28/18 40/5 40/6 48/15 49/18 55/5 62/14 64/23 65/1 66/24 85/22 86/13 91/10 100/3 100/8 113/10 116/7 123/13 123/17 125/9 129/20 131/8 156/11 162/2 telling [2] 46/14 147/17 ten [5] 43/25 46/11 52/8 52/8 52/12 Tenaya [5] 85/11 85/17 86/24 88/6 96/18 term [1] 57/20 testified [6] 8/19 37/21 53/18 81/24 155/8 161/1 testify [6] 8/18 37/20 53/17 81/23 132/5 155/7 testifying [1] 79/21 testimony [21] 5/22 5/24 7/4 7/7 7/15 8/8 8/13 11/3 36/16 36/24 37/13 52/19 53/2 76/20 80/9 80/23 81/6 154/5 154/14 167/8 167/12 testing [2] 106/17 114/1 than [19] 12/14 16/20 16/22 17/1 19/23 19/23 60/23 61/7 61/12 62/6 73/20 78/8 111/16 112/16 129/22 141/22 142/2 148/17 151/9 Thank [31] 7/6 7/12 7/23 8/3 27/14 28/5 29/12 35/20 36/21 37/11 52/6 52/24 53/14 77/7 78/18 79/10 79/12 80/19 81/4 81/19 146/9 153/2 153/4 153/9 154/4 154/10 154/12</p>	<p>155/3 167/2 167/4 167/12 that [899] that's [126] their [24] 6/6 9/3 27/10 27/11 28/1 66/18 86/20 92/12 95/25 96/1 96/1 99/19 100/19 114/10 130/18 134/10 139/18 140/12 140/24 142/15 147/24 148/8 160/13 161/12 theirs [1] 72/25 them [59] then [80] there [181] there's [10] 21/6 23/19 50/19 68/13 68/14 80/8 89/9 89/9 93/17 162/24 thereabouts [1] 153/13 thereafter [1] 168/9 thereon [1] 119/4 these [50] 24/4 33/11 35/6 36/3 40/8 40/13 40/25 42/24 50/21 51/17 61/11 62/17 66/5 67/2 78/9 78/21 86/14 86/25 87/21 88/2 88/7 91/3 91/12 93/24 94/10 95/17 96/11 97/5 97/20 97/22 105/4 107/15 108/7 108/9 108/9 112/25 115/1 115/3 118/11 123/24 123/24 127/3 129/6 130/3 143/8 144/7 146/17 149/13 152/13 166/13 they [245] they'll [1] 153/18 they're [10] 21/6 23/12 28/12 33/21 87/24 88/18 88/22 100/21 113/2 153/12 thing [11] 20/19 65/6 89/1 103/24 119/23 121/22 126/18 127/15 142/10 151/21 161/13 things [21] 54/3 54/13 55/11 60/12 83/10 83/12 83/18 83/19 90/22 91/6 93/2 98/23 99/12 101/23 106/8 106/9 115/25 118/19 123/22 143/1 149/1 think [39] 6/20 8/7 17/13 18/20 22/1 23/1 24/4 32/18 44/4 44/12 45/13 46/3 58/10 58/24 59/2 64/1 64/13 66/22 69/13 73/15 76/19 79/21 85/15 90/25 92/7 93/18 106/21 107/16 110/14 112/17 141/11 145/4 146/15 148/13 149/20 151/14 156/14 160/2 160/17 third [7] 9/2 48/9 54/22 125/14 135/3 149/22 157/1 Thirty [5] 14/19 46/5 46/6 69/3 162/22 Thirty-one [4] 46/5 46/6 69/3 162/22 Thirty-three [1] 14/19 this [289] THOMPSON [1] 2/13 those [94] though [11] 34/15 66/13 69/16 73/15 74/24 82/24 88/1 146/16 157/18 157/24 165/16 thought [2] 39/21 129/24 three [29] 14/19 15/14 15/15 15/18 15/25 20/1 20/2 20/6 20/11 54/15 55/4 57/24 64/1</p>
---	--	--

RA 000478

<p>T</p> <p>three... [16] 78/14 88/14 110/17 115/18 119/12 130/3 136/2 136/3 136/5 137/21 142/21 149/20 149/21 162/9 162/11 162/18</p> <p>through [36] 10/4 11/8 20/13 20/18 21/11 21/11 40/5 40/25 41/2 48/14 55/5 62/14 66/24 67/18 75/8 78/6 83/15 89/7 96/22 99/2 99/2 99/11 103/12 114/1 123/13 127/22 134/23 142/3 143/3 143/4 145/4 146/7 156/5 156/11 162/25 163/23</p> <p>throughout [1] 151/13</p> <p>Thursday [1] 1/16</p> <p>thus [2] 6/21 111/16</p> <p>tied [1] 125/25</p> <p>time [107]</p> <p>times [20] 15/19 33/7 33/18 102/21 103/8 103/8 103/9 103/10 107/14 107/15 107/18 108/13 108/24 109/7 109/12 110/25 116/6 116/13 158/17 162/16</p> <p>title [3] 129/10 129/11 169/23</p> <p>titled [1] 25/12</p> <p>today [9] 7/14 36/23 53/1 80/1 81/6 154/2 154/14 166/6 167/9</p> <p>together [3] 26/18 97/15 98/6</p> <p>told [11] 5/19 50/20 74/15 76/7 79/24 102/6 102/8 106/7 106/9 106/11 119/18</p> <p>TOM [1] 2/14</p> <p>too [7] 41/1 83/12 86/9 100/25 114/17 142/16 143/14</p> <p>took [27] 17/19 17/20 30/1 58/18 85/7 94/3 94/5 101/17 107/18 108/15 108/18 108/19 108/23 109/2 120/2 127/22 128/1 129/7 130/18 139/6 140/3 140/7 140/10 140/14 146/20 162/4 168/7</p> <p>top [16] 12/22 57/24 59/9 59/10 69/21 89/8 89/16 93/16 104/19 113/4 113/20 115/7 116/21 124/2 162/24 164/11</p> <p>topics [1] 143/5</p> <p>total [24] 15/18 15/25 16/14 58/1 71/25 72/13 73/1 104/14 136/12 136/13 136/24 137/4 137/16 137/22 138/2 162/8 162/8 162/9 162/12 162/18 162/19 162/20 162/21 164/1</p> <p>totals [1] 59/10</p> <p>track [2] 83/17 127/17</p> <p>training [1] 84/3</p> <p>transcribe [1] 5/6</p> <p>transcribed [1] 168/10</p> <p>transcript [3] 1/21 168/12 169/4</p> <p>transcripts [2] 36/4 80/2</p> <p>translate [2] 61/13 78/13</p> <p>transmitted [1] 122/1</p> <p>transpired [5] 35/8 51/19 78/23 152/15 166/15</p> <p>tried [4] 102/23 121/7 121/24 122/4</p>	<p>Trina [1] 113/19</p> <p>true [2] 36/10 168/12</p> <p>truth [33] 7/9 7/9 7/10 8/18 8/18 8/19 36/18 36/18 36/19 37/20 37/20 37/21 52/21 52/21 52/22 53/17 53/17 53/18 80/25 80/25 81/1 81/23 81/23 81/24 106/12 118/15 119/21 154/7 154/7 154/8 155/7 155/7 155/8</p> <p>try [7] 59/3 109/10 116/4 122/7 122/14 125/11 128/4</p> <p>trying [4] 99/14 128/7 131/10 145/7</p> <p>Tuesday [1] 84/24</p> <p>turn [4] 58/23 58/25 114/5 155/18</p> <p>turned [1] 101/12</p> <p>turning [1] 92/8</p> <p>Twenty [2] 16/7 136/8</p> <p>Twenty-nine [1] 16/7</p> <p>two [85]</p> <p>two feet [1] 100/23</p> <p>type [22] 13/21 24/16 24/22 38/17 38/21 43/7 43/7 43/9 49/14 50/16 55/12 55/14 55/15 57/14 66/8 69/22 72/8 143/7 144/22 152/4 161/17 161/20</p> <p>typed [1] 14/21</p> <p>types [3] 111/21 141/3 148/20</p> <p>typical [3] 42/5 83/13 96/4</p> <p>typically [9] 43/21 43/23 50/16 55/14 57/4 141/6 141/7 148/22 150/15</p> <p>U</p> <p>UB [1] 38/23</p> <p>uh [5] 76/23 77/2 106/25 165/23 166/7</p> <p>uh-huh [5] 76/23 77/2 106/25 165/23 166/7</p> <p>Uhm [1] 104/22</p> <p>UHRHAN [1] 2/14</p> <p>unbiased [2] 6/7 80/11</p> <p>under [27] 7/18 13/1 13/15 13/24 17/17 18/6 24/13 24/14 37/2 43/10 43/22 44/19 49/14 53/5 60/1 62/23 63/9 67/23 70/9 71/25 72/8 81/10 112/24 143/22 154/18 161/14 168/10</p> <p>undersigned [1] 169/4</p> <p>understand [23] 7/21 15/21 26/2 28/5 34/14 35/18 37/5 39/1 42/20 52/4 53/8 54/10 74/23 79/8 81/13 87/17 117/6 121/9 137/3 152/25 154/21 163/9 166/25</p> <p>understanding [3] 47/11 105/21 114/14</p> <p>undetermined [1] 167/14</p> <p>unique [1] 15/8</p> <p>unit [22] 14/22 15/7 15/9 15/10 15/12 15/13 15/20 16/16 16/17 19/17 20/1 20/2 20/6 23/10 23/11 23/14 26/14 57/12 61/14 63/18 84/20 162/14</p> <p>United [5] 38/7 69/24 71/1 72/25 96/25</p> <p>units [60]</p>	<p>units/minutes [1] 77/13</p> <p>University [1] 84/6</p> <p>unless [1] 35/1</p> <p>until [4] 82/16 84/13 120/1 144/20</p> <p>up [50] 8/7 14/18 15/14 15/16 29/14 29/22 32/2 43/23 69/20 74/17 77/24 86/5 86/6 86/7 91/5 91/6 91/7 91/22 92/2 93/16 94/14 98/14 103/21 104/23 105/9 105/17 107/22 109/3 109/25 111/8 111/9 114/5 114/8 116/19 116/20 116/22 118/3 119/6 119/16 120/3 121/8 121/11 122/14 123/9 132/4 134/10 134/15 139/12 139/13 160/5</p> <p>upon [5] 7/8 36/17 52/20 80/24 154/6</p> <p>upper [11] 13/21 24/19 26/11 45/19 63/15 69/20 133/2 133/7 133/15 133/19 160/6</p> <p>upstairs [1] 86/20</p> <p>us [37] 9/9 28/4 28/18 35/8 38/16 42/3 46/14 49/18 50/20 51/19 64/23 65/1 67/7 78/23 85/22 86/13 100/3 100/8 101/23 113/10 123/13 123/18 125/9 129/20 131/3 131/8 149/16 152/15 159/21 160/10 160/11 162/2 162/20 162/25 163/23 166/6 166/15</p> <p>use [5] 120/24 133/4 136/22 138/8 160/13</p> <p>used [30] 16/20 108/15 117/19 132/6 132/23 134/1 135/9 135/12 135/14 136/3 136/20 136/25 137/4 137/6 139/9 141/6 141/7 147/2 147/9 147/17 148/16 148/22 148/25 150/7 150/8 151/17 151/22 151/24 152/4 161/12</p> <p>using [4] 102/3 123/3 131/18 134/19</p> <p>V</p> <p>validate [2] 61/21 158/20</p> <p>validating [1] 156/7</p> <p>value [1] 162/14</p> <p>variation [1] 43/17</p> <p>varied [2] 107/15 147/23</p> <p>various [1] 134/7</p> <p>vary [3] 42/4 42/5 42/7</p> <p>Vegas [11] 1/15 5/1 18/2 42/18 42/19 50/2 58/21 69/9 69/10 82/11 168/14</p> <p>vendor [5] 132/6 132/11 156/6 160/13 160/15</p> <p>vendors [4] 130/19 132/7 132/9 132/14</p> <p>verdict [2] 80/15 80/15</p> <p>verified [1] 156/7</p> <p>verify [1] 128/9</p> <p>versus [6] 5/15 61/1 63/15 76/15 153/25 162/12</p> <p>very [13] 6/17 17/12 45/3 64/18 65/13 71/14 87/18 92/18 93/16 113/20 116/4 162/15 167/4</p> <p>veteran [2] 156/23 156/24</p> <p>VETERANS [4] 4/18 155/14 158/15 163/7</p>
---	---	--

RA 000479

V

via [1] 10/1
 vial [7] 130/22 136/2 137/2
 138/18 142/1 151/22 152/6
 vials [36] 134/3 134/13
 134/14 134/14 134/22 135/9
 135/11 135/16 136/1 136/4
 136/13 136/21 136/23 136/24
 136/25 137/1 137/3 137/15
 137/16 137/16 137/17 137/19
 137/22 138/10 138/15 138/17
 139/1 141/23 141/24 141/25
 142/3 142/4 142/6 142/7
 143/23 144/19
 victim [2] 97/16 106/16
 victims [6] 97/3 97/17 98/17
 98/20 99/5 123/24
 Vietnamese [1] 124/15
 view [2] 157/7 163/6
 virtually [1] 104/3
 virus [1] 114/14
 VOLUME [1] 1/23

W

waiting [7] 5/10 89/9 89/14
 89/24 92/14 92/14 93/17
 walk [4] 92/15 99/10 162/25
 163/23
 want [31] 8/6 14/10 18/19
 20/14 21/25 24/3 32/3 32/4
 35/24 36/1 45/7 45/12 50/12
 62/5 79/19 89/1 91/22 102/7
 106/8 110/20 115/11 117/3
 118/1 126/18 131/17 134/4
 145/25 153/14 161/1 161/22
 165/18
 wanted [4] 55/10 60/12 64/16
 161/13
 warrant [15] 83/21 83/22
 84/25 85/4 85/6 85/9 85/23
 86/10 86/15 98/24 127/23
 129/8 131/22 132/1 132/7
 warrants [3] 83/19 83/21
 85/14
 was [321]
 Washington [11] 106/17 107/2
 109/18 109/22 110/16 126/14
 127/7 156/25 158/24 161/7
 163/4
 Washington's [1] 160/7
 wasn't [6] 105/3 114/16
 127/4 147/2 151/1 165/25
 way [7] 54/17 82/7 86/24
 117/16 121/25 122/12 152/4
 we [187]
 We'd [1] 52/8
 we'll [10] 7/3 14/18 59/1
 69/12 80/20 100/1 143/20
 160/1 162/24 167/12
 we're [29] 12/21 15/22 17/13
 21/14 28/15 32/4 32/6 32/22
 34/2 38/7 54/9 58/10 64/22
 71/16 76/9 79/19 94/21 100/8
 101/9 122/19 123/18 129/23
 139/25 153/23 158/14 159/24
 162/2 162/25 163/23
 we've [1] 21/10
 week [5] 142/6 142/8 142/15
 142/17 142/19
 weeks [5] 141/15 141/15
 142/7 142/12 142/19
 welcome [4] 79/13 146/10

153/5 155/4
 well [43] 6/13 8/12 9/17
 27/6 27/22 29/23 37/16 38/4
 38/9 39/10 42/10 64/25 73/21
 83/19 85/12 88/8 91/6 91/19
 92/5 92/23 101/7 104/24
 108/9 109/10 115/19 116/3
 118/5 119/25 122/9 125/4
 125/7 126/6 127/4 128/9
 131/4 135/19 139/16 145/11
 147/12 147/23 150/22 157/6
 158/5
 Wells [1] 129/9
 went [20] 19/8 61/13 86/5
 86/21 91/5 92/5 99/2 99/2
 109/15 116/13 122/4 122/9
 127/11 127/12 127/16 127/22
 135/15 143/3 143/3 153/13
 were [189]
 weren't [2] 61/19 140/25
 West [1] 87/8
 what [236]
 what's [6] 16/20 22/14 24/1
 48/15 77/18 147/21
 whatever [11] 15/19 34/5 39/9
 42/1 73/11 109/9 114/17
 117/5 124/21 145/11 147/17
 when [58]
 where [46] 12/23 13/9 14/11
 17/19 18/4 18/6 32/22 39/2
 44/24 58/18 64/5 64/9 70/9
 71/25 73/13 85/7 85/14 89/4
 89/9 89/10 91/12 92/12 93/3
 94/9 94/19 95/11 95/12 95/17
 96/15 96/20 97/19 101/20
 102/1 104/2 108/17 115/16
 117/6 121/1 121/7 132/23
 144/15 144/18 145/8 145/8
 149/20 164/24
 whether [8] 6/1 48/2 74/13
 78/9 107/16 109/7 114/16
 125/15
 which [57]
 whichever [1] 15/20
 Whiteley [1] 86/3
 who [61]
 whole [15] 7/9 8/18 36/18
 37/20 52/21 53/17 71/7 71/9
 80/25 81/23 89/1 94/17
 151/14 154/7 155/7
 whom [1] 115/10
 Whose [1] 41/7
 why [12] 19/13 23/17 23/19
 50/12 66/9 99/10 102/4
 118/17 120/10 125/6 152/7
 162/25
 will [20] 6/17 8/9 8/11 8/12
 17/12 36/6 37/13 37/16 52/12
 54/7 55/9 64/25 77/18 80/2
 83/16 102/14 112/1 112/2
 153/9 167/11
 WILLOUGHBY [1] 2/4
 wise [2] 60/14 134/12
 wit [1] 169/13
 within [1] 118/23
 without [2] 27/18 130/23
 witness [21] 8/5 8/9 26/24
 35/24 36/13 37/13 51/14
 52/11 52/12 74/9 79/20 79/21
 118/18 143/17 148/14 153/9
 153/16 153/17 154/1 154/2
 166/9

WITNESSES [1] 3/1
 woman [1] 77/4
 words [1] 54/8
 work [12] 9/23 47/13 54/11
 84/2 84/24 99/8 101/1 105/1
 121/21 143/6 149/15 166/5
 worked [2] 84/6 103/2
 working [6] 23/12 82/9 82/11
 82/18 83/4 90/14
 worried [1] 132/11
 would [118]
 wouldn't [7] 30/23 30/24
 34/14 34/24 46/19 117/3
 144/19
 written [2] 78/7 108/16
 wrong [2] 77/5 103/11
 wrote [1] 135/10

Y

Yeah [3] 34/12 34/24 100/25
 year [17] 35/13 47/14 51/24
 79/3 82/17 129/21 141/21
 142/5 142/13 145/13 151/1
 151/3 151/8 151/13 151/14
 152/20 166/20
 years [5] 47/14 84/8 129/22
 144/25 146/6
 yellow [4] 114/7 124/15
 124/17 124/18
 yes [348]
 yet [1] 66/23
 YOLANDA [2] 2/9 52/15
 you [642]
 you'd [2] 101/23 103/19
 you'll [1] 76/3
 you're [36] 5/25 9/23 11/3
 11/4 12/6 28/18 29/3 31/16
 32/24 33/17 38/9 39/6 41/1
 47/8 60/25 67/6 75/1 76/6
 79/13 83/3 95/10 101/5
 101/22 101/24 116/20 121/12
 122/22 128/12 131/3 131/18
 132/5 132/17 143/9 146/10
 153/5 155/4
 you've [11] 73/20 80/9 84/14
 88/2 88/7 112/24 121/22
 125/9 135/19 142/22 160/25
 YOUNG [2] 2/3 100/12
 your [79]
 yours [2] 73/1 101/15
 yourself [1] 67/15

Z

ZARATE [1] 2/15
 ZIYAD [17] 4/5 54/22 54/24
 55/19 55/24 66/6 76/25 77/4
 106/19 106/20 109/17 109/19
 110/14 110/16 126/13 127/9
 127/10
 zoom [12] 29/3 32/21 44/12
 59/3 64/21 64/25 70/9 71/16
 77/18 89/2 92/9 123/14
 zoomed [1] 59/7
 zooming [1] 123/16

RA 000480

1 that that was done so that the turning could be done
2 quicker.

3 Q. Okay. And, again, at this point, you said
4 that this had a pretty significant affect on you; is
5 that right?

6 A. Right.

7 MR. STAUDAHNER: That last statement and
8 any statements related to that one that she elicits are
9 hearsay statements, ladies and gentlemen. They are
10 being offered for the truth of the matter at this point
11 under a hearsay exception, which is the effect on the
12 listener, how these things that happened to her
13 affected her and what she did as a result of them.

14 So with that, I would like to continue on.
15 BY MR. STAUDAHNER:

16 Q. So during your training, had that ever
17 occurred to you before? Had anybody ever come up to
18 you and given you something that was already filled out
19 on the condition of the patient or what the patient was
20 experiencing or not experiencing before you ever
21 actually saw them?

22 A. You mean prior to working?

23 Q. At the Endoscopy Center?

24 A. They had discussed it in nursing school
25 that that was improper procedure.

1 Q. So you were actually taught that that was
2 not proper?

3 A. Yes.

4 Q. So when you saw it on your first job on
5 your first day, what was going through your mind?

6 A. That I didn't want to work in a place like
7 that because I don't want to risk my license doing the
8 same thing.

9 Q. Okay. Now, when you raised this to these
10 nurses, I mean did you -- did anybody else work with
11 you at the time that was new?

12 A. No.

13 Q. Did you, during the three days you were
14 there, were there any other additional nurses or
15 personnel that came on that were also in the same
16 position as you were in?

17 A. No.

18 Q. Did you ever work with people who were
19 already at the clinic who were in the same position
20 that you were in?

21 A. I'm not sure.

22 Q. I mean as nurses, charting, things like
23 that in procedure rooms?

24 A. No.

25 Q. Now, when you said that the charting was

1 done beforehand, or when the -- when some of the stuff
2 came to you. I mean we're talking about filled out
3 documents on patients that you have not seen yet?

4 A. Right.

5 Q. Now, that's different than them just
6 handing you a blank document and saying, you know, go
7 ahead and start filling out vital signs or whatever on
8 this patient, even before he's wheeled in the door?

9 A. Right.

10 Q. Did both of those things happen, though?

11 A. Yes, both happened.

12 Q. What about the documentation after the
13 patient leaves your sort of area and goes out into the
14 post-care area?

15 A. Again, in training, I was encouraged to
16 start charting post-op information on a patient to save
17 time.

18 Q. Okay. And when you say training, you're
19 talking about training at the Endoscopy Center?

20 A. Yes.

21 Q. Again, did that affect you in any way as
22 far as being something that concerned you?

23 A. It did because that's still pre-charting.

24 Q. So you -- if I understand you correctly,
25 you were encouraged to pre-chart for other persons down

1 the line as well?

2 A. Right, right.

3 Q. Now, as far as the types of things that
4 were being pre-charted or that you were encouraged to
5 pre-chart, did that include start times and stop times
6 for procedures, and things like that?

7 A. Yes, it did.

8 Q. Did it include vital signs or, like you
9 said, how the patient was doing, things like that?

10 A. Not vital signs, but yes, how the patient
11 was doing.

12 Q. As far as the condition of the patient,
13 had you had a chance, when asked to just go ahead and
14 fill out stuff about the patients, to actually maybe
15 step out and look at the patient in the post-op area
16 just to confirm that that was the way they were?

17 A. No.

18 Q. What happened if you -- well, I guess let
19 me step back.

20 If you were encouraged to pre-chart the
21 condition of the patient, was the condition supposed to
22 be a certain way all the time?

23 A. Generally, it was documented the same way
24 every time.

25 Q. And how was that documented?

1 A. That the patient was in good condition and
2 good health.
3 Q. What happened if you had a patient that
4 came in that was not in such good condition or good
5 health?
6 A. Every time it was documented exactly the
7 same way, that they were in good health.
8 Q. Were you ever asked, or did you ever
9 change the documentation if, in fact, you saw that
10 somebody was not doing well?
11 A. I did, yes.
12 Q. Okay. Was that something that you were
13 allowed or you were told to do or was it just something
14 you did?
15 A. Just something I did.
16 Q. Did you, in fact, comply with what they
17 were asking you to do in and pre-chart?
18 A. No, I didn't.
19 Q. Did that cause trouble for you?
20 A. Yes. The nurses were continually saying
21 "Hurry up, hurry up." And the doctors were like "Why
22 aren't we ready yet?" So there was a lot of pressure,
23 a lot of frustration in the procedure room because I
24 wouldn't pre-chart.
25 Q. And was this pervasive amongst the --

1 during the time around the people that you were working
2 with --
3 A. Yes.
4 Q. -- that this was going on?
5 Did you ever get the impression that just
6 what was happening with you was an isolated thing, and
7 this was not happening elsewhere in the practice?
8 A. No, I felt it was general to the practice.
9 Q. Did you ever see Desai?
10 A. No, I didn't.
11 Q. So during the three days that you're
12 there, you didn't work with him as a doctor during any
13 of these procedures?
14 A. No, I never saw him.
15 Q. Never interviewed with him?
16 A. No.
17 Q. When you left, did you see him?
18 A. No.
19 Q. So this whole operation, the way you
20 described it, was able to run without him being
21 present?
22 A. Yes.
23 Q. Do you know if vital signs at any time
24 would be faked on charts?
25 A. No, I don't recall any of that.

1 Q. You had said that people were described as
2 being happy or being healthy, everybody was supposed to
3 be in good condition, things like that, correct?
4 A. Correct.
5 Q. Do you recall having an interview with the
6 police?
7 A. Yes, I do.
8 Q. Was that interview taped?
9 A. Yes, it was.
10 Q. Was that interview provided to you in
11 advance of this testimony today so that you could
12 review it?
13 A. Yes, it was.
14 Q. I'm showing you what has been -- I think
15 the front page of it. It's not an exhibit. The front
16 page of it bears your name; is that correct?
17 A. Yes.
18 Q. And the date of the 29th of May of 2008?
19 A. Yes.
20 Q. Does that look like the transcription of
21 the -- not the testimony but the statement that you
22 gave to the police?
23 A. Yes, it does.
24 Q. I'm going to ask you to -- or ask you to
25 review page 8, the bottom of it. When you're done, let

1 me know. Just turn that over, give it back to me, and
2 then I'll ask you if that refreshes your memory as to
3 the issue regarding vital signs.
4 A. Okay.
5 Q. Okay. Does that refresh your memory?
6 A. Yes, it does.
7 Q. I'll ask you the question again. Were you
8 aware of or told to document fake vital signs on
9 patients?
10 A. No.
11 Q. Do you see what the words were there and
12 asked? Can you explain what you meant by that?
13 A. Sure. I was responding yes to the second
14 portion where he asked if the patient was bluish.
15 Q. Okay. What you're talking about is the
16 condition of the patient?
17 A. The condition of the patient.
18 Q. So not vital signs?
19 A. Right.
20 Q. So with regard to that, were you told --
21 what were you told to do as far as charting the patient
22 then in a situation like that where the patient came in
23 and they weren't happy, healthy, and doing well?
24 A. I'm not understanding.
25 Q. Well, if you had a patient come in, you

1 said that you would -- you would actually do your own
2 thing. You would re-chart or fix the chart so that it
3 would reflect that.

4 But were you ever instructed on what to do
5 in a situation like that?

6 A. No, I wasn't.

7 Q. So you just -- that everybody's supposed
8 to be in good shape?

9 A. Right.

10 Q. Now, as far as propofol, let me ask you
11 some questions about that. And, actually, let me go
12 back just a minute and ask you some things about some
13 safety issues.

14 Did you have, beside that whole
15 pre-charting thing, did you have any concerns about
16 safety issues within the practice, the things that you
17 saw in your limited three days you were there?

18 A. At the time, I didn't.

19 Q. Was there anything about the speed of the
20 procedures or the volume of procedures that were being
21 done?

22 A. Yes. I did have some concern about that.
23 People were going in pretty rapidly. It seemed like
24 sometimes seven minutes' time would pass and the
25 procedure would be over. I wouldn't be done charting,

1 and they would be moving another patient in the room.

2 Q. Now, the CRNA that was present, the person
3 giving the anesthesia, did you ever see that person get
4 up and walk out and administer to the patients out in
5 the recovery area?

6 A. I saw them leave the procedure room, yes.
7 I didn't have a view of the recovery area.

8 Q. Okay. Would they leave after every single
9 patient?

10 A. No.

11 Q. How often would they leave and why, if you
12 know?

13 A. I don't know how often they would leave or
14 why.

15 Q. Were they in the room more often than not?
16 I mean how was it going? Did they reside in the room
17 most of the time, or did they get up and leave after
18 every patient?

19 A. The majority of the time they would stay
20 in the room and would not leave. Occasionally, they
21 would leave for about 30 seconds at a time maybe.

22 Q. Was there ever an incident that you recall
23 regarding a scope, a special request for a scope?

24 A. Yes, there was a doctor who was requesting
25 a special type of scope. And from the room where the

1 scopes are being cleaned, somebody said that scope is
2 not ready.

3 Q. Okay.

4 A. And then all of a sudden that scope came
5 out, and it was handed to the doctor.

6 Q. Did that give you concern at the time?

7 A. It did because I wondered how it wasn't
8 ready and then all of a sudden it was ready.

9 Q. Did you know that there was a specific
10 amount of time that was needed to process the scopes
11 after they had been used?

12 A. I'm not aware of the length of time, no.

13 Q. But that there was some time?

14 A. There is some time.

15 Q. Now, let's move on to the issue of
16 propofol. You're familiar with that drug, I assume, or
17 at least it's used at that time in the facility?

18 A. Yes.

19 Q. Did you notice how propofol was used at
20 that facility when you were in the room?

21 A. I did. There were roughly two vials of it
22 at any given time. They were in a drawer. The doctor
23 would pull them out. I mean, sorry, not the doctor.
24 The CRNA would take them out and draw from the two
25 vials at any given time.

1 Q. Would that -- would there be a vial maybe
2 or two left on the table when a patient was moved out
3 of the room and a new patient was moved in?

4 A. Yeah, the same two vials.

5 Q. Okay. Would you see those subsequent
6 vials being used on another patient?

7 A. Yes.

8 Q. Not the subsequent vials, but the vials
9 that remained used on a subsequent patient?

10 A. Right.

11 Q. Did you see them being drawn up
12 individually out of different vials for the same
13 syringe, so to speak?

14 A. I didn't see the syringe actually taking
15 from the propofol, but I know that at any given time
16 there were only two vials that were being drawn from.

17 Q. Did you see the new ones being opened up
18 periodically or not?

19 A. No.

20 Q. Do you remember the sizes of the bottles
21 that were up there?

22 A. I could show with my hand I guess the
23 size. I'm not sure of the milligrams or anything.

24 Q. Okay. Just were they big bottles or small
25 bottles?

1 A. They were larger, yes.
 2 Q. Now, as far as the multiple patients,
 3 multiple use of propofol, you actually saw this, right?
 4 A. Yes.
 5 Q. What about syringe reuse, did you ever see
 6 syringes being used on more than one patient?
 7 A. No, I couldn't see the syringe use, how
 8 they CRNA was using the syringes.
 9 Q. Is that because of your positioning in the
 10 room?
 11 A. Yeah, because of my position.
 12 Q. So you're still in the room, you're doing
 13 your charting. Did you ever see the CRNAs move from
 14 room to room?
 15 A. At lunchtime they would switch from one
 16 room to another to fill in for each other.
 17 Q. Did you ever see the CRNAs leave the room
 18 when a patient was unconscious?
 19 A. I did.
 20 Q. Was the doctor still in the room at this
 21 point or was nobody in the room beside you?
 22 A. The doctor was there.
 23 Q. So the CRNA might leave the room. Was he
 24 gone for a very short time or for a longer time?
 25 A. About 30 seconds.

1 were training me to try to clean the rails on the beds
 2 to, you know, just for cleanliness.
 3 Q. Did you have a lot of spare time?
 4 A. No.
 5 Q. Now, after you left the facility, and did
 6 you leave the facility because of the things we've
 7 described?
 8 A. Yes, I did.
 9 Q. When you left the facility, did you tell
 10 anybody about this or try to?
 11 A. In my resignation letter, I specified why
 12 I was leaving.
 13 Q. So the resignation letter to the facility?
 14 A. Yes.
 15 Q. Who was that addressed to?
 16 A. Katie Maley.
 17 Q. You specifically mentioned this
 18 pre-charting stuff that was a concern?
 19 A. Yes, I did.
 20 Q. Ever get a response back from them?
 21 A. No.
 22 Q. Did anybody ever call you up to even talk
 23 to you about trying to come back or anything?
 24 A. No.
 25 Q. After you sent the -- or put that

1 Q. Then would come back?
 2 A. Yes.
 3 Q. Did you ever see when the CRNAs moved from
 4 room to room for lunch or whatever that they carried
 5 anything with them, syringes, propofol, anything like
 6 that?
 7 A. No, I didn't see that.
 8 Q. Okay. What was your concern -- what was
 9 your sort of observation about the cleanliness and
 10 sanitation of the rooms?
 11 A. There was no cleaning crew between the
 12 procedures. One person would -- one patient would come
 13 in, the procedure would be done, then the patient would
 14 be taken out and someone else would be brought in
 15 without the room being cleaned.
 16 Q. What about the table that the patient had
 17 been lying on having the procedure? Were they wiped
 18 down and cleaned?
 19 A. They had their own individual gurneys that
 20 we brought in, individual bed. They would already
 21 start on the bed and then that would be brought in.
 22 Then that would be wheeled out, so they would be on the
 23 same bed the whole time.
 24 Q. Okay.
 25 A. Now, when we had spare time, the nurses

1 information in the resignation letter, did you ever try
 2 and tell anybody else?
 3 A. Yes, I reported it to the State Board of
 4 Nursing.
 5 Q. And what happened with that?
 6 A. I was told that I had to specifically pick
 7 a certain nurse that was doing it.
 8 MR. STAUDAHER: And I'm going to caution
 9 the Grand Jury, that statement is not being offered for
 10 the truth of the matter, just for what happens next and
 11 why.
 12 BY MR. STAUDAHER:
 13 Q. Go ahead.
 14 A. And at the time, we only knew each other
 15 by first names, that's how we worked together. You
 16 know, it was Jane or Bob, so I didn't know the nurses'
 17 last names. There was no way to specifically pick a
 18 nurse to report to the State Board of Nursing.
 19 Q. So because you didn't have a name to
 20 report to them, is that why it didn't go any further
 21 than that?
 22 A. Right. They said they couldn't process it
 23 any further without somebody to point a finger at.
 24 Q. Okay. Did you ever follow-up after that
 25 or not?

1 A. I sent a couple emails saying that this
2 was a practice that was occurring there and hopefully
3 that someone would follow-up with it.
4 Q. And just so I'm clear, you're there
5 during, I think it was -- what was the date that -- you
6 said it was in January, or excuse me, July, right
7 around the Fourth of July?
8 A. Right.
9 Q. Of 2007?
10 A. Right.
11 Q. Okay. So on July 25th, you actually
12 weren't there, though?
13 A. Right.
14 Q. Now, as far as the postoperative area, did
15 you ever see doctors in there seeing the patients or
16 taking care of the patients out there?
17 A. I didn't see it, no.
18 Q. Did you ever see that there was any
19 changes in paperwork if a biopsy was done, for example?
20 A. During a procedure, a doctor would be
21 possibly looking at a biopsy, and then they might
22 discover something else going on with the patient, and
23 we would have to change some paperwork to update the
24 condition, say there was a mal polyp that they had
25 discovered, so then the paperwork would change to

1 still there?
2 A. Yes.
3 Q. What was the process at that point until
4 the next patient actually was wheeled out of the door?
5 Kind of walk us through it. What you would do? When
6 the patient would come in, what would happen? Just
7 kind of tell us what would happen.
8 A. The patient would come in, and we would
9 document their condition and find out who their family
10 physician was so we could send them the information on
11 their records.
12 Ask the patient their name, of course, how
13 they were feeling. If they're anxious. Set up --
14 start charting like the time that the patient had
15 entered the room.
16 Then, you know, the doctor would come in
17 and the anesthesiologist would be there, and he would
18 start to put the patient under, and then we would
19 document on how the patient was doing.
20 And then that was about it. And then when
21 the procedure was done, we would document the time that
22 it's over.
23 Q. Now, as far as the procedure itself,
24 procedure times and so forth like that, was there any
25 issue about being careful about over -- you know, the

1 document the polyp.
2 Q. So that's a time when it might change?
3 A. Yes.
4 Q. As far as the change, who would do that?
5 Would that be something you were supposed to do or
6 what?
7 A. Yes, the doctor would say, "Okay, now we
8 have a polyp," and then we would have to pull out
9 specific paperwork and start completing that.
10 Q. Now, walk me through, just if you would,
11 you're sitting in the room before the patient actually
12 rolls in. Let's say the patient you just have done a
13 procedure on has just left the room. CRNA still
14 present in the room, right? Is that correct?
15 A. Yes.
16 Q. Did the doctor walk out or would the
17 doctor have still been hanging around at that point?
18 A. The doctor is still there.
19 Q. Okay. And you're there?
20 A. Yes.
21 Q. Is there a tech there also? Somebody
22 helping the doctor with the scopes, or did they already
23 take the scope away?
24 A. I don't recall.
25 Q. Okay. So roughly the three of you are

1 times that you were documenting, not overlapping with
2 other patients?
3 A. Right. With the pre-charting issue, we
4 would have the situation where, let's say that it's
5 9:45. The procedure isn't supposed to start until
6 10:19 and you already have the chart. That -- it's
7 9:45 now, but make sure you write 10:00 so that you're
8 not documenting on what the previous nurse
9 MR. STAUDAHER: Now, again, I caution the
10 Grand Jury about that.
11 BY MR. STAUDAHER:
12 Q. Did this statement, the way that they were
13 describing this, and how to handle that, did that have
14 an affect on you as far as what you're doing and
15 whether that's proper or not?
16 A. Yes, it did.
17 Q. And, obviously, gave you concern, I
18 assume; is that correct?
19 A. Right.
20 Q. Okay.
21 MR. STAUDAHER: With that, ladies and
22 gentlemen, that statement is being offered for the
23 effect on this listener as to how she's supposed to do
24 her job and the issues that that may have caused with
25 her, you know, mentally and emotionally at the time.

1 BY MR. STAUDAHNER:
 2 Q. So if you're being told to do that, you're
 3 given specifics on how not to overlap patients
 4 essentially, correct?
 5 A. Yes.
 6 Q. Now if I understand you correctly, you
 7 have a -- and I just want to walk through this so I
 8 understand it. You have a patient that, let's say, the
 9 information you're getting from the pre-procedure room
 10 has a time on it of say 10:00 o'clock. And it
 11 currently in your room is 9:45.
 12 A. Yes.
 13 Q. In that situation, you're still writing
 14 something down on the chart, correct?
 15 A. Encouraged to, yes.
 16 Q. Okay. Encouraged to.
 17 What are you -- how are you supposed to
 18 handle that situation if the times on the chart at the
 19 point you get it says 10:00 o'clock and you know that
 20 it's not 10:00 o'clock yet, what do you do?
 21 A. I refused to write the incorrect time.
 22 Q. What were you supposed to do based on the
 23 policy or what was going on at the time?
 24 A. Based on what I was encouraged to do, I
 25 should have written 10:00 o'clock when it was 9:45 to

1 Q. You're there three days during July. Do
 2 you see that happen on all those days?
 3 A. Yes.
 4 Q. Do you see it happen more than once on all
 5 those days?
 6 A. Yes.
 7 Q. Did it appear to be a regular thing on
 8 each day you were there?
 9 A. Yes.
 10 Q. Was there ever any issue of the
 11 pre-charting thing and overlapping of times related to
 12 specific insurance companies, like Pacific Care, for
 13 example?
 14 A. No.
 15 Q. Just in general this is the way you did
 16 it?
 17 A. Right.
 18 Q. As far as the times that were in the room
 19 that you -- or times that you were supposed to
 20 document, what times in the record were you supposed to
 21 document?
 22 I mean, I assume there is a place in the
 23 chart or the record where a patient comes in and you're
 24 supposed to write down when the patient is in the room,
 25 when the patient is out of the room, various things

1 be able to start the chart earlier.
 2 Q. So you would match whatever the time was
 3 coming in or put it a little bit, few minutes ahead?
 4 A. Yeah, make sure that the times don't
 5 overlap. Excuse me. Like if it's 9:45 and that nurse
 6 previously is still working on the chart, make sure
 7 that you give enough leeway so that by the time the
 8 patient gets into your room you've documented the
 9 correct time.
 10 Q. Now, I want to be clear on this. Desai is
 11 not standing there during this process, correct?
 12 A. Right.
 13 Q. All of this is going on, all of these
 14 people are doing all of this stuff without him being
 15 present?
 16 A. Right.
 17 Q. Now, at the point that that level of
 18 deception is going on, I mean, are you telling people
 19 about this, saying "I'm not going to do this," or at
 20 least expressing some concern and about that issue?
 21 A. I was a new nurse, and I was anxious. I
 22 wasn't sure of how procedures were done like that. I
 23 thought it was maybe just how this particular office
 24 did it, but I expressed that I wasn't going to do it
 25 improperly.

1 during the process?
 2 A. Uh-huh.
 3 Q. Are you the one responsible to put all
 4 that information in at the time?
 5 A. Yes, I am.
 6 Q. Now, beside you doing your work, does the
 7 doctor do things with his record as well?
 8 A. Yes.
 9 Q. Does the anesthesia or anesthesia person
 10 do things with their record?
 11 A. Yes.
 12 Q. Are there machine tapes and things that
 13 are handed to you that have times and things stamped on
 14 them?
 15 A. Yes.
 16 Q. Did you ever look at all those times?
 17 A. No.
 18 Q. So you don't know if they were all the
 19 same time or if they were all different?
 20 A. Right.
 21 Q. Would it surprise you to find out that
 22 they were all different times?
 23 A. It would not surprise me.
 24 Q. Did you ever have a situation occur where
 25 you saw patients waking up prematurely on the table?

1 A. Yes, I did.
 2 Q. Was that something that happened on
 3 infrequent or frequent basis?
 4 A. Infrequent.
 5 Q. Okay. How often did you see that while
 6 you were there?
 7 A. I would say twice.
 8 Q. And that's during three days?
 9 A. Yes.
 10 Q. And you had a regular shift?
 11 A. Yes.
 12 Q. And what was happening during those
 13 instances?
 14 A. The patient would have been administered
 15 the propofol. And the procedure would have almost
 16 started or started, and the patient would sit up during
 17 the procedure. And I would ask the nurse training me
 18 is that normal and she said yes, that happens,
 19 sometimes people will sit up during the procedure and
 20 not know it.
 21 Q. Okay. Did it kind of startle you when
 22 that happened?
 23 A. Yes, it did.
 24 MR. STAUDAHNER: Again, that statement is
 25 offered for the effect on the listener at this time,

1 addition, you may be held in contempt of court
 2 punishable by an additional \$500 fine, and 25 days in
 3 the Clark County Detention Center.
 4 Do you understand this admonition?
 5 THE WITNESS: Yes, I do.
 6 THE FOREPERSON: Thank you. You can be
 7 excused.
 8 Okay. At this time, I would like to call
 9 for our lunch break, please, for an hour and a half.
 10 MR. STAUDAHNER: I have three more
 11 witnesses here right now. We can just keep going if
 12 you would like.
 13 (A lunch recess was taken.)
 14 THE FOREPERSON: Sir, can you raise your
 15 right hand, please? Thank you.
 16 Do you solemnly swear the testimony you
 17 are about to give upon the investigation now pending
 18 before this Grand Jury shall be the truth, the whole
 19 truth, and nothing but the truth, so help you God?
 20 THE WITNESS: Yes.
 21 THE FOREPERSON: Thank you. You may be
 22 seated.
 23 You are advised that you are here today to
 24 give testimony in the investigation pertaining to the
 25 offenses of performance of act in reckless disregard of

1 not offered for the truth of the matter.
 2 At this stage, I have nothing further for
 3 this witness.
 4 THE FOREPERSON: Are there any questions
 5 from the jury? None at this time?
 6 A JUROR: I have one.
 7 You talk about this 9:45, 10:00 o'clock.
 8 If the procedures stopped at 9:45, were you ever told
 9 to put down 10:00 o'clock?
 10 THE WITNESS: No.
 11 A JUROR: So you were never told to
 12 lengthen the procedure?
 13 THE WITNESS: No. Not ever to lengthen
 14 it.
 15 THE FOREPERSON: Any further questions?
 16 None.
 17 By law these proceedings are secret. You
 18 are prohibited from disclosing to anyone anything that
 19 transpired before us, including evidence presented to
 20 the Grand Jury, any event occurring or a statement made
 21 in the presence of the Grand Jury, or information
 22 obtained by the Grand Jury.
 23 Failure to comply with this admonition is
 24 a gross misdemeanor punishable by a year in the Clark
 25 County Detention Center and a \$2,000 fine. In

1 persons or property, criminal neglect of patients,
 2 insurance fraud, obtaining money under false pretenses,
 3 and racketeering, involving Dipak Kantilal Desai,
 4 Ronald Ernest Lakeman, and Keith H. Mathahs.
 5 Do you understand this advisement?
 6 THE WITNESS: Yes.
 7 THE FOREPERSON: Could you please state
 8 both your first and last names and spell them for the
 9 record.
 10 THE WITNESS: My first name is Vincent,
 11 V-I-N-C-E-N-T. My last name is Sagendorf,
 12 S-A-G-E-N-D-O-R-F.
 13 THE FOREPERSON: Thank you.
 14
 15 VINCENT SAGENDORF,
 16 having been first duly sworn by the Foreperson of the
 17 Grand Jury to tell the truth, the whole truth, and
 18 nothing but the truth, testified as follows:
 19
 20 EXAMINATION
 21 BY MR. STAUDAHNER:
 22 Q. Mr. Sagendorf, what do you do for a
 23 living?
 24 A. I'm a certified registered nurse
 25 anesthetist.

1 Q. And what do you do as a nurse anesthetist?

2 A. I administer anesthesia to patients who

3 are having surgery or procedures.

4 Q. Can you give us a brief synopsis of your

5 background and training?

6 A. I went to Middlesex County College in New

7 Jersey for my RN. I went to Jersey Shore Medical

8 Center Hospital in 1970 for my CRNA for my anesthesia

9 training. I graduated in 1972, took my boards and came

10 to California.

11 Q. Okay. And you eventually got to Las

12 Vegas?

13 A. Yes.

14 Q. And how was that? Not by car or boat or

15 whatever.

16 A. I had worked in San Luis Obispo for

17 approximately 36 years. My wife and I were looking for

18 a place to retire so we thought we would take a look at

19 Las Vegas, so I quit my job in California. I came out

20 here. I got an apartment, and I started working for

21 Gastroenterology of Nevada.

22 MR. STAUDAHNER: And can everybody hear

23 this witness?

24 THE FOREPERSON: Yes.

25

1 specifically on anesthesia?

2 A. Yes.

3 Q. Do you work in a hospital or some sort of

4 setting where you're giving anesthesia to patients

5 during that time?

6 A. Yes, hospital.

7 Q. Do you do any kind of apprentice program

8 afterward or are you able to just go to work?

9 A. No, you have to take boards. And if you

10 pass boards, you get to practice anesthesia.

11 Q. Now, when you go to facilities, and I

12 assume you can practice in hospitals and clinics and

13 things like that if you need to; is that correct?

14 A. Yes.

15 Q. Do you work with any other physicians when

16 you perform your services?

17 A. Not necessarily.

18 Q. So you can independently perform

19 anesthesia services?

20 A. Yes. As long as there is a physician or a

21 dentist there.

22 Q. Okay. And I guess that's what I meant,

23 not necessarily an anesthesia doctor --

24 A. Right.

25 Q. -- but an MD or something --

1 BY MR. STAUDAHNER:

2 Q. Sir, now you -- that was your first job

3 that you had when you came to Las Vegas then is the

4 Gastroenterology Center?

5 A. Yes.

6 Q. And who was the individual who was in

7 charge of that center at the time?

8 A. Desai.

9 Q. Is that Dipak Desai?

10 A. Dipak Desai. I'm sorry.

11 Q. And as far as your -- let's just touch on

12 your background just one minute for just a -- or just a

13 second.

14 A. Okay.

15 Q. You said that you're a nurse primarily by

16 training at one point, and then you went and later got

17 your anesthesia portion of that, or was it one program

18 altogether?

19 A. No, it was two programs, but I immediately

20 went from the nursing program to the anesthesia

21 program.

22 Q. The anesthesia program itself, how long is

23 that?

24 A. Two years.

25 Q. The program that you -- is it all focused

1 A. Right.

2 Q. -- or dentist, at least in the facility

3 doing the procedure with you?

4 A. Right.

5 Q. So if I understand you correctly, you

6 would not just be able to go set up shop on Las Vegas

7 Boulevard and give anesthesia to Michael Jackson or

8 anybody else that came by?

9 A. No. Good name, but no.

10 Q. Okay. As far as this particular case is

11 concerned, I know that you're familiar with the

12 circumstances surrounding the endoscopy matter; is that

13 correct?

14 A. Yes.

15 Q. With regard to your time with Dr. Desai

16 when you first came to work here, when was that again?

17 A. I started October 1, 2007.

18 Q. And how long did you work at that

19 facility?

20 A. The facility closed March 4 of 2008. I

21 was paid through April the 25th of 2008.

22 Q. So you -- did you stay in town or did you

23 leave at that point?

24 A. Well, I had a seven-month lease on the

25 apartment so I went back and forth to California.

1 Q. Okay. And is that where you currently
2 live is in California?
3 A. Yes.
4 Q. Are you performing anesthesia services in
5 California?
6 A. Yes.
7 Q. Where do you work currently?
8 A. I work at Pain Management Specialists in
9 San Luis Obispo and in Santa Maria, California.
10 Q. Do you work with physicians in that
11 location --
12 A. Yes.
13 Q. -- or those locations? I guess you said
14 two, correct?
15 A. Two.
16 Q. Now, as far as the time that you were with
17 Desai, that period --
18 A. Uh-huh.
19 Q. And when I say Desai, I'm talking about
20 the Endoscopy Center.
21 A. Right.
22 Q. He had a number of clinics in town, did he
23 not?
24 A. Yes.
25 Q. And did you work at all of them or just

1 one or two or ...
2 A. I was mainly at Shadow, but I did get to
3 Burnham, and then there was one over on Flamingo that
4 they opened just before we were closed up, and I don't
5 remember the name of it.
6 Q. Okay. But, primarily, you were working at
7 the Shadow Lane clinic?
8 A. Yes.
9 Q. Now, at the Shadow Lane clinic, what were
10 your job duties exactly?
11 A. Just to put the endoscopy patients to
12 sleep -- the colonoscopies and the endoscopies.
13 Q. Beside doing the anesthesia portion, did
14 you do any nursing functions as well?
15 A. No.
16 Q. Just anesthesia?
17 A. Just anesthesia.
18 Q. At any time after you came to the clinic,
19 did you work with an anesthesiologist, an MD
20 anesthesiologist at the time?
21 A. Never.
22 Q. Did you work with MD physicians that were
23 in the practice, the gastroenterologists?
24 A. Yes.
25 Q. Were they the only physicians that you

1 worked with in the practice?
2 A. Yes.
3 Q. Were there specific physicians that you
4 worked with more than others?
5 A. Yes.
6 Q. And who were they?
7 A. Dr. Carrol, Dr. Faris, and Dr. Carrera.
8 Q. Now, did you work with other physicians
9 within the practice beside those three?
10 A. Yes, Dr. McCurdy, Dr. Sharma and Dr. -- I
11 forget his name. It starts with a Y, so ...
12 Q. Y?
13 A. Yeah.
14 Q. Okay. Did you ever work with Dr. Desai?
15 A. I worked with Dr. Desai a few times, maybe
16 half a dozen to a dozen times.
17 Q. So, primarily, when you were at the
18 facility, he either was not there or there infrequently
19 or how -- or how did that work?
20 A. When I first got there, he was recovering
21 from what was supposed to be a stroke. And so we
22 didn't see him for the first two or two-and-a-half
23 months.
24 And then he came in, and he wanted to see
25 if he still had the hands to do the endoscopies so he

1 had Dr. Carrol come in the room with him. I happened
2 to be there and he did one colonoscopy.
3 Q. How did that go?
4 A. It went okay.
5 Q. So he seemed to be functional and able to
6 do that work?
7 A. Uh-huh.
8 Q. Any problems associated with the
9 procedure?
10 A. No.
11 Q. Now, as far as the procedures that
12 followed after that, was he then back at full strength
13 or was he doing work intermittently?
14 A. Intermittently.
15 Q. Now, prior to his return to the clinic,
16 had you noticed that there was any kind of a volume
17 decrease at the clinic?
18 A. No.
19 Q. So when you start, when you were working
20 with him, when did you start working in proximity to
21 when he had his stroke?
22 A. Well, I don't know exactly when he had his
23 stroke. He was out of the country, but he came back
24 like two-and-a-half months after I got there. We had
25 the same volume of patients from day one that I got

1 there.
 2 Q. After he comes back fully into the
 3 practice which happens at a later date; is that
 4 correct?
 5 A. Uh-huh.
 6 Q. Did you notice that the patient load
 7 increased?
 8 A. No.
 9 Q. So from your standpoint, it was always
 10 about the same?
 11 A. Yes.
 12 Q. Now, did you work full time at the Shadow
 13 Lane clinic primarily?
 14 A. Yes.
 15 Q. When you were working at the clinic, were
 16 there other certified nurse anesthetists that worked at
 17 the clinic as well?
 18 A. Yes.
 19 Q. Did you work with all of them or just a
 20 few?
 21 A. Eventually I worked with all of them, but
 22 mainly with Keith Mathahs and Linda Hubbard.
 23 Q. Was there a supervisor amongst the
 24 anesthesia individuals?
 25 A. When I first got there, it was Ron

1 Q. Five months.
 2 A. Yeah.
 3 Q. Now, during the time you were with the
 4 clinic, did you -- when you came to work there, who did
 5 you interview with?
 6 A. Tonya Rushing.
 7 Q. Did you ever interview with Dr. Desai at
 8 any point?
 9 A. I did. After I interviewed with Tonya
 10 Rushing, she told me to go down and talk with Dr. Desai
 11 so Ron Lakeman took me down there.
 12 Dr. Desai asked me if, you know, I had
 13 used propofol before, and I told him I was working in a
 14 pain center where we did approximately five to 10,000
 15 cases since I was there for 10 years, 11 years. And he
 16 said the job is yours, and that was the end of the
 17 interview.
 18 Q. So when he found out that you used
 19 propofol, he hired you on the spot?
 20 A. Yeah.
 21 Q. Okay. As far as the use of propofol, I am
 22 assuming you're familiar with the drug; is that
 23 correct?
 24 A. Yes.
 25 Q. Had you used it many, many times in the

1 Lakeman, but he left two weeks after I got there or
 2 approximately two weeks after I got there, and then it
 3 fell to Keith Mathahs.
 4 Q. And, again, I know you told me this
 5 already, but could you tell me once again the date that
 6 you actually arrived in October?
 7 A. October 1 of 2007.
 8 Q. Now, you're aware that as part of this
 9 case that there were two specific incident days on
 10 July 25th of 2007 and September 21st of 2007?
 11 A. I wasn't aware of the July one but now I
 12 am.
 13 Q. Well, if I represent that to you, at
 14 either of those two dates, I know that you didn't start
 15 work, but had you visited the clinic and done any locum
 16 tenens work or anything like that at that time?
 17 A. I visited the clinic to apply for the job,
 18 but I had never done any locum tenens or done any
 19 anesthesia until October 1 of 2007.
 20 Q. So, basically, the questions that I have
 21 will be from that short period from October through the
 22 time that you left the clinic the following year, mid
 23 year, so you're only working at the clinic for half a
 24 year roughly?
 25 A. Five months.

1 past over those years?
 2 A. Yeah. I work in a pain center again, and
 3 when I worked at Desai's, I did 3600 cases, which is in
 4 the report, and I have been doing 70 cases a week since
 5 I went back. So I'm constantly using propofol every
 6 day.
 7 Q. And I assume you're aware that the package
 8 insert on the medication has some wording as to whether
 9 it's single use or multi use; is that right?
 10 A. Yes.
 11 Q. And what is your understanding as to
 12 whether it's a single --
 13 A. It says single use.
 14 Q. And just for the -- I know that you're
 15 being -- trying to answer the questions, but for the
 16 court reporter, who is sitting here taking down all the
 17 words, if you'll let me finish my question before you
 18 answer --
 19 A. Okay.
 20 Q. -- I'll try to do the same thing for you.
 21 A. Okay. I'm sorry.
 22 Q. It just makes it harder for her to take
 23 down everything if we're talking over each other.
 24 A. I'm sorry.
 25 Q. Okay. Now, single use only, I think you

1 said, for that drug?

2 A. Yes.

3 Q. The label actually says that on the

4 package or on the bottles in which they're contained?

5 A. Yes.

6 Q. As far as that drug is concerned, was

7 there any other -- I mean, I know that that was the

8 primary drug that you used in the facility, and I'm

9 talking about the Shadow Lane clinic that you worked

10 primarily with; is that right?

11 A. Yes.

12 Q. Were there other drugs used for anesthesia

13 at that location?

14 A. For the rare patient who would be allergic

15 to eggs or lecithin or sulfa, not so much sulfa but the

16 eggs, if there was a patient who was highly allergic to

17 eggs, we would have to use something different besides

18 propofol, and so we had some Versed and Fentanyl there

19 that we would use in lieu of it.

20 Q. And you said that Keith Mathahs was kind

21 of in charge of the CRNAs at the time at least that you

22 were working there?

23 A. Yes.

24 Q. And that Mr. Lakeman, I think, had been

25 the one in charge prior to that time?

1 Q. Okay. Now, was this primarily every time

2 a patient left, or would this be periodically walking

3 out to try and check on some of the patients?

4 A. Just periodically walking out to check on

5 the patients.

6 Q. So is it fair to say that primarily your

7 time was spent in the room?

8 A. Yes.

9 Q. Now, as far as the procedure itself was

10 concerned, tell me how you did a procedure, I mean from

11 the anesthesia side.

12 You've got a patient that is about to,

13 let's say, either is the first patient of the day just

14 rolling into the room, or the last patient you have

15 just done has left the room and they are about to bring

16 that next patient in.

17 Tell me what happens from your side.

18 A. Okay. I would usually fill two syringes,

19 one with propofol and Xylocaine and one with just

20 propofol because propofol by itself is acidic, and it

21 hurts a lot when you inject it into a patient's vein,

22 so we would add the Xylocaine to cut down the amount of

23 pain.

24 If I had the time, I would go out and talk

25 to the patient and try and get a part of the history

1 A. Yes.

2 Q. Now, let me ask you a couple questions

3 about just the process by which the procedure got done

4 at the facility or was done.

5 Where typically would you stay in the

6 facility? Would you be in the room where the procedure

7 was done primarily, or would you circulate? How did

8 you interact at the facility?

9 A. I would circulate until the patient was

10 rolling into the room. Then I would be in the room.

11 Q. Okay. Now, in the -- during the day,

12 there were lots of patients that came through, were

13 there not?

14 A. Yes.

15 Q. Once the patient started rolling through,

16 did you primarily stay in the room and just administer

17 to the patients that came in and then after they left

18 the next patient that came in after that?

19 A. Yes.

20 Q. Did you ever go out to the recovery area

21 and follow patients out there and take care of them out

22 there?

23 A. Yes, I would try and see most of my

24 patients. At least I would walk by and look behind the

25 curtain and see, make sure they are doing okay.

1 and physical done in the PI or actually the bed's

2 across from the door.

3 Q. Okay. And a PI is what?

4 A. Preinduction room.

5 Q. Induction meaning anesthesia?

6 A. Yes.

7 Q. So the area where the patients are held

8 before they are brought to you?

9 A. It served both as preinduction and

10 recovery.

11 Q. Oh, same area?

12 A. Okay. Our door was here and eight feet

13 away were six beds.

14 Q. Okay. And here you, just for the record,

15 you kind of motioned in reference to closer to this

16 person, and then the area that you -- that the patients

17 were coming from and going to was a few feet away,

18 eight or so feet away?

19 A. Yes.

20 Q. Is that correct?

21 A. Yes.

22 Q. Now, the patients come into the room, into

23 the procedure room from that area?

24 A. Yes.

25 Q. Once the patient gets into the room, what

1 do you do, besides drawing up those two syringes?

2 A. We place the patient on the table, and the

3 physician necessary for the procedure, being an endo,

4 they would be sitting up. Or being a colonoscopy, they

5 would be lateral, on their side, usually on their right

6 side.

7 And I would put -- they would put the

8 blood pressure cup on, EKG leads, o2 sat monitor, and

9 then I would wait for the doctor to come in the room

10 and I would take and give the propofol.

11 Q. Would you ever go ahead and start the

12 propofol before the physician got into the room?

13 A. Not usually.

14 Q. Was there ever situations where you maybe

15 started anesthesia and the physician left the room for

16 some reason?

17 A. Yes. And as I told you, that's a little

18 different than what I had said in there.

19 Q. And, again, for the record, what are you

20 referring to, your statement to the police?

21 A. My statement to the police.

22 Q. Okay.

23 A. In reflection, there were a couple of

24 instances when Dr. Carroll would be in the room and I

25 would start the anesthetic. I would turn around and he

1 Q. Now, patient in the room, positioned,

2 you're ready to give anesthesia, waiting for the

3 doctor. Are you with me?

4 A. Right.

5 Q. What is the next thing that happens?

6 Doctor comes in the room, and then what goes on?

7 A. He usually types in a few things into the

8 computer, and then he goes ahead and starts the

9 procedure.

10 Q. What -- as far as the bottles of propofol

11 that you were using, do you remember the sizes that you

12 were using at that time?

13 A. It was either 20s or 50s. It depended on

14 the cost at the time.

15 Q. Did you use predominantly one versus the

16 other?

17 A. Predominantly 50s.

18 Q. So let's say you have a 50cc syringe --

19 A. They're not syringe, but a bottle of

20 propofol.

21 Q. Right.

22 Open that up, draw out your syringes.

23 A. Uh-huh.

24 Q. They're not drawn up, your syringes, both

25 of them; is that correct?

1 would be gone.

2 I would say, "Where is Dr. Carroll?" And

3 the nurses would usually say, "Well, he had a meeting

4 with Dr. Desai." And I'd say, "So when was somebody

5 going to tell me this?" And I would say, "Go get him.

6 I have a patient asleep on the table."

7 MR. STAUDAHER: And, again, ladies and

8 gentlemen, none of that is offered for the truth of the

9 matter, just to answer the question about why he did

10 what he did at this point.

11 BY MR. STAUDAHER:

12 Q. So that's a correction to the statement

13 that you made to the police?

14 A. Exactly.

15 Q. Any other issues regarding that particular

16 statement?

17 A. No.

18 Q. Okay. And you don't have in front of you

19 at the moment as you're testifying your statement

20 sitting in front of you referring to it?

21 A. No.

22 Q. If you need to look at that statement to

23 refresh your memory at any time during this proceeding,

24 just let me know and I can provide it to you. Okay?

25 A. Okay.

1 A. Uh-huh.

2 Q. Now, at any time, would you use, in doing

3 that, a syringe that you had used on a prior patient?

4 A. No.

5 Q. Would at times you use the same syringe on

6 the same patient?

7 A. No.

8 Q. So you always got rid of the syringes?

9 A. Yes.

10 Q. Was that a general practice or your

11 specific practice?

12 A. It's supposed to be general practice.

13 Q. Was it your specific practice?

14 A. It was my specific practice.

15 Q. Now, once the syringes are drawn up,

16 though, obviously if you're using a 50, I mean what

17 size syringes are these?

18 A. These are 10cc syringes.

19 Q. So there is approximately 30cc's left in

20 the bottle?

21 A. Yes.

22 Q. Now, at that point, it's clean?

23 A. It's still sterile.

24 Q. You could potentially use it on this

25 patient again?

1 A. Yes.
 2 Q. Could you use it on another patient?
 3 A. Yes.
 4 Q. Did you do that?
 5 A. Yes.
 6 Q. Now, before we get to that, let's stick
 7 with where we're at with the patient rolling in the
 8 room. You have two syringes drawn up. Doctor's ready
 9 to start the procedure. What do you do?
 10 A. I take -- pick up the syringe with the
 11 Xylocaine, I give that, usually the 10cc's, depending
 12 on the ability of the patient. Older patients receive
 13 less. Alcoholic patients receive more just depending
 14 on how their reaction was to the drug.
 15 And then I would take that syringe, put it
 16 in the sharps container, take the next syringe, uncap
 17 it, and put it into the line.
 18 Q. So when you say put it into the line, are
 19 we talking about like one of the heplocks that are --
 20 A. Yes.
 21 Q. -- at the IV access ports?
 22 A. Yes.
 23 Q. And, again, if you can wait until I'm
 24 done --
 25 A. I'm sorry.

1 needle and the syringe in the trash container.
 2 Q. Okay. Would you ever, after that had been
 3 connected up like that to the patient, take the syringe
 4 out with propofol in it or empty, remove the needle,
 5 put a new needle on it, and re-enter the propofol
 6 container?
 7 A. Never.
 8 Q. Why would you never do that?
 9 A. Because you don't know what's -- what's
 10 happening with that out of the -- that syringe out of
 11 the patient. You don't want to cross contaminate
 12 anything.
 13 And if you're going to use that method,
 14 blood is drawn up into the old -- to the syringe, so
 15 you could contaminate. If you have to go back and get
 16 more propofol, and you're not using the sterile
 17 syringe, which I always did, you would contaminate the
 18 propofol.
 19 Q. So you saw that there was at least a risk
 20 of that happening; is that correct?
 21 A. Yes.
 22 Q. Now, were you told by anyone to reuse
 23 syringes?
 24 A. Never.
 25 Q. And you did not do that as part of your

1 Q. -- just to make it a little easier.
 2 You say that you would hook it up to that
 3 port, or would it be, a needle be penetrating the
 4 actual port itself?
 5 A. Yes.
 6 Q. So if I understand you correctly, I have a
 7 picture in my mind of a patient with a heplock in a
 8 vein and the procedure beginning and you taking the
 9 second syringe with the needle on it and basically
 10 inserting it into the heplock; is that correct?
 11 A. Yes.
 12 Q. So now the syringe is connected to the
 13 patient?
 14 A. Yes.
 15 Q. Once that is done, I assume as the patient
 16 needs additional anesthesia would you give some?
 17 A. Yes.
 18 Q. So you monitor the patient for their needs
 19 and do that?
 20 A. Exactly.
 21 Q. At the end of the procedure, if you hadn't
 22 given all of the propofol in that particular syringe,
 23 what would you do with the syringe?
 24 A. I would take it out of the line, I would
 25 squirt the remainder into the garbage can and put the

1 practice I think you said?
 2 A. Right.
 3 Q. Now, you've left now, the patient is done.
 4 Let's say that you've either wasted the remainder of
 5 the propofol and the one syringe where you've used it,
 6 and those syringes are discarded?
 7 A. Uh-huh.
 8 Q. Patient leaves the room. And you have a
 9 bottle, a 50cc bottle that has roughly 30cc's
 10 remaining, correct?
 11 A. Yes.
 12 Q. New patient is rolled into the room. What
 13 do you do?
 14 A. I draw up two more syringes of propofol,
 15 one with Xylocaine, from that bottle because it's still
 16 sterile with two sterile syringes and needles and
 17 proceed.
 18 Q. Okay. Was that common practice to
 19 continue to use the propofol until it was gone on the
 20 next -- on subsequent patients?
 21 A. Every place I have been, yes.
 22 Q. Including this clinic?
 23 A. Yes.
 24 Q. Now, the practice that you described, the
 25 technique that you used, would that be termed a septic

1 technique?
 2 A. Yes.
 3 Q. No cross contamination possibility based
 4 on the way you did it I think?
 5 A. Right.
 6 Q. If somebody had done what I described
 7 earlier, hypothetically, removed a syringe and
 8 potentially -- and put that syringe with a new needle
 9 or not into the propofol bottle and drawn up a new
 10 syringe, would that, even for use on the same patient,
 11 could that bottle be contaminated?
 12 A. Yes.
 13 Q. Possibly contaminated?
 14 A. Yes.
 15 Q. If you had ever done something like that,
 16 would you have used that propofol on a subsequent
 17 patient?
 18 A. No.
 19 Q. Would that be the appropriate method of
 20 dealing with that situation?
 21 A. You should never try -- you never cross
 22 contaminate anybody.
 23 Q. Now, were you told to reuse propofol on
 24 subsequent patients?
 25 A. Yes.

1 Q. Do you know, in fact, if any of the clinic
 2 doctors treated those kinds of conditions on patients?
 3 A. I don't know.
 4 Q. So it's possible that they did that?
 5 A. Yes.
 6 Q. Now --
 7 A. Can I make a point?
 8 Q. Certainly.
 9 A. None of the other doctors cared whether
 10 you kept or threw away the propofol, only Dr. Desai.
 11 Q. How do you know that?
 12 A. Because they never said a word to me, and
 13 I would throw it away. So I just assumed that he
 14 was -- he was -- that was something that they weren't
 15 going to pay attention to.
 16 Q. So they never mentioned it to you, and
 17 they don't object when you throw it away?
 18 A. No.
 19 Q. Did you throw it away when he was around?
 20 A. When he would leave the room.
 21 Q. Okay. Did he ever talk to you about that
 22 or admonish you about throwing away propofol?
 23 A. No.
 24 Q. Did he even know that you were doing it?
 25 A. No.

1 Q. And who told you that?
 2 A. Mr. Mathahs.
 3 Q. Specifically?
 4 A. Well, he told me that that was Dr. Desai's
 5 order.
 6 Q. And did you try to carry out that order?
 7 A. Not always.
 8 Q. When would you not carry it out?
 9 A. Well, if I had a hepatitis patient or an
 10 HIV patient, I would throw everything away that I had.
 11 Q. So would there be times that you would
 12 actually know that you had a patient like that?
 13 A. Oh, yes. Because you knew the history and
 14 physical on them.
 15 Q. So they would tell you that they had those
 16 conditions?
 17 A. Yes.
 18 Q. Were there situations in which the clinic
 19 doctors were actually treating patients for conditions
 20 like Hepatitis C that came in for procedures?
 21 A. No.
 22 Q. That you were aware of anyway?
 23 A. Well, we just did them one time for a
 24 colonoscopy or upper endoscopy. The liver situation
 25 was treated by somebody else.

1 Q. Now, we talked already about the bottles
 2 being labeled as single use?
 3 A. Yes.
 4 Q. Do you know if you ever witnessed or were
 5 involved with propofol being moved from room to room at
 6 any time during the days?
 7 A. Usually at the end of the day, if one of
 8 the other practitioners would usually have bottles
 9 partially filled with propofol, and she would bring
 10 them over and lay them on my counter and say, you know,
 11 "If you have another patient, you can use these."
 12 And I would usually ask the nurse for
 13 another clean bottle of propofol, and I would throw all
 14 those away because I don't draw out from bottles that I
 15 didn't draw from in the first place, and I don't give
 16 anything I haven't drawn up personally.
 17 Q. Did you see that that happened on a few
 18 occasions at least?
 19 A. No.
 20 Q. As far as you just mentioned that
 21 sometimes they would bring those bottles --
 22 A. Oh, they would bring the bottles to me,
 23 but I never saw anybody use those bottles.
 24 Q. My point is, did you see the propofol from
 25 one room was at least brought to another room?

1 A. Yes.
 2 Q. Okay. Did that happen on more than one
 3 occasion?
 4 A. Yes.
 5 Q. And but you said you would never use that?
 6 A. No. If I don't draw it up, I don't give
 7 it.
 8 Q. As far as the lunch breaks and any other
 9 break that you might give to a fellow CRNA, go into
 10 their room, were there times when you did that that you
 11 walked into the room and saw propofol syringes drawn up
 12 or open bottles of propofol?
 13 A. Yes.
 14 Q. In situations like that, would you use
 15 those open bottles of propofol or syringes to
 16 administer anesthesia to a patient?
 17 A. No.
 18 Q. Did you always start fresh with your own
 19 stuff if you were there?
 20 A. Yes.
 21 Q. Did you have a discussion with Mr. Mathahs
 22 about not throwing away propofol on more than one
 23 occasion?
 24 A. No.
 25 Q. So he told you that initially?

1 Q. Okay. We're talking about the --
 2 A. Single use bite blocks.
 3 Q. The things that you put around the scope,
 4 so that you don't bite the scope?
 5 A. Well, you put it in the mouth. It's got a
 6 hole in it. You put the scope in there so the patient
 7 can't bite down on the \$30,000 scope.
 8 Q. To try to protect the scope then?
 9 A. Yes, but also that protects the teeth,
 10 so ...
 11 Q. And then you saw those washed or whatever
 12 and processed in some way?
 13 A. They were processed in some way and
 14 brought back, yes.
 15 Q. Did you ever see any other items like
 16 airway tubes or anything like that reused or washed?
 17 A. Yes. Single use airways were washed and
 18 reused.
 19 Q. And what is an airway?
 20 A. Airway is a device that keeps the tongue
 21 from falling back and obstructing the trachea. So
 22 during a situation where the patient is not breathing
 23 on their own, or you have to bag them or whatever with
 24 the ambu bag, you put it in the mouth, it keeps the
 25 tongue away from the epiglottis, and it also gives you

1 A. Yes.
 2 Q. Did he indicate what would happen if you
 3 didn't try to use all the propofol?
 4 A. Well, his term was that Dr. Desai would
 5 have a hissy fit.
 6 Q. Did he tell you why or did you know?
 7 A. Money.
 8 Q. Now, we talked about the lunch issue. I'm
 9 going to ask you about some other issues regarding some
 10 other items besides propofol.
 11 A. Okay.
 12 Q. Did you ever witness the reuse of bite
 13 blocks? And you know what bite blocks are?
 14 A. Yes.
 15 Q. And so you know what they are?
 16 A. Yes.
 17 Q. And did you ever witness the use -- reuse
 18 of those items?
 19 A. Yes.
 20 Q. What would happen with those? How would
 21 they get reused?
 22 A. Well, they would take them and they would
 23 wash them, and I don't know, they may have sterilized
 24 them. I don't know that, but they would bring them
 25 back in and use them, yeah.

1 an airway.
 2 Q. So this is not a tube that goes into the
 3 trachea then?
 4 A. No.
 5 Q. This is just one of those little plastic
 6 things that keeps the tongue down essentially?
 7 A. Exactly.
 8 Q. Are those really expensive items?
 9 A. No. They are a nickel.
 10 Q. But you guys would rewash and reuse those?
 11 A. Yes.
 12 Q. Was there ever an issue or concern that
 13 you had regarding the handling of certain items in the
 14 endoscopy suites, such as forceps, anything like that?
 15 A. Yes. The techs tended to not pay
 16 attention to what those things were touching, and they
 17 may touch the floor, they may drag them across the
 18 patient or they may hit me in the head with them.
 19 It's a long, long cable with scissors-type
 20 handle, and it goes through the scope. And you can
 21 take bites of things and move things out of the way or
 22 whatever. And they just -- their sterility technique
 23 was questionable.
 24 Q. So you actually saw these things
 25 contacting the floor and the various things you talked

1 about and then being used on a patient?

2 A. Yeah.

3 Q. As far as the -- that situation, did you

4 ever try and tell anybody about that or get anything

5 done regarding that issue?

6 A. I told Mr. Kruger, who was the head nurse.

7 Q. Okay.

8 A. And he said he would take care of it.

9 Q. Well, I was going to say without getting

10 into what he said.

11 MR. STAUDAHER: And I would ask the Grand

12 Jury to disregard that statement.

13 BY MR. STAUDAHER:

14 Q. You at least sought out somebody to take

15 care of that?

16 A. Yes.

17 Q. To your knowledge, did the practice

18 change?

19 A. No.

20 Q. Now, I'm going to ask you specifically

21 about -- I know that you didn't work extensively with

22 Dr. Desai, but specifically, I want to ask you about

23 any issues you ever had with him with trying to start a

24 procedure before anesthesia was actually on board on a

25 patient?

1 period. Was the patient still writhing or had the

2 anesthesia taken effect by that time?

3 A. Well, by the last minute, it had worked.

4 Q. Okay. Now, as far as upper endoscopies

5 are concerned for most of the doctors in the group, I

6 mean what were the average times for doing that? And

7 I'm not talking about Desai or Carrol, who I believe

8 also was pretty fast.

9 A. Well, if you averaged it out, an endoscopy

10 would be 15 minutes. A colonoscopy would be 20

11 minutes, tops.

12 Q. Okay.

13 A. Except for the slower ones.

14 Q. And when you say slower ones, are you

15 talking about slower doctors?

16 A. Slower doctors.

17 Q. And who were the slower doctors?

18 A. Dr. Manuel. He was a new physician out of

19 school. He was quite cautious and quite slow.

20 Dr. Faris was another one who was slow. Those are the

21 two slowest.

22 Q. How did Dr. Carrera fare in that group?

23 A. He was in the middle.

24 Q. And then on the faster end, who are we

25 talking about?

1 A. I think two instances for upper

2 endoscopies. I turned around to administer the

3 propofol, and he was already inserting the endoscope

4 into the esophagus.

5 Q. Did you indicate to him that you hadn't

6 given anesthesia yet?

7 A. I said, "We're not ready." And he just

8 kept on like I wasn't there so I gave the propofol as

9 fast as I could.

10 Q. In those instances when you yell out to

11 him what you just said, did he tell you he was just

12 going to go forward anyway I mean or just do it?

13 A. No, he would just ignore me.

14 Q. So what was -- how was the patient

15 reacting during these times?

16 A. The patient was gagging and bucking.

17 Q. Was he, in those instances, those couple

18 of instances, were they both upper endoscopies you

19 said?

20 A. Yes.

21 Q. How long a procedure did that take to do

22 those with the patient bucking and writhing like you

23 said?

24 A. Well, two or three minutes.

25 Q. So those would be done within that time

1 A. Dr. Desai and Dr. Carrol.

2 Q. Who was the fastest in the group?

3 A. Dr. Desai.

4 Q. Noticeably faster than the rest?

5 A. Yes.

6 Q. For him to do -- and how long did it take?

7 You said the average colonoscopy was around 20 minutes

8 or so?

9 A. Yes.

10 Q. How long did it take Dr. Desai to do an

11 average colonoscopy?

12 A. Six, seven minutes.

13 Q. What about an upper endoscopy?

14 A. Minute or two.

15 Q. Now, did you ever have a situation happen

16 where a patient woke up during the time that the

17 procedure was going on and started having trouble while

18 a procedure was actually happening?

19 A. Yes.

20 Q. What happened? What typically would

21 happen?

22 A. They would either have a spasm because

23 they got light. It looked like the doctor might be

24 finishing, so you would start cutting back on the

25 titration, and they would spasm or just buck a little

1 bit or move around a little bit, and then we would just
2 give them more propofol.

3 Q. Now, did you ever have any issues with
4 regard to how patients were moved out of rooms to the
5 recovery area and the way they were positioned out
6 there?

7 A. I had big situation with that because the
8 protective equipment for the patient is on the far
9 wall. And that means that the oxygen was there, the
10 suction was there, the ambu bag was there.

11 Q. And what is an ambu bag?

12 A. Ambu bag is a bag that you see the rescue
13 squads use, you put a mask over it, and then they pump
14 on it --

15 Q. So it has a portion of the bag that you
16 can squeeze?

17 A. Right. And you're forcing air up to the
18 lungs.

19 All that equipment was on the far wall,
20 and they would push the patients in feet first. So the
21 equipment that was necessary to take care of them if
22 there was a problem was at the other end of the bed and
23 it wouldn't stretch.

24 So if you had a problem, you would have to
25 pull the patient out, turn the bed around, and shove

1 the patient back in.

2 Q. Why didn't they just bring the patients in
3 headfirst to begin with?

4 A. We're lazy.

5 Q. Was there -- was speed any portion of
6 that?

7 A. That was the whole thing.

8 Q. So was that the resuscitation kind of
9 equipment if there was a problem with the patient that
10 needed help?

11 A. Yes.

12 And I made mention of that, and they said
13 that's the way we've always done it.

14 Q. What about issues regarding suction tubing
15 on canisters and so forth?

16 A. When I first got there, there were no
17 canisters.

18 Q. And what are we talking about when we
19 say --

20 A. Canister is attached to a vacuum and fluid
21 are sucked up out of the patient's pharynx and it goes
22 to this canister, which collects it.

23 Q. Is that an important thing to have
24 available?

25 A. It is because it maintains the vacuum for

1 the suction.

2 Q. But why is the suction in itself even
3 important --

4 A. Because the patient may be having a
5 problem with saliva or Lauren's spasm or they are
6 bleeding or, you never know, they are vomiting, and you
7 want to get that out of the trachea or out of the
8 posterior pharynx so you need the suction. It's one of
9 the most important pieces of equipment.

10 Q. So posterior pharynx, just so we're clear,
11 is the back part of the throat; is that right? Is it
12 the back part of the throat?

13 A. Yes, yes, I'm sorry.

14 Q. So if fluids or things, whatever,
15 collected in that area, would the potential be to
16 breathe that into your lungs?

17 A. Yes.

18 Q. Is that why you would want to try and suck
19 it out?

20 A. Yes, or they would have a Lauren's spasm,
21 which means that the vocal cords clamp together, and
22 then you have to get the ambu bag to breathe for them.

23 Q. Now, as far as this suction tubing then,
24 you said the canisters didn't even exist when you first
25 got there?

1 A. They weren't on the wall.

2 Q. How was it that they later came to be on
3 the wall?

4 A. Because I insisted.

5 Q. Now, did they work in that current
6 condition with just being hooked up to the wall?

7 A. Yeah.

8 Q. Okay. Were they usable by you at that
9 point?

10 A. Yes.

11 Q. Did you require anything else like tubing
12 to utilize them?

13 A. Yes.

14 Q. Was there an issue regarding the tubing?

15 A. Not the tubing on those, but the tubing on
16 the ventilator. The tubing on the ventilator had dry
17 rotted from years of -- we didn't use a ventilator very
18 much, but the tubes were all dry rotted.

19 And I had noticed that one day and said,
20 "How are you going to use this piece of equipment?"
21 The head nurse said --

22 Q. And, again, I don't want to get into --

23 A. Okay.

24 Q. Who was the head nurse? Was this Mathahs?

25 A. No.

1 Q. Who was it?
 2 A. Kruger.
 3 Q. Kruger. Okay. I don't want to get into
 4 what he said.
 5 A. Okay.
 6 Q. You pointed it out?
 7 A. Yes.
 8 Q. Was that corrected at some point?
 9 A. Yes.
 10 Q. Okay. Now, after but beside that issue,
 11 any other concern you had with regard to how things
 12 were done, sterility, cleanliness, anything like that?
 13 A. Well, overall the facility itself was --
 14 sterility wasn't one of the main concerns.
 15 Q. And I guess sterility may not have been
 16 because this wasn't necessarily -- colonoscopies aren't
 17 a sterile procedure?
 18 A. They are not a sterile procedure, but you
 19 can make them clean.
 20 Q. And was the facility clean?
 21 A. Relatively, yes.
 22 Q. Were there any problems with that that you
 23 were concerned about?
 24 A. Not that I recollect.
 25 Q. Now, I want to move to another area

1 instances the patient, you didn't follow the patients
 2 out. They would leave the room. Would it be then when
 3 they left the room?
 4 A. Yes.
 5 Q. So start time beginning of anesthesia,
 6 stop time beginning patient leave the room?
 7 A. Yes.
 8 Q. Was there an issue with the stop times and
 9 the start times --
 10 A. Yes.
 11 Q. -- of anesthesia?
 12 And tell us about that.
 13 A. When I got there on the first day, I went
 14 downstairs and to get the lay of the land from
 15 Mr. Mathahs. And he told me that Dr. Desai insisted
 16 that the cases last at least 31 minutes. So we juggled
 17 the numbers usually to make sure that it always came up
 18 to 31 minutes or close to it.
 19 Q. Now, when he told you this, did it have
 20 some -- did it have an affect on you as far as what was
 21 going on?
 22 A. Yeah. I knew it was wrong, but I had quit
 23 my job in California. I had a wife, and I had house
 24 payments, and I needed that job.
 25 Q. Okay. So as far as the times that you

1 regarding anesthesia times and start times and stop
 2 times.
 3 You do this type of work, and you know, I
 4 assume, what anesthesia start times and stop times are
 5 supposed to be, correct?
 6 A. Yes.
 7 Q. When is anesthesia start times supposed to
 8 begin from your perspective?
 9 A. When you give the anesthetic.
 10 Q. So does it begin when you first make
 11 contact with the patient or when they enter your room
 12 or anything like that?
 13 A. No.
 14 Q. Okay. So at some point when you're ready
 15 to give anesthetic, that's when your anesthesia would
 16 start?
 17 A. Yes.
 18 Q. Is that what you would typically document
 19 on paperwork?
 20 A. Yes.
 21 Q. What about anesthesia stop time, when
 22 would that supposedly happen?
 23 A. That would be when you turn the patient
 24 over to the recovery room nurse.
 25 Q. So in this instance, you said most

1 actually witnessed from all of these doctors, the
 2 procedures, would you say they typically went 31
 3 minutes or more or less?
 4 A. Less.
 5 Q. Significantly less than that?
 6 A. Yes.
 7 Q. Did you see any that went above 30
 8 minutes?
 9 A. Yes.
 10 Q. Was that a rare event?
 11 A. Except for Dr. Manuel.
 12 Q. Excluding Dr. Manuel?
 13 A. Yes.
 14 Q. For most of the other doctors?
 15 A. Ask me the question again.
 16 Q. I said excluding Dr. Manuel, from most of
 17 the other doctors, was that a rare event?
 18 A. Yes.
 19 Q. Now, when you said you had to juggle the
 20 numbers, tell me how you guys would juggle the numbers.
 21 A. Well, we would -- you could start by when
 22 the patient -- when you went out and saw the patient
 23 for the history and physical.
 24 And then you could just add, at the end,
 25 you could add some, whatever you needed to make up for

1 the 31.
 2 Q. So was it pretty clear that you were
 3 having to do that on pretty much every single patient
 4 that came through?
 5 A. Yes.
 6 Q. The -- I assume -- well, again, I
 7 shouldn't assume.
 8 Did you know if you were the only one that
 9 was doing this in the practice?
 10 A. Everybody was doing it.
 11 Q. And was it pretty well a common occurrence
 12 then?
 13 A. Yes, and if I didn't put down the correct
 14 numbers, either the nurses would tell me that I hadn't,
 15 or a young lady from upstairs would come down and say
 16 you forgot to sign this and the times are wrong.
 17 Q. When that would happen, would that cause
 18 some affect on your person as well?
 19 A. I didn't feel good about it.
 20 Q. Now, did you then correct the sheets?
 21 A. I corrected them to the day. I left the
 22 31 minutes.
 23 Q. Was it always 31 or was it sometimes 32 or
 24 33?
 25 A. Sometimes 32, sometimes 33.

1 practice anesthesia by the bills, so I never -- I was
 2 always salaried, so there was no reason for me to find
 3 out. And to this day, I don't know what things cost.
 4 Q. As far as the anesthesia times and so
 5 forth are concerned, you are aware how anesthesia is
 6 typically billed, though, in increments and things like
 7 that?
 8 A. Yes.
 9 Q. So are you aware that there is, usually
 10 based on whatever the code is for the procedure, that
 11 there is a base number of units that's assigned to that
 12 procedure, and then your time is added on to that in
 13 increments?
 14 A. I know that.
 15 Q. Okay. And what are the typical increments
 16 that are time added on?
 17 A. That I don't know.
 18 Q. So it could be one minute, five minutes,
 19 ten minutes?
 20 A. Exactly.
 21 Q. If I represented to you that the increment
 22 typically is 15 minutes, would that surprise you?
 23 A. No.
 24 Q. So in a situation where a person was
 25 billing for 31, 32, 33 minutes, in that scenario,

1 Q. Would you have put your start time down at
 2 some point and then just calculate how many minutes it
 3 was beyond that to get your stop time?
 4 A. Yes.
 5 Q. Now, on the anesthesia records that you're
 6 keeping track of, there are also vital signs being
 7 tracked during that entire 31, 32, 33-minute period; is
 8 that correct?
 9 A. Yes.
 10 Q. And, obviously, the patient isn't even in
 11 your care during that whole time?
 12 A. Right.
 13 Q. So the documents that were being produced,
 14 did they contain accurate patient information?
 15 A. No.
 16 Q. Did you know what was happening with those
 17 anesthesia records?
 18 A. No.
 19 Q. Did you involve yourself at all in the
 20 billing?
 21 A. Never.
 22 Q. And why was that?
 23 A. I made a point when I started in
 24 anesthesia to never find out or know about what things
 25 cost or what the billing was all about. I don't

1 hypothetically, you could bill for three anesthesia
 2 units on top of the base, correct?
 3 A. Correct.
 4 Q. If you were using 15 minutes as the
 5 increment?
 6 A. Right.
 7 Q. Now, did you ever get the actual -- when
 8 the bills went in, I know you weren't involved with the
 9 actual mechanics or nuts and bolts of doing that, but
 10 when the anesthesia bills went in to get paid to
 11 whatever insurance company it was, did you ever get any
 12 of that money directly back to you?
 13 A. No.
 14 Q. Did you ever get bonuses or other
 15 remuneration based on the number of procedures you did
 16 or the amount of minutes that were billed to your
 17 knowledge?
 18 A. No.
 19 Q. What kind of bonuses, if any, did you
 20 receive?
 21 A. None.
 22 Q. The entire time you were there?
 23 A. Entire time I was there.
 24 Q. Now, when you first got there, were you
 25 under the impression that there would be some bonuses?

1 A. They said that they always gave out
2 quarterly bonuses.
3 Q. But you never got one?
4 A. No.
5 Q. As far as the anesthesia records, although
6 you weren't involved with the actual billing itself, I
7 assume you knew that they were used for billing
8 purposes?
9 A. Yes.
10 Q. That those would be submitted in some way
11 to an insurance company and they would make a
12 determination based on that to provide money back to
13 the practice?
14 A. Yes.
15 Q. Was it general knowledge that those --
16 well, I think you've already testified that it was
17 general knowledge that you guys were fudging the time,
18 so to speak; is that correct?
19 A. Yes.
20 Q. Did everybody realize that those bills
21 were going to insurance companies, generally?
22 A. I would think so.
23 Q. And you did, certainly?
24 A. Yeah.
25 Q. Now, as far as the times were concerned,

1 if you didn't know, I know you said you were going out
2 there and you're using -- adding on a few minutes.
3 Did you ever have to extrapolate times
4 like to get out to that 31, 32, 33 minutes?
5 A. Yeah.
6 Q. Okay. As far as the people that would
7 come down from billing or whoever they were, was Tonya
8 Rushing ever one of those persons that would come to
9 you with the records and say you need to fix this?
10 A. I know that young lady worked directly
11 with Tonya, but I don't know if Tonya sent her down.
12 Q. So she never came down and actually --
13 A. No.
14 Q. -- did that with you?
15 Okay. As far as the records themselves,
16 did -- were there times where somebody would change the
17 record for you?
18 A. On a couple instances, the nurses would
19 say, you didn't get this time right. Do you want me to
20 change it for you? And I would say yes.
21 Q. Was it a well-known fact that Desai wanted
22 at least 31 minutes put on those anesthesia records?
23 A. Yes.
24 Q. Did everyone work within the practice to
25 make that happen?

1 A. I think so.
2 Q. And I'm talking about the billers, the
3 nurses, supervisors, all that stuff?
4 A. I don't know.
5 Q. That you were aware of or that you saw
6 happen?
7 A. I just knew about the nurses. I don't
8 know about the supervisors.
9 Q. Okay. Why did you do that? I know you
10 said the things about your job and your family. Is
11 that the main reason why this was going on?
12 A. I needed that job. And like I had said to
13 you earlier I had to -- another job that I had applied
14 for, and I was about -- after three weeks there because
15 I wanted to leave.
16 Q. So you actually get into Desai's practice
17 and then you start applying for another position?
18 A. Exactly.
19 Q. Talk to me about that for a minute.
20 A. When I got there, there was a -- there was
21 some openings over at Southwest. So I went over there
22 and I talked to one of the CRNAs over there, and I
23 talked to their hiring people, and they had me take a
24 battery of tests on line for executive positions.
25 And I guess I passed all of those. And

1 then I had a round-table discussion and interviews, and
2 then I was offered the job and told what the salary
3 would be and what the benefits would be and that I was
4 first in line and that there were two jobs.
5 And so I assumed that I would be leaving
6 posthaste, but United came in and said they were buying
7 the business and that they suspended all contracts.
8 Nobody could sign a new contract.
9 And by the time January rolled around and
10 they still hadn't called me because they still had the
11 moratorium on the contracts, the CDC came and laid that
12 bomb on the group, and I wasn't hireable anywhere.
13 Q. So that's after, at least, the CDC comes
14 in to do the investigation, is that what you're talking
15 about?
16 A. And it gets reported in the papers and on
17 the news and so on. I couldn't get a job as a janitor.
18 Q. As far as the work that you were doing, so
19 initially you come in in October of the prior year,
20 '07. This practice is going on pretty regularly and
21 rampantly at that time?
22 A. Yes.
23 Q. Is that fair to say?
24 A. Yes.
25 Q. Am I clear that within three weeks of that

1 you were out looking for another job?

2 A. Yes.

3 Q. Was it because of that stuff that was

4 going on in the practice?

5 A. That was part of it. Plus when I came to

6 work there, I was told it was an eight-hour-a-day job,

7 five days a week. And I never got out of there with at

8 least 10, 11, 12, 13 hours, and I worked 56 hours in

9 the first week. Well, that's two more days over 40

10 hours.

11 So I was looking -- I was -- I'm not a

12 youngster anymore, and I needed to find something else

13 to do because I couldn't handle that kind of schedule.

14 Q. Just be careful of this microphone. I

15 think it's hurting some ears in the room.

16 A. I'm sorry.

17 Q. As far as the story, you said that once it

18 broke that that became an impossibility, correct?

19 A. Yes.

20 Q. As far as the story itself, when you have

21 that happen, when this starts coming out, are you guys

22 at some point talked to by the administrative

23 personnel?

24 A. We were talked to by Tonya Rushing.

25 Q. Okay. Now, was that at a meeting or was

1 that individually?

2 A. It was at a meeting.

3 Q. How many people were at the meeting?

4 A. I think four.

5 Q. Four people total?

6 A. Five with Tonya.

7 Q. And who were the people at the meeting

8 except Tonya?

9 A. I think it was myself and Keith and Winnie

10 Mione, and Ralph.

11 Q. I believe it's M-I-O-N-E.

12 Now, before we get to the part about what

13 may or may not have been said at that meeting, at this

14 point, you know what's been going on in the practice

15 and what you've been doing?

16 A. Yes.

17 Q. The CDC has come?

18 A. Yes.

19 Q. They have left, and they have -- they have

20 given you kind of a report, correct?

21 A. Yes.

22 Q. This has been in the news?

23 A. Yes.

24 Q. Were you concerned at this point?

25 A. I was because all this was coming out.

1 Q. So when Tonya Rushing comes down to talk

2 to you, or gathers you together to talk to you, without

3 telling us what she said at this moment, when she said

4 those words, did that affect you in some way?

5 A. Yes, because I knew that this was -- that

6 this was all going to be coming out and we were in a

7 lot of trouble.

8 Q. So did you see the implications of what

9 was about to happen?

10 A. Yes, I did.

11 Q. Did you see the implications of what she

12 was about to say to you or what she said to you? What

13 it potentially meant?

14 A. Yes.

15 Q. What did she say to you?

16 MR. STAUDAHER: And, ladies and gentlemen,

17 at this time, this is going to be a hearsay statement,

18 but it's being offered for the affect on this listener,

19 how it affected him in relation to hearing the words

20 that were said, not necessarily for the truth of the

21 matter, although they are offered for that at this

22 point, but the affect on the listener.

23 BY MR. STAUDAHER:

24 Q. Go ahead and tell us what you were told by

25 her.

1 A. She said that no one is allowed to mention

2 Dr. Desai's 31-minute add on times.

3 Q. Was that pretty much it?

4 A. Yeah.

5 Q. So the whole meeting was about that

6 particular issue?

7 A. Exactly.

8 Q. So what did you do after you -- after that

9 was said to you? What was going through your mind?

10 A. Well, that we were, you know, they knew

11 about that, and we had been doing it, and we were in a

12 lot of trouble for it and life was not going to be the

13 same.

14 Q. So a significant affect on you, basically?

15 A. Oh, yes.

16 MR. STAUDAHER: I have nothing further for

17 this witness, ladies and gentlemen.

18 THE FOREPERSON: Are there any questions

19 from the jury?

20 Yes.

21 A JUROR: How many patients a day did you

22 work on approximately?

23 THE WITNESS: Sixty to 70.

24 A JUROR: Okay. Now, how did they justify

25 31 minutes a person? Let's just use your lower figure

1 60. That's 30 hours.
 2 THE WITNESS: Yes.
 3 A JUROR: Right? At 31 minutes a piece,
 4 that's 30 hours.
 5 MR. STAUDAHER: I'm going to interrupt for
 6 just a second.
 7 BY MR. STAUDAHER:
 8 Q. I think they did run two rooms; is that
 9 correct?
 10 A. We ran two rooms, yes.
 11 A JUROR: Okay. Well, still that's 15
 12 hours then, let's say cutting it in half. I don't know
 13 how they could justify the time or juggle your sheets
 14 to show 31 minutes on each sheet and have that many
 15 people in a day, in a 10-hour, 12-hour --
 16 THE WITNESS: I don't have an answer for
 17 that. I know that the numbers were juggled, and
 18 whatever they did upstairs in billing was totally out
 19 of my hands. So they may have hedged funds then --
 20 those just the same way.
 21 MR. STAUDAHER: And I would admonish the
 22 Grand Jury not to take that speculation at issue here
 23 or to consider it in your deliberations later on.
 24 THE FOREPERSON: Bianca?
 25 A JUROR: So, Mr. Sagendorf, all of the

1 other things that they asked you to do at the Endoscopy
 2 Center, you didn't do morally, reusing propofol and
 3 things like that.
 4 Just out of curiosity, you had a lot of
 5 concern for your job, your security. If you didn't do
 6 those items, why did you juggle the numbers?
 7 THE WITNESS: All I had was my job
 8 security. That's the only excuse I have for juggling
 9 the numbers. Why I didn't -- why I didn't do the
 10 propofol thing is --
 11 A JUROR: No, that's not what I'm asking.
 12 I'm sorry to cut you off, but what I'm asking you is
 13 all of the -- you didn't do those things because
 14 morally you knew that it wasn't the right thing to do.
 15 So in regards to that juggling the
 16 numbers, would you say it's fair to say it wasn't
 17 morally correct either?
 18 Were you not concerned about your job
 19 security when you refused to do those other things with
 20 propofol or reusing items or where you would throw
 21 things away behind Dr. Desai's back? I'm just trying
 22 to understand why the juggling of the numbers weighed
 23 differently?
 24 THE WITNESS: Well, it was morally wrong,
 25 yes. But the other things I couldn't do directly to a

1 patient because I had never done them. I had never
 2 done this either, but I don't have a real good answer
 3 for you. It was wrong. I was wrong. What I did was
 4 wrong.
 5 A JUROR: Did you ever at any time report
 6 or try to report that facility to a higher authority?
 7 THE WITNESS: No.
 8 THE FOREPERSON: Are there any further
 9 questions? There are none.
 10 MR. STAUDAHER: I have one related to that
 11 that I just want to clarify.
 12 BY MR. STAUDAHER:
 13 Q. The fudging of the numbers did not have a
 14 direct impact on patient care; is that correct?
 15 A. Right.
 16 Q. The reuse of a syringe or the reuse of
 17 propofol that might be contaminated would have a direct
 18 impact to a patient's potential health and outcome;
 19 correct?
 20 A. Most definitely.
 21 Q. Okay. Is that part of the reason why that
 22 is the line you would not cross?
 23 A. Right.
 24 MR. STAUDAHER: I have nothing further.
 25 THE FOREPERSON: Yes.

1 A JUROR: Did you ever discuss with the
 2 other nurse anesthesiologist about this timing problem?
 3 THE WITNESS: No. We were all doing it.
 4 A JUROR: You were all doing it. But how
 5 can you say that? You were in one room, they are in
 6 another room, how do you know they were doing it in the
 7 other room?
 8 THE WITNESS: I wouldn't know. I just
 9 know that they weren't getting hollered at so I assumed
 10 that they were doing it, too, because they were the
 11 ones that told me they -- you know, at least Keith was
 12 the one told me to do it.
 13 A JUROR: So you never discussed it over a
 14 cup of coffee or a drink or anything?
 15 THE WITNESS: No.
 16 THE FOREPERSON: Any further questions?
 17 There is none.
 18 By law these proceedings are secret. You
 19 are prohibited from disclosing to anyone anything that
 20 transpired before us, including evidence presented to
 21 the Grand Jury, any event occurring or a statement made
 22 in the presence of the Grand Jury, or information
 23 obtained by the Grand Jury.
 24 Failure to comply with this admonition is
 25 a gross misdemeanor punishable by a year in the Clark

1 County Detention Center and a \$2,000 fine. In
 2 addition, you may be held in contempt of court
 3 punishable by an additional \$500 fine, and 25 days in
 4 the Clark County Detention Center.
 5 Do you understand this admonition?
 6 THE WITNESS: Yes.
 7 THE FOREPERSON: Thank you. You may be
 8 excused.
 9 THE WITNESS: Thank you very much.
 10 THE FOREPERSON: You're welcome.
 11 Okay. We're going to call a ten-minute
 12 break.
 13 (A recess was taken.)
 14 THE FOREPERSON: Please remain standing
 15 and raise your right hand.
 16 Do you solemnly swear that the testimony
 17 you are about to give upon the investigation now
 18 pending before this Grand Jury shall be the truth, the
 19 whole truth, and nothing but the truth, so help you
 20 God?
 21 THE WITNESS: Yes.
 22 THE FOREPERSON: Thank you. Please be
 23 seated.
 24 You are advised that you are here today to
 25 give testimony in the investigation pertaining to the

1 offenses of performance of act in reckless disregard of
 2 persons or property, criminal neglect of patients,
 3 insurance fraud, obtaining money under false pretenses,
 4 and racketeering, involving Dipak Kantilal Desai,
 5 Ronald Ernest Lakeman, and Keith H. Mathahs.
 6 Do you understand this advisement?
 7 THE WITNESS: Yes.
 8 THE FOREPERSON: Could you please state
 9 both your first and last names and spell them for the
 10 record.
 11 THE WITNESS: Ryan Cerda. R-Y-A-N. Last
 12 name C-E-R-D-A.
 13 THE FOREPERSON: Thank you.
 14
 15 RYAN CERDA,
 16 having been first duly sworn by the Foreperson of the
 17 Grand Jury to tell the truth, the whole truth, and
 18 nothing but the truth, testified as follows:
 19
 20 EXAMINATION
 21 BY MR. STAUDAHER:
 22 Q. Mr. Cerda, what do you currently do for a
 23 living?
 24 A. Right now I work security.
 25 Q. I want to take you back in time to around

1 July/August of 2007. After you -- I assume you shortly
 2 before that graduated from high school; is that
 3 correct?
 4 A. Yeah.
 5 Q. Did you get a job in a business that did
 6 some medical billing around that time, July/August of
 7 that year?
 8 A. Yes, I did.
 9 Q. And if you could, tell us what the name of
 10 the -- excuse me. Excuse me. If you could, tell us
 11 what the name of the business was, if you know?
 12 A. Health Care Business Solutions.
 13 Q. Who was the owner of that business?
 14 A. Tonya Rushing.
 15 Q. Where was the business located at?
 16 A. Cheyenne and Tenaya.
 17 Q. There was not -- or was it associated in
 18 any way that you know of with the Endoscopy Clinics of
 19 Southern Nevada, anything like that?
 20 A. Yes.
 21 Q. And how was it associated with them?
 22 A. We did the billing for them.
 23 Q. Okay. Physical location, though, was it
 24 the same or different? Obviously, the Tenaya address
 25 isn't on Shadow Lane.

1 A. Yeah, it was different.
 2 Q. Okay. Who was the owner of the business
 3 to your knowledge?
 4 A. Which business?
 5 Q. The one you worked at.
 6 A. Tonya Rushing.
 7 Q. How did you come to work in that facility?
 8 A. I knew her son and I just graduated high
 9 school so, you know, I needed a job. I didn't really
 10 want to go to college. I was -- I could type fast so,
 11 you know, he brought me to his mom, I spoke with her,
 12 and she interviewed me and got me started.
 13 Q. Now, once you go to the Tenaya facility,
 14 you said Cheyenne and Tenaya, correct?
 15 A. Yes.
 16 Q. What kind of place was that? Was it an
 17 office building? Home?
 18 A. Yes, it was a little office building.
 19 Q. How many people worked in the facility,
 20 roughly, if you know?
 21 A. Around six or seven.
 22 Q. What was your job specifically?
 23 A. Well, the medical billing. The data entry
 24 and ICD 9 coding.
 25 Q. What is ICD 9?

1 A. Basically, the coding of the diagnosis
2 that we got from the anesthesia records.
3 Q. So at this point, if I understand you
4 correctly, you get records from some source, and then
5 do some coding, and then take those records and bill
6 the insurance companies?
7 A. Yes.
8 Q. What kind of records did you bill from?
9 What kind of records did you get to bill with?
10 A. Like how, what do you mean?
11 Q. Well, you had mentioned anesthesia
12 records.
13 A. Yeah.
14 Q. Were there other types of records that you
15 billed beside anesthesia?
16 A. Well, it was just a packet of it, yeah,
17 and then the anesthesia records basically.
18 Q. Did you ever do colonoscopy billing or
19 endoscopy, upper endoscopy billings, EGDs?
20 A. Yes.
21 Q. So those as well as the anesthesia?
22 A. Yes.
23 Q. When you would get those, would they
24 come -- how would they arrive in your office?
25 A. They would be brought in by a courier, and

1 them?
2 A. There is a sheet that we fill out, and
3 basically you would fill it out, patient's name, and
4 then you would enter their data entry, like their name,
5 address, and you would look at the anesthesia time, get
6 the time, the diagnosis, the ASA classification.
7 Q. What is ASA?
8 A. It's -- I really don't know. It's just
9 like a P1, P2, P3 or P4.
10 Q. So whatever it said, you just put down on
11 the records?
12 A. Yeah, exactly.
13 Q. So one of the items that you mentioned
14 that you specifically looked at and utilized was the
15 anesthesia billing time; is that correct?
16 A. Yes.
17 Q. What did you do with the -- was it in
18 minutes or what?
19 A. It was in minutes.
20 Q. What would you do with that?
21 A. Well, basically, depending on the minutes,
22 where it ranged, around 30, you know, 28 up through
23 about 34, was depending on how much the anesthesia
24 billing would be.
25 Q. Were they billed -- were the increments --

1 then be in like stacks and then they would be handed to
2 us.
3 Q. Was this every day that you would get
4 these?
5 A. Yes.
6 Q. And how many days a week did you work?
7 A. Monday through Friday.
8 Q. How many would you typically get from say
9 the Endoscopy Center of Southern Nevada on Shadow Lane,
10 that clinic?
11 A. A day?
12 Q. Yeah.
13 A. Probably roughly around maybe a hundred or
14 more, around a hundred.
15 Q. So you would get a lot of them?
16 A. Yeah.
17 Q. When you got those from that center, tell
18 me how -- I know you said that the courier brings them
19 over, they are in stacks. When they get to the
20 business, are you the one that actually takes them?
21 A. Well, they were brought to me, but yeah.
22 Q. So you actually get them at some point,
23 though?
24 A. Yes.
25 Q. What do you do with them when you get

1 were the billing increments in 15-minute levels or
2 increments at that point?
3 A. When I had first started, no. But then
4 later on as I was working there, yeah, they had dropped
5 to about ten minutes, around that area.
6 Q. Okay. I'm not talking about what the
7 actual minutes that came in were. I'm saying the
8 amount that you would then bill to the insurance
9 company or code, was that based on a certain number
10 of -- like an increment, a 15-minute increment?
11 A. Yes.
12 Q. Okay. So for a 31-minute or 32-minute or
13 whatever it was, was that the typical number that you
14 were seeing?
15 A. Yeah.
16 Q. For ones that were in that range, how many
17 units were you talking about?
18 A. It would be like \$560.
19 Q. So would that relate to three separate
20 15-minute increments, though?
21 A. No, no, not that I know. I mean it would
22 just be from 31 and up would be 560.
23 Q. So you knew it by just looking at the
24 minutes, period?
25 A. Yeah, there is a paper that we had been

1 given with the times and what they would be money-wise,
 2 how much they would cost.
 3 Q. So when you saw 31 minutes or more, you
 4 would bill \$560?
 5 A. Yes.
 6 Q. Every single patient?
 7 A. Yes.
 8 Q. Now, if the minutes were less than 30 but
 9 more than 15, what would be the amount that you would
 10 bill?
 11 A. 490.
 12 Q. And if you know, below 15 minutes, what
 13 would you typically bill?
 14 A. Well, what I can remember was 150.
 15 Q. Okay. Is it possible that it's a little
 16 bit different than that but close to it?
 17 A. Yeah.
 18 Q. Okay. When you were working for -- and
 19 you worked there from this -- you said you thought it
 20 was around July/August or so of 2008 until when?
 21 A. Well, I worked --
 22 Q. I think I meant July/August of
 23 '07 until --
 24 A. Well, six months. Six months at least I
 25 know that.

1 A. Well, yeah, about 560 or 490.
 2 Q. Okay. So if it fell below that 30, was
 3 it --
 4 A. Thirty-one.
 5 Q. If it fell below, you would have to charge
 6 490?
 7 A. Yes, from what I remember. Yeah, I'm
 8 pretty sure.
 9 Q. Now, somewhere down the road, did you
 10 notice that the actual anesthesia records that were
 11 coming in had changed dramatically?
 12 A. Yeah, they had changed.
 13 Q. Do you remember roughly about when that
 14 was?
 15 A. No, I don't really remember around what
 16 time because I wasn't, you know, I was just --
 17 Q. Was it around the time that all of this
 18 endoscopy thing was hitting the news?
 19 A. Not that I remember. I mean, I wasn't,
 20 no, not that I know of.
 21 Q. Was it in 2008 that that happened?
 22 A. Yes.
 23 Q. Okay. So in 2008, and obviously you left
 24 in early 2008, so it had to have happened before you
 25 left?

1 Q. So that would have put it around January
 2 or so of the following year?
 3 A. Yeah, it might have been a little bit
 4 after that sometime.
 5 Q. Okay. At some point in early 2008, you
 6 stopped working there; is that right?
 7 A. Yeah.
 8 Q. Why did you stop working there?
 9 A. I just -- well, it wasn't for me really.
 10 I didn't enjoy sitting there doing that all day. It
 11 was kind of boring for me.
 12 Q. Now, during the time that you worked
 13 there, did the stacks of papers that came from the
 14 Endoscopy Center with the billing minute times on them,
 15 were they all about the same or did they vary?
 16 A. Yeah, they were all around 31 around,
 17 yeah.
 18 Q. If there had been some big differences in
 19 that, would that have been something that you would
 20 have noticed?
 21 A. Yes.
 22 Q. So if you're getting upwards of a hundred
 23 of these a day, you're coding them and writing those
 24 \$560 charges for all of these during that time, pretty
 25 much it's 560 for every one of them?

1 A. Yeah.
 2 Q. So at some point, you said that the times
 3 dramatically changed. What are we talking about as far
 4 as dramatically changed?
 5 A. Well, the anesthesia times were around
 6 like 10, 12 minutes. They were roughly around there
 7 like all of the stacks that we were getting.
 8 Q. So instead of 31 plus, they are now down
 9 to the 10, 12, even up to 15 possibly?
 10 A. Yeah, up to 15, yeah.
 11 Q. Okay. At that point of this, of all these
 12 stacks that were being billed, how much were you then
 13 billing out to the insurance companies to pay?
 14 A. From what I remember, 150.
 15 Q. So big difference between 150 and 560?
 16 A. Yeah.
 17 Q. Were there many that were -- I mean, of
 18 all, let's say, out of a hundred that you received on
 19 average that were down in that range, how many of those
 20 would be in this 12-to-15 range and how many of them
 21 would be higher than that?
 22 A. Well, I remember getting a few stacks of
 23 them. All of them were like that, so ...
 24 Q. So at this point, was it unusual to see
 25 one that was higher?

1 A. Yeah, it was.
 2 Q. When you saw that happen, did that kind of
 3 get your attention?
 4 A. Yeah. I had brought it to my supervisor's
 5 attention because, you know, the billing is different,
 6 you know, the times and it's not normal for me. I
 7 haven't seen that. You know, I don't know if I should
 8 send it to the insurance or not, you know.
 9 Q. And if I understand you correctly, your
 10 job is to take that, code it, and then actually send it
 11 off to the insurance with that dollar amount in it; is
 12 that correct?
 13 A. Yeah, on the computer, yeah.
 14 Q. Without getting into what people told you,
 15 after your conversations and raising this, did you ever
 16 go back to the 30-plus minute billing or did you stick
 17 with what was actually showing up on the forms?
 18 A. I stuck with what was on the form then and
 19 billed it out that way.
 20 Q. Did that stay like it was until you quit?
 21 A. I don't know. I don't remember.
 22 Q. Okay.
 23 MR. STAUDAHER: I have nothing further for
 24 this witness, ladies and gentlemen.
 25 THE FOREPERSON: Are there any questions

1 from the jury?
 2 Yes.
 3 A JUROR: To your knowledge, did Health
 4 Care Business Solutions have any other clients or do
 5 any other billing for anybody other than the endoscopy
 6 or gastroenterology?
 7 THE WITNESS: Well, from what I know is
 8 Desert Shadow and the Endoscopy Center.
 9 A JUROR: Okay.
 10 THE FOREPERSON: Any further questions?
 11 None.
 12 A JUROR: I have one.
 13 THE FOREPERSON: Yes. Go ahead.
 14 A JUROR: Did you ever think that the
 15 billing time was quite extensive based on how many
 16 claims you got each day?
 17 In other words, did you feel that the
 18 billing hours were more than what was actually -- had
 19 actually occurred based on the claim forms you got?
 20 THE WITNESS: No, not -- when they were
 21 normal or --
 22 A JUROR: No. When they were at the 31
 23 minutes, I'm talking about.
 24 THE WITNESS: On the 31 minutes, no, that
 25 was normal.

1 A JUROR: How many people would you say
 2 there were claims for at 31 minutes or thereabouts?
 3 How many a day on the average?
 4 THE WITNESS: About a hundred a day.
 5 MR. STAUDAHER: And I'm going to ask a
 6 follow-up to that.
 7 BY MR. STAUDAHER:
 8 Q. You worked in a -- did not work in the
 9 actual Endoscopy Center?
 10 A. No.
 11 Q. Did you know what was going on there as
 12 far as how many patients were seen, what was normal,
 13 not normal, anything like that?
 14 A. No.
 15 Q. So you are just taking in what's given
 16 you, coding it and sending it off to another entity for
 17 payment?
 18 A. Yeah.
 19 Q. Did you ever get the payment to you?
 20 A. No.
 21 Q. Ever get any deposits to your bank to keep
 22 doing it the way you were doing it?
 23 A. No.
 24 MR. STAUDAHER: Okay.
 25 THE FOREPERSON: Any further questions?

1 None.
 2 By law these proceedings are secret. You
 3 are prohibited from disclosing to anyone anything that
 4 transpired before us, including evidence presented to
 5 the Grand Jury, any event occurring or a statement made
 6 in the presence of the Grand Jury, or information
 7 obtained by the Grand Jury.
 8 Failure to comply with this admonition is
 9 a gross misdemeanor punishable by a year in the Clark
 10 County Detention Center and a \$2,000 fine. In
 11 addition, you may be held in contempt of court
 12 punishable by an additional \$500 fine, and 25 days in
 13 the Clark County Detention Center.
 14 Do you understand this admonition?
 15 THE WITNESS: Yes.
 16 THE FOREPERSON: Thank you. You may be
 17 excused.
 18 (A recess was taken.)
 19 THE FOREPERSON: Please remain standing
 20 and raise your right hand.
 21 Do you solemnly swear the testimony you
 22 are about to give upon the investigation now pending
 23 before this Grand Jury shall be the truth, the whole
 24 truth, and nothing but the truth, so help you God?
 25 THE WITNESS: Yes, I swear.

1 THE FOREPERSON: Thank you. You may be
2 seated.
3 You are advised that you are here today to
4 give testimony in the investigation pertaining to the
5 offenses of performance of act in reckless disregard of
6 persons or property, criminal neglect of patients,
7 insurance fraud, obtaining money under false pretenses,
8 and racketeering, involving Dipak Kantilal Desai,
9 Ronald Ernest Lakenan, and Keith H. Mathahs.
10 Do you understand this advisement?
11 THE WITNESS: Yes, I do.
12 THE FOREPERSON: Could you please state
13 both your first and last names and spell them for the
14 record?
15 THE WITNESS: It's Marion VanDruff.
16 M-A-R-I-O-N. V-A-N, capital D-R-U-F, as in Frank, F,
17 as in Frank.
18 THE FOREPERSON: Thank you.
19
20 MARION VAN DRUFF,
21 having been first duly sworn by the Foreperson of the
22 Grand Jury to tell the truth, the whole truth, and
23 nothing but the truth, testified as follows:
24
25

1 find work as a medical assistant, just because it was a
2 little bit more difficult than I thought it was going
3 to be, I worked at Glamour Shots, and then started
4 looking for positions as a medical assistant.
5 First place I worked was Medical Group at
6 Sun City. After being let go from there, I just got
7 out on foot looking for another job just because I
8 found out my fiancée at the time was pregnant, so I
9 needed to be able to support a child.
10 Walked into the 700 Shadow Lane building
11 and passed out my resumes, and Endoscopy Center called
12 me back in the next day.
13 Q. Okay. When you went back in the next day,
14 are we talking about just shortly after your graduation
15 or was it later on?
16 A. This is about a year after I graduated.
17 Q. Okay. When were you actually hired by the
18 Endoscopy Center?
19 A. It was May of '07.
20 Q. And you worked with them until when?
21 A. Up until -- up until the center got closed
22 down by the mayor.
23 Q. So in '08; is that correct?
24 A. Yeah. I think it was in May or something.
25 Q. So you worked for them just about a year

EXAMINATION

1
2 BY MR. STAUDAHER:
3 Q. Mr. VanDruff, I'm going to go back and ask
4 you a couple questions about your background.
5 A. Okay.
6 Q. What do you do for a living currently?
7 A. Right now I'm a customer service
8 specialist at Sitel.
9 Q. I direct your attention back to February
10 of '06. Did you graduate from the Nevada Career
11 Institute?
12 A. Yes, I did.
13 Q. What did you graduate with?
14 A. Just a diploma for medical assisting.
15 Q. Okay. And after you had that, was it a
16 certificate or degree or what was it?
17 A. It was just a diploma. It was essentially
18 the same as like a high school diploma, just like a
19 halfway between high school and college.
20 Q. Okay. So had you gone to college yet or
21 was this just a step after high school?
22 A. There was a step after high school.
23 Q. What did you do after you got that
24 diploma?
25 A. I -- first thing I did was while trying to

1 then?
2 A. Yeah.
3 Q. Now, as far as the things that you did for
4 the center, were you assisting with patients?
5 A. Well, yeah, I was assisting with patient
6 care. When I first started out there, I was just
7 bringing patients back, triaging them, getting them
8 ready for the procedures, making sure that they had
9 done all their prep and everything properly, making
10 sure that they were ready and getting them into the
11 examination rooms.
12 After about a month or so, I actually
13 started assisting with the doctors and cleaning the
14 scopes during the procedures and after the procedures.
15 Q. Okay. And at the time that you finally
16 left the clinic, is that what you were primarily doing
17 then is assisting with the doctors in the procedure
18 rooms and doing the scope work?
19 A. Well, we would alternate, so it was, you
20 know, one day you would be out on the floor. The next
21 day you would be in back. Or depending on the week,
22 you would spend the first half of the day on the floor.
23 The second half of the day you would be in the
24 procedure rooms and the scope room.
25 Q. Okay. Let's talk a little bit about the

1 procedure room when you were there?

2 A. Okay.

3 Q. We'll get to the scope room in a little

4 bit.

5 But when you were in the procedure room,

6 what was your job? What did you do?

7 A. Just assisting, giving the doctor whatever

8 he needed for the procedure, whether it be getting

9 forceps, giving swabs, just water flushes with the

10 syringe.

11 It was just, you know -- you watch a

12 medical show and, you know, a doctor calls for a

13 scalpel or something like that, that's essentially what

14 I was doing.

15 Q. Did you handle the scopes both before they

16 were used and after they were done using them?

17 A. Yes, I did.

18 Q. And then what did you do with the scopes

19 after they were done?

20 A. We would take them into the scope room.

21 Whoever the technician was in the scope room, would be

22 the one responsible for cleaning it.

23 Q. Now, during the procedure itself, are you

24 helping the doctor then actually do the procedure?

25 A. Doctor -- the doctor is doing the

1 procedure. The only thing I'm doing is, I'm

2 essentially an extra arm.

3 Like if he had to take a -- if one of the

4 doctors had to take a biopsy of a polyp or cancerous

5 part of the colon, I would hand them the forceps. He

6 would squeeze it in.

7 It was just like this long snake-like

8 thing that had teeth at the end, and there is a little

9 plunger, and my only job would be to open and close the

10 forceps.

11 The doctor would go ahead and pull the

12 forceps to take the sample, and then I would put it in

13 a specimen bottle.

14 Q. When you were doing that particular type

15 of work, I mean was there any single physician that you

16 worked with, or did you work with all of them?

17 A. When it came to the Shadow Lane office, I

18 worked -- I worked with every one of the physicians.

19 Q. Did you note a difference in, for example,

20 the speed at which they operated, the different

21 doctors?

22 A. Some were slower, some were faster. There

23 were certain doctors that just based on the caseload

24 that we were hoping that we wouldn't be working with

25 that day just because they had a reputation for being

1 slower.

2 And, obviously, now after this all

3 happened and doing my own research, just reading on

4 line on like what the typical time should take, found

5 out that the slower doctors --

6 Q. I'm not going to ask you to bring -- I

7 mean that was just public information you were just

8 looking at then?

9 A. Yeah.

10 Q. Okay.

11 A. Just like web MD and stuff like that.

12 Q. Okay. And beside, you know, whatever your

13 research may have been on the computer, and I don't

14 really want to get into that at this point --

15 A. Okay.

16 Q. -- but your observation of what a normal

17 procedure would take. I'm not talking about the faster

18 doctors, I'm just saying on an average, how long would

19 they take in a clinic to do? Colonoscopy? Upper

20 endoscopy?

21 A. Colonoscopy, you're saying pretty much

22 like if I was to take one of the slower doctors versus

23 one of the faster doctors, the average time between the

24 two?

25 Q. Yeah.

1 A. Average time between the two would

2 probably be about eight, nine minutes for a

3 colonoscopy. Five, six minutes for an upper endoscopy.

4 Q. Okay. And was that -- what about the

5 faster doctors, who were they?

6 A. The faster doctors in the clinic were --

7 well, the two fastest were Dr. Carrol and Dr. Desai.

8 Q. Who was the fastest?

9 A. Desai.

10 Q. Noticeably faster?

11 A. Yeah.

12 Q. How long did it take him to do those two

13 procedures on average?

14 A. Usually, if I was in the procedure room

15 with Dr. Desai and we were doing a colonoscopy, we

16 would be done with the colonoscopy in five minutes,

17 unless it was something that really caught his

18 attention when it came to cancer and stuff like that.

19 When it came to the upper endoscopies,

20 those were usually done in about three minutes.

21 Q. So three to five minutes is what we're

22 talking about?

23 A. Yeah.

24 Q. For both types of procedures?

25 A. Well, like I said, the colonoscopy would

1 be five minutes. Three minutes for the upper.

2 Q. Fair enough.

3 Now, related to Dr. Desai, when he was
4 dealing with the scopes, if he's doing them that
5 quickly, when it comes time to remove the scope, what
6 was the procedure that you had to get involved yourself
7 with as far as he was concerned?

8 A. He would pull the scope out and hand it to
9 us and take it back in. I mean unless there was --
10 again, this was unless there was something that, you
11 know, really caught his attention. Then he's like,
12 Okay. We have to make sure that we get that on the way
13 out. Then I would usually get it.

14 But, typically, on a day-to-day basis, if
15 I was working with Dr. Desai, scope came right out
16 within under a minute and into my hands.

17 Q. Okay. When he was actually physically
18 taking the scope out, how fast would he typically do
19 that? Would that be a slow process, rapid process,
20 what was it?

21 A. It was pretty quick. It was -- we joked
22 on the floor that it was almost like he was cracking a
23 whip when he would take the scope out.

24 Q. Okay. When the scope came out, were you
25 responsible to kind of catch the scope then?

1 A. Yeah.

2 Q. Is that a fair description?

3 A. Yeah, it's pretty fair. I had to -- I had
4 to change garb quite a bit just because we couldn't
5 clean off residue and couldn't sterilize afterwards,
6 so ...

7 Q. What do you mean you had to change garb?

8 A. Well, we had protective -- we had
9 protective barriers we had to wear over our scrubs.
10 Typically, in a day we'd change them maybe two or three
11 times a day. Working with Dr. Desai, that number could
12 have easily doubled.

13 Q. Why was that?

14 A. Because it just -- he swings out and you
15 get fecal matter all over it, and then you don't really
16 want to wear that into the next procedure.

17 Q. Okay. So if I understand you correctly,
18 were you getting this fecal matter on your person
19 because of the speed that he was taking the scope out
20 of the body?

21 A. On occasion.

22 Q. Okay. And was this a general sort of joke
23 around the sort of center that he was pulling them out
24 like cracking a whip?

25 A. It was said a couple of times.

1 Q. Now, as far as the procedure times and so
2 forth, did you ever see Dr. -- or Dr. Desai start
3 procedures before anesthesia was on, administered to
4 the patient?

5 A. I don't necessarily know if anesthesia was
6 admitted. Sorry. I don't know if anesthesia was
7 necessarily not administered to the patient yet. Some
8 people just take longer to go under when it comes to
9 anesthesia.

10 He would start the procedure before they
11 were completely sedated before, though. I had seen
12 that before.

13 Q. Okay. How often would that occur in your
14 experience with him?

15 A. In my experience with him, it was probably
16 one in every 20 procedures.

17 Q. Okay. And in situations like that, would
18 there be any communication between the CRNA and
19 Dr. Desai about that issue?

20 A. There is -- there was communications. I
21 do recall the CRNAs actually tell me, you know, can you
22 hold on? The patient's not even completely asleep yet,
23 so ...

24 Q. Were they kind of emphatic about saying
25 that, or was it just normal speech, you know, wait for

1 a little bit, or --

2 A. It was -- to me it was real concern. It
3 was, you know, pretty much they were looking at it in a
4 situation of, you know, if that was them on the table,
5 they would want to be completely asleep before the
6 procedure was to start.

7 Q. Okay. And so about one in every 20
8 procedures you saw you thought?

9 A. Yeah.

10 Q. Did that happen with the other doctors in
11 the group?

12 A. Not as often. I mean it would happen just
13 on occasion, just out of, I don't know if I ever should
14 really say negligence, but it did. I would say it
15 would happen just out of, you know, general negligence.
16 It's you don't quite realize that the patient's not
17 asleep yet.

18 Usually other doctors, though, would
19 actually look over the patient, since they are behind
20 the patient, look over, make sure that they are asleep
21 before actually inserting the scope.

22 Q. Okay. On the instances when the scope was
23 inserted and the CRNAs made some comment about this
24 patient not being asleep yet, did Dr. Desai stop what
25 he was doing?

1 A. No. I don't think he even heard the CRNA
2 saying the patient wasn't even asleep yet.
3 Q. You were there?
4 A. Yeah.
5 Q. You heard it?
6 A. Uh-huh.
7 Q. He was standing next to you?
8 A. Uh-huh, but I just don't think he was
9 paying attention.
10 Q. Okay. What about reuse of various items
11 in the -- sort of the procedure room? And I'm talking
12 about, kind of go through them, bite blocks, did you
13 ever see those reused on patients and washed off or
14 whatever?
15 A. Unless the patient had a sexually
16 transmitted disease, we would go ahead and wash and
17 sanitize them through our scope cleaning machine. And
18 then go ahead and reuse them on the next patient.
19 Q. So if I understand you correctly, the
20 scopes that have been in somebody's bottom --
21 A. Uh-huh.
22 Q. -- so to speak, were put into a machine
23 for cleaning?
24 A. Well, it's -- we had a -- we had a process
25 we had to go through. We had to first go ahead and

1 potentially reused, did you notice anything, any
2 forceps or any snares or anything like that that were
3 ever reused?
4 A. Forceps and snares we did not reuse. We
5 made sure that they went into biohazard sharps to be
6 disposed of properly.
7 The only thing that I could actually say
8 that on a personal level that I did reuse because I was
9 instructed to use were just syringes for the purposes
10 of flushing water, cleaning out the actual -- the
11 actual -- the actual beaker, container, whatever it was
12 called, that we would actually use to go ahead and
13 suction up the water with the syringe.
14 And cleaning out another container, we had
15 to go ahead and actually prewash, kind of prerinse the
16 scope in the procedure room before we brought it into
17 the scope room.
18 Q. What about the solutions that were used to
19 clean the scopes? Was there any issue with that?
20 A. We -- pretty much we were told -- well, I
21 was told by other techs, by other GI techs on the floor
22 who were the ones that were assisting me and telling me
23 how to do this, that we were supposed to do it by
24 sight.
25 MR. STAUDAHER: Okay. And I don't want to

1 actually clean the outside by hand of the scope, when
2 it came to actually cleaning the scopes.
3 It would go into a first -- it would first
4 go into a tub with some machines connected to it that
5 would actually go ahead and just flush the solution
6 through it to make sure that it's completely flushed
7 out and cleaned out.
8 Go through another solution to rinse it,
9 and then into the scope machine to actually go ahead
10 and go through the sterilization process.
11 Q. Okay. Did the bite blocks go through that
12 same process then?
13 A. Without flushing them, but we did wash
14 them by hand, make sure they were rinsed, and then put
15 them in the sterilization machine.
16 Q. So once the scopes have gone through this
17 flushing and whatever, they are put together with the
18 bite blocks and processed; is that right?
19 A. Yes.
20 Q. Okay. So the same scopes that go in the
21 bottom, the mouth things are in the same --
22 A. Uh-huh.
23 Q. -- together?
24 A. Yes.
25 Q. Now, as far as the other items that were

1 necessarily -- that's -- I'm going to admonish the
2 Grand Jury on that particular statement about it being
3 a hearsay statement about something related to what he
4 was supposed to do.
5 BY MR. STAUDAHER:
6 Q. That's not offered for the truth of the
7 matter, just for what you did or did not do?
8 A. Okay.
9 Q. Based on whatever you were trained or
10 told, how did you handle the solutions?
11 A. Solutions, if they became -- the solutions
12 were like a very bright blue whenever they were
13 completely clean, fresh out of the bottle.
14 I was told whenever they got murky to a
15 point where you couldn't tell that they were blue, or
16 where you could -- it was -- you were able to no longer
17 tell that they were going to be blue for too much
18 longer, then you go ahead and dump it and refill it.
19 Q. How often would that be? How many scopes
20 would you process through before that would occur?
21 A. Depending on the procedure, depending on
22 the cleanliness of the procedures, it would be --
23 sorry -- anywhere from 10 to 20 scopes.
24 Q. And when the CDC came in, you were there
25 when that occurred, right?

1 A. Yes, I was.
 2 Q. Did that process change?
 3 A. When the CDC was in there, we were told to
 4 go ahead, and this is what I was doing is I was
 5 actually cleaning four scopes, and then dumping it.
 6 Found out from the CDC while they were
 7 there, though, that we were supposed to be dumping it
 8 after every two scopes.
 9 Q. Did that process then get initiated after
 10 that?
 11 A. Yes, it did.
 12 Q. Okay. As far as the bite blocks are
 13 concerned, just re-visit that for a second. How many
 14 of those would you typically open up in a day?
 15 A. Six.
 16 Q. And that was to service everybody for the
 17 whole day?
 18 A. Uh-huh. As I said, unless -- it was six
 19 at the beginning of the day, unless, as I said, they
 20 had, you know, a sexually transmitted disease or a
 21 communicable disease, then that bite block would be
 22 thrown away and a new one would be opened up for the
 23 rest of the day.
 24 Q. Now, when the state CDC were coming in to
 25 sort of look at what was going on in the clinic, was

1 there some discussion about that before they actually
 2 arrived?
 3 A. We were told that there were going to be
 4 visitors who were coming in, that we would have to
 5 change procedures a little bit, such as making sure
 6 that after every four scopes were cleaned, that we went
 7 ahead and dumped the cleaning solution and re-did it.
 8 We were told that we would be -- we would
 9 need to go ahead and change the aprons that we were
 10 using during procedures after every procedure and make
 11 sure that we were wearing a mask during the procedures.
 12 Q. Okay. Did you actually do those things?
 13 A. Yes, I did.
 14 Q. Now, prior to the state coming in, that, I
 15 assume, was not the practice, though?
 16 A. Like I said, it was -- usually you would
 17 go through like maybe three aprons in a day before the
 18 state had come in.
 19 And I would only ever wear a mask if I was
 20 feeling sick as a protective barrier, just to protect
 21 other patients from myself, just because I had never
 22 worked in the GI field before.
 23 I had never worked doing endoscopies or
 24 any other surgical procedures for that matter, so I
 25 didn't know that this was really something that I

1 should be wearing the face masks through every
 2 procedure until this happened.
 3 Q. Now, when you -- so I guess where I'm
 4 going with this is, when -- before the CDC and the
 5 state show up, is there some discussion about at least
 6 tightening up procedures?
 7 A. Yeah.
 8 Q. So when they show up, the CDC and the
 9 state, did they see the way things had been actually
 10 happening in the clinic prior to their arrival?
 11 A. No.
 12 Q. Okay. Had the sort of procedures improved
 13 by the time the state actually got there?
 14 A. When the state actually got there, even
 15 the doctors that would go, you know, a little bit
 16 quicker, would actually slow down and went at the rate
 17 of the doctors who were actually going slower, so ...
 18 Q. Was Desai working during any of that time?
 19 A. I don't remember if he was or wasn't
 20 actually.
 21 Q. Do you remember during any of the period,
 22 and they were there about a week or so; is that
 23 correct?
 24 A. Yes.
 25 Q. Do you recall ever seeing Desai work

1 during that whole time?
 2 A. I mean I hate to say just because it's
 3 something on a personal level, but it's my son was
 4 actually -- I was actually having my son be born around
 5 the same time. So it's most -- my attention was pulled
 6 away to that. I really don't remember if Dr. Desai was
 7 working during that week or not.
 8 Q. Fair enough. And that's fine. We'll move
 9 to another area.
 10 Once the state came and left, though, did
 11 the process or the procedures that had been recommended
 12 by them, did you guys institute those?
 13 A. We -- yeah, we instituted those. We were
 14 under the impression that it was going to be happening
 15 again, that they might be dropping by randomly. So we
 16 made sure that we continued to do exactly what we were
 17 doing prior to them coming in.
 18 We weren't even told why they were coming
 19 in. We were just told it was essentially just another
 20 inspection that any medical clinic would go through to
 21 make sure that they can keep their license to be open.
 22 Q. Okay. Now, I'm going to ask you a couple
 23 questions about propofol. You know what that is, do
 24 you not?
 25 A. Yes, I do.

1 Q. Did you ever see propofol being reused by
2 the CRNAs that worked at the facility when you were in
3 the procedure rooms?

4 A. I do know it was reused from patient to
5 patient.

6 Q. Okay. And is that because of your
7 personal observation?

8 A. Yeah.

9 Q. And was that a -- seemed to be a regular
10 thing or was that just an occasional thing that
11 occurred?

12 A. That was a regular thing.

13 Q. Was that one of the things that the CDC
14 had recommended not having occur at the facility?

15 A. Afterwards, yeah, it was. I found out
16 that it was actually recommended that it was supposed
17 to be one -- one patient per vial.

18 Q. Okay. Is that the practice that took
19 place after the CDC came, or did that change?

20 A. Yeah, it went to that practice afterwards.

21 Q. Okay. Now, did you ever see the same
22 syringe used during this procedure and then used on
23 another procedure?

24 A. My direction was mostly on the patient,
25 the monitor that showed us what was going on inside the

1 colon, and the doctor themselves, just so I could know
2 what's going on.

3 From my understanding -- well, I really
4 shouldn't give what my understanding of what's going on
5 because you said you wanted to know what I actually
6 saw. So I can't really tell you if the syringes were
7 used from one patient to another.

8 Q. Is that because of your positioning in the
9 room --

10 A. Yeah.

11 Q. -- and what you could see?

12 Okay. That's fine.

13 A. I was aware of the CRNA, but I wasn't
14 really paying attention to what the CRNA was doing.

15 Q. Did Dr. Desai ever talk about syringe use
16 or reuse or anything like that at any time, either
17 before or after the CDC came?

18 A. No, not that I know of.

19 Q. Did you ever hear him discuss any of this
20 stuff, about propofol use or anything like that?

21 A. Honestly, when it came to procedures and
22 policies of what was going to be going on inside the
23 clinic, I had no interaction with Dr. Desai.

24 It was -- it all came down the ladder of
25 okay, well, this is what we're doing. This is what

1 your job is, so this is the information that you get to
2 know is what's going on because it pertains to your
3 job.

4 So I never really heard anything of what
5 Dr. Desai was saying about reusing any of the
6 equipment.

7 Q. How many patients would you typically be
8 seeing in a day, dealing with?

9 A. If I remember correctly, a minimum of 60.

10 Q. Was it more than that at times?

11 A. Oh, yeah.

12 Q. You said, "Oh, yeah," were there a lot
13 more?

14 A. There was quite a few days that even with
15 patients canceling and patients being added on the day
16 of we would end up seeing 90 patients in the day.

17 Q. And that's procedures done on patients --

18 A. Yes.

19 Q. -- is that right?

20 Now, did you ever see CRNAs move from room
21 to room?

22 A. Yes.

23 Q. How would that happen? And was it during
24 breaks, was it the end of the day, beginning of the
25 day, what?

1 A. Typically, there was one doctor working.
2 Okay. Usually I would only see this in the morning or
3 if the CRNAs -- if we were breaking out for lunch
4 because we would only have two CRNAs there.

5 So for the first two hours of the day,
6 there would be one CRNA and one doctor. So since there
7 is one CRNA and one doctor and we are doing procedures,
8 the CRNA would follow the doctor back and forth to be
9 able to give the anesthesia for the procedure.

10 If a doctor was -- if we were during our
11 lunch -- if we were during the lunchtime, we would go
12 back to only having one doctor on the floor, and then
13 the CRNA would swap out, half hour for one CRNA, half
14 hour for the other, and then they would go back, but
15 usually it was just from one room to another after the
16 procedure.

17 Q. So you did see the CRNAs move at least
18 from room to room for various reasons during the day?

19 A. Yeah.

20 Q. During the time that you saw the CRNAs go
21 from room to room, did they carry anything with them?
22 Did they carry any syringes, drugs, toolboxes, anything
23 like that?

24 A. They had like a tackle box that had the
25 medicines that they would use for the day.

1 Q. And they would take that with them from
2 one room to the other?

3 A. Yes.

4 Q. Beside that -- was that a fairly regular
5 occurrence?

6 A. Yeah.

7 Q. Beside that, did you ever see a CRNA that
8 came from a different room come into a procedure room
9 that you were in and use propofol or set up or drugs or
10 anything that were in that room already?

11 A. Typically, what I saw -- okay. So you're
12 asking if a CRNA would come into a room and handle
13 supplies that they didn't set up?

14 Q. Yes.

15 A. I don't think I ever saw that happen.

16 Q. So they would bring their own stuff to the
17 room?

18 A. Yes.

19 Q. So did you ever see, when that occurred, a
20 bottle of propofol, for example, that had some propofol
21 in it just sitting on the -- on the table or wherever,
22 where the anesthesia person would be?

23 A. I would only see that happening if we were
24 just setting up the procedure and it was the CRNA
25 that's been in the room the whole time.

1 with the doctors. Did you ever deal with any of the
2 other parts of the clinic?

3 A. No, I didn't.

4 Q. Okay. When you were there, was there
5 anything there beside the things we talked about that
6 were -- that you saw that were concerning to you or
7 that gave you pause?

8 A. I just thought that we were doing too many
9 patients in a day honestly, and it was -- I'm an
10 adaptable person. I just shrugged it off and learned
11 how to cope with it.

12 But there wasn't a whole lot that I really
13 paid attention to during the day. I just kind of did
14 my job and was hoping that one day I would be able to
15 move on to another clinic because I didn't really like
16 the work.

17 Q. Did you feel pressure in any way to
18 maintain that schedule and that patient load?

19 A. Yeah.

20 Q. And I'm talking about even back in the
21 scope room when you were cleaning scopes, did you feel
22 like you were pushed to, you know, get them ready, keep
23 them available, that kind of thing?

24 A. Yeah. I mean there was a couple of times,
25 just because we had procedures going on that were just

1 Q. Okay. Who was in charge of the facility?

2 A. When I was hired in, Katie Maley was the
3 office manager. Shortly after, she was going on to
4 assist in opening up the other clinic that they were
5 opening in the Spanish Hills.

6 And then Jeff Kruger was the nurse in
7 charge of the facility, and he was the one that I would
8 be taking orders from pretty much.

9 Q. Okay. As far as procedural stuff that
10 went on in the clinic, who made the shots or who called
11 the shots, so to speak?

12 A. The doctors. I mean, it's -- I mean I
13 don't think I actually understand the question.

14 Q. Okay. Was somebody else able to make the
15 decisions as to what happened and how things occurred
16 and what to order and all that stuff in the office?

17 A. Well, the -- Jeff and then later Janine,
18 whenever she became head nurse, would actually do the
19 supply ordering.

20 But when it came to how to do the
21 procedures and everything, that was something that was
22 completely handled by the doctors.

23 Q. Okay. Did you ever deal with the
24 administration and how things, you know, beyond just
25 working in the scope room and the procedures dealing

1 going on really quick, that it's -- I can't -- I'm
2 processing the scopes for the full time that they are
3 supposed to be processed, but I have them piling up on
4 me, and we have no scopes left available.

5 So we're getting backed up because they
6 are waiting for me to get scopes finished and cleaned
7 and dried before they can hang up for the next
8 procedure.

9 Q. So did that sometimes sort of cause
10 trouble with the whole machine?

11 A. Yeah.

12 Q. When that happened what would occur?

13 Would somebody come back and talk to you about it, yell
14 at you, anything?

15 A. They just said, you know, you have to pick
16 up the pace and everything. And it's just, me being
17 just, you know, a typical worker that your boss comes
18 in and tells you that, hey, you need to pick up this
19 pace.

20 You're just kind of thinking to yourself,
21 hey, you should come back here and do this yourself if
22 you think I'm not doing it that well.

23 But, like I said, I -- when it comes to
24 medicine, the one thing that I was definitely taught
25 was that you don't do anything to compromise

1 cleanliness.

2 So I wasn't going to cut corners or

3 anything like that just to try to catch up, and I

4 wasn't told to, but it just kind of seemed like that's

5 what was expected to me. But just because of the way I

6 was taught that wasn't going to happen, so ...

7 Q. So you didn't engage in that, but you felt

8 pressure to do that. Is that what you're saying?

9 A. Yeah.

10 Q. And if I understand you correctly, the

11 actual things that you were doing back there had fixed

12 times associated with them. You couldn't process -- if

13 you put the machine -- what was the machine that you

14 put the scopes into called?

15 A. Oh, I don't even remember what that

16 machine was called. It was just a scope-processing

17 machine. I don't remember the actual name of what the

18 machine was called.

19 Q. Does medivator sound familiar to you?

20 A. Yeah.

21 Q. Okay. When the scopes went into that

22 machine, did they have to be in there for a fixed

23 period of time?

24 A. Yeah. There was just a button you pushed,

25 and it went ahead and did it. It went through the

1 get us the scopes, get us mouthpieces faster?

2 THE WITNESS: No. Like I said, it wasn't

3 exactly something that was actually said to me to, you

4 know, well, get this done, you know, get the machine

5 out quicker, you know, and everything like that.

6 It was just something that, as I said, in

7 any job, you have your boss hovering over you. You

8 would kind of feel pressured to get things done

9 quicker, but, as I said, when it comes to cleanliness,

10 I'm not going to sacrifice that at all.

11 THE FOREPERSON: Ann?

12 A JUROR: You said you felt pressure that

13 they told you you needed to pick up the pace.

14 Did they in any way instruct you on how

15 they felt you should do that?

16 THE WITNESS: No. So I just continued

17 doing what I was doing.

18 THE FOREPERSON: Okay.

19 Steve?

20 A JUROR: And back to the same question,

21 are you aware of any of your coworkers taking shortcuts

22 because of that pressure?

23 THE WITNESS: No.

24 THE FOREPERSON: I have a question.

25 On the bite blocks and scopes being

1 whole cycle for you.

2 I mean you could open the machine up, but

3 the machine could possibly fail if you opened the

4 machine up before it finished processing.

5 Q. But even though that's a fixed amount of

6 time, you're still getting pressure to get the scopes

7 out of the machine?

8 A. Yeah, but I was waiting until the time was

9 over.

10 Q. Okay. Anything else that concerned you

11 about anything that was going on with the clinic and

12 what Dr. Desai was doing?

13 A. Not really. If I had more experience as a

14 surgical tech or as a gastro tech, I probably would

15 have been a little more concerned. But like I said,

16 this was the first job I worked at as a GI technician,

17 so I wasn't really familiar with what should be going

18 on.

19 MR. STAUDAHER: I have nothing further.

20 THE FOREPERSON: Are there any questions

21 from the jury?

22 Yes.

23 A JUROR: At any time did they tell you,

24 they being one of the doctors or one of the

25 supervisors, tell you take shortcuts if you have to to

1 cleaned, were they being cleaned together in the same

2 solution at the same time?

3 THE WITNESS: Yes.

4 THE FOREPERSON: All right. Are there any

5 further questions? I do have one more.

6 When the scope was removed from the

7 patient by Dr. Desai, when you said he came out so fast

8 you got fecal matter on your garments --

9 THE WITNESS: Yes.

10 THE FOREPERSON: Did it sometimes go

11 beyond you and splatter around?

12 THE WITNESS: It would occasionally get on

13 like on the floor or the walls. And, you know, just

14 being the procedure room technician, after I got the

15 scope into the scope room, I would have to go ahead and

16 make sure that that was cleaned up and everything like

17 that.

18 Going through with actual hospital grade

19 disinfectants and hospital grade sanitizers to go ahead

20 and clean it up and make sure that there was no trace

21 of it before the next patient got in.

22 THE FOREPERSON: No visible trace?

23 THE WITNESS: No visible trace. And like

24 I said, it was actually -- we actually used hospital

25 grade disinfectants and cleaners, that if you went into

1 a hospital, you would see them all around to make sure
2 that it was cleaned up.

3 THE FOREPERSON: Thank you. Any other
4 questions? None.

5 By law these proceedings are secret. You
6 are prohibited from disclosing to anyone anything that
7 transpired before us, including evidence presented to
8 the Grand Jury, any event occurring or a statement made
9 in the presence of the Grand Jury, or information
10 obtained by the Grand Jury.

11 Failure to comply with this admonition is
12 a gross misdemeanor punishable by a year in the Clark
13 County Detention Center and a \$2,000 fine. In
14 addition, you may be held in contempt of court
15 punishable by an additional \$500 fine, and 25 days in
16 the Clark County Detention Center.

17 Do you understand this admonition?

18 THE WITNESS: Yes, I do.

19 THE FOREPERSON: Thank you. You may be
20 excused.

21 We are off the record now.

22 * * * * *

23 ATTEST: Full, true and accurate transcript.

24 
25 MARCEL LEONARD, CCR 204

RA 000398

\$	29th [1] 35/18	ass [2] 9/17 77/21
\$2,000 [5] 20/9 54/25 117/1 132/10 165/13	3	accurate [2] 102/14 165/23
\$30,000 [1] 87/7	30 [8] 38/21 41/25 100/7 113/1 113/4 123/22 125/8 127/2	accurately [1] 5/6
\$306 [3] 18/4 18/8 18/19	30-plus [1] 129/16	acidic [1] 71/20
\$500 [5] 20/11 55/2 117/3 132/12 165/15	30A [3] 4/4 12/5 16/17	across [2] 72/2 88/17
\$560 [5] 14/25 15/3 124/18 125/4 126/24	30B [4] 4/5 10/1 12/12 14/14	act [5] 5/21 21/4 55/25 118/1 133/5
'	30cc's [2] 76/19 80/9	activities [1] 9/17
'06 [1] 134/10	31 [20] 99/16 99/18 100/2 101/1 101/22 101/23 102/7 103/25 106/4 106/22 112/25 113/3 113/14 124/22 125/3 126/16 128/8 130/22 130/24 131/2	activity [1] 24/21
'07 [3] 108/20 125/23 135/19	31-minute [2] 112/2 124/12	actual [14] 7/14 78/4 104/7 104/9 105/6 124/7 127/10 131/9 147/10 147/11 147/11 161/11 161/17 164/18
'07 until [1] 125/23	32 [5] 101/23 101/25 102/7 103/25 106/4	actually [72]
'08 [1] 135/23	32-minute [1] 124/12	adaptable [1] 159/10
0	33 [7] 14/25 15/17 19/6 101/24 101/25 103/25 106/4	add [4] 71/22 100/24 100/25 112/2
00810 [1] 14/24	33-minute [1] 102/7	added [3] 103/12 103/16 155/15
09BGJ049A-C [1] 1/11	34 [1] 123/23	adding [1] 106/2
1	36 [1] 57/17	addition [5] 20/10 55/1 117/2 132/11 165/14
10 [6] 4/5 67/15 109/8 128/6 128/9 148/23	3600 [1] 68/3	additional [8] 7/23 20/11 30/14 55/2 78/16 117/3 132/12 165/15
10,000 [1] 67/14	3:00 [1] 2/6	address [5] 11/18 16/3 16/4 119/24 123/5
10-hour [1] 113/15	4	addressed [1] 43/15
10:00 [2] 48/7 49/20	4-A [1] 1/22	administer [6] 7/4 38/4 57/2 70/16 85/16 90/2
10:00 o'clock [5] 49/10 49/19 49/25 54/7 54/9	40 [1] 109/9	administered [3] 53/14 143/3 143/7
10:19 [1] 48/6	490 [3] 125/11 127/1 127/6	administration [2] 7/3 158/24
10cc [1] 76/18	5	administrative [1] 109/22
10cc's [1] 77/11	50 [1] 76/16	administrator [2] 7/1 18/13
11 [2] 67/15 109/8	50cc [2] 75/18 80/9	admitted [2] 13/14 143/6
118 [1] 3/6	50s [2] 75/13 75/17	admonish [3] 83/22 113/21 148/1
11:32 [1] 1/19	56 [2] 3/5 109/8	admonition [10] 20/7 20/13 54/23 55/4 116/24 117/5 132/8 132/14 165/11 165/17
12 [4] 4/4 109/8 128/6 128/9	560 [4] 124/22 126/25 127/1 128/15	advance [1] 35/11
12-hour [1] 113/15	6	advised [5] 5/19 21/2 55/23 117/24 133/3
12-to-15 [1] 128/20	60 [2] 113/1 155/9	advisement [5] 6/1 21/9 56/5 118/6 133/10
13 [1] 109/8	7	affect [10] 27/10 29/4 31/21 48/14 99/20 101/18 111/4 111/18 111/22 112/14
134 [1] 3/7	70 [2] 68/4 112/23	affected [2] 29/13 111/19
15 [9] 91/10 103/22 104/4 113/11 125/9 125/12 128/9 128/10 128/20	700 [3] 16/4 16/6 135/10	AFORESAID [1] 1/5
15-minute [3] 124/1 124/10 124/20	8	after [53] 2/6 22/25 23/2 25/18 25/20 25/23 26/4 31/12 38/8 38/17 39/11 43/5 43/25 44/24 62/18 64/12 64/24 65/2 66/1 66/2 67/9 70/17 70/18 79/2 97/10 107/14 108/13 112/8 112/8 119/1 126/4 129/15 134/15 134/21 134/22 134/23 135/6 135/14 135/16 136/12 136/14 137/16 137/19 139/2 149/8 149/9 150/6 150/10 153/19 154/17 156/15 158/3 164/14
150 [3] 125/14 128/14 128/15	89106 [2] 16/5 16/7	afterward [1] 59/8
1500 [3] 8/12 8/14 10/5	9	afterwards [3] 142/5 153/15 153/20
165 [1] 16/7	9/21 [1] 14/21	again [20] 6/9 29/3 31/15 31/21 36/7 48/9 53/24 60/16 66/4 66/5 68/2 73/19 74/7 76/25 77/23 96/22 100/15 101/6 141/10 152/15
165A [1] 16/4	9/25 [1] 12/7	
1970 [1] 57/8	90 [1] 155/16	
1972 [1] 57/9	9:45 [4] 48/5 49/11 54/7 54/8	
1A [1] 11/6	9:45 and [1] 50/5	
2	9:45 now [1] 48/7	
20 [5] 91/10 92/7 143/16 144/7 148/23	9:45 to [1] 49/25	
2007 [11] 12/7 14/21 22/14 23/6 45/9 60/17 66/7 66/10 66/10 66/19 119/1	A	
2008 [8] 35/18 60/20 60/21 125/20 126/5 127/21 127/23 127/24	A-N-N-E [1] 21/14	
2010 [3] 1/18 2/1 5/1	A-S [2] 6/7 6/11	
204 [2] 1/25 165/25	A.M [1] 1/19	
20s [1] 75/13	ability [2] 5/7 77/12	
21 [1] 14/21	able [12] 25/12 25/21 34/20 50/1 59/8 60/6 64/5 135/9 148/16 156/9 158/14 159/14	
21st [1] 66/10	about [134]	
22 [4] 1/18 2/1 3/4 5/1	above [1] 100/7	
24 [1] 14/22	ABPA [1] 6/25	
25 [6] 12/7 20/11 55/2 117/3 132/12 165/15	AC [1] 14/23	
25th [3] 45/11 60/21 66/10		
28 [1] 123/22		

A		
<p>AGNES [1] 2/6 agree [1] 27/13 agreement [1] 7/12 ahead [26] 13/18 15/21 28/19 31/7 32/13 44/13 50/3 73/11 75/8 111/24 130/13 138/11 145/16 145/18 145/25 146/5 146/9 147/12 147/15 148/18 149/4 150/7 150/9 161/25 164/15 164/19 air [1] 93/17 airway [4] 87/16 87/19 87/20 88/1 airways [1] 87/17 Alcoholic [1] 77/13 Alfaro [3] 4/5 8/20 11/17 Alfaro-Orellana [2] 4/5 8/20 ALICE [1] 2/12 all [58] allergic [2] 69/14 69/16 allowed [2] 33/13 112/1 almost [2] 53/15 141/22 already [12] 28/23 28/24 29/18 30/19 42/20 46/22 48/6 66/5 84/1 90/3 105/16 157/10 also [9] 2/22 15/13 27/4 30/15 46/21 87/9 87/25 91/8 102/6 alternate [1] 136/19 although [2] 105/5 111/21 altogether [1] 58/18 always [10] 65/9 76/8 79/17 82/7 85/18 94/13 99/17 101/23 103/2 105/1 am [6] 6/25 22/16 52/5 66/12 67/21 108/25 ambu [5] 87/24 93/10 93/11 93/12 95/22 amongst [2] 33/25 65/23 amount [12] 14/25 15/3 15/17 19/10 19/13 39/10 71/22 104/16 124/8 125/9 129/11 162/5 and/or [1] 7/13 anesthesia [72] anesthesiologist [5] 18/20 47/17 62/19 62/20 116/2 anesthetic [3] 73/25 98/9 98/15 anesthetist [2] 56/25 57/1 anesthetists [1] 65/16 Ann [1] 163/11 ANNE [4] 2/17 3/4 21/14 21/18 another [26] 25/21 25/24 26/7 38/1 40/6 41/16 77/2 84/11 84/13 84/25 91/20 97/25 107/13 107/17 109/1 116/6 131/16 135/7 146/8 147/14 152/9 152/19 153/23 154/7 156/15 159/15 answer [6] 24/3 68/15 68/18 74/9 113/16 115/2 anxiety [1] 27/21 anxious [2] 47/13 50/21 any [93] anybody [10] 29/17 30/10 43/10 43/22 44/2 60/8 81/22 84/23 89/4 130/5 anymore [1] 109/12</p>	<p>anyone [6] 20/2 54/18 79/22 116/19 132/3 165/6 anything [38] 11/8 20/2 28/15 37/19 40/23 42/5 42/5 43/23 54/18 66/16 79/12 84/16 87/16 88/14 89/4 96/11 97/12 98/12 116/14 116/19 119/19 131/13 132/3 147/1 147/2 154/16 154/20 155/4 156/21 156/22 157/10 159/5 160/14 160/25 161/3 162/10 162/11 165/6 anyway [2] 82/22 90/12 anywhere [2] 108/12 148/23 apartment [2] 57/20 60/25 appalled [1] 27/11 appear [1] 51/7 applied [1] 107/13 apply [1] 66/17 applying [1] 107/17 apprentice [1] 59/7 appropriate [1] 81/19 approximately [5] 57/17 66/2 67/14 76/19 112/22 April [4] 1/18 2/1 5/1 60/21 aprons [2] 150/9 150/17 are [115] area [18] 28/7 28/11 31/13 31/14 32/15 38/5 38/7 45/14 70/20 72/7 72/11 72/16 72/23 93/5 95/15 97/25 124/5 152/9 aren't [2] 33/22 97/16 arm [1] 138/2 around [30] 34/1 45/7 46/17 73/25 83/19 87/3 90/2 92/7 93/1 93/25 108/9 118/25 119/6 120/21 122/13 122/14 123/22 124/5 125/20 126/1 126/16 126/16 127/15 127/17 128/5 128/6 142/23 152/4 164/11 165/1 arrival [1] 151/10 arrive [1] 121/24 arrived [2] 66/6 150/2 as [161] ASA [3] 14/23 123/6 123/7 aside [1] 14/11 ask [22] 10/1 24/1 28/24 35/24 35/24 36/2 36/7 37/10 37/12 47/12 53/17 70/2 84/12 86/9 89/11 89/20 89/22 100/15 131/5 134/3 139/6 152/22 asked [6] 32/13 33/8 36/12 36/14 67/12 114/1 asking [5] 26/11 33/17 114/11 114/12 157/12 asleep [7] 74/6 143/22 144/5 144/17 144/20 144/24 145/2 assigned [1] 103/11 assist [1] 158/4 assistant [2] 135/1 135/4 assisting [7] 134/14 136/4 136/5 136/13 136/17 137/7 147/22 associated [6] 8/11 14/1 64/8 119/17 119/21 161/12 assume [15] 9/4 12/14 27/24 39/16 48/18 51/22 59/12 68/7 78/15 98/4 101/6 101/7 105/7 119/1 150/15 assumed [3] 83/13 108/5 116/9</p>	<p>assuming [1] 67/22 at [185] attached [1] 94/20 attention [11] 83/15 88/16 129/3 129/5 134/9 140/18 141/11 145/9 152/5 154/14 159/13 ATTEST [1] 165/23 Attorney [1] 2/24 August [4] 119/1 119/6 125/20 125/22 authority [1] 115/6 available [3] 94/24 159/23 160/4 average [9] 91/6 92/7 92/11 128/19 131/3 139/18 139/23 140/1 140/13 averaged [1] 91/9 aware [11] 36/8 39/12 66/8 66/11 68/7 82/22 103/5 103/9 107/5 154/13 163/21 away [17] 26/1 46/23 72/13 72/17 72/18 82/10 83/10 83/13 83/17 83/19 83/22 84/14 85/22 87/25 114/21 149/22 152/6</p> <p>B</p> <p>back [42] 18/5 22/23 24/10 32/19 36/1 37/12 42/1 43/20 43/23 60/25 64/12 64/23 65/2 68/5 79/15 86/25 87/14 87/21 92/24 94/1 95/11 95/12 104/12 105/12 114/21 118/25 129/16 134/3 134/9 135/12 135/13 136/7 136/21 141/9 156/8 156/12 156/14 159/20 160/13 160/21 161/11 163/20 backed [1] 160/5 background [3] 57/5 58/12 134/4 bag [8] 87/23 87/24 93/10 93/11 93/12 93/12 93/15 95/22 bank [1] 131/21 barrier [1] 150/20 barriers [1] 142/9 base [2] 103/11 104/2 based [15] 10/24 10/25 11/6 14/3 49/22 49/24 81/3 103/10 104/15 105/12 124/9 130/15 130/19 138/23 148/9 basically [11] 14/20 15/22 16/9 27/20 66/20 78/9 112/14 121/1 121/17 123/3 123/21 basis [2] 53/3 141/14 battery [1] 107/24 be [141] beaker [1] 147/11 bears [1] 35/16 became [3] 109/18 148/11 158/18 because [51] 24/5 30/7 31/23 33/23 39/7 41/9 41/11 43/6 44/19 71/20 79/9 80/15 82/13 83/12 84/14 92/22 93/7 94/25 95/4 96/4 97/16 107/14 108/10 109/3 109/13 110/25 111/5 114/13 115/1 116/10 127/16 129/5 135/1 135/7 138/25 142/4 142/14 142/19 147/8 150/21 152/2 153/6</p>

B		
because... [9] 154/5 154/8 155/2 156/4 159/15 159/25 160/5 161/5 163/22	102/25 103/25 105/6 105/7 106/7 113/18 119/6 119/22 120/23 121/18 123/15 123/24 124/1 126/14 128/13 129/5 129/16 130/5 130/15 130/18	be [1] 109/18 brought [13] 13/11 14/12 42/14 42/20 42/21 72/8 84/25 87/14 120/11 121/25 122/21 129/4 147/16
bed [5] 42/20 42/21 42/23 93/22 93/25	billings [1] 121/19	buck [1] 92/25
bed's [1] 72/1	bills [4] 103/1 104/8 104/10 105/20	bucking [2] 90/16 90/22
beds [2] 43/1 72/13	biohazard [1] 147/5	building [4] 22/21 120/17 120/18 135/10
been [39] 5/5 6/14 8/7 9/25 17/6 19/10 19/20 21/19 22/5 28/17 28/23 35/14 39/11 42/17 46/17 53/14 56/16 68/4 69/24 79/2 80/21 97/15 110/13 110/14 110/15 110/22 112/11 118/16 124/25 126/3 126/18 126/19 133/21 139/13 145/20 151/9 152/11 157/25 162/15	biopsy [3] 45/19 45/21 138/4 birth [1] 11/18 bit [13] 22/24 50/3 93/1 93/1 125/16 126/3 135/2 136/25 137/4 142/4 144/1 150/5 151/15 bite [11] 86/12 86/13 87/2 87/4 87/7 145/12 146/11 146/18 149/12 149/21 163/25	Burnham [1] 62/3 business [12] 14/4 16/3 108/7 119/5 119/11 119/12 119/13 119/15 120/2 120/4 122/20 130/4
before [45] 1/5 5/13 20/3 20/21 26/19 27/16 28/4 29/17 29/20 31/8 46/11 54/19 55/18 62/4 67/13 68/17 72/8 73/12 77/6 89/24 110/12 116/20 117/18 119/2 127/24 132/4 132/23 137/15 143/3 143/10 143/11 143/12 144/5 144/21 147/16 148/20 150/1 150/17 150/22 151/4 154/17 160/7 162/4 164/21 165/7	bites [1] 88/21 blank [1] 31/6 bleeding [1] 95/6 block [1] 149/21 blocks [8] 86/13 86/13 87/2 145/12 146/11 146/18 149/12 163/25 blood [2] 73/8 79/14 blue [3] 148/12 148/15 148/17 bluish [1] 36/14 board [3] 44/3 44/18 89/24 boards [3] 57/9 59/9 59/10 boat [1] 57/14 Bob [1] 44/16 body [1] 142/20 bolts [1] 104/9 bomb [1] 108/12 bonuses [4] 104/14 104/19 104/25 105/2 boring [1] 126/11 born [1] 152/4 boss [2] 160/17 163/7 both [13] 6/4 21/12 26/24 31/10 31/11 56/8 72/9 75/24 90/18 118/9 133/13 137/15 140/24	but [84] button [1] 161/24 buying [1] 108/6
beforehand [1] 31/1	bottle [11] 75/19 76/20 80/9 80/9 80/15 81/9 81/11 84/13 138/13 148/13 157/20	C
begin [3] 94/3 98/8 98/10	bottles [13] 40/20 40/24 40/25 69/4 75/10 84/1 84/8 84/14 84/21 84/22 84/23 85/12 85/15	C-E-R-D-A [1] 118/12 CABILES [1] 2/3 cable [1] 88/19 calculate [1] 102/2 California [7] 57/10 57/19 60/25 61/2 61/5 61/9 99/23
beginning [5] 78/8 99/5 99/6 149/19 155/24	bottom [3] 35/25 145/20 146/21	call [4] 17/22 43/22 55/8 117/11 called [8] 17/2 108/10 135/11 147/12 158/10 161/14 161/16 161/18
behind [3] 70/24 114/21 144/19	Boulevard [1] 60/7	calls [1] 137/12 came [45] 18/6 25/8 28/10 30/15 31/2 33/4 36/22 39/4 57/9 57/19 58/3 60/8 60/16 62/18 63/24 64/23 67/4 70/12 70/17 70/18 82/20 96/2 99/17 101/4 106/12 108/6 108/11 109/5 124/7 126/13 138/17 140/18 140/19 141/15 141/24 146/2 148/24 152/10 153/19 154/17 154/21 154/24 157/8 158/20 164/7
being [43] 16/10 19/6 29/10 31/22 32/4 34/20 35/2 35/2 37/20 39/1 40/6 40/11 40/16 40/17 41/6 42/15 44/9 47/25 48/22 49/2 50/14 68/15 73/3 73/4 84/2 84/5 89/1 96/6 102/6 102/13 111/18 128/12 135/6 138/25 144/24 148/2 153/1 155/15 160/16 162/24 163/25 164/1 164/14	box [4] 10/12 10/12 11/6 156/24	CAMP [1] 2/4 can [26] 6/8 12/5 16/17 19/14 20/16 36/12 55/6 55/11 55/14 57/4 57/22 59/12 59/18 74/24 77/23 78/25 83/7 84/11 88/20 93/16 97/19 116/5 125/14 143/21 152/21 160/7
believe [6] 10/10 13/8 24/12 26/1 91/7 110/11	Box 1 [2] 10/12 10/12	can't [3] 87/7 154/6 160/1
below [3] 125/12 127/2 127/5	Box 1A [1] 11/6	canceling [1] 155/15
benefits [6] 4/4 7/5 16/25 17/4 18/15 108/3	BRADLEY [1] 2/2	cancer [1] 140/18
beside [12] 18/23 37/14 41/21 52/6 62/13 63/9 97/10 121/15 139/12 157/4 157/7 159/5	break [3] 55/9 85/9 117/12	cancerous [1] 138/4
besides [3] 69/17 73/1 96/10	breaking [1] 156/3	canister [2] 94/20 94/22
best [1] 5/7	breaks [2] 85/8 155/24	canisters [3] 94/15 94/17 95/24
between [6] 42/11 128/15 134/19 139/23 140/1 143/18	breathe [2] 95/16 95/22	capacity [2] 7/16 7/20
beyond [3] 102/3 158/24 164/11	breathing [2] 27/23 87/22	capital [1] 133/16
BIANCA [2] 2/8 113/24	brief [1] 57/4	car [1] 57/14
big [4] 40/24 93/7 126/18 128/15	bright [1] 148/12	care [14] 7/8 7/8 31/14 45/16 51/12 70/21 89/8 89/15 93/21 102/11 115/14 119/12 130/4 136/6
bill [9] 19/18 104/1 121/5 121/8 121/9 124/8 125/4 125/10 125/13	bring [9] 9/21 71/15 84/9 84/21 84/22 86/24 94/2 139/6 157/16	cared [1] 83/9
billed [12] 14/24 15/8 15/10 15/11 15/23 15/24 103/6 104/16 121/15 123/25 123/12 129/19	bringing [1] 136/7	Career [1] 134/10
billers [1] 107/2	brings [1] 122/18	careful [2] 47/25 109/14
billing [22] 13/3 102/20		Carrera [2] 63/7 91/22

C		
case [5] 1/11 8/17 19/3 60/10 66/9	claims [17] 7/4 7/7 7/10 7/16 7/17 7/18 7/21 7/24 8/2 8/13 9/1 9/2 9/6 18/15 18/16 130/16 131/2	claim [2] 80/18 101/11
caseload [1] 138/23	clamp [1] 95/21	communicable [1] 149/21
cases [4] 67/15 68/3 68/4 99/16	clarify [1] 115/11	communication [1] 143/18
catch [2] 141/25 161/3	CLARK [11] 1/3 20/8 20/12 54/24 55/3 116/25 117/4 132/9 132/13 165/12 165/16	communications [1] 143/20
caught [2] 140/17 141/11	classification [1] 123/6	Community [1] 22/11
cause [3] 33/19 101/17 160/9	clean [10] 43/1 76/22 84/13 97/19 97/20 142/5 146/1 147/19 148/13 164/20	companies [4] 51/12 105/21 121/6 128/13
caused [1] 48/24	cleaned [10] 39/1 42/15 42/18 146/7 150/6 160/6 164/1 164/1 164/16 165/2	company [3] 104/11 105/11 124/9
caution [2] 44/8 48/9	cleaners [1] 164/25	completed [1] 28/17
cautious [1] 91/19	cleaning [11] 42/11 136/13 137/22 145/17 145/23 146/2 147/10 147/14 149/5 150/7 159/21	completely [6] 143/11 143/22 144/5 146/6 148/13 158/22
CCR [2] 1/25 165/25	cleanliness [6] 42/9 43/2 97/12 148/22 161/1 163/9	completing [1] 46/9
CDC [12] 108/11 108/13 110/17 148/24 149/3 149/6 149/24 151/4 151/8 153/13 153/19 154/17	clear [8] 17/14 18/12 18/18 45/4 50/10 95/10 101/2 108/25	comply [6] 20/7 33/16 54/23 116/24 132/8 165/11
center [37] 8/22 9/13 16/6 16/10 18/5 18/21 20/9 20/12 23/3 23/5 29/23 31/19 54/25 55/3 57/8 58/4 58/7 61/20 67/14 68/2 114/2 117/1 117/4 122/9 122/17 126/14 130/8 131/9 132/10 132/13 135/11 135/18 135/21 136/4 142/23 165/13 165/16	clients [1] 130/4	compromise [1] 160/25
Cerda [4] 3/6 118/11 118/15 118/22	clinic [31] 30/19 62/7 62/9 62/18 64/15 64/17 65/13 65/15 65/17 66/15 66/17 66/22 66/23 67/4 69/9 80/22 82/18 83/1 122/10 136/16 139/19 140/6 149/25 151/10 152/20 154/23 158/4 158/10 159/2 159/15 162/11	computer [3] 75/8 129/13 139/13
certain [6] 8/8 32/22 44/7 88/13 124/9 138/23	clinics [3] 59/12 61/22 119/18	concern [10] 37/22 39/6 42/8 43/18 48/17 50/20 88/12 97/11 114/5 144/2
certainly [2] 83/8 105/23	close [3] 99/18 125/16 138/9	concerned [14] 31/22 60/11 69/6 71/10 91/5 97/23 103/5 105/25 110/24 114/18 141/7 149/13 162/10 162/15
certificate [1] 134/16	closed [3] 60/20 62/4 135/21	concerning [1] 159/6
certified [2] 56/24 65/16	closer [1] 72/15	concerns [2] 37/15 97/14
chance [1] 32/13	code [6] 14/23 14/24 15/23 103/10 124/9 129/10	condition [14] 24/25 27/20 29/19 32/12 32/21 32/21 33/1 33/4 35/3 36/16 36/17 45/24 47/9 96/6
change [15] 33/9 45/23 45/25 46/2 46/4 89/18 106/16 106/20 142/4 142/7 142/10 149/2 150/5 150/9 153/19	coding [5] 120/24 121/1 121/5 126/23 131/16	conditions [3] 82/16 82/19 83/2
changed [4] 127/11 127/12 128/3 128/4	coffee [1] 116/14	confined [1] 9/10
changes [1] 45/19	collected [1] 95/15	confirm [1] 32/16
charge [8] 15/10 15/18 58/7 69/21 69/25 127/5 158/1 158/7	collects [1] 94/22	connected [3] 78/12 79/3 146/4
charges [6] 15/9 15/11 15/24 19/5 19/8 126/24	college [5] 22/11 57/6 120/10 134/19 134/20	consider [1] 113/23
chart [16] 25/2 25/12 26/18 31/25 32/5 32/20 33/17 33/24 37/2 37/2 48/6 49/14 49/18 50/1 50/6 51/23	colon [2] 138/5 154/1	CONSTANCE [1] 2/3
charted [1] 32/4	colonoscopies [3] 9/12 62/12 97/16	constantly [1] 68/5
charting [18] 24/20 25/15 26/18 28/8 28/17 28/19 30/22 30/25 31/16 31/23 36/21 37/15 37/25 41/13 43/18 47/14 48/3 51/11	colonoscopy [15] 9/11 12/23 64/2 73/4 82/24 91/10 92/7 92/11 121/18 139/19 139/21 140/3 140/15 140/16 140/25	contact [1] 98/11
charts [1] 34/24	color [1] 27/21	contacting [1] 88/25
check [3] 17/22 71/3 71/4	come [28] 8/14 19/9 24/10 24/14 27/7 29/17 36/25 42/1 42/12 43/23 47/6 47/8 47/16 64/1 72/22 73/9 101/15 106/7 106/8 108/19 110/17 120/7 121/24 150/18 157/8 157/12 160/13 160/21	contain [1] 102/14
Cheyenne [2] 119/16 120/14	comes [10] 51/23 65/2 75/6 108/13 111/1 141/5 143/8 160/17 160/23 163/9	contained [1] 69/4
child [1] 135/9	coming [13] 18/23 28/14 50/3 72/17 109/21 110/25 111/6 127/11 149/24 150/4 150/14 152/17 152/18	container [5] 77/16 79/1 79/6 147/11 147/14
CHRISTINE [1] 2/5	comment [1] 144/23	contaminate [4] 79/11 79/15 79/17 81/22
circulate [2] 70/7 70/9		contaminated [3] 81/11 81/13 115/17
circumstances [1] 60/12		contamination [1] 81/3
City [3] 22/22 22/23 135/6		contempt [5] 20/10 55/1 117/2 132/11 165/14
claim [31] 4/5 6/25 8/6 8/21 8/22 8/24 9/18 10/4 10/5 10/20 11/19 11/20 12/1 12/8 14/1 14/21 15/3 15/19 16/9 16/12 17/1 17/23 17/25 18/6 18/7 18/19 18/24 18/25 19/9 19/13 130/19		continually [1] 33/20

<p>C</p> <p>cost... [3] 102/25 103/3 125/2</p> <p>could [33] 6/3 14/13 21/11 29/1 35/11 40/22 47/10 56/7 66/5 76/24 77/2 79/15 81/11 90/9 100/21 100/24 100/25 103/18 104/1 108/8 113/13 118/8 119/9 119/10 120/10 133/12 142/11 147/7 148/16 154/1 154/11 162/2 162/3</p> <p>couldn't [9] 41/7 44/22 108/17 109/13 114/25 142/4 142/5 148/15 161/12</p> <p>counter [1] 84/10</p> <p>country [1] 64/23</p> <p>COUNTY [12] 1/3 20/9 20/12 54/25 55/3 57/6 117/1 117/4 132/10 132/13 165/13 165/16</p> <p>couple [11] 24/10 26/1 45/1 70/2 73/23 90/17 106/18 134/4 142/25 152/22 159/24</p> <p>courier [2] 121/25 122/18</p> <p>course [1] 47/12</p> <p>court [9] 1/2 1/6 20/10 23/24 55/1 68/16 117/2 132/11 165/14</p> <p>coworkers [1] 163/21</p> <p>cracking [2] 141/22 142/24</p> <p>crew [1] 42/11</p> <p>criminal [5] 5/22 21/5 56/1 118/2 133/6</p> <p>CRNA [20] 18/20 38/2 39/24 41/8 41/23 46/13 57/8 85/9 143/18 145/1 154/13 154/14 156/6 156/7 156/8 156/13 156/13 157/7 157/12 157/24</p> <p>CRNAs [13] 41/13 41/17 42/3 69/21 107/22 143/21 144/23 153/2 155/20 156/3 156/4 156/17 156/20</p> <p>cross [4] 79/11 81/3 81/21 115/22</p> <p>Culinary [7] 7/1 7/2 7/12 8/19 12/16 18/14 18/16</p> <p>cup [2] 73/8 116/14</p> <p>curiosity [1] 114/4</p> <p>current [1] 96/5</p> <p>currently [6] 22/16 49/11 61/1 61/7 118/22 134/6</p> <p>curtain [1] 70/25</p> <p>customer [3] 7/5 17/21 134/7</p> <p>cut [3] 71/22 114/12 161/2</p> <p>cutting [2] 92/24 113/12</p> <p>cycle [1] 162/1</p>	<p>136/23 138/25 141/14 141/14 142/10 142/11 149/14 149/17 149/19 149/23 150/17 155/8 155/15 155/16 155/24 155/25 156/5 156/18 156/25 159/9 159/13 159/14</p> <p>day-to-day [1] 141/14</p> <p>days [19] 20/11 25/14 30/13 34/11 37/17 51/1 51/2 51/5 53/8 55/2 66/9 84/6 109/7 109/9 117/3 122/6 132/12 155/14 165/15</p> <p>deal [3] 23/19 158/23 159/1</p> <p>dealing [6] 25/1 27/25 81/20 141/4 155/8 158/25</p> <p>deception [1] 50/18</p> <p>decisions [1] 158/15</p> <p>decrease [1] 64/17</p> <p>Defendants [1] 1/14</p> <p>define [1] 9/7</p> <p>definitely [2] 115/20 160/24</p> <p>degree [1] 134/16</p> <p>deliberations [1] 113/23</p> <p>dentist [2] 59/21 60/2</p> <p>depended [1] 75/13</p> <p>depending [7] 77/11 77/13 123/21 123/23 136/21 148/21 148/21</p> <p>deposits [1] 131/21</p> <p>Deputy [1] 2/24</p> <p>DESAI [46] 1/12 5/24 21/7 34/9 50/10 56/3 58/8 58/9 58/10 60/15 61/17 61/19 63/14 63/15 67/7 67/10 67/12 74/4 83/10 86/4 89/22 91/7 92/1 92/3 92/10 99/15 106/21 118/4 133/8 140/7 140/9 140/15 141/3 141/15 142/11 143/2 143/19 144/24 151/18 151/25 152/6 154/15 154/23 155/5 162/12 164/7</p> <p>Desai's [6] 9/14 68/3 82/4 107/16 112/2 114/21</p> <p>described [7] 9/18 23/13 34/20 35/1 43/7 80/24 81/6</p> <p>describing [1] 48/13</p> <p>description [1] 142/2</p> <p>Desert [1] 130/8</p> <p>designation [1] 8/14</p> <p>desktop [1] 17/21</p> <p>Detention [10] 20/9 20/12 54/25 55/3 117/1 117/4 132/10 132/13 165/13 165/16</p> <p>determination [1] 105/12</p> <p>device [1] 87/20</p> <p>diagnosis [2] 121/1 123/6</p> <p>did [272]</p> <p>didn't [42] 26/8 27/13 27/13 27/16 28/9 30/6 33/18 34/10 34/12 37/18 38/7 40/14 42/7 44/16 44/19 44/20 45/17 63/22 66/14 84/15 86/3 89/21 94/2 95/24 96/17 99/1 101/13 101/19 106/1 106/19 114/2 114/5 114/9 114/9 114/13 120/9 126/10 150/25 157/13 159/3 159/15 161/7</p> <p>difference [2] 128/15 138/19</p> <p>differences [1] 126/18</p> <p>different [13] 14/24 31/5 40/12 52/19 52/22 69/17 73/18 119/24 120/1 125/16</p>	<p>/5 138/20 157/8</p> <p>differently [1] 114/23</p> <p>difficult [1] 135/2</p> <p>difficulty [1] 27/22</p> <p>DIPAK [9] 1/12 5/24 9/14 21/7 56/3 58/9 58/10 118/4 133/8</p> <p>diploma [4] 134/14 134/17 134/18 134/24</p> <p>direct [3] 115/14 115/17 134/9</p> <p>direction [1] 153/24</p> <p>directly [3] 104/12 106/10 114/25</p> <p>director [1] 23/21</p> <p>discarded [1] 80/6</p> <p>disclosing [5] 20/2 54/18 116/19 132/3 165/6</p> <p>discover [1] 45/22</p> <p>discovered [1] 45/25</p> <p>discuss [2] 116/1 154/19</p> <p>discussed [2] 29/24 116/13</p> <p>discussion [4] 85/21 108/1 150/1 151/5</p> <p>disease [3] 145/16 149/20 149/21</p> <p>disinfectants [2] 164/19 164/25</p> <p>disposed [1] 147/6</p> <p>disregard [6] 5/21 21/4 55/25 89/12 118/1 133/5</p> <p>DISTRICT [3] 1/2 1/6 2/24</p> <p>do [169]</p> <p>doctor [34] 15/24 34/12 38/24 39/5 39/22 39/23 41/20 41/22 45/20 46/7 46/16 46/17 46/18 46/22 47/16 52/7 59/23 73/9 75/3 75/6 92/23 137/7 137/12 137/24 137/25 137/25 138/11 154/1 156/1 156/6 156/7 156/8 156/10 156/12</p> <p>doctor's [3] 15/25 17/6 77/8</p> <p>doctors [31] 33/21 45/15 82/19 83/2 83/9 91/5 91/15 91/16 91/17 100/1 100/14 100/17 136/13 136/17 138/4 138/21 138/23 139/5 139/18 139/22 139/23 140/5 140/6 144/10 144/18 151/15 151/17 158/12 158/22 159/1 162/24</p> <p>document [19] 10/11 10/14 13/17 13/19 14/17 16/8 16/17 16/23 16/24 27/16 31/6 36/8 46/1 47/9 47/19 47/21 51/20 51/21 98/18</p> <p>documentation [4] 27/18 27/19 31/12 33/9</p> <p>documented [4] 32/23 32/25 33/6 50/8</p> <p>documenting [4] 24/25 26/19 48/1 48/8</p> <p>documents [8] 10/18 12/14 13/6 13/10 17/9 17/24 31/3 102/13</p> <p>does [11] 8/10 18/2 24/9 35/20 35/23 36/5 36/6 52/6 52/9 98/10 161/19</p> <p>doing [57]</p> <p>dollar [4] 15/3 15/17 19/13 129/11</p> <p>don't [55] 8/3 11/11 26/1 30/7 34/25 38/13 46/24 50/4</p>
<p>D</p> <p>D-R-U-F [1] 133/16</p> <p>D-U-E-N [2] 6/7 6/10</p> <p>data [2] 120/23 123/4</p> <p>date [9] 11/4 11/18 12/25 14/21 23/7 35/18 45/5 55/3 66/5</p> <p>dates [2] 12/24 66/14</p> <p>day [50] 23/13 25/23 30/5 51/8 64/25 68/6 70/11 71/13 84/7 96/19 99/13 101/21 103/3 109/6 112/21 113/15 122/3 122/11 126/10 126/23 130/16 131/3 131/4 135/12 135/13 136/20 136/21 136/22</p>		

<p>D</p> <p>don't... [47] 52/18 62/4 64/22 74/18 79/9 79/11 83/3 83/17 84/14 84/15 85/6 85/6 86/23 86/24 87/4 96/22 97/3 102/25 103/3 103/17 106/11 107/4 107/7 113/12 113/16 115/2 123/8 127/15 129/7 129/21 129/21 139/13 142/15 143/5 143/6 144/13 144/16 145/1 145/8 147/25 151/19 152/6 157/15 158/13 160/25 161/15 161/17</p> <p>done [41] 8/4 19/2 28/17 29/1 29/1 31/1 35/25 37/21 37/25 42/13 45/19 46/12 47/21 50/22 66/15 66/18 66/18 70/3 70/4 70/7 71/15 72/1 77/24 78/15 80/3 81/6 81/15 89/5 90/25 94/13 97/12 115/1 115/2 136/9 137/16 137/19 140/16 140/20 155/17 163/4 163/8</p> <p>door [4] 31/8 47/4 72/2 72/12</p> <p>doubled [1] 142/12</p> <p>down [28] 19/19 24/6 31/25 42/18 49/14 51/24 54/9 67/10 67/11 68/16 68/23 71/22 87/7 88/6 101/13 101/15 102/1 106/7 106/11 106/12 111/1 123/10 127/9 128/8 128/19 135/22 151/16 154/24</p> <p>downstairs [1] 99/14</p> <p>dozen [2] 63/16 63/16</p> <p>Dr [49] 18/19 18/19 60/15 63/7 63/7 63/7 63/10 63/10 63/10 63/14 63/15 64/1 67/7 67/10 67/12 73/24 74/2 74/4 82/4 83/10 86/4 89/22 91/18 91/22 92/1 92/1 92/3 92/10 99/15 100/11 100/12 100/16 112/2 114/21 140/7 140/7 140/15 141/3 141/15 142/11 143/2 143/2 144/24 152/6 154/15 154/23 155/5 162/12 164/7</p> <p>Dr. [3] 18/8 91/20 143/19</p> <p>Dr. Desai [1] 143/19</p> <p>Dr. Faris [1] 91/20</p> <p>Dr. Mathahs [1] 18/8</p> <p>drag [1] 88/17</p> <p>dramatically [3] 127/11 128/3 128/4</p> <p>draw [6] 39/24 75/22 80/14 84/14 84/15 85/6</p> <p>drawer [1] 39/22</p> <p>drawing [1] 73/1</p> <p>drawn [9] 40/11 40/16 75/24 76/15 77/8 79/14 81/9 84/16 85/11</p> <p>dried [1] 160/7</p> <p>drink [1] 116/14</p> <p>dropped [2] 8/4 124/4</p> <p>dropping [1] 152/15</p> <p>DRUFF [1] 133/20</p> <p>drug [6] 39/16 67/22 69/1 69/6 69/8 77/14</p> <p>drugs [3] 69/12 156/22 157/9</p> <p>dry [2] 96/16 96/18</p> <p>Dueñas [6] 3/3 6/7 6/13 6/22</p>	<p>6/23 6/24</p> <p>duly [6] 5/5 6/14 21/19 56/16 118/16 133/21</p> <p>dump [1] 148/18</p> <p>dumped [1] 150/7</p> <p>dumping [2] 149/5 149/7</p> <p>during [41] 29/16 30/13 34/1 34/11 34/12 45/5 45/20 50/11 51/1 52/1 53/8 53/12 53/16 53/19 59/5 67/3 70/11 74/23 84/6 87/22 90/15 92/16 102/7 102/11 126/12 126/24 136/14 137/23 150/10 150/11 151/18 151/21 152/1 152/7 153/22 155/23 156/10 156/11 156/18 156/20 159/13</p> <p>duties [1] 62/10</p> <p>E</p> <p>each [7] 24/5 41/16 44/14 51/8 68/23 113/14 130/16</p> <p>earlier [3] 50/1 81/7 107/13</p> <p>early [2] 126/5 127/24</p> <p>ears [1] 109/15</p> <p>ease [1] 23/24</p> <p>easier [2] 9/8 78/1</p> <p>easily [1] 142/12</p> <p>EDI [3] 7/22 7/25 10/3</p> <p>effect [4] 29/11 48/23 53/25 91/2</p> <p>EGDs [1] 121/19</p> <p>eggs [3] 69/15 69/16 69/17</p> <p>eight [4] 72/12 72/18 109/6 140/2</p> <p>eight feet [1] 72/12</p> <p>eight-hour-a-day [1] 109/6</p> <p>EIGHTH [1] 1/2</p> <p>either [12] 7/13 7/22 63/18 66/14 71/13 75/13 80/4 92/22 101/14 114/17 115/2 154/16</p> <p>EKG [1] 73/8</p> <p>electronic [2] 8/5 9/18</p> <p>electronically [2] 8/2 10/6</p> <p>elicits [1] 29/8</p> <p>eligibility [1] 7/6</p> <p>else [10] 30/10 42/14 44/2 45/22 60/8 82/25 96/11 109/12 158/14 162/10</p> <p>elsewhere [1] 34/7</p> <p>emails [1] 45/1</p> <p>emotionally [1] 48/25</p> <p>emphatic [1] 143/24</p> <p>empty [1] 79/4</p> <p>encouraged [9] 26/21 26/25 31/15 31/25 32/4 32/20 49/15 49/16 49/24</p> <p>encouraging [1] 26/18</p> <p>end [9] 67/16 78/21 84/7 91/24 93/22 100/24 138/8 155/16 155/24</p> <p>endo [1] 73/3</p> <p>Endoscopy [3] 16/10 23/5 130/8</p> <p>endoscope [1] 90/3</p> <p>endoscopies [8] 24/17 62/12 63/25 90/2 90/18 91/4 140/19 150/23</p> <p>endoscopy [27] 8/22 16/6 18/5 18/21 23/3 29/23 31/19 60/12 61/20 62/11 82/24 88/14 91/9 92/13 114/1 119/18 121/19 121/19 122/9 126/14 127/18</p>	<p>9/5 131/9 135/11 135/18 139/20 140/3</p> <p>engage [1] 161/7</p> <p>enjoy [1] 126/10</p> <p>enough [3] 50/7 141/2 152/8</p> <p>enter [3] 79/5 98/11 123/4</p> <p>entered [1] 47/15</p> <p>entire [3] 102/7 104/22 104/23</p> <p>entity [2] 12/19 131/16</p> <p>entry [2] 120/23 123/4</p> <p>EOB [2] 17/2 17/4</p> <p>epiglottis [1] 87/25</p> <p>equipment [7] 93/8 93/19 93/21 94/9 95/9 96/20 155/6</p> <p>ERNEST [6] 1/12 5/25 21/8 56/4 118/5 133/9</p> <p>esophagus [1] 90/4</p> <p>essentially [6] 49/4 88/6 134/17 137/13 138/2 152/19</p> <p>even [18] 18/12 31/8 43/22 81/10 83/24 95/2 95/24 102/10 128/9 143/22 145/1 145/2 151/14 152/18 155/14 159/20 161/15 162/5</p> <p>event [7] 20/4 54/20 100/10 100/17 116/21 132/5 165/8</p> <p>eventually [2] 57/11 65/21</p> <p>ever [72]</p> <p>every [18] 32/24 33/6 38/8 38/18 68/5 71/1 80/21 101/3 122/3 125/6 126/25 138/18 143/16 144/7 149/8 150/6 150/10 151/1</p> <p>everybody [5] 35/2 57/22 101/10 105/20 149/16</p> <p>everybody's [1] 37/7</p> <p>everyone [1] 106/24</p> <p>everything [8] 18/25 68/23 82/10 136/9 158/21 160/16 163/5 164/16</p> <p>evidence [5] 20/3 54/19 116/20 132/4 165/7</p> <p>exactly [12] 33/6 62/10 64/22 74/14 78/20 88/7 103/20 107/18 112/7 123/12 152/16 163/3</p> <p>examination [6] 6/18 22/1 56/20 118/20 134/1 136/11</p> <p>Examined [1] 3/2</p> <p>example [4] 45/19 51/13 138/19 157/20</p> <p>except [3] 91/13 100/11 110/8</p> <p>exception [1] 29/11</p> <p>excluding [2] 100/12 100/16</p> <p>excuse [5] 45/6 50/5 114/8 119/10 119/10</p> <p>excused [1] 20/16 55/7 117/8 132/17 165/20</p> <p>executive [1] 107/24</p> <p>exhibit [9] 10/1 10/11 11/23 12/5 12/12 14/3 14/14 17/15 35/15</p> <p>exhibits [3] 4/1 4/3 13/15</p> <p>exist [1] 95/24</p> <p>expected [1] 161/5</p> <p>expensive [1] 88/8</p> <p>experience [3] 143/14 143/15 162/13</p> <p>experiencing [2] 29/20 29/20</p> <p>explain [1] 36/12</p>
--	--	---

E	fellow [1] 85/9	ing [1] 93/17
explanation [3] 4/4 16/25	felt [5] 27/11 34/8 161/7	foreperson [5] 6/14 21/19
17/4	163/12 163/15	56/16 118/16 133/21
express [1] 27/12	Fentanyl [1] 69/18	forget [1] 63/11
expressed [1] 50/24	few [9] 50/3 63/15 65/20	forgot [1] 101/16
expressing [1] 50/20	72/17 75/7 84/17 106/2	form [8] 4/5 8/6 8/8 8/9
extensive [1] 130/15	128/22 155/14	11/13 11/21 11/22 129/18
extensively [1] 89/21	fiancée [1] 135/8	forms [4] 9/18 9/19 129/17
extra [1] 138/2	field [1] 150/22	130/19
extrapolate [1] 106/3	fifth [1] 23/8	forth [6] 47/24 60/25 94/15
F	figure [1] 112/25	103/5 143/2 156/8
face [1] 151/1	filed [1] 8/5	forward [1] 90/12
facilities [1] 59/11	fill [5] 32/14 41/16 71/18	found [5] 67/18 135/8 139/4
facility [36] 14/23 14/23	123/2 123/3	149/6 153/15
22/21 23/14 23/16 23/19	filled [5] 28/23 28/25 29/18	four [5] 10/10 110/4 110/5
24/14 25/8 25/20 26/13 26/16	31/2 84/9	149/5 150/6
27/6 39/17 39/20 43/5 43/6	filling [1] 31/7	fourth [3] 16/1 23/10 45/7
43/9 43/13 60/2 60/19 60/20	finally [1] 136/15	Frank [2] 133/16 133/17
63/18 69/8 70/4 70/6 70/8	find [9] 11/12 25/21 26/9	fraud [5] 5/23 21/6 56/2
97/13 97/20 115/6 120/7	47/9 52/21 102/24 103/2	118/3 133/7
120/13 120/19 153/2 153/14	109/12 135/1	frequent [1] 53/3
158/1 158/7	fine [12] 20/9 20/11 54/25	fresh [2] 85/18 148/13
fact [5] 19/18 33/9 33/16	55/2 117/1 117/3 132/10	Friday [1] 122/7
83/1 106/21	132/12 152/8 154/12 165/13	front [4] 35/15 35/15 74/18
fail [1] 162/3	165/15	74/20
Failure [5] 20/7 54/23 116/24	finger [1] 44/23	frustration [1] 33/23
132/8 165/11	finish [3] 24/1 24/2 68/17	fudging [2] 105/17 115/13
fair [7] 71/6 108/23 114/16	finished [2] 160/6 162/4	full [4] 64/12 65/12 160/2
141/2 142/2 142/3 152/8	finishing [1] 92/24	165/23
fairly [1] 157/4	first [42] 5/5 6/4 6/14	fully [1] 65/2
faithfully [1] 5/5	21/12 21/14 21/19 23/18	functional [1] 64/5
fake [1] 36/8	25/17 30/4 30/5 44/15 56/8	functions [1] 62/14
faked [1] 34/24	56/10 56/16 58/2 60/16 63/20	Fund [1] 7/1
falling [1] 87/21	63/22 65/25 71/13 84/15	funds [1] 113/19
false [5] 5/23 21/6 56/2	94/16 95/24 98/10 99/13	further [14] 19/22 44/20
118/3 133/7	104/24 108/4 109/9 118/9	44/23 54/2 54/15 112/16
familiar [9] 8/21 10/8 10/17	118/16 124/3 133/13 133/21	115/8 115/24 116/16 129/23
17/12 39/16 60/11 67/22	134/25 135/5 136/6 136/22	130/10 131/25 162/19 164/5
161/19 162/17	145/25 146/3 146/3 156/5	
family [2] 47/9 107/10	162/16	G
far [47] 19/13 25/17 23/22	fist [1] 93/20	gagging [1] 90/16
31/22 32/3 32/12 36/21 37/10	fit [1] 86/5	garb [2] 142/4 142/7
41/2 45/14 46/4 47/23 48/14	five [10] 66/25 67/1 67/14	garbage [1] 78/25
51/18 58/11 60/10 61/16	103/18 109/7 110/6 140/3	garments [1] 164/8
64/11 67/21 69/6 71/9 75/10	140/16 140/21 141/1	gastro [1] 162/14
84/20 85/8 89/3 91/4 93/8	fix [2] 37/2 106/9	gastroenterologists [1] 62/23
93/19 95/23 99/20 99/25	fixed [3] 161/11 161/22	gastroenterology [4] 9/13
103/4 105/5 105/25 106/6	162/5	57/21 58/4 130/6
106/15 108/18 109/17 109/20	Flamingo [1] 62/3	gathers [1] 111/2
128/3 131/12 136/3 141/7	flip [1] 10/16	gave [5] 35/22 48/17 90/8
143/1 146/25 149/12 153/9	floor [8] 88/17 88/25 136/20	105/1 159/7
fare [1] 91/22	136/22 141/22 147/21 156/12	general [8] 34/8 51/15 76/10
Faris [2] 63/7 91/20	164/13	76/12 105/15 105/17 142/22
fast [5] 90/9 91/8 120/10	fluid [1] 94/20	144/15
141/18 164/7	fluids [1] 95/14	generally [2] 32/23 105/21
faster [9] 91/24 92/4 138/22	flush [1] 146/5	gentlemen [7] 19/23 29/9
139/17 139/23 140/5 140/6	flushed [1] 146/6	48/22 74/8 111/16 112/17
140/10 163/1	flushes [1] 137/9	129/24
fastest [3] 92/2 140/7 140/8	flushing [3] 146/13 146/17	get [65]
fax [1] 10/4	147/10	gets [3] 50/8 72/25 108/16
February [1] 134/9	focused [1] 58/25	getting [13] 49/9 89/9 116/9
fecal [3] 142/15 142/18	follow [6] 44/24 45/3 70/21	126/22 128/7 128/22 129/14
164/8	99/1 131/6 156/8	136/7 136/10 137/8 142/18
feel [5] 101/19 130/17	follow-up [3] 44/24 45/3	160/5 162/6
159/17 159/21 163/8	131/6	GI [3] 147/21 150/22 162/16
feeling [3] 24/24 47/13	followed [1] 64/12	give [27] 5/12 5/20 20/20
150/20	following [3] 5/6 66/22 126/2	21/3 36/1 39/6 50/7 55/17
feet [4] 72/12 72/17 72/18	follows [5] 6/16 21/21 56/18	55/24 57/4 60/7 73/10 75/2
93/20	118/18 133/23	77/11 78/16 84/15 85/6 85/9
fell [3] 66/3 127/2 127/5	foot [1] 135/7	93/2 98/9 98/15 117/17
	forceps [7] 88/14 137/9 138/5	117/25 132/22 133/4 154/4
	138/10 138/12 147/2 147/4	156/9

G given [10] 29/18 39/22 39/25 40/15 49/3 78/22 90/6 110/20 125/1 131/15 gives [1] 87/25 giving [4] 38/3 59/4 137/7 137/9 Glamour [1] 135/3 go [60] God [5] 5/15 20/23 55/19 117/20 132/24 goes [6] 31/13 75/6 75/8 88/2 88/20 94/21 going [74] gone [5] 41/24 74/1 80/19 134/20 146/16 good [10] 33/1 33/2 33/4 33/4 33/7 35/3 37/8 60/9 101/19 115/2 got [40] 13/9 18/22 22/11 28/4 57/11 57/20 58/16 63/20 64/24 64/25 65/25 66/1 66/2 70/3 71/12 73/12 76/8 87/5 92/23 94/16 95/25 99/13 104/24 105/3 107/20 109/7 120/12 121/2 122/17 130/16 130/19 134/23 135/6 135/21 148/14 151/13 151/14 164/8 164/14 164/21 grade [3] 164/18 164/19 164/25 graduate [4] 22/8 22/13 134/10 134/13 graduated [8] 22/14 22/25 23/2 25/18 57/9 119/2 120/8 135/16 graduation [1] 135/14 GRAND [36] 1/5 2/1 2/22 4/3 5/13 6/15 9/23 12/5 20/4 20/5 20/6 20/21 21/20 44/9 48/10 54/20 54/21 54/22 55/18 56/17 89/11 113/22 116/21 116/22 116/23 117/18 118/17 132/5 132/6 132/7 132/23 133/22 148/2 165/8 165/9 165/10 gross [5] 20/8 54/24 116/25 132/9 165/12 group [6] 91/5 91/22 92/2 108/12 135/5 144/11 guess [8] 9/3 32/18 40/22 59/22 61/13 97/15 107/25 151/3 gurneys [1] 42/19 guys [5] 88/10 100/20 105/17 109/21 152/12	88/20 109/13 137/15 148/10 157/12 handled [2] 19/2 158/22 handling [1] 88/13 hands [4] 24/21 63/25 113/19 141/16 hands-on [1] 24/21 hang [1] 160/7 hanging [1] 46/17 happen [23] 31/10 47/6 47/7 51/2 51/4 85/2 86/2 86/20 92/15 92/21 98/22 101/17 106/25 107/6 109/21 111/9 129/2 144/10 144/12 144/15 155/23 157/15 161/6 happened [18] 11/13 27/7 29/12 31/11 32/18 33/3 44/5 53/2 53/22 64/1 84/17 92/20 127/21 127/24 139/3 151/2 158/15 160/12 happening [10] 34/6 34/7 53/12 79/10 79/20 92/18 102/16 151/10 152/14 157/23 happens [5] 44/10 53/18 65/3 71/17 75/5 happy [2] 35/2 36/23 hard [4] 7/22 8/3 10/4 24/5 harder [1] 68/22 has [12] 7/13 9/25 27/21 35/14 46/13 49/10 68/8 71/15 80/9 93/15 110/17 110/22 hate [1] 152/2 have [121] haven't [2] 84/16 129/7 having [16] 5/5 6/14 21/19 27/22 35/5 42/17 56/16 57/3 92/17 95/4 101/3 118/16 133/21 152/4 153/14 156/12 he [80] he's [3] 31/8 141/4 141/11 head [5] 88/18 89/6 96/21 96/24 158/18 headfirst [1] 94/3 health [8] 7/1 7/8 33/2 33/5 33/7 115/18 119/12 130/3 healthy [2] 35/2 36/23 hear [2] 57/22 154/19 heard [3] 145/1 145/5 155/4 hearing [1] 111/19 hearsay [4] 29/9 29/11 111/17 148/3 hedged [1] 113/19 held [6] 20/10 55/1 72/7 117/2 132/11 165/14 help [7] 5/14 14/6 20/22 55/19 94/10 117/19 132/24 helping [2] 46/22 137/24 hepatitis [2] 82/9 82/20 heplock [2] 78/7 78/10 heplocks [1] 77/19 her [16] 5/7 9/2 10/22 10/22 11/18 11/18 24/6 29/12 29/13 48/24 48/25 68/22 106/11 111/25 120/8 120/11 here [14] 5/19 14/14 21/2 55/11 55/23 57/20 60/16 68/16 72/12 72/14 113/22 117/24 133/3 160/21 hey [3] 15/5 160/18 160/21 HF [1] 10/5 HICFA [5] 8/9 8/12 8/14 10/5 10/12	[6] 119/2 120/8 134/18 134/19 134/21 134/22 higher [3] 115/6 129/21 128/25 highly [1] 69/16 Hills [1] 158/5 him [20] 34/12 34/14 34/15 34/17 34/20 50/14 63/22 64/1 64/20 67/13 74/5 89/23 90/5 90/11 92/6 111/19 140/12 143/14 143/15 154/19 hire [2] 23/19 24/9 hireable [1] 108/12 hired [5] 24/13 26/1 67/19 135/17 158/2 hiring [1] 107/23 his [9] 52/7 63/11 64/15 64/21 64/22 86/4 120/11 140/17 141/11 hissy [1] 86/5 history [3] 71/25 82/13 100/23 hit [1] 88/18 hitting [1] 127/18 HIV [1] 82/10 hold [1] 143/22 hole [1] 87/6 hollered [1] 116/9 Home [1] 120/17 honestly [2] 154/21 159/9 hook [1] 78/2 hooked [1] 96/6 hopefully [1] 45/2 hoping [2] 138/24 159/14 hospital [8] 7/24 57/8 59/3 59/6 164/18 164/19 164/24 165/1 hospitals [2] 8/15 59/12 hour [6] 55/9 109/6 113/15 113/15 156/13 156/14 hours [8] 109/8 109/8 109/10 113/1 113/4 113/12 130/18 156/5 house [1] 99/23 hovering [1] 163/7 how [97] Hubbard [1] 65/22 huh [16] 17/10 17/10 17/13 17/13 52/2 61/18 64/7 65/5 75/23 76/1 80/7 145/6 145/8 145/21 146/22 149/18 Huh-huh [2] 17/10 17/13 hundred [5] 122/13 122/14 126/22 128/18 131/4 hurry [2] 33/21 33/21 hurting [1] 109/15 hurts [1] 71/21 hypothetically [3] 19/8 81/7 104/1 I I'd [1] 74/4 I'll [5] 23/25 24/2 36/2 36/7 68/20 I'm [60] ICD [2] 120/24 120/25 Identified [1] 4/3 if [122] ignore [1] 90/13 immediately [1] 58/19 impact [2] 115/14 115/18 IMPANELED [1] 1/5
---	---	--

<p>I</p> <p>implications [2] 111/8 111/11 importance [1] 19/1 important [3] 94/23 95/3 95/9 impossibility [1] 109/18 impression [3] 34/5 104/25 152/14 improper [1] 29/25 improperly [1] 50/25 improved [1] 151/12 in [361] incident [2] 38/22 66/9 include [2] 32/5 32/8 including [6] 20/3 54/19 80/22 116/20 132/4 155/7 incorrect [1] 49/21 increased [1] 65/7 increment [4] 103/21 104/5 124/10 124/10 increments [7] 103/6 103/13 103/15 123/25 124/1 124/2 124/20 independently [1] 59/18 INDEX [2] 3/1 4/1 indicate [3] 17/24 86/2 90/5 individual [4] 8/23 42/19 42/20 58/6 individually [2] 40/12 110/1 individuals [1] 65/24 Induction [1] 72/5 information [19] 7/22 7/23 9/19 9/22 11/25 16/9 20/5 31/16 44/1 47/10 49/9 52/4 54/21 102/14 116/22 132/6 139/7 155/1 165/9 infrequent [2] 53/3 53/4 infrequently [1] 63/18 initially [3] 28/1 85/25 108/19 initiated [1] 149/9 inject [1] 71/21 insert [1] 68/8 inserted [1] 144/23 inserting [3] 78/10 90/3 144/21 inside [2] 153/25 154/22 insisted [2] 96/4 99/15 inspection [1] 152/20 instance [1] 98/25 instances [9] 53/13 73/24 90/1 90/10 90/17 90/18 99/1 106/18 144/22 instead [1] 128/8 institute [2] 134/11 152/12 instituted [1] 152/13 instruct [1] 163/14 instructed [2] 37/4 147/9 insurance [15] 5/23 7/2 21/6 51/12 56/2 104/11 105/11 105/21 118/3 121/6 124/8 128/13 129/8 129/11 133/7 insured's [1] 11/17 interact [1] 70/8 interaction [1] 154/23 intermittently [2] 64/13 64/14 interpreting [1] 14/2 interrupt [1] 113/5 interview [6] 35/5 35/8 35/10 67/5 67/7 67/17 interviewed [4] 23/22 34/15</p>	<p>67/9 120/12 interviews [2] 24/9 108/1 into [49] 24/14 25/8 27/5 31/13 50/8 65/2 70/10 71/14 71/21 72/22 72/22 72/25 73/12 75/7 77/17 77/18 78/10 78/25 79/14 80/12 81/9 85/9 85/11 88/2 89/10 90/4 95/16 96/22 97/3 107/16 129/14 135/10 136/10 137/20 139/14 141/16 142/16 145/22 146/3 146/4 146/9 147/5 147/16 157/8 157/12 161/14 161/21 164/15 164/25 investigation [11] 5/12 5/20 20/20 21/3 55/17 55/24 108/14 117/17 117/25 132/22 133/4 involve [1] 102/19 involved [4] 84/5 104/8 105/6 141/6 involving [5] 5/24 21/7 56/3 118/4 133/8 is [213] isn't [3] 48/5 102/10 119/25 isolated [1] 34/6 issue [16] 36/3 39/15 47/25 48/3 50/20 51/10 86/8 88/12 89/5 96/14 97/10 99/8 112/6 113/22 143/19 147/19 issues [9] 26/12 37/13 37/16 48/24 74/15 86/9 89/23 93/3 94/14 it [352] it's [44] 8/4 8/5 11/15 16/19 17/6 22/9 24/5 35/15 39/17 47/22 48/4 48/6 49/20 50/5 68/9 68/12 76/12 76/22 76/23 80/15 83/4 87/5 88/19 95/8 109/15 110/11 111/18 114/16 123/8 123/8 125/15 126/25 129/6 133/15 142/3 144/16 145/24 146/6 152/2 152/3 152/5 158/12 160/1 160/16 item [2] 10/2 19/1 items [11] 14/9 86/10 86/18 87/15 88/8 88/13 114/6 114/20 123/13 145/10 146/25 itself [13] 12/22 16/10 17/9 47/23 58/22 71/9 71/20 78/4 95/2 97/13 105/6 109/20 137/23 IV [1] 77/21</p> <p>J</p> <p>Jackson [1] 60/7 jail [2] 22/22 22/23 Jane [1] 44/16 Janine [1] 158/17 janitor [1] 108/17 January [3] 45/6 108/9 126/1 Jeff [2] 158/6 158/17 Jersey [2] 57/7 57/7 job [35] 24/15 25/17 25/18 25/21 30/4 48/24 57/19 58/2 62/10 66/17 67/16 99/23 99/24 107/10 107/12 107/13 108/2 108/17 109/1 109/6 114/5 114/7 114/18 119/5 120/9 120/22 129/10 135/7 137/6 138/9 155/1 155/3</p>	<p>/14 162/16 163/7 jobs [1] 108/4 joke [1] 142/22 joked [1] 141/21 JOSEPH [1] 2/15 JUDICIAL [1] 1/2 juggle [4] 100/19 100/20 113/13 114/6 juggled [2] 99/16 113/17 juggling [3] 114/8 114/15 114/22 July [13] 23/6 23/9 23/10 45/6 45/7 45/11 51/1 66/10 66/11 119/1 119/6 125/20 125/22 July 25th [2] 45/11 66/10 July/August [4] 119/1 119/6 125/20 125/22 JURORS [1] 2/1 jury [40] 1/5 2/22 4/3 5/13 6/15 9/23 12/5 19/25 20/4 20/5 20/6 20/21 21/20 44/9 48/10 54/5 54/20 54/21 54/22 55/18 56/17 89/12 112/19 113/22 116/21 116/22 116/23 117/18 118/17 130/1 132/5 132/6 132/7 132/23 133/22 148/2 162/21 165/8 165/9 165/10 just [157] justify [2] 112/24 113/13</p> <p>K</p> <p>KANTILAL [6] 1/12 5/24 21/7 56/3 118/4 133/8 Katie [4] 23/21 24/8 43/16 158/2 keep [4] 55/11 131/21 152/21 159/22 keeping [1] 102/6 keeps [3] 87/20 87/24 88/6 KEITH [12] 1/13 5/25 16/2 21/8 56/4 65/22 66/3 69/20 110/9 116/11 118/5 133/9 Keith H [1] 118/5 kept [2] 83/10 90/8 kind [27] 25/11 27/19 47/5 47/7 53/21 59/7 64/16 69/20 72/15 94/8 104/19 109/13 110/20 120/16 121/8 121/9 126/11 129/2 141/25 143/24 145/12 147/15 159/13 159/23 160/20 161/4 163/8 kinds [2] 7/19 83/2 knew [10] 44/14 82/13 99/22 105/7 107/7 111/5 112/10 114/14 120/8 124/23 know [118] knowledge [6] 89/17 104/17 105/15 105/17 120/3 130/3 known [1] 106/21 Kruger [4] 89/6 97/2 97/3 158/6</p> <p>L</p> <p>label [1] 69/3 labeled [1] 84/2 ladder [1] 154/24 ladies [7] 19/23 29/9 48/21 74/7 111/16 112/17 129/24 lady [2] 101/15 106/10 laid [1] 108/11</p>
--	---	---

L	Linda [1] 65/22	22
LAKEMAN [9] 1/12 5/25 21/8	line [8] 32/1 77/17 77/18	maintain [1] 159/18
56/4 66/1 67/11 69/24 118/5	78/24 107/24 108/4 115/22	maintains [1] 94/25
133/9	139/4	majority [1] 38/19
land [1] 99/14	LISA [1] 2/4	make [27] 7/10 9/8 10/8
Lane [10] 16/4 16/7 62/7	listener [5] 29/12 48/23	13/19 23/25 48/7 50/4 50/6
62/9 65/13 69/9 119/25 122/9	53/25 111/18 111/22	70/25 78/1 83/7 97/19 98/10
135/10 138/17	little [20] 9/7 9/8 22/24	99/17 100/25 105/11 106/25
larger [1] 41/1	50/3 73/17 78/1 88/5 92/25	141/12 144/20 146/6 146/14
Las [8] 1/17 5/1 16/4 16/7	93/1 120/18 125/15 126/3	150/10 152/21 158/14 164/16
57/11 57/19 58/3 60/6	135/2 136/25 137/3 138/8	164/20 165/1
last [18] 6/4 6/9 6/20 16/1	144/1 150/5 151/15 162/15	makes [1] 68/22
17/19 17/20 21/12 21/15 29/7	live [1] 61/2	making [3] 136/8 136/9 150/5
44/17 56/8 56/11 71/14 91/3	liver [1] 82/24	mal [1] 45/24
99/16 118/9 118/11 133/13	living [5] 6/24 22/3 56/23	Maley [4] 23/21 24/8 43/16
later [11] 24/10 24/12 24/13	118/23 134/6	158/2
26/2 58/16 65/3 96/2 113/23	load [2] 65/6 159/18	Management [1] 61/8
124/4 135/15 158/17	locate [1] 25/24	manager [1] 158/3
lateral [1] 73/5	located [1] 119/15	Manuel [4] 91/18 100/11
lauren's [2] 95/5 95/20	location [4] 18/9 61/11 69/13	100/12 100/16
law [5] 20/1 54/17 116/18	119/23	many [21] 67/25 67/25 102/2
132/2 165/5	locations [1] 61/13	110/3 112/21 113/14 120/19
lay [2] 84/10 99/14	locum [2] 66/15 66/18	122/6 122/8 124/16 128/17
lazy [1] 94/4	long [15] 22/5 25/23 26/8	128/19 128/20 130/15 131/1
leader [3] 6/25 7/17 7/18	26/8 58/22 59/20 60/18 88/19	131/3 131/12 148/19 149/13
leads [1] 73/8	88/19 90/21 92/6 92/10 138/7	155/7 159/8
learn [1] 25/12	139/18 140/12	March [1] 60/20
learned [2] 25/14 159/10	longer [4] 41/24 143/8	March 4 [1] 60/20
lease [1] 60/24	148/16 148/18	MARCIA [3] 1/25 5/4 165/25
least [18] 12/17 39/17 50/20	look [15] 9/21 12/2 12/4	Maria [1] 61/9
60/2 69/21 70/24 79/19 84/18	13/6 15/5 32/15 35/20 52/16	Marion [3] 3/7 133/15 133/20
84/25 89/14 99/16 106/22	57/18 70/24 74/22 123/5	marked [1] 10/1
108/13 109/8 116/11 125/24	144/19 144/20 149/25	mask [3] 93/13 150/11 150/19
151/5 156/17	looked [3] 12/15 92/23	masks [1] 151/1
leave [15] 38/6 38/8 38/11	123/14	match [1] 50/2
38/13 38/17 38/20 38/21	looking [20] 11/3 12/11 13/12	MATHAHS [17] 1/13 5/25 16/2
41/17 41/23 43/6 60/23 83/20	13/22 13/24 14/14 16/22	18/8 18/19 18/19 21/8 56/4
99/2 99/6 107/15	25/25 26/3 26/4 26/7 45/21	65/22 66/3 69/20 82/2 85/21
leaves [2] 31/13 80/8	57/17 109/1 109/11 124/23	96/24 99/15 118/5 133/9
leaving [2] 43/12 108/5	135/4 135/7 139/8 144/3	matter [11] 29/10 44/10 54/1
lecithin [1] 69/15	looks [3] 17/5 17/21 27/22	60/12 74/9 111/21 142/15
leeway [1] 50/7	lot [10] 33/22 33/23 43/3	142/18 148/7 150/24 164/8
left [24] 25/20 26/13 26/16	71/21 111/7 112/12 114/4	may [28] 5/17 9/4 20/10
34/17 40/2 43/5 43/9 46/13	122/15 155/12 159/12	20/25 22/14 35/18 48/24 55/1
66/1 66/22 70/17 71/2 71/15	lots [1] 70/12	55/21 86/23 88/17 88/17
73/15 76/19 80/3 99/3 101/21	LOUISE [1] 2/18	88/18 95/4 97/15 110/13
110/19 127/23 127/25 136/16	lower [1] 112/25	110/13 113/19 117/2 117/7
152/10 160/4	LPN [1] 22/17	132/11 132/16 133/1 135/19
length [1] 39/12	Luis [2] 57/16 61/9	135/24 139/13 165/14 165/19
lengthen [2] 54/12 54/13	lunch [7] 42/4 55/9 55/13	maybe [9] 32/14 38/21 40/1
LEONARD [3] 1/25 5/4 165/25	85/8 86/8 156/3 156/11	50/23 63/15 73/14 122/13
less [7] 19/9 19/20 77/13	lunchtime [2] 41/15 156/11	142/10 150/17
100/3 100/4 100/5 125/8	lungs [2] 93/18 95/16	mayor [1] 135/22
lesser [1] 19/10	lying [1] 42/17	McCurdy [1] 63/10
let [13] 9/7 11/20 13/11	LYONAI [1] 2/5	MD [4] 59/25 62/19 62/22
24/1 24/2 32/18 35/25 37/10	M	139/11
37/11 68/17 70/2 74/24 135/6	M-A-R-I-O-N [1] 133/16	me [69]
let's [17] 11/1 11/4 12/21	M-I-O-N-E [1] 110/11	mean [29] 7/25 26/3 29/22
27/21 39/15 46/12 48/4 49/8	ma'am [1] 6/21	30/10 30/22 31/2 38/16 39/23
58/11 71/13 75/18 77/6 80/4	machine [17] 52/12 145/17	50/18 51/22 69/7 71/10 76/16
112/25 113/12 128/18 136/25	145/22 146/9 146/15 160/10	90/12 91/6 121/10 124/21
lets [1] 16/25	161/13 161/13 161/16 161/17	127/19 128/17 138/15 139/7
letter [3] 43/11 43/13 44/1	161/18 161/22 162/2 162/3	141/9 142/7 144/12 152/2
level [3] 50/17 147/8 152/3	162/4 162/7 163/4	158/12 158/12 159/24 162/2
levels [1] 124/1	machines [1] 146/4	meaning [1] 72/5
license [2] 30/7 152/21	made [14] 8/22 13/25 20/5	means [2] 93/9 95/21
lieu [1] 69/19	54/20 74/13 94/12 102/23	meant [4] 36/12 59/22 111/13
life [1] 112/12	116/21 132/5 144/23 147/5	125/22
light [1] 92/23	152/16 158/10 165/8	mechanics [1] 104/9
like [92]	main [2] 97/14 107/11	medical [10] 8/15 57/7 119/6
limited [1] 37/17	mainly [4] 24/20 24/23 62/2	120/23 134/14 135/1 135/4
		135/5 137/12 152/20

<p>M</p> <p>medication [1] 68/8</p> <p>medicine [1] 160/24</p> <p>medicines [1] 156/25</p> <p>medivator [1] 161/19</p> <p>meet [1] 23/19</p> <p>meeting [7] 74/3 109/25 110/2 110/3 110/7 110/13 112/5</p> <p>member [7] 7/14 8/8 8/19 8/19 9/13 16/24 16/25</p> <p>member's [1] 11/7</p> <p>memory [4] 14/7 36/2 36/5 74/23</p> <p>mentally [1] 48/25</p> <p>mention [2] 94/12 112/1</p> <p>mentioned [7] 15/12 19/5 43/17 83/16 84/20 121/11 123/13</p> <p>method [2] 79/13 81/19</p> <p>MICHAEL [3] 2/13 2/23 60/7</p> <p>microphone [1] 109/14</p> <p>mid [1] 66/22</p> <p>middle [1] 91/23</p> <p>Middlesex [1] 57/6</p> <p>might [9] 17/6 41/23 45/21 46/2 85/9 92/23 115/17 126/3 152/15</p> <p>milligrams [1] 40/23</p> <p>mimics [1] 10/4</p> <p>mind [3] 30/5 78/7 112/9</p> <p>minimum [1] 155/9</p> <p>minute [22] 8/25 19/5 19/8 19/19 25/16 37/12 58/12 91/3 92/14 102/7 103/18 107/19 112/2 117/11 124/1 124/10 124/12 124/12 124/20 126/14 129/16 141/16</p> <p>minutes [51] 15/1 15/16 15/18 15/24 19/6 19/12 19/15 50/3 90/24 91/10 91/11 92/7 92/12 99/16 99/18 100/3 100/8 101/22 102/2 103/18 103/19 103/22 103/25 104/4 104/16 106/2 106/4 106/22 112/25 113/3 113/14 123/18 123/19 123/21 124/5 124/7 124/24 125/3 125/8 125/12 123/6 130/23 130/24 131/2 140/2 140/3 140/16 140/20 140/21 141/1 141/1</p> <p>minutes' [1] 37/24</p> <p>Mione [1] 110/10</p> <p>misdemeanor [5] 20/8 54/24 116/25 132/9 165/12</p> <p>mistake [1] 24/1</p> <p>modifiers [2] 14/1 14/25</p> <p>mom [1] 120/11</p> <p>moment [2] 74/19 111/3</p> <p>Monday [1] 122/7</p> <p>money [13] 5/23 17/25 18/3 18/25 19/16 21/6 56/2 86/7 104/12 105/12 118/3 125/1 133/7</p> <p>money-wise [1] 125/1</p> <p>monitor [3] 73/8 78/18 153/25</p> <p>month [2] 60/24 136/12</p> <p>months [7] 26/2 63/23 64/24 66/25 67/1 125/24 125/24</p> <p>morally [4] 114/2 114/14 114/17 114/24</p> <p>moratorium [1] 108/11</p>	<p>more [25] 9/7 26/22 38/15 41/6 51/4 55/10 63/4 77/13 79/16 80/14 85/2 85/22 93/2 100/3 109/9 122/14 125/3 125/9 130/18 135/2 155/10 155/13 162/13 162/15 164/5</p> <p>morning [2] 13/25 156/2</p> <p>most [10] 8/13 38/17 70/23 91/5 95/9 98/25 100/14 100/16 115/20 152/5</p> <p>mostly [1] 153/24</p> <p>motioned [1] 72/15</p> <p>mouth [3] 87/5 87/24 146/21</p> <p>mouthpieces [1] 163/1</p> <p>move [10] 16/16 39/15 41/13 88/21 93/1 97/25 152/8 155/20 156/17 159/15</p> <p>moved [5] 40/2 40/3 42/3 84/5 93/4</p> <p>moving [1] 38/1</p> <p>Mr. [9] 56/22 69/24 82/2 85/21 89/6 99/15 113/25 118/22 134/3</p> <p>Mr. Cerda [1] 118/22</p> <p>Mr. Kruger [1] 89/6</p> <p>Mr. Lakeman [1] 69/24</p> <p>Mr. Mathahs [3] 82/2 85/21 99/15</p> <p>Mr. Sagendorf [2] 56/22 113/25</p> <p>Mr. VanDruff [1] 134/3</p> <p>Ms [2] 6/24 10/21</p> <p>Ms. [1] 22/3</p> <p>Ms. Yost [1] 22/3</p> <p>much [18] 17/25 18/3 19/16 25/1 69/15 96/18 101/3 112/3 117/9 123/23 125/2 126/25 128/12 139/21 144/3 147/20 148/17 158/8</p> <p>multi [2] 16/19 68/9</p> <p>multiple [2] 41/2 41/3</p> <p>murky [1] 148/14</p> <p>my [41] 6/6 9/10 22/11 23/17 24/2 30/7 40/22 41/11 43/11 56/10 56/11 57/7 57/8 57/8 57/9 57/17 57/19 68/17 70/23 73/21 76/14 78/7 84/10 84/24 99/23 113/19 114/7 129/4 135/8 135/11 138/9 139/3 141/16 143/15 152/3 152/4 152/5 153/24 154/3 154/4 159/14</p> <p>myself [2] 110/9 150/21</p> <p>N</p> <p>name [23] 6/6 6/9 6/20 8/19 11/16 11/17 15/25 21/14 21/15 35/16 44/19 47/12 56/10 56/11 60/9 62/5 63/11 118/12 119/9 119/11 123/3 123/4 161/17</p> <p>names [7] 6/4 21/12 44/15 44/17 56/8 118/9 133/13</p> <p>nd [1] 38/20</p> <p>necessarily [9] 13/15 19/9 59/17 59/23 97/16 111/20 143/5 143/7 148/1</p> <p>necessary [2] 73/3 93/21</p> <p>need [12] 7/24 11/8 12/4 13/6 13/10 13/17 59/13 74/22 95/8 106/9 150/9 160/18</p> <p>needed [10] 39/10 94/10 99/24</p>	<p>/25 107/12 109/12 120/9 155/9 137/8 163/13</p> <p>needle [6] 78/3 78/9 79/1 79/4 79/5 81/8</p> <p>needles [1] 80/16</p> <p>needs [2] 78/16 78/18</p> <p>neglect [5] 5/22 21/5 56/1 118/2 133/6</p> <p>negligence [2] 144/14 144/15</p> <p>NEVADA [15] 1/3 1/8 1/17 5/1 8/23 9/14 16/5 16/6 16/7 18/6 22/12 57/21 119/19 122/9 134/10</p> <p>never [27] 34/14 34/15 54/11 62/21 66/18 79/7 79/8 79/24 81/21 81/21 83/12 83/16 84/23 85/5 95/6 102/21 102/24 103/1 105/3 106/12 109/7 115/1 115/1 116/13 150/21 150/23 155/4</p> <p>new [14] 13/25 26/5 30/11 40/3 40/17 50/21 57/6 79/5 80/12 81/8 81/9 91/18 108/8 149/22</p> <p>news [3] 108/17 110/22 127/18</p> <p>next [16] 16/16 44/10 47/4 70/18 71/16 75/5 77/16 80/20 135/12 135/13 136/20 142/16 145/7 145/18 160/7 164/21</p> <p>nickel [1] 88/9</p> <p>nine [1] 140/2</p> <p>no [102]</p> <p>nobody [2] 41/21 108/8</p> <p>none [11] 19/25 54/5 54/16 74/8 83/9 104/21 115/9 116/17 130/11 132/1 165/4</p> <p>normal [9] 9/16 53/18 129/6 130/21 130/25 131/12 131/13 139/16 143/25</p> <p>not [106]</p> <p>note [1] 138/19</p> <p>nothing [16] 5/14 6/16 19/22 20/22 21/21 54/2 55/19 56/18 112/16 115/24 117/19 118/18 129/23 132/24 133/23 162/19</p> <p>notice [4] 39/19 65/6 127/10 147/1</p> <p>Noticeably [2] 92/4 140/10</p> <p>noticed [3] 64/16 96/19 126/20</p> <p>now [111]</p> <p>number [11] 8/10 11/7 14/14 19/12 19/15 61/22 103/11 104/15 124/9 124/13 142/11</p> <p>Number 30B [1] 14/14</p> <p>numbers [11] 11/12 99/17 100/20 100/20 101/14 113/17 114/6 114/9 114/16 114/22 115/13</p> <p>nurse [23] 22/4 22/5 22/15 22/16 28/25 44/7 44/18 48/8 50/5 50/21 53/17 56/24 57/1 58/15 65/16 84/12 89/6 96/21 96/24 98/24 116/2 158/6 158/18</p> <p>nurses [13] 26/24 27/15 28/16 30/10 30/14 30/22 33/20 42/25 74/3 101/14 106/18 107/3 107/7</p> <p>nurses' [1] 44/16</p> <p>nursing [6] 23/21 29/24 44/4</p>
---	--	--

N	162/3	[4] 61/8 67/14 68/2
nursing... [3] 44/18 58/20	opening [2] 158/4 158/5	11/23
62/14	openings [1] 107/21	PAMELA [1] 2/16
nuts [1] 104/9	operated [1] 138/20	paper [1] 124/25
O	operation [1] 34/19	papers [2] 108/16 126/13
o'clock [6] 49/10 49/19 49/20	or [244]	paperwork [10] 24/20 28/11
49/25 54/7 54/9	order [3] 82/5 82/6 158/16	28/14 28/15 28/24 45/19
o2 [1] 73/8	ordering [1] 158/19	45/23 45/25 46/9 98/19
Obispo [2] 57/16 61/9	orders [1] 158/8	PARKER [2] 2/6 2/7
object [1] 83/17	Orellana [4] 4/5 8/20 10/21	part [11] 9/16 12/16 66/8
observation [3] 42/9 139/16	11/17	71/25 79/25 95/11 95/12
153/7	Orellana-Alfaro [1] 11/17	109/5 110/12 115/21 138/5
obstructing [1] 87/21	organization [2] 9/14 19/3	partially [1] 84/9
obtained [5] 20/6 54/22	other [55] 7/7 9/4 9/6 12/24	participant [1] 7/14
116/23 132/7 165/10	12/25 17/2 19/1 24/6 27/1	participants [2] 7/23 17/22
obtaining [5] 5/23 21/6 56/2	30/14 31/25 41/16 44/14 48/2	particular [16] 8/10 8/17
118/3 133/7	59/15 63/8 65/16 68/23 69/7	9/12 10/11 11/22 13/5 16/23
obviously [6] 48/17 75/16	69/12 74/15 75/16 83/9 84/8	17/15 19/2 50/23 60/10 74/15
102/10 119/24 127/23 139/2	85/8 86/9 86/10 87/15 93/22	78/22 112/6 138/14 148/2
occasion [4] 85/3 85/23	97/11 100/14 100/17 104/14	parts [1] 159/2
142/21 144/13	114/1 114/19 114/25 116/2	party [5] 7/1 7/3 12/17
occasional [1] 153/10	116/7 121/14 130/4 130/5	12/17 18/13
occasionally [2] 38/20 164/12	130/5 130/17 144/10 144/18	pass [2] 37/24 59/10
occasions [1] 84/18	146/25 147/21 147/21 150/21	passed [2] 107/25 135/11
occur [5] 52/24 143/13	150/24 156/14 157/2 158/4	past [1] 68/1
148/20 153/14 160/12	159/2 165/3	patient [135]
occurred [6] 29/17 130/19	others [1] 63/4	patient's [7] 11/16 71/21
148/25 153/11 157/19 158/15	our [8] 10/4 10/5 17/21 55/9	94/21 115/18 123/3 143/22
occurrence [2] 101/11 157/5	72/12 142/9 145/17 156/10	144/16
occurring [6] 20/4 45/2 54/20	out [107]	patients [52] 5/22 21/5 28/4
116/21 132/5 165/8	outcome [1] 115/18	28/10 31/3 32/14 36/9 38/4
October [6] 60/17 66/6 66/7	outpatient [2] 14/22 14/22	41/2 45/15 45/16 48/2 49/3
66/19 66/21 108/19	outside [1] 146/1	52/25 56/1 57/2 59/4 62/11
October 1 [3] 60/17 66/7	over [24] 23/10 24/5 36/1	64/25 70/12 70/17 70/21
66/19	37/25 47/22 47/25 62/3 68/1	70/24 71/3 71/5 72/7 72/16
off [8] 11/1 114/12 129/11	68/23 84/10 93/13 98/24	72/22 77/12 77/13 80/20
131/16 142/5 145/13 159/10	107/21 107/21 107/22 109/9	81/24 82/19 83/2 93/4 93/20
165/21	116/13 122/19 142/9 142/15	94/2 99/1 112/21 118/2
offenses [5] 5/21 21/4 55/25	144/19 144/20 162/9 163/7	131/12 133/6 136/4 136/7
118/1 133/5	overall [1] 97/13	145/13 150/21 155/7 155/15
offered [10] 29/10 44/9 48/22	overlap [2] 49/3 50/5	155/15 155/16 155/17 159/9
53/25 54/1 74/8 108/2 111/18	overlapping [2] 48/1 51/11	pause [1] 159/7
111/21 148/6	own [7] 13/10 37/1 42/19	pay [3] 83/15 88/15 128/13
office [8] 17/7 50/23 120/17	85/18 87/23 139/3 157/16	paying [3] 18/15 145/9
120/18 121/24 138/17 158/3	owner [2] 119/13 120/2	154/14
158/16	oxygen [1] 93/9	payment [6] 8/22 9/19 18/25
often [7] 38/11 38/13 38/15	P	19/19 131/17 131/19
53/5 143/13 144/12 148/19	P.M [3] 2/3 2/4 2/6	payments [2] 7/10 99/24
Oh [7] 72/11 82/13 84/22	P1 [1] 123/9	pend [1] 7/22
112/15 155/11 155/12 161/15	P2 [2] 14/25 123/9	pending [5] 5/13 20/21 55/17
okay [187]	P3 [1] 123/9	117/18 132/22
old [1] 79/14	P4 [1] 123/9	penetrating [1] 78/3
Older [1] 77/12	pace [3] 160/16 160/19	people [18] 27/7 30/18 34/1
on [242]	163/13	35/1 37/23 50/14 50/18 53/19
once [10] 51/4 66/5 70/15	Pacific [1] 51/12	106/6 107/23 110/3 110/5
72/25 76/15 78/15 109/17	package [2] 68/7 69/4	110/7 113/15 120/19 129/14
120/13 146/16 152/10	packet [1] 121/16	131/1 143/8
one [83]	page [19] 10/14 10/15 10/15	per [2] 7/12 153/17
ones [7] 18/14 40/17 91/13	10/24 10/25 11/1 11/6 12/12	perform [3] 24/17 59/16 59/18
91/14 116/11 124/16 147/22	14/16 16/1 16/1 17/5 17/8	performance [5] 5/21 21/4
only [16] 40/16 44/14 62/25	17/15 17/19 17/20 35/15	55/25 118/1 133/5
66/23 68/25 83/10 101/8	35/16 35/25	performed [1] 9/11
114/8 138/1 138/9 147/7	page 1 [4] 10/14 10/15 11/1	performing [1] 61/4
150/19 156/2 156/4 156/12	11/6	period [11] 23/10 23/13 25/11
157/23	Page 2 [1] 10/15	25/23 61/17 66/21 91/1 102/7
op [7] 27/4 28/6 28/7 28/10	page 3 [2] 10/24 10/25	124/24 151/21 161/23
28/16 31/16 32/15	pages [4] 10/8 10/10 16/19	periodically [3] 40/18 71/2
open [7] 75/22 85/12 85/15	16/21	71/4
138/9 149/14 152/21 162/2	paid [11] 17/25 18/3 18/4	person [16] 26/22 26/22 27/21
opened [4] 40/17 62/4 149/22	18/5 18/7 19/10 19/13 19/16	27/25 28/1 38/2 38/3 42/12
	60/21 104/10 159/13	52/9 72/16 101/18 103/24
		112/25 142/18 157/22 159/10

P	128/9 162/3	blems [2] 64/8 97/22
personal [4] 26/15 147/8	post [3] 31/14 31/16 32/15	procedural [1] 158/9
152/3 153/7	post-care [1] 31/14	procedure [80]
personally [1] 84/16	post-op [2] 31/16 32/15	procedures [35] 9/11 32/6
personnel [2] 30/15 109/23	posterior [2] 95/8 95/10	34/13 37/20 37/20 42/12
persons [8] 5/22 21/5 27/1	posthaste [1] 108/6	50/22 54/8 57/3 64/11 82/20
31/25 56/1 106/8 118/2 133/6	postoperative [1] 45/14	100/2 104/15 136/8 136/14
perspective [1] 98/8	potential [2] 95/15 115/18	136/14 140/13 140/24 143/3
pertaining [5] 5/20 21/3	potentially [4] 76/24 81/8	143/16 144/8 148/22 150/5
55/24 117/25 133/4	111/13 147/1	150/10 150/11 150/24 151/6
pertains [1] 155/2	practice [31] 26/23 34/7 34/8	151/12 152/11 154/21 155/17
pervasive [1] 33/25	37/16 45/2 59/10 59/12 62/23	156/7 158/21 158/25 159/25
pharynx [3] 94/21 95/8 95/10	63/1 63/9 65/3 76/10 76/11	proceed [1] 80/17
physical [4] 72/1 82/14	76/12 76/13 76/14 80/1 80/18	proceeding [1] 74/23
100/23 119/23	80/24 89/17 101/9 103/1	proceedings [7] 1/21 5/7 20/1
physically [1] 141/17	105/13 106/24 107/16 108/20	54/17 116/18 132/2 165/5
physician [7] 47/10 59/20	109/4 110/14 150/15 153/18	process [20] 7/4 7/21 7/24
73/3 73/12 73/15 91/18	153/20	17/1 39/10 44/22 47/3 50/11
138/15	practitioners [1] 84/8	52/1 70/3 141/19 141/19
physicians [8] 8/15 59/15	pre [19] 26/18 26/18 27/4	145/24 146/10 146/12 148/20
61/10 62/22 62/25 63/3 63/8	28/6 28/7 28/10 28/16 31/23	149/2 149/9 152/11 161/12
138/18	31/25 32/4 32/5 32/20 33/17	processed [4] 87/12 87/13
PI [2] 72/1 72/3	33/24 37/15 43/18 48/3 49/9	146/18 160/3
pick [6] 44/6 44/17 77/10	51/11	processing [3] 160/2 161/16
160/15 160/18 163/13	pre-chart [6] 26/18 31/25	162/4
picture [1] 78/7	32/5 32/20 33/17 33/24	produced [1] 102/13
piece [2] 96/20 113/3	pre-charted [1] 32/4	professional [2] 26/15 26/17
pieces [1] 95/9	pre-charting [6] 26/18 31/23	program [6] 58/17 58/20 58/21
piling [1] 160/3	37/15 43/18 48/3 51/11	58/22 58/25 59/7
place [11] 14/22 28/4 30/6	pre-op [5] 27/4 28/6 28/7	programs [1] 58/19
51/22 57/18 73/2 80/21 84/15	28/10 28/16	prohibited [5] 20/2 54/18
120/16 135/5 153/19	pre-procedure [1] 49/9	116/19 132/3 165/6
Plaintiff [1] 1/9	predominantly [2] 75/15 75/17	pronounce [1] 6/20
plan [5] 7/14 8/7 8/18 8/19	pregnant [1] 135/8	proper [2] 30/2 48/15
9/13	preinduction [2] 72/4 72/9	properly [2] 136/9 147/6
plastic [1] 88/5	prematurely [1] 52/25	property [5] 5/22 21/5 56/1
please [12] 5/9 6/3 20/17	prep [1] 136/9	118/2 133/6
21/11 55/9 55/15 56/7 117/14	prerinse [1] 147/15	propofol [55] 37/10 39/16
117/22 118/8 132/19 133/12	presence [5] 20/5 54/21	39/19 40/15 41/3 42/5 53/15
plunger [1] 138/9	116/22 132/6 165/9	67/13 67/19 67/21 68/5 69/18
plus [3] 109/5 128/8 129/16	present [9] 2/1 2/3 2/4 2/6	71/19 71/20 71/20 73/10
point [36] 9/22 10/16 24/22	2/22 34/21 38/2 46/14 50/15	73/12 75/10 75/20 78/22 79/4
29/3 29/10 41/21 44/23 46/17	presented [5] 20/3 54/19	79/5 79/16 79/18 80/5 80/14
47/3 49/19 50/17 58/16 60/23	116/20 132/4 165/7	80/19 81/9 81/16 81/23 83/10
67/8 74/10 76/22 83/7 84/24	pressure [7] 33/22 73/8	83/22 84/5 84/9 84/13 84/24
96/9 97/8 98/14 102/2 102/23	159/17 161/8 162/6 163/12	85/11 85/12 85/15 85/22 86/3
109/22 110/14 110/24 111/22	163/22	86/10 90/3 90/8 93/2 114/2
121/3 122/22 124/2 126/5	pressured [1] 163/8	114/10 114/20 115/17 152/23
128/2 128/11 128/24 139/14	pretenses [5] 5/23 21/6 56/2	153/1 154/20 157/9 157/20
148/15	118/3 133/7	157/20
pointed [1] 97/6	pretty [18] 8/13 25/1 29/4	protect [2] 87/8 150/20
police [6] 9/23 35/6 35/22	37/23 91/8 101/2 101/3	protective [4] 93/8 142/8
73/20 73/21 74/13	101/11 108/20 112/3 126/24	142/9 150/20
policies [1] 154/22	127/8 139/21 141/21 142/3	protects [1] 87/9
policy [1] 49/23	144/3 147/20 158/8	provide [4] 7/5 9/22 74/24
polyp [4] 45/24 46/1 46/8	prevalent [1] 26/22	105/12
138/4	previous [1] 48/8	provided [5] 8/7 12/3 12/25
poor [1] 9/3	previously [1] 50/6	13/25 35/10
port [2] 78/3 78/4	prewash [1] 147/15	provider [2] 7/13 8/6
portion [7] 10/22 16/13 36/14	primarily [12] 25/6 27/3	providers [3] 7/8 7/24 17/22
58/17 62/13 93/15 94/5	58/15 62/6 63/17 65/13 69/10	proximity [1] 64/20
ports [1] 77/21	70/7 70/16 71/1 71/6 136/16	psychiatric [2] 22/16 22/20
position [9] 23/17 25/24	primary [2] 27/25 69/8	public [1] 139/7
25/25 26/5 26/7 30/16 30/19	printout [1] 17/20	pull [6] 12/24 39/23 46/8
41/11 107/17	printouts [1] 13/25	93/25 138/11 141/8
positioned [2] 75/1 93/5	prior [8] 29/22 64/15 69/25	pulled [1] 152/5
positioning [2] 41/9 154/8	76/3 108/19 150/14 151/10	pulling [1] 142/23
positions [2] 107/24 135/4	152/17	pump [1] 93/13
possibility [1] 81/3	probably [4] 122/13 140/2	punishable [10] 20/8 20/11
possible [2] 83/4 125/15	143/15 162/14	54/24 55/2 116/25 117/3
possibly [4] 45/21 81/13	problem [5] 93/22 93/24 94/9	132/9 132/12 165/12 165/15
	95/5 116/2	purposes [2] 105/8 147/9

P push [1] 93/20 pushed [2] 159/22 161/24 put [31] 14/11 43/25 47/18 50/3 52/3 54/9 62/11 73/7 73/7 77/15 77/17 77/18 78/25 79/5 81/8 87/3 87/5 87/6 87/24 93/13 101/13 102/1 106/22 123/10 126/1 138/12 145/22 146/14 146/17 161/13 161/14	152/6 154/3 154/6 154/14 155/4 159/12 159/15 160/1 162/13 162/17 reason [5] 26/17 73/16 103/2 107/11 115/21 reasons [2] 26/16 156/18 recall [6] 34/25 35/5 38/22 46/24 143/21 151/25 receive [5] 7/7 7/21 77/12 77/13 104/20 received [4] 12/7 14/21 19/18 128/18 receiving [1] 18/15 recess [3] 55/13 117/13 132/18 reckless [5] 5/21 21/4 55/25 118/1 133/5 recognize [1] 10/2 recollect [1] 97/24 recommended [3] 152/11 153/14 153/16 record [14] 6/5 13/23 21/13 51/20 51/23 52/7 52/10 56/9 72/14 73/19 106/17 118/10 133/14 165/21 records [21] 9/17 12/16 14/3 18/24 47/11 102/5 102/17 105/5 106/9 106/15 106/22 121/2 121/4 121/5 121/8 121/9 121/12 121/14 121/17 123/11 127/10 recovering [1] 63/20 recovery [6] 38/5 38/7 70/20 72/10 93/5 98/24 refer [2] 13/10 13/17 reference [1] 72/15 referring [2] 73/20 74/20 refill [1] 148/18 reflect [1] 37/3 reflection [1] 73/23 refresh [4] 13/18 14/6 36/5 74/23 refreshes [1] 36/2 refused [2] 49/21 114/19 regard [4] 36/20 60/15 93/4 97/11 regarding [11] 10/22 19/2 36/3 38/23 74/15 86/9 88/13 89/5 94/14 96/14 98/1 regards [1] 114/15 registered [2] 22/4 56/24 regular [5] 51/7 53/10 153/9 153/12 157/4 regularly [1] 108/20 relate [2] 26/13 124/19 related [9] 8/23 9/12 11/15 16/9 29/8 51/11 115/10 141/3 148/3 relates [1] 8/18 relation [1] 111/19 Relatively [1] 97/21 remain [3] 20/17 117/14 132/19 remainder [2] 78/25 80/4 remained [1] 40/9 remaining [1] 80/10 remember [17] 40/20 62/5 75/11 125/14 127/7 127/13 127/15 127/19 128/14 128/22 129/21 151/19 151/21 152/6 155/9 161/15 161/17 remove [2] 79/4 141/5	moved [2] 81/7 164/6 remuneration [1] 104/15 rendered [2] 16/5 13/20 repeat [1] 19/14 report [6] 44/18 44/20 68/4 110/20 115/5 115/6 reported [3] 1/25 44/3 108/16 reporter [2] 23/25 68/16 REPORTER'S [1] 1/21 represent [1] 66/13 represented [1] 103/21 reputation [1] 138/25 request [3] 2/22 7/23 38/23 requesting [1] 38/24 require [1] 96/11 rescue [1] 93/12 research [2] 139/3 139/13 reside [1] 38/16 residue [1] 142/5 resignation [3] 43/11 43/13 44/1 resigned [2] 23/17 26/6 responding [1] 36/13 response [1] 43/20 responsible [4] 18/14 52/3 137/22 141/25 rest [2] 92/4 149/23 result [1] 29/13 resumes [1] 135/11 resuscitation [1] 94/8 retire [1] 57/18 return [1] 64/15 reuse [13] 41/5 79/22 81/23 86/12 86/17 88/10 115/16 115/16 145/10 145/18 147/4 147/8 154/16 reused [8] 86/21 87/16 87/18 145/13 147/1 147/3 153/1 153/4 reusing [3] 114/2 114/20 155/5 review [3] 14/3 35/12 35/25 rewash [1] 88/10 rid [1] 76/8 right [64] rinse [1] 146/8 rinsed [1] 146/14 risk [2] 30/7 79/19 RN [4] 22/17 22/18 22/19 57/7 road [1] 127/9 ROBERSON [1] 2/8 ROBERT [1] 2/9 role [1] 24/18 rolled [2] 80/12 108/9 rolling [4] 70/10 70/15 71/14 77/7 rolls [1] 46/12 Ron [2] 65/25 67/11 RONALD [6] 1/12 5/25 21/8 56/4 118/5 133/9 room [104] rooms [10] 24/16 30/23 42/10 93/4 113/8 113/10 136/11 136/18 136/24 153/3 ROSE [1] 2/9 rotted [2] 96/17 96/18 roughly [8] 39/21 46/25 66/24 80/9 120/20 122/13 127/13 128/6 round [1] 108/1 round-table [1] 108/1
Q QS [1] 14/25 quarterly [1] 105/2 question [10] 9/3 19/14 24/2 36/7 68/17 74/9 100/15 158/13 163/20 163/24 questionable [1] 88/23 questions [19] 9/10 19/24 37/11 54/4 54/15 66/20 68/15 70/2 112/18 115/9 116/16 129/25 130/10 131/25 134/4 152/23 162/20 164/5 165/4 quick [2] 141/21 160/1 quicker [4] 29/2 151/16 163/5 163/9 quickly [1] 141/5 quit [3] 57/19 99/22 129/20 quite [6] 91/19 91/19 130/15 142/4 144/16 155/14 QZ [1] 14/25		
R R-Y-A-N [1] 118/11 racketeering [5] 5/24 21/7 56/3 118/4 133/8 rails [1] 43/1 raise [5] 5/9 20/17 55/14 117/15 132/20 raised [1] 30/9 raising [1] 129/15 Ralph [1] 110/10 rampantly [1] 108/21 ran [1] 113/10 randomly [1] 152/15 range [5] 19/19 23/11 124/16 128/19 128/20 ranged [1] 123/22 rapid [1] 141/19 rapidly [1] 37/23 rare [3] 69/14 100/10 100/17 rate [1] 151/16 re [4] 37/2 79/5 149/13 150/7 re-chart [1] 37/2 re-did [1] 150/7 re-enter [1] 79/5 re-visit [1] 149/13 reacting [1] 90/15 reaction [1] 77/14 read [2] 11/8 11/11 reading [1] 139/3 ready [11] 33/22 39/2 39/8 39/8 75/2 77/8 90/7 98/14 136/8 136/10 159/22 real [2] 115/2 144/2 realize [2] 105/20 144/16 really [21] 88/8 120/9 123/8 126/9 127/15 139/14 140/17 141/11 142/15 144/14 150/25		

R	164/15	12 29/8 29/13 53/18 67/10
run [2] 34/20 113/8	scope-processing [1] 161/16	84/9 106/12 111/3 111/3
Rushing [7] 67/6 67/10 106/8	scopes [26] 39/1 39/10 46/22	111/11 111/12 111/15 112/1
109/24 111/1 119/14 120/6	136/14 137/15 137/18 141/4	120/12 158/3 158/18
Ryan [3] 3/6 118/11 118/15	145/20 146/2 146/16 146/20	she's [1] 48/23
S	147/19 148/19 148/23 149/5	sheet [2] 113/14 123/2
S-A-G-E-N-D-O-R-F [1] 56/12	149/8 150/6 159/21 160/2	sheets [2] 101/20 113/13
sacrifice [1] 163/10	160/4 160/6 161/14 161/21	SHELLY [1] 2/10
safety [2] 37/13 37/16	162/6 163/1 163/25	shift [1] 53/10
Sagendorf [5] 3/5 56/11 56/15	screen [4] 10/3 10/5 15/23	SHLUKER [1] 2/11
56/22 113/25	17/20	shop [1] 60/6
said [70]	scrubs [1] 142/9	Shore [1] 57/7
SALAMANOPOULOS [1] 2/10	seated [5] 5/18 21/1 55/22	short [2] 41/24 66/21
salaried [1] 103/2	117/23 133/2	shortcuts [2] 162/25 163/21
salary [1] 108/2	second [11] 15/25 17/5 17/8	shortly [3] 119/1 135/14
saliva [1] 95/5	17/14 23/8 36/13 58/13 78/9	158/3
same [31] 26/25 27/2 30/8	113/6 136/23 149/13	shots [3] 135/3 158/10
30/15 30/19 32/23 33/7 40/4	seconds [2] 38/21 41/25	158/11
40/12 42/23 52/19 64/25	secret [5] 20/1 54/17 116/18	should [9] 49/25 81/21 129/7
65/10 68/20 72/11 76/5 76/6	132/2 165/5	139/4 144/13 151/1 160/21
81/10 112/13 113/20 119/24	security [6] 11/7 11/12 114/5	162/17 163/15
126/15 134/18 146/12 146/20	114/8 114/19 118/24	shouldn't [2] 101/7 154/4
146/21 152/5 153/21 163/20	sedated [1] 143/11	shove [1] 93/25
164/1 164/2	see [51] 10/17 11/20 12/2	show [5] 40/22 113/14 137/12
sample [1] 138/12	27/1 27/21 28/15 34/9 34/17	151/5 151/8
San [2] 57/16 61/9	36/11 38/3 40/5 40/11 40/14	showed [1] 153/25
sanitation [1] 42/10	40/17 41/5 41/7 41/13 41/17	showing [3] 9/25 35/14 129/17
sanitize [1] 145/17	42/3 42/7 45/15 45/17 45/18	shrugged [1] 159/10
sanitizers [1] 164/19	51/2 51/4 53/5 63/22 63/24	sick [1] 150/20
Santa [1] 61/9	70/23 70/25 84/17 84/24	side [4] 71/11 71/17 73/5
sat [1] 73/8	87/15 93/12 100/7 111/8	73/6
save [1] 31/16	111/11 128/24 143/2 145/13	sight [1] 147/24
saw [25] 27/24 28/14 29/21	151/9 153/1 153/21 154/11	sign [2] 101/16 108/8
30/4 33/9 34/14 37/17 38/6	155/20 156/2 156/17 157/7	significant [3] 19/12 29/4
41/3 52/25 79/19 84/23 85/11	157/19 157/23 165/1	112/14
87/11 88/24 100/22 107/5	seeing [5] 45/15 124/14	Significantly [1] 100/5
125/3 129/2 144/8 154/6	151/25 155/8 155/16	signs [8] 31/7 32/8 32/10
156/20 157/11 157/15 159/6	seemed [4] 37/23 64/5 153/9	34/23 36/3 36/8 36/18 102/6
say [46] 15/5 23/8 26/21	161/4	since [4] 67/15 68/4 144/19
28/25 31/18 45/24 46/7 46/12	seen [6] 26/19 27/17 31/3	156/6
48/4 49/8 49/10 53/7 61/19	129/7 131/12 143/11	single [11] 38/8 68/9 68/12
71/6 71/13 74/2 74/3 74/4	send [3] 47/10 129/8 129/10	68/13 68/25 84/2 87/2 87/17
74/5 75/18 77/18 78/2 80/4	sending [1] 131/16	101/3 125/6 138/15
84/10 89/9 91/14 94/19 100/2	sends [1] 8/6	sir [3] 12/20 55/14 58/2
101/15 106/9 106/19 106/20	sent [3] 43/25 45/1 106/11	sit [2] 53/16 53/19
108/23 111/12 111/15 113/12	separate [1] 124/19	Sitel [1] 134/8
114/16 114/16 116/5 122/8	September [1] 66/10	sitting [6] 46/11 68/16 73/4
128/18 131/1 144/14 144/14	September 21st [1] 66/10	74/20 126/10 157/21
147/7 152/2	septic [1] 80/25	situation [14] 36/22 37/5
saying [11] 31/6 33/20 45/1	served [1] 72/9	48/4 49/13 49/18 52/24 81/20
50/19 124/7 139/18 139/21	service [9] 7/5 8/7 12/25	82/24 87/22 89/3 92/15 93/7
143/24 145/2 155/5 161/8	13/1 14/21 14/22 17/21 134/7	103/24 144/4
says [3] 49/19 68/13 69/3	149/16	situations [4] 73/14 82/18
scalpel [1] 137/13	services [6] 12/25 16/5 18/21	85/14 143/17
scenario [1] 103/25	59/16 59/19 61/4	six [8] 72/13 92/12 120/21
schedule [2] 109/13 159/18	set [4] 47/13 60/6 157/9	125/24 125/24 140/3 149/15
school [9] 25/13 29/24 91/19	157/13	149/18
119/2 120/9 134/18 134/19	setting [2] 59/4 157/24	Sixty [1] 112/23
134/21 134/22	seven [5] 19/19 37/24 60/24	size [2] 40/23 76/17
scissors [1] 88/19	92/12 120/21	sizes [2] 40/20 75/11
scissors-type [1] 88/19	seven-minute [1] 19/19	sleep [1] 62/12
scope [38] 38/23 38/23 38/25	seven-month [1] 60/24	slow [4] 91/19 91/20 141/19
39/1 39/4 46/23 87/3 87/4	sexually [2] 145/15 149/20	151/16
87/6 87/7 87/8 88/20 136/18	Shadow [12] 16/4 16/6 62/2	slower [10] 91/13 91/14 91/15
136/24 137/3 137/20 137/21	62/7 62/9 65/12 69/9 119/25	91/16 91/17 138/22 139/1
141/5 141/8 141/15 141/18	122/9 130/8 135/10 138/17	139/5 139/22 151/17
141/23 141/24 141/25 142/19	shall [5] 5/13 20/21 55/18	slowest [1] 91/21
144/21 144/22 145/17 146/1	117/18 132/23	small [1] 40/24
146/9 147/16 147/17 158/25	shape [1] 37/8	snake [1] 138/7
159/21 161/16 164/6 164/15	Sharma [1] 63/10	snake-like [1] 138/7
	sharps [2] 77/16 147/5	snakes [2] 147/2 147/4
	she [19] 9/4 23/22 24/9	so [232]

S		
social [2] 11/7 11/11	specified [1] 43/11	stop [9] 32/5 98/1 98/4
solemnly [5] 5/11 20/19 55/16	specimen [1] 138/13	stopped [2] 54/8 126/6
117/16 132/21	speculation [1] 113/22	story [2] 109/17 109/20
solution [4] 146/5 146/8	speech [1] 143/25	strange [1] 27/21
150/7 164/2	speed [4] 37/19 94/5 138/20	strength [1] 64/12
solutions [6] 119/12 130/4	142/19	stretch [1] 93/23
147/18 148/10 148/11 148/11	spell [4] 21/12 56/8 118/9	stroke [3] 63/21 64/21 64/23
some [52] 8/7 9/1 9/4 9/22	133/13	stuck [1] 129/18
13/9 28/18 31/1 37/11 37/12	spelling [1] 6/4	stuff [13] 31/1 32/14 43/18
37/12 37/22 39/13 39/14	spend [1] 136/22	50/14 85/19 107/3 109/3
45/23 50/20 59/3 68/8 69/18	spent [1] 71/7	139/11 140/18 154/20 157/16
71/3 73/16 78/16 86/9 86/9	splatter [1] 164/11	158/9 158/16
87/12 87/13 97/8 98/14 99/20	spoke [1] 120/11	submission [2] 9/18 18/24
100/25 101/18 102/2 104/25	spot [3] 24/10 24/13 67/19	submitted [17] 8/2 9/2 10/5
105/10 107/21 109/15 109/22	squads [1] 93/13	10/21 11/13 11/19 11/20 12/1
111/4 119/6 121/4 121/5	squeeze [2] 93/16 138/6	12/9 15/13 15/18 16/10 17/6
122/22 126/5 126/18 128/2	squirt [1] 78/25	17/16 18/1 19/6 105/10
138/22 138/22 143/7 144/23	stacks [6] 122/1 122/19	subsequent [6] 40/5 40/8 40/9
146/4 150/1 151/5 157/20	126/13 128/7 128/12 128/22	80/20 81/16 81/24
somebody [11] 33/10 39/1	stage [1] 54/2	such [4] 9/18 33/4 88/14
44/23 46/21 74/4 81/6 82/25	stamped [1] 52/13	150/5
89/14 106/16 158/14 160/13	standard [1] 8/13	suck [1] 95/18
somebody's [1] 145/20	standing [5] 20/17 50/11	sucked [1] 94/21
someone [2] 42/14 45/3	117/14 132/19 145/7	suction [7] 93/10 94/14 95/1
something [30] 12/15 17/11	standpoint [1] 65/9	95/2 95/8 95/23 147/13
17/15 27/13 28/22 29/18	start [34] 11/1 26/4 26/4	sudden [2] 39/4 39/8
31/22 33/12 33/13 33/15	26/11 31/7 31/16 32/5 42/21	suites [1] 88/14
45/22 46/5 49/14 53/2 59/25	46/9 47/14 47/18 48/5 50/1	sulfa [2] 69/15 69/15
69/17 81/15 83/14 109/12	64/19 64/20 66/14 73/11	Sun [1] 135/6
126/19 135/24 137/13 140/17	73/25 77/9 85/18 89/23 92/24	supervisor [1] 65/23
141/10 148/3 150/25 152/3	98/1 98/4 98/7 98/16 99/5	supervisor's [1] 129/4
158/21 163/3 163/6	99/9 100/21 102/1 107/17	supervisors [3] 107/3 107/8
sometime [1] 126/4	143/2 143/10 144/6	162/25
sometimes [10] 23/25 28/16	started [22] 23/2 23/4 24/13	supplies [1] 157/13
37/24 53/19 84/21 101/23	25/4 25/9 25/25 26/3 26/6	supply [1] 158/19
101/25 101/25 160/9 164/10	28/18 53/16 53/16 57/20	support [1] 135/9
somewhere [1] 127/9	60/17 70/15 73/15 92/17	supposed [20] 32/21 35/2 37/7
son [3] 120/8 152/3 152/4	102/23 120/12 124/3 135/3	46/5 48/5 48/23 49/17 49/22
Sonia [4] 4/5 8/19 11/16	136/6 136/13	51/19 51/20 51/24 63/21
11/17	startle [1] 53/21	76/12 98/5 98/7 147/23 148/4
soon [2] 26/3 26/6	starts [4] 10/12 63/11 75/8	149/7 153/16 160/3
sorry [14] 6/8 6/9 15/10	109/21	supposedly [1] 98/22
19/14 39/23 58/10 68/21	state [16] 1/8 6/3 21/11	sure [26] 10/8 13/19 30/21
68/24 77/25 95/13 109/16	44/3 44/18 56/7 118/8 133/12	36/13 40/23 48/7 50/4 50/6
114/12 143/6 148/23	149/24 150/14 150/18 151/5	50/22 70/25 99/17 127/8
sort [11] 8/7 12/19 31/13	151/9 151/13 151/14 152/10	136/8 136/10 141/12 144/20
42/9 59/3 142/22 142/23	State's [1] 10/1	146/6 146/14 147/5 150/5
145/11 149/25 151/12 160/9	statement [21] 20/4 29/7	150/11 152/16 152/21 164/16
sought [1] 89/14	35/21 44/9 48/12 48/22 53/24	164/20 165/1
sound [1] 161/19	54/20 73/20 73/21 74/12	surgery [1] 57/3
source [1] 121/4	74/16 74/19 74/22 89/12	surgical [2] 150/24 162/14
Southern [7] 8/23 9/13 16/6	111/17 116/21 132/5 148/2	surprise [4] 27/8 52/21 52/23
18/6 22/12 119/19 122/9	148/3 165/8	103/22
Southwest [1] 107/21	statements [2] 29/8 29/9	surrounding [1] 60/12
Spanish [2] 17/5 158/5	status [1] 17/22	suspended [1] 108/7
spare [2] 42/25 43/3	STAUDAHER [1] 2/23	SVEN [1] 2/2
spasm [4] 92/22 92/25 95/5	stay [5] 38/19 60/22 70/5	swabs [1] 137/9
95/20	70/16 129/20	swap [1] 156/13
speak [4] 40/13 105/18	step [4] 32/15 32/19 134/21	swear [6] 5/11 20/19 55/16
145/22 158/11	134/22	117/16 132/21 132/25
special [2] 38/23 38/25	sterile [6] 76/23 79/16 80/16	swings [1] 142/14
specialist [1] 134/8	80/16 97/17 97/18	switch [1] 41/15
Specialists [1] 61/8	sterility [4] 88/22 97/12	sworn [6] 5/5 6/14 21/19
specific [10] 23/7 25/15 39/9	97/14 97/15	56/16 118/16 133/21
46/9 51/12 63/3 66/9 76/11	sterilization [2] 146/10	synopsis [1] 57/4
76/13 76/14	146/15	syringe [29] 40/13 40/14 41/5
specifically [10] 13/2 43/17	sterilize [1] 142/5	41/7 75/18 75/19 76/3 76/5
44/6 44/17 59/1 82/3 89/20	sterilized [1] 86/23	
89/22 120/22 123/14	Steve [1] 163/19	
specifics [2] 27/5 49/3	STEVEN [1] 2/11	
	stick [2] 77/6 129/16	
	still [17] 31/23 41/12 41/20	

S	tells [2] 14/20 160/18	/3 103/6 107/10 114/1
syringe... [21] 77/10 77/15	ten [3] 103/19 117/11 124/5	114/3 114/13 114/19 114/21
77/16 78/9 78/12 78/22 78/23	ten-minute [1] 117/11	114/25 136/3 146/21 150/12
79/1 79/3 79/10 79/14 79/17	Tenaya [4] 119/16 119/24	151/9 153/13 158/15 158/24
80/5 81/7 81/8 81/10 115/16	120/13 120/14	159/5 161/11 163/8
137/10 147/13 153/22 154/15	tended [1] 88/15	think [26] 7/17 14/16 16/19
syringes [21] 41/6 41/8 42/5	tenens [2] 66/16 66/18	19/5 35/14 45/5 68/25 69/24
71/18 73/1 75/22 75/24 76/8	term [1] 86/4	80/1 81/4 90/1 105/16 105/22
76/15 76/17 76/18 77/8 79/23	termed [1] 80/25	107/1 109/15 110/4 110/9
80/6 80/14 80/16 85/11 85/15	terminated [1] 23/16	113/8 125/22 130/14 135/24
147/9 154/6 156/22	testified [6] 6/16 21/21	145/1 145/8 157/15 158/13
system [3] 8/3 8/4 10/4	56/18 105/16 118/18 133/23	160/22
SZURAN [1] 2/12	testify [1] 14/13	thinking [1] 160/20
T	testifying [3] 17/16 18/23	third [8] 7/1 7/3 12/12
table [8] 40/2 42/16 52/25	74/19	12/17 12/17 14/16 18/13 23/8
73/2 74/6 108/1 144/4 157/21	testimony [12] 5/11 5/20	third-party [3] 7/1 7/3 18/13
tackle [1] 156/24	20/19 21/3 35/11 35/21 55/16	Thirty [2] 15/16 127/4
take [42] 24/6 25/24 26/8	55/24 117/16 117/25 132/21	Thirty-one [1] 127/4
39/24 46/23 57/18 59/9 68/22	133/4	Thirty-three [1] 15/16
70/21 73/10 77/10 77/15	tests [1] 107/24	this [165]
77/16 78/24 79/3 86/22 88/21	than [21] 19/9 26/22 31/5	THOMAS [1] 2/14
89/8 89/14 90/21 92/6 92/10	38/15 41/6 44/21 51/4 63/4	THOMPSON [1] 2/13
93/21 107/23 113/22 118/25	73/18 85/2 85/22 92/4 100/5	those [64]
121/5 129/10 137/20 138/3	125/8 125/9 125/16 128/21	though [15] 18/13 26/9 31/10
138/4 138/12 139/4 139/17	130/5 130/18 135/2 155/10	45/12 76/16 103/6 119/23
139/19 139/22 140/12 141/9	Thank [17] 5/17 20/15 20/25	122/23 124/20 143/11 144/18
141/23 143/8 157/1 162/25	21/16 55/6 55/15 55/21 56/13	149/7 150/15 152/10 162/5
taken [6] 1/17 42/14 55/13	117/7 117/9 117/22 118/13	thought [6] 50/23 57/18
91/2 117/13 132/18	132/16 133/1 133/18 165/3	125/19 135/2 144/8 159/8
takes [1] 122/20	165/19	three [26] 14/24 15/16 16/21
taking [9] 40/14 45/16 68/16	that [875]	22/9 22/10 23/13 25/14 25/23
78/8 131/15 141/18 142/19	that's [35] 6/10 8/7 12/8	30/13 34/11 37/17 46/25 51/1
158/8 163/21	15/5 15/22 19/7 25/8 31/5	53/8 55/10 63/9 90/24 104/1
talk [16] 8/18 11/4 12/21	31/23 44/15 46/2 48/15 53/8	107/14 108/25 124/19 140/20
24/5 27/18 43/22 54/7 67/10	59/22 73/17 74/12 94/13	140/21 141/1 142/10 150/17
71/24 83/21 107/19 111/1	98/15 103/11 108/13 109/9	three-day [2] 23/13 25/23
111/2 136/25 154/15 160/13	113/1 113/4 113/11 114/8	threw [1] 83/10
talked [8] 84/1 86/8 88/25	114/11 137/13 148/1 148/6	throat [2] 95/11 95/12
107/22 107/23 109/22 109/24	152/8 154/12 155/17 157/25	through [33] 8/3 8/4 10/7
159/5	161/4 162/5	10/17 10/18 12/15 30/5 46/10
talking [27] 10/21 13/19	their [25] 7/4 7/4 7/5 17/23	47/5 49/7 60/21 66/21 70/12
24/23 27/19 31/2 31/19 36/15	25/15 42/19 47/9 47/9 47/11	70/15 88/20 101/4 112/9
61/19 68/23 69/9 77/19 87/1	47/12 52/10 73/5 73/5 77/14	122/7 123/22 145/12 145/17
91/7 91/15 91/25 94/18 107/2	78/18 85/10 87/23 88/22	145/25 146/6 146/8 146/10
108/14 124/6 124/17 128/3	107/23 123/4 123/4 136/9	146/11 146/16 148/20 150/17
130/23 135/14 139/17 140/22	151/10 152/21 157/16	151/1 152/20 161/25 164/18
145/11 159/20	them [93]	throw [6] 82/10 83/13 83/17
talks [1] 16/8	themselves [2] 106/15 154/1	83/19 84/13 114/20
taped [1] 35/8	then [93]	throwing [2] 83/22 85/22
tapes [1] 52/12	there [190]	thrown [1] 149/22
taught [3] 30/1 160/24 161/6	thereabouts [1] 131/2	thumb [1] 10/7
team [2] 6/25 7/18	these [19] 20/1 29/12 30/9	Thursday [3] 1/18 2/1 5/1
tech [3] 46/21 162/14 162/14	34/13 50/13 54/17 76/17	tightening [1] 151/6
technician [3] 137/21 162/16	76/18 84/11 88/24 90/15	tilde [2] 6/7 6/11
164/14	100/1 116/18 122/4 126/23	time [121]
technique [3] 80/25 81/1	126/24 128/11 132/2 165/5	times [48] 28/15 32/5 32/5
88/22	they [200]	47/24 48/1 49/18 50/4 51/11
techs [3] 88/15 147/21	they're [5] 15/8 47/13 69/4	51/18 51/19 51/20 52/13
147/21	75/19 75/24	52/16 52/22 63/15 63/16
teeth [2] 87/9 138/8	thing [24] 26/25 27/2 30/8	67/25 76/5 82/11 85/10 90/15
tell [34] 6/15 11/3 13/12	34/6 37/2 37/15 51/7 51/11	91/6 98/1 98/1 98/2 98/4
16/17 16/22 21/20 25/5 43/9	68/20 75/5 94/7 94/23 114/10	98/4 98/7 99/8 99/9 99/25
44/2 47/7 56/17 66/5 71/10	114/14 127/18 134/25 138/1	101/16 103/4 105/25 106/3
71/17 74/5 82/15 86/6 89/4	138/8 147/7 153/10 153/10	106/16 112/2 125/1 126/14
90/11 99/12 100/20 101/14	153/12 159/23 160/24	128/2 128/5 129/6 142/11
111/24 118/17 119/9 119/10	things [50] 7/19 9/4 14/2	142/25 143/1 155/10 159/24
122/17 133/22 143/21 148/15	27/6 29/12 30/22 31/10 32/3	161/12
148/17 154/6 162/23 162/25	32/6 32/9 35/3 37/12 37/16	timing [1] 116/2
telling [4] 15/23 50/18 111/3	43/6 51/25 52/7 52/10 52/12	titration [1] 92/25
147/22	52/13 59/13 75/7 87/3 88/6	today [8] 5/19 8/18 17/16
	88/16 88/21 88/21 88/24	21/2 35/11 55/23 117/24
	88/25 95/14 97/11 102/24	133/3

<p>T</p> <p>together [6] 44/15 95/21 111/2 146/17 146/23 164/1</p> <p>told [38] 27/15 33/13 36/8 36/20 36/21 44/6 49/2 54/8 54/11 66/4 67/10 67/13 73/17 79/22 81/23 82/1 82/4 85/25 89/6 99/15 99/19 108/2 109/6 111/24 116/11 116/12 129/14 147/20 147/21 148/10 148/14 149/3 150/3 150/8 152/18 152/19 161/4 163/13</p> <p>tongue [3] 87/20 87/25 88/6</p> <p>Tonya [11] 67/6 67/9 106/7 106/11 106/11 109/24 110/6 110/8 111/1 119/14 120/6</p> <p>too [3] 116/10 148/17 159/8</p> <p>took [3] 57/9 67/11 153/18</p> <p>toolboxes [1] 156/22</p> <p>top [1] 104/2</p> <p>tops [1] 91/11</p> <p>total [1] 110/5</p> <p>totally [1] 113/18</p> <p>touch [2] 58/11 88/17</p> <p>touching [1] 88/16</p> <p>town [2] 60/22 61/22</p> <p>trace [3] 164/20 164/22 164/23</p> <p>trachea [3] 87/21 88/3 95/7</p> <p>track [1] 102/6</p> <p>tracked [1] 102/7</p> <p>trained [3] 26/24 27/3 148/9</p> <p>training [14] 22/7 22/11 25/11 27/15 28/25 29/16 31/15 31/18 31/19 43/1 53/17 57/5 57/9 58/16</p> <p>transcribe [1] 5/6</p> <p>transcript [2] 1/21 165/23</p> <p>transcription [1] 35/20</p> <p>transmitted [2] 145/16 149/20</p> <p>transpired [5] 20/3 54/19 116/20 132/4 165/7</p> <p>trash [1] 79/1</p> <p>treated [2] 82/25 83/2</p> <p>treating [1] 82/19</p> <p>triaging [1] 136/7</p> <p>trouble [5] 33/19 92/17 111/7 112/12 160/10</p> <p>true [1] 165/23</p> <p>truth [36] 5/13 5/14 5/14 6/15 6/15 6/16 20/21 20/22 20/22 21/20 21/20 21/21 29/10 44/10 54/1 55/18 55/19 55/19 56/17 56/17 56/18 74/8 111/20 117/18 117/19 117/19 118/17 118/17 118/18 132/23 132/24 132/24 133/22 133/22 133/23 148/6</p> <p>try [18] 23/25 24/2 27/8 43/1 43/10 44/1 68/20 70/23 71/3 71/25 81/21 82/6 86/3 87/8 89/4 95/18 115/6 161/3</p> <p>trying [6] 11/12 43/23 68/15 89/23 114/21 134/25</p> <p>tub [1] 146/4</p> <p>tube [1] 88/2</p> <p>tubes [2] 87/16 96/18</p> <p>tubing [7] 94/14 95/23 96/11 96/14 96/15 96/15 96/16</p> <p>turn [4] 36/1 73/25 93/25 98/23</p>	<p>turned [1] 90/2</p> <p>turning [1] 29/1</p> <p>twice [1] 53/7</p> <p>two [41] 22/6 26/24 27/3 39/21 39/24 40/2 40/4 40/16 58/19 58/24 61/14 61/15 62/1 63/22 63/22 64/24 66/1 66/2 66/9 66/14 71/18 73/1 77/8 80/14 80/16 90/1 90/24 91/21 92/14 108/4 109/9 113/8 113/10 139/24 140/1 140/7 140/12 142/10 149/8 156/4 156/5</p> <p>two-and-a-half [2] 63/22 64/24</p> <p>type [10] 8/8 8/11 9/22 11/4 22/15 38/25 88/19 98/3 120/10 138/14</p> <p>types [4] 32/3 75/7 121/14 140/24</p> <p>typical [4] 103/15 124/13 139/4 160/17</p> <p>typically [15] 70/5 92/20 98/18 100/2 103/6 103/22 122/8 125/13 141/14 141/18 142/10 149/14 155/7 156/1 157/11</p> <p>U</p> <p>UB [1] 8/16</p> <p>UBs [1] 8/16</p> <p>Uh [12] 52/2 61/18 64/7 65/5 75/23 76/1 80/7 145/6 145/8 145/21 146/22 149/18</p> <p>Uh-huh [12] 52/2 61/18 64/7 65/5 75/23 76/1 80/7 145/6 145/8 145/21 146/22 149/18</p> <p>UHRHAN [1] 2/14</p> <p>uncap [1] 77/16</p> <p>unconscious [1] 41/18</p> <p>under [12] 5/23 8/14 21/6 29/11 47/18 56/2 104/25 118/3 133/7 141/16 143/8 152/14</p> <p>understand [23] 6/1 15/2 20/13 21/9 31/24 49/6 49/8 55/4 56/5 60/5 78/6 114/22 117/5 118/6 121/3 129/9 132/14 133/10 142/17 145/19 158/13 161/10 165/17</p> <p>understanding [4] 36/24 68/11 154/3 154/4</p> <p>Union [1] 12/16</p> <p>unit [1] 22/20</p> <p>United [1] 108/6</p> <p>units [3] 103/11 104/2 124/17</p> <p>unless [6] 140/17 141/9 141/10 145/15 149/18 149/19</p> <p>until [15] 26/1 47/3 48/5 66/19 70/9 77/23 80/19 125/20 125/23 129/20 135/20 135/21 135/21 151/2 162/8</p> <p>unusual [2] 28/15 128/24</p> <p>up [71]</p> <p>update [1] 45/23</p> <p>upon [5] 5/12 20/20 55/17 117/17 132/22</p> <p>upper [10] 82/24 90/1 90/18 91/4 92/13 121/19 139/19 140/3 140/19 141/1</p> <p>upstairs [2] 101/15 113/18</p>	<p>urds [1] 126/22</p> <p>us [24] 11/3 13/11 13/12 14/20 16/17 16/22 20/3 47/5 47/7 54/19 57/4 99/12 111/3 111/24 116/20 119/9 119/10 122/2 132/4 141/9 153/25 163/1 163/1 165/7</p> <p>usable [1] 96/8</p> <p>use [38] 8/16 41/3 41/7 67/21 68/9 68/9 68/13 68/25 69/17 69/19 75/15 76/2 76/5 76/24 77/2 79/13 80/19 81/10 84/2 84/11 84/23 85/5 85/14 86/3 86/17 86/25 87/2 87/17 93/13 96/17 96/20 112/25 147/9 147/12 154/15 154/20 156/25 157/9</p> <p>used [23] 39/11 39/17 39/19 40/6 40/9 41/6 67/13 67/18 67/25 69/8 69/12 76/3 80/5 80/25 81/16 89/1 105/7 137/16 147/18 153/22 153/22 154/7 164/24</p> <p>using [12] 15/6 15/8 41/8 68/5 75/11 75/12 76/16 79/16 104/4 106/2 137/16 150/10</p> <p>usually [18] 71/18 73/5 73/13 74/3 75/7 77/11 84/7 84/8 84/12 99/17 103/9 140/14 140/20 141/13 144/18 150/16 156/2 156/15</p> <p>utilize [1] 96/12</p> <p>utilized [1] 123/14</p> <p>V</p> <p>V-A-N [1] 133/16</p> <p>V-I-N-C-E-N-T [1] 56/11</p> <p>vacuum [2] 94/20 94/25</p> <p>VAN [1] 133/20</p> <p>VanDruff [3] 3/7 133/15 134/3</p> <p>various [4] 51/25 88/25 145/10 156/18</p> <p>vary [1] 126/15</p> <p>Vegas [8] 1/17 5/1 16/5 16/7 57/12 57/19 58/3 60/6</p> <p>vein [2] 71/21 78/8</p> <p>ventilator [3] 96/16 96/16 96/17</p> <p>verbally [1] 25/2</p> <p>Versed [1] 69/18</p> <p>versus [2] 75/15 139/22</p> <p>very [4] 41/24 96/17 117/9 148/12</p> <p>vial [2] 40/1 153/17</p> <p>vials [8] 39/21 39/25 40/4 40/6 40/8 40/8 40/12 40/16</p> <p>view [1] 38/7</p> <p>Vincent [3] 3/5 56/10 56/15</p> <p>Vinnie [1] 110/9</p> <p>visible [2] 164/22 164/23</p> <p>visit [1] 149/13</p> <p>visited [2] 66/15 66/17</p> <p>visitors [1] 150/4</p> <p>vital [8] 31/7 32/8 32/10 34/23 36/3 36/8 36/18 102/6</p> <p>vocal [1] 95/21</p> <p>volume [4] 1/22 37/20 64/16 64/25</p> <p>vomiting [1] 95/6</p> <p>W</p> <p>wait [3] 73/9 77/23 143/25</p>
--	--	---

<p>W</p> <p>waiting [3] 75/2 160/6 162/8</p> <p>waking [1] 52/25</p> <p>walk [6] 38/4 46/10 46/16 47/5 49/7 70/24</p> <p>walked [2] 85/11 135/10</p> <p>walking [2] 71/2 71/4</p> <p>wall [5] 93/9 93/19 96/1 96/3 96/6</p> <p>walls [1] 164/13</p> <p>want [26] 10/7 10/16 18/12 18/18 22/9 27/13 27/16 30/6 30/7 49/7 50/10 79/11 89/22 95/7 95/18 96/22 97/3 97/25 106/19 115/11 118/25 120/10 139/14 142/16 144/5 147/25</p> <p>wanted [4] 63/24 106/21 107/15 154/5</p> <p>was [484]</p> <p>wash [3] 86/23 145/16 146/13</p> <p>washed [4] 87/11 87/16 87/17 145/13</p> <p>wasn't [23] 37/6 39/7 50/22 50/24 66/11 90/8 97/14 97/16 108/12 114/14 114/16 126/9 127/16 127/19 145/2 151/19 154/13 159/12 161/2 161/4 161/6 162/17 163/2</p> <p>wasted [1] 80/4</p> <p>watch [1] 137/11</p> <p>water [3] 137/9 147/10 147/13</p> <p>way [28] 25/15 27/10 31/21 32/16 32/22 32/23 33/7 34/19 44/17 48/12 51/15 81/4 87/12 87/13 88/21 93/5 94/13 105/10 111/4 113/20 119/18 129/19 131/22 141/12 151/9 159/17 161/5 163/14</p> <p>we [126]</p> <p>we'd [1] 142/10</p> <p>we'll [5] 8/25 10/18 25/16 137/3 152/8</p> <p>we're [20] 10/21 11/3 13/19 14/14 14/16 15/6 16/22 17/14 27/5 31/2 68/23 77/7 87/1 90/7 94/4 95/10 117/11 140/21 154/25 160/5</p> <p>we've [2] 43/6 94/13</p> <p>wear [3] 142/9 142/16 150/19</p> <p>wearing [2] 150/11 151/1</p> <p>web [1] 139/11</p> <p>website [1] 17/23</p> <p>week [9] 24/12 24/13 68/4 109/7 109/9 122/6 136/21 151/22 152/7</p> <p>weeks [5] 24/10 66/1 66/2 107/14 108/25</p> <p>weighed [1] 114/22</p> <p>welcome [1] 117/10</p> <p>well [68]</p> <p>well-known [1] 106/21</p> <p>went [26] 23/18 28/4 57/6 57/7 58/16 58/20 60/25 64/4 68/5 99/13 100/2 100/7 100/22 104/8 104/10 107/21 135/13 147/5 150/6 151/16 153/20 158/10 161/21 161/25 161/25 164/25</p> <p>were [264]</p> <p>weren't [9] 27/25 36/23 45/12</p>	<p>83/14 96/1 104/8 105/6 116/9 152/18</p> <p>what [207]</p> <p>what's [8] 16/3 79/9 79/9 110/14 131/15 154/2 154/4 155/2</p> <p>whatever [21] 11/5 31/7 42/4 50/2 57/15 87/11 87/23 88/22 95/14 100/25 103/10 104/11 113/18 123/10 124/13 137/7 139/12 145/14 146/17 147/11 148/9</p> <p>wheeled [3] 31/8 42/22 47/4</p> <p>when [155]</p> <p>whenever [3] 148/12 148/14 158/18</p> <p>where [34] 18/6 18/9 18/20 22/7 22/25 24/16 36/14 36/22 38/25 48/4 51/23 52/24 59/4 61/1 61/7 67/14 70/5 70/6 72/7 73/14 74/2 77/7 80/5 87/22 92/16 103/24 106/16 114/20 119/15 123/22 148/15 148/16 151/3 157/22</p> <p>wherever [1] 157/21</p> <p>whether [5] 48/15 68/8 68/12 83/9 137/8</p> <p>which [18] 10/3 10/4 14/22 14/23 16/1 16/1 16/17 29/11 65/3 68/3 69/4 70/3 79/17 82/18 94/22 95/21 120/4 138/20</p> <p>while [4] 53/5 92/17 134/25 149/6</p> <p>whip [2] 141/23 142/24</p> <p>who [36] 11/15 23/19 30/18 30/19 38/24 43/15 46/4 47/9 57/2 58/6 58/6 63/6 67/4 68/16 69/14 69/16 82/1 89/6 91/7 91/17 91/20 91/24 92/2 96/24 97/1 110/7 119/13 120/2 140/5 140/8 147/22 150/4 151/17 158/1 158/10 158/10</p> <p>whoever [3] 7/13 106/7 137/21</p> <p>whole [22] 5/14 6/15 20/22 21/20 34/19 37/14 42/23 55/18 56/17 94/7 102/11 112/5 117/19 118/17 132/23 133/22 149/17 152/1 157/25 159/12 160/10 162/1</p> <p>why [26] 26/13 26/16 28/24 33/21 38/11 38/14 43/11 44/11 44/20 74/9 79/8 86/6 94/2 95/2 95/18 102/22 107/9 107/11 114/6 114/9 114/9 114/22 115/21 126/8 142/13 152/18</p> <p>wife [2] 57/17 99/23</p> <p>will [2] 53/19 66/21</p> <p>WILLOUGHBY [1] 2/15</p> <p>wiped [1] 42/17</p> <p>wise [1] 125/1</p> <p>within [6] 37/16 63/9 90/25 106/24 108/25 141/16</p> <p>without [8] 34/20 42/15 44/23 50/14 89/9 111/2 129/14 146/13</p> <p>witness [7] 19/23 54/3 57/23 86/12 86/17 112/17 129/24</p> <p>witnessed [2] 84/4 100/1</p> <p>witnesses [2] 3/1 55/11</p>	<p>[1] 92/16</p> <p>wondered [1] 39/7</p> <p>word [1] 83/12</p> <p>wording [1] 68/8</p> <p>words [8] 7/7 17/2 24/6 36/11 68/17 111/4 111/19 130/17</p> <p>work [49] 7/3 23/1 23/18 27/6 28/8 30/6 30/10 30/18 34/12 52/6 59/3 59/8 59/15 60/16 60/18 61/7 61/8 61/10 61/25 62/19 62/22 63/8 63/14 63/19 64/6 64/13 65/12 65/19 66/15 66/16 67/4 68/2 89/21 96/5 98/3 106/24 108/18 109/6 112/22 118/24 120/7 122/6 131/8 135/1 136/18 138/15 138/16 151/25 159/16</p> <p>worked [30] 23/14 44/15 57/16 63/1 63/4 63/15 65/16 65/21 68/3 69/9 91/3 106/10 109/8 120/5 120/19 125/19 125/21 126/12 131/8 135/3 135/5 135/20 135/25 138/16 138/18 138/18 150/22 150/23 153/2 162/16</p> <p>worker [1] 160/17</p> <p>working [28] 18/9 22/20 23/2 23/4 25/4 26/4 29/22 34/1 50/6 57/20 62/6 64/19 64/20 65/15 66/23 67/13 69/22 124/4 125/18 126/6 126/8 138/24 141/15 142/11 151/18 152/7 156/1 158/25</p> <p>would [299]</p> <p>wouldn't [5] 33/24 37/25 93/23 116/8 138/24</p> <p>write [3] 48/7 49/21 51/24</p> <p>writhing [2] 90/22 91/1</p> <p>writing [2] 49/13 126/23</p> <p>written [1] 49/25</p> <p>wrong [6] 99/22 101/16 114/24 115/3 115/3 115/4</p> <tr> <td colspan="3">X</td></tr> <tr> <td colspan="3"> <p>Xylocaine [4] 71/19 71/22 77/11 80/15</p> </td></tr> <tr> <td colspan="3">Y</td></tr> <tr> <td colspan="3"> <p>Y-E-R-E-N-Y [1] 6/7</p> <p>Y-O-S-T [1] 21/15</p> <p>yeah [70]</p> <p>year [13] 20/8 54/24 66/22 66/23 66/24 108/19 116/25 119/7 126/2 132/9 135/16 135/25 165/12</p> <p>years [9] 22/6 22/9 22/10 57/17 58/24 67/15 67/15 68/1 96/17</p> <p>yell [2] 90/10 160/13</p> <p>Yeremy [3] 3/3 6/6 6/13</p> <p>yes [264]</p> <p>yet [10] 31/3 33/22 49/20 90/6 134/20 143/7 143/22 144/17 144/24 145/2</p> <p>YOLANDA [1] 2/7</p> <p>Yost [4] 3/4 21/15 21/18 22/3</p> <p>you [971]</p> <p>you'll [1] 68/17</p> <p>you're [57]</p> <p>you've [10] 9/17 12/2 26/19</p> </td></tr>	X			<p>Xylocaine [4] 71/19 71/22 77/11 80/15</p>			Y			<p>Y-E-R-E-N-Y [1] 6/7</p> <p>Y-O-S-T [1] 21/15</p> <p>yeah [70]</p> <p>year [13] 20/8 54/24 66/22 66/23 66/24 108/19 116/25 119/7 126/2 132/9 135/16 135/25 165/12</p> <p>years [9] 22/6 22/9 22/10 57/17 58/24 67/15 67/15 68/1 96/17</p> <p>yell [2] 90/10 160/13</p> <p>Yeremy [3] 3/3 6/6 6/13</p> <p>yes [264]</p> <p>yet [10] 31/3 33/22 49/20 90/6 134/20 143/7 143/22 144/17 144/24 145/2</p> <p>YOLANDA [1] 2/7</p> <p>Yost [4] 3/4 21/15 21/18 22/3</p> <p>you [971]</p> 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you've... [7] 50/8 71/12 80/3
80/4 80/5 105/16 110/15
young [3] 2/16 101/15 106/10
youngster [1] 109/12
your [106]
yours [1] 67/16
yourself [4] 102/19 141/6
160/20 160/21

Z

ZARATE [1] 2/17
ZUNIGA [1] 2/18

EIGHTH JUDICIAL DISTRICT COURT
CLARK COUNTY, NEVADA

BEFORE THE GRAND JURY IMPANELED BY THE AFORESAID
DISTRICT COURT

THE STATE OF NEVADA,

Plaintiff,

vs.

DIPAK KANTILAL DESAI, RONALD
ERNEST LAKEMAN, KEITH H. MATHAHS,
Defendants.

ORIGINAL

No. 09BGJ049AEC

0265107

Taken at Las Vegas, Nevada

Thursday, April 29, 2010

9:19 a.m.

REPORTER'S TRANSCRIPT OF PROCEEDINGS

VOLUME 5

Reported by: Danette L. Antonacci, C.C.R. No. 222

GRAND JURORS PRESENT ON APRIL 29, 2010

PAM YOUNG, Foreperson

JOSEPH WILLOUGHBY, Deputy Foreperson

SHELLEY SALAMANOUPOULUS, Assistant Secretary

LISA CAMP

CHRISTINE LYONAIS

AGNES PARKER (Leaves at 3:35 p.m.)

YOLANDA PARKER (Arrives at 10:07 a.m.)

BIANCA ROBERSON

BOB ROSE

ALICE SZURAN

MICHAEL THOMPSON

TOM UHRHAN

ANNE ZARATE

FILED

JUN 08 2010

John & Blaine
CLERK OF COURT

Also present at the request of the Grand Jury:
Michael Staudaher,
Deputy District Attorney

INDEX OF WITNESSES

Examined

ELAINE MYERS	8
CORRINE SPAETH	37
PATRICIA GONZALEZ	53
NANCY SAMPSON	81
JOANNE SAMS	155

INDEX OF EXHIBITS

Grand Jury Exhibits

Identified

2 - INSTRUCTIONS	6
31 - CLAIM FORMS REGARDING S. ZIYAD	55
32 - CLAIM FORMS REGARDING KENNETH RUBINO	62
33 - CLAIM FORMS REGARDING PATTY ASPINWALL	66
34 - CLAIM FORMS REGARDING GWENDOLYN MARTIN	20
35 - CLAIM DOCUMENTS RELATING TO R. MEANA	11
36 - CLAIM FORMS REGARDING CAROLE GRUESKIN	48
37 - CLAIM FORMS RELATING TO STACY HUTCHISON	40
38 - DIAGRAMS	86
39 - ASSOCIATION CHART	122
40 - SUMMARY OF ANALYSIS	128
41 - SUMMARY REPORT	131
42 - SPREADSHEET	112
43 - SPREADSHEET	99
44 - VETERANS ADMINISTRATION DOCUMENTS	156

0515

RA 000419

1 LAS VEGAS, NEVADA, APRIL 29, 2010

2 * * * * *

3 DANETTE L. ANTONACCI,

4 having been first duly sworn to faithfully
5 and accurately transcribe the following
6 proceedings to the best of her ability.

7
8 THE FOREPERSON: Let the record reflect
9 that I have canvassed the waiting area and no one has
10 appeared in response to Notice of Intent to Seek
11 Indictment.

12 MR. STAUDAHER: Ladies and gentlemen of the
13 Grand Jury, this is the continuation of Grand Jury case
14 number 09BGJ049A-C, State of Nevada versus Dipak
15 Kantilal Desai, Ronald Ernest Lakeman and Keith H.
16 Mathahs.

17 As I have said before in the previous
18 presentations to you I told you that I would address you
19 each and every time to make sure that there was, we
20 address the issue of potential bias. If after the
21 testimony that occurred last time and between now and
22 then you have developed any or harbor any new biases now
23 based on that testimony which would cloud your judgment
24 or your impartiality in rendering a decision when you're
25

1 asked to do so down the road as to whether or not the
2 State has met its burden in this case on the charges or
3 not, that's the issue that I have to address each time.
4 So with that being said, does any Grand Juror now
5 present, have they developed or has anything come into
6 their mind that would prevent them from being completely
7 unbiased and just listening to the facts and applying
8 them to the charges as presented?

9 A JUROR: No.

10 THE FOREPERSON: No.

11 MR. STAUDAHER: There is a general
12 consensus that there has been no change in that as there
13 has been in the previous presentations as well.

14 That being said, are there any questions
15 that the Grand Jury has at this time regarding the law
16 pertaining to any of the charges that have been
17 presented? And I will revisit the law at the very end
18 to make sure there is no question as to what law you are
19 to follow. You all have copies of the statutes and they
20 are an exhibit, I think Exhibit Number 2 in this
21 particular case. Any issues with any questions thus far
22 regarding the law?

23 THE FOREPERSON: No.

24 MR. STAUDAHER: Are there any questions
25 that the Grand Jury has at this time that they would

1 like answered if I can?

2 THE FOREPERSON: No.

3 MR. STAUDAHER: With that we'll go ahead
4 and continue the testimony.

5 THE FOREPERSON: Please raise your right
6 hand. Thank you.

7 You do solemnly swear the testimony you are
8 about to give upon the investigation now pending before
9 this Grand Jury shall be the truth, the whole truth, and
10 nothing but the truth, so help you God?

11 THE WITNESS: I do.

12 THE FOREPERSON: Thank you. You may be
13 seated.

14 You are advised that you are here today to
15 give testimony in the investigation pertaining to the
16 offenses of performance of act of reckless disregard of
17 persons or property, criminal neglect of patients,
18 insurance fraud, obtaining money under false pretenses,
19 and racketeering, involving Dipak Kantilal Desai, Ronald
20 Ernest Lakeman and Keith H. Mathahs.

21 Do you understand this advisement?

22 THE WITNESS: Yes, I do.

23 THE FOREPERSON: Thank you. Could you
24 please state both your first and last names and spell
25 them for the record.

1 THE WITNESS: Elaine Myers. E-L-A-I-N-E,
2 M-Y-E-R-S.

3 THE FOREPERSON: Thank you.

4 MR. STAUDAHER: And ladies and gentlemen of
5 the Grand Jury, before I get started with this witness I
6 do want to refer you to the criminal complaint; or
7 rather the Indictment I think is what we have up there
8 right now before you, the testimony of this particular
9 witness will pertain specifically to Counts, 14, 23, 44,
10 53, and 18, 27, 48 and 57. The two patients in question
11 will be Rudolfo Meana and Gwendolyn Martin. In addition
12 the racketeering counts will be referred to as well from
13 this testimony which are Counts 28 and 29 and Counts 58
14 and 59 and that's with the information or the Indictment
15 as it's currently constituted.

16 ELAINE MYERS,

17 having been first duly sworn by the Foreperson of the
18 Grand Jury to testify to the truth, the whole truth,
19 and nothing but the truth, testified as follows:

20 EXAMINATION

21 BY MR. STAUDAHER:

22 Q. Now, that being said, ma'am, what do you do
23 for a living?
24
25

1 A. I'm director of operations for Health Care
2 Partners. We are a third party administrator for
3 Pacific Care. We pay their claims.

4 Q. Now Pacific Care is what, an insurance
5 company?

6 A. Pacific Care is a HMO. We pay the HMO
7 claims. It's an insurance company for HMO products.
8 They have both a commercial and senior product.

9 Q. Can you tell us what the commercial product
10 is called?

11 A. It's Pacific Care Commercial.

12 Q. What is the senior called?

13 A. Secure Horizon.

14 Q. If we see something called Secure Horizon
15 that is in fact Pacific Care?

16 A. That is Pacific Care.

17 Q. Now directing your attention to -- well,
18 before I do that let me ask you just a couple more
19 predicate questions regarding what your company does.

20 You say you take in claims and so forth and
21 then pay those claims?

22 A. Yes, sir.

23 Q. How does that work? I mean you're sitting
24 in your office or your company is and how does a claim
25 come in, how does it get processed and then paid?

1 A. The provider submits the claim via mail, we
2 receive hard copy claims, and then we process those
3 claims, we take them in, date stamp them and then put
4 them through a computer adjudication system that pays
5 the claim.

6 Q. And when you pay the claim do you pay it
7 back to that provider that sent it to you originally?

8 A. That's correct.

9 Q. I'm going to direct your attention to
10 specific instances involving two patients. Let's start
11 off with one, I believe it's a Secure Horizon product,
12 it was an individual by the name of Rudolfo Meana.

13 A. Yes.

14 Q. Is that one of the individuals that your
15 company dealt with as far as dealing with the claim and
16 payment for a claim?

17 A. Yes.

18 Q. Specifically I'm going to direct you to a
19 time period of September 21st of 2007, a claim regarding
20 that day. Did you have a chance to review any
21 information in your company pertaining to that claim?

22 A. Yes, I have.

23 Q. Now I'm going to be showing you some
24 documents specifically related to that particular person
25 and that particular claim. They have been marked as

1 Grand Jury Exhibit Number 35. It's a six-page document.
2 So if you are referring to this document during your
3 testimony and you're referring to a specific page I ask
4 that you identify which page of the exhibit you're
5 referring to. Fair enough?

6 A. Yes.

7 Q. I'm going to hand that to you and ask you
8 to flip through it generally at this time and just tell
9 me if you recognize the document itself or series of
10 document I guess.

11 A. Yes, I do.

12 Q. Okay. What are those series of documents?
13 Let's start off with page 1, what is it?

14 A. That's a HCVA 1500, it's the name of the
15 claim form that providers submit claims for professional
16 services.

17 Q. Is that the claim that was submitted for
18 that patient for the date of the 21st of September of
19 2007?

20 A. Yes, it is.

21 Q. Company received that. Did your company
22 process that claim?

23 A. Yes, we did.

24 Q. After the claim was processed did you
25 actually make a payment on that claim as it was

1 submitted to you?

2 A. Yes, we did.

3 Q. And do you have other documents that show
4 what payment was made on that claim?

5 A. Yes.

6 Q. And you're referring now to another page of
7 the document?

8 A. To page 2 of the exhibit, explanation of
9 benefits.

10 Q. And how much money was paid on that
11 particular claim?

12 A. \$131.20.

13 Q. Now the amount that was actually submitted
14 as a bill was greater than that was it not?

15 A. Yes, it was.

16 Q. What was the amount submitted initially?

17 A. \$560.

18 Q. I'm going to take this claim form from you
19 for a moment and the associated document and I'm going
20 to display them for the Grand Jury and I'm going to ask
21 you some specifics about what we're looking at.

22 Now at the top of the form it says 1500
23 insurance claim form. Is this where you get your
24 designation of the HCVA 1500?

25 A. Yes, it is.

1 Q. Under number 2 on that form we have a name,
2 that's Rudolfo Meana, is that what designates this
3 patient as being on that claim form?

4 A. Yes, it is.

5 Q. I'm going to move down the claim form to
6 the section, I believe it is, it looks like it's section
7 24, do you see that here?

8 A. Yes.

9 Q. And then below that where it's talking
10 about date of service and so forth.

11 A. Yes.

12 Q. Date of service on that form?

13 A. 9/21/07.

14 Q. Now there is a designation for, I believe
15 it's under section D, procedure and services. Do you
16 see that?

17 A. Yes.

18 Q. It's got a number there 00810, what does
19 that designate?

20 A. That's an endoscopy procedure.

21 Q. So a specific type, upper, lower endoscopy?

22 A. Yes.

23 Q. If we move to the end of the claim I see
24 under charges, and I believe that's section F of that
25 portion, there is a dollar amount?

1 A. Yes.

2 Q. How much is that?

3 A. \$560, that is the billed amount.

4 Q. The amount that actually came from the
5 center?

6 A. Yes.

7 Q. To your office for a charge or as a charge
8 to be paid?

9 A. Yes.

10 Q. And then next to that, specifically I want
11 to ask you about section G across there where it says
12 days or units, that portion. You see that?

13 A. Yes.

14 Q. There is a designation of a number there.
15 What is that number?

16 A. It's blurry, I'm sorry, I can't --

17 Q. That's fine, I'll show you the document and
18 we'll put it back up. Handing you the direct document.

19 A. Thirty-three.

20 Q. Now I'll display that once again for the
21 Grand Jury. I know it's typed and a little difficult to
22 read, but 33, does that designate some sort of unit or
23 minute or something like that?

24 A. It signifies minutes.

25 Q. Let's talk about minutes for a minute. So

1 on that claim form for that patient it's 33 minutes; is
2 that right?

3 A. That's correct.

4 Q. Do you know how anesthesia is billed and
5 how it comes in and you pay on it?

6 A. Yes. Anesthesia is paid by units and the
7 one unit is equal to 15 minutes. There are base units,
8 every unique procedure code, the 00810 signifies a
9 procedure and there is a base unit assigned to that
10 procedure. That base unit is five, an increment of five
11 units. In addition to that there are the 33 minutes.
12 And for every 15 minutes that's one unit. So 15 minutes
13 is one unit, 30 minutes is two units, 45 minutes is
14 three units. It is always rounded up. So 33 minutes is
15 equal to three units. So that claim was paid based on
16 five base units which includes like set-up and the
17 preliminary plan that the anesthesiologist does and then
18 three base units for a total of eight units. That is
19 multiplied then times whatever the contracted rate per
20 unit is by whichever health insurance company.

21 Q. So let me understand this correctly. That
22 particular bill that we're looking at for Rudolfo Meana
23 which says 33 minutes of anesthesia time, they would
24 have five base units, plus for this particular one an
25 additional three units for a total of eight?

1 A. Yes, that's correct.

2 Q. Now if the submitted amount minutes on this
3 particular form had been let's say 29 minutes, how many
4 units would have been paid on by, or first of all how
5 many units would have been billed and how many would
6 have been paid on?

7 A. Twenty-nine minutes would have been billed
8 and two units would have been paid.

9 Q. So it would have been seven instead of
10 eight?

11 A. It would have been seven instead of eight.

12 Q. If it was 12 minutes how many units would
13 be paid?

14 A. A total of six because it would be five
15 base units and one --

16 Q. One unit for the time?

17 A. -- one time unit.

18 Q. Is it fair to say then if the submitted
19 claim form contained an increased or fraudulent number
20 of minutes, meaning more than what's used on the actual
21 patient, that your company would pay a claim, pay more
22 money than they should have?

23 A. Yes, that's correct.

24 Q. And conversely if you had received this
25 claim form and it had said 22 minutes would you have

<p>R</p> <p>realized [1] 133/5</p> <p>really [24] 51/17 59/20 74/10 74/19 85/21 87/9 89/18 99/4 99/15 102/15 105/6 105/9 105/15 112/8 114/2 114/5 114/7 118/3 121/9 124/7 145/14 145/20 152/7 153/21</p> <p>reason [9] 84/17 87/6 87/7 87/15 93/12 93/13 112/13 120/15 157/1</p> <p>recall [2] 43/16 155/17</p> <p>receive [6] 11/13 12/13 22/6 30/22 30/24 100/5</p> <p>received [8] 14/25 15/12 15/13 17/5 17/6 31/1 59/15 65/9</p> <p>receives [1] 9/4</p> <p>receiving [1] 11/23</p> <p>recent [1] 118/19</p> <p>recently [1] 119/2</p> <p>Recess [1] 96/25</p> <p>reckless [3] 6/1 27/13 125/19</p> <p>recollected [1] 17/11</p> <p>recommendations [1] 99/7</p> <p>recommended [1] 22/24</p> <p>record [15] 6/10 6/25 16/16 17/18 20/24 21/3 27/23 31/15 65/21 78/17 95/9 123/12 126/3 130/2 161/13</p> <p>recorded [10] 65/24 85/22 87/8 87/25 88/6 88/8 94/20 96/19 96/20 138/10</p> <p>recording [2] 66/21 89/11</p> <p>records [6] 13/4 32/11 71/11 101/6 133/11 133/12</p> <p>recover [2] 136/22 137/3</p> <p>recovery [13] 88/15 95/5 95/19 95/20 96/18 137/4 138/7 139/12 139/18 139/23 139/24 140/1 158/22</p> <p>recruit [1] 146/1</p> <p>rectum [1] 149/13</p> <p>red [3] 37/22 112/4 112/14</p> <p>redundant [1] 13/16</p> <p>refer [4] 51/1 56/16 56/20 60/17</p> <p>reference [1] 19/11</p> <p>referencing [1] 102/9</p> <p>referred [1] 43/20</p> <p>referring [5] 17/19 20/12 20/25 56/19 72/14</p> <p>refers [1] 33/1</p> <p>reflushing [1] 69/21</p> <p>refresh [1] 57/2</p> <p>regard [1] 117/13</p> <p>regarding [11] 8/7 16/2 54/18 66/21 76/13 93/22 108/25 154/11 154/14 160/7 160/13</p> <p>regardless [1] 90/11</p> <p>regularly [1] 111/13</p> <p>reinitiated [1] 102/18</p> <p>relate [1] 14/2</p> <p>related [27] 10/3 12/8 12/10 13/11 21/13 29/12 29/19 31/3 33/24 36/4 41/1 42/15 46/18 46/20 58/12 68/8 68/15 70/7 71/19 73/5 73/15 91/18 104/5 106/6 119/25 120/18 129/1</p> <p>relating [1] 46/22</p> <p>relation [1] 109/1</p> <p>relations [1] 43/19</p> <p>relationship [2] 75/15 107/19</p> <p>relative [2] 109/1 109/5</p> <p>relatively [1] 84/25</p> <p>relay [1] 38/6</p> <p>release [1] 139/6</p> <p>releases [1] 139/6</p> <p>relevant [3] 86/9 87/10 87/13</p> <p>reliable [2] 89/16 90/5</p> <p>remain [1] 27/1</p>	<p>remaining [2] 53/17 54/4</p> <p>remains [1] 24/12</p> <p>remember [4] 56/2 154/25 155/10 158/6</p> <p>remotely [2] 72/24 89/22</p> <p>removal [1] 79/9</p> <p>removed [1] 79/18</p> <p>repeatedly [1] 123/10</p> <p>repeating [1] 82/19</p> <p>replacement [1] 123/20</p> <p>report [34] 4/5 24/15 25/8 25/9 25/10 29/9 30/2 30/5 30/8 56/6 56/13 56/15 57/7 59/1 64/15 64/17 76/19 76/20 87/24 94/8 97/10 97/15 98/2 100/8 100/10 100/12 101/5 109/2 110/16 111/21 114/11 114/14 115/17 123/13</p> <p>reportable [2] 7/21 32/25</p> <p>reported [18] 1/25 29/25 30/24 31/3 34/23 37/13 45/3 65/21 66/12 79/13 95/6 95/24 96/2 102/7 102/13 110/21 118/23 120/20</p> <p>reporter [1] 30/15</p> <p>REPORTER'S [2] 1/20 161/1</p> <p>reporting [2] 72/23 100/21</p> <p>reports [6] 30/11 31/1 37/1 84/20 88/17 101/4</p> <p>represents [1] 18/24</p> <p>reprocessed [1] 73/18</p> <p>request [6] 2/21 9/22 39/3 39/5 39/6 39/13</p> <p>requested [2] 46/23 140/20</p> <p>requests [1] 9/25</p> <p>required [4] 13/1 30/1 30/7 83/22</p> <p>requiring [1] 11/17</p> <p>requisition [4] 10/25 11/5 12/25 22/12</p> <p>research [1] 124/2</p> <p>reship [2] 23/19 23/25</p> <p>respect [1] 142/14</p> <p>responsible [5] 9/16 36/23 43/2 99/4 99/9</p> <p>rest [2] 152/6 158/18</p> <p>result [7] 73/8 85/10 100/19 118/25 119/13 121/2 147/19</p> <p>results [22] 9/4 15/11 17/4 24/7 24/8 24/9 24/12 24/14 24/14 24/19 24/22 25/1 25/6 25/8 25/14 32/10 33/21 98/8 102/7 116/4 118/23 123/2</p> <p>resume [1] 160/14</p> <p>retain [1] 23/9</p> <p>retested [3] 122/25 123/5 123/11</p> <p>retired [3] 126/15 126/16 144/21</p> <p>return [1] 120/22</p> <p>returned [2] 57/11 97/4</p> <p>reuse [18] 54/13 57/25 60/10 60/11 64/1 64/24 70/6 71/8 71/8 79/9 83/3 143/5 143/10 144/1 144/9 147/8 150/10 151/4</p> <p>reused [7] 54/10 58/6 64/3 64/16 71/9 106/20 106/23</p> <p>reusing [1] 71/12</p> <p>review [25] 13/7 46/1 47/10 47/17 47/21 48/18 48/21 48/23 49/9 49/11 49/12 49/15 49/16 50/3 51/10 51/12 51/22 59/7 67/6 67/12 68/7 68/11 89/20 108/17 155/14</p> <p>reviewed [1] 55/13</p> <p>reviewing [4] 48/25 74/15 89/23 109/24</p> <p>reviews [1] 46/15</p> <p>rid [1] 151/10</p> <p>right [40] 5/13 16/23 17/20 18/7 20/10 21/25 26/25 27/2 33/12 37/16 40/9 40/16 41/17 43/12 47/11 49/22</p>	<p>50/1 56/8 68/1 68/5 69/8 72/21 75/9 75/17 76/3 77/23 78/19 79/2 79/4 79/7 85/16 89/14 93/9 93/14 97/9 104/10 118/10 125/7 130/15 147/11</p> <p>risk [14] 31/24 32/9 32/12 34/10 34/19 34/21 35/18 35/21 73/14 109/1 109/5 110/22 114/14 115/17</p> <p>risks [1] 81/9</p> <p>risky [1] 34/17</p> <p>RN [4] 97/20 97/21 139/24 140/2</p> <p>RNs [1] 97/20</p> <p>road [2] 50/15 112/8</p> <p>ROBERSON [1] 2/13</p> <p>role [4] 28/21 118/8 146/4 146/22</p> <p>roles [1] 44/6</p> <p>roll [2] 156/6 156/8</p> <p>roller [1] 156/9</p> <p>rollers [1] 156/4</p> <p>RONALD [5] 1/10 6/4 27/17 97/19 125/22</p> <p>room [106] 42/16 49/22 50/7 50/8 50/8 50/10 50/12 50/22 51/3 51/3 51/11 51/12 52/6 52/9 52/11 52/19 52/22 54/19 58/15 59/25 64/18 70/21 70/25 71/4 79/12 84/9 84/18 85/8 85/11 85/21 87/12 88/10 88/12 88/15 89/8 90/13 90/14 91/1 91/3 91/7 91/10 92/1 92/3 92/6 92/7 92/9 92/13 92/13 92/22 92/22 92/23 92/25 93/1 93/11 93/12 93/14 93/17 93/19 95/5 95/19 96/16 96/18 97/6 110/2 112/19 112/19 112/22 112/24 112/25 113/2 113/2 131/14 131/16 131/18 131/20 134/1 134/2 134/9 134/13 134/15 135/19 135/21 138/3 138/6 139/18 139/20 139/24 140/1 145/14 148/5 148/7 148/11 148/12 148/21 148/24 151/9 154/1 154/3 154/8 154/9 154/15 155/20 155/24 157/13 157/18 158/4</p> <p>rooms [20] 49/23 49/24 49/25 50/6 52/17 55/12 70/23 84/13 84/23 85/1 85/4 85/6 90/12 92/9 93/4 134/1 134/5 134/20 153/16 154/23</p> <p>ROSE [1] 2/14</p> <p>roughly [4] 95/22 96/10 116/21 117/22</p> <p>rubber [2] 154/4 154/5</p> <p>Rudolfo [1] 16/15</p> <p>rule [5] 61/8 62/20 63/16 65/4 71/13</p> <p>ruled [5] 64/4 66/4 68/18 72/18 73/23</p> <p>ruling [1] 62/4</p> <p>run [4] 93/13 142/25 143/9 146/15</p> <p>running [2] 94/11 141/9</p> <p>Rushing [2] 43/20 44/22</p> <p>S</p> <p>safe [1] 140/15</p> <p>safety [2] 69/13 74/24</p> <p>said [38] 30/20 31/2 43/9 44/9 44/10 44/13 50/17 59/19 63/11 65/9 68/3 74/20 84/21 84/21 89/4 89/6 92/2 96/7 96/12 108/5 111/12 114/20 115/21 119/21 120/1 130/22 143/10 144/11 145/13 147/7 148/4 148/24 150/16 152/10 153/2 154/12 160/12 161/10</p> <p>SALAMANOUPOULUS [1] 2/6</p> <p>saline [1] 70/1</p> <p>same [40] 11/25 20/10 28/23 31/1 31/3 31/14 35/11 36/4 36/9 36/15 37/18 38/1 38/2 41/15 41/20 41/21 46/12 50/22 63/20 64/8 65/22 65/25 68/22 68/23 82/14 82/19 85/11 93/6</p>
---	--	--

<p>S</p> <p>same... [12] 103/16 109/9 110/22 115/1 115/11 115/13 115/23 118/2 118/2 131/15 142/20 149/9</p> <p>sample [39] 9/5 9/9 9/9 10/18 10/21 11/20 11/25 12/21 12/25 14/2 14/25 15/2 15/7 15/15 15/16 16/17 16/24 17/2 17/9 17/10 17/11 17/16 20/21 21/9 21/12 21/13 22/2 22/8 22/11 23/1 23/8 23/13 23/14 23/18 23/20 23/21 23/25 24/2 104/23</p> <p>samples [34] 7/25 8/6 8/6 8/17 9/12 9/19 9/21 10/1 10/7 10/10 10/22 10/23 11/1 12/6 12/21 12/24 13/1 13/12 14/8 14/9 18/25 19/12 19/13 20/1 20/13 21/24 22/5 22/6 22/12 22/18 22/24 23/11 23/17 24/5</p> <p>San [1] 145/2</p> <p>sanitizer [3] 143/24 146/16 148/15</p> <p>sanitizers [1] 148/14</p> <p>sanitizing [1] 158/17</p> <p>sat [4] 44/22 53/25 54/20 106/19</p> <p>Saturday [3] 135/11 135/11 136/11</p> <p>saw [7] 33/23 53/15 54/13 102/17 122/22 138/24 157/5</p> <p>say [32] 17/19 31/20 40/19 47/9 62/8 66/20 82/14 84/18 94/24 99/13 105/9 106/19 108/18 112/25 114/7 114/9 114/10 115/10 115/13 115/14 115/19 115/23 115/24 118/1 118/24 124/7 128/5 128/17 136/18 141/23 141/25 154/19</p> <p>saying [4] 38/20 55/18 119/17 155/18</p> <p>says [3] 20/17 20/20 96/15</p> <p>Schaefer [4] 42/2 49/21 50/17 51/4</p> <p>schedule [2] 67/7 68/10</p> <p>scheduled [1] 135/7</p> <p>school [5] 29/5 29/13 131/11 145/2 146/10</p> <p>scope [22] 65/22 65/25 65/25 66/18 68/23 69/2 69/3 94/10 129/13 141/11 145/18 149/6 149/8 149/11 149/14 149/15 149/18 149/23 149/24 150/5 154/17 156/22</p> <p>scopes [18] 65/18 65/19 69/1 73/17 73/18 73/19 143/25 148/5 148/11 148/13 148/18 149/5 151/18 151/21 151/23 157/12 158/13 158/15</p> <p>screen [3] 19/5 20/16 20/17</p> <p>screening [1] 121/8</p> <p>scrubs [1] 154/2</p> <p>seated [3] 5/22 27/10 125/15</p> <p>second [22] 15/24 20/22 31/6 38/18 46/11 46/12 47/13 50/8 58/17 58/20 62/13 76/10 82/17 85/17 87/20 90/14 91/10 92/22 93/1 93/11 93/18 122/15</p> <p>secret [3] 26/6 124/11 159/11</p> <p>Secretary [2] 2/5 2/6</p> <p>sedate [1] 58/16</p> <p>sedated [1] 53/23</p> <p>sedation [1] 71/6</p> <p>see [39] 9/7 9/8 19/10 43/10 55/19 61/15 62/16 63/19 64/2 71/5 72/3 85/6 87/20 90/15 91/21 91/22 92/15 92/17 92/21 93/5 93/6 93/21 94/5 95/23 107/7 111/14 117/1 120/11 121/18 121/21 129/8 129/19 135/17 135/19 140/16 151/8 151/9 156/12 160/11</p> <p>seeing [9] 45/23 52/7 53/10 57/17 82/4 90/8 94/4 94/7 135/1</p> <p>seek [1] 112/2</p> <p>seem [3] 76/5 86/17 129/2</p>	<p>seemed [3] 76/7 89/24 106/18</p> <p>seems [1] 84/1</p> <p>seen [3] 63/9 97/11 103/9</p> <p>select [1] 136/12</p> <p>selected [1] 94/1</p> <p>sell [1] 124/6</p> <p>seminars [2] 29/8 29/12</p> <p>send [11] 13/1 14/9 21/25 23/8 23/14 25/9 38/14 39/7 103/21 131/4 132/12</p> <p>sending [3] 11/23 12/22 104/3</p> <p>senior [3] 28/11 28/15 28/20</p> <p>sense [4] 94/6 98/25 108/4 108/7</p> <p>sent [10] 7/25 12/19 12/24 13/24 19/15 20/13 22/22 23/5 24/15 113/15</p> <p>separate [6] 20/13 41/15 51/15 69/8 75/6 116/2</p> <p>separated [2] 36/12 69/7</p> <p>separately [3] 124/1 124/4 124/6</p> <p>September [25] 18/4 36/10 37/21 57/5 57/12 63/6 63/11 63/12 67/5 74/17 75/21 84/10 84/17 84/19 84/21 85/20 101/19 101/24 102/4 102/6 103/18 104/17 108/12 115/2 127/5</p> <p>September 21st [18] 37/21 57/5 57/12 63/12 75/21 84/10 84/17 84/19 84/21 85/20 101/19 101/24 102/4 102/6 103/18 104/17 108/12 115/2</p> <p>September 22nd [2] 63/6 63/11</p> <p>September of [1] 127/5</p> <p>sequentially [1] 12/18</p> <p>serious [2] 112/8 151/20</p> <p>serum [5] 22/21 23/2 23/5 23/11 23/13</p> <p>served [1] 144/22</p> <p>service [1] 145/11</p> <p>Services [1] 42/7</p> <p>set [16] 8/13 38/13 39/15 43/21 45/18 51/11 53/8 69/20 70/20 70/25 84/18 88/19 117/5 131/24 131/25 139/20</p> <p>set-up [2] 69/20 131/25</p> <p>sets [1] 151/24</p> <p>settings [1] 124/5</p> <p>seven [4] 28/16 95/10 96/3 110/19</p> <p>several [8] 37/4 52/21 53/5 54/1 54/1 55/6 66/11 82/6</p> <p>sexual [1] 34/25</p> <p>shaded [2] 90/23 91/12</p> <p>Shadow [8] 40/9 40/18 132/7 134/10 134/25 137/25 142/15 145/25</p> <p>shall [3] 5/18 27/6 125/11</p> <p>share [2] 40/17 45/1</p> <p>shared [1] 41/21</p> <p>sharp [1] 143/19</p> <p>Sharps [1] 79/4</p> <p>Sharrieff [1] 19/7</p> <p>she [10] 43/21 50/21 52/24 53/21 54/19 72/16 109/22 110/5 110/6 139/25</p> <p>she's [3] 51/3 72/18 80/18</p> <p>sheet [4] 12/19 17/20 18/10 153/7</p> <p>sheets [1] 89/12</p> <p>SHELLEY [1] 2/6</p> <p>ship [2] 9/10 13/2</p> <p>shipment [4] 19/14 19/15 20/1 20/4</p> <p>shipped [7] 9/10 11/1 15/8 17/3 18/25 19/12 20/5</p> <p>shipping [11] 4/7 4/8 4/9 4/10 4/11 4/12 18/25 19/8 19/19 23/24 24/3</p> <p>SHLUKER [1] 2/15</p> <p>shooter [1] 144/24</p> <p>short [2] 31/9 91/20</p> <p>shorter [1] 128/22</p> <p>shorthand [2] 161/7 161/10</p>	<p>shot [1] 130/7</p> <p>shots [1] 156/14</p> <p>should [8] 37/10 37/10 68/8 68/10 79/11 130/8 131/9 138/17</p> <p>show [14] 13/17 16/13 43/7 46/10 70/18 71/12 73/6 74/20 76/17 87/7 107/22 107/24 114/17 135/4</p> <p>showed [4] 74/21 75/14 107/25 108/10</p> <p>showing [5] 13/15 56/9 79/21 111/6 112/11</p> <p>shown [1] 105/1</p> <p>shows [1] 46/10</p> <p>shut [4] 119/13 119/18 120/20 121/16</p> <p>sic [1] 157/1</p> <p>sick [1] 102/15</p> <p>side [5] 79/2 135/9 135/9 135/16 148/11</p> <p>sign [1] 88/11</p> <p>signature [1] 19/17</p> <p>signed [3] 88/20 89/4 95/1</p> <p>significant [5] 62/18 63/16 66/24 86/19 93/23</p> <p>signs [2] 95/18 96/19</p> <p>similar [3] 33/20 58/8 115/10</p> <p>since [7] 15/22 43/1 50/6 75/24 99/13 144/21 160/9</p> <p>single [10] 11/20 54/9 57/17 63/1 65/2 81/6 86/4 98/15 98/23 118/11</p> <p>sir [2] 27/2 125/6</p> <p>sit [2] 106/16 139/5</p> <p>site [3] 15/11 44/12 118/17</p> <p>sitting [6] 21/24 77/11 82/9 82/9 133/12 154/16</p> <p>situation [7] 30/21 35/3 80/14 106/3 127/19 130/1 131/11</p> <p>situations [1] 23/16</p> <p>six [7] 101/18 104/15 117/4 120/8 121/17 143/16 149/13</p> <p>six inches [1] 149/13</p> <p>six percent [1] 117/4</p> <p>size [5] 53/11 53/14 91/18 150/20 154/18</p> <p>sizes [1] 53/12</p> <p>skin [2] 69/17 77/20</p> <p>slash [1] 61/7</p> <p>slide [1] 155/7</p> <p>slipping [1] 155/6</p> <p>slow [3] 129/2 135/18 135/24</p> <p>slower [4] 128/2 132/18 141/5 142/19</p> <p>slowing [1] 129/1</p> <p>small [4] 15/21 73/20 91/19 130/13</p> <p>smaller [1] 132/1</p> <p>smoke [2] 109/7 109/8</p> <p>snapping [1] 94/14</p> <p>SNPHL [1] 23/13</p> <p>so [343]</p> <p>soap [1] 158/14</p> <p>social [1] 34/17</p> <p>soiling [2] 153/7 153/7</p> <p>solemnly [3] 5/15 27/3 125/8</p> <p>solution [1] 78/18</p> <p>solutions [2] 158/11 158/12</p> <p>some [62] 10/16 11/15 13/10 13/11 18/8 24/1 31/18 34/14 36/5 40/11 41/22 44/15 45/4 46/15 46/21 48/25 49/8 49/10 49/11 52/3 52/23 52/25 53/1 53/17 59/14 59/18 61/2 63/8 73/20 79/14 80/7 84/17 84/20 93/12 97/10 98/4 99/9 100/20 101/13 102/23 103/6 106/19 107/16 108/19 113/15 117/10 117/20 117/21 118/18</p>
---	--	--

<p>S</p> <p>some... [13] 118/23 119/3 127/12 127/23 138/20 138/23 142/4 143/14 148/4 150/9 151/13 153/13 155/4</p> <p>somebody [23] 34/16 49/18 49/18 54/10 72/6 74/11 75/22 92/5 92/12 102/9 105/23 113/3 115/3 115/15 115/23 119/1 132/12 139/22 140/17 144/4 144/4 152/17 158/9</p> <p>someone [4] 64/7 74/4 81/1 142/8</p> <p>something [28] 10/12 24/2 26/3 30/4 34/13 35/15 44/9 56/25 57/1 58/23 62/15 65/1 65/1 71/18 74/12 75/1 75/3 83/24 92/12 105/9 106/16 107/6 132/12 137/16 142/11 142/24 150/4 153/8</p> <p>sometimes [11] 89/15 89/15 128/9 132/2 135/3 140/2 142/1 149/12 149/20 151/7 153/18</p> <p>somewhere [4] 120/9 131/4 145/6 148/6</p> <p>soon [2] 117/17 145/20</p> <p>sorry [6] 7/12 20/8 63/12 81/21 115/8 130/13</p> <p>sort [21] 13/11 33/23 34/14 36/20 36/25 39/7 39/13 52/9 66/17 71/11 75/8 80/19 81/16 97/12 98/10 100/20 106/5 107/5 109/9 115/7 153/13</p> <p>sorts [2] 74/23 113/3</p> <p>sounds [1] 38/4</p> <p>source [58] 10/16 16/1 18/2 45/6 61/7 62/3 64/3 64/13 64/25 65/3 65/5 65/10 65/20 66/1 66/3 66/5 66/14 66/16 67/4 67/9 67/12 70/20 71/14 72/2 72/4 72/20 74/21 74/22 74/25 75/3 75/7 76/1 85/7 90/21 91/1 91/6 93/17 98/17 98/22 101/23 101/25 104/14 104/18 107/23 107/23 108/6 109/10 110/24 111/2 114/23 115/5 115/11 115/13 115/14 115/23 118/15 120/16 146/25</p> <p>sources [2] 60/12 76/2</p> <p>Southern [32] 7/2 7/8 7/13 7/14 7/17 7/20 7/21 8/8 8/13 9/13 9/15 9/22 11/9 15/4 16/25 17/5 17/11 17/16 24/9 28/12 28/18 29/1 29/20 34/12 37/17 40/8 44/18 71/21 97/5 121/7 126/20 130/21</p> <p>Southwest [14] 127/20 128/9 130/4 130/20 131/19 131/24 137/11 137/21 137/22 141/2 144/5 145/16 145/24 145/25</p> <p>span [1] 31/9</p> <p>speak [2] 25/20 54/17</p> <p>spear [1] 143/19</p> <p>special [2] 12/23 15/3</p> <p>specific [4] 12/16 23/1 71/19 127/23</p> <p>specifically [6] 35/9 35/11 70/15 84/10 127/15 148/23</p> <p>specimen [1] 17/1</p> <p>specimens [1] 61/17</p> <p>speed [5] 127/23 129/22 130/2 141/4 149/21</p> <p>spelling [3] 6/9 27/22 126/2</p> <p>spent [1] 100/21</p> <p>spiel [1] 154/21</p> <p>split [2] 23/12 90/15</p> <p>splits [1] 90/12</p> <p>spoke [2] 43/17 92/2</p> <p>spread [3] 18/10 61/13 73/22</p> <p>spreading [1] 72/11</p> <p>Springs [1] 132/11</p> <p>staff [24] 32/5 40/17 41/22 52/9 55/4</p>	<p>55/5 57/15 60/3 61/10 61/21 62/5 62/14 64/15 64/17 69/19 71/10 72/10 72/10 79/12 86/20 92/2 135/16 142/16 142/18</p> <p>staff's [1] 133/4</p> <p>stage [4] 36/18 79/17 87/2 140/5</p> <p>stages [1] 13/22</p> <p>stained [1] 151/5</p> <p>stamp [1] 88/22</p> <p>stamped [1] 89/5</p> <p>stamps [1] 88/16</p> <p>stand [2] 21/17 26/25</p> <p>standard [3] 34/23 131/7 137/14</p> <p>standing [2] 27/1 52/6</p> <p>start [27] 13/15 14/16 18/20 19/4 40/2 46/1 47/16 47/18 48/25 52/5 70/22 76/25 88/7 88/8 88/13 88/24 88/24 90/25 94/9 94/18 120/11 140/17 141/9 142/23 143/4 152/3 158/4</p> <p>started [26] 6/24 8/21 8/24 13/21 18/9 33/24 38/10 39/16 67/9 67/10 89/2 90/20 94/21 95/5 95/15 96/9 97/2 103/17 108/18 122/24 131/24 134/13 135/13 137/22 141/6 160/9</p> <p>starting [6] 12/18 36/2 45/25 49/13 94/3 133/17</p> <p>state [13] 1/2 1/7 6/8 27/21 38/15 39/4 39/6 39/9 39/11 43/1 119/2 126/1 161/3</p> <p>statement [7] 26/10 73/4 124/15 155/10 155/14 159/5 159/14</p> <p>States [1] 107/13</p> <p>station [2] 132/1 152/1</p> <p>statistically [2] 62/18 63/16</p> <p>STAUDAHER [2] 2/22 6/21</p> <p>stay [2] 15/22 157/3</p> <p>stayed [1] 92/8</p> <p>Stenotype [1] 161/8</p> <p>step [2] 16/7 35/25</p> <p>stepped [1] 113/21</p> <p>steps [2] 99/1 111/8</p> <p>sterility [1] 146/15</p> <p>sterilized [1] 73/19</p> <p>sterilizer [3] 146/16 148/14 148/15</p> <p>STEVE [2] 2/15 27/25</p> <p>sticking [1] 138/18</p> <p>still [15] 15/16 17/16 33/9 39/11 83/5 90/1 96/1 96/12 96/19 96/20 122/13 122/25 131/21 140/13 145/15</p> <p>stomach [2] 130/12 148/19</p> <p>stool [1] 33/5</p> <p>stop [2] 20/24 52/17</p> <p>stopped [1] 95/17</p> <p>storage [1] 17/16</p> <p>stored [1] 15/16</p> <p>straight [3] 78/1 130/7 130/8</p> <p>straighten [1] 149/18</p> <p>street [3] 40/10 43/12 139/4</p> <p>strictly [1] 83/19</p> <p>strong [2] 110/15 114/16</p> <p>stuck [1] 73/14</p> <p>studies [1] 105/21</p> <p>study [10] 15/6 17/3 19/10 19/11 20/23 21/6 21/16 104/13 105/19 106/5</p> <p>stuff [15] 24/21 58/10 88/19 104/3 104/9 108/16 130/15 131/12 135/4 142/13 144/9 148/1 153/21 156/5 158/15</p> <p>style [1] 22/8</p> <p>submitting [1] 24/8</p> <p>subsequent [5] 10/6 51/19 57/14 122/21 122/23</p>	<p>subsequently [1] 50/23</p> <p>succumb [1] 81/3</p> <p>succumbed [1] 105/1</p> <p>such [1] 11/12</p> <p>sudden [2] 119/23 150/17</p> <p>sufficient [8] 23/11 83/15 84/3 89/24 104/3 111/7 117/15 118/5</p> <p>sufficiently [1] 157/18</p> <p>sufficit [2] 62/8 66/20</p> <p>suffocating [1] 141/18</p> <p>suites [1] 41/21</p> <p>supervision [1] 161/12</p> <p>supplies [2] 143/3 152/20</p> <p>supply [1] 144/7</p> <p>suppose [1] 33/22</p> <p>supposed [8] 111/21 139/5 139/23 146/5 146/5 146/14 151/1 153/25</p> <p>supposedly [4] 32/8 96/16 96/18 130/5</p> <p>sure [16] 11/24 25/23 38/24 51/17 55/1 78/25 97/17 104/21 105/21 118/12 143/21 143/23 147/10 149/16 155/19 155/24</p> <p>surgeries [1] 35/10</p> <p>surgery [1] 145/11</p> <p>surgical [5] 40/14 40/19 76/23 151/23 155/1</p> <p>surrogate [1] 99/24</p> <p>survive [3] 105/24 106/1 106/2</p> <p>surviving [1] 106/7</p> <p>suspect [1] 95/13</p> <p>Suzanne [2] 2/24 97/3</p> <p>SVEN [1] 2/7</p> <p>swear [3] 5/15 27/3 125/8</p> <p>sworn [4] 5/5 6/16 28/4 126/8</p> <p>symptoms [10] 33/2 33/3 33/6 33/8 33/13 33/21 103/25 105/2 112/2 120/11</p> <p>syringe [30] 53/22 57/25 58/9 58/16 58/18 58/20 60/10 69/25 70/6 77/18 77/18 77/19 78/12 78/13 78/22 79/1 79/3 79/6 79/10 79/15 79/20 79/22 79/24 79/25 80/1 80/6 82/15 83/3 83/4 83/6</p> <p>syringes [17] 54/3 58/6 58/11 69/14 69/21 71/8 71/10 80/24 82/7 82/8 82/11 106/23 107/1 107/3 123/19 124/4 124/4</p> <p>system [16] 11/7 11/10 20/19 22/15 24/11 24/15 25/7 78/8 84/18 94/9 94/13 95/1 104/25 117/25 118/25 122/25</p> <p>SZURAN [1] 2/16</p> <p>T</p> <p>table [4] 53/25 60/18 60/20 60/21</p> <p>tables [1] 60/18</p> <p>take [30] 9/20 76/8 79/6 87/20 92/5 98/25 101/2 105/22 111/8 112/20 128/5 129/7 129/22 135/25 138/8 139/17 141/21 141/22 142/7 142/8 142/9 143/15 147/22 151/25 152/2 152/5 153/9 156/5 158/20 159/3</p> <p>taken [3] 1/16 23/2 89/3</p> <p>takes [2] 131/15 137/19</p> <p>taking [4] 95/2 131/13 138/12 141/25</p> <p>talk [8] 19/2 43/15 44/11 102/16 117/18 141/16 148/2 150/9</p> <p>talked [10] 44/24 71/7 101/13 106/13 110/19 128/25 129/3 138/15 140/14 155/18</p> <p>talking [24] 12/2 34/6 37/12 39/16 40/20 45/10 51/2 52/10 57/14 64/25 83/19 84/6 93/24 102/21 110/11</p>
--	--	---

<p>T</p> <p>talking... [9] 116/1 128/17 129/5 130/17 133/13 137/2 148/9 148/25 153/14</p> <p>talks [2] 17/8 37/3</p> <p>tape [1] 88/12</p> <p>taped [1] 155/13</p> <p>tapes [1] 88/15</p> <p>tattoos [1] 35/2</p> <p>tax [1] 100/21</p> <p>taxi [1] 142/10</p> <p>teach [1] 29/13</p> <p>team [5] 8/12 12/14 37/6 42/12 42/13</p> <p>tech [21] 127/10 127/11 127/20 129/23 131/20 131/22 136/16 140/2 140/3 145/3 145/3 145/4 145/5 145/23 146/10 146/13 148/10 148/25 152/6 152/12 156/19</p> <p>technical [2] 36/6 38/13</p> <p>technician [1] 62/20</p> <p>technicians [1] 62/25</p> <p>techs [9] 140/4 140/7 145/17 146/9 146/12 146/14 147/1 152/6 154/1</p> <p>teens [2] 133/22 134/7</p> <p>telephone [1] 43/7</p> <p>tell [33] 12/8 12/12 13/20 14/17 16/5 16/22 18/22 20/15 32/22 43/25 50/7 56/12 57/3 60/4 61/7 77/1 85/17 86/20 89/8 90/8 97/13 97/15 107/14 109/2 116/24 123/23 141/16 141/21 143/5 144/8 145/19 151/19 154/11</p> <p>telling [1] 152/17</p> <p>tells [1] 17/15</p> <p>ten [18] 33/14 70/4 82/10 94/20 94/23 95/22 96/1 96/23 109/7 115/10 122/8 122/10 122/19 131/12 131/21 137/6 138/1 138/4</p> <p>ten-minute [1] 96/23</p> <p>tend [1] 117/1</p> <p>terms [2] 106/3 124/6</p> <p>terrorism [1] 7/20</p> <p>Terry [3] 2/23 7/1 97/4</p> <p>test [12] 9/4 10/25 12/25 17/12 22/12 24/10 62/17 113/13 114/17 116/7 122/20 122/22</p> <p>tested [13] 17/9 33/11 61/14 61/16 61/20 61/21 113/17 114/1 118/15 119/2 120/25 122/5 122/15</p> <p>testified [4] 6/18 28/6 104/21 126/10</p> <p>testify [3] 6/17 28/5 126/9</p> <p>testimony [7] 5/16 5/24 27/4 27/12 62/7 125/9 125/17</p> <p>testing [40] 7/19 7/20 7/21 9/8 9/11 9/24 15/12 15/15 17/5 17/8 22/17 22/23 22/23 24/6 24/19 24/23 62/1 66/15 101/24 101/25 103/14 103/20 104/5 110/18 110/21 110/23 111/3 113/21 113/25 115/7 116/2 116/5 116/6 116/8 117/9 121/4 121/5 121/22 122/23 123/2</p> <p>tests [5] 21/15 122/1 122/3 122/10 123/8</p> <p>than [16] 22/2 57/8 65/20 66/1 75/21 78/9 99/2 108/21 109/8 109/14 121/12 128/2 128/22 131/21 141/5 143/14</p> <p>Thank [19] 5/21 6/13 16/8 16/14 26/22 26/24 27/9 28/1 110/7 113/5 124/8 125/2 125/4 125/7 125/14 160/1 160/3 160/16 160/17</p> <p>that [884]</p> <p>that you [1] 36/18</p> <p>that's [115] 7/19 10/25 11/4 11/5</p>	<p>11/21 12/1 14/7 14/14 16/3 16/10 18/6 18/7 18/13 19/20 20/6 20/9 20/14 20/21 21/1 21/4 21/9 21/9 21/19 21/20 21/22 22/1 23/23 24/23 30/18 31/19 32/17 33/22 36/24 38/5 40/22 41/8 47/1 52/12 54/14 55/3 55/22 55/25 56/6 57/7 59/4 59/8 59/13 60/20 60/21 61/1 62/11 63/6 63/13 64/20 65/12 67/19 68/1 69/9 71/20 71/24 72/1 72/19 74/10 76/4 76/24 77/7 77/23 78/7 79/15 79/19 80/8 80/22 83/25 85/9 86/6 86/8 87/10 87/17 90/4 90/7 91/7 91/8 91/23 92/17 93/5 95/1 95/3 99/18 99/22 99/25 100/7 100/16 100/19 101/8 105/3 105/19 106/2 112/9 113/19 116/11 116/25 119/20 121/12 123/7 131/22 134/2 135/8 140/11 143/12 150/5 150/7 154/7 154/19 154/20 155/2</p> <p>their [51] 14/19 17/7 19/17 23/18 33/9 38/11 38/14 40/2 42/25 43/10 43/18 44/5 45/23 47/5 51/14 51/14 61/13 67/18 81/13 92/9 94/15 94/18 95/3 95/20 98/22 101/2 102/17 104/25 110/21 114/12 115/14 116/25 117/20 117/24 118/1 118/19 120/22 121/4 129/7 131/23 137/14 138/11 140/8 140/9 141/14 142/19 142/20 146/10 146/11 147/1 150/16</p> <p>them [137] 10/2 11/13 11/23 11/23 11/23 12/6 12/13 12/13 12/21 12/22 13/2 13/20 17/5 21/24 21/25 22/3 22/4 27/22 30/3 33/20 34/22 37/3 38/1 38/2 38/11 39/21 39/25 43/11 43/14 44/4 45/10 45/21 47/6 51/17 60/4 60/7 60/8 61/20 62/4 67/25 69/7 85/25 86/25 89/11 100/14 101/13 103/19 103/21 107/2 107/3 111/23 112/21 114/2 115/5 124/1 124/6 126/2 128/10 129/9 129/18 131/16 132/16 133/23 133/25 135/18 135/23 136/2 136/10 136/13 138/12 138/13 138/15 138/15 138/24 139/13 139/14 139/16 139/17 140/8 140/13 140/14 141/10 141/15 141/16 141/16 141/21 142/1 142/8 142/9 142/10 143/10 143/12 143/17 143/23 143/24 143/24 143/25 144/1 144/6 146/9 146/15 148/13 148/16 150/19 150/20 150/20 150/25 150/25 151/4 151/4 151/4 151/8 151/11 152/17 153/6 153/8 153/10 153/16 155/20 155/23 156/5 156/6 156/7 156/8 156/13 156/23 157/1 157/2 157/9 157/21 158/5 158/8 158/8 158/16 158/18 158/20 158/21</p> <p>themselves [1] 101/12</p> <p>then [106] 10/1 10/6 10/6 11/5 17/15 18/10 19/18 19/23 21/14 22/12 22/17 24/13 24/15 24/25 25/7 25/9 25/15 31/25 38/10 39/2 39/5 39/14 39/25 41/11 43/1 43/20 45/19 48/5 48/6 49/4 49/13 54/2 56/21 57/3 60/3 65/10 68/13 78/8 78/23 79/25 80/9 81/13 82/3 82/13 83/2 88/16 88/20 90/13 90/14 90/23 91/3 91/9 92/22 92/22 92/23 95/22 96/11 97/21 98/25 99/13 103/20 115/22 116/11 122/19 130/18 131/4 131/13 134/20 134/22 134/23 134/24 135/14 135/19 138/2 138/11 141/19 141/20 142/22 142/24 143/24 143/25 145/8 148/8 148/13 149/18 149/19 151/23 152/1 152/1</p>	<p>152/3 152/5 152/8 153/25 154/20 155/7 156/2 156/22 156/23 157/4 157/6 158/9 158/16 158/18 158/19 158/20 158/22</p> <p>theoretically [1] 105/10</p> <p>theory [1] 103/5</p> <p>there [208]</p> <p>there's [35] 15/9 22/9 32/14 34/19 40/13 44/12 61/11 64/19 66/2 71/2 72/15 76/15 81/5 81/15 83/10 86/1 90/9 92/23 95/25 96/1 101/20 105/6 105/9 105/14 105/18 106/4 108/25 112/10 113/1 122/19 123/10 143/21 143/23 155/7 160/12</p> <p>thereafter [1] 161/10</p> <p>therefore [1] 70/25</p> <p>these [43] 11/22 13/4 13/12 13/21 14/2 18/24 21/23 22/14 22/18 23/10 23/17 25/14 26/6 54/23 61/23 62/17 72/17 93/7 94/6 100/17 100/23 100/25 101/14 109/6 111/15 114/19 114/25 115/10 116/3 116/10 118/4 121/10 123/8 123/9 124/11 136/22 142/12 143/21 146/6 147/13 149/3 156/4 159/10</p> <p>they [352]</p> <p>they'd [3] 53/1 136/14 140/3</p> <p>they're [21] 14/21 22/14 30/1 33/12 34/22 40/16 43/2 64/22 68/25 94/13 94/15 114/10 115/15 120/23 131/13 135/20 138/4 140/10 153/15 153/19 158/13</p> <p>they've [3] 42/25 143/22 151/20</p> <p>thin [1] 153/19</p> <p>thing [29] 20/10 33/20 39/8 46/9 52/9 58/8 63/5 63/14 73/13 73/15 81/7 92/7 92/8 93/6 95/15 97/9 100/15 106/6 106/22 108/24 119/12 129/10 132/1 136/20 141/5 143/11 150/18 151/17 153/14</p> <p>things [49] 29/9 34/15 34/18 35/6 37/6 41/8 45/18 47/6 47/19 49/2 51/8 53/1 59/21 62/17 63/15 65/7 68/3 71/11 72/17 89/21 93/9 94/14 96/13 97/10 99/4 99/9 100/13 100/25 101/5 101/9 105/15 105/24 109/4 109/6 113/4 119/3 128/25 132/17 136/23 143/4 143/5 150/10 150/13 150/21 152/21 153/5 156/17 157/19 158/1</p> <p>think [29] 35/10 41/1 41/16 43/18 43/19 45/22 48/5 50/17 56/11 62/6 68/1 70/11 74/19 83/14 101/13 104/20 106/4 108/21 108/24 108/25 112/6 113/1 128/14 130/4 133/24 138/8 140/23 144/12 153/1</p> <p>thinking [1] 72/19</p> <p>third [5] 37/11 37/13 49/4 49/5 102/10</p> <p>this [179]</p> <p>THOMPSON [1] 2/17</p> <p>those [103] 10/23 11/1 11/3 11/24 13/7 13/19 13/25 16/22 18/22 23/5 24/13 25/1 25/6 28/22 30/1 30/2 33/23 34/8 35/15 35/21 35/23 41/2 41/8 46/19 47/7 48/22 50/5 54/4 55/20 62/10 62/18 63/15 64/4 64/9 64/12 66/16 66/17 66/22 67/12 67/22 71/11 73/19 74/4 80/16 80/16 80/23 81/16 84/2 84/12 84/24 85/6 86/16 87/9 87/16 88/16 89/10 89/17 91/16 91/22 93/9 94/14 98/1 98/17 101/9 103/2 104/18 105/15 105/23 106/5 106/19 107/3 107/19 108/3 109/8 110/1 110/3 111/5 111/14 112/20</p>
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<p>T</p> <p>those... [24] 113/3 114/18 114/23 114/23 115/1 116/4 116/6 118/14 122/14 122/21 122/22 128/2 128/18 136/9 137/16 141/9 143/5 152/5 153/1 153/4 153/12 156/7 156/24 156/25</p> <p>though [8] 33/16 69/5 75/6 81/10 94/21 94/22 111/21 118/3</p> <p>thought [8] 53/2 72/9 90/5 102/24 103/8 130/2 141/10 142/2</p> <p>thousand [1] 120/24</p> <p>three [35] 12/16 20/2 20/4 20/12 36/12 37/24 44/24 46/25 48/4 48/16 51/24 51/25 52/4 62/19 63/15 63/25 79/2 82/21 90/9 91/24 95/4 97/18 101/16 102/13 119/22 120/12 120/13 122/9 128/8 128/13 129/20 138/8 143/15 144/23 149/3</p> <p>three-minute [1] 129/20</p> <p>through [40] 10/12 13/12 18/21 33/8 45/17 46/16 56/11 58/13 60/22 61/13 62/1 64/23 65/9 69/5 77/8 82/4 83/11 84/8 94/7 94/12 98/4 98/8 98/9 101/23 101/25 103/14 103/23 108/2 109/23 109/24 122/12 126/24 133/11 133/21 141/20 142/25 144/24 154/7 155/3 157/22</p> <p>throughout [2] 71/16 111/15</p> <p>throw [5] 79/6 83/5 137/18 151/3 156/24</p> <p>throwing [1] 156/2</p> <p>thrown [2] 79/18 106/17</p> <p>Thursday [7] 1/17 2/1 5/1 47/14 48/5 49/13 160/15</p> <p>ties [1] 154/5</p> <p>time [100] 8/20 8/23 11/11 22/3 23/1 26/1 28/17 30/22 30/25 31/9 32/19 36/11 36/16 39/10 39/11 39/15 42/25 48/9 48/17 50/20 50/22 52/15 53/11 54/6 54/18 55/4 55/5 61/19 66/8 66/24 70/3 74/12 76/6 83/10 83/24 86/17 86/24 87/1 87/11 87/14 87/15 88/5 88/6 88/7 88/7 88/8 88/9 88/14 88/16 88/18 88/21 88/24 88/24 89/1 89/3 89/3 89/5 89/14 90/5 90/17 91/18 93/9 93/15 94/9 95/12 96/8 102/19 103/16 107/3 109/6 111/16 120/6 121/16 122/14 122/20 123/6 123/8 127/4 127/11 128/7 123/20 130/15 130/23 131/9 133/15 135/25 136/10 136/18 138/24 141/6 142/21 143/6 144/22 148/2 149/9 152/11 154/1 157/11 158/21 161/9</p> <p>times [37] 21/25 48/15 66/22 67/1 85/20 86/13 86/14 86/15 87/8 87/9 87/19 87/24 87/25 88/3 88/4 89/9 89/11 89/15 89/17 89/20 94/1 94/3 94/5 94/6 94/19 95/14 107/11 109/7 109/13 111/22 122/8 122/10 124/5 134/25 140/9 144/8 145/7</p> <p>timing [5] 66/19 66/21 93/22 98/5 108/1</p> <p>tissue [2] 143/21 143/23</p> <p>today [10] 5/11 5/24 13/8 27/11 59/1 101/14 110/19 125/17 155/15 160/7</p> <p>together [14] 14/8 18/8 22/3 31/10 40/17 43/11 75/10 75/11 75/14 76/13 80/19 88/1 90/10 107/25</p> <p>told [7] 44/4 60/7 88/3 95/9 95/9 107/16 147/20</p> <p>TOM [2] 2/18 123/15</p> <p>Tonya [2] 43/20 44/22</p>	<p>too [14] 129/14 138/17 139/19 150/12 150/13 151/11 151/11 152/10 152/11 154/13 154/19 154/21 154/24 155/21</p> <p>took [7] 45/16 53/21 58/18 120/23 136/9 136/22 161/7</p> <p>tooth [1] 143/19</p> <p>toothpaste [1] 156/5</p> <p>top [11] 19/10 20/20 21/2 56/5 85/18 86/14 90/10 90/12 90/25 94/8 122/19</p> <p>total [6] 57/6 57/9 85/23 101/18 113/24 114/21</p> <p>totem [1] 28/24</p> <p>tours [1] 144/23</p> <p>towards [1] 149/16</p> <p>town [2] 48/2 146/10</p> <p>track [4] 10/17 13/24 13/25 24/13</p> <p>tracking [1] 14/24</p> <p>train [5] 146/13 146/14 146/15 158/5 158/18</p> <p>trained [3] 144/20 147/23 157/18</p> <p>training [14] 29/8 29/12 131/10 144/17 145/1 146/8 146/23 147/4 147/14 147/21 147/21 152/11 157/21 157/25</p> <p>transcribe [1] 5/6</p> <p>transcribed [1] 161/11</p> <p>transcript [2] 1/20 161/12</p> <p>transfer [3] 25/17 25/24 74/9</p> <p>transfusions [2] 34/17 34/24</p> <p>transit [1] 23/15</p> <p>transmission [20] 46/24 57/21 60/13 60/22 61/6 61/11 62/16 65/17 78/10 81/9 82/19 83/1 83/22 103/6 108/11 108/22 111/9 112/5 112/15 118/6</p> <p>transmit [1] 80/13</p> <p>transmitted [1] 61/24</p> <p>transpired [3] 26/8 124/13 159/12</p> <p>transplant [1] 145/3</p> <p>transplants [1] 34/25</p> <p>tray [2] 53/8 112/21</p> <p>treat [1] 93/12</p> <p>treated [2] 67/23 121/3</p> <p>tried [3] 86/11 102/14 119/5</p> <p>Trip [1] 100/12</p> <p>trouble [1] 111/1</p> <p>true [2] 64/8 161/13</p> <p>truer [1] 121/12</p> <p>trust [2] 87/9 87/16</p> <p>truth [20] 5/18 5/18 5/19 6/17 6/17 6/18 27/6 27/6 27/7 28/5 28/5 28/6 73/4 73/9 125/11 125/11 125/12 126/9 126/9 126/10</p> <p>try [6] 30/3 30/16 31/25 54/25 98/17 108/1</p> <p>trying [13] 14/19 74/5 86/10 98/18 99/3 99/5 99/20 102/22 110/14 111/5 117/14 118/10 118/12</p> <p>tub [1] 158/13</p> <p>tube [9] 11/4 23/3 23/12 41/5 64/20 155/5 156/4 156/7 156/9</p> <p>tubes [3] 154/23 155/19 156/2</p> <p>Tuesday [1] 48/6</p> <p>tug [1] 141/24</p> <p>turn [4] 131/16 131/21 135/20 146/10</p> <p>turn-out [1] 146/10</p> <p>turned [1] 141/6</p> <p>turnover [1] 131/18</p> <p>two [102] 28/22 29/24 30/24 31/1 31/3 31/8 31/10 33/16 33/23 34/7 34/10 35/19 36/3 36/7 36/8 36/9 36/20 37/18 37/20 38/1 40/12 41/4 41/18 41/20 41/22 42/1 42/22 46/25 48/15 49/24 49/25 50/6 51/25 52/25</p>	<p>55/24 57/8 62/8 62/9 63/7 64/4 64/12 65/21 68/20 69/1 69/8 69/11 75/6 76/1 76/2 76/15 77/21 78/17 80/17 82/13 83/13 84/3 84/23 88/10 90/12 90/14 91/23 92/21 94/23 94/25 95/5 95/14 97/12 97/18 97/20 97/21 102/3 102/12 104/18 108/11 110/11 111/14 114/23 114/23 115/22 115/24 116/4 116/9 118/5 118/15 120/10 120/12 120/13 122/9 129/20 132/15 134/1 134/20 140/3 140/7 143/21 144/6 151/24 152/2 152/14 156/22 156/24 158/17</p> <p>type [7] 35/2 41/12 68/14 68/16 90/3 99/13 137/2</p> <p>types [3] 68/22 88/4 154/23</p> <p>typical [5] 30/11 79/10 120/6 122/2 128/6</p> <p>typically [15] 9/3 9/5 10/21 10/24 22/19 31/17 100/20 112/9 112/25 120/10 120/13 124/7 133/20 137/1 137/3</p> <p>U</p> <p>U-S [1] 27/25</p> <p>Uh [3] 91/2 147/3 149/2</p> <p>Uh-huh [3] 91/2 147/3 149/2</p> <p>UHRHAN [1] 2/18</p> <p>unable [1] 104/10</p> <p>uncommon [2] 36/5 92/8</p> <p>uncontaminated [2] 82/16 82/17</p> <p>under [9] 6/3 21/3 27/15 30/6 112/16 125/21 130/5 153/10 161/11</p> <p>undergoing [1] 45/3</p> <p>undergone [1] 34/11</p> <p>undergraduate [1] 124/2</p> <p>underneath [3] 150/24 153/3 153/7</p> <p>understand [12] 6/6 11/18 26/20 27/19 92/24 99/5 108/1 116/1 124/25 125/24 146/21 159/24</p> <p>understanding [2] 98/14 98/24</p> <p>unique [12] 10/19 10/21 11/8 11/16 14/3 14/5 14/22 15/3 15/6 20/21 21/9 23/7</p> <p>United [1] 107/13</p> <p>units [1] 86/22</p> <p>University [2] 29/4 29/6</p> <p>unknown [1] 105/17</p> <p>unless [4] 33/11 56/25 140/20 152/4</p> <p>unlikely [3] 76/5 76/7 84/1</p> <p>UNLV [1] 29/14</p> <p>unrelated [1] 104/6</p> <p>unsafe [3] 108/21 111/12 118/7</p> <p>until [6] 24/12 40/3 66/15 112/8 139/6 142/25</p> <p>unusual [3] 31/9 31/11 31/11</p> <p>up [86] 8/13 11/24 15/22 16/7 18/7 20/9 20/25 24/2 32/7 33/18 37/2 38/13 39/15 43/7 43/21 45/14 45/18 46/10 46/10 48/13 49/17 49/18 51/11 53/9 53/22 54/2 54/3 59/10 60/8 61/4 63/19 64/12 65/7 69/20 71/21 75/3 77/13 77/20 84/24 88/19 89/10 89/12 94/11 97/16 102/16 105/10 108/8 108/14 110/12 112/11 112/14 114/2 116/18 117/16 118/24 121/5 121/10 121/22 123/1 123/3 129/2 129/22 130/10 131/14 131/24 131/25 132/19 133/24 134/14 137/18 137/20 138/2 139/7 140/5 140/15 143/2 144/4 145/22 150/17 150/19 151/8 154/17 155/8 156/8 156/19 160/8</p> <p>upon [4] 5/16 27/4 37/7 125/9</p> <p>upper [8] 40/20 64/10 68/17 69/2</p>
---	---	--

<p>U</p> <p>upper... [4] 69/3 69/6 77/9 140/23 upset [2] 150/11 152/15 upstairs [1] 134/3 urine [1] 33/5 us [75] 9/10 11/1 11/2 11/16 11/17 12/8 12/12 12/19 13/23 14/17 16/5 16/22 18/22 19/5 19/9 20/15 21/8 24/13 26/8 30/24 32/22 42/2 43/3 43/20 45/16 45/16 51/9 51/11 54/15 56/12 58/22 59/1 61/2 61/7 72/5 72/23 77/1 77/8 82/3 85/17 86/20 88/3 89/2 89/7 89/14 89/18 89/25 90/2 90/8 94/6 97/13 97/13 97/15 101/17 102/16 105/9 107/14 107/16 107/16 108/21 109/2 111/6 112/14 114/8 117/18 118/4 118/23 122/10 124/13 132/19 134/21 134/21 134/23 152/18 159/12 use [33] 11/14 11/17 16/12 34/25 54/3 54/10 56/2 57/15 58/15 64/18 68/19 69/1 69/3 69/5 69/18 70/2 74/1 77/12 88/2 89/17 92/5 98/11 107/9 112/23 124/4 151/4 153/16 155/5 155/21 156/21 157/2 157/9 158/21 used [39] 53/10 55/16 56/4 57/9 57/12 58/12 59/9 64/2 64/9 64/11 65/2 65/16 65/19 65/20 65/25 66/1 73/17 79/11 80/2 80/12 82/9 82/10 82/18 84/9 88/11 88/11 88/15 88/24 89/10 102/2 105/8 106/9 106/10 106/12 136/3 136/16 141/3 154/23 154/24 uses [1] 57/17 using [17] 53/14 54/8 80/18 86/16 95/12 147/1 150/12 151/11 152/10 152/11 152/12 152/13 152/13 152/17 152/21 154/13 154/21 usual [1] 152/13 usually [11] 129/9 131/3 132/22 136/1 136/13 136/13 140/3 143/1 144/1 144/3 157/6 utilized [1] 15/11</p>	<p>viral [2] 81/7 123/6 virus [22] 33/9 75/8 75/13 75/20 75/25 76/1 78/19 78/19 78/23 78/23 81/12 81/15 81/17 82/25 83/10 104/4 104/25 105/1 105/12 105/22 105/24 106/1 visibility [1] 129/8 visit [4] 43/5 46/11 46/12 153/17 visual [1] 109/23 visualize [1] 76/14 vital [3] 88/11 95/18 96/19 voice [1] 147/17 Volume [1] 1/22</p> <p>W</p> <p>wait [2] 137/11 137/12 waited [1] 40/3 waiting [2] 82/12 94/11 wake [1] 137/18 wakes [1] 137/20 walk [6] 45/17 77/8 82/3 94/7 133/10 139/7 walked [2] 139/1 139/3 walking [2] 117/5 139/3 want [28] 6/25 13/17 15/19 16/20 23/17 38/17 40/1 43/10 73/25 84/5 85/16 97/9 99/9 102/16 104/20 104/21 108/24 117/18 119/25 127/22 142/6 148/22 150/9 151/3 154/10 155/6 156/25 157/23 wanted [8] 38/23 47/22 48/14 59/21 142/17 156/3 156/18 157/4 warning [1] 24/2 warning [1] 43/11 was [458] washing [2] 52/25 158/13 wasn't [29] 30/4 45/24 55/16 62/22 63/1 63/9 65/2 65/2 65/18 65/25 68/16 68/17 69/24 72/16 74/3 83/17 92/7 92/7 95/12 96/13 104/3 107/5 112/4 118/4 119/16 119/17 136/17 141/3 152/17 watch [1] 142/2 watched [1] 53/5 watching [5] 47/18 49/1 49/8 49/11 52/7 water [1] 158/13 way [48] 10/17 35/11 36/6 49/10 53/1 59/15 59/21 64/6 65/16 66/2 69/4 69/13 69/22 70/24 71/2 71/3 74/20 74/24 78/21 81/16 82/20 83/16 83/25 84/8 85/4 89/15 90/19 99/24 103/11 104/11 105/6 105/9 105/14 105/18 106/4 112/9 115/6 118/18 123/2 127/6 129/12 131/15 133/18 137/24 138/19 142/25 149/14 151/24 ways [2] 113/1 119/3 we [417] we'd [4] 37/25 66/13 135/14 156/7 we'll [11] 7/5 9/20 14/16 18/21 49/15 50/15 61/2 62/2 66/19 120/11 160/14 we're [26] 5/10 9/5 12/2 14/17 19/6 20/15 34/6 37/12 44/10 53/4 64/25 77/2 82/4 90/8 94/7 97/2 99/3 99/8 110/11 111/5 112/16 123/4 141/23 141/25 152/11 153/14 we've [12] 18/21 38/1 44/11 62/6 79/15 91/1 91/9 92/25 97/11 101/16 110/19 123/9 wear [8] 151/1 151/23 151/24 154/2 154/2 154/3 154/8 154/9 wearing [1] 52/24 website [1] 59/6 Wednesday [5] 48/3 48/3 48/5 48/7</p>	<p>161/16 week [7] 39/17 48/2 48/4 48/6 117/25 122/2 158/8 weekly [1] 122/4 weeks [5] 34/3 48/16 55/6 72/7 122/9 welcome [2] 125/5 160/4 well [41] 7/19 8/16 12/24 12/25 13/22 14/11 16/8 17/13 23/13 35/12 37/9 38/7 41/7 41/22 44/3 46/13 46/25 49/14 56/22 68/16 71/16 73/24 97/10 100/12 105/21 106/18 107/10 108/5 113/23 114/21 116/14 116/20 121/24 121/25 126/19 131/17 131/19 134/2 144/25 148/14 157/20 went [29] 10/12 33/8 33/8 40/2 45/22 48/15 52/16 53/8 58/20 65/1 71/3 84/2 92/1 96/6 96/10 101/5 102/3 108/2 114/18 115/18 117/24 123/3 134/5 135/21 144/15 144/24 145/25 146/3 156/3 were [310] weren't [16] 49/25 53/2 54/7 66/17 69/20 89/16 107/2 111/18 115/1 115/2 115/9 115/24 118/10 133/10 146/9 148/9 wet [3] 152/4 153/22 154/10 what [162] what's [13] 10/17 14/21 22/7 38/12 56/9 61/5 79/5 79/8 85/17 91/15 95/3 131/8 153/4 whatever [9] 9/14 54/4 70/4 80/6 92/6 93/13 104/23 112/13 131/7 whatsoever [1] 119/18 when [130] 9/2 9/3 10/15 11/1 11/2 12/14 12/21 13/1 13/22 15/2 15/11 15/12 15/13 17/5 17/6 17/7 18/25 19/15 21/24 22/2 22/6 23/10 24/13 24/21 28/20 32/2 33/11 34/13 39/19 39/24 40/19 41/23 41/23 42/11 43/6 43/15 45/22 47/9 47/16 50/3 50/4 50/16 51/18 53/7 53/23 60/5 68/8 68/9 69/15 72/17 72/19 75/18 78/12 84/7 84/24 85/6 88/3 88/19 88/20 88/25 89/4 89/5 89/7 89/10 90/1 90/2 90/23 92/2 93/9 93/15 94/10 94/10 95/1 95/17 96/11 96/15 102/14 103/4 103/15 106/25 107/9 110/1 112/20 113/20 114/8 117/22 118/16 120/11 127/8 128/5 128/8 130/17 130/20 131/17 131/19 132/4 132/25 133/5 133/16 134/2 134/3 134/4 134/13 134/20 137/1 140/5 141/21 141/23 143/13 144/7 145/11 145/25 146/3 146/19 148/24 149/1 149/4 149/12 149/19 150/4 151/1 151/24 153/17 154/15 155/20 155/23 157/16 158/1 158/11 158/12 where [36] 11/7 15/1 19/15 20/17 22/10 22/16 23/16 23/25 35/3 37/10 38/13 40/7 40/14 46/24 47/23 51/6 52/5 58/8 64/20 80/14 83/4 90/16 93/17 98/21 107/5 110/11 120/18 130/1 131/11 134/11 136/20 138/19 140/10 145/1 148/20 155/9 where's [1] 156/9 whether [6] 14/20 15/16 34/16 89/19 95/11 118/18 which [48] 7/14 8/13 11/10 15/10 16/18 20/12 20/23 21/14 22/16 22/21 24/13 24/15 29/9 30/25 33/4 34/24 36/6 40/6 50/10 62/1 65/22 66/13 67/1 70/1 73/5 73/18 75/13 76/19 78/5 79/10 84/9 85/21 88/19 94/19 96/9 99/23 105/8 105/14 106/24</p>
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<p>W</p> <p>which... [9] 107/22 107/24 112/14 120/1 136/2 140/22 142/16 153/1 156/19</p> <p>while [6] 77/11 120/23 129/10 129/21 132/22 139/17</p> <p>white [1] 153/18</p> <p>Whitehead [2] 2/24 97/3</p> <p>who [52] 15/14 15/25 16/5 19/17 25/11 33/7 34/8 37/20 39/9 42/21 43/15 43/19 43/22 44/5 45/11 46/10 51/2 61/18 62/3 62/23 66/2 66/12 67/3 72/6 91/5 97/13 97/15 98/23 101/1 101/21 102/24 103/7 103/24 104/1 104/16 105/13 109/7 109/8 109/9 109/11 110/17 114/1 115/4 117/19 118/11 118/16 119/1 121/1 121/14 136/17 140/23 158/9</p> <p>who's [4] 41/24 99/4 99/8 143/18</p> <p>whoever [1] 138/12</p> <p>whole [17] 5/18 6/17 8/25 22/19 27/6 28/5 47/17 76/13 95/15 112/10 116/22 119/12 120/19 125/11 126/9 155/5 155/11</p> <p>whom [1] 104/16</p> <p>why [13] 56/6 61/9 65/4 85/17 87/6 87/10 98/11 104/9 111/14 133/8 137/13 146/18 151/16</p> <p>wildfire [1] 133/17</p> <p>will [11] 5/12 7/3 7/4 11/15 32/11 32/12 56/21 86/7 87/20 112/2 123/8</p> <p>WILLOUGHBY [1] 2/4</p> <p>wipe [1] 53/1</p> <p>within [20] 9/16 22/25 38/3 41/15 41/21 43/13 49/2 55/9 67/23 89/13 98/2 102/4 106/12 106/17 115/9 115/22 115/24 117/25 122/9 138/4</p> <p>without [3] 114/4 124/5 145/7</p> <p>witness [6] 5/12 26/2 86/24 87/1 109/17 159/7</p> <p>witnesses [2] 3/1 160/14</p> <p>won't [2] 57/1 141/24</p> <p>wondering [1] 123/24</p> <p>word [3] 61/6 133/7 133/17</p> <p>words [1] 63/1</p> <p>wore [3] 154/2 154/3 154/4</p> <p>wore in [1] 154/3</p> <p>work [20] 9/17 37/6 39/15 103/6 121/13 126/19 127/15 127/18 131/1 132/6 132/9 142/17 143/14 144/18 145/14 146/3 147/5 148/7 153/21 158/4</p> <p>worked [17] 18/11 61/15 124/2 126/22 127/8 128/20 130/22 130/24 132/7 132/10 134/11 135/11 135/12 145/8 145/10 145/15 148/17</p> <p>working [10] 42/9 61/19 63/7 72/15 72/16 74/3 130/18 130/20 146/8 148/6</p> <p>worried [1] 152/20</p> <p>would [117] 8/18 10/1 10/1 13/19 21/11 25/13 31/11 34/23 34/24 45/5 47/13 47/14 49/5 49/16 54/12 64/7 65/14 65/17 66/3 69/22 69/23 70/18 70/24 72/24 73/21 75/13 75/24 75/25 78/18 78/21 78/23 80/22 81/11 81/12 81/23 84/3 84/22 86/25 92/4 92/9 96/4 96/22 99/1 99/13 105/22 106/23 106/25 107/3 107/5 107/14 109/2 110/23 110/24 112/3 113/24 119/1 121/1 121/17 128/5 128/10 129/10 129/22 131/3 131/4 131/23 132/12 132/21 133/5 133/15 133/15 133/16</p>	<p>133/16 133/17 134/22 134/23 135/3 135/17 135/18 135/19 135/24 140/7 142/22 142/25 143/1 143/9 144/4 144/5 145/14 146/19 146/22 147/22 148/21 149/4 149/5 149/10 149/11 149/12 149/20 149/20 150/4 151/6 151/7 151/9 151/23 151/24 152/5 154/7 154/15 154/17 154/19 154/20 156/8 156/8 157/6 158/8 158/19 158/20</p> <p>wouldn't [6] 33/10 64/11 108/7 112/10 129/22 155/21</p> <p>wound [1] 117/16</p> <p>written [3] 10/25 86/15 96/13</p> <p>wrong [2] 20/8 108/19</p> <p>wrote [2] 56/13 89/1</p> <p>Y</p> <p>yeah [26] 128/15 129/21 130/4 130/7 130/8 131/19 134/9 134/16 136/7 137/8 140/14 141/2 142/6 142/18 144/20 150/15 150/22 151/7 153/25 154/15 155/12 155/16 156/3 156/18 157/11 158/7</p> <p>year [11] 8/4 8/5 26/15 30/11 30/23 37/25 115/1 119/23 124/20 126/17 159/19</p> <p>year's [1] 30/22</p> <p>years [6] 28/16 28/17 28/22 112/7 126/22 144/23</p> <p>yelling [1] 150/3</p> <p>yellow [1] 153/18</p> <p>yes [190]</p> <p>yet [3] 11/7 96/18 110/13</p> <p>YOLANDA [1] 2/12</p> <p>you [643]</p> <p>you'd [4] 135/4 140/7 140/7 142/22</p> <p>you'll [3] 19/10 124/4 141/23</p> <p>you're [48] 5/16 5/23 11/11 11/14 13/20 15/22 20/6 20/25 27/4 27/11 27/11 34/13 34/15 37/2 40/20 43/22 47/1 51/3 51/20 52/10 53/12 55/18 56/11 56/19 71/23 77/11 98/5 98/6 99/15 99/16 99/19 99/23 105/19 112/7 116/1 119/23 125/5 125/9 127/1 137/11 139/5 141/18 141/24 148/4 151/1 151/21 151/22 160/4</p> <p>you've [13] 24/4 24/17 25/22 34/1 60/25 82/16 98/5 98/7 104/20 130/14 130/14 137/17 155/13</p> <p>YOUNG [1] 2/3</p> <p>younger [1] 146/6</p> <p>your [83] 5/13 6/9 7/23 8/3 9/15 10/7 10/12 10/12 13/3 13/12 16/12 21/23 23/21 25/2 25/18 27/2 27/22 29/1 29/1 29/7 29/15 30/17 34/3 34/4 35/5 36/21 37/7 47/1 49/16 51/21 52/5 54/24 57/2 58/4 58/5 59/6 59/10 59/10 59/16 59/25 60/25 65/9 67/6 70/9 78/16 84/5 84/8 87/5 89/20 97/15 98/7 99/15 100/2 100/2 100/6 100/21 101/10 104/13 109/1 113/15 113/17 118/8 123/5 123/6 123/7 125/6 126/2 126/18 127/9 131/6 134/7 136/19 141/20 141/22 144/7 144/17 144/25 145/24 146/4 148/22 151/14 153/20 156/9</p> <p>yours [1] 147/13</p> <p>yourself [7] 10/7 12/4 18/17 44/16 49/20 151/18 151/21</p> <p>Z</p> <p>ZARATE [1] 2/19</p> <p>zip [1] 22/8</p>	<p>zip-style [1] 22/8</p> <p>zipped [1] 22/9</p> <p>Ziyad [1] 19/7</p> <p>zoom [3] 61/3 76/25 86/7</p> <p>ZUNIGA [1] 2/5</p>
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EIGHTH JUDICIAL DISTRICT COURT
CLARK COUNTY, NEVADA

BEFORE THE GRAND JURY IMPANELED BY THE AFORESAID
DISTRICT COURT

THE STATE OF NEVADA,
Plaintiff,
vs.
DIPAK KANTILAL DESAI, RONALD
ERNEST LAKEMAN, KEITH H. MATHAHS,
Defendants.

ORIGINAL

No. 09BGJ049ABC

205107

Taken at Las Vegas, Nevada
Thursday, April 22, 2010
8:53 a.m.

REPORTER'S TRANSCRIPT OF PROCEEDINGS

VOLUME 4

Reported by: Danette L. Antonacci, C.C.R. No. 222

GRAND JURORS PRESENT ON APRIL 22, 2010

PAM YOUNG, Foreperson
JOSEPH WILLOUGHBY, Deputy Foreperson
LOUISE ZUNIGA, Secretary
SHELLEY SALAMANOUPOULUS, Assistant Secretary
SVEN BRADLEY
CONSTANCE CABILES
LISA CAMP
CHRISTINE LYONAIS
AGNES PARKER
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BIANCA ROBERSON
BOB ROSE
STEVE SHLUKER
ALICE SZURAN
MICHAEL THOMPSON
TOM UHRMAN
ANNE ZARATE

FILED

JUN 08 2010

Alvin L. Johnson
CLERK OF COURT

Also present at the request of the Grand Jury:
Michael Staudaher,
Deputy District Attorney

INDEX OF WITNESSES

Examined

THOMAS YEE	8
SATISH SHARMA	77

INDEX OF EXHIBITS

Grand Jury Exhibits

Identified

25 - SUPERVISING PHYSICIAN AGREEMENT	88
26 - LETTER OF INTENT	49
27 - SUPERVISING PHYSICIAN AGREEMENT	50
28 - FEDERAL LAW REGARDING CRNA & SUPERVISION BY PHYSICIAN	44
29 - ANESTHESIA RECORD	25

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RA 000312

1 LAS VEGAS, NEVADA, APRIL 22, 2010

2 * * * * *

3
4 DANETTE L. ANTONACCI,

5 having been first duly sworn to faithfully
6 and accurately transcribe the following
7 proceedings to the best of her ability.

8
9 THE FOREPERSON: Let the record reflect
10 that I have canvassed the waiting area and no one has
11 appeared in response to Notice of Intent to Seek
12 Indictment.

13 MR. STAUDAHER: Good morning ladies and
14 gentlemen of the Grand Jury. My name is Michael
15 Staudaher. I'm the deputy district attorney assigned to
16 prosecute the case of Dipak Kantilal Desai, Ronald
17 Ernest Lakeman, Keith H. Mathahs, Grand Jury case number
18 09BGJ049A-C.

19 This is the continuation of the Grand Jury
20 presentment in that matter. At the last time we were
21 here and as I told you on previous occasions I would ask
22 each one of you if after the presentations that had been
23 done, prior to you deliberating or prior to you even
24 hearing additional testimony for a new day, that we
25 would go around the room or at least ask the Grand

1 Jurors if there has been any change in the Grand Jury's
2 belief that they cannot sit as a, that they can rather
3 sit as an impartial hearer of the facts and can
4 deliberate in an unbiased manner. Can anybody, or does
5 anybody have any change in what they previously stated
6 they could do in this particular case with that regard?

7 THE FOREPERSON: No.

8 MR. STAUDAHER: So there is a general
9 acknowledgment from the Grand Jury that they can all
10 still sit as impartial, unbiased listeners of the facts
11 and then deliberate in an unbiased manner in this case
12 just taking the facts and applying them to the law as
13 provided to you; is that correct?

14 THE FOREPERSON: Yes.

15 MR. STAUDAHER: General acknowledgment on
16 the record from all Grand Jurors.

17 And also the other portion that I need to
18 make sure I address is that I know at times during the
19 presentation that one or more of you may have left the
20 Grand Jury proceeding, a prior proceeding for a short
21 time or maybe even a whole day. In those instances I
22 need to make sure that you all are aware that before you
23 can deliberate in this case, and I will not have you
24 deliberate today, but before you can deliberate that you
25 all in order to deliberate must have fully read or been

1 present, fully read the transcripts of or been present
2 for the presentations for each and every witness in this
3 case. Do I have a general acknowledgment from the Grand
4 Jury related to that?

5 THE FOREPERSON: Yes.

6 MR. STAUDAHER: And that's on the record as
7 well.

8 Okay. We'll continue on with the testimony
9 today. We're going to start off with Dr. Thomas Yee.

10 THE FOREPERSON: Would you please raise
11 your right hand, sir.

12 You do solemnly swear the testimony you are
13 about to give upon the investigation now pending before
14 this Grand Jury shall be the truth, the whole truth, and
15 nothing but the truth, so help you God?

16 THE WITNESS: Yes, I do.

17 THE FOREPERSON: Thank you. You may be
18 seated.

19 You are advised that you are here today to
20 give testimony in the investigation pertaining to the
21 offenses of performance of act in reckless disregard of
22 persons or property, criminal neglect of patients,
23 insurance fraud, obtaining money under false pretenses,
24 and racketeering, involving Dipak Kantilal Desai, Ronald
25 Ernest Lakeman and Keith H. Mathahs.

1 Do you understand this advisement?

2 THE WITNESS: Yes.

3 THE FOREPERSON: Thank you.

4 Could you please state your first and last
5 names spelling both for the record.

6 THE WITNESS: Thomas Yee. First name
7 spelled T-H-O-M-A-S, last name is spelled Y-E-E.

8 THE FOREPERSON: Thank you.

9 THOMAS YEE,

10 having been first duly sworn by the Foreperson of the
11 Grand Jury to testify to the truth, the whole truth,
12 and nothing but the truth, testified as follows:

13
14 EXAMINATION

15
16 BY MR. STAUDAHER:

17 Q. Dr. Yee, what do you do for a living?

18 A. I'm an anesthesiologist.

19 Q. How long have you been an anesthesiologist?

20 A. I've been an anesthesiologist for 20 years.

21 Q. Can you walk us through some of your
22 background and training to get to where you are today?

23 A. I graduate from Tongji Medical University,
24 spelled T-O-N-G-J-I, in the People's Republic, China in
25 1989. And I passed the foreign medical graduate

1 examination and entered internal medicine internship in
2 Roosevelt Hospital in New York City, which is a teaching
3 hospital of Columbia University, and after one year I
4 started anesthesiology residency at University of
5 California San Diego. Three years later I completed a
6 program and passed the certification exam by the
7 American Board of Anesthesiology and I began practicing
8 medicine in Las Vegas.

9 Q. So what time did you get to or what year
10 did you come to Las Vegas?

11 A. 1993.

12 Q. And did you immediately start practicing as
13 an anesthesiologist at that time?

14 A. Yes.

15 Q. Now before we get into your work history
16 I'd like to ask you just some general questions about
17 anesthesia and anesthesiologists. Are you with me?

18 A. Okay.

19 Q. What is an anesthesiologist, what do you
20 do?

21 A. An anesthesiologist is a medical doctor
22 whose primary mission are three. Number one, ensuring
23 patient safety in the operating room which includes
24 pre-op, inter-op and post-op. Number two, ensure
25 patient's comfort during that time. Number three is

1 perform the role of the resuscitation, for example if a
2 patient had any kind of say cardiopulmonary arrest or
3 other serious medical problem during that time we happen
4 to be the medical specialist on-site who are most
5 familiar with the steps that need to be taken to rescue
6 the patient. So these are the three main roles of an
7 anesthesiologist.

8 Q. And I assume that training, the specialized
9 training that you described is related to just that
10 field; is that correct?

11 A. Yes.

12 Q. Are there areas of specialty within
13 anesthesia?

14 A. Yes. There are areas such as pain
15 management, cardiac anesthesia, obstetric anesthesia and
16 pediatric anesthesia.

17 Q. Are you specialized in any of those areas?

18 A. Yes. I have specialized in pain management
19 and cardiac anesthesia.

20 Q. As far as other individuals that are able
21 to give or utilize some form of anesthesia, who can do
22 this? Does it have to be a doctor like yourself? Can
23 it be a regular medical doctor, a lay person off the
24 street?

25 A. In the rest of the world my understanding

1 is that anesthesiology is practiced by doctors only.
2 But in this country, the United States, through some
3 historical factors there are nurses who give anesthesia
4 under the supervision of an anesthesiologist. And in
5 recent years I believe things have evolved so nurse
6 anesthetist in some situations are working either by
7 themselves without any supervision, that's permitted in
8 certain states, or they're under the supervision of the
9 operating doctor, the surgeon. There are also doctors
10 who have not performed, who have not done anesthesiology
11 residency or passed the board certification exam but
12 just through a history of familiarity of practice
13 perhaps in rural area they assume the role of performing
14 anesthesia for patients.

15 Q. Now you mentioned a certified nurse
16 anesthetist; is that correct?

17 A. Yes.

18 Q. Have you ever dealt with nurse anesthetists
19 before?

20 A. The CRNA nurse anesthetist, I have met
21 them, for example in my training at UC San Diego, but I
22 have never supervised CRNA.

23 Q. Not any time in your training or history,
24 just in general, or what?

25 A. In my private practice in Las Vegas I have

1 never supervised CRNA. In my training as a resident I
2 worked in a sense side by side with some CRNA because
3 they would be attending a faculty member
4 anesthesiologist that would teach me for example who was
5 a resident and there might be a CRNA alongside me in the
6 operating room to perform anesthesia. And also between
7 my training and the time that I was practicing in Las
8 Vegas on occasions I've been to Los Angeles to do
9 temporary work, these are called Locum Tenem work,
10 L-O-C-U-M-T-E-N-E-M, that's just temporary work, and in
11 that capacity as a temporary anesthesiologist in some
12 hospitals in Los Angeles I have worked with CRNA, nurse
13 anesthetist.

14 Q. Now when you say work with them does that
15 mean you worked with them in a supervisory role or you
16 just, they were just at the hospital doing anesthesia
17 and you were doing anesthesia?

18 A. It was a supervisory role in Los Angeles on
19 those few. I imagine all together no more than three,
20 four days.

21 Q. In the instances when you have in fact
22 supervised a CRNA what kind of things did you have to do
23 from your perspective to adequately supervise a person
24 like that?

25 A. I would have to, and this is required by

1 regulation, I would have to see the patient before the
2 anesthesia was started, I would have to discuss the
3 anesthesia plan with the CRNA, the nurse anesthetist,
4 and afterwards I have to see the patient to make sure
5 the patient was okay. And if everything was
6 satisfactory then I will sign my name to the anesthesia
7 record along the name of the, with the name of the CRNA,
8 nurse anesthetist. So there would be two signatures on
9 the anesthesia record under anesthesiologist.

10 Q. Beside meeting with the patient and
11 discussing things with the CRNA and signing documents, I
12 mean is it something that you would have to or did, you
13 know, stand side by side with the CRNA as they were
14 administering anesthesia to a patient?

15 A. Yes. During the critical stage of
16 anesthesia, for example what we call induction, the
17 beginning of anesthesia, it was my habit, and I believe
18 it's a national standard, that the MD would have to be
19 in the room looking over the shoulder of the nurse
20 anesthetist to make sure everything has gone smoothly at
21 the beginning which is the most critical time during an
22 anesthesia process. And when the anesthesia has started
23 smoothly I would then walk to say another room to
24 supervise another CRNA. And also I'm available on-site.
25 That means in an operating suite with a number of

1 operating rooms I would have to walk among these two,
2 three, four rooms or sit down immediately outside these
3 rooms making myself available for the nurse anesthetist.
4 Q. Now we're going to get into the details of
5 issues related to supervision in a moment, but I just
6 want to ask you a couple more general questions before
7 we go to another area.

8 When you say that you were in the area,
9 what do you mean in the area? I mean could you be in a
10 different building, could you be down the street at your
11 office for example if a CRNA that you were supervising
12 was actually taking care of a patient?

13 A. No. There are laws on this issue, and also
14 national standard care, which is the MD anesthesiologist
15 supervising the CRNAs have to be on-site, has to be in
16 the same general area. Meaning that in a surgical
17 department with a number of operating rooms that MD
18 anesthesiologist has to be inside that operating suite,
19 maybe not the same room but he has to be in the same
20 suite.

21 Q. Okay. I'd like to move to another area
22 before we come back to that eventually. I'd like to ask
23 you some questions about a drug by the name of propofol.
24 Are you familiar with that drug?

25 A. Yes.

1 Q. Does it have another name; Diprivan?

2 A. Yes.

3 Q. Same drug though?

4 A. Same drug.

5 Q. And we'll call it propofol from here on
6 out. But I wanted to ask you if you were familiar with
7 that particular drug.

8 A. Yes, I am.

9 Q. What is it anyway?

10 A. It's an anesthetic.

11 Q. When you say anesthetic what kind of
12 properties or characteristics does it have to make it a
13 anesthetic?

14 A. It's a medication, it's an injectable
15 medication that has replaced Sodium Pentothal about 25
16 years ago. It's a emulsified solution so it looks white
17 when you look at it and it renders a person unconscious
18 making that person go to sleep and it has some superior
19 properties compared to Sodium Pentothal. For example,
20 it's very short acting, patients can wake up with
21 relatively clear head, they can regain consciousness
22 very quickly and to some extent it prevents nausea after
23 the patient wakes up. So it has multiple advantages.
24 That's why it's the predominant anesthetic induction
25 agent in the whole world right now.

1 Q. And when you say induction I think you had
2 mentioned before the actual beginning portion of
3 anesthesia when you're first putting the patient to
4 sleep; is that correct?

5 A. Yes.

6 Q. Now if you were having a patient that was
7 going to be asleep for a long period of time would you
8 use Diprivan throughout the procedure? Excuse me. And
9 I said Diprivan, I meant propofol in this case.

10 A. It is an option that an anesthesiologist
11 may choose, but cost wise it's very expensive so we
12 often would start the anesthesia by injecting propofol
13 and then turn on oxygen nitrous oxide mixed with some
14 anesthetic gas to maintain the whole duration of
15 anesthesia.

16 Q. Okay. So you said it was short acting.
17 Does that mean it has a short onset of action as well?

18 A. Yes, it goes in and takes effect quickly
19 and then it's metabolized and loses effect quickly
20 unless you continuously replenish it.

21 Q. So when you were in a longer procedure
22 after you, or when you were getting near the end of the
23 procedure, is that where you would sort of slow down
24 your use or minimize your use of those longer acting
25 anesthetic agents and start adding propofol back in so

1 that when you were done with the procedure the person
2 would wake up?

3 A. Personally as a board certified
4 anesthesiologist my technique is for a long procedure
5 toward the end I would turn down the anesthetic gas so
6 the patient can wake up quickly. Usually I don't give
7 propofol at the end of the anesthesia.

8 Q. So for you that is strictly, not strictly
9 but it's primarily a induction agent only then?

10 A. Yes.

11 Q. Now for shorter procedures, and you know
12 you're here to testify about issues related to
13 colonoscopies and upper endoscopies, for those types of
14 procedures is the use of propofol for the duration of
15 the procedure an appropriate use?

16 A. Yes, it is.

17 Q. So the time frame for the use of propofol
18 for an entire procedure ranges into what period usually?

19 A. It can be as short as one minute and as
20 long as days. In the intensive care unit for example
21 it's very common for a patient to be kept on propofol if
22 you want to induce a coma-like state in a patient. So
23 it can be used for as short as one minute as long as
24 multiple days.

25 Q. So for a procedure that would last say

1 between 15 and 30 minutes, would that be an appropriate
2 use of just propofol?

3 A. Yes.

4 Q. For that particular type of drug, I know
5 you said the onset and essentially the recovery is very
6 short on both ends; correct?

7 A. Yes.

8 Q. As far as the amount that would be
9 required, I'm assuming that it would be different
10 depending on the type of person, how heavy they are,
11 their medical condition, their age, things like that?

12 A. Yes.

13 Q. In general for a colonoscopy procedure do
14 you have an idea of what the average amount of propofol
15 per procedure would be necessary?

16 A. In my own practice, in my own experience
17 for colonoscopy it requires between 10 to 20 ml of
18 propofol.

19 Q. When you say ml, is that milliliters?

20 A. Yes.

21 Q. Is that what you on average would use?

22 A. Yes.

23 Q. Sometimes more, sometimes less I would
24 assume?

25 A. Yes.

1 Q. What kind of duration of procedure are we
2 talking about for that kind of use?

3 A. That would be about 10, 15 minutes.

4 Q. So if you had procedures that were lasting
5 into the 30 plus minute range you would use more?

6 A. Yes.

7 Q. If you had procedures that were only
8 lasting between three to five minutes would you use
9 less?

10 A. Yes.

11 Q. Now as far as the drug itself, you had
12 mentioned some of the properties it had, primarily to
13 put people to sleep I assume; correct?

14 A. Yes.

15 Q. Are there other properties of that drug
16 that make it something that's beneficial? For example,
17 does it have an amnestic effect making people not
18 remember the procedure, things like that?

19 A. Yes, but it's part of the overall property
20 of an anesthetic. For a drug to be called an anesthetic
21 it has components of three different properties. One is
22 hypnosis, it makes a person go to sleep. The second
23 part is amnestic, it makes a person forget. The third
24 one is it may take away anxiety, antianxiety. So for
25 the anesthetic to work it generally has these three

1 properties.

2 Q. As far as the amnestic effect, the part
3 that you mentioned of the three, I want to ask you just
4 a couple of questions about that. If for example during
5 induction or during the time that you're using an
6 anesthetic to put someone to sleep for a procedure, at
7 the beginning of the procedure something would happen, I
8 don't know, you drop a pan on a person's leg and it
9 didn't cause any injury that would be present afterwards
10 but it hurt the patient, would that be something the
11 patient may not remember happening as a result of being
12 given the anesthetic drug?

13 A. If the patient already received adequate
14 dose of propofol he should not be able to remember that
15 incident.

16 Q. As far as a procedure being started for
17 example before anesthesia, before propofol is actually
18 given, would the propofol used subsequent to that
19 potentially make a person not remember it?

20 A. In the usual dose no. That's a phenomenon
21 called retrograde amnesia, making a person forget what
22 has happened before, and propofol in my experience does
23 not have that property.

24 Q. Okay. So it would be something that would
25 be contemporaneous with the use of propofol?

1 A. Yes.
 2 Q. Not with things that happened before?
 3 A. No.
 4 Q. Now do you know an individual by the name
 5 of Dr. Dipak Desai?
 6 A. Yes.
 7 Q. Before I get to him specifically I have one
 8 last question regarding the propofol. You said you're
 9 familiar with it, you've used it a lot over the years
 10 that you've had it. How many times would you estimate
 11 just in generality you've used that particular drug?
 12 A. Probably over 25,000 times.
 13 Q. Is this a drug that the average doctor is,
 14 you know, allowed to use in regular practice?
 15 A. I believe the law allows a licensed MD to
 16 use just about any drug.
 17 Q. And in your experience as a doctor, not
 18 just an anesthesiologist, would you use drugs that you
 19 were unfamiliar with or didn't know the history of or
 20 the background of?
 21 A. I would not.
 22 Q. Would you think that that was reasonable
 23 for a physician to rely on others who had more knowledge
 24 about certain drugs to use those particular drugs?
 25 A. Yes.

1 relationship starts at the beginning?
 2 A. Yes.
 3 Q. When you said hospital and other locations,
 4 what was your primary at least initial interaction with
 5 him, where did it occur?
 6 A. I believe it was in his endoscopy center.
 7 Q. Did you also deal with him in the hospital
 8 situation?
 9 A. I might have given anesthesia for a few of
 10 his patients in the very beginning but I think I have
 11 worked with him in hospitals and also in his own
 12 endoscopy center.
 13 Q. Now when you were working with him, when
 14 you would be called to go to the endoscopy center, was
 15 it for these types of procedures, upper endoscopy,
 16 colonoscopies, things like that?
 17 A. Yes.
 18 Q. All short duration procedures?
 19 A. Yes.
 20 Q. As far as the other people that may have
 21 been providing that service, were you the only one or
 22 did other people appear as well?
 23 A. There were many, many anesthesiologists
 24 that were called to provide anesthesia service for Dr.
 25 Desai.

1 Q. Would you think that it would be reasonable
 2 for a person to supervise another individual if they
 3 didn't have, with regard to a drug or any other
 4 procedure, if they didn't have knowledge of those
 5 procedures or drugs?
 6 A. No.
 7 Q. Now let's get onto Dr. Desai. How did you
 8 come to meet or come in contact with Dr. Desai initially
 9 after you came into town?
 10 A. I believe, the way we work as
 11 anesthesiologists in Las Vegas which is a surgeon
 12 request system, we do not just sit in the operating room
 13 waiting for patients or surgeons to come along, we
 14 actually receive phone calls to, for appointments. The
 15 surgeon's office will call days in advance to ask us to
 16 appear at a certain place and a certain time to take
 17 care of certain operations by giving the patient
 18 anesthesia. And on that day and time we, the
 19 anesthesiologist, would then go to that facility and
 20 perform the anesthesia service. And I believe Dr.
 21 Desai, similar to other surgeons and doctors, would have
 22 requested my service, simply called my office, requested
 23 me to go to a hospital or a facility to give anesthesia
 24 for a procedure he was about to perform.
 25 Q. Okay. So is that how it starts, the

1 Q. So you weren't the only individual that was
 2 sent over there to do that work?
 3 A. No. I would imagine I probably was the one
 4 that went maybe the fewest times to his, to perform
 5 anesthesia for him.
 6 Q. In a typical week how many times did you go
 7 there?
 8 A. I would go probably once every six month.
 9 Q. So it wasn't very often at all?
 10 A. No.
 11 Q. Now at some point, I mean did that whole
 12 process of going to see him change at all and did you go
 13 with more frequency, or what he requested or he required
 14 of you change during that time?
 15 A. Yes, there was a change around 2001.
 16 Q. What was that change?
 17 A. I believe he hired CRNAs.
 18 Q. So at that time you said the only
 19 experience at least supervising or dealing with CRNAs
 20 was this Locum Tenem work that you did in California; is
 21 that right?
 22 A. Yes.
 23 Q. And I think during your training too did
 24 you have some?
 25 A. Right, but my training I did not supervise

1 the CRNA, I was only a student, a resident.

2 Q. Now when you go do anesthesia -- and we'll

3 get to the supervision in a minute.

4 When you go do anesthesia tell me, I'm not

5 asking about the mechanics of doing the procedure itself

6 but I assume that there is sort of a process that

7 happens once you get, if somebody asks you to come in to

8 do a procedure and you come there to do the anesthesia,

9 what do you do when you get on-site?

10 A. I would evaluate the patient, explain to

11 the patient what we were about to do for him or her and

12 get the permission which is a consent, and then I would

13 check the equipment, the anesthesia equipment, the

14 anesthesia medications, and then I would return to the

15 patient, make sure an IV, intravenous access has been

16 established, and then that's the, those are the

17 preparations that we would do before anesthesia.

18 Q. Okay. I'm going to show you what has been

19 marked as Grand Jury Exhibit 29 and ask you if you are

20 recognize that item.

21 A. Yes, I do.

22 Q. Okay. What is it?

23 A. It's an anesthesia record.

24 Q. Okay. Did you in fact bring this with you

25 to the Grand Jury proceeding?

1 that go out from left to right across the page. Do you

2 see that?

3 A. Yes.

4 Q. And can you tell us what the purpose of all

5 those boxes are that are on the form and what you do

6 with them?

7 A. Those are for us to record the vital signs

8 such as blood pressure, heart rate and even respiration.

9 Q. Do you ever have a situation where you know

10 you've just done so many of these and they're all kind

11 of just so routine that you just go ahead and fill that

12 out in advance?

13 A. No, never.

14 Q. Would you ever do that?

15 A. No.

16 Q. And when I say fill out, I'm talking about

17 the vital signs for example, would you ever say what the

18 patient's vital signs are going to be in advance?

19 A. No.

20 Q. Is there any way to really know what their

21 vital signs are going to be in advance?

22 A. No.

23 Q. I mean heart rate, blood pressure,

24 respiration rate, things like that?

25 A. No.

1 A. Yes.

2 Q. And you said an anesthesia record. What do

3 you mean by that? Is that something that you just keep

4 track of what you're doing, is it something you fill out

5 in advance; what do you do with that?

6 A. An anesthesia record is a way that

7 anesthesiologists document the events and the patient

8 conditions during the anesthesia.

9 Q. And this is a blank document is it not?

10 A. Yes, it is.

11 Q. Okay. And I've displayed that for the

12 Grand Jury on the document camera and if we need to we

13 can refer to it as we go along.

14 Now I know that it looks like, on the top

15 portion of that, it looks like some patient information

16 or at least some things to put various I guess

17 documenting information down. What is the purpose of

18 that?

19 A. It's for us to record the results of our

20 pre-anesthesia interview. If there were disease states

21 that the patient had we were to record it, if there were

22 allergies to medication we were supposed to record it.

23 Q. There is a portion that is in sort of box

24 type format that has on the left hand column side of the

25 page it says temperature and there is a bunch of boxes

1 Q. Do the boxes indicate an increment of time

2 as well that those different measurements need to be

3 done or not done or what they are at those times?

4 A. The standard way of doing this is to

5 designate each small box horizontally as five minutes.

6 Q. So as we go across each box that we move to

7 would be another five minutes and then another five

8 minutes?

9 A. Yes.

10 Q. And I assume you fill that out, based on

11 your testimony, that you would fill that out after that

12 five minute period to say what the patient's blood

13 pressure, pulse and so forth were during the previous

14 five minute interval?

15 A. Yes.

16 Q. As far as the start time stop time kind of

17 thing, is that ever designated any place on this

18 particular form?

19 A. Yes, it's at the bottom of these forms.

20 Q. I'll move it up so we can see that.

21 And where specifically would you be talking

22 about; in this area down here, the lower right hand

23 corner?

24 A. Yes. There is a space for anesthesia start

25 time and anesthesia stop time.

1 Q. Now how do you figure that out? I mean is
2 that from the time you get called by the doctor to come
3 out to their facility to do the work, is that when your
4 start time starts or is there another time that you use?

5 A. No, I start at the time when the patient
6 actually enters into the operating room.

7 Q. So when you actually make contact and start
8 dealing with the patient then?

9 A. No, I don't deal for pre-op visit, there
10 may be other doctors that do but personally I don't deal
11 with just talking to the patient in the pre-op holding
12 area. I start when the patient is actually brought into
13 the operating room.

14 Q. Is that the standard that most
15 anesthesiologists use to your knowledge?

16 A. To my knowledge, yes.

17 Q. So that would be the start time when they
18 physically enter into your sort of zone of care; is that
19 right?

20 A. Yes.

21 Q. Once that happens do you write down that
22 time or do you ask somebody what the time is? I mean
23 how do you actually get that figure, that number?

24 A. In the operating room we have to
25 synchronize all the times since the operating room

1 nurses also record the anesthesia time so we talk to
2 each other and announce the time together and then I
3 will write down the time.

4 Q. Now when you put that start time down then,
5 let's say whatever it is, 12:00 noon, and then I assume
6 at some point the procedure takes place; correct?

7 A. Yes.

8 Q. Now during the time after you put that
9 start time down are you doing things like monitoring the
10 patient's blood pressure and vital signs, things like
11 that?

12 A. Yes. First I would apply the monitors, the
13 EKG, blood pressure cuff, and the pulse oximeter probe
14 to the patient.

15 Q. Are any of those things ever done in
16 advance before they wheel the patient into the room?

17 A. The monitoring?

18 Q. Any of it, the IV access, any of that
19 stuff?

20 A. Yes, IV access can be put in before the
21 patient's entry into the operating room.

22 Q. So once they come in and you're working on
23 them, again the procedure goes on, whatever that
24 procedure is at some point?

25 A. Yes.

1 Q. Now after the procedure is completed at
2 what stage do you sign off or put down your end time for
3 anesthesia?

4 A. The end time is the time when I walk away
5 from the patient which is after I have pushed the
6 patient's bed to the recovery area and after I have
7 given the report to the recovery nurse. So I write down
8 the time that I walk away and hand over the care to the
9 recovery nurse.

10 Q. Do you ever continue to have anesthesia
11 time recording when you are not in fact dealing with the
12 patient? If you walked away from the patient and let's
13 say you're going to have a cup of coffee or you're
14 actually going to go pre-op another patient, would you
15 still continue to record anesthesia time for the patient
16 you just finished with?

17 A. No.

18 Q. Would that be an inappropriate recording if
19 you did that?

20 A. I think that's correct, it is not
21 appropriate to count that time.

22 Q. Now if you were in a situation like in the
23 short colonoscopy endoscopy procedures where you were
24 the anesthesiologist and you just stayed in the room
25 and, you know, you said bye to the patient as they are

1 wheeled out of the room but never went out to the
2 recovery area, checked on the patient or gave a report
3 to the nurse or whatever, would your anesthesia time
4 then stop when they left the room?

5 A. First of all I would not accompany the
6 patient to the recovery area and give a report to the
7 recovery nurse, but if there is a situation where say
8 some other professionals such as other anesthesiologists
9 are taking over immediately outside the operating room
10 and escort the patient to recovery and so on, I would
11 stop my own anesthesia time at the moment when the
12 patient is pushed out of the operating room.

13 Q. Even if the place where they were taking
14 the patient to was 10, 20 feet away from where the
15 anesthesia room that you were in was?

16 A. No. Because an anesthesiologist cannot
17 claim service to two patients at the same time. If the
18 next patient's wheeled in after the first patient has
19 been wheeled out I can't take credit for both care for
20 both patients.

21 Q. I'm going to give you a hypothetical
22 situation. You're supervising a CRNA, the CRNA stays in
23 the room from the point that the patient is wheeled in
24 to the point the patient is wheeled out and does not
25 accompany that patient into the recovery area, what

1 would the appropriate times to mark anesthesia time for
2 that particular patient be?

3 A. It would be, in my own opinion, in my own
4 practice I would mark the start time as the time when
5 the patient was brought into the room and the finish
6 time as the time when the patient was pushed out of the
7 room.

8 Q. Okay. Now have you ever in your practice
9 ever documented vital signs on a patient when that
10 patient was no longer in your care?

11 A. No.

12 Q. And billed for that or charged for that
13 time?

14 A. No.

15 Q. Have you ever submitted or put one of these
16 forms together that you said these anesthesia forms with
17 incorrect information to your knowledge?

18 A. No.

19 Q. As far as the forms themselves are
20 concerned what do you do with those forms after the
21 procedure is done?

22 A. One copy stays with the patient file and
23 stay with the hospital, that goes into the patient's
24 permanent record. I will also make a copy, a Xerox copy
25 and I will bring that along with the patient insurance

1 information which we call a face sheet that has the
2 patient's name, address and insurance information, I
3 will bring the face sheet and a copy of the anesthesia
4 record back to my own office for my assistant to bill
5 the insurance company with.

6 Q. So anesthesia record and the patient
7 information for insurance?

8 A. Yes.

9 Q. Those two documents?

10 A. Yes.

11 Q. So then you or somebody for you bills for
12 your services then?

13 A. Yes.

14 Q. Do you ever have the doctor bill for your
15 services that you didn't work with?

16 A. Never.

17 Q. Now the reimbursement that comes in, does
18 that reimbursement come to you or does it go to the
19 doctor who did the procedure?

20 A. It does to the anesthesiologist, me.

21 Q. Does the doctor get a piece of that at all?

22 A. No.

23 Q. When I'm saying the doctor, not that you're
24 not a doctor but I'm talking about the doctor who did
25 the procedure.

1 A. No.

2 Q. Do you ever fee split or give him a portion
3 of that because of the referral?

4 A. No. In many situations my understanding is
5 that fee splitting, for a physician to pay another
6 physician for referral, is illegal.

7 Q. And you have not done that I assume?

8 A. No.

9 Q. Now going back to this form again, I think
10 it's Grand Jury Exhibit 29 if I'm not mistaken, below
11 those little small boxes up here on the upper half of
12 the form there is some larger boxes that are just
13 immediately below that. Do you see those?

14 A. Yes.

15 Q. What are the purposes of those boxes?

16 A. The boxes toward the top are meant to
17 provide a space for us to enter the more complicated
18 vital signs such as oxygen saturation, entitled CO2, we
19 had a machine that measured the exhaled carbon dioxide
20 in a patient's breath, and there is one that we would
21 record the oxygen level concentration that patient was
22 receiving, and there is a box for recording the time,
23 and in the next box is remarks, that's for us to
24 designate a symbol such as number one, number two,
25 number three, so that we can explain the event on the

1 right hand side of the chart. Typically I would mark
2 say number one and explain the number.

3 Q. Is that this space over here on the right
4 hand side of the chart that you're referring to?

5 A. Yes. I would explain the remark number one
6 as pre-oxygenation, giving the patient oxygen and begin
7 intravenous anesthesia induction.

8 Q. Would you also put down things like when
9 you administered drugs and so forth with the patient?

10 A. I would mark the beginning of the propofol
11 as induction, but also in the boxes on the, in the
12 middle of the page at the appropriate time in that
13 particular box I would write down all medications given
14 to the patient.

15 Q. So if you were in your first beginning
16 portion and you gave your let's say 100Cs of -- and CCs
17 are like milliliters, correct, they're individual units
18 of drug or whatever fluid that you're using?

19 A. Yes.

20 Q. When you gave the dose of, the initial dose
21 of the propofol and wrote that down, if you had to give
22 a subsequent dose would you then write that down as
23 well?

24 A. Yes, I would write down every dose I give
25 to the patient.

1 Q. Would that be chronologically in the right
2 time frame that dose was given?

3 A. Yes.

4 Q. So when you look at this record after the
5 fact if you were an anesthesiologist and you were
6 looking at the record would you expect that if it had
7 those kinds of things on it that would have indicated
8 when drugs were given, when vital signs were taken, that
9 information would be accurate?

10 A. Yes.

11 Q. Do you ever have a situation where you want
12 to know how somebody has reacted to anesthesia from
13 previous procedures?

14 A. Yes.

15 Q. And the types of drugs that had been given
16 to them and how much had been used and things like that?

17 A. Yes.

18 Q. How does that play or why is that a concern
19 to you?

20 A. If a patient told me pre-op that last time
21 he had anesthesia there was complications I would want
22 to review the anesthesia record from that previous
23 surgery.

24 Q. If you reviewed that anesthesia record and
25 it hypothetically turned out to have false information,

1 false recordings of time, vital signs that the patient
2 had actually done well when maybe even the patient
3 wasn't even there, would that give you false information
4 to which you would base your plan on potentially?

5 A. Yes.

6 Q. Would that be something that would be
7 concerning to you?

8 A. Yes.

9 Q. Would you ever do that yourself, give false
10 information out to somebody that might rely on it later
11 on in the anesthesia record?

12 A. No.

13 Q. As far as the documentation of the things
14 you're talking about, do you also, in those numbered
15 boxes where you put the comment on the right hand side,
16 do you discuss any problems that may have occurred
17 during the anesthesia?

18 A. Yes.

19 Q. Do you ever just say that somebody is
20 healthy and happy and did well when in fact you hadn't
21 even worked on them yet?

22 A. No.

23 Q. Now let's go back a little bit to the
24 process by which you go through the anesthesia on a
25 particular patient on these type of procedures, the

1 colonoscopy endoscopy. Okay? Are you with me?

2 A. Yes.

3 Q. Patient is wheeled into the room, you go
4 ahead and perform the various things that you said, give
5 the anesthetic agent and procedure is performed, patient
6 leaves the room, you, typically you said follow that
7 patient out?

8 A. Yes.

9 Q. Let's say that's the only one you did for
10 the day. If I understand you correctly you take this
11 anesthesia form and you would take the patient's
12 insurance information and you would leave and then later
13 bill the insurance company with that?

14 A. Yes.

15 Q. When you bill the form, the insurance
16 company form, do you use a specific type of form that
17 you submit to insurance companies?

18 A. Yes.

19 Q. Are those called claim type forms or what?

20 A. Yes, those are insurance claim forms
21 submitted by physicians.

22 Q. Do they have a particular number
23 designation?

24 A. I'm not sure.

25 Q. What type of form, is it the same form for

1 all insurance companies essentially?

2 A. Yeah, there is a uniform form used for all
3 insurance company.

4 Q. Okay. And when you submit that form I
5 assume that the information contained on it needs to be
6 accurate as well?

7 A. Yes.

8 Q. Would you ever put false information on a
9 insurance form to submit for a claim?

10 A. No.

11 Q. Once that claim goes in typically you said
12 I think you get reimbursement back to you directly or to
13 the company that's billing for you; correct?

14 A. Yes.

15 Q. Is that based on the actual amount of work
16 that you did?

17 A. Yes.

18 Q. Now let's talk about your work for a
19 minute. How does anesthesia work, sort of designated or
20 recorded, how is it that you derive an amount to send to
21 the insurance company for reimbursement?

22 A. There is a conversion based on the
23 complexity of the case, so we're given a certain number
24 of units or different type of procedures, and for the
25 time we spend with the patient usually is one unit for

1 every 15 minutes.

2 Q. So one unit is a 15-minute interval. When

3 you say unit, is that a billable type thing?

4 A. Yes, one billing unit.

5 Q. Are there any, do you start off with any

6 certain number of units in a procedure or do you just

7 bill the amount of time you did on a procedure?

8 A. Yeah, there is certain number units that is

9 associated with the procedure.

10 Q. Do you know what the numbers are pertaining

11 to upper endoscopies and colonoscopies?

12 A. These numbers used by my office are such

13 that the upper endoscopy EGD I believe the code is

14 00740, and the units are five units.

15 Q. Is that for both of those procedures or are

16 they different?

17 A. They're different. For colonoscopy the

18 code is 00810 and the unit value is five units.

19 Q. So before you do anything to the patient

20 you code that procedure, your upper endoscopy or

21 colonoscopy, you get to start off with five units; is

22 that what you're saying?

23 A. Yes.

24 Q. And then on top of that do you add the time

25 for the units that you actually gave anesthesia?

1 A. Yes.

2 Q. Now depending on the number of units that

3 you submit to the insurance company does that vary the

4 amount of reimbursement you get back typically?

5 A. Yes.

6 Q. So if I -- and I don't want to make this

7 too simple, I'm just trying to understand it. If I bill

8 more units you get more money back, if you bill less

9 units you get less money back?

10 A. Yes.

11 Q. Or fewer units you get less money back?

12 A. Yes.

13 Q. And the situation where you said you try to

14 be conservative, do you ever just, you know, gosh, you

15 got to 29 minutes so you just put it up to 30 so you

16 could bill an extra unit?

17 A. No.

18 Q. Would that be an appropriate billing method

19 for any individual?

20 A. No.

21 Q. Now I'm showing you what has been marked as

22 Grand Jury Exhibit Number 28 and I want to ask you if

23 you can tell me what that item is. First of all if

24 you're familiar with it and then tell me what it is.

25 A. Yes, I'm familiar with this.

1 A. Yes.

2 Q. So if you had a, and I'm trying to make

3 sure I understand how this would go, if you had say a

4 14-minute procedure how many units would you bill for?

5 A. One unit.

6 Q. So you would have five plus one which would

7 be six?

8 A. Yes.

9 Q. And if you had a procedure that was 16

10 minutes long, one minute past the 15-minute increment,

11 how many units would you bill for?

12 A. I would bill for usually still one unit.

13 Q. How many could you bill for in that

14 situation?

15 A. I could bill for two.

16 Q. Because you're in that next 15-minute

17 increment?

18 A. Yes, but that's controversial so I just

19 stay on the conservative side.

20 Q. If you went up to say 30 minutes or let's

21 say in this case 31 minutes or 32 minutes, how many

22 units could you potentially bill for?

23 A. Maximum three units.

24 Q. So your base unit of five plus a maximum of

25 three would be eight?

1 Q. What is it?

2 A. This is the federal law regarding the

3 relation between CRNA nurse anesthetist and the

4 supervision by physician.

5 Q. And I know we've got it there, it's an

6 admitted exhibit. What does it tell us about that

7 issue?

8 A. I'm not a lawyer but my reading of this

9 tells me, it says a nurse anesthetist has to be

10 supervised immediately by a physician. If the

11 supervising doctor is not a MD anesthesiologist, if such

12 a person is not available, then the burden of

13 supervision falls on whichever operating physician or

14 surgeon that happens to be there who required the

15 service of the nurse anesthetist.

16 Q. To your knowledge is that the way it is in

17 Nevada?

18 A. I believe it is.

19 Q. So either MD anesthesiologist or if that

20 person isn't readily available a doctor, MD doctor who

21 is doing the procedure?

22 A. Yes.

23 Q. Now with regard to the supervision issue

24 again, and we're back to that, as a MD anesthesiologist

25 is there a limit on the number of individual CRNAs that

1 you can supervise?

2 A. Again I'm not a lawyer but I was told

3 Medicare rule limit the supervision to four CRNAs by one

4 MD at any given time.

5 Q. And ladies and gentlemen of the Grand Jury,

6 I'm going to caution you on the issue related to the

7 hearsay. That's not offered for the truth of the matter

8 asserted, just what his understanding and belief is

9 about how many he could supervise.

10 And based on that, what you were told or

11 what you believed the law was, would you supervise more

12 than four individuals?

13 A. No.

14 Q. But you think you could supervise up to

15 four individuals?

16 A. Yes.

17 Q. Now in supervising nurse anesthetists,

18 would you be able to bill for their services?

19 A. Yes.

20 Q. So if you had let's say gone to the

21 Endoscopy Center and were doing procedures for Dr. Desai

22 and are supervising two or three nurse anesthetists at

23 that time and they were all doing procedures, could you

24 then take those face sheets or those insurance

25 information, the anesthesia records, and bill for those

1 A. He made that remark and I believe I mention

2 to him that my understanding of the law is if you do not

3 have a MD anesthesiologist there in the room supervising

4 the nurse anesthetist then the surgeon or the operating

5 physician would be the supervising doctor and they hold

6 the responsibility.

7 Q. You actually told him that?

8 A. Yes, I explained to him my understanding of

9 the law is the MD anesthesiologist is responsible for a

10 CRNA if the MD anesthesiologist is in the operating

11 suite, but without the MD anesthesiologist in the

12 operating suite then whatever surgeon or operating

13 physician happens to be there then they become the one

14 assuming the responsibility.

15 Q. So beside that discussion with him, was

16 that just a single discussion or did you have that on

17 more than one occasion?

18 A. I think it was just one discussion.

19 Q. At some point down the road did you learn

20 that he was using nurse anesthetists?

21 A. Yes.

22 Q. At the time that he started using them were

23 you involved in any supervisory role with those nurse

24 anesthetists?

25 A. No, never.

1 services?

2 A. Yes.

3 Q. If you were the one there doing supervision

4 would Dr. Desai or any of his fellow physicians be able

5 to bill for those services?

6 A. No.

7 Q. Would the CRNAs themselves be able to

8 submit it as bills without you?

9 A. I believe not.

10 Q. And that's because you're the supervising

11 physician I assume; correct?

12 A. Yes.

13 Q. Now at some point down the road you had

14 said that, and I think it was 2001 or was it right

15 around 2001 you thought that Dr. Desai was going to use

16 nurse anesthetists?

17 A. Yes.

18 Q. Can you talk to us about that issue? What

19 you know about it, were you involved in that at all?

20 A. I was not involved in the process.

21 Q. How did you know he was going to use them?

22 A. During one occasion when we work together

23 he said he's planning on hiring nurse anesthetist.

24 Q. Did you ask him about that or talk to him

25 about it?

1 Q. At that time were you asked to potentially

2 be involved with that supervisory or any supervision of

3 those nurse anesthetists?

4 A. Yes, I was asked.

5 Q. At that time back in 2001 or 2002?

6 A. Yes, I was asked.

7 Q. By who?

8 A. By Dr. Desai.

9 Q. And did you agree to do that?

10 A. Yes, I agreed.

11 Q. Did you enter into some sort of agreement

12 or start that process to do that supervisory work?

13 A. There was a letter of intent that if he

14 called me, like he would, as any surgeon request system

15 doctor would, if he called my office, asked me to

16 perform the service which that would include supervising

17 nurse anesthetist, then if that day I'm free I will go

18 and perform the service.

19 Q. Now I'm going to show you what has been

20 marked as Grand Jury Exhibit Number 27. And I'm also

21 going to show you at the same time Grand Jury Exhibit

22 Number 26. Are you familiar with those documents?

23 A. Yes.

24 Q. Have you seen these before?

25 A. Yes.

1 Q. What are they? I mean same type of
2 document; correct?
3 A. They're similar.
4 Q. But there are differences between the two
5 documents?
6 A. Yes, there is a very important difference.
7 Q. We'll get to that in just a second. But
8 what types of documents are these again?
9 A. These are agreements or my understanding
10 was letter of intent to supervise nurse anesthetist.
11 Q. Now they have different dates on them do
12 they not?
13 A. Yes.
14 Q. What are -- let's look at Exhibit Number 26
15 first of all and tell me what the date is on that
16 particular document.
17 A. The date is July 31, 2006.
18 Q. Okay. Does that document bear your
19 signature?
20 A. Yes.
21 Q. Does that bear some additional handwriting
22 on the document itself beside the typed portion?
23 A. Yes.
24 Q. Is that something you're familiar with? Do
25 you know where that came from?

1 signature.
2 Q. Okay. Do you sign your name in different
3 ways?
4 A. I sign my name similar to the one appearing
5 on document Number 26.
6 Q. You say that you don't know that that's
7 your signature. Do you recall ever signing this
8 document?
9 A. I don't recall signing document Number 27.
10 Q. Did you, I mean I know that you say you
11 signed the document above 26. Did you ever sign other
12 documents like that for Dr. Desai?
13 A. I'm not sure. I think that these were the
14 only two but there might have been other ones similar to
15 document 26.
16 Q. Now let's talk about, let's start off with
17 the one that's earlier in time and that would be Exhibit
18 27. Can you tell me what that document purports to be?
19 A. It says me in conjunction with Dr. Desai
20 and Dr. Shama agree to co-supervise and consult with
21 CRNAs employed at the Gastro Center of Nevada,
22 supervision and consultation service would be provided
23 regarding the anesthesiology service provided by the
24 Gastro Center of Nevada employees, it is agreed that I
25 would be available by phone consultation in addition to

1 A. Yes.
2 Q. Where did it come from?
3 A. I wrote it.
4 Q. Now I'm showing you the next document down
5 which is Grand Jury Exhibit 27 still entitled
6 Supervising Physician Agreement; is that correct?
7 A. Yes.
8 Q. And even the typed portion of this is
9 different than the one up here bearing your signature;
10 correct?
11 A. Yes.
12 Q. Now on this corrected form does this bear
13 at least a signature line for your name?
14 A. Yes, there is a line there.
15 Q. Now there is a signature there and a date.
16 What is the date of that signature?
17 A. April 1st, 2002.
18 Q. So this second document, Exhibit 27, is
19 earlier in time at least it appears than the document
20 you signed above in 2006; correct?
21 A. Yes.
22 Q. And the signatures as I see them on this
23 document appear to be different. The signature line on
24 Exhibit 27, is that your signature?
25 A. The 27 is the '02. I'm not sure that's my

1 on-call premise consultation as necessary. And later it
2 said the agreement shall include all ASA cases performed
3 at the Endoscopy Center located at 700 Shadow Lane and
4 the other center located at 4275 Burnham Avenue. And
5 it's also agreed that the ASA4 cases will not be
6 performed at either facility.
7 Q. What are ASA4 cases?
8 A. Those are the more critically ill patients.
9 Q. Now that particular physician agreement
10 there, do you have any -- can you tell us about that, I
11 mean your personal knowledge of this, what you did, and
12 what you agreed or not agreed to the discussions you had
13 about that with Dr. Desai?
14 A. I agreed to be called by him on certain
15 days that he wanted my service and if I went responding
16 to his call to go supervise cases then I would bill for
17 all the cases that I supervised. For example, if I were
18 to watch over the shoulders of one or two nurse
19 anesthetist, at the end of the day I get to gather up
20 all the anesthesia record, all the patients' insurance
21 form and bring it back to my office and bill for all the
22 cases done.
23 Q. So typically when you would actually go out
24 to the facility just by yourself, I mean how many
25 patients would you do procedures on in a day?

1 A. At the Endoscopy Center I could do up to 20
2 cases a day.

3 Q. By yourself?

4 A. By myself.

5 Q. So if you were out there supervising a
6 couple of certified nurse anesthetists how many
7 procedures could you potentially bring back and bill
8 for?

9 A. I could probably bring back 40 to 50 cases
10 to bill.

11 Q. And a typical reimbursement for anesthesia
12 for a colonoscopy or upper endoscopy was roughly what?

13 A. Medicare pays the anesthesiologist
14 ultimately probably a hundred dollars.

15 Q. What about private insurance companies, are
16 they higher typically?

17 A. Yes, they're higher.

18 Q. So at least if you did the numbers that
19 you're talking about it would be a hundred dollars or
20 more times however many patients; correct?

21 A. Yes.

22 Q. That would be a significant amount of money
23 I believe doing that work?

24 A. Yes.

25 Q. That supervisory work.

1 A. Yes.

2 Q. Now, and I think you've testified before
3 but I just want to make sure I'm clear on this, if you
4 had actually implemented that and done that work would
5 that money have come to you or would it have gone to the
6 clinic or Dr. Desai?

7 A. It would have come to me unless we reach
8 other compensation agreement, but if I bill the
9 insurance company will send the money to my office.

10 Q. If Dr. Desai didn't use you or people from
11 his clinic didn't use you or any other anesthesiologist
12 and took on the role as being the physician who was
13 supervising as delineated in Exhibit 28 that you
14 mentioned, would he be able to then bill for those
15 services?

16 A. I imagine he could, but to my knowledge
17 many insurance companies require that the doctor
18 submitting the bill be a doctor on their panel.
19 Insurance companies have a limited panel. For example,
20 if they want to have cardiac surgeon providing service,
21 not every cardiac surgeon in town can bill. Only the
22 cardiac surgeons that insurance company have accepted
23 can bill for the service provided.

24 Q. Now during this whole process when you're
25 involved with sort of this agreement or the agreements

1 that you think you're initially involved with, did you
2 talk to Dr. Desai about whether or not you could
3 remotely supervise somebody or would agree to do that?

4 A. No. Supervision in anesthesia is different
5 from so-called supervision in other lines of business.
6 In anesthesiology supervision by a doctor has to be
7 immediate, on-site, in the same physical vicinity, while
8 in some other professions so-called supervision can be
9 done where, with the supervisor being away from the
10 person being supervised, but not so in anesthesia.

11 Q. This document though, and this is Grand
12 Jury Exhibit 27, seems to indicate though that there
13 would be some kind of remote or not on-site supervision;
14 is that right?

15 A. Yeah, it indicated that there would be
16 telephone consultation.

17 Q. Did you agree to do that with Dr. Desai?

18 A. I agreed to be called to answer questions
19 if they ran into a complicated situation, but that is
20 not supervision.

21 Q. So if I, just so I understand you
22 correctly, somebody may call you up and ask you
23 questions about what's going on, but you're not taking
24 responsibility for the actual anesthesia work being done
25 at the facility?

1 A. No, no. And it's not whether I would
2 choose to take responsibility or not. My understanding
3 is that by law I could not take responsibility because
4 the responsibility is born by the nurse anesthetist
5 himself and the operating physician in that room, nobody
6 else, even if that person wants to, can take
7 responsibility for that patient.

8 Q. Now did you inform Dr. Desai of this fact?

9 A. Yes.

10 Q. Before you entered into any potential
11 agreement with him?

12 A. Yes.

13 Q. Now did he ever pay you, and I'm talking
14 about ever, pay you a single penny or dime for doing any
15 kind of work or supervisory, or hold a supervisory
16 position at the clinic?

17 A. No, never paid.

18 Q. Did he ever call you for either
19 consultation or to come out and do supervision of any
20 CRNA?

21 A. Ever since he hired CRNAs he never called
22 me.

23 Q. And when you signed the letter of intent
24 that you're talking about -- well, you said this one
25 you're not sure you actually signed, 27; correct?

1 A. Correct.

2 Q. Let's move to the one above which is

3 actually dated 7/31/06 and you said does bear your

4 signature; correct?

5 A. Yes.

6 Q. The handwriting is on that document, first

7 of all the typed portion, what is the difference between

8 these two documents?

9 A. The 2006 document listed the names of the

10 nurse anesthetist.

11 Q. And it also bears some handwritten

12 information on there as well; correct?

13 A. Yes.

14 Q. What kind of handwritten information did

15 you add into that agreement there before you signed it?

16 A. I added that all supervisions by the MD

17 anesthesiologist has to be on-site, other than that I

18 will only agree to do chart review for quality assurance

19 purpose.

20 Q. So chart review means what?

21 A. It means if the endoscopy clinic has had

22 some negative incident involving the patient or

23 anesthesia and they want an outside opinion to help them

24 determine what caused the problem, they would submit a

25 chart for a doctor such as myself to review to find out

1 nurse anesthetist.

2 Q. Did you discuss it with him multiple times

3 after that period?

4 A. I believe it was more than once but the

5 purpose of the discussion was to emphasis my knowledge

6 of the law that the nurse anesthetist has to be

7 supervised by an MD anesthesiologist. Without such then

8 all responsibility would fall on the shoulders of the

9 surgeon or operating physician.

10 Q. Okay. Now I notice that your initials

11 apparently appear on both of those handwritten portions;

12 is that correct?

13 A. Yes.

14 Q. I don't see a corresponding by Dr. Desai or

15 anyone else.

16 A. Yeah, I guess he refused to agree to this

17 document.

18 Q. So when you, I mean how do you get this

19 document back to him after he sends it to you?

20 A. He sent it to my office, I reviewed it, I

21 put in the necessary addendum and then it was sent back

22 to his office.

23 Q. Did you ever hear from him again?

24 A. No.

25 Q. Did you ever get this back?

1 the cause of the problem.

2 Q. Now as far as the handwriting portion I see

3 off to the side of that there is a couple of lines and

4 it appears to have some initials on at least one of the

5 lines; is that correct?

6 A. Yes.

7 Q. And there is also a portion above where you

8 have added the words CRNA who are under the off-site

9 supervision and it's talking about, it's got initials

10 there as well; is that correct?

11 A. Yes.

12 Q. Now why did you add the words off-site on

13 that third paragraph?

14 A. Because the anesthesiology service that

15 they wanted me to perform, my understanding was I need

16 to be on-site, I need to be inside the facility for the

17 supervision to take place. If they, if I'm not on-site

18 in the facility my duty would be limited only to chart

19 review and for quality assurance purpose if they ever

20 submitted cases to me.

21 Q. Now as far as that's concerned, the

22 handwritten statement, I mean do you talk to Dr. Desai

23 about this?

24 A. Yes, that's something that I discussed with

25 him from the very beginning when he proposed to hire

1 A. No.

2 Q. Have you ever again get a penny of work or

3 a penny of money in response to doing anything on that

4 document?

5 A. No.

6 THE FOREPERSON: It's 10 'clock. At this

7 point the jury would like to take a 15 minute break.

8 MR. STAUDAHER: What I'd like to do is

9 to -- well, okay, we can do that, that's fine.

10 THE FOREPERSON: Okay. Thank you.

11 (Recess.)

12 THE FOREPERSON: Okay.

13 BY MR. STAUDAHER:

14 Q. Doctor, you're still under oath. We just

15 returned from our break. I think when we were -- I

16 can't remember what we'd actually talked about right

17 before the break.

18 But as far as the document that we have up

19 on the screen right now, the on-site off-site

20 supervision, I notice that in the, I believe it is the

21 third paragraph of that document, you have off-site

22 supervision of the various CRNAs that are listed;

23 correct?

24 A. Yes.

25 Q. That's something that you actually put in

1 there?

2 A. Yes.

3 Q. Now am I correct in what you said before,
4 just for clarification, that paragraph then refers in
5 some way to what you would do specifically for off-site
6 supervision which would be just review of the charts for
7 quality assurances purposes?

8 A. Yes, only for chart review. If there were
9 any incidents that they are concerned about they could
10 submit a chart to me for me to review to point out to
11 them whether there was any quality problems by the nurse
12 anesthetist.

13 Q. Now again were you ever called to do even
14 that particular task, review charts or incidents or
15 anything like that?

16 A. No, I was never called to review charts, I
17 was never called to go into their facility to supervise
18 CRNA, I never even met a CRNA, I have never even talked
19 to the CRNA at any time.

20 Q. Now have you heard of obviously the
21 differences between vials of propofol, the sizes of
22 those propofol containers?

23 A. Yes.

24 Q. And the next few questions I am going to
25 ask you I don't know if you will have specific knowledge

1 of but it is information that's been asked to be
2 provided to the Grand Jury.

3 As far as the different types of propofol,
4 are you aware of whether each one of the vials are multi
5 or single use vials?

6 A. My understanding is that propofol should be
7 single use.

8 Q. When you say single use, do you mean you
9 use it just one time out of the bottle or just one
10 bottle per patient?

11 A. One bottle per patient.

12 Q. In the bottles themselves are they marked
13 in some way with some delineation to that effect?

14 A. I think and I remember seeing that on these
15 bottles, it says single use only.

16 Q. Now as far as the different types of or
17 sizes of propofol bottles, what kinds are out there that
18 you know of?

19 A. I know of the 2000 bottles, I know of the
20 5000 bottles and I have seen 10000 bottles.

21 Q. Have you seen 1000 bottles as well?

22 A. I have not seen 1000 bottles.

23 Q. So if I understand you correctly you're at
24 least aware that in the distribution you could order or
25 get ahold of 100, 50 and 2000 bottles?

1 A. Yes.

2 Q. Have you used those different quantity
3 bottles in your practice?

4 A. Yes, I have.

5 Q. Have you used hundreds?

6 A. Yes.

7 Q. Have you used 50s?

8 A. Yes.

9 Q. And 20s I assume?

10 A. Yes.

11 Q. For colonoscopy procedures, if you were to
12 use either a hundred or a 5000 bottle, based on your
13 prior testimony that would seem to exceed the amount
14 which would normally be required for the procedure;
15 correct?

16 A. Yes.

17 Q. At the end of the procedure what would you
18 typically do with that additional propofol?

19 A. I would discard it.

20 Q. Would you ever use it on another patient?

21 A. No.

22 Q. Would you ever reuse a syringe on the same
23 patient, meaning that you drew up some propofol, you
24 injected a patient with it and then went back into that
25 same vial to draw up some additional propofol for the

1 same patient, would you do that?

2 A. Yes, same patient, same case, it is
3 perfectly acceptable to use the same syringe on the same
4 patient.

5 Q. Would you ever use the same syringe or a
6 syringe on a different patient after that?

7 A. No.

8 Q. Again the bottle itself once it has been
9 opened, whether you use all of it or not, would you ever
10 use additional propofol remaining on another patient?

11 A. No.

12 Q. Why would you not do that?

13 A. Because of the risk of contamination.

14 Q. When you say contamination what do you
15 mean?

16 A. Propofol is a solution that can harbor
17 bacteria growth so of course we would never put one
18 patient's body fluid into the bottle and then draw it
19 and give it to another patient. Not only that, once the
20 bottle has been opened it begins to become a location
21 where bacteria can grow so it has to be discarded right
22 after the case.

23 Q. So regardless of whether or not it's
24 contaminated by the patient itself, just bacteria
25 getting into it could cause trouble?

1 A. Yes.

2 Q. Do you know about the aseptic technique
3 used in ambulatory care centers regarding the use of
4 propofol or other types of agents like that?

5 A. Yes, there's a general standard care among
6 anesthesiologist.

7 Q. Can you explain what that is related to
8 what we just discussed?

9 A. With propofol, for every patient I would
10 open a new bottle and I would use a new syringe, new
11 needle to draw the propofol from the bottle to give to
12 the patient, at the end of the case I would throw away
13 the bottle, the needle and the syringe.

14 Q. Is that the standard of care?

15 A. I think that's the standard care.

16 Q. Again have you ever seen another
17 anesthesiologist or the few CRNAs that you supervised
18 ever deviate from that practice?

19 A. No.

20 Q. Do you typically watch other doctors do
21 their procedures?

22 A. No.

23 Q. Have you had occasion to do so however?

24 A. Many years ago when I was in training I
25 would see other doctors do anesthesia and I would

1 Q. Did you ever tell Dr. Desai that if he
2 didn't use you for example, or somebody like yourself,
3 that he or whoever the doctor was doing the procedure
4 would be responsible for the anesthesia if there was no
5 MD there?

6 A. Yes.

7 Q. And when I say MD, I'm talking about MD
8 anesthesiologist.

9 A. Yes.

10 Q. I know you said that you would not yourself
11 reuse propofol or syringes or the like on successive
12 patients, but in your role as an anesthesiologist or
13 even a supervise, potentially supervising
14 anesthesiologists for CRNAs, if a physician that you
15 were working with -- and you work in a referral type
16 position; correct?

17 A. Yes.

18 Q. -- knowing that if you make the referring
19 physician unhappy that he may not or she may not ever
20 ask you to do work for him or her again?

21 A. Yes.

22 Q. So knowing that, in the position you're in
23 as a physician or supervisor, would you ever, if the
24 doctor said to you hey, look, I want you to save that
25 propofol and reuse it on the next patient because it's

1 observe their work.

2 Q. If you saw another doctor or CRNA or
3 another person who would use a syringe or medication
4 like propofol in an inappropriate way would that give
5 you concern?

6 A. Yes.

7 Q. And when I say inappropriate way I'm
8 talking about reusing the syringe on multiple patients
9 or reusing the propofol on multiple patients.

10 A. Yes, it would give me concern.

11 Q. Is that because of the contamination
12 potential that you discussed earlier?

13 A. Yes.

14 Q. Now by not hiring you, as these agreements
15 that we talked about, which means that they didn't
16 actually ever call you to do any of this stuff, right?

17 A. No, these letters of intent were never
18 carried out. I was never paid, never called and I never
19 went in.

20 Q. And as far as those letters of intent that
21 you say were never carried out, did you assume any
22 supervisory role at any time regardless of whether or
23 not you had a signed agreement?

24 A. No, I've never met, spoken with or worked
25 with the CRNAs hired by Dr. Desai.

1 expensive and I don't want to waste it, would you ever
2 do that?

3 A. No.

4 Q. Why not?

5 A. Because it would put the patient in danger.

6 Q. Would you ever, same question except for
7 syringes at this time, would you ever, even if the
8 doctor that you were working with said look, I want to
9 save money, or for whatever reason, I want you to reuse
10 the syringes or needles or whatever on the next patient?

11 A. No, I would not do that.

12 Q. Do you think that would be at any time an
13 appropriate procedural way of dealing with either
14 propofol or syringes?

15 A. No, it's not appropriate.

16 Q. The one last question I think I have for
17 you before I turn it over to the Grand Jury is can you
18 tell us what the difference between supervising
19 anesthesia for CRNAs versus supervising in other
20 situations might be, is there a difference?

21 A. Yes.

22 Q. What is that difference and why?

23 A. Different terms mean different things in
24 different walks of life. In anesthesia supervising
25 means that the more senior doctor supervising the junior

1 doctor or MD anesthesiologist supervising the nurse
 2 anesthetist, they have to be at the same place at the
 3 same time. In other words, if a professor was
 4 supervising junior anesthesiologist, that professor has
 5 to be in the operating suite, perhaps walking among a
 6 number of rooms looking over the shoulders of the junior
 7 doctors. The same thing happens between the MD
 8 anesthesiologist and the nurse anesthetist. The MD
 9 anesthesiologist has to be in the operating suite
 10 walking among patients, walking say between two rooms
 11 staffed by two CRNAs and making himself immediately
 12 available to troubleshoot, to answer questions by the
 13 patient or by the nurse anesthetist. I believe this is
 14 the standard care in the country. And I also believe
 15 this is the law. Outside anesthesia, when we say
 16 supervising, for example you can have a lawyer being
 17 supervised by a senior member of the law firm, the
 18 senior member of, the senior partner does not have to
 19 sit in the office all day looking over the shoulder of
 20 the junior lawyer, the junior lawyer would do his work
 21 and maybe once every few works the senior lawyer would
 22 look over the accumulated work by the junior lawyer and
 23 that process can be called supervision. But that's
 24 absolutely not the case in anesthesia. There is no
 25 supervision unless the senior anesthesiologist or the MD

1 anesthesiologist is in the same room. The law backs
 2 that up because the Medicare will actually refuse to pay
 3 if the supervising anesthesiologist's name does not
 4 appear on the billing record.

5 Q. And one last question, I'm sorry, I said
 6 there was going to be only one but sometimes I have one
 7 additional one. In a situation where you have -- you
 8 understand what a capitated payment arrangement is with
 9 insurance companies; correct?

10 A. Yes.

11 Q. And just for the Grand Jury, just explain
 12 that if you could in general.

13 A. I've never been involved in such
 14 arrangement myself, but just as a piece of common
 15 information capitation is when an insurance company
 16 enters the contract with the group or a single physician
 17 and they, the insurance company will pay a set amount of
 18 money to that doctor or doctor's group every month
 19 regardless of how much work is done by that doctor or by
 20 the doctor's group.

21 Q. So in a situation where let's say the
 22 Endoscopy Center hypothetically had a capitated
 23 arrangement with an insurance company for colonoscopies,
 24 they would be paid in that particular situation a flat
 25 fee for doing a procedure on the patient; correct?

1 A. That's my general understanding of what
 2 capitation does.

3 Q. In a situation like that, if you were to go
 4 to the Endoscopy Center, or any other place for that
 5 matter, and the doctor that you're going to work with
 6 had a capitated arrangement with the insurance company,
 7 would that mean that you could not then bill the
 8 insurance company for your anesthesia services?

9 A. I've never been in that situation so I
 10 really don't know.

11 Q. Would you ever, I mean do you always bill
 12 for your anesthesia services regardless whether or not
 13 there is some arrangement with the doctor that referred
 14 you or was your referral source?

15 A. When I did the temporary work in California
 16 the company that hired me to go do temporary work paid
 17 me per day reimbursement, they paid me by the day, so I
 18 turned over the anesthesia record to them and they would
 19 do the billing and collection and get paid by the
 20 insurance company.

21 MR. STAUDAHER: I have nothing further for
 22 this witness.

23 THE FOREPERSON: Okay. Let's start with
 24 you.
 25

1 BY A JUROR:

2 Q. Doctor, so my understanding is that if the
 3 operating physician has accepted that responsibility by
 4 not having been an MD anesthesiologist on-site ready to
 5 go, ready to supervise, he then becomes, you know, he's
 6 then responsible for the anesthesia going on in his
 7 particular, at his particular procedure. Does that also
 8 mean to your knowledge that he needs to know or is also
 9 responsible for what is going on in the anesthesia
 10 record?

11 A. He is the captain of the ship. When he's
 12 the only MD in the room my understanding is he is
 13 responsible for everything that takes place in that
 14 room.

15 Q. Okay.

16 THE FOREPERSON: Yes.

17 BY A JUROR:

18 Q. While you were in college and training was
 19 the procedures for the propofol handling using part of
 20 the training and education would you say?

21 A. During my residency, yes, we were taught
 22 that certain medications have certain potential of being
 23 contaminated and they have to be treated differently.
 24 And propofol was one such medication.

25 THE FOREPERSON: Are there any further

1 questions? Yes.
 2 BY A JUROR:
 3 Q. Doctor, using propofol, it comes in 200Cs,
 4 500Cs and 1000Cs. What is the maximum amount allowed to
 5 give to one patient?
 6 A. It's actually, there is no limit. For
 7 example, in the intensive care unit when we induce
 8 intentional sedation or coma in a patient they could
 9 receive propofol for days.
 10 Q. Thank you.
 11 THE FOREPERSON: Yes.
 12 BY A JUROR:
 13 Q. Dr. Yee, in all your years of experience
 14 have you ever seen any patient go into convulsions from
 15 too much anesthesia?
 16 A. No.
 17 Q. Never?
 18 A. Never.
 19 Q. Thank you.
 20 BY THE FOREPERSON:
 21 Q. Is there a limit on the amount of propofol
 22 that can be given to a comatose patient to keep them in
 23 the coma?
 24 A. If propofol is given in excessive amount it
 25 will suppress, reduce the blood pressure and can reduce

1 the heart rate so you could have, you could put a
 2 patient into that situation if you gave too much.
 3 THE FOREPERSON: Okay. Thank you.
 4 Yes.
 5 BY A JUROR:
 6 Q. Dr. Yee, to your knowledge was your name
 7 submitted as the supervising MD anesthesiologist on the
 8 CRNA records at the Endoscopy Center?
 9 A. To my knowledge, no.
 10 Q. Thank you.
 11 THE FOREPERSON: Are there any further
 12 questions?
 13 MR. STAUDAHER: I'll follow-up to that.
 14 THE FOREPERSON: Okay.
 15 BY MR. STAUDAHER:
 16 Q. If that had been done was that under your
 17 approval?
 18 A. No.
 19 Q. Okay. Would you have approved that to be
 20 done without you being present on-site to supervise?
 21 A. No. On the anesthesia record the space
 22 where we put in the anesthesiologist name, those people
 23 have to be physically present in order to have their
 24 names put down. And to put down someone that's not
 25 there I believe is illegal.

1 THE FOREPERSON: Any further questions?
 2 None.
 3 By law, these proceedings are secret and
 4 you are prohibited from disclosing to anyone anything
 5 that has transpired before us, including evidence and
 6 statements presented to the Grand Jury, any event
 7 occurring or statement made in the presence of the Grand
 8 Jury, and information obtained by the Grand Jury.
 9 Failure to comply with this admonition is a
 10 gross misdemeanor punishable by a year in the Clark
 11 County Detention Center and a \$2,000 fine. In addition,
 12 you may be held in contempt of court punishable by an
 13 additional \$500 fine and 25 days in the Clark County
 14 Detention Center.
 15 Do you understand this admonition?
 16 THE WITNESS: Yes.
 17 THE FOREPERSON: Thank you. You may be
 18 excused now.
 19 Please raise your right hand, sir. Thank
 20 you.
 21 You do solemnly swear the testimony you are
 22 about to give upon the investigation now pending before
 23 this Grand Jury shall be the truth, the whole truth, and
 24 nothing but the truth, so help you God?
 25 THE WITNESS: I do.

1 THE FOREPERSON: Thank you. You may be
 2 seated.
 3 You are advised that you are here today to
 4 give testimony in the investigation pertaining to the
 5 offenses of performance of act in reckless disregard of
 6 persons or property, criminal neglect of patients,
 7 insurance fraud, obtaining money under false pretenses,
 8 and racketeering, involving Dipak Kantilal Desai, Ronald
 9 Ernest Lakeman and Keith H. Mathahs.
 10 Do you understand this advisement?
 11 THE WITNESS: Could you repeat what you
 12 said please? And if you could speak a little louder
 13 please.
 14 THE FOREPERSON: Okay.
 15 You are advised that you are here today to
 16 give testimony in the investigation pertaining to the
 17 offenses of performance of act in reckless disregard of
 18 persons or property, criminal neglect of patients,
 19 insurance fraud, obtaining money under false pretenses,
 20 and racketeering, involving Dipak Kantilal Desai, Ronald
 21 Ernest Lakeman and Keith H. Mathahs.
 22 Do you understand this advisement?
 23 THE WITNESS: Okay. I do. But some of the
 24 meaning of some of the words you used I do not know so I
 25 don't know what to say.

1 THE FOREPERSON: I'm sure our deputy D.A.
2 will explain them.

3 MR. STAUDAHER: I'll try to make it a
4 little easier.

5 THE FOREPERSON: Could you please state
6 your first and last name.

7 THE WITNESS: My first name is Satish,
8 S-A-T-I-S-H, last name Sharma, S-H-A-R-M-A.

9 THE FOREPERSON: Thank you.

10 SATISH SHARMA,
11 having been first duly sworn by the Foreperson of the
12 Grand Jury to testify to the truth, the whole truth,
13 and nothing but the truth, testified as follows:

14
15 EXAMINATION

16
17 BY MR. STAUDAHER:

18 Q. Dr. Sharma, before I get into your
19 background or whatever, I want to clear up that issue.
20 What the foreman of the Grand Jury was saying is she
21 read off the charges that are facing the individuals
22 that are being charged in this particular case and that
23 you're here to give testimony in that case. Do you
24 understand that?

25 A. Yeah, I understand that.

1 Q. And she's asking you to be truthful and all
2 that.

3 A. Yes.

4 Q. So you don't have to necessarily understand
5 the charges but just that you're here to give testimony
6 in the Grand Jury proceeding related to those.

7 A. Okay.

8 Q. And those individuals.

9 A. Got it. Thanks.

10 Q. Now Doctor, what do you do for a living?

11 A. I am an anesthesiologist and a pain
12 specialist so I practice pain management at the present
13 time.

14 Q. And to get to where you are today where did
15 you go to school and where did you do your residency,
16 things like that?

17 A. I went to medical school in India, it was
18 1981, finished my medical schooling in '86. I did my
19 anesthesia residency there for three years and practiced
20 there for two years before I immigrated here in December
21 of '92. After moving to this country I started, I
22 passed my exam, required exams, and started my
23 internship in internal medicine in '94 to '95 and then I
24 did my anesthesia residency from '95 to '98 followed by
25 one year of fellowship in pain medicine.

1 Q. Where did you actually get those different
2 fellowships and so forth, where were they?

3 A. It was in Pittsburgh I did my internal med,
4 internship and anesthesia residency at the West Penn
5 Hospital or Western Pennsylvania Hospital in Pittsburgh,
6 and fellowship was also in Pittsburgh at the Allegheny
7 General Hospital.

8 Q. Now after you came out here to Las Vegas,
9 and you said you came out in April of '06?

10 A. That is correct, sir.

11 Q. When you were out here did you come out for
12 a job or did you come out looking for a job?

13 A. When I came here I started my pain
14 management practice right away. And initially the way
15 it works, pain management practice I started from one
16 patient so obviously it takes time to grow your
17 practice, and then on the side I was also practicing
18 anesthesia.

19 Q. Now did you ever meet an individual by the
20 name of Dipak Desai?

21 A. Yes, sir, I did.

22 Q. And how did you meet him and under what
23 circumstances?

24 A. It was, it was I would guess end of
25 October, we have this --

1 Q. Of what year?

2 A. Of '06. We have, he used to throw like
3 party like you guys have your Christmas party, our kind
4 of Christmas comes in either October, end of October or
5 beginning of November, there is no fixed date like you
6 have Christmas for 25th. So before that he used to
7 throw a party and that party I was invited by one of his
8 partner, his last name is also Sharma, Vishvinder
9 Sharma. That's how I got to basically meet him.

10 Q. You meet him, it was a social setting; is
11 that correct?

12 A. That's correct, it was a huge gathering,
13 hundreds of people.

14 Q. Did you ever deal with him professionally?
15 Did you ever provide services to him or his patients at
16 any time?

17 A. No, never to his patient or to him
18 personally, but I did work with his partner Dr.
19 Vishvinder Sharma and few more, but most of the time it
20 was that Vishvinder Sharma, I was providing anesthesia
21 at the Spring Valley Hospital.

22 Q. So just hospitals or did you ever go to the
23 clinics as well?

24 A. Never, just at the hospitals.

25 Q. And just to Vishvinder Sharma?

1 A. No. As I said most of the time it was
2 Vishvinder Sharma. Very occasionally I will go to
3 Southern Hills Hospital, there was another doctor, Dr.
4 Weiss, and the same way rarely to Mountain View
5 Hospital, there was one doctor, Faris, and sometimes it
6 could be Summerlin Hospital, and I think one or two
7 cases at the Valley Hospital. But it was all the
8 hospitals.

9 Q. Okay. Now did you ever work at that time
10 or prior to coming to Las Vegas with certified nurse
11 anesthetists?

12 A. Could you repeat your question please?

13 Q. Before coming to Las Vegas have you ever
14 worked with CRNAs, certified registered nurse
15 anesthetists?

16 A. Indeed for almost eight years. For most of
17 the time it was in Pittsburgh. I finished my pain
18 fellowship in '99 and then for about, I don't know,
19 eight to ten months maybe I got, I took my first job in
20 Richmond, Virginia, then I moved back to the same
21 program where I did my fellow, pain fellowship, and then
22 from that point on I was there in that particular
23 hospital, that's where I supervised CRNAs or residents
24 or fellows.

25 Q. So when you supervised them was it a thing

1 where you actively, I mean supervised one or two or more
2 than that, or how many did you do at a time?

3 A. It could be, it depends, like it could be
4 either two of the CRNAs usually on an average, I use to
5 supervise as part of the group policy two rooms. Now it
6 could be two CRNAs or it could be one anesthesia
7 resident and one CRNA, so on an average, or occasionally
8 it could be three rooms.

9 Q. When you were supervising them were you
10 ever in a situation where you would do that supervisory
11 work from another building or another town or anything
12 like that? I mean were you --

13 A. Never.

14 Q. Where were you specifically? I mean how
15 close to the rooms where the CRNAs were working did you
16 have to be typically?

17 A. We were accessible like most of the time,
18 again nothing is hundred percent, most of the time it
19 could be like there was this medical staff office where
20 most of the doctors are sitting and the O.R. could be
21 like from here to outside.

22 Q. So from here to outside this entire
23 building?

24 A. No, not the building, maybe like couple of
25 rooms from here.

1 Q. Thirty, 40 feet away, something like that?

2 A. Thirty, 40, or you can call it maybe even,
3 yeah, 50 feet depending on, because it was a huge
4 hospital.

5 Q. Same floor, same general area though?

6 A. Most of the time.

7 Q. Would there be times when you would be
8 further away, like for example in a different part of
9 the hospital supervising somebody?

10 A. No, it could be a different floor because
11 there were, most of the operating rooms were on one
12 floor, then if somebody having some special procedure,
13 there's one case, you could go there, it could be,
14 sometimes it could be different floors but it was the
15 same building.

16 Q. So when a CRNA that you were supervising
17 would start a procedure were you typically there for the
18 beginning of it or nearby or how did that work?

19 A. When a patient goes to sleep we were there,
20 when patient goes to sleep and when patient wakes up.
21 And in between we could randomly go in there or if
22 there's a problem the CRNA could call us.

23 Q. Did you have to be readily available to
24 come if there was an emergency or some problem with an
25 airway or something like that?

1 A. Yes, sir. Always.

2 Q. Have you ever been in a situation where you
3 would let's say decide to go to lunch and just be
4 available down the street at Applebee's or something?

5 A. No. In case we are going to go somewhere
6 else for either the coverage of some other room on a
7 different floor or we are going to cafeteria let's say
8 because that's again two floor down, you always tell
9 your partner hey, keep an eye on my rooms, I'm going to
10 grab lunch.

11 Q. Another anesthesiologist?

12 A. Yes.

13 Q. So either you or somebody that you tell to
14 supervise the CRNAs that you're working with; is that
15 correct?

16 A. That is correct.

17 Q. Okay. Now that was back in another city
18 before you came to Las Vegas?

19 A. That is correct.

20 Q. Was that pretty much the way the
21 supervision went in your experience over that eight year
22 period?

23 A. Yes, always like that.

24 Q. When you got out here to Las Vegas did you
25 work with CRNAs?

1 A. No, never.
 2 Q. You've never worked with CRNAs out here?
 3 A. No, never.
 4 Q. Now when you met Dr. Desai, you said you
 5 worked with some of the people who were in his practice
 6 in some of the hospitals; correct?
 7 A. Yes.
 8 Q. Did you ever work with Dr. Desai
 9 professionally from a medical type standpoint?
 10 A. I did not.
 11 Q. Did you ever talk to him or contemplate
 12 entering into a relationship with him to supervise CRNAs
 13 working with him?
 14 A. I never did.
 15 Q. Do you recall ever signing any paperwork or
 16 supervising sort of agreement, anything like that
 17 related to him?
 18 A. I remember that.
 19 Q. And how did that come about?
 20 A. What happened was after that first meeting
 21 in the party I came here to just practice pain only,
 22 because in Pittsburgh I was practicing both, kind of
 23 50/50 anesthesia and pain, and I relocated here with the
 24 mindset that I would practice pain only. But as I said
 25 earlier, pain practice takes time to grow before you

1 compensate you for your lost revenue for your pain
 2 procedures.
 3 Q. So he wanted you to come into the facility
 4 and that was how he was going to do it?
 5 A. Yes.
 6 Q. So he was going to have you come in as
 7 medical director so to speak?
 8 A. Right, that was his way of compensating me
 9 for my losses, financial losses, if I do my pain
 10 procedures there at the surgery center.
 11 Q. Did you ever go into the center and do your
 12 pain procedures there?
 13 A. No, it never started.
 14 Q. It never started?
 15 A. No.
 16 Q. You said it was being built though?
 17 A. It was being built but it was, first of all
 18 there was delay in construction as you know we see all
 19 the time and then also they did not have this Medicare
 20 certification. To best of my, I'm giving you best of my
 21 knowledge of what I know. They might know the details,
 22 they can tell you better about that. But that surgery
 23 center never started to my knowledge and we did not do
 24 any procedures, I did not do any pain procedures there.
 25 Q. So if I understand you correctly you were

1 have certain number of patients where you find yourself
 2 comfortable to quit anesthesia. So when I met Dr. Desai
 3 he brought up this issue of doing pain procedures in
 4 this new surgery center he was building across, almost
 5 across the Spring Valley Hospital. Back then the name
 6 was Spanish Hills Surgery Center. It was under
 7 construction. And he said can you do your pain
 8 procedures in my, at this new surgery center, we are
 9 building a new surgery center. So after, you know,
 10 going back and forth I gave him my reasoning what is my
 11 loss because there are a lot of insurances, they
 12 encourage you to do pain procedures because these are
 13 kind of outpatient procedures, we can do it in the
 14 office like I'm doing right now, so a lot of insurance,
 15 including Medicare, they encourage you to do as much in
 16 the office as you can and they pay you almost three
 17 times as what I would get paid in the surgery center or
 18 the hospital. So I gave him this reasoning that, you
 19 know, I will be a loser if I do them at the surgery
 20 center. So anyway --
 21 Q. You said you would be a loser. I assume
 22 you would lose money?
 23 A. Financially, yeah. So then he came up with
 24 this idea that I'll make you medical director of the
 25 surgery center and I will also give you the ownership to

1 just going to do your pain procedures, no anesthesia
 2 procedures; is that right?
 3 A. That is correct.
 4 Q. And you were going to be the medical
 5 director but it never actually happened?
 6 A. Yes, because we never came up, first of all
 7 it was not ready so there was no rush to really do the
 8 paperwork, secondly we never agreed upon the numbers
 9 like what would be my salary as a medical director or
 10 what would be my ownership, so we were going back and
 11 forth, so we were still in the middle of negotiations
 12 before this story kind of appeared in the newspaper.
 13 Q. So after this endoscopy issue came up did
 14 that kind of fizzle away and not happen then?
 15 A. It never happened, yeah.
 16 Q. I'm showing you what's been marked as Grand
 17 Jury Exhibit Number 25 and I'm going to have you look at
 18 that and tell me if it looks familiar to you.
 19 A. Yes, it is familiar, I remember this.
 20 Q. What is this?
 21 A. The is, obviously this is a supervising
 22 physician agreement. And it was brought to my office by
 23 one of Dr. Desai's girls.
 24 Q. When you say girls are you talking about
 25 office people?

1 A. Office people. I was in the middle of my
2 patients, seeing patients, and she came over, before
3 that actually he did tell me that, you know, I, see for
4 me to do the pain procedure at any facility, including
5 this, what he was building, the new surgery center, I
6 needed an X-ray machine, what we call a C-Arm, that
7 costs almost \$150,000. His argument was that well, I'm
8 not comfortable until you kind of give me something in
9 writing that you will bring your pain business to the
10 surgery center. And that's when he just -- I said okay,
11 that's reasonable, I'm compensated, I will do my pain
12 procedures here, buy the C-Arm and that way whenever the
13 office is ready or the surgery center is ready with
14 certification and all that I will bring my pain patients
15 there. So that's when I basically, all this started,
16 this paperwork. Again we were in the middle of the
17 negotiations, nothing was finalized, but this agreement,
18 his employee brought it over, I just signed it and that
19 was it.

20 Q. Did you really look at it?

21 A. No, I did not, unfortunately.

22 Q. Because before I ask you additional
23 questions about this, were you ever asked by Dr. Desai
24 to supervise CRNAs at the Endoscopy Center of Southern
25 Nevada on Shadow Lane?

1 A. Never, not at all.

2 Q. Now on this I think you'll agree that it
3 does say that you in conjunction with Dr. Desai and
4 Vishvinder Shama of the Gastroenterology Center of
5 Southern Nevada agree to co-supervise and consult with
6 CRNAs employed at the Gastroenterology Center of Nevada,
7 supervision and consultation services will be provided
8 regarding the anesthesia services provided by the
9 Gastroenterology Center of Nevada employees, and it says
10 here that it is agrees (sic) that MD, Satish MD will be
11 available for phone consultations in addition to on-call
12 premises consultations if necessary.

13 Do you see that?

14 A. Yes, I do.

15 Q. So all of this is related to the fact that
16 there is at least an apparent agreement to do some
17 supervisory work for the CRNAs; is that correct?

18 A. Not at all, that is incorrect.

19 Q. Then go ahead and explain.

20 A. It was -- first of all he never talked
21 about supervising anybody and we never discussed
22 anesthesia aspect ever. His only interest from me was
23 that I should bring my pain business to the surgery
24 center so he can bill for the -- when we do, when you
25 have a surgery performed there are two major components.

1 A. No, never.

2 Q. Did you ever go to that facility, even set
3 foot in the facility?

4 A. I, I don't know how you will say go, I did
5 go there to meet him a couple of times, but I did not
6 enter in the working area where they see the patients or
7 where they do their endoscopy, it was to his office and
8 there was I guess one more office, it was upstairs
9 somewhere.

10 Q. Again did he ever ask you to supervise
11 CRNAs at any time?

12 A. He never did.

13 Q. Did you supervise any CRNAs at any time?

14 A. No, never.

15 Q. Did he ever pay you to do any supervisory
16 work for anybody?

17 A. Not at all.

18 Q. Including CRNAs.

19 A. Not at all.

20 Q. As part of this thing that you signed here
21 that says supervising physician agreement, did he ever
22 pay you anything related to this?

23 A. Not at all.

24 Q. Have you ever received a dime of
25 compensation from him for any purpose?

1 One is the professional component that a doctor bills,
2 the other is the facility charges. So when you bill as
3 a doctor, I will bill for the professional, and whoever
4 owns the facility will bill for the facility charges.
5 So his only interest was to bring my pain patients there
6 so obviously he'll bill for the facility. We never
7 talked about anesthesia ever, whether it was supervising
8 or whether even I providing anesthesia to any of his
9 patients. He did offer directorship and as I said --
10 first of all it had nothing to do with any of his other
11 endoscopy centers or the surgery center, I do not know
12 what you call them, we always talked about this Spanish
13 Hills Surgery Center and that's where it always started
14 and that's where it ended.

15 Q. So you signed this agreement that's sent
16 over because you think he needs something in writing
17 before the C-Arm is bought for the facility that you're
18 going to do pain at?

19 A. That is correct. And actually I was
20 interviewed by one detective and when he interviewed
21 me -- first of all unfortunately I did not make a copy
22 of this letter or agreement so I hope when detective
23 called me I thought he might have the copy, he did not
24 have either, and during that interview I did tell him
25 that this particular letter agreement should contain

1 something about, okay, being medical director and this
2 would be your, he just gave me like not definite numbers
3 but anywhere from five to \$10,000 per month being the
4 medical director of Spanish Hills Surgery Center.

5 Q. When you're talking about he, are you
6 talking about Dr. Desai?

7 A. Only Dr. Desai, I never talked to anybody
8 else. So I told that's what it should contain, that
9 letter. I did not make a copy. So when he interviewed
10 me it was already after almost a year and a half after
11 this incident.

12 Q. When you say he now you're talking about
13 the detective?

14 A. The detective, yeah. So I forgot more like
15 exactly what -- I did not read it and then but I thought
16 it should contain what we talk, like me and Dr. Desai,
17 about Spanish Hills Surgery Center, being the medical
18 director of the Spanish Hills Surgery Center, and
19 ownership and pain, that's it.

20 Q. If Dr. Desai had said to you that I'm going
21 to send over an agreement that I want you to sign so
22 that you can be a supervisor for the CRNAs doing
23 anesthesia at any location, if you had realized that
24 would you have signed the agreement?

25 A. No, never.

1 Q. Did you realize at any time that he wanted
2 you to supervise any CRNAs at any time, he being Dr.
3 Desai?

4 A. I'm sorry, repeat your question please.

5 Q. Bad question. Did you know at any time
6 whether Dr. Desai wanted you to supervise CRNAs at any
7 location?

8 A. He never expressed it. I do not know what
9 was he thinking, but we never even talked about
10 anesthesia so if he was thinking I would supervise I do
11 not know, but we never talked about it.

12 Q. Okay. I'm going to move on to a little bit
13 of a different area then. One of the reasons I provide
14 this to the Grand Jury and I asked you the questions
15 about it is because the State is under an affirmative
16 obligation if we know anything that tends to show, point
17 away from somebody's guilt or whatever we have to
18 provide that information as well. So that's the purpose
19 of this being offered at this point and to allow you to
20 explain it. But I want to ask you some specifics about
21 your own personal use of anesthesia, in anesthesia
22 regarding equipment and supplies and things like that.
23 Okay?

24 A. Okay.

25 Q. Have you ever reused syringes between

1 patients?

2 A. Never.

3 Q. Would you ever do that?

4 A. No.

5 Q. If a doctor that you worked with, a
6 referring doctor that you worked with told you he wanted
7 you, he or she wanted you to do that, would you do that?

8 A. No.

9 Q. Why not?

10 A. Because it's not standard of care. Even --
11 I don't know, it's beyond my imagination using a dirty
12 syringe on somebody else.

13 Q. What about propofol, the drug propofol, are
14 you familiar with that drug?

15 A. Yes, I am.

16 Q. Have you used it many times?

17 A. Thousands, hundreds and thousands of times.

18 Q. So over your career lots and lots of time?

19 A. Yes, sir.

20 Q. Single use or multi-use vials?

21 A. Single use.

22 Q. All of them?

23 A. Yes.

24 Q. What is the reason for that do you know?

25 A. It was availability in the operating room.

1 Usually they have those small vials and you use what is
2 there in the operating room.

3 Q. Ever any issue of contamination of vials
4 that you're concerned about?

5 A. No.

6 Q. Why not?

7 A. Because to begin with the whole vial is
8 gone on one particular patient and secondly sometimes,
9 you know, some patients need more, you may have to use
10 two vials.

11 Q. What about in a situation where you had a
12 big vial that you didn't use all of the propofol, what
13 would you do with the rest of it?

14 A. Either you throw it or -- there are two
15 ways. This question was asked earlier also. If you
16 have a big vial you can, if you're drawing syringes
17 again it has nothing to do with this particular case,
18 it's common sense thing, you can draw like, let's say
19 you have, what, 500CC vial, you can draw them in like two
20 or three different syringes, and now all those syringes
21 are clean, I can use one on you, I can use one on
22 myself, because those, so it is not the size of vial, it
23 is the aseptic technique that is important.

24 Q. Let's talk about aseptic technique for a
25 moment. Is it standard of care or proper technique to

1 use a single syringe, use it, draw up out of the bottle
2 of propofol, to use then that propofol to administer
3 anesthesia to a patient and if you need more to go back
4 into that bottle and use it on the same patient; can you
5 do that?

6 A. Same patient you can use.

7 Q. Okay. Now same scenario except for at the
8 end of the procedure the patient is wheeled away, you've
9 gone into the bottle, this one bottle twice or three
10 times and there is remaining propofol in the bottle, can
11 you then take that bottle and use it on the next
12 patient?

13 A. No, I would not.

14 Q. Why is that?

15 A. Because there is no, because of the blood,
16 possibility of, I already went back in there in that
17 vial with a, because I used the syringe, I needed more
18 propofol, so with that particular syringe which I have
19 already used on a patient I went back to that vial.

20 Q. Let's say that you even changed the needle
21 in between but you used the same syringe.

22 A. Does not matter, syringe and needle, they
23 go together.

24 Q. Okay.

25 A. So either it has to be a completely new

1 needle and a new syringe if you're accessing a clean
2 vial. You cannot go back with a dirty needle or dirty
3 syringe and then use it back and forth. Then you have
4 to throw it.

5 Q. What if you were told to do that or it was
6 policy to do that; would you follow it?

7 A. No, I would not.

8 Q. Is that because of this contamination
9 concern?

10 A. Yeah. And also every physician does what
11 they are, how they are trained and what they believe in.
12 And that's beyond my imagination, I cannot do it, that's
13 not how, I have trained a lot of resident doctors and
14 fellows, we go by the books.

15 MR. STAUDAHER: I have nothing further for
16 this witness, ladies and gentlemen.

17 THE FOREPERSON: Are there any questions
18 from the jury? Yes.

19 BY A JUROR:

20 Q. Were you friends with Dr. Desai?

21 A. No, I was not friends, but I used to see
22 him in get-togethers.

23 Q. Okay.

24 A. Not very often, but once a year, twice a
25 year, something like that.

1 Q. Were you intimidated or in awe of him?

2 A. No.

3 Q. As a professional?

4 A. No. I was new. Back then I didn't even
5 know that he was that powerful or big so I was not
6 intimidated. I was not new out of medical school
7 either, I practiced in Pittsburgh for eight years before
8 I relocated here.

9 Q. That brings me to my next question. You
10 obviously are a very intelligent person. Why would you
11 sign a contract or a form without reading it completely
12 especially if it's a one page letter, contract?

13 A. Because, because my understanding was that
14 is not a contract because we were still in the middle of
15 negotiations. Contract, I'm not an attorney and I do
16 not know anything about the legal aspects of it, of any
17 paper actually, but when you get contract, because I do
18 sign contracts with insurance companies, with a lot of
19 hospitals, you know, it's always, it's never like just
20 few lines, it will define your role, it will define your
21 responsibility, it will define how much you will be
22 paid, it will define what are the terms of contract,
23 like at what point we will terminate our relationship.
24 So it was not a contract. And when -- because I don't
25 sign contract without showing it to my attorney. I

1 didn't even care to take it to the attorney because I
2 said yeah, we are in the middle of negotiations, all we
3 needed just to move the process forward, because first
4 you have to decide about the C-Arm, then you have to
5 order it, it will come back whatever months it takes, so
6 just to move the process forward I said okay, here you
7 go, I signed it and I said, we were like okay, we'll
8 talk, get to the numbers, final numbers later, but at
9 least let's start the process. And moreover I thought,
10 you know, it should have what we walked about. So it
11 was basically signed in good faith. I wish I read it
12 and I did not unfortunately.

13 THE FOREPERSON: Okay. Bianca.

14 BY A JUROR:

15 Q. I had actually the same follow-up as the
16 previous Grand Juror. I understand you're saying that
17 you signed it in good faith and you didn't consider it a
18 contract. You never even read it and you just signed
19 it?

20 A. Yes.

21 Q. In good faith?

22 A. Yes, ma'am.

23 Q. Would you do that again?

24 A. No, obviously not now. It's too late, but
25 I would not do that now.

1 Q. Prior to doing that with him had you done
2 that in the past?

3 A. No. That was a different story all
4 together because here I started my new business
5 together, I had no clue about the business or the
6 legality of any paperwork. In Pittsburgh where I moved
7 from it was a huge group, we were like almost 30 MDs and
8 75 nurse anesthetists or CRNAs and then maybe 20
9 resident doctors and some fellows, so it was a huge
10 group and those groups have everything, you know, they
11 take care of everything, they have their legal
12 department, they have their everything, so they come to
13 you with a flag, sign here and you sign, because you
14 know there is somebody who will take care of it. Here I
15 started out of no where, new, didn't know anything about
16 business and that's how I kind of got stuck in it.

17 THE FOREPERSON: Steve.

18 BY A JUROR:

19 Q. Do you know of anybody, or you say of the
20 medicine, of the propofol, have you ever seen anybody
21 use propofol on two different people, one bottle?

22 A. I have not seen that. I have never seen
23 that during my like residency and attending doctor when
24 we were training resident doctors or when we were
25 working with nurse anesthetist I didn't see it.

1 Q. So it's understood that one bottle goes to
2 one patient and that's it?

3 A. That is correct, sir.

4 THE FOREPERSON: Constance.

5 BY A JUROR:

6 Q. Would you say is it legal or illegal to use
7 propofol on more than one person?

8 MR. STAUDAHER: I'm going to ask that he
9 not answer that question. I don't want him to get into
10 anything that might call for a legal conclusion. You
11 could ask him if he thinks --

12 A JUROR: I can revise the question.

13 MR. STAUDAHER: Yes. Okay.

14 BY A JUROR:

15 Q. In your training, going to school and in
16 training, as far as policy and procedures, is that
17 taught to you propofol is used only for one patient at a
18 time?

19 A. Well, I, honestly -- you don't teach them
20 like, you just see things around and then you practice
21 that way. Nobody teaches you that hey, you cannot use
22 this -- it is not about propofol. Let's take propofol
23 out of the way. It could be any vial. They teach you
24 aseptic technique, that you cannot have the possibility
25 where you can transmit infection from one person to

1 another, that is aseptic technique. So nobody talks
2 about particularly propofol. It could be anything.
3 Because there are vials of, there are bottles and you
4 can go and use them with a clean syringe and a clean
5 needle and that's fine because everything is clean. So
6 it's not regarding propofol. But you don't teach, I
7 don't know, it's more of a hypothetical question. You
8 just do what you see and what makes sense to you that
9 yeah, this is a clean technique is what I'm doing, there
10 is absolutely no possibility of transmitting infection
11 from one person to another.

12 Q. So is it safe to say then, what I'm trying
13 to get at is what you're saying it's the individual
14 doctor thinking that it is a safe process?

15 A. Yeah, I would say so. Yes.

16 Q. Yeah. So in that case you're saying is
17 this common sense or something that is trained in
18 school? In general. We're not talking about propofol.
19 We're talking about any type of needle and medicine that
20 should be used only for one person and not reusing the
21 same syringe or medication for another patient.

22 A. Yes, it is trained but not in direct words
23 like okay, that's how, that's today's lesson, this is
24 this, but yes, you're taught to use aseptic technique.
25 You cannot use the needles or the dirty syringes on more

1 than one patient or the dirty vial. Once you have
2 inject, you know, used a vial with a dirty needle, now
3 it's a dirty vial, it's the same thing. So obviously,
4 yeah, those are the things you are taught. But during
5 the training we are taught more about the infections
6 which are really kind of, how should I put it, like I'm
7 a pain specialist and when we use, we do anything we do
8 it with everything sterile, sterile gloves, everything
9 sterile. So that's where you focus more. Because this
10 injecting IV, it does not have to be like sterile gloves
11 or anything, it has to be just clean. But there are
12 certain procedures that have to be absolutely sterile
13 and you have to have a mask on to do some things. When
14 we go inside the spine, because you don't want to spread
15 the infection from your own, like for example I'm
16 putting a needle in, I'm coughing at the same time, the
17 needle is going to get dirty too. So those are the
18 things you train more your students or your teachers
19 teach you more.

20 BY MR. STAUDAHER:

21 Q. I'm going to interrupt here for just a
22 second. I want to make sure we have something defined.
23 You mentioned this term a number of times and I think
24 even I used it, aseptic technique. If we break that
25 down, septic means infection; correct?

1 A. That is correct.

2 Q. And a means without or trying to prevent,

3 or not have happen; correct?

4 A. That is correct.

5 Q. So aseptic means in a way to not promote or

6 process or transfer infection; is that correct?

7 A. That is correct.

8 Q. When you say aseptic technique are you

9 referring to specific techniques that are taught in your

10 training and all of the training whereby you can handle

11 things, whether they be drugs or other items, in a clean

12 way that prevents infection from going from one patient

13 to the other?

14 A. Yeah.

15 MR. STAUDAHNER: Does that help a little

16 bit?

17 THE FOREPERSON: Agnes, did you have a

18 question?

19 BY A JUROR:

20 Q. I got one. Doc, you're talking about pain

21 procedure. Can you tell us the difference between a

22 pain procedure and anesthesia?

23 A. Yes, ma'am. It's like, it's completely

24 different thing. Pain procedures we do for pain related

25 symptoms mainly which are spine related issues, somebody

1 reused? So all medication to the best of your knowledge

2 is only usable one time? Propofol is not the only

3 anesthesia that you've used in your career; is that

4 right?

5 A. That is correct.

6 Q. So when you say that this is nothing that

7 was trained, because I've heard other testimony that

8 they, that it was stated that was trained, they were

9 trained in propofol is a single patient, single

10 application. So when I listen to you and you said that

11 it wasn't anything that was said to you out of anyone's

12 mouth, it's just a procedure that you do and you're

13 taught, you know, it's just common sense, my question

14 now is every medication, since no one just specifies

15 propofol to you, all medication, all anesthesia is a one

16 dose application, one dosage per person, you cannot draw

17 out of another, even with a clean syringe you cannot

18 draw out of a different type of anesthesia or medication

19 and submit to a new patient?

20 A. For most, yes, that is correct. But I

21 remember in Pittsburgh before the propofol was

22 introduced in the market, okay, it was early '90's I

23 guess and it could be mid '90's, we used to use what we

24 call Pentothal, okay, Pentothal bottle was this big,

25 like this bottle of water.

1 having low back pain, back pain, arm pain.

2 Anesthesia -- so those procedures are performed with

3 everything sterile, like completely untouched and packed

4 in a way that are not exposed to air even. So you just

5 open them, use them, throw them. So there you need

6 really sterile technique. Versus anesthesia.

7 Anesthesia has to be clean syringe. It could be sitting

8 on the cart for last, doesn't matter, even 24 hours, as

9 long as nobody has touched it it's still clean. The

10 needle is still clean. Anesthesia when we put you to

11 sleep we give medicine through the vein. And with the

12 pain procedures we are going inside the spine that need

13 a little more even really stricter aseptic technique.

14 THE FOREPERSON: Bianca.

15 THE WITNESS: I hope I'm answering your

16 question.

17 A JUROR: I think I understood a little

18 bit.

19 THE FOREPERSON: Bianca.

20 BY A JUROR:

21 Q. We've heard several different testimonies

22 in regards to propofol and that single vial should be

23 used one time. So when you say let's take propofol out

24 of the picture, to the best of your knowledge is there

25 no, is there any particular medication that cannot be

1 MR. STAUDAHNER: And for the record he's

2 referring to a container that appears to be almost a

3 quart in size.

4 THE WITNESS: Okay. So now you cannot use

5 that whole bottle on one patient and you don't want to

6 throw it either. So what they used to do, there are

7 some connectors that you put on top of that bottle, so

8 you come with your clean syringe, take how much you

9 need, make like two or three syringes, whatever, and you

10 go to your room. Now the other person, he could be

11 working in the other room, he will come, he will draw

12 his syringes, take it to his room. So for most part

13 what you're saying and what other people you referred,

14 they are correct, but it also depends on that it is

15 nothing is like one hundred percent that's how it is

16 because this particular bottle you cannot use, you need

17 only 200ccs out of 500 ml.

18 BY A JUROR:

19 Q. And I understand that. And like I said it

20 just poses confusion, you said they trained you on a

21 procedure what was sanitary and not sanitary and I heard

22 several different testimonies about when it came to

23 propofol in their training they were trained and they

24 were taught not to reuse that. And I also heard you say

25 that you used to draw up syringes in order not to

1 contaminate it, that you can draw up that solution, if
2 it was 100CCs of propofol you can draw multiple needles
3 and have them to the side just like you said you could
4 with the Pentothal. So that was why my question was,
5 which you did answer, that there are some medications
6 you can reuse, it depends on how you do it.

7 A. Medication we can reuse, let's be a little
8 more specific, that particular bottle we can have access
9 multiple times with clean syringes.

10 Q. Right.

11 A. Yes.

12 BY MR. STAUDAHNER:

13 Q. Let me follow-up with that. If, whatever
14 the medication is, in this case I'm going to use
15 propofol, if you have a situation where you take a clean
16 syringe and draw it up --

17 A. Uh-huh.

18 Q. -- and then use it on a patient, take the
19 same syringe which is now technically, whether it is
20 clean or not clean, it's considered not clean; correct?

21 A. That is correct.

22 Q. And you re-enter the bottle, do you then
23 consider that bottle to be contaminated?

24 A. Yes.

25 Q. In that situation would you ever use that

1 potentially contaminated bottle on a second patient?

2 A. No, never.

3 Q. Even if it was the Pentothal bottle that
4 was very large, 500 milliliters I think you said and you
5 had done that same technique the same way that I just
6 described, you would have to pitch that bottle; correct?

7 A. That is correct.

8 Q. So when you were describing this large
9 bottle that people would come and get their drugs from,
10 are you talking about them walking up with a clean,
11 unused syringe, using an aseptic technique, drawing from
12 that bottle and walking away and never coming back to
13 use that contaminated syringe in that bottle?

14 A. That's correct. It's like early in the
15 morning, 25 operating rooms, 25 people and everyone is
16 filling their syringes going back to their rooms.

17 MR. STAUDAHNER: Does that help?

18 A JUROR: Uh-huh.

19 THE FOREPERSON: Are there any further
20 questions? Lisa.

21 BY A JUROR:

22 Q. Dr. Sharma, we saw an agreement where you
23 signed as the MD anesthesiologist to supervise CRNAs.
24 To your knowledge was your name ever used as the MD
25 anesthesiologist supervising CRNAs on any records that

1 Dr. Desai submitted to insurance or that he kept for his
2 office records?

3 A. Not to my knowledge. I didn't give anybody
4 any permission and I was never involved with any of the
5 CRNAs. I don't even know any of them. I know few of
6 the doctors that were performing endoscopies because I
7 was providing anesthesia for their cases as an
8 independent anesthesiologist, but if he has used my name
9 I'll be surprised myself.

10 Q. Okay. Did you ever earn any income off the
11 practice of Dr. Desai?

12 A. Never.

13 Q. Thank you.

14 THE FOREPERSON: Any further questions.
15 Anne.

16 BY A JUROR:

17 Q. Doctor, you talked about three draws where
18 they set, they've gone sterile or aseptic procedures and
19 drawn a number of syringes and needles for us.

20 A. Yes.

21 Q. How long are those kept? Are they gotten
22 rid of at the end of the procedures, do they stay there
23 all day?

24 A. That's a good important question in regard
25 to propofol particularly. There are certain medications

1 which don't really matter, like for example when they
2 draw normal saline syringes they draw it from a bag,
3 when they are clean and they are sitting in a drawer you
4 can go in and use them any time. But with propofol it's
5 different. Propofol, what they recommend is that if you
6 do not use it like in five or it could be six hours just
7 throw it. Because propofol has something that promotes
8 bacterial growth, what they use as a media for this, so
9 that way this particular question pertains more to
10 propofol than any of the medications because there is a
11 possibility of bacterial growth so they do not recommend
12 it, if you have opened the vial or if you had accessed
13 the vial or if you have drawn it in the syringe, if you
14 don't use it like about five hours or so pitch it.

15 Q. Thank you.

16 THE FOREPERSON: Are there any further
17 questions? There are none.

18 BY A JUROR:

19 Q. I have just one more follow-up. So based
20 off of what you just said about even in a clean syringe
21 sitting around propofol could gather its own bacteria
22 possibly?

23 A. Possibility. Because in air there are
24 always bacteria. We are talking, coughing, everybody in
25 the operating room or wherever it is, so yes, it is

1 recommended you throw it after five hours.

2 THE FOREPERSON: Okay. Any further
3 questions? There are none.

4 By law, these proceedings are secret and
5 you are prohibited from disclosing to anyone anything
6 that has transpired before us, including evidence and
7 statements presented to the Grand Jury, any event
8 occurring or statement made in the presence of the Grand
9 Jury, and information obtained by the Grand Jury.

10 Failure to comply with this admonition is a
11 gross misdemeanor punishable by a year in the Clark
12 County Detention Center and a \$2,000 fine. In addition,
13 you may be held in contempt of court punishable by an
14 additional \$500 fine and 25 days in the Clark County
15 Detention Center.

16 Do you understand this admonition?

17 THE WITNESS: Yes, ma'am.

18 THE FOREPERSON: Thank you. You can be
19 excused.

20 MR. STAUDAHER: Thank you all.

21 (Proceedings adjourned, to reconvene
22 at a later, undetermined time.)

23 --oo00--
24
25

1 REPORTER'S CERTIFICATE

2
3 STATE OF NEVADA)
4 COUNTY OF CLARK) Ss

5
6 I, Danette L. Antonacci, C.C.R. 222, do
7 hereby certify that I took down in Shorthand (Stenotype)
8 all of the proceedings had in the before-entitled matter
9 at the time and place indicated and thereafter said
10 shorthand notes were transcribed at and under my
11 direction and supervision and that the foregoing
12 transcript constitutes a full, true, and accurate record
13 of the proceedings had.

14 Dated at Las Vegas, Nevada,
15 May 5, 2010.

16 *Danette L. Antonacci*
17 Danette L. Antonacci, C.C.R. 222
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25

1 AFFIRMATION

2 Pursuant to NRS 239B.030

3
4 The undersigned does hereby affirm that the
5 preceding TRANSCRIPT filed in GRAND JURY CASE NUMBER
6 09BGJ049ABC:
7

8 X Does not contain the social security number of any
9 person,

10 -OR-

11 Contains the social security number of a person as
12 required by:

13 A. A specific state or federal law, to-
14 wit: NRS 656.250.

15 -OR-

16 B. For the administration of a public program
17 or for an application for a federal or
18 state grant.

19 *Danette L. Antonacci*
20 Signature Date

21 Danette L. Antonacci
22 Print Name

23 Official Court Reporter
24 Title
25

\$	28 [2] 43/22 54/13 29 [3] 25/19 35/10 43/15	added [2] 57/16 58/8 addendum [1] 59/21 adding [1] 16/25 addition [4] 51/25 75/11 91/11 113/12 additional [9] 5/24 49/21 63/18 63/25 64/10 70/7 75/13 89/22 113/14 address [2] 6/18 34/2 adequate [1] 20/13 adequately [1] 12/23 adjourned [1] 113/21 administer [1] 97/2 administered [1] 36/9 administering [1] 13/14 administration [1] 115/15 admitted [1] 44/6 admonition [4] 75/9 75/15 113/10 113/16 advance [6] 22/15 26/5 27/12 27/18 27/21 30/16 advantages [1] 15/23 advised [3] 7/19 76/3 76/15 advisement [3] 8/1 76/10 76/22 affirm [1] 115/4 AFFIRMATION [1] 115/1 affirmative [1] 94/15 AFORESAID [1] 1/4 after [25] 5/22 9/3 15/22 16/22 22/9 28/11 30/8 31/1 31/5 31/6 32/18 33/20 37/4 59/3 59/19 64/6 64/22 78/21 79/8 85/20 86/9 88/13 93/10 93/10 113/1 afterwards [2] 13/4 20/9 again [17] 30/23 35/9 44/24 45/2 49/8 59/23 60/2 61/13 64/8 65/16 67/20 82/18 84/8 89/16 90/10 96/17 100/23 age [1] 18/11 agent [3] 15/25 17/9 39/5 agents [2] 16/25 65/4 AGNES [2] 2/11 105/17 ago [2] 15/16 65/24 agree [8] 48/9 51/20 55/3 55/17 57/18 59/16 91/2 91/5 agreed [8] 48/10 51/24 52/5 52/12 52/12 52/14 55/18 88/8 agreement [22] 4/4 4/6 48/11 50/6 52/2 52/9 54/8 54/25 56/11 57/15 66/23 85/16 88/22 89/17 90/21 91/16 92/15 92/22 92/25 93/21 93/24 110/22 agreements [3] 49/9 54/25 66/14 agrees [1] 91/10 ahead [3] 27/11 39/4 91/19 ahold [1] 62/25 air [2] 106/4 112/23 airway [1] 83/25 ALICE [1] 2/16 all [59] Allegheny [1] 79/6 allergies [1] 26/22 allow [1] 94/19 allowed [2] 21/14 73/4 allows [1] 21/15 almost [7] 81/16 86/4 86/16 89/7 93/10 101/7 108/2 along [4] 13/7 22/13 26/13
\$10,000 [1] 93/3 \$150,000 [1] 89/7 \$2,000 [2] 75/11 113/12 \$500 [2] 75/13 113/14 '	3 30 [5] 18/1 19/5 42/20 43/15 101/7 31 [2] 42/21 49/17 32 [1] 42/21	
'02 [1] 50/25 '06 [2] 79/9 80/2 '86 [1] 78/18 '90's [2] 107/22 107/23 '92 [1] 78/21 '94 [1] 78/23 '95 [2] 78/23 78/24 '98 [1] 78/24 '99 [1] 81/18 'clock [1] 60/6 -	4 40 [2] 53/9 83/2 40 feet [1] 83/1 4275 [1] 52/4	
--oo0oo [1] 113/23 -OR [2] 115/10 115/14 0	5 5-5-10 [1] 115/18 50 [3] 53/9 62/25 85/23 50 feet [1] 83/3 50/50 [1] 85/23 500 [1] 108/17 500 milliliters [1] 110/4 50CC [3] 62/20 63/12 96/19 50CCs [1] 73/4 50s [1] 63/7	
00740 [1] 41/14 00810 [1] 41/18 06 [1] 57/3 09BGJ049A-C [1] 5/18 09BGJ049ABC [2] 1/9 115/5 1	6 656.250 [1] 115/13 7 7/31/06 [1] 57/3 700 [1] 52/3 75 [1] 101/8	
10 [5] 18/17 19/3 32/14 60/6 115/18 100 [1] 62/25 100CC [1] 62/20 100CCs [2] 73/4 109/2 10CC [2] 62/21 62/22 10CCs [1] 36/16 12:00 [1] 30/5 14-minute [1] 42/4 15 [4] 18/1 19/3 41/1 60/7 15-minute [3] 41/2 42/10 42/16 16 [1] 42/9 1981 [1] 78/18 1989 [1] 8/25 1993 [1] 9/11 1st [1] 50/17 2	8 8:53 [1] 1/17 A a.m [1] 1/17 ability [1] 5/7 able [6] 10/20 20/14 45/18 46/4 46/7 54/14 about [79] above [4] 50/20 51/11 57/2 58/7 absolutely [3] 69/24 103/10 104/12 acceptable [1] 64/3 accepted [2] 54/22 72/3 access [4] 25/15 30/18 30/20 109/8 accessed [1] 112/12 accessible [1] 82/17 accessing [1] 98/1 accompany [2] 32/5 32/25 accumulated [1] 69/22 accurate [3] 37/9 40/6 114/12 accurately [1] 5/6 acknowledgment [3] 6/9 6/15 7/3 across [4] 27/1 28/6 86/4 86/5 act [3] 7/21 76/5 76/17 acting [3] 15/20 16/16 16/24 action [1] 16/17 actively [1] 82/1 actual [3] 16/2 40/15 55/24 actually [26] 14/12 20/17 22/14 29/6 29/7 29/12 29/23 31/14 38/2 41/25 47/7 52/23 54/4 56/25 57/3 60/16 60/25 66/16 70/2 73/6 79/1 88/5 89/3 92/19 99/17 100/15 add [3] 41/24 57/15 58/12	
20 [4] 8/20 18/17 53/1 101/8 20 feet [1] 32/14 2001 [4] 24/15 46/14 46/15 48/5 2002 [2] 48/5 50/17 2006 [3] 49/17 50/20 57/9 2010 [4] 1/16 2/1 5/1 114/15 20CC [2] 62/19 62/25 20CCs [2] 73/3 108/17 20s [1] 63/9 22 [3] 1/16 2/1 5/1 222 [3] 1/25 114/6 114/17 239B.030 [1] 115/2 24 [1] 106/8 25 [6] 15/15 75/13 88/17 110/15 110/15 113/14 25,000 [1] 21/12 25th [1] 80/6 26 [5] 48/22 49/14 51/5 51/11 51/15 27 [9] 48/20 50/5 50/18 50/24 50/25 51/9 51/18 55/12 56/25		

RA 000341

A along... [1] 33/25 alongside [1] 12/5 already [4] 20/13 93/10 97/16 97/19 also [29] 2/23 6/17 11/9 12/6 13/24 14/13 23/7 23/11 30/1 33/24 36/8 36/11 38/14 48/20 52/5 57/11 58/7 69/14 72/7 72/8 79/6 79/17 80/8 86/25 87/19 96/15 98/10 108/14 108/24 always [8] 71/11 84/1 84/8 84/23 92/12 92/13 99/19 112/24 am [5] 15/8 61/3 61/24 78/11 95/15 ambulatory [1] 65/3 American [1] 9/7 amnesia [1] 20/21 amnesic [3] 19/17 19/23 20/2 among [4] 14/1 65/5 69/5 69/10 amount [12] 18/8 18/14 40/15 40/20 41/7 43/4 53/22 63/13 70/17 73/4 73/21 73/24 anesthesia [115] anesthesiologist [50] anesthesiologist's [1] 70/3 anesthesiologists [7] 9/17 22/11 23/23 26/7 29/15 32/8 67/14 anesthesiology [7] 9/4 9/7 11/1 11/10 51/23 55/6 58/14 anesthetic [13] 15/10 15/11 15/13 15/24 16/14 16/25 17/5 19/20 19/20 19/25 20/6 20/12 39/5 anesthetist [25] 11/6 11/16 11/20 12/13 13/3 13/8 13/20 14/3 44/3 44/9 44/15 46/23 47/4 48/17 49/10 52/19 56/4 57/10 59/1 59/6 61/12 69/2 69/8 69/13 101/25 anesthetists [11] 11/18 45/17 45/22 46/16 47/20 47/24 48/3 53/6 81/11 81/15 101/8 Angeles [3] 12/8 12/12 12/18 ANNE [2] 2/19 111/15 announce [1] 30/2 another [26] 13/23 13/24 14/7 14/21 15/1 22/2 28/7 28/7 29/4 31/14 35/5 63/20 64/10 64/19 65/16 66/2 66/3 81/3 82/11 82/11 84/11 84/17 103/1 103/11 103/21 107/17 answer [4] 55/18 69/12 102/9 109/5 answering [1] 106/15 antianxiety [1] 19/24 Antonacci [5] 1/25 5/4 114/6 114/17 115/21 anxiety [1] 19/24 any [79] anybody [8] 6/4 6/5 90/16 91/21 93/7 101/19 101/20 111/3 anyone [3] 59/15 75/4 113/5 anyone's [1] 107/11 anything [16] 41/19 60/3 61/15 75/4 82/11 85/16 90/22	94/16 99/16 101/15 102/10 103/2 104/7 104/11 107/11 113/5 anyway [2] 15/9 86/20 anywhere [1] 93/3 apparent [1] 91/16 apparently [1] 59/11 appear [5] 22/16 23/22 50/23 59/11 70/4 appeared [2] 5/11 88/12 appearing [1] 51/4 appears [3] 50/19 58/4 108/2 Applebee's [1] 84/4 application [3] 107/10 107/16 115/15 apply [1] 30/12 applying [1] 6/12 appointments [1] 22/14 appropriate [8] 17/15 18/1 31/21 33/1 36/12 43/18 68/13 68/15 approval [1] 74/17 approved [1] 74/19 April [5] 1/16 2/1 5/1 50/17 79/9 April 1st [1] 50/17 are [127] area [16] 5/10 11/13 14/7 14/8 14/9 14/16 14/21 28/22 29/12 31/6 32/2 32/6 32/25 83/5 90/6 94/13 areas [3] 10/12 10/14 10/17 argument [1] 89/7 arm [5] 89/6 89/12 92/17 100/4 106/1 around [5] 5/25 24/15 46/15 102/20 112/21 arrangement [5] 70/8 70/14 70/23 71/6 71/13 arrest [1] 10/2 as [117] ASA [1] 52/2 ASA4 [2] 52/5 52/7 aseptic [12] 65/2 96/23 96/24 102/24 103/1 103/24 104/24 105/5 105/8 106/13 110/11 111/18 ask [20] 5/21 5/25 9/16 14/6 14/22 15/6 20/3 22/15 25/19 29/22 43/22 46/24 55/22 61/25 67/20 89/22 90/10 94/20 102/8 102/11 asked [8] 48/1 48/4 48/6 48/15 62/1 89/23 94/14 96/15 asking [2] 25/5 78/1 asks [1] 25/7 asleep [1] 16/7 aspect [1] 91/22 aspects [1] 99/16 asserted [1] 45/8 assigned [1] 5/15 assistant [2] 2/6 34/4 associated [1] 41/9 assume [13] 10/8 11/13 18/24 19/13 25/6 28/10 30/5 35/7 40/5 46/11 63/9 66/21 86/21 assuming [2] 18/9 47/14 assurance [2] 57/18 58/19 assurances [1] 61/7 at [114] attending [2] 12/3 101/23 attorney [5] 2/24 5/15 99/15	99/25 100/1 availability [1] 95/25 available [9] 13/24 14/3 44/12 44/20 51/25 69/12 83/23 84/4 91/11 Avenue [1] 52/4 average [5] 18/14 18/21 21/13 82/4 82/7 aware [3] 6/22 62/4 62/24 away [14] 19/24 31/4 31/8 31/12 32/14 55/9 65/12 79/14 83/1 83/8 88/14 94/17 97/8 110/12 ave [1] 99/1 B back [35] 14/22 16/25 34/4 35/9 38/23 40/12 43/4 43/8 43/9 43/11 44/24 48/5 52/21 53/7 53/9 59/19 59/21 59/25 63/24 81/20 84/17 86/5 86/10 88/10 97/3 97/16 97/19 98/2 98/3 99/4 100/5 106/1 106/1 110/12 110/16 background [3] 8/22 21/20 77/19 backs [1] 70/1 bacteria [5] 64/17 64/21 64/24 112/21 112/24 bacterial [2] 112/8 112/11 Bad [1] 94/5 bag [1] 112/2 base [2] 38/4 42/24 based [6] 28/10 40/15 40/22 45/10 63/12 112/19 basically [3] 80/9 89/15 100/11 be [152] bear [4] 49/18 49/21 50/12 57/3 bearing [1] 50/9 bears [1] 57/11 because [48] become [2] 47/13 64/20 becomes [1] 72/5 bed [1] 31/6 been [28] 5/5 5/22 6/1 6/25 7/1 8/10 8/19 8/20 12/8 23/21 25/15 25/18 32/19 37/15 37/16 43/21 48/19 51/14 62/1 64/8 64/20 70/13 71/9 72/4 74/16 77/11 84/2 88/16 before [42] before-entitled [1] 114/8 began [1] 9/7 begin [2] 36/6 96/7 beginning [11] 13/17 13/21 16/2 20/7 23/1 23/10 36/10 36/15 58/25 80/5 83/18 begins [1] 64/20 being [17] 20/11 20/16 54/12 55/9 55/10 55/24 69/16 72/22 74/20 77/22 87/16 87/17 93/1 93/3 93/17 94/2 94/19 belief [2] 6/2 45/8 believe [18] 11/5 13/17 21/15 22/10 22/20 23/6 24/17 41/13 44/18 46/9 47/1 53/23 59/4 60/20 69/13 69/14 74/25 98/11 believed [1] 45/11
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RA 000342

B	built [2] 87/16 87/17 bunch [1] 26/25 burden [1] 44/12 Burnham [1] 52/4 business [6] 55/5 89/9 91/23 101/4 101/5 101/16 but [76] buy [1] 89/12 bye [1] 31/25	52/14 72/22 72/22 86/1 104/12 111/25 CERTIFICATE [1] 114/1 certification [4] 9/6 11/11 87/20 89/14 certified [5] 11/15 17/3 53/6 81/10 81/14 certify [1] 114/7 change [6] 6/1 6/5 24/12 24/14 24/15 24/16 changed [1] 97/20 characteristics [1] 15/12 charged [2] 33/12 77/22 charges [4] 77/21 78/5 92/2 92/4 chart [8] 36/1 36/4 57/18 57/20 57/25 58/18 61/8 61/10 charts [3] 61/6 61/14 61/16 check [1] 25/13 checked [1] 32/2 China [1] 8/24 choose [2] 16/11 56/2 CHRISTINE [1] 2/10 Christmas [3] 80/3 80/4 80/6 chronologically [1] 37/1 circumstances [1] 79/23 city [2] 9/2 84/17 claim [5] 32/17 39/19 39/20 40/9 40/11 clarification [1] 61/4 CLARK [6] 1/2 75/10 75/13 113/11 113/14 114/4 clean [21] 96/21 98/1 103/4 103/4 103/5 103/9 104/11 105/11 106/7 106/9 106/10 107/17 108/8 109/9 109/15 109/20 109/20 109/20 110/10 112/3 112/20 clear [3] 15/21 54/3 77/19 clinic [4] 54/6 54/11 56/16 57/21 clinics [1] 80/23 close [1] 82/15 clue [1] 101/5 co [2] 51/20 91/5 co-supervise [2] 51/20 91/5 CO2 [1] 35/18 code [3] 41/13 41/18 41/20 coffee [1] 31/13 collection [1] 71/19 college [1] 72/18 colonoscopies [4] 17/13 23/16 41/11 70/23 colonoscopy [8] 18/13 18/17 31/23 39/1 41/17 41/21 53/12 63/11 Columbia [1] 9/3 column [1] 26/24 coma [3] 17/22 73/8 73/23 coma-like [1] 17/22 comatose [1] 73/22 come [25] 9/10 14/22 22/8 22/8 22/13 25/7 25/8 29/2 30/22 34/18 50/2 54/5 54/7 56/19 79/11 79/12 83/24 85/19 87/3 87/6 100/5 101/12 108/8 108/11 110/9 comes [3] 34/17 73/3 80/4 comfort [1] 9/25 comfortable [2] 86/2 89/8 coming [3] 81/10 81/13 110/12
below [2] 35/10 35/13 beneficial [1] 19/16 beside [3] 13/10 47/15 49/22 best [5] 5/7 87/20 87/20 106/24 107/1 better [1] 87/22 between [15] 12/6 18/1 18/17 19/8 44/3 49/4 57/7 61/21 68/18 69/7 69/10 83/21 94/25 97/21 105/21 beyond [2] 95/11 98/12 BIANCA [4] 2/13 100/13 106/14 106/19 big [4] 96/12 96/16 99/5 107/24 bill [33] 34/4 34/14 39/13 39/15 41/7 42/4 42/11 42/12 42/13 42/15 42/22 43/7 43/8 43/16 45/18 45/25 46/5 52/16 52/21 53/7 53/10 54/8 54/14 54/18 54/21 54/23 71/7 71/11 91/24 92/2 92/3 92/4 92/6 billable [1] 41/3 billed [1] 33/12 billing [5] 40/13 41/4 43/18 70/4 71/19 bills [3] 34/11 46/8 92/1 bit [4] 38/23 94/12 105/16 106/18 blank [1] 26/9 blood [7] 27/8 27/23 28/12 30/10 30/13 73/25 97/15 board [3] 9/7 11/11 17/3 BOB [1] 2/14 body [1] 64/18 books [1] 98/14 born [1] 56/4 both [7] 8/5 18/6 32/19 32/20 41/15 59/11 85/22 bottle [32] 62/9 62/10 62/11 63/12 64/8 64/18 64/20 65/10 65/11 65/13 97/1 97/4 97/9 97/9 97/10 97/11 101/21 102/1 107/24 107/25 108/5 108/7 108/16 109/8 109/22 109/23 110/1 110/3 110/6 110/9 110/12 110/13 bottles [11] 62/12 62/15 62/17 62/19 62/20 62/20 62/21 62/22 62/25 63/3 103/3 bottom [1] 28/19 bought [1] 92/17 box [6] 26/23 28/5 28/6 35/22 35/23 36/13 boxes [9] 26/25 27/5 28/1 35/11 35/12 35/15 35/16 36/11 38/15 BRADLEY [1] 2/7 break [4] 60/7 60/15 60/17 104/24 breath [1] 35/20 bring [10] 25/24 33/25 34/3 52/21 53/7 53/9 89/9 89/14 91/23 92/5 brings [1] 99/9 brought [5] 29/12 33/5 86/3 88/22 89/18 building [8] 14/10 82/11 82/23 82/24 83/15 86/4 86/9 89/5	C C-Arm [4] 89/6 89/12 92/17 100/4 C.C.R [3] 1/25 114/6 114/17 CABILES [1] 2/8 cafeteria [1] 84/7 California [3] 9/5 24/20 71/15 call [16] 13/16 15/5 22/15 34/1 52/1 52/16 55/22 56/18 66/16 83/2 83/22 89/6 91/11 92/12 102/10 107/24 called [21] 12/9 19/20 20/21 22/22 23/14 23/24 29/2 39/19 48/14 48/15 52/14 55/5 55/8 55/18 56/21 61/13 61/16 61/17 66/18 69/23 92/23 calls [1] 22/14 came [12] 22/9 49/25 79/8 79/9 79/13 84/18 85/21 86/23 88/6 88/13 89/2 108/22 camera [1] 26/12 CAMP [1] 2/9 can [64] can't [2] 32/19 60/16 cannot [12] 6/2 32/16 98/2 98/12 102/21 102/24 103/25 106/25 107/16 107/17 108/4 108/16 canvassed [1] 5/10 capacity [1] 12/11 capitated [3] 70/8 70/22 71/6 capitation [2] 70/15 71/2 captain [1] 72/11 carbon [1] 35/19 cardiac [5] 10/15 10/19 54/20 54/21 54/22 cardiopulmonary [1] 10/2 care [19] 14/12 14/14 17/20 22/17 29/18 31/8 32/19 33/10 65/3 65/5 65/14 65/15 69/14 73/7 95/10 96/25 100/1 101/11 101/14 career [2] 95/18 107/3 carried [2] 66/18 66/21 cart [1] 106/8 case [21] 5/16 5/17 6/6 6/11 6/23 7/3 16/9 40/23 42/21 64/2 64/22 65/12 69/24 77/22 77/23 83/13 84/5 96/17 103/16 109/14 115/4 cases [11] 52/2 52/5 52/7 52/16 52/17 52/22 53/2 53/9 58/20 81/7 111/7 cause [3] 20/9 58/1 64/25 caused [1] 57/24 caution [1] 45/6 CCs [1] 36/16 center [39] centers [2] 65/3 92/11 certain [14] 11/8 21/24 22/16 22/16 22/17 40/23 41/6 41/8	

RA 000343

RA 000343

C comment [1] 38/15 common [5] 17/21 70/14 96/18 103/17 107/13 companies [7] 39/17 40/1 53/15 54/17 54/19 70/9 99/18 company [16] 34/5 39/13 39/16 40/3 40/13 40/21 43/3 54/9 54/22 70/15 70/17 70/23 71/6 71/8 71/16 71/20 compared [1] 15/19 compensate [1] 87/1 compensated [1] 89/11 compensating [1] 87/8 compensation [2] 54/8 90/25 completed [2] 9/5 31/1 completely [4] 97/25 99/11 105/23 106/3 complexity [1] 40/23 complicated [2] 35/17 55/19 complications [1] 37/21 comply [2] 75/9 113/10 component [1] 92/1 components [2] 19/21 91/25 concentration [1] 35/21 concern [4] 37/18 66/5 66/10 98/9 concerned [4] 33/20 58/21 61/9 96/4 concerning [1] 38/7 conclusion [1] 102/10 condition [1] 18/11 conditions [1] 26/8 confusion [1] 108/20 conjunction [2] 51/19 91/3 connectors [1] 108/7 consciousness [1] 15/21 consent [1] 25/12 conservative [2] 42/19 43/14 consider [2] 100/17 109/23 considered [1] 109/20 CONSTANCE [2] 2/8 102/4 constitutes [1] 114/12 construction [2] 86/7 87/18 consult [2] 51/20 91/5 consultation [6] 51/22 51/25 52/1 55/16 56/19 91/7 consultations [2] 91/11 91/12 contact [2] 22/8 29/7 contain [4] 92/25 93/8 93/16 115/8 contained [1] 40/5 container [1] 108/2 containers [1] 61/22 Contains [1] 115/11 contaminate [1] 109/1 contaminated [5] 64/24 72/23 109/23 110/1 110/13 contamination [5] 64/13 64/14 66/11 96/3 98/8 contemplate [1] 85/11 contemporaneous [1] 20/25 contempt [2] 75/12 113/13 continuation [1] 5/19 continue [3] 7/8 31/10 31/15 continuously [1] 16/20 contract [10] 70/16 99/11 99/12 99/14 99/15 99/17 99/22 99/24 99/25 100/18 contracts [1] 99/18 controversial [1] 42/18	conversion [1] 40/22 convulsions [1] 73/14 copy [7] 33/22 33/24 33/24 34/3 92/21 92/23 93/9 corner [1] 28/23 correct [54] corrected [1] 50/12 correctly [4] 39/10 55/22 62/23 87/25 corresponding [1] 59/14 cost [1] 16/11 costs [1] 89/7 coughing [2] 104/16 112/24 could [52] count [1] 31/21 country [3] 11/2 69/14 78/21 COUNTY [6] 1/2 75/11 75/13 113/12 113/14 114/4 couple [6] 14/6 20/4 53/6 58/3 82/24 90/5 course [1] 64/17 court [5] 1/1 1/5 75/12 113/13 115/23 coverage [1] 84/6 credit [1] 32/19 criminal [3] 7/22 76/6 76/18 critical [2] 13/15 13/21 critically [1] 52/8 CRNA [29] 4/7 11/20 11/22 12/1 12/2 12/5 12/12 12/22 13/3 13/7 13/11 13/13 13/24 14/11 25/1 32/22 32/22 44/3 47/10 56/20 58/8 61/18 61/18 61/19 66/2 74/8 82/7 83/16 83/22 CRNAs [36] 14/15 24/17 24/19 44/25 45/3 46/7 51/21 56/21 60/22 65/17 66/25 67/14 68/19 69/11 81/14 81/23 82/4 82/6 82/15 84/14 84/25 85/2 85/12 89/24 90/11 90/13 90/18 91/6 91/17 93/22 94/2 94/6 101/8 110/23 110/25 111/5 cuff [1] 30/13 cup [1] 31/13	defined [1] 104/22 definite [1] 93/2 delay [1] 87/18 deliberate [6] 6/4 6/11 6/23 6/24 6/24 6/25 deliberating [1] 5/23 delineated [1] 54/13 delineation [1] 62/13 department [2] 14/17 101/12 depending [3] 18/10 43/2 83/3 depends [3] 82/3 108/14 109/6 deputy [4] 2/4 2/24 5/15 77/1 derive [1] 40/20 DESAI [41] Desai's [1] 88/23 described [2] 10/9 110/6 describing [1] 110/8 designate [2] 28/5 35/24 designated [2] 28/17 40/19 designation [1] 39/23 details [2] 14/4 87/21 detective [4] 92/20 92/22 93/13 93/14 Detention [4] 75/11 75/14 113/12 113/15 determine [1] 57/24 deviate [1] 65/18 did [102] didn't [16] 20/9 21/19 22/3 22/4 34/15 54/10 54/11 66/15 67/2 96/12 99/4 100/1 100/17 101/15 101/25 111/3 Diego [2] 9/5 11/21 difference [6] 49/6 57/7 68/18 68/20 68/22 105/21 differences [2] 49/4 61/21 different [33] 14/10 18/9 19/21 28/2 40/24 41/16 41/17 49/11 50/9 50/23 51/2 55/4 62/3 62/16 63/2 64/6 68/23 68/23 68/24 79/1 83/8 83/10 83/14 84/7 94/13 96/20 101/3 101/21 105/24 106/21 107/18 108/22 112/5 differently [1] 72/23 dime [2] 56/14 90/24 dioxide [1] 35/19 DIPAK [7] 1/10 5/16 7/24 21/5 76/8 76/20 79/20 Diprivan [3] 15/1 16/8 16/9 direct [1] 103/22 direction [1] 114/11 directly [1] 40/12 director [7] 86/24 87/7 88/5 88/9 93/1 93/4 93/18 directorship [1] 92/9 dirty [8] 95/11 98/2 98/2 103/25 104/1 104/2 104/3 104/17 discard [1] 63/19 discarded [1] 64/21 disclosing [2] 75/4 113/5 discuss [3] 13/2 38/16 59/2 discussed [4] 58/24 65/8 66/12 91/21 discussing [1] 13/11 discussion [4] 47/15 47/16 47/18 59/5 discussions [1] 52/12 disease [1] 26/20 displayed [1] 26/11
---	---	---

RA 000344

<p>D</p> <p>disregard [3] 7/21 76/5 76/17 distribution [1] 62/24 district [4] 1/1 1/5 2/24 5/15 do [167] Doc [1] 105/20 doctor [45] doctor's [2] 70/18 70/20 doctors [12] 11/1 11/9 22/21 29/10 65/20 65/25 69/7 82/20 98/13 101/9 101/24 111/6 document [25] 26/7 26/9 26/12 49/2 49/16 49/18 49/22 50/4 50/18 50/19 50/23 51/5 51/8 51/9 51/11 51/15 51/18 55/11 57/6 57/9 59/17 59/19 60/4 60/18 60/21 documentation [1] 38/13 documented [1] 33/9 documenting [1] 26/17 documents [7] 13/11 34/9 48/22 49/5 49/8 51/12 57/8 does [33] 6/4 10/22 12/14 15/1 15/12 16/17 19/17 20/22 32/24 34/17 34/18 34/20 34/21 37/18 40/19 43/3 44/6 49/18 49/21 50/12 57/3 69/18 70/3 71/2 72/7 91/3 97/22 98/10 104/10 105/15 110/17 115/4 115/8 doesn't [1] 106/8 doing [20] 12/16 12/17 25/5 26/4 28/4 30/9 44/21 45/21 45/23 46/3 53/23 56/14 60/3 67/3 70/25 86/3 86/14 93/22 101/1 103/9 dollars [2] 53/14 53/19 don't [26] 17/6 20/8 29/9 29/10 43/6 51/6 51/9 59/14 61/25 68/1 71/10 76/25 78/4 81/18 90/4 95/11 99/24 102/9 102/19 103/6 103/7 104/14 108/5 111/5 112/1 112/14 done [19] 5/23 11/10 17/1 27/10 28/3 28/3 30/15 33/21 35/7 38/2 52/22 54/4 55/9 55/24 70/19 74/16 74/20 101/1 110/5 dosage [1] 107/16 dose [8] 20/14 20/20 36/20 36/20 36/22 36/24 37/2 107/16 down [26] 14/2 14/10 16/23 17/5 26/17 28/22 29/21 30/3 30/4 30/9 31/2 31/7 36/8 36/13 36/21 36/22 36/24 46/13 47/19 50/4 74/24 74/24 84/4 84/8 104/25 114/7 Dr [45] draw [15] 63/25 64/18 65/11 96/18 96/19 97/1 107/16 107/18 108/11 108/25 109/1 109/2 109/16 112/2 112/2 drawer [1] 112/3 drawing [2] 96/16 110/11 drawn [2] 111/19 112/13 draws [1] 111/17 drew [1] 63/23 drop [1] 20/8 drug [17] 14/23 14/24 15/3</p>	<p>15/4 15/7 18/4 19/11 19/15 19/20 20/12 21/11 21/13 21/16 22/3 36/18 95/13 95/14 drugs [9] 21/18 21/24 21/24 22/5 36/9 37/8 37/15 105/11 110/9 duly [3] 5/5 8/10 77/11 duration [4] 16/14 17/14 19/1 23/18 during [19] 6/18 9/25 10/3 13/15 13/21 20/4 20/5 24/14 24/23 26/8 28/13 30/8 38/17 46/22 54/24 72/21 92/24 101/23 104/4 duty [1] 58/18</p> <p>E</p> <p>each [6] 5/22 7/2 28/5 28/6 30/2 62/4 earlier [5] 50/19 51/17 66/12 85/25 96/15 early [2] 107/22 110/14 earn [1] 111/10 easier [1] 77/4 education [1] 72/20 effect [5] 16/18 16/19 19/17 20/2 62/13 EGD [1] 41/13 eight [5] 42/25 81/16 81/19 84/21 99/7 EIGHTH [1] 1/1 either [15] 11/6 44/19 52/6 56/18 63/12 68/13 80/4 82/4 84/6 84/13 92/24 96/14 97/25 99/7 108/6 EKG [1] 30/13 else [5] 56/6 59/15 84/6 93/8 95/12 emergency [1] 83/24 emphasis [1] 59/5 employed [2] 51/21 91/6 employee [1] 89/18 employees [2] 51/24 91/9 emulsified [1] 15/16 encourage [2] 86/12 86/15 end [12] 16/22 17/5 17/7 31/2 31/4 52/19 63/17 65/12 79/24 80/4 97/8 111/22 ended [1] 92/14 endoscopies [3] 17/13 41/11 111/6 endoscopy [20] 23/6 23/12 23/14 23/15 31/23 39/1 41/13 41/20 45/21 52/3 53/1 53/12 57/21 70/22 71/4 74/8 88/13 89/24 90/7 92/11 ends [1] 18/6 ensure [1] 9/24 ensuring [1] 9/22 enter [5] 29/18 35/17 48/11 90/6 109/22 entered [2] 9/1 56/10 entering [1] 85/12 enters [2] 29/6 70/16 entire [2] 17/18 82/22 entitled [3] 35/18 50/5 114/8 entry [1] 30/21 equipment [3] 25/13 25/13 94/22 ERNEST [5] 1/10 5/17 7/25 76/9 76/21 escort [1] 32/10</p>	<p>especially [1] 99/12 essentially [2] 18/5 40/1 established [1] 25/16 estimate [1] 21/10 evaluate [1] 25/10 even [31] 5/23 6/21 27/8 32/13 38/2 38/3 38/21 50/8 56/6 61/13 61/18 61/18 67/13 68/7 83/2 90/2 92/8 94/9 95/10 97/20 99/4 100/1 100/18 104/24 106/4 106/8 106/13 107/17 110/3 111/5 112/20 event [3] 35/25 75/6 113/7 events [1] 26/7 eventually [1] 14/22 ever [70] every [10] 7/2 24/8 36/24 41/1 54/21 65/9 69/21 70/18 98/10 107/14 everybody [1] 112/24 everyone [1] 110/15 everything [10] 13/5 13/20 72/13 101/10 101/11 101/12 103/5 104/8 104/8 106/3 evidence [2] 75/5 113/6 evolved [1] 11/5 exactly [1] 93/15 exam [3] 9/6 11/11 78/22 examination [3] 8/14 9/1 77/15 Examined [1] 3/2 example [19] 10/1 11/21 12/4 13/16 14/11 15/19 17/20 19/16 20/4 20/17 27/17 52/17 54/19 67/2 69/16 73/7 83/8 104/15 112/1 exams [1] 78/22 exceed [1] 63/13 except [2] 68/6 97/7 excessive [1] 73/24 Excuse [1] 16/8 excused [2] 75/18 113/19 exhaled [1] 35/19 exhibit [14] 25/19 35/10 43/22 44/6 48/20 48/21 49/14 50/5 50/18 50/24 51/17 54/13 55/12 88/17 Exhibit 27 [2] 50/24 55/12 Exhibit 28 [1] 54/13 Exhibit 29 [1] 25/19 EXHIBITS [2] 4/1 4/3 expect [1] 37/6 expensive [2] 16/11 68/1 experience [6] 18/16 20/22 21/17 24/19 73/13 84/21 explain [9] 25/10 35/25 36/2 36/5 65/7 70/11 77/2 91/19 94/20 explained [1] 47/8 exposed [1] 106/4 expressed [1] 94/8 extent [1] 15/22 extra [1] 43/16 eye [1] 84/9</p> <p>F</p> <p>face [3] 34/1 34/3 45/24 facility [18] 22/19 22/23 29/3 52/6 52/24 55/25 58/16 58/18 61/17 87/3 89/4 90/2 90/3 92/2 92/4 92/4 92/6</p>
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RA 000345

F facility... [1] 92/17 facing [1] 77/21 fact [7] 12/21 25/24 31/11 37/5 38/20 56/8 91/15 factors [1] 11/3 facts [3] 6/3 6/10 6/12 faculty [1] 12/3 Failure [2] 75/9 113/10 faith [3] 100/11 100/17 100/21 faithfully [1] 5/5 fall [1] 59/8 falls [1] 44/13 false [8] 7/23 37/25 38/1 38/3 38/9 40/8 76/7 76/19 familiar [11] 10/5 14/24 15/6 21/9 43/24 43/25 48/22 49/24 88/18 88/19 95/14 familiarity [1] 11/12 far [16] 10/20 18/8 19/11 20/2 20/16 23/20 28/16 33/19 38/13 58/2 58/21 60/18 62/3 62/16 66/20 102/16 Faris [1] 81/5 federal [4] 4/7 44/2 115/12 115/15 fee [3] 35/2 35/5 70/25 feet [3] 32/14 83/1 83/3 fellow [2] 46/4 81/21 fellows [3] 81/24 98/14 101/9 fellowship [4] 78/25 79/6 81/18 81/21 fellowships [1] 79/2 few [8] 12/19 23/9 61/24 65/17 69/21 80/19 99/20 111/5 fewer [1] 43/11 fewest [1] 24/4 field [1] 10/10 figure [2] 29/1 29/23 file [1] 33/22 filed [1] 115/4 fill [5] 26/4 27/11 27/16 28/10 28/11 filling [1] 110/16 final [1] 100/8 finalized [1] 89/17 financial [1] 87/9 Financially [1] 86/23 find [2] 57/25 86/1 fine [6] 60/9 75/11 75/13 103/5 113/12 113/14 finish [1] 33/5 finished [3] 31/16 78/18 81/17 firm [1] 69/17 first [23] 5/5 8/4 8/6 8/10 16/3 30/12 32/5 32/18 36/15 43/23 49/15 57/6 77/6 77/7 77/11 81/19 85/20 87/17 88/6 91/20 92/10 92/21 100/3 five [15] 19/8 28/5 28/7 28/7 28/12 28/14 41/14 41/18 41/21 42/6 42/24 93/3 112/6 112/14 113/1 fixed [1] 80/5 fizzle [1] 88/14 flag [1] 101/13 flat [1] 70/24 floor [5] 83/5 83/10 83/12	84/7 84/8 floors [1] 83/14 fluid [2] 36/18 64/18 focus [1] 104/9 follow [6] 39/6 74/13 98/6 100/15 109/13 112/19 follow-up [4] 74/13 100/15 109/13 112/19 followed [1] 78/24 following [1] 5/6 follows [2] 8/12 77/13 foot [1] 90/3 foregoing [1] 114/11 foreign [1] 8/25 foreman [1] 77/20 Foreperson [4] 2/3 2/4 8/10 77/11 forget [2] 19/23 20/21 forgot [1] 93/14 form [17] 10/21 27/5 28/18 35/9 35/12 39/11 39/15 39/16 39/16 39/25 39/25 40/2 40/4 40/9 50/12 52/21 99/11 format [1] 26/24 forms [7] 28/19 33/16 33/16 33/19 33/20 39/19 39/20 forth [6] 28/13 36/9 79/2 86/10 88/11 98/3 forward [2] 100/3 100/6 four [5] 12/20 14/2 45/3 45/12 45/15 frame [2] 17/17 37/2 fraud [3] 7/23 76/7 76/19 free [1] 48/17 frequency [1] 24/13 friends [2] 98/20 98/21 full [1] 114/12 fully [2] 6/25 7/1 further [10] 71/21 72/25 74/11 75/1 83/8 98/15 110/19 111/14 112/16 113/2 G gas [2] 16/14 17/5 Gastro [2] 51/21 51/24 Gastroenterology [3] 91/4 91/6 91/9 gather [2] 52/19 112/21 gathering [1] 80/12 gave [8] 32/2 36/16 36/20 41/25 74/2 86/10 86/18 93/2 general [14] 6/8 6/15 7/3 9/16 11/24 14/6 14/16 18/13 65/5 70/12 71/1 79/7 83/5 103/18 generality [1] 21/11 generally [1] 19/25 gentlemen [3] 5/14 45/5 98/16 get [37] 8/22 9/9 9/15 14/4 21/7 22/7 25/3 25/7 25/9 25/12 29/2 29/23 34/21 40/12 41/21 43/4 43/8 43/9 43/11 49/7 52/19 59/18 59/25 60/2 62/25 71/19 77/18 78/14 79/1 86/17 98/22 99/17 100/8 102/9 103/13 104/17 110/9 get-togethers [1] 98/22 getting [2] 16/22 64/25 girls [2] 88/23 88/24 give [28] 7/13 7/20 10/21 11/3 17/6 22/23 32/6 32/21 35/2 36/21 36/24 38/3 38/9	39/4 64/19 65/11 66/4 66/10 73/5 75/22 76/4 76/16 77/23 78/5 86/25 89/8 106/11 111/3 given [12] 20/12 20/18 23/9 31/7 36/13 37/2 37/8 37/15 40/23 45/4 73/22 73/24 giving [3] 22/17 36/6 87/20 gloves [2] 104/8 104/10 go [51] God [2] 7/15 75/24 goes [7] 16/18 30/23 33/23 40/11 83/19 83/20 102/1 going [43] gone [6] 13/20 45/20 54/5 96/8 97/9 111/18 good [5] 5/13 100/11 100/17 100/21 111/24 gosh [1] 43/14 got [9] 43/15 44/5 58/9 78/9 80/9 81/19 84/24 101/16 105/20 gotten [1] 111/21 grab [1] 84/10 graduate [2] 8/23 8/25 GRAND [42] grant [1] 115/16 gross [2] 75/10 113/11 group [6] 70/16 70/18 70/20 82/5 101/7 101/10 groups [1] 101/10 grow [3] 64/21 79/16 85/25 growth [3] 64/17 112/8 112/11 guess [5] 26/16 59/16 79/24 90/8 107/23 guilt [1] 94/17 guys [1] 80/3 H habit [1] 13/17 had [41] hadn't [1] 38/20 half [2] 35/11 93/10 hand [8] 7/11 26/24 28/22 31/8 36/1 36/4 38/15 75/19 handle [1] 105/10 handling [1] 72/19 handwriting [3] 49/21 57/6 58/2 handwritten [4] 57/11 57/14 58/22 59/11 happen [4] 10/3 20/7 88/14 105/3 happened [5] 20/22 21/2 85/20 88/5 88/15 happening [1] 20/11 happens [5] 25/7 29/21 44/14 47/13 69/7 happy [1] 38/20 harbor [1] 64/16 has [42] have [153] having [7] 5/5 8/10 16/6 72/4 77/11 83/12 106/1 he [76] he'll [1] 92/6 he's [4] 46/23 72/5 72/11 108/1 head [1] 15/21 healthy [1] 38/20 hear [1] 59/23 heard [5] 61/20 106/21 107/7 RA 000346
--	---	--

H	I'm [52] I've [7] 8/20 12/8 26/11 66/24 70/13 71/9 107/7 idea [2] 18/14 86/24 Identified [1] 4/3 if [118] ill [1] 52/8 illegal [3] 35/6 74/25 102/6 imagination [2] 95/11 98/12 imagine [3] 12/19 24/3 54/16 immediate [1] 55/7 immediately [6] 9/12 14/2 32/9 35/13 44/10 69/11 immigrated [1] 78/20 IMPANELED [1] 1/4 impartial [2] 6/3 6/10 implemented [1] 54/4 important [3] 49/6 96/23 111/24 in [316] inappropriate [3] 31/18 66/4 66/7 incident [3] 20/15 57/22 93/11 incidents [2] 61/9 61/14 include [2] 48/16 52/2 includes [1] 9/23 including [5] 75/5 86/15 89/4 90/18 113/6 income [1] 111/10 incorrect [2] 33/17 91/18 increment [3] 28/1 42/10 42/17 Indeed [1] 81/16 independent [1] 111/8 INDEX [2] 3/1 4/1 India [1] 78/17 indicate [2] 28/1 55/12 indicated [3] 37/7 55/15 114/9 Indictment [1] 5/12 individual [8] 21/4 22/2 24/1 36/17 43/19 44/25 79/19 103/13 individuals [5] 10/20 45/12 45/15 77/21 78/8 induce [2] 17/22 73/7 induction [7] 13/16 15/24 16/1 17/9 20/5 36/7 36/11 infection [6] 102/25 103/10 104/15 104/25 105/6 105/12 infections [1] 104/5 inform [1] 56/8 information [21] 26/15 26/17 33/17 34/1 34/2 34/7 37/9 37/25 38/3 38/10 39/12 40/5 40/8 45/25 57/12 57/14 62/1 70/15 75/8 94/18 113/9 initial [2] 23/4 36/20 initially [3] 22/8 55/1 79/14 initials [3] 58/4 58/9 59/10 inject [1] 104/2 injectable [1] 15/14 injected [1] 63/24 injecting [2] 16/12 104/10 injury [1] 20/9 inside [4] 14/18 58/16 104/14 106/12 instances [2] 6/21 12/21 insurance [34] 7/23 33/25 34/2 34/5 34/7 39/12 39/13 39/15 39/17 39/20 40/1 40/3	40/9 40/21 43/3 45/24 52/20 53/15 54/9 54/17 54/19 54/22 70/9 70/15 70/17 70/23 71/6 71/8 71/20 76/7 76/19 86/14 99/18 111/1 insurances [1] 86/11 intelligent [1] 99/10 intensive [2] 17/20 73/7 intent [7] 4/5 5/11 48/13 49/10 56/23 66/17 66/20 intentional [1] 73/8 inter [1] 9/24 inter-op [1] 9/24 interaction [1] 23/4 interest [2] 91/22 92/5 internal [3] 9/1 78/23 79/3 internship [3] 9/1 78/23 79/4 interrupt [1] 104/21 interval [2] 28/14 41/2 interview [2] 26/20 92/24 interviewed [3] 92/20 92/20 93/9 intimidated [2] 99/1 99/6 into [31] 9/15 14/4 17/18 19/5 22/9 29/6 29/12 29/18 30/16 30/21 32/25 33/5 33/23 39/3 48/11 55/19 56/10 57/15 61/17 63/24 64/18 64/25 73/14 74/2 77/18 85/12 87/3 87/11 97/4 97/9 102/9 intravenous [2] 25/15 36/7 introduced [1] 107/22 investigation [5] 7/13 7/20 75/22 76/4 76/16 invited [1] 80/7 involved [8] 46/19 46/20 47/23 48/2 54/25 55/1 70/13 111/4 involving [4] 7/24 57/22 76/8 76/20 is [268] isn't [1] 44/20 issue [9] 14/13 44/7 44/23 45/6 46/18 77/19 86/3 88/13 96/3 issues [3] 14/5 17/12 105/25 it [284] it's [47] item [2] 25/20 43/23 items [1] 105/11 its [1] 112/21 itself [5] 19/11 25/5 49/22 64/8 64/24 IV [4] 25/15 30/16 30/20 104/10
I	J	
I'd [4] 9/16 14/21 14/22 60/8 I'll [5] 28/20 74/13 77/3 86/24 111/9	job [3] 79/12 79/12 81/19 JOSEPH [1] 2/4 JUDICIAL [1] 1/1 July [1] 49/17 July 31 [1] 49/17 junior [6] 68/25 69/4 69/6 69/20 69/20 69/22 Juror [1] 100/16 JURORS [3] 2/1 6/1 6/16 jury [39] Jury's [1] 6/1 just [74]	
	K	
	KANTILAL [5] 1/10 5/16 7/24 76/8 76/20	
	RA 000347	

K	life [1] 68/24 like [73] limit [4] 44/25 45/3 73/6 73/21 limited [2] 54/19 58/18 line [3] 50/13 50/14 50/23 lines [4] 55/5 58/3 58/5 99/20 LISA [2] 2/9 110/20 listed [2] 57/9 60/22 listen [1] 107/10 listeners [1] 6/10 little [9] 35/11 38/23 76/12 77/4 94/12 105/15 106/13 106/17 109/7 living [2] 8/17 78/10 located [2] 52/3 52/4 location [3] 64/20 93/23 94/7 locations [1] 23/3 Locum [2] 12/9 24/20 long [8] 8/19 16/7 17/4 17/20 17/23 42/10 106/9 111/21 longer [3] 16/21 16/24 33/10 look [8] 15/17 37/4 49/14 67/24 68/8 69/22 88/17 89/20 looking [5] 13/19 37/6 69/6 69/19 79/12 looks [4] 15/16 26/14 26/15 88/18 Los [3] 12/8 12/12 12/18 lose [1] 86/22 loser [2] 86/19 86/21 loses [1] 16/19 loss [1] 86/11 losses [2] 87/9 87/9 lost [1] 87/1 lot [5] 21/9 86/11 86/14 98/13 99/18 lots [2] 95/18 95/18 louder [1] 76/12 LOUISE [1] 2/5 low [1] 106/1 lower [1] 28/22 lunch [2] 84/3 84/10 LYONAIS [1] 2/10	36/10 marked [5] 25/19 43/21 48/20 62/12 88/16 market [1] 107/22 mask [1] 104/13 MATHAHS [5] 1/10 5/17 7/25 76/9 76/21 matter [7] 5/20 45/7 71/5 97/22 106/8 112/1 114/8 maximum [3] 42/23 42/24 73/4 may [17] 6/19 7/17 16/11 19/24 20/11 23/20 29/10 38/16 55/22 67/19 67/19 75/12 75/17 76/1 96/9 113/13 114/15 maybe [9] 6/21 14/19 24/4 38/2 69/21 81/19 82/24 83/2 101/8 MD [29] 13/18 14/14 14/17 21/15 44/11 44/19 44/20 44/24 45/4 47/3 47/9 47/10 47/11 57/16 59/7 67/5 67/7 67/7 69/1 69/7 69/8 69/25 72/4 72/12 74/7 91/10 91/10 110/23 110/24 MDs [1] 101/7 me [40] mean [25] 12/15 13/12 14/9 14/9 16/17 24/11 26/3 27/23 29/1 29/22 49/1 51/10 52/11 52/24 58/22 59/18 62/8 64/15 68/23 71/7 71/11 72/8 82/1 82/12 82/14 meaning [3] 14/16 63/23 76/24 means [8] 13/25 57/20 57/21 66/15 68/25 104/25 105/2 105/5 meant [2] 16/9 35/16 measured [1] 35/19 measurements [1] 28/2 mechanics [1] 25/5 med [1] 79/3 media [1] 112/8 medical [19] 8/23 8/25 9/21 10/3 10/4 10/23 18/11 78/17 78/18 82/19 85/9 86/24 87/7 88/4 88/9 93/1 93/4 93/17 99/6 Medicare [5] 45/3 53/13 70/2 86/15 87/19 medication [13] 15/14 15/15 26/22 66/3 72/24 103/21 106/25 107/1 107/14 107/15 107/18 109/7 109/14 medications [6] 25/14 36/13 72/22 109/5 111/25 112/10 medicine [7] 9/1 9/8 78/23 78/25 101/20 103/19 106/11 meet [6] 22/8 79/19 79/22 80/9 80/10 90/5 meeting [2] 13/10 85/20 member [3] 12/3 69/17 69/18 mention [1] 47/1 mentioned [6] 11/15 16/2 19/12 20/3 54/14 104/23 met [5] 11/20 61/18 66/24 85/4 86/2 metabolized [1] 16/19 method [1] 43/18 MICHAEL [3] 2/17 2/23 5/14 mid [1] 107/23 middle [6] 36/12 88/11 89/1
L		
L-O-C-U-M-T-E-N-E-M [1] 12/10 ladies [3] 5/13 45/5 98/16 LAKEMAN [5] 1/10 5/17 7/25 76/9 76/21 Lane [2] 52/3 89/25 large [2] 110/4 110/8 larger [1] 35/12 Las [13] 1/15 5/1 9/8 9/10 11/25 12/7 22/11 79/8 81/10 81/13 84/18 84/24 114/14 last [12] 5/20 8/4 8/7 17/25 21/8 37/20 68/16 70/5 77/6 77/8 80/8 106/8 lasting [2] 19/4 19/8 late [1] 100/24 later [6] 9/5 38/10 39/12 52/1 100/8 113/22 law [15] 4/7 6/12 21/15 44/2 45/11 47/2 47/9 56/3 59/6 69/15 69/17 70/1 75/3 113/4 115/12 laws [1] 14/13 lawyer [7] 44/8 45/2 69/16 69/20 69/20 69/21 69/22 lay [1] 10/23 learn [1] 47/19 least [11] 5/25 23/4 24/19 26/16 50/13 50/19 53/18 58/4 62/24 91/16 100/9 leave [1] 39/12 leaves [1] 39/6 left [4] 6/19 26/24 27/1 32/4 leg [1] 20/8 legal [4] 99/16 101/11 102/6 102/10 legality [1] 101/6 less [5] 18/23 19/9 43/8 43/9 43/11 lesson [1] 103/23 Let [2] 5/9 109/13 let's [24] 22/7 30/5 31/12 36/16 38/23 39/9 40/18 42/20 45/20 49/14 51/16 51/16 57/2 70/21 71/23 84/3 84/7 96/18 96/24 97/20 100/9 102/22 106/23 109/7 letter [8] 4/5 48/13 49/10 56/23 92/22 92/25 93/9 99/12 letters [2] 66/17 66/20 level [1] 35/21 licensed [1] 21/15	M ma'am [3] 100/22 105/23 113/17 machine [2] 35/19 89/6 made [3] 47/1 75/7 113/8 main [1] 10/6 mainly [1] 105/25 maintain [1] 16/14 major [1] 91/25 make [20] 6/18 6/22 13/4 13/20 15/12 19/16 20/19 25/15 29/7 33/24 42/2 43/6 54/3 67/18 77/3 86/24 92/21 93/9 104/22 108/9 makes [3] 19/22 19/23 103/8 making [5] 14/3 15/18 19/17 20/21 69/11 management [5] 10/15 10/18 78/12 79/14 79/15 manner [2] 6/4 6/11 many [18] 21/10 23/23 23/23 24/6 27/10 35/4 42/4 42/11 42/13 42/21 45/9 52/24 53/6 53/20 54/17 65/24 82/2 95/16 mark [4] 33/1 33/4 36/1	

RA 000348

M	necessarily [1] 78/4 necessary [4] 18/15 52/1 59/21 91/12 need [13] 6/17 6/22 10/5 26/12 28/2 58/15 58/16 96/9 97/3 106/5 106/12 108/9 108/16 needed [3] 89/6 97/17 100/3 needle [12] 65/11 65/13 97/20 97/22 98/1 98/2 103/5 103/19 104/2 104/16 104/17 106/10 needles [4] 68/10 103/25 109/2 111/19 needs [3] 40/5 72/8 92/16 negative [1] 57/22 neglect [3] 7/22 76/6 76/18 negotiations [4] 88/11 89/17 99/15 100/2 NEVADA [13] 1/2 1/7 1/15 5/1 44/17 51/21 51/24 89/25 91/5 91/6 91/9 114/3 114/14 never [57] new [16] 5/24 9/2 65/10 65/10 65/10 86/4 86/8 86/9 89/5 97/25 98/1 99/4 99/6 101/4 101/15 107/19 newspaper [1] 88/12 next [9] 32/18 35/23 42/16 50/4 61/24 67/25 68/10 97/11 99/9 nitrous [1] 16/13 no [94] nobody [4] 56/5 102/21 103/1 106/9 none [3] 75/2 112/17 113/3 noon [1] 30/5 normal [1] 112/2 normally [1] 63/14 not [136] notes [1] 114/10 nothing [12] 7/15 8/12 71/21 75/24 77/13 82/18 89/17 92/10 96/17 98/15 107/6 108/15 notice [3] 5/11 59/10 60/20 November [1] 80/5 now [72] NRS [2] 115/2 115/13 number [33] 5/17 9/22 9/24 9/25 13/25 14/17 29/23 35/24 35/24 35/25 36/2 36/2 36/5 39/22 40/23 41/6 41/8 43/2 43/22 44/25 48/20 48/22 49/14 51/5 51/9 69/6 86/1 88/17 104/23 111/19 115/4 115/8 115/11 Number 26 [2] 48/22 49/14 numbered [1] 38/14 numbers [7] 41/10 41/12 53/18 88/8 93/2 100/8 100/8 nurse [40] nurses [2] 11/3 30/1	88/21 92/6 99/10 100/24 104/3 occasion [3] 46/22 47/17 65/23 occasionally [2] 81/2 82/7 occasions [2] 5/21 12/8 occur [1] 23/5 occurred [1] 38/16 occurring [2] 75/7 113/8 October [3] 79/25 80/4 80/4 off [15] 7/9 10/23 31/2 41/5 41/21 51/16 58/3 58/8 58/12 60/19 60/21 61/5 77/21 111/10 112/20 off-site [5] 58/8 58/12 60/19 60/21 61/5 offenses [3] 7/21 76/5 76/17 offer [1] 92/9 offered [2] 45/7 94/19 office [21] 14/11 22/15 22/22 34/4 41/12 48/15 52/21 54/9 59/20 59/22 69/19 82/19 86/14 86/16 88/22 88/25 89/1 89/13 90/7 90/8 111/2 Official [1] 115/23 often [3] 16/12 24/9 98/24 okay [48] on [140] on-call [2] 52/1 91/11 on-site [12] 10/4 13/24 14/15 25/9 55/7 55/13 57/17 58/16 58/17 60/19 72/4 74/20 once [11] 24/8 25/7 29/21 30/22 40/11 59/4 64/8 64/19 69/21 98/24 104/1 one [90] ones [1] 51/14 only [27] 11/1 17/9 19/7 23/21 24/1 24/18 25/1 39/9 51/14 54/21 57/18 58/18 61/8 62/15 64/19 70/6 72/12 85/21 85/24 91/22 92/5 93/7 102/17 103/20 107/2 107/2 108/17 onset [2] 16/17 18/5 onto [1] 22/7 oo0oo [1] 113/23 op [7] 9/24 9/24 9/24 29/9 29/11 31/14 37/20 open [2] 65/10 106/5 opened [3] 64/9 64/20 112/12 operating [30] 9/23 11/9 12/6 13/25 14/1 14/17 14/18 22/12 29/6 29/13 29/24 29/25 30/21 32/9 32/12 44/13 47/4 47/10 47/12 47/12 56/5 59/9 69/5 69/9 72/3 83/11 95/25 96/2 110/15 112/25 operations [1] 22/17 opinion [2] 33/3 57/23 option [1] 16/10 or [220] order [5] 6/25 62/24 74/23 100/5 108/25 other [36] 6/17 10/3 10/20 19/15 22/3 22/21 23/3 23/20 23/22 29/10 30/2 32/8 32/8 51/11 51/14 52/4 54/8 54/11 55/5 55/8 57/17 65/4 65/20 65/25 68/19 69/3 71/4 84/6 92/2 92/10 105/11 105/13 107/7 108/10 108/11 108/13 others [1] 21/23
N		
name [25] 5/14 8/6 8/7 13/6 13/7 13/7 14/23 15/1 21/4 34/2 50/13 51/2 51/4 70/3 74/6 74/22 77/6 77/7 77/8 79/20 80/8 86/5 110/24 111/8 115/21 names [3] 8/5 57/9 74/24 national [2] 13/18 14/14 nausea [1] 15/22 near [1] 16/22 nearby [1] 83/18		
O		
O.R [1] 82/20 oath [1] 60/14 obligation [1] 94/16 observe [1] 66/1 obstetric [1] 10/15 obtained [2] 75/8 113/9 obtaining [3] 7/23 76/7 76/19 obviously [7] 61/20 79/16		

RA 000349

RA 000349

<p>O</p> <p>our [5] 26/19 60/15 77/1 80/3 99/23</p> <p>out [43]</p> <p>outpatient [1] 86/13</p> <p>outside [6] 14/2 32/9 57/23 69/15 82/21 82/22</p> <p>over [19] 13/19 21/9 21/12 24/2 31/8 32/9 36/3 52/18 68/17 69/6 69/19 69/22 71/18 84/21 89/2 89/18 92/16 93/21 95/18</p> <p>overall [1] 19/19</p> <p>own [10] 18/16 18/16 23/11 32/11 33/3 33/3 34/4 94/21 104/15 112/21</p> <p>ownership [3] 86/25 88/10 93/19</p> <p>owns [1] 92/4</p> <p>oxide [1] 16/13</p> <p>oximeter [1] 30/13</p> <p>oxygen [4] 16/13 35/18 35/21 36/6</p> <p>oxygenation [1] 36/6</p>	<p>32/20 52/8 52/25 53/20 66/8 66/9 67/12 69/10 76/6 76/18 80/15 86/1 89/2 89/2 89/14 90/6 92/5 92/9 95/1 96/9</p> <p>patients' [1] 52/20</p> <p>pay [8] 35/5 56/13 56/14 70/2 70/17 86/16 90/15 90/22</p> <p>payment [1] 70/8</p> <p>pays [1] 53/13</p> <p>pediatric [1] 10/16</p> <p>pending [2] 7/13 75/22</p> <p>Penn [1] 79/4</p> <p>Pennsylvania [1] 79/5</p> <p>penny [3] 56/14 60/2 60/3</p> <p>Pentothal [6] 15/15 15/19 107/24 107/24 109/4 110/3</p> <p>people [14] 19/13 19/17 23/20 23/22 54/10 74/22 80/13 85/5 88/25 89/1 101/21 108/13 110/9 110/15</p> <p>People's [1] 8/24</p> <p>per [6] 18/15 62/10 62/11 71/17 93/3 107/16</p> <p>percent [2] 82/18 108/15</p> <p>perfectly [1] 64/3</p> <p>perform [9] 10/1 12/6 22/20 22/24 24/4 39/4 48/16 48/18 58/15</p> <p>performance [3] 7/21 76/5 76/17</p> <p>performed [6] 11/10 39/5 52/2 52/6 91/25 106/2</p> <p>performing [2] 11/13 111/6</p> <p>perhaps [2] 11/13 69/5</p> <p>period [5] 16/7 17/18 28/12 59/3 84/22</p> <p>permanent [1] 33/24</p> <p>permission [2] 25/12 111/4</p> <p>permitted [1] 11/7</p> <p>person [25] 10/23 12/23 15/17 15/18 17/1 18/10 19/22 19/23 20/19 20/21 22/2 44/12 44/20 55/10 56/6 66/3 99/10 102/7 102/25 103/11 103/20 107/16 108/10 115/8 115/11</p> <p>person's [1] 20/8</p> <p>personal [2] 52/11 94/21</p> <p>personally [3] 17/3 29/10 80/18</p> <p>persons [3] 7/22 76/6 76/18</p> <p>perspective [1] 12/23</p> <p>pertaining [4] 7/20 41/10 76/4 76/16</p> <p>pertains [1] 112/9</p> <p>phenomenon [1] 20/20</p> <p>phone [3] 22/14 51/25 91/11</p> <p>physical [1] 55/7</p> <p>physically [2] 29/18 74/23</p> <p>physician [25] 4/4 4/6 4/7 21/23 35/5 35/6 44/4 44/10 44/13 46/11 47/5 47/13 50/6 52/9 54/12 56/5 59/9 67/14 67/19 67/23 70/16 72/3 88/22 90/21 98/10</p> <p>physicians [2] 39/21 46/4</p> <p>picture [1] 106/24</p> <p>piece [2] 34/21 70/14</p> <p>pitch [2] 110/6 112/14</p> <p>Pittsburgh [8] 79/3 79/5 79/6 81/17 85/22 99/7 101/6 107/21</p> <p>place [9] 22/16 28/17 30/6</p>	<p>32/13 58/17 69/2 71/4 72/13 114/9</p> <p>Plaintiff [1] 1/8</p> <p>plan [2] 13/3 38/4</p> <p>planning [1] 46/23</p> <p>play [1] 37/18</p> <p>please [8] 7/10 8/4 75/19 76/12 76/13 77/5 81/12 94/4</p> <p>plus [3] 19/5 42/6 42/24</p> <p>point [13] 24/11 30/6 30/24 32/23 32/24 46/13 47/19 60/7 61/10 81/22 94/16 94/19 99/23</p> <p>policy [3] 82/5 98/6 102/16</p> <p>portion [11] 6/17 16/2 26/15 26/23 35/2 36/16 49/22 50/8 57/7 58/2 58/7</p> <p>portions [1] 59/11</p> <p>poses [1] 108/20</p> <p>position [3] 56/16 67/16 67/22</p> <p>possibility [5] 97/16 102/24 103/10 112/11 112/23</p> <p>possibly [1] 112/22</p> <p>post [1] 9/24</p> <p>post-op [1] 9/24</p> <p>potential [3] 56/10 66/12 72/22</p> <p>potentially [7] 20/19 38/4 42/22 48/1 53/7 67/13 110/1</p> <p>powerful [1] 99/5</p> <p>practice [18] 11/12 11/25 18/16 21/14 33/4 33/8 63/3 65/18 78/12 79/14 79/15 79/17 85/5 85/21 85/24 85/25 102/20 111/11</p> <p>practiced [3] 11/1 78/19 99/7</p> <p>practicing [5] 9/7 9/12 12/7 79/17 85/22</p> <p>pre [7] 9/24 26/20 29/9 29/11 31/14 36/6 37/20</p> <p>pre-anesthesia [1] 26/20</p> <p>pre-op [5] 9/24 29/9 29/11 31/14 37/20</p> <p>pre-oxygenation [1] 36/6</p> <p>preceding [1] 115/4</p> <p>predominant [1] 15/24</p> <p>premise [1] 52/1</p> <p>premises [1] 91/12</p> <p>preparations [1] 25/17</p> <p>presence [2] 75/7 113/8</p> <p>present [8] 2/1 2/23 7/1 7/1 20/9 74/20 74/23 78/12</p> <p>presentation [1] 6/19</p> <p>presentations [2] 5/22 7/2</p> <p>presented [2] 75/6 113/7</p> <p>presentment [1] 5/20</p> <p>pressure [6] 27/8 27/23 28/13 30/10 30/13 73/25</p> <p>pretenses [3] 7/23 76/7 76/19</p> <p>pretty [1] 84/20</p> <p>prevent [1] 105/2</p> <p>prevents [2] 15/22 105/12</p> <p>previous [5] 5/21 28/13 37/13 37/22 100/16</p> <p>previously [1] 6/5</p> <p>primarily [2] 17/9 19/12</p> <p>primary [2] 9/22 23/4</p> <p>Print [1] 115/21</p> <p>prior [6] 5/23 5/23 6/20 63/13 81/10 101/1</p> <p>private [2] 11/25 53/15</p>
---	---	--

RA 000350

P	<p>quart [1] 108/3</p> <p>question [18] 21/8 68/6 68/16 70/5 81/12 94/4 94/5 96/15 99/9 102/9 102/12 103/7 105/18 106/16 107/13 109/4 111/24 112/9</p> <p>questions [18] 9/16 14/6 14/23 20/4 55/18 55/23 61/24 69/12 73/1 74/12 75/1 89/23 94/14 98/17 110/20 111/14 112/17 113/3</p> <p>quickly [4] 15/22 16/18 16/19 17/6</p> <p>quit [1] 86/2</p>	<p>recovery [9] 18/5 31/6 31/7 31/9 32/2 32/6 32/7 32/10 32/25</p> <p>reduce [2] 73/25 73/25</p> <p>refer [1] 26/13</p> <p>referral [4] 35/3 35/6 67/15 71/14</p> <p>referred [2] 71/13 108/13</p> <p>referring [5] 36/4 67/18 95/6 105/9 108/2</p> <p>refers [1] 61/4</p> <p>reflect [1] 5/9</p> <p>refuse [1] 70/2</p> <p>refused [1] 59/16</p> <p>regain [1] 15/21</p> <p>regard [4] 6/6 22/3 44/23 111/24</p> <p>regarding [8] 4/7 21/8 44/2 51/23 65/3 91/8 94/22 103/6</p> <p>regardless [4] 64/23 66/22 70/19 71/12</p> <p>regards [1] 106/22</p> <p>registered [1] 81/14</p> <p>regular [2] 10/23 21/14</p> <p>regulation [1] 13/1</p> <p>reimbursement [7] 34/17 34/18 40/12 40/21 43/4 53/11 71/17</p> <p>related [12] 7/4 10/9 14/5 17/12 45/6 65/7 78/6 85/17 90/22 91/15 105/24 105/25</p> <p>relation [1] 44/3</p> <p>relationship [3] 23/1 85/12 99/23</p> <p>relatively [1] 15/21</p> <p>relocated [2] 85/23 99/8</p> <p>rely [2] 21/23 38/10</p> <p>remaining [2] 64/10 97/10</p> <p>remark [2] 36/5 47/1</p> <p>remarks [1] 35/23</p> <p>remember [9] 19/18 20/11 20/14 20/19 60/16 62/14 85/18 88/19 107/21</p> <p>remote [1] 55/13</p> <p>remotely [1] 55/3</p> <p>renders [1] 15/17</p> <p>repeat [3] 76/11 81/12 94/4</p> <p>replaced [1] 15/15</p> <p>replenish [1] 16/20</p> <p>report [3] 31/7 32/2 32/6</p> <p>Reported [1] 1/25</p> <p>Reporter [1] 115/23</p> <p>REPORTER'S [2] 1/21 114/1</p> <p>Republic [1] 8/24</p> <p>request [3] 2/23 22/12 48/14</p> <p>requested [3] 22/22 22/22 24/13</p> <p>require [1] 54/17</p> <p>required [7] 12/25 18/9 24/13 44/14 63/14 78/22 115/11</p> <p>requires [1] 18/17</p> <p>rescue [1] 10/5</p> <p>residency [8] 9/4 11/11 72/21 78/15 78/19 78/24 79/4 101/23</p> <p>resident [7] 12/1 12/5 25/1 82/7 98/13 101/9 101/24</p> <p>residents [1] 81/23</p> <p>respiration [2] 27/8 27/24</p> <p>responding [1] 52/15</p> <p>response [2] 5/11 60/3</p> <p>responsibility [10] 47/6 47/14 55/24 56/2 56/3 56/4</p>
<p>probably [5] 21/12 24/3 24/8 53/9 53/14</p> <p>probe [1] 30/13</p> <p>problem [5] 10/3 57/24 58/1 83/22 83/24</p> <p>problems [2] 38/16 61/11</p> <p>procedural [1] 68/13</p> <p>procedure [47]</p> <p>procedures [38] 17/11 17/14 19/4 19/7 22/5 23/15 23/18 31/23 37/13 38/25 40/24 41/15 45/21 45/23 52/25 53/7 63/11 65/21 72/19 86/3 86/8 86/12 86/13 87/2 87/10 87/12 87/24 87/24 88/1 88/2 89/12 102/16 104/12 105/24 106/2 106/12 111/18 111/22</p> <p>proceeding [4] 6/20 6/20 25/25 78/6</p> <p>proceedings [7] 1/21 5/7 75/3 113/4 113/21 114/8 114/13</p> <p>process [13] 13/22 24/12 25/6 38/24 46/20 48/12 54/24 69/23 100/3 100/6 100/9 103/14 105/6</p> <p>professional [3] 92/1 92/3 99/3</p> <p>professionally [2] 80/14 85/9</p> <p>professionals [1] 32/8</p> <p>professions [1] 55/8</p> <p>professor [2] 69/3 69/4</p> <p>program [3] 9/6 81/21 115/15</p> <p>prohibited [2] 75/4 113/5</p> <p>promote [1] 105/5</p> <p>promotes [1] 112/7</p> <p>proper [1] 96/25</p> <p>properties [6] 15/12 15/19 19/12 19/15 19/21 20/1</p> <p>property [5] 7/22 19/19 20/23 76/6 76/18</p> <p>propofol [75]</p> <p>proposed [1] 58/25</p> <p>prosecute [1] 5/16</p> <p>provide [5] 23/24 35/17 80/15 94/13 94/18</p> <p>provided [7] 6/13 51/22 51/23 54/23 62/2 91/7 91/8</p> <p>providing [5] 23/21 54/20 80/20 92/8 111/7</p> <p>public [1] 115/15</p> <p>pulse [2] 28/13 30/13</p> <p>punishable [4] 75/10 75/12 113/11 113/13</p> <p>purports [1] 51/18</p> <p>purpose [7] 26/17 27/4 57/19 58/19 59/5 90/25 94/18</p> <p>purposes [2] 35/15 61/7</p> <p>Pursuant [1] 115/2</p> <p>pushed [3] 31/5 32/12 33/6</p> <p>put [23] 19/13 20/6 26/16 30/4 30/8 30/20 31/2 33/15 36/8 38/15 40/8 43/15 59/21 60/25 64/17 68/5 74/1 74/22 74/24 74/24 104/6 106/10 108/7</p> <p>putting [2] 16/3 104/16</p>	<p>R</p> <p>racketeering [3] 7/24 76/8 76/20</p> <p>raise [2] 7/10 75/19</p> <p>ran [1] 55/19</p> <p>randomly [1] 83/21</p> <p>range [1] 19/5</p> <p>ranges [1] 17/18</p> <p>rarely [1] 81/4</p> <p>rate [4] 27/8 27/23 27/24 74/1</p> <p>rather [1] 6/2</p> <p>ray [1] 89/6</p> <p>re [1] 109/22</p> <p>re-enter [1] 109/22</p> <p>reach [1] 54/7</p> <p>reacted [1] 37/12</p> <p>read [6] 6/25 7/1 77/21 93/15 100/11 100/18</p> <p>readily [2] 44/20 83/23</p> <p>reading [2] 44/8 99/11</p> <p>ready [5] 72/4 72/5 88/7 89/13 89/13</p> <p>realize [1] 94/1</p> <p>realized [1] 93/23</p> <p>really [8] 27/20 71/10 88/7 89/20 104/6 106/6 106/13 112/1</p> <p>reason [2] 68/9 95/24</p> <p>reasonable [3] 21/22 22/1 89/11</p> <p>reasoning [2] 86/10 86/18</p> <p>reasons [1] 94/13</p> <p>recall [3] 51/7 51/9 85/15</p> <p>receive [2] 22/14 73/9</p> <p>received [2] 20/13 90/24</p> <p>receiving [1] 35/22</p> <p>recent [1] 11/5</p> <p>Recess [1] 60/11</p> <p>reckless [3] 7/21 76/5 76/17</p> <p>recognize [1] 25/20</p> <p>recommend [2] 112/5 112/11</p> <p>recommended [1] 113/1</p> <p>reconvene [1] 113/21</p> <p>record [32] 4/8 5/9 6/16 7/6 8/5 13/7 13/9 25/23 26/2 26/6 26/19 26/21 26/22 27/7 30/1 31/15 33/24 34/4 34/6 35/21 37/4 37/6 37/22 37/24 38/11 52/20 70/4 71/18 72/10 74/21 108/1 114/12</p> <p>recorded [1] 40/20</p> <p>recording [3] 31/11 31/18 35/22</p> <p>recordings [1] 38/1</p> <p>records [4] 45/25 74/8 110/25 111/2</p>	
Q	<p>quality [4] 57/18 58/19 61/7 61/11</p> <p>quantity [1] 63/2</p>	

RA 000351

R responsibility... [4] 56/7 59/8 72/3 99/21 responsible [5] 47/9 67/4 72/6 72/9 72/13 rest [2] 10/25 96/13 result [1] 20/11 results [1] 26/19 resuscitation [1] 10/1 retrograde [1] 20/21 return [1] 25/14 returned [1] 60/15 reuse [7] 63/22 67/11 67/25 68/9 108/24 109/6 109/7 reused [2] 94/25 107/1 reusing [3] 66/8 66/9 103/20 revenue [1] 87/1 review [10] 37/22 57/18 57/20 57/25 58/19 61/6 61/8 61/10 61/14 61/16 reviewed [2] 37/24 59/20 revise [1] 102/12 Richmond [1] 81/20 rid [1] 111/22 right [24] 7/11 15/25 24/21 24/25 27/1 28/22 29/19 36/1 36/3 37/1 38/15 46/14 55/14 60/16 60/19 64/21 66/16 75/19 79/14 86/14 87/8 88/2 107/4 109/10 risk [1] 64/13 road [2] 46/13 47/19 ROBERSON [1] 2/13 role [9] 10/1 11/13 12/15 12/18 47/23 54/12 66/22 67/12 99/20 roles [1] 10/6 RONALD [5] 1/10 5/16 7/24 76/8 76/20 room [36] 5/25 9/23 12/6 13/19 13/23 14/19 22/12 29/6 29/13 29/24 29/25 30/16 30/21 31/24 32/1 32/4 32/9 32/12 32/15 32/23 33/5 33/7 39/3 39/6 47/3 56/5 70/1 72/12 72/14 84/6 95/25 96/2 108/10 108/11 108/12 112/25 rooms [14] 14/1 14/2 14/3 14/17 69/6 69/10 82/5 82/8 82/15 82/25 83/11 84/9 110/15 110/16 Roosevelt [1] 9/2 ROSE [1] 2/14 roughly [1] 53/12 routine [1] 27/11 rule [1] 45/3 rural [1] 11/13 rush [1] 88/7	Satish [3] 77/7 77/10 91/10 saturation [1] 35/18 save [2] 67/24 68/9 saw [2] 66/2 110/22 say [51] saying [7] 34/23 41/22 77/20 100/16 103/13 103/16 108/13 says [6] 26/25 44/9 51/19 62/15 90/21 91/9 scenario [1] 97/7 school [5] 78/15 78/17 99/6 102/15 103/18 schooling [1] 78/18 screen [1] 60/19 seated [2] 7/18 76/2 second [5] 19/22 49/7 50/18 104/22 110/1 secondly [2] 88/8 96/8 secret [2] 75/3 113/4 Secretary [2] 2/5 2/6 security [2] 115/8 115/11 sedation [1] 73/8 see [18] 13/1 13/4 24/12 27/2 28/20 35/13 50/22 58/2 59/14 65/25 87/18 89/3 90/6 91/13 98/21 101/25 102/20 103/8 seeing [2] 62/14 89/2 Seek [1] 5/11 seem [1] 63/13 seems [1] 55/12 seen [9] 48/24 62/20 62/21 62/22 65/16 73/14 101/20 101/22 101/22 send [3] 40/20 54/9 93/21 sends [1] 59/19 senior [6] 68/25 69/17 69/18 69/18 69/21 69/25 sense [5] 12/2 96/18 103/8 103/17 107/13 sent [4] 24/2 59/20 59/21 92/15 septic [1] 104/25 serious [1] 10/3 service [14] 22/20 22/22 23/21 23/24 32/17 44/15 48/16 48/18 51/22 51/23 52/15 54/20 54/23 58/14 services [11] 34/12 34/15 45/18 46/1 46/5 54/15 71/8 71/12 80/15 91/7 91/8 set [3] 70/17 90/2 111/18 setting [1] 80/10 several [2] 106/21 108/22 Shadow [2] 52/3 89/25 shall [3] 7/14 52/2 75/23 Sharma [12] 51/20 77/8 77/10 77/18 80/8 80/9 80/19 80/20 80/25 81/2 91/4 110/22 she [4] 67/19 77/20 89/2 95/7 she's [1] 78/1 sheet [2] 34/1 34/3 sheets [1] 45/24 SHELLEY [1] 2/6 ship [1] 72/11 SHLUKER [1] 2/15 short [9] 6/20 15/20 16/16 16/17 17/19 17/23 18/6 23/18 31/23 shorter [1] 17/11 shorthand [2] 114/7 114/10	should [10] 20/14 62/6 91/23 92/25 93/8 93/16 100/10 103/20 104/6 106/22 shoulder [2] 13/19 69/19 shoulders [3] 52/18 59/8 69/6 show [4] 25/18 48/19 48/21 94/16 showing [4] 43/21 50/4 88/16 99/25 sic [1] 91/10 side [12] 12/2 12/2 13/13 13/13 26/24 36/1 36/4 38/15 42/19 58/3 79/17 109/3 sign [11] 13/6 31/2 51/2 51/4 51/11 93/21 99/11 99/18 99/25 101/13 101/13 signature [11] 49/19 50/9 50/13 50/15 50/16 50/23 50/24 51/1 51/7 57/4 115/19 signatures [2] 13/8 50/22 signed [15] 50/20 51/11 56/23 56/25 57/15 66/23 89/18 90/20 92/15 93/24 100/7 100/11 100/17 100/18 110/23 significant [1] 53/22 signing [4] 13/11 51/7 51/9 85/15 signs [9] 27/7 27/17 27/18 27/21 30/10 33/9 35/18 37/8 38/1 similar [4] 22/21 49/3 51/4 51/14 simple [1] 43/7 simply [1] 22/22 since [3] 29/25 56/21 107/14 single [13] 47/16 56/14 62/5 62/7 62/8 62/15 70/16 95/20 95/21 97/1 106/22 107/9 107/9 sir [7] 7/11 75/19 79/10 79/21 84/1 95/19 102/3 sit [6] 6/2 6/3 6/10 14/2 22/12 69/19 site [17] 10/4 13/24 14/15 25/9 55/7 55/13 57/17 58/8 58/12 58/16 58/17 60/19 60/19 60/21 61/5 72/4 74/20 sitting [4] 82/20 106/7 112/3 112/21 situation [20] 23/8 27/9 31/22 32/7 32/22 37/11 42/14 43/13 55/19 70/7 70/21 70/24 71/3 71/9 74/2 82/10 84/2 96/11 109/15 109/25 situations [3] 11/6 35/4 68/20 six [3] 24/8 42/7 112/6 size [2] 96/22 108/3 sizes [2] 61/21 62/17 sleep [8] 15/18 16/4 19/13 19/22 20/6 83/19 83/20 106/11 slow [1] 16/23 small [3] 28/5 35/11 96/1 smoothly [2] 13/20 13/23 so [155] so-called [2] 55/5 55/8 social [3] 80/10 115/8 115/11 Sodium [2] 15/15 15/19 solemnly [2] 7/12 75/21 solution [3] 15/16 64/16
S S-A-T-I-S-H [1] 77/8 S-H-A-R-M-A [1] 77/8 safe [2] 103/12 103/14 safety [1] 9/23 said [45] SALAMANOUPOULUS [1] 2/6 salary [1] 88/9 saline [1] 112/2 same [39] San [2] 9/5 11/21 sanitary [2] 108/21 108/21 satisfactory [1] 13/6		

RA 000352

S	94/15 114/3 115/12 115/16 stated [2] 6/5 107/8 statement [3] 58/22 75/7 113/8 statements [2] 75/6 113/7 states [3] 11/2 11/8 26/20 Staudaher [2] 2/23 5/15 stay [3] 33/23 42/19 111/22 stayed [1] 31/24 stays [2] 32/22 33/22 Stenotype [1] 114/7 steps [1] 10/5 sterile [8] 104/8 104/8 104/9 104/10 104/12 106/3 106/6 111/18 STEVE [2] 2/15 101/17 still [9] 6/10 31/15 42/12 50/5 60/14 88/11 99/14 106/9 106/10 stop [4] 28/16 28/25 32/4 32/11 story [2] 88/12 101/3 street [3] 10/24 14/10 84/4 stricter [1] 106/13 strictly [2] 17/8 17/8 stuck [1] 101/16 student [1] 25/1 students [1] 104/18 stuff [2] 30/19 66/16 submit [8] 39/17 40/4 40/9 43/3 46/8 57/24 61/10 107/19 submitted [5] 33/15 39/21 58/20 74/7 111/1 submitting [1] 54/18 subsequent [2] 20/18 36/22 successive [1] 67/11 such [11] 10/14 27/8 32/8 35/18 35/24 41/12 44/11 57/25 59/7 70/13 72/24 suite [7] 13/25 14/18 14/20 47/11 47/12 69/5 69/9 Summerlin [1] 81/6 superior [1] 15/18 supervise [27] 12/23 13/24 22/2 24/25 45/1 45/9 45/11 45/14 49/10 51/20 52/16 55/3 61/17 67/13 72/5 74/20 82/5 84/14 85/12 89/24 90/10 90/13 91/5 94/2 94/6 94/10 110/23 supervised [12] 11/22 12/1 12/22 44/10 52/17 55/10 59/7 65/17 69/17 81/23 81/25 82/1 supervising [35] 4/4 4/6 14/11 14/15 24/19 32/22 44/11 45/17 45/22 46/10 47/3 47/5 48/16 50/6 53/5 54/13 67/13 68/18 68/19 68/24 68/25 69/1 69/4 69/16 70/3 74/7 82/9 83/9 83/16 85/16 88/21 90/21 91/21 92/7 110/25 supervision [30] 4/7 11/4 11/7 11/8 14/5 25/3 44/4 44/13 44/23 45/3 46/3 48/2 51/22 55/4 55/5 55/6 55/8 55/13 55/20 56/19 58/9 58/17 60/20 60/22 61/6 69/23 69/25 84/21 91/7 114/11 supervisions [1] 57/16 supervisor [3] 55/9 67/23 93/22	supervisory [12] 12/15 12/18 47/23 48/2 48/12 53/25 56/15 56/15 66/22 82/10 90/15 91/17 supplies [1] 94/22 supposed [1] 26/22 suppress [1] 73/25 sure [13] 6/18 6/22 13/4 13/20 25/15 39/24 42/3 50/25 51/13 54/3 56/25 77/1 104/22 surgeon [9] 11/9 22/11 44/14 47/4 47/12 48/14 54/20 54/21 59/9 surgeon's [1] 22/15 surgeons [3] 22/13 22/21 54/22 surgery [20] 37/23 86/4 86/6 86/8 86/9 86/17 86/19 86/25 87/10 87/22 89/5 89/10 89/13 91/23 91/25 92/11 92/13 93/4 93/17 93/18 surgical [1] 14/16 surprised [1] 111/9 SVEN [1] 2/7 swear [2] 7/12 75/21 sworn [3] 5/5 8/10 77/11 symbol [1] 35/24 symptoms [1] 105/25 synchronize [1] 29/25 syringe [27] 63/22 64/3 64/5 64/6 65/10 65/13 66/3 66/8 95/12 97/1 97/17 97/18 97/21 97/22 98/1 98/3 103/4 103/21 106/7 107/17 108/8 109/16 109/19 110/11 110/13 112/13 112/20 syringes [16] 67/11 68/7 68/10 68/14 94/25 96/16 96/20 96/20 103/25 108/9 108/12 108/25 109/9 110/16 111/19 112/2 system [2] 22/12 48/14 SZURAN [1] 2/16
	T	
	T-H-O-M-A-S [1] 8/7 T-O-N-G-J-I [1] 8/24 take [21] 19/24 22/16 32/19 39/10 39/11 45/24 56/2 56/3 56/6 58/17 60/7 97/11 100/1 101/11 101/14 102/22 106/23 108/8 108/12 109/15 109/18 taken [3] 1/15 10/5 37/8 takes [6] 16/18 30/6 72/13 79/16 85/25 100/5 taking [5] 6/12 14/12 32/9 32/13 55/23 talk [11] 30/1 40/18 46/18 46/24 51/16 55/2 58/22 85/11 93/16 96/24 100/8 talked [10] 60/16 61/18 66/15 91/20 92/7 92/12 93/7 94/9 94/11 111/17 talking [21] 19/2 27/16 28/21 29/11 34/24 38/14 53/19 56/13 56/24 58/9 66/8 67/7 88/24 93/5 93/6 93/12 103/18 103/19 105/20 110/10 112/24 talks [1] 103/1 task [1] 61/14 taught [8] 72/21 102/17 103/24 104/4 104/5 105/9	

PA 000353

RA 000353

T	they're [6] 11/8 27/10 36/17 41/17 49/3 53/17 they've [1] 111/18 thing [8] 28/17 41/3 69/7 81/25 90/20 96/18 104/3 105/24 things [25] 11/5 12/22 13/11 18/11 19/18 21/2 23/16 26/16 27/24 30/9 30/10 30/15 36/8 37/7 37/16 38/13 39/4 68/23 78/16 94/22 102/20 104/4 104/13 104/18 105/11 think [25] 16/1 21/22 22/1 23/10 24/23 31/20 35/9 40/12 45/14 46/14 47/18 51/13 54/2 55/1 60/15 62/14 65/15 68/12 68/16 81/6 91/2 92/16 104/23 106/17 110/4 thinking [3] 94/9 94/10 103/14 thinks [1] 102/11 third [3] 19/23 58/13 60/21 Thirty [2] 83/1 83/2 this [114] Thomas [3] 7/9 8/6 8/9 THOMPSON [1] 2/17 those [48] though [5] 15/3 55/11 55/12 83/5 87/16 thought [4] 46/15 92/23 93/15 100/9 thousands [2] 95/17 95/17 three [21] 9/5 9/22 9/25 10/6 12/19 14/2 19/8 19/21 19/25 20/3 35/25 42/23 42/25 45/22 78/19 82/8 86/16 96/20 97/9 108/9 111/17 through [5] 8/21 11/2 11/12 38/24 106/11 throughout [1] 16/8 throw [9] 65/12 80/2 80/7 96/14 98/4 106/5 108/6 112/7 113/1 Thursday [1] 1/16 time [98] times [18] 6/18 21/10 21/12 24/4 24/6 28/3 29/25 33/1 53/20 59/2 83/7 86/17 90/5 95/16 95/17 97/10 104/23 109/9 Title [1] 115/23 today [7] 6/24 7/9 7/19 8/22 76/3 76/15 78/14 today's [1] 103/23 together [7] 12/19 30/2 33/16 46/22 97/23 101/4 101/5 togethers [1] 98/22 told [8] 5/21 37/20 45/2 45/10 47/7 93/8 95/6 98/5 TOM [1] 2/18 Tongji [1] 8/23 too [6] 24/23 43/7 73/15 74/2 100/24 104/17 took [3] 54/12 81/19 114/7 top [4] 26/14 35/16 41/24 108/7 touched [1] 106/9 toward [2] 17/5 35/16 town [3] 22/9 54/21 82/11 track [1] 26/4 train [1] 104/18 trained [9] 98/11 98/13	103/17 103/22 107/7 107/8 107/9 108/20 108/23 training [19] 8/22 10/8 10/9 11/21 11/23 12/1 12/7 24/23 24/25 65/24 72/18 72/20 101/24 102/15 102/16 104/5 105/10 105/10 108/23 transcribe [1] 5/6 transcribed [1] 114/10 transcript [3] 1/21 114/12 115/4 transcripts [1] 7/1 transfer [1] 105/6 transmit [1] 102/25 transmitting [1] 103/10 transpired [2] 75/5 113/6 treated [1] 72/23 trouble [1] 64/25 troubleshoot [1] 69/12 true [1] 114/12 truth [13] 7/14 7/14 7/15 8/11 8/11 8/12 45/7 75/23 75/23 75/24 77/12 77/12 77/13 truthful [1] 78/1 try [2] 43/13 77/3 trying [4] 42/2 43/7 103/12 105/2 turn [3] 16/13 17/5 68/17 turned [2] 37/25 71/18 twice [2] 97/9 98/24 two [27] 9/24 13/8 14/1 32/17 34/9 35/24 42/15 45/22 49/4 51/14 52/18 57/8 69/10 69/11 78/20 81/6 82/1 82/4 82/5 82/6 84/8 91/25 96/10 96/14 96/19 101/21 108/9 type [14] 18/4 18/10 26/24 38/25 39/16 39/19 39/25 40/24 41/3 49/1 67/15 85/9 103/19 107/18 typed [3] 49/22 50/8 57/7 types [7] 17/13 23/15 37/15 49/8 62/3 62/16 65/4 typical [2] 24/6 53/11 typically [10] 36/1 39/6 40/11 43/4 52/23 53/16 63/18 65/20 82/16 83/17
taught... [2] 107/13 108/24 teach [5] 12/4 102/19 102/23 103/6 104/19 teachers [1] 104/18 teaches [1] 102/21 teaching [1] 9/2 technically [1] 109/19 technique [15] 17/4 65/2 96/23 96/24 96/25 102/24 103/1 103/9 103/24 104/24 105/8 106/6 106/13 110/5 110/11 techniques [1] 105/9 telephone [1] 55/16 tell [17] 25/4 27/4 43/23 43/24 44/6 49/15 51/18 52/10 67/1 68/18 84/8 84/13 87/22 88/18 89/3 92/24 105/21 tells [1] 44/9 temperature [1] 26/25 temporary [5] 12/9 12/10 12/11 71/15 71/16 ten [1] 81/19 tends [1] 94/16 Tenem [2] 12/9 24/20 term [1] 104/23 terminate [1] 99/23 terms [2] 68/23 99/22 testified [3] 8/12 54/2 77/13 testify [3] 8/11 17/12 77/12 testimonies [2] 106/21 108/22 testimony [12] 5/24 7/8 7/12 7/20 28/11 63/13 75/21 76/4 76/16 77/23 78/5 107/7 than [11] 12/19 45/12 47/17 50/9 50/19 57/17 59/4 82/2 102/7 104/1 112/10 Thank [16] 7/17 8/3 8/8 60/10 73/10 73/19 74/3 74/10 75/17 75/19 76/1 77/9 111/13 112/15 113/18 113/20 Thanks [1] 78/9 that [596] that's [50] their [18] 18/11 18/11 27/20 29/3 45/18 54/18 61/17 65/21 66/1 74/23 90/7 101/11 101/12 108/23 110/9 110/16 110/16 111/7 them [32] 6/12 11/21 12/14 12/15 27/6 30/23 37/16 38/21 46/21 47/22 49/11 50/22 57/23 61/11 71/18 73/22 77/2 81/25 82/9 86/19 92/12 95/22 96/19 102/19 103/4 106/5 106/5 106/5 109/3 110/10 111/5 112/4 themselves [4] 11/7 33/19 46/7 62/12 then [62] there [122] there's [3] 65/5 83/13 83/22 thereafter [1] 114/9 these [23] 10/6 12/9 14/1 14/2 19/25 23/15 27/10 28/19 33/15 33/16 38/25 41/12 48/24 49/8 49/9 51/13 57/8 62/14 66/14 66/17 75/3 86/12 113/4 they [84]	UC [1] 11/21 Uh [2] 109/17 110/18 Uh-huh [2] 109/17 110/18 UHRHAN [1] 2/18 ultimately [1] 53/14 unbiased [3] 6/4 6/10 6/11 unconscious [1] 15/17 under [13] 7/23 11/4 11/8 13/9 58/8 60/14 74/16 76/7 76/19 79/22 86/6 94/15 114/10 undersigned [1] 115/4 understand [17] 8/1 39/10 42/3 43/7 55/21 62/23 70/8 75/15 76/10 76/22 77/24 77/25 78/4 87/25 100/16 108/19 113/16 understanding [13] 10/25 35/4 45/8 47/2 47/8 49/9 56/2 58/15 62/6 71/1 72/2 72/12 99/13 understood [2] 102/1 106/17	

RA 000354

<p>U</p> <p>undetermined [1] 113/22 unfamiliar [1] 21/19 unfortunately [3] 89/21 92/21 100/12 unhappy [1] 67/19 uniform [1] 40/2 unit [11] 17/20 40/25 41/2 41/3 41/4 41/18 42/5 42/12 42/24 43/16 73/7 United [1] 11/2 units [17] 36/17 40/24 41/6 41/8 41/14 41/14 41/18 41/21 41/25 42/4 42/11 42/22 42/23 43/2 43/8 43/9 43/11 University [3] 8/23 9/3 9/4 unless [3] 16/20 54/7 69/25 until [1] 89/8 untouched [1] 106/3 unused [1] 110/11 up [32] 15/20 15/23 17/2 17/6 28/20 35/11 42/20 43/15 45/14 50/9 52/19 53/1 55/22 60/18 63/23 63/25 70/2 74/13 77/19 83/20 86/3 86/23 88/6 88/13 97/1 100/15 108/25 109/1 109/13 109/16 110/10 112/19 upon [3] 7/13 75/22 88/8 upper [7] 17/13 23/15 35/11 41/11 41/13 41/20 53/12 upstairs [1] 90/8 us [16] 8/21 22/15 26/19 27/4 27/7 35/17 35/23 44/6 46/18 52/10 68/18 75/5 83/22 105/21 111/19 113/6 usable [1] 107/2 use [74] used [30] 17/23 20/18 21/9 21/11 37/16 40/2 41/12 63/2 63/5 63/7 65/3 76/24 80/2 80/6 95/16 97/17 97/19 97/21 98/21 102/17 103/20 104/2 104/24 106/23 107/3 107/23 108/6 108/25 110/24 111/8 using [8] 20/5 36/18 47/20 47/22 72/19 73/3 95/11 110/11 usual [1] 20/20 usually [6] 17/6 17/18 40/25 42/12 82/4 96/1 utilize [1] 10/21</p>	<p>95/20 96/1 96/3 96/10 103/3 vicinity [1] 55/7 View [1] 81/4 Virginia [1] 81/20 Vishvinder [6] 80/8 80/19 80/20 80/25 81/2 91/4 visit [1] 29/9 vital [9] 27/7 27/17 27/18 27/21 30/10 33/9 35/18 37/8 38/1 VOLUME [1] 1/23</p>	<p>where [46] whereby [1] 105/10 wherever [1] 112/25 whether [13] 55/2 56/1 61/11 62/4 64/9 64/23 66/22 71/12 92/7 92/8 94/6 105/11 109/19 which [23] 9/2 9/23 13/21 14/14 22/11 25/12 31/5 34/1 38/4 38/24 42/6 48/16 50/5 57/2 61/6 63/14 66/15 97/18 104/6 105/25 109/5 109/19 112/1</p>
<p>V</p> <p>Valley [3] 80/21 81/7 86/5 value [1] 41/18 various [3] 26/16 39/4 60/22 vary [1] 43/3 Vegas [13] 1/15 5/1 9/8 9/10 11/25 12/8 22/11 79/8 81/10 81/13 84/18 84/24 114/14 vein [1] 106/11 versus [2] 68/19 106/6 very [13] 15/20 15/22 16/11 17/21 18/5 23/10 24/9 49/6 58/25 81/2 98/24 99/10 110/4 vial [16] 63/25 96/7 96/12 96/16 96/19 96/22 97/17 97/19 98/2 102/23 104/1 104/2 104/3 106/22 112/12 112/13 vials [8] 61/21 62/4 62/5</p>	<p>W</p> <p>waiting [2] 5/10 22/13 wake [3] 15/20 17/2 17/6 wakes [2] 15/23 83/20 walk [5] 8/21 13/23 14/1 31/4 31/8 walked [2] 31/12 100/10 walking [5] 69/5 69/10 69/10 110/10 110/12 walks [1] 68/24 want [21] 14/6 17/22 20/3 37/11 37/21 43/6 43/22 54/3 54/20 57/23 67/24 68/1 68/8 68/9 77/19 93/21 94/20 102/9 104/14 104/22 108/5 wanted [8] 15/6 52/15 58/15 87/3 94/1 94/6 95/6 95/7 wants [1] 56/6 was [151] wasn't [3] 24/9 38/3 107/11 waste [1] 68/1 watch [2] 52/18 65/20 water [1] 107/25 way [22] 22/10 26/6 27/20 28/4 44/16 61/5 62/13 66/4 66/7 68/13 79/14 81/4 84/20 87/8 89/12 102/21 102/23 105/5 105/12 106/4 110/5 112/9 ways [2] 51/3 96/15 we [96] we'd [1] 60/16 we'll [5] 7/8 15/5 25/2 49/7 100/7 we're [6] 7/9 14/4 40/23 44/24 103/18 103/19 we've [2] 44/5 106/21 week [1] 24/6 Weiss [1] 81/4 well [17] 7/7 16/17 23/22 28/2 36/23 38/2 38/20 40/6 56/24 57/12 58/10 60/9 62/21 80/23 89/7 94/18 102/19 went [10] 24/4 32/1 42/20 52/15 63/24 66/19 78/17 84/21 97/16 97/19 were [88] weren't [1] 24/1 West [1] 79/4 Western [1] 79/5 what [128] what's [2] 55/23 88/16 whatever [12] 30/5 30/23 32/3 36/18 47/12 68/9 68/10 77/19 94/17 100/5 108/9 109/13 wheel [1] 30/16 wheeled [7] 32/1 32/18 32/19 32/23 32/24 39/3 97/8 when [98] whenever [1] 89/12</p>	<p>whichever [1] 44/13 while [2] 55/7 72/18 white [1] 15/16 who [17] 10/4 10/21 11/3 11/10 11/10 12/4 21/23 34/19 34/24 44/14 44/20 48/7 54/12 58/8 66/3 85/5 101/14 whoever [2] 67/3 92/3 whole [11] 6/21 7/14 8/11 15/25 16/14 24/11 54/24 75/23 77/12 96/7 108/5 whose [1] 9/22 why [11] 15/24 37/18 58/12 64/12 68/4 68/22 95/9 96/6 97/14 99/10 109/4 will [37] 6/23 13/6 22/15 30/3 33/24 33/25 34/3 48/17 52/5 54/9 57/18 61/25 70/2 70/17 73/25 77/2 81/2 86/19 86/25 89/9 89/11 89/14 90/4 91/7 91/10 92/3 92/4 99/20 99/20 99/21 99/21 99/22 99/23 100/5 101/14 108/11 108/11 WILLOUGHBY [1] 2/4 wise [1] 16/11 wish [1] 100/11 wit [1] 115/13 within [1] 10/12 without [8] 11/7 46/8 47/11 59/7 74/20 99/11 99/25 105/2 witness [3] 7/2 71/22 98/16 WITNESSES [1] 3/1 words [5] 58/8 58/12 69/3 76/24 103/22 work [39] worked [11] 12/2 12/12 12/15 23/11 38/21 66/24 81/14 85/2 85/5 95/5 95/6 working [11] 11/6 23/13 30/22 67/15 68/8 82/15 84/14 85/13 90/6 101/25 108/11 works [2] 69/21 79/15 world [2] 10/25 15/25 would [188] write [6] 29/21 30/3 31/7 36/13 36/22 36/24 writing [2] 89/9 92/16 wrote [2] 36/21 50/3</p> <p>X</p> <p>X-ray [1] 89/6 Xerox [1] 33/24</p> <p>Y</p> <p>Y-E-E [1] 8/7 yeah [16] 40/2 41/8 55/15 59/16 77/25 83/3 86/23 88/15 93/14 98/10 100/2 103/9 103/15 103/16 104/4 105/14 year [10] 9/3 9/9 75/10</p> <p>RA 000355</p>

Y

year... [7] 78/25 80/1 84/21
93/10 98/24 98/25 113/11
years [11] 8/20 9/5 11/5
15/16 21/9 65/24 73/13 78/19
78/20 81/16 99/7
Yee [6] 7/9 8/6 8/9 8/17
73/13 74/6
yes [170]
yet [1] 38/21
YOLANDA [1] 2/12
York [1] 9/2
you [719]
you'll [1] 91/2
you're [44]
you've [8] 21/9 21/10 21/11
27/10 54/2 85/2 97/8 107/3
YOUNG [1] 2/3
your [84]
yourself [7] 10/22 39/9 52/24
53/3 67/2 67/10 86/1

Z

ZARATE [1] 2/19
zone [1] 29/18
ZUNIGA [1] 2/5

EIGHTH JUDICIAL DISTRICT COURT

CLARK COUNTY, NEVADA

BEFORE THE GRAND JURY IMPANELED BY THE AFORESAID
DISTRICT COURT

THE STATE OF NEVADA,

Plaintiff,

vs.

CASE NO. 09BGJ049A-C

DIPAK KANTILAL DESAI,
RONALD ERNEST LAKEMAN,
KEITH H. MATHAHS,

Defendants.

Taken at Las Vegas, Nevada

Thursday, April 22, 2010

11:32 A.M.

REPORTER'S TRANSCRIPT OF PROCEEDINGS

VOLUME 4-A

Reported by: MARCIA LEONARD, OCR 204

ORIGINAL

C265107

GRAND JURORS PRESENT ON THURSDAY, APRIL 22, 2010:

SVEN BRADLEY

CONSTANCE CABILES (Not present in P.M.)

LISA CAMP (Not present in P.M.)

CHRISTINE LYONNAIS

AGNES PARKER (Not present after 3:00 P.M.)

YOLANDA PARKER

BIANCA ROBERSON

ROBERT ROSE

SHELLY SALAMANOPoulos

STEVEN SHLUKER

ALICE SZURAN

MICHAEL THOMPSON

THOMAS UHRHAN

JOSEPH WILLOUGHBY

PAMELA YOUNG

ANNE ZARATE

LOUISE ZUNIGA

FILED

JUN 08 2010

Clerk of Court

Also present at the request of the Grand Jury:

MICHAEL V. STALDAHER
Deputy District AttorneyINDEX OF WITNESSESExamined

Yeremy Dueñas	6
Anne Yost	22
Vincent Sagendorf	56
Ryan Cerda	118
Marion VanDruff	134

INDEX OF EXHIBITSGrand Jury ExhibitsIdentified

30A	Explanation of Benefits	12
30B	Claim Form for Sonia Alfaro-Orellana	10

1 LAS VEGAS, NEVADA, THURSDAY, APRIL 22, 2010

2 * * * * *

3
4 MARCIA J. LEONARD,

5 having been first duly sworn to faithfully
6 and accurately transcribe the following
7 proceedings to the best of her ability.

8
9 THE FOREPERSON: Okay. Please raise your
10 right hand.

11 Do you solemnly swear that the testimony
12 you are about to give upon the investigation now
13 pending before this Grand Jury shall be the truth, the
14 whole truth, and nothing but the truth, so help you
15 God?

16 THE WITNESS: I do.

17 THE FOREPERSON: Thank you. You may be
18 seated.

19 You are advised that you are here today to
20 give testimony in the investigation pertaining to the
21 offenses of performance of act in reckless disregard of
22 persons or property, criminal neglect of patients,
23 insurance fraud, obtaining money under false pretenses,
24 and racketeering, involving Dipak Kantilal Desai,
25 Ronald Ernest Lakeman, and Keith H. Mathahs.

1 Do you understand this advisement?

2 THE WITNESS: Yes.

3 THE FOREPERSON: Could you please state
4 both your first and last names, spelling them for the
5 record.

6 THE WITNESS: My name is Yereny,
7 Y-E-R-E-N-Y, Dueñas, D-U-E-N tilde A-S.

8 A JUROR: I'm sorry. Can you just do the
9 last name again? Sorry.

10 THE WITNESS: That's okay. D-U-E-N, with
11 a tilde, A-S.

12
13 YERENY DUEÑAS,

14 having been first duly sworn by the Foreperson of the
15 Grand Jury to tell the truth, the whole truth, and
16 nothing but the truth, testified as follows:

17
18 EXAMINATION

19 BY MR. STAUDAHER:

20 Q. And how do you pronounce your last name,
21 ma'am?

22 A. Dueñas.

23 Q. Dueñas.

24 Ms. Dueñas, what do you do for a living?

25 A. I am the claim team leader for ABPA, the

1 third-party administrator for the Culinary Health Fund.

2 Q. So the Culinary insurance, you do the
3 third-party administration work?

4 A. We process their claims, administer their
5 benefits, provide customer service, handle their
6 eligibility, yes.

7 Q. So, in other words, do you receive claims
8 from providers of care, health care?

9 A. Yes.

10 Q. And then make payments on those claims?

11 A. That is correct.

12 Q. Is that per the agreement that Culinary
13 has with whoever the -- either the provider and/or the
14 actual participant, plan member?

15 A. Correct.

16 Q. Okay. In your capacity as the claims --
17 claims leader I think --

18 A. Claims team leader.

19 Q. -- what kinds of things do you do in that
20 capacity?

21 A. We process claims. We receive them.
22 Either a hard copy, EDI. We pend for information from
23 participants. Request additional information from
24 providers if we need them. We process hospital claims.

25 Q. When you said EDI, what do you mean by

1 that?

2 A. Claims are submitted electronically
3 through the system. We don't actually get a hard copy
4 dropped. It's actually done all through the system.
5 It's filed electronic.

6 Q. So when a provider sends in a claim form
7 for some sort of service that's been provided to a plan
8 member, is that a certain type of form?

9 A. Yes, it is a HICFA form.

10 Q. And does it have a particular number and
11 type associated with it?

12 A. Yes, a HICFA 1500.

13 Q. Is that pretty standard that most claims
14 come in under this HICFA 1500 designation?

15 A. Yes, for medical physicians. Hospitals
16 use UB, UBs.

17 Q. Okay. And the particular case that I'm
18 going to talk to you about today relates to a plan
19 member, a Culinary plan member by the name of Sonia
20 Alfaro-Orellana.

21 Are you familiar with the claim and the
22 payment for the claim made by the Endoscopy Center of
23 Southern Nevada related to that individual?

24 A. The anesthesia claim?

25 Q. Yes. Well, we'll get to that in a minute.

1 Some claims --
 2 A. The claims submitted for her, yes.
 3 Q. And I guess that was a poor question. I
 4 assume she may have had some other things as well,
 5 correct?
 6 A. Yes, other claims.
 7 Q. So let me define that a little more and
 8 make it a little easier for you.
 9 A. Okay.
 10 Q. My questions are going to be confined to
 11 procedures that were performed for colonoscopy and
 12 anesthesia related to colonoscopies on that particular
 13 plan member at the Gastroenterology Center of Southern
 14 Nevada by Dipak Desai's organization. Are you with me?
 15 A. Yes.
 16 Q. Okay. Did you, as part of your normal
 17 activities, do you have access to the records you've
 18 described, such as claim forms or electronic submission
 19 forms and payment information?
 20 A. Yes, we do. Yes, I do.
 21 Q. Did you look up or bring with you or
 22 provide at some point that type of information to the
 23 police and to this Grand Jury?
 24 A. Yes, we did.
 25 Q. Okay. I'm showing you what has been

1 marked as State's Exhibit 30B and ask you if you
 2 recognize that item?
 3 A. Yes, this is the EDI screen, which is in
 4 our system claim fax, which mimics the hard copy of a
 5 HICFA 1500 in our HF screen when a claim is submitted
 6 electronically.
 7 Q. Okay. I want you to thumb through all the
 8 pages and make sure you're familiar with them.
 9 A. Okay.
 10 Q. And I believe there are four pages to this
 11 particular exhibit document?
 12 A. And a HICFA starts with Box 1, and Box 1
 13 is there.
 14 Q. On page 1 of that document, correct?
 15 A. Yes. Page 1. Page 2.
 16 Q. At this point, I just want you to flip
 17 through and see if you are familiar with them. Then
 18 we'll go through the documents.
 19 A. Okay. Yes.
 20 Q. Now, is this the claim actually that was
 21 submitted that we're talking about for Ms. Orellana
 22 regarding her -- the anesthesia portion of her
 23 procedure?
 24 A. Yes, it is based on page 3.
 25 Q. Based on page 3.

1 Okay. Let's start off with page 1.
 2 A. Okay.
 3 Q. Tell us what we're looking at and how you
 4 know that -- let's talk about the date, the type of
 5 procedure, whatever it is?
 6 A. Okay. Based on page 1, is the -- Box 1A
 7 is the member's social security number.
 8 Do I need to read anything out?
 9 Q. No.
 10 A. Okay.
 11 Q. You don't have to read out the social
 12 security numbers. I'm just trying to find out when it
 13 happened, when the form was submitted --
 14 A. Okay.
 15 Q. -- and who it's related to.
 16 A. Okay. The patient's name is Sonia
 17 Orellana-Alfaro. The insured's name is Sonia as well.
 18 Her address. Her date of birth.
 19 Q. When was the claim submitted?
 20 A. The claim is submitted -- let me see -- is
 21 not on this. It is not on this form.
 22 Q. Okay. The form, not on that particular
 23 exhibit?
 24 A. Yes.
 25 Q. Do you have the information about when the

1 claim was submitted?
 2 A. I would have to look and see what you've
 3 provided.
 4 Q. Okay. This is the -- you need to look at
 5 Grand Jury Exhibit 30A to do so. You can do so at that
 6 time.
 7 A. It was received 9/25 of 2007.
 8 Q. So that's when the claim was actually
 9 submitted?
 10 A. Correct.
 11 Q. And you're looking at this time on the
 12 third page of Exhibit 30B, correct?
 13 A. Correct.
 14 Q. Now, are those documents, and I assume you
 15 looked through that one as well, is that something that
 16 is part of the records of the Culinary Union or at
 17 least the third party, your third party --
 18 A. Yes.
 19 Q. -- sort of entity?
 20 A. Yes, sir.
 21 Q. Now, let's talk about the procedure
 22 itself. Was this for an anesthesia procedure for a
 23 colonoscopy?
 24 A. I would have to pull the other dates of
 25 service, the other services provided for this date of

1 service.

2 Q. But this is specifically for an anesthesia

3 billing, correct?

4 A. Yes, yes.

5 Q. Now, on this particular — do you have any

6 of those documents with you if you need to look at

7 them?

8 A. I believe I do.

9 Q. Okay. And I have got some as well. If

10 you need to refer to any documents of your own that you

11 brought with you at any time, just let us know you're

12 doing so and tell us what you're looking at. Okay?

13 A. Okay.

14 Q. But those are not going to be admitted

15 necessarily as exhibits.

16 A. Okay.

17 Q. If you need to refer to any document you

18 have at this time, go ahead and do so just to refresh

19 to make sure we're talking about the right document.

20 Okay?

21 A. Okay.

22 Q. Now, what were you just looking at just

23 for the record?

24 A. I was looking at the copies that we had

25 provided you and new printouts that I made this morning

1 minutes.

2 Q. So if I understand you correctly, the

3 dollar amount of the claim was \$560; is that correct?

4 A. That is correct.

5 Q. So that's what they say, hey, look this is

6 what it cost or what we're using as the cost for an

7 anesthesia; is that correct?

8 A. That is what they're using as the billed

9 charges.

10 Q. Billed charge? Okay. Sorry about that.

11 A. Billed charges.

12 Q. Now, you had mentioned that there was a

13 time that was also submitted as well.

14 A. Correct.

15 Q. And you said —

16 A. Thirty-three minutes.

17 Q. — 33. Is that — now, that dollar amount

18 and that minutes charge, that was actually submitted in

19 the claim?

20 A. Yes.

21 Q. Go ahead.

22 A. Okay. So that's basically what this

23 screen is telling me, that that is the code, the billed

24 charges and the minutes billed by the doctor.

25 The doctor's name is on the second -- on

1 of modifiers that are associated with the claim.

2 Q. Okay. So you're interpreting things on

3 the exhibit based on your review of records in your

4 business?

5 A. Yes.

6 Q. Okay. Did that help refresh your

7 memory —

8 A. Yes.

9 Q. — as to what those items were?

10 A. Yes, it did.

11 Q. Okay. Put that aside, if you would, what

12 you brought with you.

13 And now if you could testify about what

14 we're looking at here on Exhibit Number 30B?

15 A. Okay.

16 Q. And I think we're on the third page of the

17 document.

18 A. That is correct.

19 Q. Okay.

20 A. Okay. So this basically tells us that we

21 received a claim for date of service 9/21 of 2007, for

22 place of service 24, which is an outpatient, outpatient

23 facility, AC facility. For ASA code, which is an

24 anesthesia code of 00810. Billed with three different

25 modifiers, QZ, QS and P2, in the amount of \$560 for 33

1 the last page, which is the fourth page, which is for

2 Keith Mathahs.

3 Q. What's the address and the business?

4 A. The address is 700 Shadow Lane, 165A, Las

5 Vegas, Nevada 89106. And the services were rendered at

6 the Endoscopy Center of Southern Nevada, 700 Shadow

7 Lane, 165, Las Vegas, Nevada 89106.

8 Q. Okay. Now, that document there talks --

9 is basically the information related to the claim

10 itself being submitted by the Endoscopy Center,

11 correct?

12 A. This is the claim for the anesthesia.

13 Q. The anesthesia portion of that procedure,

14 correct?

15 A. Correct.

16 Q. Okay. Now, if you move on to the next

17 document, which is 30A, can you tell us what this is?

18 A. Okay.

19 Q. And I think it's multi pages as well; is

20 that correct?

21 A. Yes, it is three pages.

22 Q. Okay. Tell us what we're looking at on

23 this particular document.

24 A. Okay. This document is the member

25 explanation of benefits that lets the member know how

1 we process the claim.
 2 Q. So in other words, is that called an EOB,
 3 then?
 4 A. Yes, an EOB, explanation of benefits. It
 5 is in Spanish. The second page is -- it looks like
 6 it's -- this might have been submitted by the doctor's
 7 office.
 8 Q. So the second page is not one of your
 9 documents itself?
 10 A. Huh-huh.
 11 Q. Okay. And then is it something you're
 12 familiar with or not?
 13 A. Huh-huh.
 14 Q. Okay. So just so we're clear, the second
 15 page of that particular exhibit is not something
 16 submitted or that you're testifying about today,
 17 correct?
 18 A. Correct.
 19 Q. Okay. And what is the last page?
 20 A. The last page is the screen printout, it
 21 looks like, from our customer service desktop when
 22 providers or participants call to check the status of
 23 their claim on the website.
 24 Q. Okay. Do any of those documents indicate
 25 how much money was actually paid on the claim

1 submitted?
 2 A. Yes, it does.
 3 Q. How much money was paid?
 4 A. We paid \$306.
 5 Q. Was that paid back to the Endoscopy Center
 6 of Southern Nevada where the claim came from?
 7 A. This claim was paid actually to
 8 Dr. Mathahs, the \$306.
 9 Q. At the location where he was working,
 10 correct?
 11 A. Correct.
 12 Q. Okay. And I just want to be clear. Even
 13 though you're the third-party administrator for
 14 Culinary, you're the ones that were responsible for
 15 receiving the claims and then paying the benefits on
 16 those claims for Culinary; is that correct?
 17 A. That is correct.
 18 And I just want to be clear that this
 19 claim is for Dr. Mathahs. The \$306 were Dr. Mathahs,
 20 the anesthesiologist, CRNA, where he rendered the
 21 services at the Endoscopy Center.
 22 Q. Got it.
 23 Now, beside just coming and testifying
 24 about the records, the claim, and the submission of
 25 everything or the payment of the money on the claim, is

1 there any other item there of importance to you
 2 regarding what was done or handled in this particular
 3 case by your organization?
 4 A. No.
 5 Q. I think you mentioned the minute charges
 6 of being submitted as 33 minutes, correct?
 7 A. That's correct.
 8 Q. Now, hypothetically, if the minute charges
 9 had come in less than that, would the claim necessarily
 10 have been paid for a lesser amount?
 11 A. Yes, it would have.
 12 Q. So the number of minutes was significant
 13 as far as the dollar amount paid on the claim?
 14 A. I'm sorry. Can you repeat the question?
 15 Q. So the number of minutes was -- correlates
 16 to how much money was actually going to be paid?
 17 A. Correct.
 18 Q. If, in fact, you had received a bill that
 19 was down in the seven-minute range, would the payment
 20 have been less?
 21 A. Yes, it would have.
 22 MR. STAUDAHER: I have nothing further for
 23 this witness, ladies and gentlemen.
 24 THE FOREPERSON: Are there any questions
 25 from the jury? There are none. Okay.

1 By law these proceedings are secret. And
 2 you are prohibited from disclosing to anyone anything
 3 that transpired before us, including evidence presented
 4 to the Grand Jury, any event occurring or a statement
 5 made in the presence of the Grand Jury, or information
 6 obtained by the Grand Jury.
 7 Failure to comply with this admonition is
 8 a gross misdemeanor punishable by a year in the Clark
 9 County Detention Center and a \$2,000 fine. In
 10 addition, you may be held in contempt of court
 11 punishable by an additional \$500 fine, and 25 days in
 12 the Clark County Detention Center.
 13 Do you understand this admonition?
 14 THE WITNESS: Yes, I do.
 15 THE FOREPERSON: Okay. Thank you. You
 16 can be excused.
 17 Please remain standing and raise your
 18 right hand.
 19 Do you solemnly swear that the testimony
 20 you are about to give upon the investigation now
 21 pending before this Grand Jury shall be the truth, the
 22 whole truth, and nothing but the truth, so help you
 23 God?
 24 THE WITNESS: I do.
 25 THE FOREPERSON: Thank you. You may be

1 seated.

2 You are advised that you are here today to

3 give testimony in the investigation pertaining to the

4 offenses of performance of act in reckless disregard of

5 persons or property, criminal neglect of patients,

6 insurance fraud, obtaining money under false pretenses,

7 and racketeering, involving Dipak Kantilal Desai,

8 Ronald Ernest Lakeman, and Keith H. Mathahs.

9 Do you understand this advisement?

10 THE WITNESS: Yes, I do.

11 THE FOREPERSON: Could you please state

12 both your first and last names and spell them for the

13 record?

14 THE WITNESS: First name is Anne, A-N-N-E.

15 Last name is Yost, Y-O-S-T.

16 THE FOREPERSON: Thank you.

18 ANNE YOST,

19 having been first duly sworn by the Foreperson of the

20 Grand Jury to tell the truth, the whole truth, and

21 nothing but the truth, testified as follows:

23 / / /

24 / / /

25

1 EXAMINATION

2 BY MR. STAUDAHER:

3 Q. Ms. Yost, what do you do for a living?

4 A. I'm a registered nurse.

5 Q. How long have you been a nurse?

6 A. Two years.

7 Q. Where did you get your training and when

8 did you graduate?

9 A. I want to correct that. It's three years.

10 Three years.

11 I got my training at the Community College

12 of Southern Nevada.

13 Q. And when did you graduate?

14 A. I graduated in May of 2007.

15 Q. Okay. What type of a nurse are you?

16 A. Currently, I am a psychiatric nurse.

17 Q. Are you an LPN, RN?

18 A. RN.

19 Q. RN. Okay.

20 And you're working at a psychiatric unit

21 or building or facility?

22 A. City jail.

23 Q. City jail. Okay. I'm going to go back in

24 time a little bit.

25 After you graduated, where did you go to

1 work?

2 A. After I graduated, I started working at

3 the Endoscopy Center.

4 Q. Do you know when you started working at

5 the Endoscopy Center?

6 A. Yes, it was July of 2007.

7 Q. Do you know the specific date?

8 A. I would say second, third and fifth of

9 July.

10 Q. Okay. So over the Fourth of July period,

11 right in that range?

12 A. Right.

13 Q. You described a three-day period. Is that

14 all that you worked at that facility?

15 A. Right.

16 Q. Were you terminated from the facility?

17 A. No, I resigned my position.

18 Q. When you first went to work at the

19 facility, who did you meet with to hire you or deal

20 with?

21 A. Katie Maley was the director of nursing.

22 Q. So she was the one that interviewed you?

23 A. Yes.

24 Q. And just for the ease of the court

25 reporter, and I'll try to do this, sometimes I make the

1 mistake as well, I'm going to ask you to let me finish

2 my question, and then I'll try to let you finish your

3 answer. Okay?

4 A. Okay.

5 Q. Because it's hard, if we talk over each

6 other, for her to take down all the words.

7 A. Okay.

8 Q. Okay. So you're at -- so Katie Maley is

9 the one that interviews you. Does she hire you on the

10 spot, or do you come back a couple weeks later? How

11 did that go?

12 A. I believe it was a week later. Well, she

13 hired me on the spot. I started about a week later.

14 Q. So when you come into the facility, what

15 is the job that you're going to do?

16 A. I was in the procedure rooms where they

17 perform the endoscopies.

18 Q. And what was your role in the procedure

19 room?

20 A. Mainly charting and paperwork.

21 Q. So did you have hands-on patient activity

22 at that point?

23 A. No, mainly talking to the patient about

24 how they were feeling about the procedure and

25 documenting the condition that they were in.

1 Q. Okay. So pretty much just dealing with
2 the chart and just verbally with the patient?
3 A. Right.
4 Q. Now, when you started working there, did
5 they tell you that that was what you were going to be
6 doing primarily?
7 A. Yes, they did.
8 Q. When you came into the facility, that's
9 what you actually started doing then?
10 A. Right.
11 Q. Was there any kind of a training period
12 for you to be able to chart, or did you learn that when
13 you were in school?
14 A. The three days that I was there I learned
15 their specific way of charting.
16 Q. Okay. And we'll get to that in a minute.
17 But as far as your job, was this the first
18 job that you had after you graduated?
19 A. Yes, it was.
20 Q. After you left that facility, were you
21 able to find another job?
22 A. Yes.
23 Q. How long after that three-day period did
24 it take you to locate another position?
25 A. I started looking for a position right

1 away. I don't believe I was hired until a couple
2 months later.
3 Q. So you started looking -- I mean, how soon
4 after you actually start working did you start looking
5 for a new position?
6 A. As soon as I had resigned, I started
7 looking for another position.
8 Q. Okay. It didn't take you a long, long
9 time, though, to find one?
10 A. No.
11 Q. Now, I'm going to start asking you about
12 what you actually did and what the issues were, if any,
13 that relate to why you left the facility. Okay?
14 A. Okay.
15 Q. Were there personal or professional
16 reasons why you left the facility?
17 A. Yes, the professional reason was that they
18 were encouraging me to pre-chart, and pre-charting is
19 documenting on a patient before you've actually seen
20 them.
21 Q. Now, when you say they encouraged you, was
22 it one person, more than one person, how prevalent was
23 this practice?
24 A. I was trained by two nurses, and both of
25 them had encouraged the same thing.

1 Q. Okay. Did you see other persons do the
2 same thing there?
3 A. Just primarily the two that had trained
4 me, and then also in pre-op.
5 Q. Now, we're going to get into the specifics
6 about how things work in the facility, but when that
7 happened, when you had people come up to you and get
8 you to try and do this, did that surprise you?
9 A. Yes, it did.
10 Q. Did it affect you in any way?
11 A. Yes, I felt -- I was appalled by it.
12 Q. Did you express at the time that this was
13 something that you didn't agree with, you didn't want
14 to do?
15 A. Yes. I told the nurses that were training
16 me that I didn't want to document on a patient before I
17 had actually seen them.
18 Q. When you talk about documentation, what
19 kind of documentation are we talking about?
20 A. Basically, the condition of the patient,
21 anxiety, let's see, if the person has a strange color
22 to them, looks like they are having difficulty
23 breathing.
24 Q. Did you ever -- when you saw -- I assume
25 that you weren't the primary person dealing with the

1 person initially, correct?
2 A. Right.
3 Q. You're in the procedure room. Was there a
4 room or a place that the patients went before they got
5 to the procedure room?
6 A. Yes, pre-op.
7 Q. In the pre-op area, did you go out and do
8 any charting or any work out there?
9 A. No, I didn't.
10 Q. When the patients came from the pre-op
11 area to the procedure room, did they have paperwork
12 with them?
13 A. Yes, they did.
14 Q. When you saw the paperwork coming, did at
15 times you see anything unusual about that paperwork?
16 A. Sometimes the nurses from pre-op had
17 completed the charting that would have been done in the
18 procedure room. They would have started some of that
19 charting ahead of time.
20 Q. For you?
21 A. For the -- yes, the procedure room.
22 Q. What about you, as far as if something had
23 already been filled out for you, what did you do then?
24 A. I would ask why the paperwork was already
25 filled out, and then the nurse training me would say

IN THE SUPREME COURT OF THE STATE OF NEVADA

KEITH MATHAHS,
Petitioner,
vs.
THE EIGHTH JUDICIAL DISTRICT
COURT OF THE STATE OF
NEVADA, IN AND FOR THE
COUNTY OF CLARK, AND THE
HONORABLE VALERIE ADAIR,
DISTRICT JUDGE
Respondent,
and
THE STATE OF NEVADA,
Real Party in Interest.

CASE NO:
D.C. NO:

Electronically Filed
Sep 20 2012 10:30 a.m.
Tracey K. Lindeman
Clerk of Supreme Court
C2654107

**RESPONDENT'S APPENDIX
VOL. II**

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Counsel for Respondent

INDEX

<u>Document</u>	<u>Page No.</u>
Recorder's Transcript of 5/10/12 (Habeas Petition And Motion to Dismiss) filed 5/16/12	651-692
Reporter's Transcript of 3/11/10, 8:33 am, (Grand Jury) Filed 6/8/10	1-56
Reporter's Transcript of 3/11/10, 12:14pm, (Grand Jury) Filed 6/8/10	57-135
Reporter's Transcript of 3/18/10, 8:39am, (Grand Jury) Filed 6/8/10	136-183
Reporter's Transcript of 4/15/10, 8:42 am, (Grand Jury) Filed 6/8/10	184-248
Reporter's Transcript of 4/15/10, 1:50pm, (Grand Jury) Filed 6/8/10	249-311
Reporter's Transcript of 4/22/10, 8:53 am, (Grand Jury) Filed 6/8/10	312-356
Reporter's Transcript of 4/22/10, 11:32 am, (Grand Jury) Filed 6/8/10	357-418
Reporter's Transcript of 4/29/10, 9:19 am, (Grand Jury) Filed 6/8/10	419-480
Reporter's Transcript of 5/6/10, 2:00 pm, (Grand Jury) Filed 6/8/10	481-514
Reporter's Transcript of 5/13/10, 1:03 pm, (Grand Jury) Filed 6/8/10	515-540
Reporter's Transcript of 5/20/10, 8:45 am, (Grand Jury) Filed 6/8/10	541-598
Reporter's Transcript of 5/27/10, 10:37 am, (Grand Jury) Filed 6/8/10	599-600
Reporter's Transcript of 6/3/10, 2:30 pm, (Grand Jury) Filed 6/8/10	601-650

1 **CERTIFICATE OF SERVICE**

2 I hereby certify and affirm that this document was filed electronically with
3 the Nevada Supreme Court on September 20, 2012. Electronic Service of the
4 foregoing document shall be made in accordance with the Master Service List as
5 follows:

6 CATHERINE CORTEZ MASTO
7 Nevada Attorney General

8 MICHAEL V. CRISTALLI, ESQ.
9 EUNICE M. MORGAN
10 Counsels for Appellant

11 RYAN J. MACDONALD
12 Deputy District Attorney

13 I further certify that I served a copy of this document by mailing a true and
14 correct copy thereof, postage pre-paid, addressed to:

15 JUDGE VALERIE ADAIR
16 Eighth Judicial District Court, Dept. XXI
17 Regional Justice Center, 11th Fl.
18 200 Lewis Avenue
19 Las Vegas, Nevada 89101

20
21
22 /s/ eileen davis

23 _____
24 Employee of the
25 Clark County District Attorney's Office

26
27 RJM//ed
28

EIGHTH JUDICIAL DISTRICT COURT
COUNTY OF CLARK, STATE OF NEVADA

BEFORE THE GRAND JURY IMPANELED BY THE AFORESAID
DISTRICT COURT

STATE OF NEVADA

Plaintiff,

vs.

DIPAK KANTILAL DESAI,
RONALD ERNEST LAKEMAN,
KEITH H. MATHAHS,

Defendants.

CASE NO. 09BGJ049A-C

ORIGINAL

265107

Taken at Las Vegas, Nevada

Thursday, April 15, 2010

1:50 p.m.

REPORTER'S TRANSCRIPT OF PROCEEDINGS

Volume 3A

Reported By: DONNA J. McCORD, C.C.R. No. 337

Donna J. McCord
CCR #337
(702) 671-3365

GRAND JURORS PRESENT ON THURSDAY, APRIL 15, 2010

FILED

JUN 08 2010

CLERK OF COURT

FILED

JUN 08 2010

CLERK OF COURT

PAM YOUNG, Foreperson

JOSEPH WILLOUGHBY, Deputy Foreperson

LOUISE ZUNIGA, Secretary

SHELLEY SALAMANOUPOULUS, Assistant

SVEN BRADLEY

CONSTANCE CABILES

LISA CAMP

CHRISTINE LYONAI

AGNES PARKER

YOLANDA PARKER

BIANCA ROBERSON

BOB ROSE

STEVE SHLOKER

ALICE SZURAN

MICHAEL THOMPSON

TOM URRHAN

ANNE ZARATE

ALSO PRESENT AT THE REQUEST OF THE GRAND JURY:

MICHAEL STAUDAHNER, ESQ.,
Deputy District Attorney

Terry Coffing, Esq.
Suzanne Whitehead, DA intern

Donna J. McCord
CCR #337
(702) 671-3365

INDEX OF WITNESSES

	<u>Examined</u>
PATRICIA ARMOUR	6
BRIAN LABUS	28
MELVIN HAWKINS	126

Donna J. McCord
CCR #337
(702) 671-3365

INDEX OF EXHIBITS

<u>Grand Jury Exhibits</u>	<u>Identified</u>
12 - document	13
13 - report	56
18 - document	13
19 - shipping form	18
20 - shipping form	18
21 - shipping form	18
22 - shipping form	18
23 - shipping form	18
24 - shipping form	18

CE15

Donna J. McCord
CCR #337
(702) 671-3365

RA 000249

1 LAS VEGAS, NEVADA, THURSDAY, APRIL 15, 2010

2 * * * * *

3
4 DONNA J. McCORD,

5 having been first duly sworn to faithfully
6 and accurately transcribe the following
7 proceedings to the best of her ability.

8
9 MR. STAUDAHER: Ladies and gentlemen of
10 the Grand Jury, we're going to go ahead and continue
11 on with the presentation for today. The next
12 witness will be Pat Armour.

13 THE FOREPERSON: Please raise your right
14 hand, ma'am.

15 You do solemnly swear that the
16 testimony you're about to give upon the
17 investigation now pending before this Grand Jury
18 shall be the truth, the whole truth, and nothing but
19 the truth, so help you God?

20 THE WITNESS: I do.

21 THE FOREPERSON: Thank you. You may be
22 seated.

23 You are advised that you're here
24 today to give testimony in the investigation
25 pertaining to the offenses of performance of act in

Donna J. McCord
CCR #337
(702) 671-3365

1 person accompanying Miss Armour. His name is Terry
2 Coffing. He's the attorney for the Southern Nevada
3 Health District. He will not be participating but
4 he will be here to lend advice to his client if he
5 needs to. And with that we'll go ahead and proceed.

6 Miss Armour, what do you do for a
7 living?

8 A I'm the laboratory manager of the Southern
9 Nevada Health District.

10 Q And what do you do as the laboratory
11 manager?

12 A I oversee the operations -- I'm sorry, I
13 misspoke. It's the Southern Nevada Public Health
14 Laboratory which is affiliated with the Southern
15 Nevada Health District.

16 Q Okay.

17 A I oversee the operations of the Southern
18 Nevada Public Health Laboratory, and that includes
19 the clinical testing that's performed there as well
20 as the bio-terrorism testing for Southern Nevada and
21 reportable disease isolate testing for Southern
22 Nevada Health District.

23 Q In your capacity in the Health District do
24 you ever get involved with the preparation,
25 grouping, processing of samples that are sent off to

Donna J. McCord
CCR #337
(702) 671-3365

1 reckless disregard of persons or property; criminal
2 neglect of patients; insurance fraud, obtaining
3 money under false pretenses; and racketeering
4 involving Dipak Kantilal Desai, Ronald Ernest
5 Lakeman and Keith H. Mathahs.

6 Do you understand this advisement?

7 THE WITNESS: I do.

8 THE FOREPERSON: Could you please state
9 your first and last name spelling both for the
10 record?

11 THE WITNESS: Patricia, P-A-T-R-I-C-I-A,
12 Armour, A-R-M-O-U-R.

13 THE FOREPERSON: Thank you.

14
15 PATRICIA ARMOUR,

16 having been first duly sworn by the Foreperson of the
17 Grand Jury to testify to the truth, the whole truth,
18 and nothing but the truth, testified as follows:

19
20 EXAMINATION

21 BY MR. STAUDAHER:

22 Q Is it Miss or Doctor?

23 A Miss.

24 Q Miss Armour -- before we get started I do
25 want to put on the record that there is another

Donna J. McCord
CCR #337
(702) 671-3365

1 other laboratories, for example CDC?

2 A Yes, I do.

3 Q I'm going to direct your attention to
4 January of this year. Geez, January not of this
5 year, January of 2008. Were you involved in the
6 preparation of samples or the collection of samples
7 or both regarding an outbreak of hepatitis in
8 Southern Nevada?

9 A Yes, I was.

10 Q And how did you become involved in that in
11 the first place?

12 A As part of the outbreak investigation team
13 which was set up with the Southern Nevada Health
14 District, the laboratory was an integral component
15 of the investigation into the Endoscopy Center. We
16 participated in meetings with the CDC as well as
17 collecting samples from employees of the facility
18 and planning for the notification that would occur
19 in February.

20 Q Now, did you know at the time that you
21 started that you were going to actually be involving
22 CDC?

23 A Not at the -- I did not know at the time
24 that we started that CDC might be involved.

25 Q Okay. So at what point in this whole

Donna J. McCord
CCR #337
(702) 671-3365

RA 000250

1 process do you actually become part of this?
 2 A The point in the process when I became
 3 part of this typically occurs when our office of
 4 epidemiology receives results of a positive test on
 5 a sample. And typically we're notified, our
 6 laboratory is notified by the epidemiology
 7 department to see if we can contact a commercial
 8 laboratory that performed the testing to see if we
 9 can get a sample of that, if we can get that sample
 10 shipped to us so that we can ship it to the CDC for
 11 additional testing.

12 Q Now, as far as samples that either come
 13 into the Southern Nevada Health District or are
 14 initiated in the form of blood draws or whatever by
 15 the Southern Nevada Health District, is your entity
 16 within that group part responsible for that kind of
 17 work?

18 A For collecting the --

19 Q Collecting the samples first of all.
 20 We'll take it piece by piece.

21 A Okay. So we collect samples at the
 22 request of the Southern Nevada Health District
 23 office of epidemiology. We are not open to the
 24 public and we don't do testing for other physicians.
 25 So if the office of epidemiology requests collection

Donna J. McCord
 CCR #337
 (702) 671-3365

1 of samples then we would be the entity that would
 2 collect them.

3 Q Did you do so in this case related to the
 4 outbreak?

5 A Yes, we did.

6 Q And then subsequent to that did you then
 7 process any of the samples that you yourself or your
 8 organization had processed?

9 A Yes, we did.

10 Q As far as samples that came into you that
 11 you obtained from other laboratories, was that
 12 something that went through your hands or your
 13 laboratory?

14 A Yes, it was.

15 Q When that happens, either if you initiate
 16 it or it comes in from another source, is there some
 17 way that you kind of keep track of what's going on?

18 A So every sample that comes into the
 19 laboratory is labeled with a unique identifier from
 20 the facility that it came from. So laboratories
 21 typically give unique identifiers for the sample.
 22 It's called an accession number for the samples that
 23 they collect. Those samples are labeled with that
 24 number. It's also typically labeled on the, or
 25 that's written on the test requisition form that

Donna J. McCord
 CCR #337
 (702) 671-3365

1 comes to us. Those samples, when they get shipped
 2 to us from the other laboratory, when they get to
 3 our facility those numbers are matched with the
 4 number and name that's on the tube, with the number
 5 and name that's on the requisition and then that
 6 information is placed into our laboratory
 7 information management system where it gets yet
 8 another number. And that unique number is part of
 9 the Southern Nevada Public Health Laboratory
 10 information system which it's called the LIMS.

11 Q Now, at any time do you, if you're
 12 interacting with an entity such as CDC, do you ever
 13 receive numbers or labels or information from them
 14 that you're going to use in the collection process?

15 A Yes, we can. In some instances they will
 16 give us an additional unique identifier that the
 17 other laboratory is requiring us to use.

18 Q So if I understand you correctly at this
 19 point, if you were doing that in general you might
 20 have multiple identifiers for one single sample?

21 A That's correct.

22 Q In the process of processing these,
 23 sending them out, receiving them, handling them, do
 24 all of those numbers have to match up to make sure
 25 that it's the same person and sample?

Donna J. McCord
 CCR #337
 (702) 671-3365

1 A That's correct.

2 Q In the particular case that we're talking
 3 about here, the Health District case that involved
 4 the hepatitis outbreak, did you involve yourself
 5 with the CDC in either obtaining that kind of
 6 material from them in order to produce the samples?

7 A Yes, I was in charge of that process.

8 Q Okay. Tell us what you did related to
 9 that.

10 A Related to getting the numbers from the
 11 CDC?

12 Q Yes. Tell us how that goes and what you
 13 receive from them and what you did with them.

14 A The outbreak investigation team, when we
 15 made the connection with the CDC, the CDC created a
 16 specific code for this investigation. It had three
 17 letters in front of it, NVC, and the numbers were
 18 sequentially numbered starting with number one.
 19 They sent us a sheet of pre-labeled, preprinted
 20 labels. The labels also had bar code numbers on
 21 them. And each patient sample, when the samples
 22 were collected if we were sending them to CDC, that
 23 label with the special NVC number was attached to
 24 the samples that were sent to the CDC as well as the
 25 test requisition forms as well as a sample log that

Donna J. McCord
 CCR #337
 (702) 671-3365

RA 000251

1 the CDC required that we send with the samples when
2 we ship them to CDC.

3 Q In your position, do you have access to
4 all of these records and logs and so forth that are
5 done?

6 A Yes, I do.

7 Q Did you review those in preparation for
8 coming in today?

9 A Yes, I did.

10 Q Did you actually produce some documents or
11 copy some documents related to the, sort of the flow
12 of these samples through your laboratory back to
13 CDC?

14 A Yes, I did.

15 Q I'm going to start off by showing you a
16 couple of exhibits. One is, it may be redundant but
17 I just want to show it to you anyway, one is marked
18 as Exhibit Number 12 and one is marked as Exhibit
19 Number 18. Would you look over those documents and
20 tell me if you're familiar with them?

21 A Yes. These were documents that we started
22 in the beginning stages as well as when the
23 investigation was going on that helped us to keep
24 track of the patients that had been sent to CDC and
25 keep track of all those numbers.

Donna J. McCord
CCR #337
(702) 671-3365

1 Q So do the names of the individuals that
2 relate to a sample, do they correspond with these
3 unique identifiers that you mentioned earlier?

4 A Yes, they do.

5 Q And does that include the unique
6 identifiers from CDC, the NVC numbers?

7 A That's correct.

8 Q After the samples are put together, do you
9 send the names along with the samples to CDC or just
10 the numbers?

11 A No, the names are included as well.

12 Q Okay. So all that goes off to CDC; is
13 that correct?

14 A That's correct.

15 Q So in this particular case on Exhibit
16 Number, we'll start off with Exhibit Number 18, can
17 you tell us what we're looking at here?

18 A So on this log you have the patient's
19 name, their date of birth. We were trying to
20 identify whether they were a patient to contact, an
21 employee or a past employee. They're what's called
22 an OOEHR number and that is another unique
23 identifier that our office of epidemiology maintains
24 for morbidity tracking.

25 If the sample was received from an

Donna J. McCord
CCR #337
(702) 671-3365

1 outside commercial laboratory, we identified where
2 that came from, when the sample was collected, the
3 special unique identifier for that commercial lab.

4 If the lab was collected at Southern
5 Nevada Public Health Lab, the collection date for
6 that with our unique identifier, the CDC study code
7 number, the NVC number, the date the sample was
8 shipped to CDC.

9 There's an additional number on here
10 called a chart identifier which is another number
11 the CDC utilized when they were on site, the results
12 of the testing, when they were received by the lab,
13 when they were received by Epi and also the
14 procedure dates, who performed or collected the
15 sample, any additional testing that was done and
16 whether the sample is still stored in the laboratory
17 freezer.

18 Q Okay. I'm going to go ahead and display
19 this for the Grand Jury and I'm want to ask you a
20 few questions about it. This is the first page of
21 Grand Jury Exhibit 18. And I know it's very small
22 but since you're close I'm going to stay up here for
23 a moment and just ask you if, and I'm just going to
24 pick one for example, but on the first and second
25 page, does this depict all of the patients who were

Donna J. McCord
CCR #337
(702) 671-3365

1 either believed to be infected or source patients
2 regarding this outbreak?

3 A That's correct.

4 Q Okay. So if we pick the very first one as
5 an example, can you tell us who that was and what
6 the information is across this page? And if you
7 need to step up a little closer you can.

8 A Thank you. The first -- well, I'm going
9 to look over here.

10 Q That's fine.

11 A The first --

12 Q And you can use your finger to direct and
13 show --

14 A Thank you. So the first name on here is
15 Rudolfo Meana. Date of birth 2-20-1935. This is
16 the patient. The epidemiology medical record number
17 is 30402. This sample came from a commercial
18 laboratory which is Quest. The collection date is
19 12-27-2007. The accession number 490 -- did you
20 want me to read all the numbers?

21 Q You don't have to read all of it, just
22 tell us what those categories are.

23 A All right. So the assessment collection
24 date, the accession number. So if the sample was
25 collected at Southern Nevada Public Health Lab, the

Donna J. McCord
CCR #337
(702) 671-3365

1 specimen collection date for that, the accession
 2 number. This sample was the very first one in our
 3 study code so it's NVC-1, the date it was shipped to
 4 CDC, the chart identifier, the results of the
 5 testing at CDC, when we received them by at Southern
 6 Nevada Public Health Lab, when they were received by
 7 our office of epidemiology, when their procedure
 8 was. And this line that talks about CDC testing,
 9 this identifies that the sample that was tested at
 10 CDC was the Quest sample that was collected back on
 11 12-27-2007. The sample was recollected at Southern
 12 Nevada Public Health Lab because we needed to test
 13 the patient for Hepatitis B as well as HIV.

14 Q Okay.

15 A And then the last column tells that the
 16 sample is still in storage at Southern Nevada Public
 17 Health Lab.

18 Q So just for the record, as we moved across
 19 that as you say each category, you were referring to
 20 a different column on the sheet; is that right?

21 A Correct.

22 Q And we just picked out one for an example?

23 A Correct.

24 Q Now, again this contains, this page and
 25 the following page on this particular exhibit lists

Donna J. McCord
 CCR #337
 (702) 671-3365

1 all of that kind of information for each one of the
 2 patients, either the source patients or the infected
 3 patients for both dates, the 25th of July of 2007 or
 4 the 21st of September of 2007?

5 A Correct.

6 Q Okay. That's fine. Now, and that
 7 document that's up there right now, is that one that
 8 you put together or had some hand in crafting?

9 A Yes, I assisted with the -- I started this
 10 spread sheet and then in conjunction with our office
 11 of epidemiology, both groups worked on putting in
 12 the data.

13 Q The data that's contained in this
 14 particular document, have you actually gone back and
 15 verified that it's accurate?

16 A Yes, I have.

17 Q Okay. You yourself did this?

18 A Yes, I did.

19 Q Now, as far as the other exhibits are
 20 concerned, I'm going to start off with -- I guess
 21 we'll just go in order. We've got 19 through -- 19,
 22 20, 21, 22, 23 and 24. Can you tell us what those
 23 documents are?

24 A So each one of these documents represents
 25 the CDC shipping form, when the samples were shipped

Donna J. McCord
 CCR #337
 (702) 671-3365

1 to the CDC. They --

2 Q And as you talk, I'm going to go ahead and
 3 display one so that we can have that for the Grand
 4 Jury. I'm going to start off with, I'll put Exhibit
 5 24 on the screen and you can describe for us what
 6 we're looking at. And I believe this one looks like
 7 it goes to Sharrieff Ziyad.

8 A Correct. This was a shipping form that
 9 the CDC provided to us at the beginning of the
 10 study. At the top of this you'll see that the NVC
 11 hepatitis reference study code is listed. It lists
 12 the date the samples were shipped. It lists a
 13 number in there to identify how many samples were
 14 included with the shipment. It lists the Fed-Ex air
 15 bill number for when the shipment was sent, where it
 16 came from. It lists our facility location, the
 17 person who completed the form and their signature,
 18 the date the form was completed and then it does
 19 list the shipping address to the CDC.

20 Q And that's on the first page; is that
 21 correct?

22 A Correct.

23 Q And then on the next page, what
 24 information is contained on that page?

25 A So on the next page is the listing of the

Donna J. McCord
 CCR #337
 (702) 671-3365

1 samples that were included in with the shipment. So
 2 there were three vials listed on the front page of
 3 the page, that was what was contained in the
 4 shipment, and there were three vials that were
 5 shipped.

6 Q Now, that's of the exhibit that you're
 7 actually looking at?

8 A Oh, I'm sorry, I'm on the wrong -- yes.

9 Q So the one that's up displayed for the
 10 jury right now, it's the same kind of thing for each
 11 one, this one only contains one but the one you were
 12 referring to which is Exhibit 23 actually has three
 13 separate samples that were sent; is that correct?

14 A That's correct.

15 Q Okay. Tell us what we're looking at there
 16 on the screen.

17 A So on the screen again where it says
 18 patient I.D., that is a label from our laboratory
 19 information management system. The number at the
 20 top, the 12839 I believe it says, is an accession
 21 number that's unique for that sample, lists the
 22 patient's first and last name. The second column
 23 which is the CDC study code --

24 Q Let me stop you there just for the record.
 25 Is this the number up here that you're referring to?

Donna J. McCord
 CCR #337
 (702) 671-3365

1 A That's correct.
 2 Q So the top of the bar code to the left
 3 under the column patient I.D. for the record?
 4 A That's correct.
 5 Q Okay.
 6 A The next column is the CDC study code and
 7 that this contains the preprinted labels that the
 8 CDC provided to us. And that is an NVC number
 9 that's listed on there that's unique to this sample.
 10 Q Okay.
 11 A The next column would be the date the
 12 sample was collected. The next column is the number
 13 of cryovials that were related to that sample. And
 14 then the diagnosis column actually identifies which
 15 tests that we performed at the CDC as part of this
 16 study.
 17 Q So in this case it's -- does this stand
 18 for Hepatitis C, Hepatitis B and HIV?
 19 A That's correct.
 20 Q And that's a Human Immunodeficiency; is
 21 that correct?
 22 A That's correct.
 23 Q Now, as far as your handling of these
 24 samples, when all of them are sitting there I assume
 25 you send them out at different times; is that right?

Donna J. McCord
 CCR #337
 (702) 671-3365

1 specific period of time and that the sample, the
 2 serum portion be aliquoted off or taken off of the
 3 tube and placed into another vial that was frozen.
 4 And the vial that -- and that vial with the frozen
 5 serum is what gets sent to the CDC. Those frozen
 6 vials were labeled with the accession label that
 7 contains our unique identifier.
 8 Q Now, do you send the entire sample off or
 9 do you retain any of it in the laboratory?
 10 A So in this case when we collected these
 11 samples we were -- there was sufficient serum off of
 12 one tube of blood to split that so that we could
 13 maintain one sample of frozen serum at SNPHL as well
 14 as send one sample to CDC, and that was to ensure
 15 that if there was any problems during transit, we
 16 had situations where our boxes might be delayed by
 17 Federal Express, these are frozen samples, we want
 18 to maintain their integrity, we maintain a sample in
 19 our freezer to ensure that we could reship the
 20 sample if needed.
 21 Q Did you maintain a sample in your freezer
 22 for all of the nine patients?
 23 A That's correct.
 24 Q Did you have any problems with shipping
 25 where you had to either reship out a sample or there

Donna J. McCord
 CCR #337
 (702) 671-3365

1 A That's correct.
 2 Q When you have more than one sample at a
 3 time, do you do them both together or how do you
 4 keep them categorized?
 5 A So the samples are all handled
 6 individually. They are -- when we receive samples
 7 at the laboratory they come in a, what's called a
 8 biohazard bag. It's a zip-style bag. The sample is
 9 included in the zipped portion of the bag. There's
 10 a pocket at the front of the bag where any paperwork
 11 attached to that sample is put. They come in with a
 12 test requisition and then the samples are all
 13 labeled with the patient's name and information.
 14 These come in. They're accessioned
 15 into our laboratory information management system
 16 which is where that preprinted label comes from.
 17 And then if any additional testing that needs to be
 18 done on these samples, they need to be centrifuged.
 19 Typically they come in as whole blood. They get
 20 placed in a centrifuge so that we can collect the
 21 liquid portion of the blood which is called serum.
 22 That is the material that is sent to the CDC or to
 23 the testing laboratory for testing. The CDC
 24 recommended that the samples, once they were
 25 collected, that they be centrifuged within a

Donna J. McCord
 CCR #337
 (702) 671-3365

1 was some problem with a delay and the, you know, the
 2 sample warming up or something like that?
 3 A We did not have any shipping problems.
 4 Q Okay. Now, beside the issues that you've
 5 addressed, after the samples go to CDC and the
 6 testing is done, are you involved with any of the
 7 results that come back?
 8 A Yes. The results, as the submitting
 9 laboratory, the results come back to Southern Nevada
 10 Public Health Laboratory. The test that was ordered
 11 in our laboratory information management system
 12 remains pending or open until we get the results
 13 back which enables us to track those. And then when
 14 the results come back we put the results in our
 15 system and then we print a report which is sent to
 16 our office of epidemiology.
 17 Q Beside that process that you've described,
 18 were you involved in any interpretation of any of
 19 the results or any testing itself at the lab?
 20 A At the CDC?
 21 Q No. When stuff comes back, do you
 22 interpret the results or is that already done?
 23 A No, that's already done and the testing
 24 laboratory provides the interpretation.
 25 Q Okay. And then what do you do with that

Donna J. McCord
 CCR #337
 (702) 671-3365

1 after you get those results and as far as
 2 incorporating it or just giving it to your people
 3 internally?
 4 A To the office of epidemiology?
 5 Q Yes.
 6 A So again those results are put into our
 7 laboratory information management system and then a
 8 report is printed that includes the CDC results.
 9 And then we also send a copy of the CDC report along
 10 with our report to the office of epidemiology.
 11 Q Who was the local epidemiologist that was
 12 involved with this particular case?
 13 A That would be Brian Labus.
 14 Q So were these results made available to
 15 him then after they came back?
 16 A Yes, they were.
 17 Q Were you involved in the actual transfer
 18 of the information that came from CDC into your
 19 information lab or information data base, so to
 20 speak?
 21 A Yes.
 22 Q Okay. And you've checked that to make
 23 sure that there were no errors or inaccuracies in
 24 the transfer?
 25 A Yes, I have.

Donna J. McCord
 CCR #337
 (702) 671-3365

1 THE FOREPERSON: Please remain standing
 2 and raise your right hand, sir.
 3 You do solemnly swear that the
 4 testimony you're about to give upon the
 5 investigation now pending before this Grand Jury
 6 shall be the truth, the whole truth, and nothing but
 7 the truth, so help you God?
 8 THE WITNESS: I do.
 9 THE FOREPERSON: Thank you. You may be
 10 seated.
 11 You're advised that you're here today
 12 to give testimony in the investigation pertaining to
 13 the offenses of performance of act in reckless
 14 disregard of persons or property; criminal neglect
 15 of patients; insurance fraud; obtaining money under
 16 false pretenses; and racketeering involving Dipak
 17 Kantilal Desai, Ronald Ernest Lakeman and Keith H.
 18 Mathahs.
 19 Do you understand this advisement?
 20 THE WITNESS: Yes, I do.
 21 THE FOREPERSON: Could you please state
 22 both your first and last name spelling them for the
 23 record?
 24 THE WITNESS: Brian Labus, B-R-I-A-N
 25 L-A-B, as in boy, U-S, as in Steve.

Donna J. McCord
 CCR #337
 (702) 671-3365

1 MR. STAUDAHER: At this time I have
 2 nothing further for this witness if the Grand Jury
 3 has something.
 4 THE FOREPERSON: Are there any questions
 5 from the jury? None?
 6 By law these proceedings are secret
 7 and you are prohibited from disclosing to anyone
 8 anything that transpired before us including any
 9 evidence presented to the Grand Jury, any event
 10 occurring or a statement made in the presence of the
 11 Grand Jury or any information obtained by the Grand
 12 Jury.
 13 Failure to comply with this
 14 admonition is a gross misdemeanor punishable by one
 15 year in the Clark County Detention Center and a
 16 \$2,000 fine. In addition you may be held in
 17 contempt of court punishable by an additional \$500
 18 fine and 25 days in the Clark County Detention
 19 Center.
 20 Do you understand this advisement?
 21 THE WITNESS: Yes, I do.
 22 THE FOREPERSON: Thank you. You may be
 23 excused.
 24 THE WITNESS: Thank you.
 25 MR. STAUDAHER: Stand right here.

Donna J. McCord
 CCR #337
 (702) 671-3365

1 THE FOREPERSON: Thank you.
 2
 3 BRIAN LABUS,
 4 having been first duly sworn by the Foreperson of the
 5 Grand Jury to testify to the truth, the whole truth,
 6 and nothing but the truth, testified as follows:
 7
 8 EXAMINATION
 9 BY MR. STAUDAHER:
 10 Q Mr. Labus, what do you do for a living?
 11 A I'm the senior epidemiologist with the
 12 Southern Nevada Health District.
 13 Q And how long have you been in that
 14 position?
 15 A I've been the senior epidemiologist for
 16 seven years. I've been an epidemiologist for nine.
 17 Q Prior to the time -- have all nine years
 18 been with the Southern Nevada Health District?
 19 A Yes, they have.
 20 Q When you were not the senior
 21 epidemiologist, what was the other role you had for
 22 those other two years?
 23 A I was an epidemiologist. The same job
 24 basically, just a little lower on the totem pole.
 25 Q In order to become an epidemiologist at

Donna J. McCord
 CCR #337
 (702) 671-3365

1 Southern Nevada in your case, what was your
2 background and experience?

3 A I have a bachelor's degree in biology from
4 Purdue University and I have a master's degree in
5 infectious diseases from the School of Public Health
6 at the University of California Berkeley.

7 Q Beside your education, have you been
8 involved in any training seminars, publications,
9 anything else things like the report which came from
10 this particular case?

11 A Yes. I've been involved in numerous
12 training seminars related to my profession. I also
13 teach infectious disease epidemiology at the School
14 of Public Health at UNLV.

15 Q I'm going to direct your attention back to
16 January of 2008, actually maybe even before that a
17 little bit, back into 2007. Did you at the Health
18 District become aware and get involved with an
19 outbreak of Hepatitis C cases related to the
20 Endoscopy Center of Southern Nevada?

21 A Yes.

22 Q And how was it that you become involved
23 with that?

24 A We had two cases of acute Hepatitis C
25 reported to our office independently by the doctor

Donna J. McCord
CCR #337
(702) 671-3365

1 received the first two reports from the same doctor
2 you said?

3 A The two cases reported related to the same
4 clinic is how we determined in our investigation,
5 but the first one came in the beginning of December,
6 2007. The second one came in the middle of
7 December, 2007.

8 Q Okay. Based on that information, was two
9 in that short of time span kind of an unusual event?

10 A Having two cases closely linked together
11 would have been a little unusual. It was unusual.
12 We had our disease investigators do the
13 investigation and find out that they both had gone
14 to the same clinic.

15 Q Okay. So this was part of the record or
16 part of the investigation that was done and
17 typically in any case that comes in that you have to
18 do some form of investigation?

19 A Yes, that's correct.

20 Q So you just can't say, gosh, this is a
21 just a Hepatitis C case and, you know, if we get
22 another one we might look into it?

23 A No. Each case is investigated according
24 to our protocol. They ask about the major risk
25 factors and then try and confirm the person actually

Donna J. McCord
CCR #337
(702) 671-3365

1 that diagnosed those cases. By law they're required
2 to report those to our office so we can investigate
3 them and try and identify links between the cases.

4 Q So this wasn't just something that a
5 doctor has discretion to report, it's an obligation
6 under law to do so?

7 A Yes. It's required that health care
8 providers and laboratories report evidence of
9 disease to the Health District for investigative
10 purposes.

11 Q In a typical year do you get reports of
12 Hepatitis C cases --

13 A Yes, we do.

14 Q -- that come to the lab? And just for
15 ease of the court reporter, if you could allow me to
16 finish my question before you answer. I'll try and
17 allow you to finish your answer before I ask the
18 next question if that's okay.

19 A Okay.

20 Q That being said, in that particular
21 situation, I mean, how many do you on an average
22 receive in a year's time?

23 A In an average year for the county we
24 receive between two and four cases reported to us.

25 Q So what was the time frame by which you

Donna J. McCord
CCR #337
(702) 671-3365

1 has that disease.

2 Q So when a case comes in do you initially
3 get involved or is that a lower investigator level
4 person?

5 A We have a disease investigation staff that
6 does the individual case investigation.

7 Q So do they follow up with not only the
8 person that supposedly has Hepatitis C but also look
9 into other issues like risk factors and so forth?

10 A Yes. They get laboratory results, they
11 will get medical records from the patient's provider
12 and they will interview the patient to look for risk
13 factors.

14 Q Now, are the cases that come in -- there's
15 a difference between chronic and acute hepatitis, is
16 there not?

17 A Yes, that's correct.

18 Q In the cases that came in, what were they
19 classified as at the time?

20 A They were both classified as acute
21 Hepatitis C.

22 Q And can you tell us about that? What is
23 the difference between acute versus chronic
24 hepatitis and how is it classified?

25 A Acute Hepatitis C is reportable in Nevada.

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1 Chronic hepatitis is not. Acute disease refers to a
2 person that develops symptoms. So they have a newly
3 acquired infection, they develop the symptoms of
4 hepatitis which include jaundice, nausea, abdominal
5 pain, dark urine, light-colored stool. They have
6 physical symptoms that are present.

7 A chronic case is a person who either
8 went through that acute phase and the symptoms went
9 away and they still have the virus present in their
10 body doing damage at a level that they wouldn't
11 notice unless they were tested. Or most people when
12 they're newly infected go right into that chronic
13 phase and never have the acute symptoms. So only
14 about one in ten people actually develop that acute
15 disease.

16 Q So even though that you had two
17 individuals that presented with hepatitis, at least
18 acute hepatitis, that could mean that there was up
19 to 20 individuals out there that maybe had the
20 similar thing happen to them but didn't essentially
21 produce results or symptoms?

22 A I suppose that's possible. We don't make
23 those sort of calculations. We just saw two
24 closely-related cases and that was what started our
25 investigation.

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1 with people that had hepatitis, medical procedures,
2 dental procedures, tattoos, basically any type of
3 situation where they could be exposed to blood or
4 blood products.

5 Q So medical procedures were on your list of
6 things to look at?

7 A Yes. And because of outbreaks that have
8 occurred with other endoscopy centers nationwide, we
9 specifically ask about that. We ask people about
10 surgeries but they may not think of the endoscopic
11 procedure in the same way. So we specifically ask
12 about that as well.

13 Q Is that a line item that you actually ask
14 the person, have you had an endoscopy or colonoscopy
15 or something along those lines?

16 A Yes, it is.

17 Q So in this particular case were there any
18 other risk factors that were associated or in common
19 with the two except for the fact that they both had
20 endoscopic procedures done at a local clinic?

21 A No. Those were the only risk factors
22 identified, that endoscopic procedure in both of
23 those cases.

24 Q So once that information comes to light,
25 what is the next step that happens at the Health

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1 Q Fair enough. So at this point you've got
2 one case that comes in and another case that comes
3 in a couple of weeks later. Do your investigators
4 or your investigative office, do they compare notes
5 on cases that come in?

6 A Yes. Our investigators, we're talking
7 about acute Hepatitis C cases that they had, the two
8 investigators who were assigned those cases, and on
9 December 28th they identified that there was a
10 common risk factor among the two, that they had both
11 undergone endoscopic procedures at the Endoscopy
12 Center of Southern Nevada.

13 Q You know, when you're looking at something
14 like that, do you have some sort of matrix that you
15 follow as far as the things you're looking at; for
16 example, whether or not somebody had blood
17 transfusions or they engaged in risky social
18 behavior, things like that?

19 A Yes, there's a number of risk factors that
20 we ask about on every case, looking at the major
21 risk factors for that disease. For Hepatitis C
22 there are a number of them that we look at. They're
23 standard across any case that would be reported
24 which would include blood transfusions, organ
25 transplants, intravenous drug use, sexual contact

Donna J. McCord
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1 District?

2 A We begin starting to look at what the
3 common factors are. In this case having two
4 Hepatitis C cases related to the same facility is
5 very uncommon. So we contacted the CDC for some
6 technical advice on which way to go with this
7 investigation. The two cases we identified had
8 procedures on different days so we didn't have two
9 people on the same day. We had two people, one in
10 late July and one in mid September. We didn't have
11 the dates or the time, but we knew they were
12 separated by about three months or so.

13 Q Later you got the dates?

14 A We got the dates later, but initially we
15 knew they at least didn't have it around the same
16 time period.

17 Q So I assume you call the CDC. Was
18 that you? Do you get involved at this stage?

19 A Yes.

20 Q Okay. So once you have two sort of cases
21 from your investigators, do you get assigned to the
22 case?

23 A Yes. Basically I'm responsible for the
24 outbreak investigation. So that's one of my normal
25 job duties is to get involved in the sort of

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RA 000257

1 clusters or reports of common links.

2 Q So you're the one that picks up the phone,
3 dials CDC and talks to them?

4 A Me and my boss. We had several people
5 actually contacting CDC at that point. We kind of
6 work as a team on most things.

7 Q Now, based upon your contact with CDC what
8 happened?

9 A Well, as we were discussing with CDC what
10 we should do and where we should go with the
11 investigation, we identified a third case. So
12 basically as we're emailing and talking to CDC a
13 third case was reported of acute Hepatitis C. It
14 was assigned to an investigator. They made it a
15 high priority. They managed to get ahold of the
16 person right away. And that person had a procedure
17 at the Endoscopy Center of Southern Nevada on the
18 same day as one of the other two cases. So now we
19 basically had the dates down. We knew there was one
20 case on July 25th and two people who had procedures
21 on September 21st.

22 Q So was this a red flag to you at this
23 point?

24 A Yes. The three cases basically are what
25 we'd expect for the entire county for the year and

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1 now we've got them linked to the same clinic, two of
2 them on the same day.

3 Q Okay. And they come in to you within a
4 period of about a month it sounds like?

5 A Yes, that's correct.

6 Q So do you relay this information to the
7 CDC as well?

8 A Yes.

9 Q Do they agree to help you?

10 A Yes. We started the process then of
11 asking for their assistance for them to come out and
12 provide what's called an Epi aid. It's a process
13 set up where the CDC can provide technical expertise
14 and send their people out to assist in outbreak
15 investigations in state and local health
16 departments.

17 Q And I just want to interrupt for just a
18 second.

19 Is everybody hearing what he's
20 saying?

21 A JUROR: Yes.

22 A JUROR: Yes.

23 MR. STAUDAHNER: Okay. I wanted to make
24 sure.

25 ///

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1 BY MR. STAUDAHNER:

2 Q I assume that that happens then?

3 A Yes, we made the official request. That
4 actually comes from our state epidemiologist. So we
5 made an informal request to CDC and then we asked
6 our state epidemiologist to make the formal request,
7 send the letter, do the paperwork and all that sort
8 of thing.

9 Q And who is the state epidemiologist or was
10 at that time?

11 A At that time and still the state
12 epidemiologist is Dr. Ihsan Assam.

13 Q Now, once that sort of formal request goes
14 out, does CDC then immediately come out or do they
15 set up a time to come out? How does it work?

16 A We started talking to CDC on January 2nd.
17 They were able to get there the following week and
18 they arrived on January 9th.

19 Q Did they meet with you when they came out?

20 A Yes.

21 Q Okay. But before meeting with them on the
22 9th, had you made contact with the clinic involved?

23 A No, we had not.

24 Q So you decided at that point when you meet
25 with them to then make contact with the clinic?

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CCR #337
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1 A Yes. We didn't want to have the clinic
2 start to change their practices before we went in
3 and did the investigation. So we waited until we
4 were out there in the field and could observe what
5 was actually going on.

6 Q Now, the clinic in question was which
7 clinic and where was it located?

8 A It was the Endoscopy Center of Southern
9 Nevada located at 700 Shadow Lane. It was right
10 across the street from the Health District. It may
11 be a little confusing for some people, but it was a
12 little more confusing because they had two actual
13 clinics in the building. There's an endoscopy
14 center where they do the surgical procedures and
15 they have a gastrointestinal, basically a doctor's
16 office right next door to that. They're linked
17 together. They share a number of staff. But it was
18 the Endoscopy Center at 700 Shadow Lane.

19 Q When you say surgical procedures, I assume
20 you're talking about upper endoscopies and
21 colonoscopies?

22 A Yes, that's correct.

23 Q Do they do any kind of other procedure
24 there?

25 A There were a couple other procedures they

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RA 000258

1 did related to that, placing of a PH probe I think
2 was one of those and there was one other procedure
3 they did occasionally. But they were, you know, one
4 or two a month maybe.

5 Q Gastrostomy tube placements?

6 A I believe that was one of the other ones
7 as well.

8 Q Beside those things, that's what they did
9 there essentially?

10 A Yes.

11 Q Okay. And then there was an associated
12 medical type gastroenterology clinic with that
13 group?

14 A Correct.

15 Q Separate entities within the same building
16 I think?

17 A They were right next door to each other.
18 They had a back door that connected the two offices.

19 Q So different buildings?

20 A It was the same building, it was just two
21 office suites within the same building and shared
22 some staff between the two offices as well.

23 Q Now, when you meet with the CDC when they
24 come out here, I mean, who's coming out to meet with
25 you?

Donna J. McCord
CCR #337
(702) 671-3365

1 A We had two people come out from the CDC to
2 assist us, Dr. Melissa Schaefer and Dr. Gayle
3 Fischer. They both came out to assist. They were
4 EIS officers assigned to this particular
5 investigation.

6 Q And EIS is what?

7 A Epidemic Investigation Services I believe.

8 Q So they come out and meet with you. Is it
9 just you or do you have anybody else working with
10 you?

11 A No. When we conduct an outbreak
12 investigation we have a large team. We have our
13 outbreak investigation team assembled with all the
14 people we need from the different disciplines
15 related to this investigation. So it was a meeting
16 of, there were probably 20 or 25 people in the room
17 in the initial meeting.

18 Q Now, all 25 people don't go over to the
19 clinic, do they?

20 A No.

21 Q Who goes over to the clinic?

22 A The clinic, it was the two people from
23 CDC, myself and we had a concurrent investigation
24 done by what was called the Bureau of Licensing and
25 Certification at the time. They've changed their

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CCR #337
(702) 671-3365

1 name since then. They were with the State Health
2 Division and they're responsible for licensing that
3 clinic. So the five of us were the ones that made
4 the initial contact with the clinic and made the
5 initial visit.

6 Q Now, when you make the initial contact, is
7 that by telephone first or do you just so show up at
8 the door?

9 A We called and said we were coming over, we
10 want to meet and see if they can get their people
11 together so we gave them a little warning we were
12 coming over. But we were right down the street so
13 within a half hour we were over at the clinic
14 meeting with them.

15 Q Who did you talk to when you first called
16 over to the clinic, if you recall?

17 A We spoke to a few people. We called the
18 main line first. I think we got one of their, I
19 think it was the director of patient relations who
20 then referred us to the administrator Tonya Rushing
21 and she set up the meeting for that day.

22 Q So they know you're coming over and who
23 you are?

24 A Yes.

25 Q Did you tell anybody either before you got

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CCR #337
(702) 671-3365

1 over there or once you did get over there that it
2 was not just the Health District but the CDC as
3 well?

4 A I don't know if we told them in advance
5 but we did explain who everybody was, what their
6 roles were in the investigation and what each person
7 was doing there basically.

8 Q Once you got there?

9 A I believe so. We may have said something
10 in advance, but we basically said we're coming over
11 to talk to you about this cluster we've identified.

12 Q So you arrive on site, there's about five
13 of you you said?

14 A Yes.

15 Q Some from the Bureau of Licensing and
16 Certification, CDC and yourself?

17 A Yes.

18 Q Anybody else from the Southern Nevada
19 Health District besides you?

20 A For the initial meeting, no, just me.

21 Q You go into the facility. What do you do?

22 A We sat down with Tonya Rushing and Dr.
23 Cliff Carrol and explained basically what we had
24 identified, that we had three cases. We talked
25 about what information we had on the cases that we

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CCR #337
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RA 000259

1 could share, that they were acute cases, they were
2 confirmed by our case definition and that they all
3 reported undergoing procedures at the clinic, the
4 dates of the procedures, some just basic
5 information, explaining we would be doing an
6 investigation to look for a common source if there
7 was one.

8 Q How long did the meeting last?

9 A Forty-five minutes, an hour maybe.

10 Q Now, after either talking to them -- and
11 you made it clear as to who all you were, all the
12 players?

13 A Yes.

14 Q After that meeting did you get up and
15 leave or what did you do?

16 A They took us downstairs and gave us a
17 quick walk through of the clinic just to get kind of
18 the overview of how things were set up.

19 Q And then?

20 A That was late in the day so it was
21 basically we had the meeting with them, got a quick
22 overview. The clinic was -- I think when we went in
23 they were seeing their last patient of the day so
24 there wasn't anything to observe. Most of the
25 people were starting to go home.

Donna J. McCord
CCR #337
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1 Q Did you start any chart review or anything
2 like that on that day?

3 A On that day, no.

4 Q So did you make arrangements to come back
5 the following day?

6 A Yes, we did.

7 Q Was that in the morning, afternoon,
8 evening?

9 A First thing in the morning.

10 Q So you show up. Who shows up on the
11 second visit?

12 A The second visit it was the same people
13 from that initial meeting as well as a couple of
14 additional investigators from my office. We were
15 going to do chart reviews so we needed some help
16 just going through lots and lots of documents.

17 Q What kind of charts did you look at?

18 A Basically anything that they had related
19 to those procedures. So they had procedure charts
20 related to how each procedure was performed that
21 particular day. In some cases they also had medical
22 charts relating to the gastro clinic next door of a
23 patient's overall health. So we requested all the
24 charts from the days where we had known transmission
25 as well as I believe two or three days prior.

Donna J. McCord
CCR #337
(702) 671-3365

1 Q Okay. So that's your group that you're
2 looking at?

3 A That was the big first group. We also
4 asked for a number of other documents in the clinic;
5 their protocols and procedures, cleaning logs, a
6 number of other things from them. But the big focus
7 the first day was the charts and looking at those
8 procedure charts.

9 Q Now, when you say the first day, the first
10 day that you actually did chart review?

11 A Right, the first full day of
12 investigation.

13 Q So this would have been the second day?

14 A This would have been Thursday, the 10th of
15 January.

16 Q So when you go back and start the chart
17 review, is that pretty much all you do the whole day
18 or do you go in and start watching and observing
19 procedures, things like that?

20 A For that day it was basically chart
21 review. We didn't go and observe anything that day.
22 We wanted to look at what information was in the
23 chart to help focus where we were going to do our
24 observations.

25 Q How long did CDC and you go do this on a

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1 daily basis?

2 A CDC was in town for a week. They arrived
3 on Wednesday and they left the following Wednesday.
4 So we were out there the three days of that week,
5 Wednesday, Thursday, Friday, and then I think Monday
6 and Tuesday of the following week and then they left
7 on Wednesday.

8 Q After CDC leaves do you go back to the
9 clinic at any time or --

10 A Yes.

11 Q And what was the purpose of you going
12 back?

13 A I was following up on different documents.
14 There was additional information I wanted to collect
15 so I went back a few times over the next two or
16 three weeks.

17 Q Now, during the time that you are doing
18 the chart review, I assume you look at a bunch of
19 charts?

20 A Yes.

21 Q Did that chart review continue on over
22 those period of days that CDC was present?

23 A Yes, they did. We were doing chart review
24 pretty much everyday that we were at the clinic.

25 Q At some point do you start reviewing or

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RA 000260

1 watching procedures and, you know, how they handle
2 things within the clinic?

3 A Yes.

4 Q Did that come on the third day then?

5 A Yes, that would have been the third day,
6 the 11th of January.

7 Q Is that only a partial day or is that a
8 full day; some people watching procedures all day,
9 other people doing chart review?

10 A It was the way you described, some
11 watching procedures, some doing chart review. It
12 was basically continuing the chart review from that
13 Thursday and then starting to do observation in the
14 clinic as well.

15 Q We'll get back to the chart review in a
16 little bit, but I would like to move to your review
17 of the procedures. Were you parented up with
18 somebody or partnered up rather with somebody as far
19 as the observational part of it or were you by
20 yourself looking at various aspects of the practice?

21 A I was with Dr. Schaefer in the procedure
22 room on the right.

23 Q So there were how many procedure rooms?

24 A There were two procedures rooms. They
25 weren't labeled A or B. They just had two rooms.

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CCR #337
(702) 671-3365

1 So we were in the one on the right and Dr. Fischer
2 was in the one on the left.

3 Q When you were doing the chart review, and
4 I'll go back to that periodically probably, but when
5 you were looking at the charts for those days and
6 since they have two rooms going, initially could you
7 tell, I mean, were they designated as room A or B or
8 first room, second room, anything like that?

9 A No, there was no indication on the chart
10 as to which room the procedure occurred in.

11 Q Later on were you able to make a
12 determination of what room was what on at least the
13 day of the 21st?

14 A On the 21st, yes, we were able to do that.

15 Q And we'll get to that down the road in a
16 little bit but back to the procedure issue. When
17 you first go with I think you said Dr. Schaefer; is
18 that correct?

19 A Yes.

20 Q What about Gayle Fischer at the time?

21 A She was observing in the other procedure
22 room at the same time.

23 Q And her name has subsequently changed to
24 Gayle Langley; is that correct?

25 A Yes.

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CCR #337
(702) 671-3365

1 Q Now, I'll probably refer to her as Fischer
2 and Langley but just so you know who I'm talking
3 about. She's in another room and you're in a room
4 with Dr. Schaefer?

5 A Correct.

6 Q Where are the other people in the clinic?
7 Are they looking around at charts at this point,
8 doing things like that?

9 A The other people that were with us, they
10 were doing the chart review. There was a conference
11 room across the hall that they had set us up in and
12 they were in that room doing the chart review.
13 People from BLC, I don't know what they were doing
14 in their investigation. They were doing their own
15 separate parallel investigation so they may have
16 been in and out or a different place so I'm not
17 really sure about them.

18 Q When you came back to the clinic on the
19 subsequent days, I know the BLC is there, I know the
20 CDC is there and I know you're there. How many of
21 your people did you bring along with you to help you
22 with the chart review and the observation?

23 A The most we ever had from my office were
24 three people including me.

25 Q Okay. On average was it three or two or

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(702) 671-3365

1 one or --

2 A It kind of varied depending on what was
3 going on that day. Some days it was just me, other
4 days there were three people.

5 Q So where do you start your observation?

6 A Basically standing in the back of the room
7 watching as they bring in a patient and seeing what
8 happens basically and how the patient flows, how the
9 staff moves around the room, that sort of thing.

10 Q And you're talking about being actually in
11 the procedure room itself at this point, correct?

12 A Yes, that's correct.

13 Q Did you go out and observe any
14 pre-anesthesia areas, post-anesthesia areas or, not
15 preparation, but cleaning areas at any time?

16 A We did eventually. At first we just went
17 into the procedure rooms. That was our first stop
18 basically.

19 Q What happened in the procedure room of
20 note?

21 A We observed several procedures. Linda
22 Hubbard was the CRNA in the room that I was
23 observing. There were some infection control issues
24 we identified. She was only wearing one glove, not
25 two. There were some hand washing issues and the

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CCR #337
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RA 000261

1 way they'd wipe the bottles and some minor things
2 like that that weren't thought to be a major problem
3 for an outbreak, an infection control issue but not
4 for the outbreak that we're interested in.

5 So we watched several procedures.
6 The first procedure, the patient got the anesthesia
7 and when it was done there was leftover propofol in
8 the vial and the vial went on the tray that was set
9 up in front of the CRNA Linda Hubbard.

10 Q And the vials that you were seeing used at
11 that time, what size vials were -- I mean, I know
12 you're familiar with the different sizes, correct?

13 A Yes.

14 Q What size bottles were they using?

15 A The vials we saw that day were all 20CC
16 vials.

17 Q So there was some remaining after the
18 first patient or the patient you observed that day?

19 A Correct.

20 Q What happened next?

21 A Another patient came in. She took a new
22 vial, clean needle, clean syringe, drew up the
23 anesthesia and sedated the patient. And when that
24 procedure ended there was a little left in the vial
25 and that one sat on the table. So this happened for

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CCR #337
(702) 671-3365

1 several patients and there were several vials lined
2 up. And then we observed her draw a couple of
3 syringes from the multiple vials, basically use up
4 whatever remaining amount there was in those vials.

5 Q Now, as far as that process, was there a
6 concern about that at the time?

7 A There was a concern that they weren't
8 using the product in accordance with the
9 manufacturer's label. It's labeled for single
10 patient use only. If the vial is reused on somebody
11 else and that vial were to be contaminated, that
12 would have been a major problem. We didn't observe
13 any contamination, we just saw the reuse of the
14 vials. But that's one piece that was a major issue
15 for us.

16 Q Now, after that day or at least that
17 observation, did you have a chance to speak with
18 Gayle Fischer or Langley at that time regarding what
19 she had observed in the other room?

20 A Yes. We sat down that afternoon and had a
21 discussion about what we observed during the
22 procedures.

23 Q Now, the purpose of these discussions I
24 assume is so that you can formulate your outbreak
25 information and try and prevent any issues that

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CCR #337
(702) 671-3365

1 arise to make sure that you are correcting any
2 problems that are out there?

3 A Yes, that's correct.

4 Q Did you also interview staff at that time?

5 A Yes, we interviewed staff at that time and
6 for the next several weeks.

7 Q Did you ever come across the impression
8 that what you had observed was a common occurrence
9 within the practice?

10 A Yes.

11 Q Was it a common occurrence?

12 A It's what we observed in both rooms. And
13 we reviewed the number of vials of propofol that
14 were checked out on the days so we knew how many
15 patients there were, we knew how many vials they
16 used and it was clear that there wasn't one vial at
17 least for each patient.

18 Q So you're saying you were able to go back
19 to the days of the 25th or 21st and look and see how
20 many actual vials had been checked out for those
21 days?

22 A Yes, that's correct.

23 Q And how many patients they had and compare
24 the two?

25 A Yes, that's correct.

Donna J. McCord
CCR #337
(702) 671-3365

1 Q What was the -- I mean, how many -- let's
2 use the 21st if you know and remember. Do you know
3 what the differences were between the number of
4 patients and vials that were used on that day?

5 A Off the top of my head, no, but I can find
6 it in the report. That's why I brought this with
7 me.

8 Q Before you go there let's do this right
9 now. I'm showing you what's been marked as Grand
10 Jury Exhibit Number 13 and ask you just to flip
11 through that. I think you're probably familiar with
12 it. Just tell us what it is.

13 A This is the final report that I wrote for
14 our investigation.

15 Q Okay. Now, in this report, I know you
16 were about ready to refer to a document, I've got
17 the copy here that is going to be a Grand Jury
18 exhibit. What I'm going to ask is that if you go to
19 a page that you're referring to a chart or a diagram
20 or any kind of information, that you just refer me
21 to that page and then I will go ahead and display it
22 for the Grand Jury as well.

23 A Okay. Let me find the page. I have the
24 number of vials they had that day so let me find it.

25 Q And unless it's a chart or something we

Donna J. McCord
CCR #337
(702) 671-3365

1 probably won't display it if it's just something you
2 need to refresh your memory. Go ahead and look at
3 the document and then you can tell me about it after
4 you do so.

5 A Okay. On September 21st there were a
6 total of 64 procedures performed on 63 patients.
7 That's on page 22 of the report. One patient had
8 two procedures so there was one more procedure than
9 patients. On that day they used a total of 24, 50CC
10 vials and they checked out four, 20CC vials and
11 returned all four. So there were 63 patients and
12 they used 24 vials on September 21st.

13 Q Okay. So based on what you had observed
14 on subsequent days and talking to patients and so
15 forth, not patients but the staff about how to use
16 propofol, was it consistent with what you were
17 seeing there is multiple uses of a single vial on
18 multiple patients?

19 A Yes.

20 Q Was that a potential concern for you as a
21 possible mode of transmission of this disease
22 process?

23 A Yes, it was.

24 Q Now, one of the other issues that arose,
25 did it have to do with syringe reuse?

Donna J. McCord
CCR #337
(702) 671-3365

1 A Yes.

2 Q Did you also look into that?

3 A Yes, we did.

4 Q Was there evidence in your investigation,
5 at least during your observational period, that
6 syringes were being reused at the clinic?

7 A Yes, there was.

8 Q Did you do a similar kind of thing where
9 you looked at syringe amounts and all that kind of
10 stuff as part of the investigation?

11 A We did not evaluate the number of syringes
12 and needles used related to the vials. That came
13 through observation of what was actually going on in
14 the clinic. Dr. Fischer was observing Keith Mathahs
15 in the other procedure room and observed him use a
16 clean needle, clean syringe, draw propofol, sedate
17 the patient. The patient needed a second dose of
18 propofol. He took the needle off the syringe,
19 disposed of the needle, put a new needle on the
20 syringe and went back into the vial to draw a second
21 dose of propofol.

22 Q Now, what you just described for us is not
23 something you personally observed, is it?

24 A Correct.

25 Q That information, however, is contained in

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CCR #337
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1 this report that you have presented to us today or
2 that is marked as Grand Jury Exhibit Number 13; is
3 that correct?

4 A Yes, that's correct.

5 Q And this is a public document that anybody
6 can download off the Internet or go to your website
7 and review or anything like that?

8 A Yes, that's correct.

9 Q And that information was I assume used as
10 part of your investigation to come up with your
11 determination as to what actually was happening at
12 the clinic?

13 A Yes, that's correct.

14 Q Was that consistent with some of the other
15 information that you received along the way during
16 the process of your investigation?

17 A Yes. In interviewing other CRNAs we
18 identified that that was a practice that some either
19 admitted to doing or said they were directed to do
20 but didn't do. And it was really expressed as kind
21 of the way they wanted things done at the clinic.
22 Not everyone necessarily followed it but enough that
23 we knew it was going on at the clinic.

24 Q Okay. Now, after you observed what you
25 did in that room, I assume you have your meeting

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CCR #337
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1 with Dr. Fischer?

2 A Yes.

3 Q Did you then go to the clinic staff and
4 tell them what you had observed?

5 A Yes. Everyday when we got done with our
6 observations in the clinic we met with the clinic
7 management and told them what we found that day and
8 kept them up to date on what was going on in the
9 investigation.

10 Q Now, beside the issue of syringe reuse and
11 propofol reuse, were there other areas that you
12 looked at as possible sources of an infectious
13 transmission?

14 A Yes. There were a number of different
15 areas that we looked at.

16 Q What were the areas that you looked at?

17 A For this one I'll refer you to one of the
18 tables because I laid out -- it's table 20-1 on page
19 76.

20 Q And that's a table?

21 A Yes, that's a table. It basically goes
22 through the different modes of transmission that we
23 considered during our investigation.

24 Q Okay. Now, I'm going to display that for
25 the Grand Jury. I know you've got your copy in

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CCR #337
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front of you so I know that's again difficult to read but we'll have you give us some information. As a matter of fact, I'll zoom in on that and move it up and down as we need to.

So what's displayed goes down to the word endoscope and the column entitled transmission mode slash source. Go ahead and tell us what you looked at and if you were able to confirm, rule it out and why.

A The first item on the list was staff to patient transmission. There's always a concern that a provider could be infected with Hepatitis C and through their actions spread it to patients. In order to evaluate that we tested all of the people that worked at the clinic. Let me see how many people we tested.

From page 28 we collected specimens from 36 employees including the physicians who were working at the facility at the time of the investigation and had them tested for Hepatitis C, Hepatitis B and HIV. All 36 staff members we tested were negative so there was nobody that we identified as being positive for these diseases that could have transmitted it to a patient.

Q Okay. Go ahead.

Donna J. McCord
CCR #337
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A We also through the genetic testing, which I assume we'll get into a lot more, identified source patients and the people who were infected and had genetic matches on them, additionally ruling out that it came from a staff member from the clinic.

Q And in fact I think, and we've already had fairly extensive testimony on the genetic aspects of this, but sufficient to say that you had two different days with two different genetic matches for patients on those days, correct?

A Yes, that's correct.

Q Go ahead.

A The second item on here was the physician so one of the concerns was it was a common staff member, something they were doing that allowed the transmission to occur. Let's see, so on page 22 now we basically did a test to look if any these things were statistically significant. And those next three items on there, the physician, the CRNA and the technician, we were all able to rule out. There was no common person for all the procedures. So it wasn't like there was one person involved in the procedures of everyone who was infected. So it was a mix of providers and a mix of CRNAs and technicians.

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CCR #337
(702) 671-3365

Q So, in other words, there wasn't a single provider on each and every person. You might have a CRNA on one, a different CRNA on another, a doctor on one, a different doctor on another, that kind of thing?

A That's correct. And on September 22nd there were only two CRNAs working in the clinic so there was some overlap there. But the patients had gone to -- had seen both CRNAs so it wasn't all linked to one CRNA.

Q You said September 22nd.

A I'm sorry, September 21st.

Q Okay. So as far as that's concerned, go ahead. What was the next thing?

A So all three of those things we were able to rule out. There was no statistically significant association.

Q Now, I'm going to move this back and move this up so the Grand Jury can see from the equipment, the biopsy equipment in that same column down to I believe the end.

A Okay.

Q Continue.

A So the next item is the biopsy equipment and it actually links to the item three lines down,

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CCR #337
(702) 671-3365

the reuse of the bite blocks. Basically looking at disposable equipment being used by the clinic to see if it was being reused and there was a common source with that. We ruled out both of those two items because not all infected patients had a biopsy. So there was the biopsy equipment. There was no way someone would have gotten it from it because they didn't have a biopsy. The same is true with the bite blocks. Those were only used for the EGDs, the upper endoscopies. And so if you only had a colonoscopy you wouldn't have used a bite block. So neither of those two items were brought up as the likely source of this outbreak.

Q What was the issue of the bite blocks?

A We had staff members report that bite blocks were being reused from patient to patient. We had one staff member report they were only allowed to use four bite blocks per room per day. The bite block is placed in the mouth and there's a hole in it and that's where they feed the tube down so the patient basically bites down on it. If they bite down in the middle of the procedure they're not biting through the equipment. But it was a concern of the reuse of that particular piece of equipment as a potential source. But we're talking about

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CCR #337
(702) 671-3365

1 something that went in the mouth and something that
2 wasn't used on every single person. So that wasn't
3 found to be a source of this outbreak.

4 Q So that was why you were able to rule that
5 out as a possible source?

6 A Yes.

7 Q Okay. So there were things that came up
8 like the bite blocks based on information you
9 received through your investigation that said, hey,
10 this is a possible source and then you looked into
11 it?

12 A Yes, that's correct.

13 Q Okay. Go ahead.

14 A Okay. So the next item on there would be
15 the endoscope. Actually looking at the piece of
16 equipment used, concerns that it was the way it was
17 cleaned that would have allowed transmission, if it
18 wasn't cleaned properly. We had different scopes
19 used on the patients and they were different scopes
20 than the ones that were used on the source patients.
21 One record reported that two back-to-back patients
22 had the same scope number which they looked into and
23 found there was a clerical error and they had it
24 recorded differently in a different place and that
25 it wasn't the same scope. But the scope used on the

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(702) 671-3365

1 source patient was different than that used on the
2 patients who were infected. So there's no way it
3 would have gone from that source patient to the
4 infected people. We ruled that out.

5 Q And again the determination of the source
6 patient and infected patients came from the genetic
7 analysis that was done later?

8 A Yes. At the time of the investigation the
9 clinic, part of the pre-anesthesia interview is
10 asking people if they have hepatitis and a number of
11 other health conditions. And so we had several
12 patients who reported to be Hepatitis C positive
13 which is what we'd expect on each day. So we had
14 identified potential source patients very early on.
15 We didn't have the genetic testing until much later,
16 but even looking at those potential source patients
17 we weren't able to have those sort of links between
18 the patients by scope.

19 Q Now, we'll get into the timing issues
20 there, but is it sufficient to say there were issues
21 regarding timing of procedures and the recording of
22 those various times?

23 A Yes, there were.

24 Q Significant time issues?

25 A Yes. There were major issues in figuring

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CCR #337
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1 out which times were appropriate and accurate in
2 order to put the procedures in order.

3 Q The person who was determined to be the
4 source patient on both days, the 25th of July of
5 2007 and 21st of September of 2007, according to
6 your review did that person appear before the
7 infected patients in the schedule?

8 A Yes. On both days the infected patients'
9 procedure started prior to the -- or the source
10 patients' procedure started prior to the infected
11 patients' procedures.

12 Q In review of those source patients, were
13 they documented as being Hepatitis C positive at the
14 outset?

15 A Yes, they were.

16 Q So both patients were identified by the
17 personnel in the facility as being Hepatitis C
18 positive prior to their procedure?

19 A Yes, that's correct.

20 Q In the chart?

21 A Yes.

22 Q Now, in fact was one or more of those
23 individuals being treated by physicians within the
24 practice itself?

25 A I believe one of them was. I'm not

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CCR #337
(702) 671-3365

1 positive but I think that's right.

2 Q Okay. As far as the procedures and
3 policies and things, you said you asked for
4 additional information from the clinic; is that
5 right?

6 A Yes.

7 Q Did you review any policies and procedures
8 that related to, you know, when a patient should
9 be -- that might have an infectious disease, when
10 they should be placed on the schedule?

11 A No, I did not review any policies like
12 that.

13 Q Go ahead and go forward then.

14 A The next item was the procedure type.
15 This is related to the bite blocks and the endoscope
16 as well. It wasn't a common type of procedure. It
17 wasn't all upper endoscopies or all colonoscopies.
18 It was a mix of both. So that one was ruled out
19 pretty easily. They use different equipment for the
20 two so it kind of goes along with the other pieces
21 of equipment, that it's not linked because they
22 didn't have the same types of procedures obviously.

23 Q So the same scope that goes in the mouth
24 doesn't go in the bottom and vice versa?

25 A It can but generally it doesn't. They're

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CCR #337
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1 two different length scopes. You can use the lower
 2 scope to do an upper endoscopic procedure if you
 3 need to, but the scope they use for an upper
 4 endoscopy just isn't long enough to make its way
 5 through the colon. Generally though they use
 6 certain ones for upper and certain ones for lower.
 7 Q In this case they had them separated into
 8 two separate groups; is that right?
 9 A Yes, that's correct.
 10 Q Go ahead.
 11 A The last two items on here, the
 12 first one -- they both have to do with the injection
 13 safety issues and the way they handle needles,
 14 syringes and medications. The first one was the
 15 placement of the IV lines when a patient came into
 16 the clinic. We evaluated that because it was,
 17 obviously there was a needle puncture in the skin
 18 and we were concerned that there was improper use of
 19 injection equipment. We observed or the CDC staff
 20 observed the IV set-up procedure. They weren't
 21 observed to be refushing the syringes so there was
 22 no way to contaminate a common vial. They would
 23 place the IV line and they would flush it once.
 24 There wasn't a need to flush it again so that needle
 25 and syringe never needed to go back into that common

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1 have been no contaminations from that vial. So on
 2 July 25th there's no way it could have even possibly
 3 occurred that way because the person never went into
 4 the IV prep room.
 5 Q I see. Go on.
 6 A The final item was the sedation injection
 7 practices, the items I've already talked about; the
 8 reuse of the vials and the reuse of the syringes.
 9 We had observed that they were being reused, both
 10 vials and syringes. We had staff members admit to
 11 those sort of things into the records. We could
 12 clearly show that they were reusing vials of
 13 propofol between patients. We were able to rule out
 14 everything else. That was our likely source of
 15 infection and one that had been identified in a
 16 number of other outbreaks as well throughout the
 17 country.
 18 Q So this was something that in the past had
 19 been done, issues related to that specific issue?
 20 A Yes, that's correct. Nationwide but not
 21 that we identified in Southern Nevada up to this
 22 point.
 23 Q Okay. So you're kind of left with that
 24 and that's what you actually observed happening and
 25 it was corroborated by the investigation itself?

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1 saline vial which was actually labeled for multiple
 2 patient use.
 3 Q Now, during the time you were all there in
 4 the ten days or eight days or whatever it was that
 5 you were there, was there any observation of any
 6 kind of reuse or double dipping of the syringe
 7 related to the IV flush?
 8 A No, there was not.
 9 Q Okay. In any of your investigation did
 10 you ever come across information that corroborated
 11 or gave you pause to think that that was actually
 12 happening?
 13 A No.
 14 Q Did you actually ask questions and look
 15 into that specifically?
 16 A Yes, we did.
 17 Q And found nothing to that effect that
 18 would show that that was being done?
 19 A Correct. And in addition on July 25th,
 20 the source patient didn't set foot in the IV prep
 21 room. They were one of the first patients of the
 22 day, the first few patients. They just start in the
 23 procedure rooms because they can move into the
 24 clinic faster that way. So they never would have
 25 set foot in the IV prep room; therefore, there could

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 (702) 671-3365

1 A Yes, that's correct.
 2 Q Was there any other source that you could
 3 see as a possible infectious, you know, mechanism?
 4 A The only other potential source was
 5 brought to us by Dr. Carol, one of the clinic
 6 doctors, who was presenting as if somebody did it
 7 intentionally. He met with me a couple weeks after
 8 our investigation completed and before we made the
 9 public announcement and thought that maybe one of
 10 the staff members, a disgruntled staff member was
 11 intentionally spreading hepatitis in the clinic. We
 12 had no evidence to corroborate that.
 13 During the conversation I had with
 14 him, he kept referring to it as a female CRNA
 15 basically and there's only one female CRNA working
 16 there, Linda Hubbard, and she wasn't working on the
 17 days when these things happened.
 18 Q So she's ruled out as being the possible
 19 person when he in fact is thinking that that's the
 20 likely source?
 21 A Right. And we had no other evidence that
 22 any other person did anything intentionally. There
 23 was no person reporting anything to us. There was
 24 nothing we found that would even remotely point in
 25 that direction.

Donna J. McCord
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 (702) 671-3365

1 MR. STAUDAHER: And that last portion,
2 ladies and gentlemen of the Grand Jury, I'm going to
3 admonish you at least that that was not offered for
4 the truth of the matter, it was a statement made by
5 another person to him which related to his
6 investigation. It only goes to show what he did in
7 his investigation, how he arrived at his decisions
8 and what he did actually investigate as a result of
9 that. So it's not offered for the truth of the
10 matter at this point.
11 BY MR. STAUDAHER:
12 Q Go ahead.
13 A That was the last thing we looked at.
14 Nothing else stuck out as a potential risk factor.
15 I guess there was one other thing. It was related
16 to the processing of the endoscopes. Different
17 scopes were used with the people. We also looked at
18 the manner in which they reprocessed the scopes, how
19 they cleaned and sterilized those scopes. We found
20 some potential small issues with that cleaning
21 process but not ones that would explain an outbreak
22 and not ones that were likely to spread infection
23 from patient to patient. So we ruled that one out
24 as well.
25 Q Okay. Now, I want to go back just a

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CCR #337
(702) 671-3365

1 There was no other evidence that something was
2 intentional. So we had a very good and very likely
3 source versus something that was brought up as a
4 possibility and there was no evidence that that
5 actually occurred.
6 Q On the two separate days though, and
7 although you had different source patients, you also
8 had very divergence of virus sort of groupings; is
9 that right?
10 A They all group together in the genetic
11 analysis so they did cluster together. They aren't
12 a hundred percent matches because of the mutation
13 rate of the virus which is exactly what we would
14 expect, but they did cluster together and showed a
15 close relationship on that genetic analysis.
16 Q For each day of the --
17 A Right.
18 Q But when you compare one day to the other
19 there was a difference, correct?
20 A Correct. The virus on July 25th was
21 different than the one on September 21st.
22 Q So if there had been somebody
23 intentionally going around and doing this, they
24 would have had to have gotten -- since none of the
25 clinic members had the virus on board, they would

Donna J. McCord
CCR #337
(702) 671-3365

1 moment to the potential intentional use issue. I
2 know at least the person that you were directed to
3 as being a concern for the clinic wasn't working on
4 those days, but did that prevent someone else from
5 going in and trying to do this?
6 A No, it didn't.
7 Q Okay. So did you look into the
8 possibility of that as being a mechanism of
9 transfer?
10 A Yes, that's a consideration really in any
11 outbreak investigation that somebody may have done
12 something on purpose. But at no time during our
13 investigation did we find any evidence that pointed
14 in that direction.
15 Q In fact, in reviewing both the genetic
16 analysis on the 25th of July and the 21st of
17 September, did you come to a conclusion that that
18 probably had not happened?
19 A I don't think the genetic evidence really
20 said anything either way about it. It didn't show
21 that that was a source. Basically showed we had a
22 different source patient on both days, but we had
23 observed all sorts of infection control or injection
24 safety issues with the way they handled the
25 propofol. That was the likely source of infection.

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CCR #337
(702) 671-3365

1 have had to have gotten a source of virus from two
2 different potential sources on two different days
3 and done this; is that right?
4 A Yes, that's correct.
5 Q Did that seem likely or unlikely at the
6 time?
7 A It seemed unlikely.
8 Q Okay. Now, I'm going to take down that
9 chart for the moment and let's center for just a
10 second on the issue of the actual injection
11 practice. I know that you kind of described that.
12 Was there any kind of diagram or anything that you
13 put together regarding that whole process that might
14 make it easier to visualize for the jury?
15 A Yes. There's two diagrams on page 74 and
16 75.
17 Q And I'll show the one on page 74. And
18 again, this is all coming from Exhibit Number 13
19 which is the report that you were involved with the
20 authorship of this report; is that correct?
21 A Yes, it is.
22 Q Entitled the "Outbreak of Hepatitis C at
23 Outpatient Surgical Centers"?
24 A Yes, that's correct.
25 Q Start off with page 74. Let me zoom out a

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CCR #337
(702) 671-3365

1 little bit and get this in. Can you tell us what
 2 we're looking at in that particular diagram?
 3 A This diagram explains how the
 4 contamination of the vials occurred.
 5 Q From what you observed and the information
 6 you obtained, correct?
 7 A Yes, that's correct.
 8 Q Go ahead. Walk us through it.
 9 A So number one at the upper left we have
 10 a --
 11 Q And while you're sitting there I'm just
 12 going to use my finger to point to this portion of
 13 it as you get there. But number one is up here?
 14 A Yes.
 15 Q Okay.
 16 A So you have a clean vial of propofol, a
 17 new vial of propofol, clean needle and a clean
 18 syringe. The syringe is a plastic piece, the needle
 19 is the metal piece that attaches to the syringe and
 20 goes into the skin. Propofol was drawn up into that
 21 injection apparatus. And in number two there it's
 22 administered into a patient.
 23 Q And that's this area right here?
 24 A Yes.
 25 Q Now, in this particular diagram you just

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1 A So now you have a contaminated syringe.
 2 Now, on number three on the right side here, the
 3 normal practice is to discard the needle and syringe
 4 right into a Sharps container.
 5 Q So is that what's depicted in the very
 6 first syringe, that you just take that and throw it
 7 right into the garbage?
 8 A What's depicted in the first piece there
 9 is the removal of the needle and the reuse of the
 10 syringe which is not the typical practice that
 11 should be used. This is what Dr. Fischer observed
 12 going on in that procedure room and what other staff
 13 members reported was what they were directed to do
 14 and what some had admitted to doing.
 15 Q So we've got a syringe that's potentially
 16 contaminated. For this particular diagram we assume
 17 that it's contaminated at this stage and the needle
 18 is removed and thrown away.
 19 A Yes, that's correct.
 20 Q So the next syringe over, a new needle --
 21 is that showing the new needle being placed on that
 22 syringe?
 23 A Yes. The new needle is being placed on
 24 the contaminated syringe.
 25 Q Okay. And then the next syringe over?

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1 got a needle going straight into a vein; is that
 2 correct?
 3 A Yes.
 4 Q But in most of the instances there was an
 5 actual heplock device which was an IV access port to
 6 that vein?
 7 A Yes, that's correct. But it's basically
 8 considered part of the venous system then at that
 9 point. It's no different than going into a vein for
 10 purposes of disease transmission.
 11 Q Okay. Go ahead.
 12 A When the syringe is put in you can get
 13 back flow of blood into the syringe and needle. So
 14 you can get contamination of that injection
 15 equipment as that injection is actually occurring.
 16 Q So if in fact that actually happens your
 17 arrow here pointing backward on two for the record
 18 would potentially cause mixing of that solution here
 19 with contaminated virus; is that right, or virus
 20 contamination?
 21 A It would allow for blood to make its way
 22 into the syringe. If that blood were contaminated
 23 with a virus then the virus would move there but not
 24 every patient was infected obviously.
 25 Q Sure. Go ahead.

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 (702) 671-3365

1 A That contaminated syringe with the new
 2 needle is being used to access a vial of propofol
 3 and in doing so passing on the contamination into
 4 that particular vial.
 5 Q So now causing contamination in the entire
 6 vial because whatever was in the syringe, at least
 7 some of it got into that vial?
 8 A Yes, that's correct.
 9 Q Okay. And then the last picture on four?
 10 A Now you have a contaminated vial in the
 11 clinic. So you have a contaminated vial of
 12 medication that could be used to potentially
 13 transmit disease to other people.
 14 Q So in the situation where you observed,
 15 for example, Linda Hubbard on that day with all
 16 those open vials, if one or more of those had been
 17 contaminated, you might have a patient or two that
 18 come in and don't, if she's holding off using that
 19 as a sort of a grouping together, you might have a
 20 couple of intervening patients that don't get
 21 contaminated at all?
 22 A Yes, that's correct. You would have
 23 patients that didn't get propofol from those
 24 contaminated vials or prefilled syringes
 25 potentially.

Donna J. McCord
 CCR #337
 (702) 671-3365

1 Q And is it also possible for someone to be
2 injected with a contaminated vial of propofol and to
3 not succumb to Hepatitis C?
4 A Yes.
5 Q Okay. It's not a hundred percent, there's
6 not a single like of infectious dose meaning one
7 viral particle causes the disease kind of thing?
8 A There are known infectious doses for
9 Hepatitis C and known risks of transmission. We
10 couldn't establish that number though because first
11 of all you would have to have a patient with
12 Hepatitis C, you would have to know how much virus
13 was in their blood and then you have to know how
14 much propofol was left in the vial basically to get
15 a concentration of virus in that vial. There's no
16 way to make those sort of calculations and determine
17 how much virus people were potentially exposed to.
18 Q If this process that you have depicted on
19 page, I believe it's 75 or --
20 A 74.
21 Q 74, I'm sorry. On page 74 of that
22 exhibit, if that had been done over and over again,
23 would it be possible to continue on with a number of
24 patients continually infecting the next vial, the
25 next vial, the next vial?

Donna J. McCord
CCR #337
(702) 671-3365

1 transmission of disease.
2 Q And then the next one here, number four?
3 A Additional syringe reuse just as before
4 where you have a contaminated syringe and needle,
5 you throw out the needle, you still have the
6 contaminated syringe, you contaminate another vial
7 of propofol.
8 Q And it just cycles over and over again?
9 A Potentially. The challenge with that is
10 over time there's going to be less and less virus as
11 it goes on, but it doesn't have to go through 30 or
12 40 vials. You could have the contamination occur in
13 just one or two vials. And the calculations I did,
14 and I think we had, let me find the page on that, we
15 had sufficient propofol -- I believe in one vial,
16 the way the injections were given, that it all could
17 have potentially come from one vial. It wasn't as
18 likely but just mathematically that was possible.
19 Q Are we talking about strictly a delusional
20 effect as you go on?
21 A Yes. But given the amount of propofol
22 that was required with the transmission, it could
23 have come from one 50CC vial given if they were just
24 getting 5CC doses at a time or something like that.
25 That's probably not the likely way it occurred. It

Donna J. McCord
CCR #337
(702) 671-3365

1 A Yes. And I have that depicted on page 75
2 in figure 20-2.
3 Q And I'll move to that then. So walk us
4 through what we're seeing here on number one first.
5 A So number one, this was the practice we
6 observed with Linda Hubbard. You could have several
7 syringes drawn from that one contaminated vial. And
8 so you could have basically prefilled syringes
9 sitting out used for the next patients, sitting
10 there not used for ten patients later. Just a
11 number of contaminated prefilled syringes basically
12 waiting for patients to come in.
13 And then on number two you could have
14 the same problem happen. Say you drew half a
15 syringe from a contaminated vial and the other half
16 from an uncontaminated vial, now you've contaminated
17 that second uncontaminated vial. Now you have
18 another vial that can be used, and basically the
19 cycle can keep repeating with transmission the same
20 way as initially happened.
21 Q And in number three here, what do we have
22 here?
23 A So basically you have a patient being
24 injected with contaminated propofol, essentially
25 being injected with the virus and having

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CCR #337
(702) 671-3365

1 seems unlikely that one vial just moved all over the
2 clinic and just went to those patients. But one or
3 two vials would have been sufficient to infect
4 everybody.
5 Q Now, I want to go back to your analysis,
6 and I'm talking about not necessarily during the
7 initial phase when CDC was there but later on. Did
8 you become aware through your investigation of a way
9 to determine what room was used in which instance
10 and specifically the 21st, September 21st date?
11 A Yes, we did.
12 Q And so were you able to categorize those
13 rooms based on that information?
14 A Yes, we were.
15 Q What was the glitch or what was the issue
16 that allowed you to do that?
17 A On September 21st for some reason the
18 computer system in one room was set to say it was
19 August 21st and not September 21st. And so in the
20 printed reports from the clinic, some of the charts
21 said September 21st and the other one said
22 August 21st and it would have been different
23 according to the two rooms.
24 Q When you matched all those up, did it look
25 like a relatively even number of patients in both

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CCR #337
(702) 671-3365

1 rooms?
 2 A Yes, it did.
 3 Q So fairly confident that that was an
 4 accurate way of determining the rooms?
 5 A Yes.
 6 Q When you looked at those rooms did you see
 7 that, for example, the patient that was the source
 8 patient was obviously in just one room, correct?
 9 A Yes, that's correct.
 10 Q Did the infections result to the other
 11 patients all from that same room?
 12 A No. And I have a figure 7-2 explains this
 13 particular piece of --
 14 Q And 7-2 is on what page?
 15 A 7-2 is on page 61, bottom of page 61.
 16 Q All right. Do you want the first part or
 17 the second part? Why don't you tell us what's at
 18 the top first.
 19 A The first part is a graph of the
 20 anesthesia times for September 21st. So it's not
 21 really in which procedure room, it has to do with
 22 the duration of anesthesia recorded on the patient
 23 charts. There were a total of 63 patients. The
 24 average for this was 32 minutes and over 90 percent
 25 of them fell between 31 and 33 minutes.

Donna J. McCord
 CCR #337
 (702) 671-3365

1 information from this witness at this time because
 2 it's hearsay at this stage.
 3 BY MR. STAUDAHER:
 4 Q Now, was that information necessary for
 5 your investigation?
 6 A The reason behind it, why it happened, it
 7 just goes to show that there was a potential reason
 8 that the times were recorded incorrectly and we
 9 couldn't really trust those times. For my purposes
 10 that's why it was relevant.
 11 (At this time, Mr. Coffing exited the
 12 Grand Jury room.)
 13 Q So what was relevant to you was not
 14 necessarily the actual time listed but there was
 15 inaccuracy in the time and that gave a reason to not
 16 trust those?
 17 A Yes, that's correct.
 18 Q Okay. Go ahead and continue on.
 19 A So we had a number of different times on
 20 the chart. Let's see, it will just take me a second
 21 to find it here.
 22 Q Okay.
 23 A Okay. So we have a number of different
 24 times and it's listed on page 21 in the report.
 25 There were a lot of different times recorded on the

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 (702) 671-3365

1 Q So there's one outlier here in the
 2 25-minute range?
 3 A Yes.
 4 Q So everyone except for that single patient
 5 was at 31 minutes or more?
 6 A Yes, that's correct.
 7 Q Now I will zoom back out.
 8 A And let me add that that's basically
 9 relevant to the public health investigation because
 10 of trying to put the patients in order. And so on
 11 this bottom graph here, figure 7-2, we tried to put
 12 the patients in order based on the many different
 13 times that were actually listed on a patient chart.
 14 The times on that top graph were the anesthesia
 15 times written down by the CRNA. And we found a lot
 16 of issues with using those particular pieces of
 17 time. They didn't seem to have any basis in
 18 reality.
 19 Q Okay. What was significant about that?
 20 A We had staff members tell us that they
 21 were basically billing for 31 minutes of anesthesia
 22 because anesthesia is billed in 15-minute units.
 23 MR. STAUDAHER: And I'm going to caution
 24 this witness at this time. And the Grand Jury, I
 25 would like them to disregard that particular

Donna J. McCord
 CCR #337
 (702) 671-3365

1 charts. And in order to put a figure together like
 2 this of the order of the patients, we had to use the
 3 times that best told us when that patient was in
 4 procedurally. The types of times they had in there
 5 were the anesthesia time that I already mentioned.
 6 Basically it was a time recorded by the CRNA as to
 7 the start time and the end time of the anesthesia.
 8 We had a time recorded by the nurse as the start and
 9 end time of the procedure. There was a nurse in the
 10 back of the room charting the procedure. We had two
 11 vital sign monitors that were used. One was used in
 12 the procedure room and it produced a tape with the
 13 blood pressure and EKG and it had a start and end
 14 time on it. They had an additional one that was
 15 used in the recovery room. So we had tapes with
 16 time stamps on those basically. And then we had the
 17 reports that were generated at the end of the
 18 procedure. There was a time that everything was
 19 initiated which basically was when stuff got set up
 20 and then when the doctor signed off on it and
 21 finished his notes, clicked done and put a time
 22 stamp on there.
 23 And so for this particular chart we
 24 used the nurse's log time start, start time because
 25 when we were observing it basically the nurse looked

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 (702) 671-3365

1 at the clock and wrote down this is the time the
2 procedure started. So that gave us our beginning
3 time. The end time was taken from the earlier of
4 when the nurse signed off and said the procedure was
5 done or when the doctor time stamped that chart and
6 said they were done charting it. So basically it
7 gave us an idea when that patient was actually in
8 that procedure room as best we could tell.

9 Q Did the times that you determined, that
10 you actually used, did those match up when comparing
11 them to the actual recording anesthesia times and
12 the anesthesia sheets, did they match up?

13 A Within a half hour, yes. I mean, it gave
14 us the right time period of the day. The anesthesia
15 times sometimes overlapped, sometimes were way off
16 and so they weren't reliable in any manner. And we
17 just couldn't use those times because they didn't
18 really mean anything to us.

19 Q And did you find out whether or not the
20 times, based on your review and determining the
21 length of procedures and things like that, if they
22 were remotely accurate based on what you were
23 reviewing in the charts?

24 A They seemed close. It was sufficient for
25 us to put the patients in order basically to figure

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CCR #337
(702) 671-3365

1 out when they were in and out of there, but it still
2 left us with a lot of questions when we produced
3 this type of figure.

4 Q Okay. And that's based on the most
5 reliable time that you thought you could figure out
6 based on the charts?

7 A Yes, that's correct.

8 Q So go ahead and tell us what we're seeing.

9 A Okay. So there's three lines here. The
10 top group is basically all the patients together
11 regardless of CRNA. The line down the middle just
12 splits the two procedure rooms. So the top line is
13 the first procedure room there and then the bottom
14 line is the second procedure room. And then the two
15 other graphs, I split it by CRNAs. So you can see
16 where CRNA one was or CRNA four was at that
17 particular time.

18 Q So this is CRNA one and CRNA four?

19 A Yes. And so the dark box all the way to
20 the left there, I started this with the beginning of
21 the source patient's procedure.

22 Q Okay.

23 A And then all the shaded boxes are when
24 people were infected.

25 Q So let's start off with this top portion.

Donna J. McCord
CCR #337
(702) 671-3365

1 So we've got source patient in room A?

2 A Uh-huh.

3 Q And then what is this box in room B, what
4 is that?

5 A That indicates the first person who was
6 infected after the source patient.

7 Q So that's a different room?

8 A Yes, that's correct.

9 Q Okay. And then we've got infections
10 proceeding in that second room; is that correct?

11 A Yes, it is.

12 Q And is the shaded area an infected
13 patient?

14 A Yes, it is.

15 Q Now, what's the indication of the lengths
16 here of this box, of those boxes? What does that
17 mean?

18 A The size of the boxes related to the time
19 of the procedure. So a very small box is a very
20 short procedure, a very long box is a longer
21 procedure. It's kind of hard to see the lines on
22 here. You can see the markings. Those are one hour
23 differences. So that's plus one hour, plus two
24 hours, plus three hours.

25 Q So did you have any explanation for how

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CCR #337
(702) 671-3365

1 the infection went from one room to another?

2 A When we spoke with staff there they said
3 the CRNAs were generally assigned to one room
4 although they would cover for each other as needed,
5 if somebody needed to take a break, use the
6 bathroom, whatever. So having people move from room
7 to room wasn't a common thing but it wasn't an
8 uncommon thing either. The CRNAs generally stayed
9 with their room but they would move between rooms as
10 needed.

11 Q So at least there was a mechanism to get
12 somebody that was contaminated or something that was
13 contaminated in one room to another room possibly?

14 A Yes.

15 Q And you actually see that happen here?

16 A Yes. And if you look at the middle lines
17 there, that's CRNA one and you can see --

18 Q This one here?

19 A Yes.

20 Q Okay.

21 A You can see two procedures in the first
22 room and then over to the second room and then back
23 to the first room and then there's a break.

24 Q Oh, so if I understand you correctly,
25 we've got CRNA one in the first room and CRNA one in

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CCR #337
(702) 671-3365

RA 000271

1 the second room?

2 A Yes.

3 Q So we know that they did -- that CRNA one

4 did procedures in both rooms on that day?

5 A Yes, that's correct. You don't see the

6 same thing as much for CRNA four, but you also see a

7 couple of gaps on both of these. The longer gaps,

8 they are likely to be the lunch periods. It was

9 right around lunch time when those things happened.

10 But the gap at the beginning there for CRNA four,

11 there was a patient in the second room that the CRNA

12 didn't treat for some reason. So he left the room

13 for whatever reason and CRNA one had to run over to

14 the other room and cover for that person. So right

15 around the time when the first infections happened,

16 you had a CRNA moving back and forth between the

17 room where the source patient was.

18 Q And from that point forward the second

19 room has infections proceeding in it?

20 A Yes.

21 Q I see. Now, beside that diagram, was

22 there another diagram regarding timing that you

23 found significant?

24 A Are you talking about -- yes, this was a

25 diagram, 6-2 on page 60. And this just goes back to

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CCR #337
(702) 671-3365

1 that's the computer system when the doctor signed

2 off on it. It was taking just a couple minutes to

3 do their notes so that's basically what's expected

4 from what we observed. Three minutes after that the

5 monitor was started in the recovery room. Two

6 minutes after that the physician was reported to be

7 at the bedside.

8 There was an issue with that because

9 we were told they were always told to record it, I

10 believe it was seven minutes after the end of the

11 procedure whether the physician was there or not.

12 That wasn't a time we were using for anything.

13 There was another one that was suspect of all the

14 times we had. Monitor two ended 36 minutes after

15 the whole thing started.

16 Q What does that mean?

17 A So that was when they stopped monitoring

18 basically doing the vital signs and all that in the

19 recovery room. So the person was kind of finished

20 with their initial recovery.

21 Q Okay.

22 A And then roughly ten minutes after that we

23 see, or 11 minutes after that the anesthesia was

24 reported to end. So after the person is already off

25 all the equipment, there's nothing else going on,

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CCR #337
(702) 671-3365

1 how we selected the different times. This is

2 basically the most egregious example we found of

3 confusing times on that particular day starting with

4 the beginning of everything and seeing kind of what

5 order the times were actually listed to see if any

6 of these times actually made sense to us.

7 Q So walk me through what we're seeing here.

8 A At the top of the graph we have the report

9 start. That is the time on the computer system. So

10 basically it's when they plug the scope in, when

11 they got the computer up and running, waiting for

12 the doctor to come in. All of this was done through

13 an automated system. It's a camera and so they're

14 snapping photos and doing all those things as

15 they're doing the procedure. It's just their normal

16 equipment.

17 And so four minutes later we have the

18 first monitor and we have the nurse both start their

19 times which is the beginning of that particular

20 procedure. Ten minutes later it was recorded that

21 the anesthesia actually started even though it

22 appears as though the procedure had been going on

23 for ten minutes already. Two minutes after that we

24 have the nurse and the monitor both say that the

25 procedure basically ended. Two minutes after that

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CCR #337
(702) 671-3365

1 there's still another ten minutes before the

2 anesthesia was reported to end and an additional

3 seven minutes after that -- at the bottom of the

4 anesthesia charts they would check off the blood

5 pressure and the heart rate. And the graph that had

6 that information went on for an additional eight

7 minutes after they said the anesthesia was done.

8 So we had an anesthesia time that

9 started which looked like at the end of the

10 procedure. It went on for roughly a half an hour

11 and then there were check boxes passed when they

12 said the anesthesia ended but they were still

13 monitoring things but it wasn't written as part of

14 the anesthesia.

15 Q So according to this it says when the

16 patient is out of the room, physician is supposedly

17 at the bedside and they even -- this is the end of

18 monitoring in the recovery room, yet supposedly

19 anesthesia is still being recorded and vital signs

20 are still being recorded?

21 A Yes.

22 THE FOREPERSON: We would like to call a

23 ten-minute break, please.

24 MR. STAUDAHNER: Certainly.

25 (Recess.)

Donna J. McCord
CCR #337
(702) 671-3365

1 MR. STAUDAHER: Ladies and gentlemen,
2 we're going to get started now after our break. The
3 intern from our office, Suzanne Whitehead, has
4 returned. And Terry Coffing, the attorney with the
5 Southern Nevada Health District, is no longer in the
6 room.

7 BY MR. STAUDAHER:

8 Q Continuing on with the questioning, let me
9 hit one thing right off the bat that I want to get
10 to. In the report as well as some of the things
11 that we've seen on the diagrams, you have designated
12 CRNA one, CRNA two, different people as sort of a
13 generic identifier. Can you tell us who -- give us
14 a list of all the people that you identified as a
15 generic identifier in your report and tell us who
16 the person matches up to, please.

17 A Sure. CRNA one is Keith Mathahs. CRNA
18 two is Linda Hubbard. CRNA three is Vincent Leone.
19 CRNA four is Ronald Lakeman. CRNA five is Ralph
20 McDowell. I list two RNs. RN one is Lynette
21 Campbell. RN two is Jeff Kruger. And then I list
22 four physicians. Physician A is Dr. Clifford
23 Carrol, physician B is Dr. Dipak Desai. Physician C
24 is Dr. Eladio Carrera. And physician D is Dr.
25 Ranadev Mukherjee.

Donna J. McCord
CCR #337
(702) 671-3365

1 Q So those are the individuals that are
2 contained within the report itself; is that correct?

3 A Yes, it is.

4 Q Okay. At some point after you go through
5 all this process, you're doing the timing, you've
6 done the analysis or you're in the process of doing
7 that, I know that you've got there, you got your
8 results at the end, but how do you go through that
9 process? How do you go through the epidemiologic
10 sort of investigation? What kind of information do
11 you use? Why is it different from other kinds of
12 investigations?

13 A The public health investigation is focused
14 on understanding kind of the big picture. Our goal
15 is not to identify every single infected case during
16 this -- that was ever infected by the clinic. It's
17 not to try and find the source patient for all those
18 people. It's trying to identify the overall public
19 health concern.

20 Now, as part of this investigation we
21 were able to identify a number of people and where
22 their source was, but we didn't have to do this for
23 every single person who was a patient with the
24 clinic to get an understanding of what happened
25 there in a broad general sense and then take the

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CCR #337
(702) 671-3365

1 steps we would in a public health investigation.

2 So it's very different than a
3 criminal investigation. We're not trying to find
4 exactly who's responsible for what things but really
5 trying to understand exactly what happened in the
6 big picture and make the appropriate public health
7 recommendations. We don't penalize people for
8 anything. We're not there to figure out who's
9 responsible for some of the things. We want to know
10 what happened and what we need to do to protect
11 public health.

12 Q Now, in the process of doing that I assume
13 you would then say since this isn't a criminal type
14 investigation, I know it eventually became one, but
15 your investigation initially is not really you're
16 the police, you're the DA's office or anything else,
17 correct?

18 A That's correct.

19 Q And you're not charged either in the
20 Health District or personally with trying to be an
21 investigator for the police?

22 A That's correct.

23 Q Which I assume means you're not a
24 surrogate in any way for the police?

25 A That's correct.

Donna J. McCord
CCR #337
(702) 671-3365

1 Q As far as the investigation is concerned,
2 it is I assume your intention in doing your
3 investigation to make public or at least make
4 available to other health care providers the
5 information that you determine and receive as part
6 of your investigative process?

7 A Yes, that's correct.

8 Q And I know that we have a large report
9 here that was entitled, that was the public health
10 investigation report that you helped author or did
11 author, but there were also other publications like
12 the MMWR that came out as well as the Trip report
13 and things from CDC that were meant to go to
14 individuals to assess and help them prevent this
15 kind of thing from happening in the future?

16 A Yes, that's correct.

17 Q All of these documents eventually become
18 public; is that correct?

19 A Yes, that's correct. The end result of
20 our investigations are typically some sort of public
21 reporting, kind of how we spent your tax dollars
22 basically. This is what we found in the
23 investigation but these are the public health
24 findings and what we need to do to protect public
25 health, how we can prevent these things in the

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CCR #337
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RA 000273

1 future or what people who have been exposed need to
2 do to take care of their own individual health
3 issues.

4 Q And all of the reports and documents and
5 things that went into all this, including the report
6 itself I assume, is part of the business records of
7 the Health District, correct?

8 A Yes, that's correct.

9 Q And you have access to all of those things
10 in your investigation?

11 A Yes, I do.

12 Q Now, as far as the cases themselves, I
13 think we talked about some of them in the discussion
14 we had today, how did you find out about all these
15 cases?

16 A The initial three cases we've already
17 discussed, the ones that led us to the investigation
18 in the clinic. There were a total of six cases
19 identified from the September 21st cluster and
20 there's only one case identified on July 25th. So
21 we did not identify any other people who had
22 procedures on July 25th and were infected. We
23 identified a source patient on that day through the
24 genetic testing. On September 21st we identified
25 the source patient through the genetic testing later

Donna J. McCord
CCR #337
(702) 671-3365

1 previously identified.

2 Q So one of those cases actually came from
3 the physicians in the practice?

4 A Yes. When Dr. Carroll brought his
5 information to me about his theory of the
6 intentional transmission, he had done some work on
7 his own and listed out a number of patients who he
8 thought were acute cases. And one of the names that
9 he had listed on his list was one I hadn't seen
10 before. And so I was able to identify one
11 additional case that way.

12 The final case we identified never
13 developed acute Hepatitis C. That person was
14 identified through the laboratory testing that we
15 put in place for that particular purpose. So when
16 we made the public announcement, at the same time we
17 started calling all the patients that we had contact
18 information for from July 25th and September 21st to
19 get them to come into the Health District for a
20 blood draw because then we could do the testing for
21 them and if it was positive, send it to off to CDC
22 and do the genetic matching. And we identified one
23 case through that process that we were able to
24 genetically match but who did not have acute
25 symptoms.

Donna J. McCord
CCR #337
(702) 671-3365

1 on, but it came down to the different methods we
2 used to identify cases.

3 So we went in there with two cases
4 from September 21st and within a couple hours we
5 found an additional case. We had a list of all the
6 patients from September 21st and we also had a list
7 of all the hepatitis results that were reported to
8 the Health District. And basically by cross
9 referencing the names we found somebody on both
10 lists and investigated that and found the third
11 case.

12 The fourth case was found two or
13 three days later. It was reported to our office as
14 an acute Hepatitis C case. When we called and tried
15 to interview the person they were really sick, hung
16 up on us and didn't want to talk to the Health
17 District. We saw their name on the list,
18 reinitiated an interview and were able to complete
19 the interview at that time and identify one
20 additional case.

21 Another case was found in talking to
22 the doctors later on. They were trying to present
23 some of the information they had about it and they
24 listed a number of people who they thought were
25 acute cases and there was a name that we had not

Donna J. McCord
CCR #337
(702) 671-3365

1 There was one additional person who
2 was found to be positive from that day, but in
3 sending the stuff off to CDC there wasn't sufficient
4 quantity of the virus in the blood to be able to do
5 the genetic testing. So it may be related, it may
6 be unrelated, we couldn't make a determination on
7 that particular case.

8 Q So possibly one other patient but not
9 enough stuff to find out why?

10 A Right. We were unable to make that
11 determination either way.

12 Q So that kind of lets how you got each one
13 of the patients in your study as positive infected
14 patients from the source individuals?

15 A Yes. So in the end we had six patients,
16 five of whom were acute and one who was a non-acute
17 case from September 21st and one new patient from
18 July 25th plus the source patients on those two
19 days.

20 Q And I want to be clear that I think you've
21 already testified but I just want to make sure that
22 it is certainly possible that even if there was, you
23 know, a contaminated sample of propofol or whatever
24 that had gone into a patient and the person had
25 gotten the virus introduced into their system, that

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CCR #337
(702) 671-3365

1 they may not have succumbed to the virus or shown
2 symptoms or anything else?

3 A Yes, that's correct.

4 Q Do you have any idea what the percentage
5 of that happening is in the population?

6 A There's no way to really know that because
7 we don't know exactly what happened with the
8 propofol, how much was used from which vials.
9 There's really no way for us to say. It's something
10 you could theoretically come up with but we didn't
11 have any of the numbers to be able to fill in that
12 kind of equation. We don't know how much virus was
13 in that person, how much propofol there was, who got
14 how much propofol from which vials. There's no way
15 to really to calculate those things. We can kind of
16 explain how it happened and how we do the
17 calculation but the numbers are all unknown.
18 There's no way to figure that out.

19 Q And you're not aware of any study that's
20 gone into that I assume?

21 A Well, I'm sure there have been studies
22 that looked at the amount of virus it would take to
23 actually infect somebody and so those kind of
24 things. They evaluated can the virus survive in
25 propofol and they found that it can. Looking at how

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CCR #337
(702) 671-3365

1 prefill a bunch of syringes with lidocaine and put
2 them in a drawer. They weren't labeled. They
3 didn't have a time on them. Those syringes would
4 have been around the next day. But the lidocaine,
5 it wasn't that sort of issue where it would have
6 gone bad after four hours or something like that.

7 Q I see. As far as the genetic information
8 that came back from the CDC, what did you do with it
9 when it came back and how did you use it?

10 A Well, we got different information at
11 different times. Initially the first information we
12 got from CDC is that they were all genotype 1A.
13 It's the most common genotype in the United States
14 and so it didn't tell us anything. It would have
15 been nice if we had a different genotype. It could
16 have given us some information. It just told us
17 that they were genotype 1A and we couldn't figure
18 out anything about the connection or the cluster or
19 relationship in any of those cases.

20 After that we got the cluster
21 analysis from the CDC, the final genetic analysis.
22 And from that we could show which one of the
23 potential source patients was the actual source
24 patient. We could show which people were infected
25 and put together the diagram we showed earlier

Donna J. McCord
CCR #337
(702) 671-3365

1 long the virus can survive and it very easily can
2 survive the entire day in a clinic. That's not a
3 problem. But in terms of this exact situation, I
4 don't think there's any way you can model it or
5 study it or figure out those sort of pieces.

6 Q One last thing related to just what you
7 mentioned about surviving the entire day in a
8 clinic. Did you ever get any indication or observe
9 the propofol that had been used on one day that was
10 left over was used the following day?

11 A No, we did not observe that. The propofol
12 is labeled that it has to be used within four hours
13 and all the people we talked to were aware of that
14 particular issue. Propofol doesn't have the
15 chemicals in it to prohibit bacterial growth and so
16 it's not something that can sit around for multiple
17 days. It has to be thrown out within four hours.
18 Everybody seemed to be well aware of that issue. I
19 can't say how long some of those vials sat around,
20 but we did not observe any propofol being reused the
21 next day.

22 There was one thing we did observe
23 being reused. They would prefill the syringes with
24 1CC of lidocaine which is given with the propofol
25 because it burns when it goes in. They would

Donna J. McCord
CCR #337
(702) 671-3365

1 looking at the timing of it and try and understand
2 how it went through the clinic and looking at how
3 those cases are connected and did that actually make
4 sense.

5 If we looked at it and said, well,
6 the source patient was after all of the infected
7 patients that wouldn't have made any sense. But it
8 matched up with everything that we had believed all
9 along, everything that we had found all along. It
10 just confirmed our findings. It clearly showed that
11 there were two different transmission occurrences,
12 one on July 25th, one on September 21st, and that
13 just kind of was in line with everything that we had
14 believed up to that point.

15 Q Did you ever come across any evidence
16 comparing the genetic stuff with the infield
17 investigation, with the review of charts, anything
18 that started to say, you know what, our conclusions
19 are wrong, we made some mistakes here?

20 A No, we have not found anything that made
21 us think it was anything other than the unsafe
22 injection practices that led to the transmission of
23 disease in this outbreak.

24 Q I think the last thing I want to go over,
25 there's an item on page 23 regarding, I think it was

Donna J. McCord
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1 relation or relative risk that you mention in your
2 report. I would like you to describe and tell us
3 about that and what that means.

4 A One of the things you can calculate in
5 epidemiology is called relative risk and you hear
6 about these things on the news all the time. People
7 who smoke are ten times more likely to get lung
8 cancer than those who don't smoke. We were able to
9 do the same sort of calculation comparing people who
10 had procedures at the clinic after the source
11 patient to everybody else who didn't have procedures
12 at the clinic on that day, and we found that the
13 clinic patients were over 31 million times more
14 likely than the non-clinic patients to be infected
15 with acute Hepatitis C.

16 MR. STAUDAHNER: I have no further
17 questions for this witness.

18 THE FOREPERSON: Are there any questions
19 from the jury?

20 BY A JUROR:

21 Q You mentioned a lot about a Linda Hubbard.
22 It appears that you found that she had made a lot of
23 errors. Was that through visual observations or was
24 that through reviewing the doctors' notes, the
25 nurses' notes?

Donna J. McCord
CCR #337
(702) 671-3365

1 trouble figuring out a list of all the patients from
2 certain days so we couldn't find the source patient,
3 couldn't even do that genetic testing.

4 But in a public health investigation
5 we're not trying to find every one of those. A
6 couple of clusters showing us what happened for the
7 outbreak is sufficient for our purposes to notify
8 the public and to take the steps we need in public
9 health to prevent more ongoing disease transmission.

10 THE FOREPERSON: Okay. Bob.

11 BY A JUROR:

12 Q Now, you said there were unsafe practices
13 going on quite regularly, apparently anyway. How
14 come only those two days? Why don't we see a
15 cluster of more of these incidents throughout the
16 time frame?

17 A There may have been other clusters that we
18 just weren't notified of. Acute Hepatitis C is a
19 little bit of a challenge for doctors to diagnose.
20 And assuming they even can diagnose it correctly,
21 even though they are supposed to report by law they
22 don't. So a lot of times cases occur and we don't
23 hear about them. So there may have been clusters
24 that we missed.

25 The challenges, the majority of

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1 A Those were the observations we had when we
2 were in the procedure room. They are considered
3 general infection control issues and those were
4 addressed with her.

5 Q And she was a CNA?

6 A She was a CRNA.

7 Q CRNA. Thank you.

8 THE FOREPERSON: Are there any other
9 questions?

10 BY A JUROR:

11 Q We're talking about two days now where we
12 had clusters of cases. Has any other cases come up
13 yet on other days?

14 A The challenge we had was actually trying
15 to make a strong link between the cases and the
16 procedures at the clinic. In our report we list 115
17 people who are likely infected because of procedures
18 at the clinic. We only have the genetic testing on
19 the seven people that we've talked about today. The
20 other people had developed -- they were positive on
21 their testing. They reported that they had no other
22 risk factors but we don't have the same genetic
23 testing. In order to do that we would need to have
24 a potential source patient and we would need to have
25 kind of what happened on that day. We had a lot of

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CCR #337
(702) 671-3365

1 people infected with Hepatitis C, a new infection,
2 will have no outward symptoms. If they never seek
3 medical care they would never know they were
4 infected. So there wasn't a big red flag. It was
5 just this background transmission that occurred.

6 Think of it like an HIV infection.
7 If you get HIV you're not going to know it for years
8 down the road until you have really serious health
9 problems. That's the way Hepatitis C typically
10 occurs. You wouldn't know it so there's not a whole
11 bunch of people showing up at a doctor's office and
12 we can find it. We just happen to have, for
13 whatever reason, more acute disease happen on this
14 day which put up that red flag and allowed us to
15 find it. But that disease transmission is generally
16 just going to go under the radar and we're not going
17 to be able to identify it.

18 BY THE FOREPERSON:

19 Q The CRNAs that moved from room to room on
20 those occasions when they did, did they take the
21 tray that held the vials of propofol with them to
22 the next room or did they leave it behind for the
23 CRNA coming in to use?

24 A We didn't observe anybody moving from room
25 to room like that so I can't say what typically they

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CCR #337
(702) 671-3365

1 were doing. There's a lot of ways we think it could
2 have moved from room to room but we didn't observe
3 directly somebody moving it doing those sorts of
4 things.

5 Q Thank you.

6 Are there any further questions?

7 Yes.

8 MR. STAUDAHER: And I have one after you.

9 A JUROR: Go ahead.

10 MR. STAUDAHER: No, go ahead, please.

11 BY A JUROR:

12 Q So is Hepatitis C diagnosed with a blood
13 test?

14 A Yes.

15 Q And at some point your organization sent
16 out a public announcement that if you were at this
17 business come and have your blood tested; is that
18 correct?

19 A Yes, that's correct.

20 Q Were anymore cases discovered when you did
21 the general testing among patients that stepped
22 forward?

23 A Well, the 115 cases that I mentioned
24 total, so that would have been an additional 105 or
25 so, in that range, that we found from the testing.

Donna J. McCord
CCR #337
(702) 671-3365

1 A majority of the people who tested positive, we
2 really couldn't match them up because the list we
3 got from the clinic didn't have a date of birth.
4 And so you have a name but without a date of birth
5 you can't really match the people. We also had an
6 incomplete list from the clinic and so we can't
7 really say how many people were actually infected.

8 It was a big a challenge for us when
9 we say they were possibly associated with the clinic
10 because we had enough information to say they're
11 Hepatitis C positive now, there was no report that
12 they were positive before their procedure, they may
13 have been but they didn't know it at least, and they
14 report that they didn't have any of the major risk
15 factors. And so it's kind of a fuzzy connection to
16 the clinic. The only real strong connections we
17 have is that genetic test and we can show it
18 absolutely occurred on those days, went from this
19 person to these people.

20 Q So the other you said 105 --

21 A Well, there were 115 total.

22 Q So the other 105 you couldn't genetically
23 link to those two source patients from those two
24 days?

25 A These were patients on different days over

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CCR #337
(702) 671-3365

1 a four-year period so they weren't on those same
2 days. They weren't on September 21st or July 25th.
3 We basically have somebody with a chronic Hepatitis
4 C case who had a procedure there but we don't even
5 have a potential source patient to match them
6 against. So there was no way we could do any of
7 that sort of analysis or testing.

8 Q Okay. So, I'm sorry, so the other 105,
9 they weren't genetically linked within that 105?
10 They could say these ten are similar and had the
11 same source?

12 A The ones that are genetically linked we
13 can say had the same source. The other 105 people
14 or so, we can't say exactly what their source is.
15 They're not genetically linked to somebody, we just
16 know that they are Hepatitis C positive now, don't
17 report any major risk factors and didn't know they
18 were at least Hep C positive before they went in.
19 So they likely got it at the clinic but we can't say
20 that for certain.

21 Q Because before they said that like if it
22 was within two percent, you know, then they could
23 say somebody had the same source. And so you
24 couldn't say like the other 105 weren't within two
25 percent?

Donna J. McCord
CCR #337
(702) 671-3365

1 A I understand what you're talking about.
2 This is completely separate and none of that testing
3 was done on any of these people. And so we don't
4 even have those kind of results. The two percent
5 means nothing because that testing was not done on
6 the people. The only testing done on those people
7 was a laboratory test to indicate the presence of
8 Hepatitis C. There was no additional testing beyond
9 that so the two percent doesn't even factor into it.
10 It's just we know these people are positive for Hep
11 C and then that's it.

12 THE FOREPERSON: Any further questions
13 from the jury?

14 MR. STAUDAHER: I have -- well, go ahead.

15 THE FOREPERSON: None? Okay.

16 MR. STAUDAHER: Just a couple.

17 BY MR. STAUDAHER:

18 Q And follow up to that, what is the
19 background incidence of Hep C in the population?

20 A Well, the background incidence of Hep C in
21 the population is roughly four percent. If you look
22 at the population as a whole, we age adjusted that
23 because the clinic population, the average age was
24 55. You tell people to get a colonoscopy at 50 and
25 that's what most of their business was. So it was

Donna J. McCord
CCR #337
(702) 671-3365

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1 an older population. We tend to see higher rates of
2 Hepatitis C in the older population. So for the
3 clinic population we expect around at most a
4 six percent background of Hepatitis C patients
5 walking in the door infected before they ever set
6 foot anywhere near the clinic.

7 Q Okay. And as far as the questions that
8 were asked by the Grand Jury member about other
9 testing and so forth, I mean, I assume you looked
10 for other clusters in some areas; is that correct?

11 A Yes, we did.

12 Q And were you able to find any other ones
13 or what did you do in that regard?

14 A We were trying to find additional
15 clusters, we just didn't have sufficient information
16 to do so. The majority of the cases wound up
17 getting lawyers as soon as they were found out to be
18 positive and didn't want to talk to us. So we
19 didn't know most of the people who were infected.
20 The ones we did know, some had their procedure
21 dates, some had a bill they got from the clinic that
22 had a date. Other ones we knew roughly when they
23 got it because on the clinic list it didn't have
24 their procedure date, it had the date they went into
25 the computer system. So it was within a week of

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CCR #337
(702) 671-3365

1 all the labs and it doesn't cover somebody who would
2 have been tested out of state and recently moved
3 here and things like that. So in some ways we could
4 find people with prior positives, and we did that
5 for anybody that we identified as a case, tried to
6 find any previous positive on that person. The fact
7 that we didn't have a positive doesn't mean one
8 didn't exist, we just couldn't find it.

9 Q But you did look at that particular issue
10 in that population of individuals?

11 A Yes, we did.

12 Q After this whole clinic thing happened,
13 and I know the clinic gets shut down as a result of
14 this, correct?

15 A Yes, but not by the Health District. I
16 wasn't involved in that.

17 Q I know. I'm not saying you did. I wasn't
18 implying that whatsoever. But it does get shut
19 down?

20 A Yes, that's correct.

21 Q The background level that you had said was
22 in the Las Vegas Valley was around three to four per
23 year and this incident, all of a sudden you're
24 getting this cluster of nine cases. Before I ask
25 that question, I want to ask you, related to the

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CCR #337
(702) 671-3365

1 their procedure generally but we couldn't say they
2 were all on the same day or not on the same day.

3 Finding the clusters though really
4 wasn't a huge priority for us because we had these
5 two clusters and that was sufficient to figure out
6 what allowed the transmission to occur and identify
7 the unsafe injection practice.

8 Q And that was your primary role, was it
9 not?

10 A Right. We weren't trying to find every
11 single person who was infected at the clinic. It
12 was trying to figure out what happened and make sure
13 it doesn't happen again.

14 Q Of those patients that were infected at
15 the clinic or tested positive, beside the two source
16 patients who were known Hepatitis patients when they
17 first arrived on site, were the other patients, did
18 they have -- was there some way to determine whether
19 or not in the recent past prior to their getting the
20 colonoscopy or endoscopy that they were positive or
21 negative for hepatitis?

22 A We do have a list of all the hepatitis
23 results that have been reported to us, so for some
24 people we can look it up and say that they had a
25 positive result in our system. But it doesn't cover

Donna J. McCord
CCR #337
(702) 671-3365

1 acute cases which you said everyone was except for
2 one was a chronic case, correct?

3 A Yes.

4 Q Of the infected patients?

5 A Yes, that is correct.

6 Q What is the typical incubation time for an
7 acute phase infection.

8 A The maximum incubation period is six
9 months, the minimum is somewhere around a month.
10 Typically about two months after the person's
11 procedure is when we'll start to see symptoms. So
12 two to three months, in that range. In the acute
13 cases we found were typically in that two to three
14 month range.

15 Q So another reason to believe that the
16 acute infections came from that source?

17 A Yes.

18 Q Related to my question where I was going
19 with this, after this whole process was done and the
20 clinic was shut down, did the rates of reported
21 Hepatitis C infections in the Las Vegas Valley
22 return to their previous baseline?

23 A It took a while. They're closer down to
24 that range now. In having 60 plus thousand people
25 get tested, we identified a lot more of background

Donna J. McCord
CCR #337
(702) 671-3365

1 disease, people who would have normally not known
2 they were infected with Hep C. As a result of that
3 they are now being treated, managed and as part of
4 their ongoing care lab testing is part of it. So
5 Hep C testing is up just because we did a better job
6 identifying all the background cases here in
7 Southern Nevada. It's basically like a big
8 screening program that we put in. And so we never
9 really expected to go back to the background level
10 because we picked up all these, I guess the number
11 of people we know about now is probably closer to
12 the truer number than it was before. And so that's
13 just going to involve a lot more work for all the
14 providers who now have to manage patients with Hep
15 C.

16 Q But from the time the clinic is shut down
17 six months afterward and beyond, because that would
18 be the incubation period, did you see at least a
19 decrease in that level of back -- or closer to the
20 baseline that you originally had?

21 A Let's see, I have a figure on this
22 testing. Could you bring up figure 13-1?

23 Q On page what?

24 A On page 65. I guess 13-2 as well. 65 and
25 66 as well. So this is figure 13-1. This is

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CCR #337
(702) 671-3365

1 basically looking at how many tests were ordered
2 above normal. We know on a typical week how many
3 Hepatitis B and Hepatitis C and HIV tests we expect
4 to get on a weekly basis, basically how many people
5 are tested both positive and negative. This line
6 across the middle here below the graph is the
7 baseline. So it's a one to one ratio, kind of our
8 normal range. That next line is ten times above
9 normal. So within two to three weeks we were
10 getting ten times as many tests coming into us,
11 positive and negative, as we did prior. This goes
12 through basically near the end of May and at that
13 point it's still a little above normal but by that
14 time it had pretty much gone back down and all those
15 people had been tested initially. The second graph
16 that I have, 13-2, this goes to looking at chronic
17 versus newly identified cases. The dark line is the
18 number of initial positives we had and this is the
19 ratio again of one and then there's ten at the top.
20 The dark line is the first time we have a lab test
21 for those people. The gray line is a subsequent
22 test for those people. And so we saw a lot more
23 subsequent testing after our announcements in April,
24 May, June as people started to get in the care
25 system and got retested. So we were still finding

Donna J. McCord
CCR #337
(702) 671-3365

1 initial positives but we had a lot more follow-up
2 testing. So the overall number of results are way
3 up but the number of new cases basically went back
4 down to baseline. We're finding a lot of people are
5 being retested. Part of your Hepatitis C management
6 is looking at your viral load over time, how much
7 Hepatitis C is in your blood. And so anybody that's
8 got it will continue to have these tests over time,
9 and because we've identified all these new cases
10 there's just a lot more people being repeatedly
11 retested.

12 Q And for the record that was from page 66
13 of the report.

14 I have nothing further.

15 THE FOREPERSON: Tom.

16 A JUROR: Yes.

17 BY A JUROR:

18 Q Do you know in a manufacturing process of
19 the syringes and the needles, is that a common
20 practice to provide this with replacement needles or
21 is it just --

22 A I know they exist but I'm not an expert in
23 that area. I couldn't tell you how common it is.

24 Q I was just wondering if you had any
25 experiences. Is this acceptable, you know --

Donna J. McCord
CCR #337
(702) 671-3365

1 A I know you can purchase them separately.
2 As an undergraduate I worked in a research
3 laboratory and you can buy needles and you can buy
4 syringes separately. You'll use syringes a lot of
5 times without a needle in different settings so they
6 do sell them separately. In terms of what they
7 typically do in a medical clinic I can't really say.

8 Q Thank you.

9 THE FOREPERSON: Are there any further
10 questions? None?

11 By law these proceedings are secret
12 and you are prohibited from disclosing to anyone
13 anything that transpired before us including any
14 evidence presented to the Grand Jury, any event
15 occurring or a statement made in the presence of the
16 Grand Jury or any information obtained by the Grand
17 Jury.

18 Failure to comply with this
19 admonition is a gross misdemeanor punishable by one
20 year in the Clark County Detention Center and a
21 \$2,000 fine. In addition you may be held in
22 contempt of court punishable by an additional \$500
23 fine and 25 days in the Clark County Detention
24 Center.

25 Do you understand this advisement?

Donna J. McCord
CCR #337
(702) 671-3365

1 THE WITNESS: Yes, I do.
 2 THE FOREPERSON: Thank you. You may be
 3 excused now.
 4 THE WITNESS: Thank you.
 5 THE FOREPERSON: You're welcome.
 6 Sir, could you please raise your
 7 right hand? Thank you.
 8 You do solemnly swear that the
 9 testimony you're about to give upon the
 10 investigation now pending before this Grand Jury
 11 shall be the truth, the whole truth, and nothing but
 12 the truth, so help you God?
 13 THE WITNESS: I do.
 14 THE FOREPERSON: Thank you. You may be
 15 seated.
 16 You are advised that you are here
 17 today to give testimony in the investigation
 18 pertaining to the offenses of performance of act in
 19 reckless disregard of persons or property; criminal
 20 neglect of patients; insurance fraud; obtaining
 21 money under false pretenses; and racketeering
 22 involving Dipak Kantilal Desai, Ronald Ernest
 23 Lakeman and Keith H. Mathahs.
 24 Do you understand this advisement?
 25 THE WITNESS: Yes.

Donna J. McCord
 CCR #337
 (702) 671-3365

1 Q You're aware of the hepatitis outbreak
 2 that occurred at the clinic?
 3 A Yes.
 4 Q At the time that that occurred, the dates
 5 in 2007, July of 2007 and September of 2007, were
 6 you associated in any way with the clinic?
 7 A No.
 8 Q Okay. When you had worked at the clinic
 9 what was your job at that location?
 10 A I was a GI tech.
 11 Q During the time that you were a GI tech,
 12 did you have interaction with Dr. Desai and some of
 13 the other physicians and CRNAs at the facility?
 14 A Yes.
 15 Q Specifically did you work with Dr. Desai
 16 prior to coming to the endoscopy center?
 17 A Yes.
 18 Q And how did you know or work with him in
 19 that situation?
 20 A I was the GI tech at Southwest Medical
 21 from 1995 to 2003.
 22 Q Now, as far as Dr. Desai, I want to ask
 23 you some specific questions about him. Speed of
 24 procedures, was he pretty fast?
 25 A Yes.

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 (702) 671-3365

1 THE FOREPERSON: Could you please state
 2 both your first and last names spelling them for the
 3 record?
 4 THE WITNESS: Melvin, M-E-L-V-I-N,
 5 Hawkins, H-A-W-K-I-N-S.
 6
 7 MELVIN HAWKINS,
 8 having been first duly sworn by the Foreperson of the
 9 Grand Jury to testify to the truth, the whole truth,
 10 and nothing but the truth, testified as follows:
 11
 12 EXAMINATION
 13 BY MR. STAUDAHER:
 14 Q Mr. Hawkins, what do you do for a living?
 15 A I'm retired.
 16 Q How long have you been retired?
 17 A Over a year.
 18 Q I'm going to direct your attention back to
 19 January -- well, actually did you ever work in the
 20 past for the Endoscopy Center of Southern Nevada?
 21 A Yes.
 22 Q What were the years that you worked for
 23 that entity?
 24 A August, 2003 through March, end of March,
 25 2006.

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 (702) 671-3365

1 Q In comparison with other doctors in
 2 general, was he faster, medium or slower than those
 3 doctors?
 4 A Faster.
 5 Q When you say fast, how long would it take
 6 him to do a typical colonoscopy on average over the
 7 time that you were with him?
 8 A Three to five minutes when we were at
 9 Southwest Medical. Sometimes he had been known to
 10 do them faster, depends on the obstructions he would
 11 have going in or if the patient was prepped out
 12 enough.
 13 Q So anywhere from three to five minutes you
 14 think?
 15 A Yeah.
 16 Q Okay. As far as procedures that for Dr.
 17 Desai lasted say, and I'm talking about
 18 colonoscopies, 30 minutes or more, how many of those
 19 kind of procedures did you observe of Dr. Desai over
 20 the time you worked with him?
 21 A None.
 22 Q So they were always much shorter than
 23 that?
 24 A Yes.
 25 Q Now, the kinds of things you talked about

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 CCR #337
 (702) 671-3365

1 that related to causing a slowing of the process,
 2 did that seem to slow Dr. Desai up much past this
 3 five-minute range that you talked about?
 4 A With certain patients it did.
 5 Q And what kind of patients are we talking
 6 about?
 7 A If they failed to take their prep so you
 8 had poor visibility, you couldn't see, you couldn't
 9 flush them out enough. That was usually the main
 10 thing. Every once in a while you would have a
 11 patient with angulation. You couldn't get all the
 12 way to the cecum. Because of the angulation of the
 13 colon you couldn't curve the scope around. Or if
 14 the person was too elderly, especially females,
 15 elderly females or if they had diverticulitis are
 16 prone to have blowouts of the diverticulum, the
 17 little blips in the gut so you can't put a lot of
 18 air in them.
 19 Q Okay. Did you ever see him do procedures
 20 in the two to three-minute range?
 21 A Every -- yeah, every once in a while he
 22 would speed up. He'd have one that wouldn't take
 23 long. Depends on, you know, what tech was with him,
 24 if anesthesia was ready, patient's in the proper
 25 position.

Donna J. McCord
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 (702) 671-3365

1 Q Did you work with Dr. Desai during that
 2 period?
 3 A Yes. He would usually be the first one in
 4 and then if he had to go somewhere he would send
 5 another doctor in.
 6 Q In your experience, not Dr. Desai, in
 7 whatever the industry standard that you know of and
 8 the experience that you have, what's the average
 9 time or how long should a procedure last?
 10 A According to the books in a training
 11 situation like where they learn it in school and
 12 fellowships and stuff, they do like ten cases a day.
 13 So they're taking 20, 30 minutes a patient then you
 14 have to clean up the room and that can be another 20
 15 minutes. I know Nellis is the same way, it takes
 16 them like 20 minutes to turn over a room.
 17 Q Well, when you came to the Endoscopy
 18 Center was the room turnover a lot faster?
 19 A Yeah. Well, at Southwest when I was there
 20 I was the only tech there so we ran one room and we
 21 could still turn over in less than ten minutes. But
 22 that's between the nurse, the tech, and anesthesia
 23 would bring their own patient and the IV is already
 24 started. Southwest was set up different. It was a
 25 different set-up. It was more -- you had people at

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 CCR #337
 (702) 671-3365

1 Q Did you ever have a situation where you
 2 thought he held a record for speed of procedures in
 3 like an EGD?
 4 A Yeah. I think he had one at Southwest
 5 that was supposedly under a minute.
 6 Q So pretty fast at what he did, huh?
 7 A Yeah, but an EGD is just a straight shot.
 8 Q Straight down. Yeah, I guess we should
 9 clarify what that is. Colonoscopy is from the anus
 10 going up?
 11 A EGD is from the mouth going down into the
 12 stomach and part of the, first part of the large
 13 bowel. Small bowel, I'm sorry.
 14 Q And you've been -- you've done this kind
 15 of stuff for a long time; is that right?
 16 A Yes.
 17 Q And I'm talking about when you were
 18 working back then.
 19 A Yes.
 20 Q When you were working at Southwest Medical
 21 before you came to the Endoscopy Center of Southern
 22 Nevada, you said you worked with Dr. Desai during
 23 that time?
 24 A I worked with Dr. Desai and all the
 25 doctors in his group.

Donna J. McCord
 CCR #337
 (702) 671-3365

1 each station. At D's it was a smaller thing but it
 2 was sometimes faster.
 3 Q As far as the numbers of patients that you
 4 were doing in a day when you were at the Endoscopy
 5 Center, what -- first of all what clinic did you
 6 work at, what facility?
 7 A I worked at the Shadow Lane clinic
 8 primarily.
 9 Q Did you ever work at other clinics?
 10 A Yes, I worked at the one over behind
 11 Desert Springs Hospital. If they had a problem or
 12 something they would send somebody over there.
 13 Q Is that the Burnham clinic?
 14 A Yes.
 15 Q Was there a difference between the two
 16 clinics as far as patients that were going into them
 17 and the rate of procedures, things like that?
 18 A Yes. Burnham had a lot slower pace. They
 19 couldn't keep up with us at Desert.
 20 Q Was Dr. Desai out at the Burnham clinic?
 21 A No. He would go over there every once in
 22 a while if they were having a problem but he usually
 23 didn't go over there and everything was at a nice
 24 calm pace.
 25 Q When Dr. Desai came to the Burnham clinic,

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 CCR #337
 (702) 671-3365

1 were you ever there before he arrived at the Burnham
2 clinic?

3 A Yes.

4 Q What was the staff's demeanor or how did
5 it change when they realized that Dr. Desai would be
6 coming over that day?

7 A One word, panic.

8 Q And why was that?

9 A Because they were afraid of Dr. Desai. If
10 you couldn't -- if you weren't doing -- he'd walk
11 through. If you were in doing records you had to be
12 doing the records, you couldn't be sitting there,
13 you couldn't be talking to anybody or you couldn't
14 be drinking a drink. Or even in the lounge he
15 would, you know, he would monitor how much time you
16 were in the lounge. And when he would come it would
17 be like a wildfire starting. You know, word would
18 come D is on his way, because everybody called him
19 D, and people were just like ah.

20 Q So typically over at the Burnham clinic
21 how many patients were coming through in a day?

22 A Oh, they were in the teens. They were
23 only doing like -- my last count with them I don't
24 even think they got up to 20. A bad day was 20 for
25 them.

Donna J. McCord
CCR #337
(702) 671-3365

1 Q Is that one room or two rooms?

2 A That's one room. They had -- well, when
3 they moved -- that was when they were upstairs.
4 When they moved to the new place downstairs I don't
5 know how many rooms they had there. I never went to
6 the new clinic.

7 Q But your observation was in the teens to
8 low 20s?

9 A Yeah, for one room.

10 Q Okay. Now, over at the Shadow Lane clinic
11 where you also worked with Dr. Desai, what were the
12 patient loads over there?

13 A When I first started we had one room and
14 we ran -- we got up to 50 patients a month.

15 Q In one room?

16 A Yeah.

17 Q A month or a day?

18 A In a day. No, in a day.

19 Q Okay.

20 A Then when we got the two rooms he had
21 assured us, because he gave us a dinner for all the
22 employees, that we would never go over 75. Then we
23 got to 75. Then he assured us that we would never
24 go over a hundred. Then we hit a hundred.

25 Q So there were times at the Shadow Lane

Donna J. McCord
CCR #337
(702) 671-3365

1 clinic that you were seeing a hundred patients in a
2 day?

3 A They would book a hundred. Sometimes, you
4 know, you'd have people that don't show and stuff so
5 they were averaging like 85 patients a day.

6 Q And is that actually patients that are
7 being done or patients that are just scheduled?

8 A That's patients being done on the endo
9 side. There are also patients on the other side,
10 new patients coming in. And I know like one
11 Saturday, we worked a Saturday, we did -- we had to
12 have at least 20 patients because we only worked
13 half a day. So we started at 7:30 and we had to be
14 out by 12. We'd have 20 patients and then I found
15 out later on he was also doing new patients over on
16 the other side. He had the other staff in. And he
17 would see maybe 15 or 20 patients in between. He
18 would jostle them. So if there was anything slow
19 down in the room then he would go over and see new
20 patients because they're easy to turn over because
21 he didn't -- I don't know. I never went in the room
22 with him for a new patient, I don't know what it
23 was, but he was fast with them.

24 Q Were there any patients that he would slow
25 down for or take a little extra time with?

Donna J. McCord
CCR #337
(702) 671-3365

1 A Yes. Usually he was afraid of frail
2 little old ladies which most of them are. We did a
3 lot of, what we used to call in the military,
4 dignitaries. We did a lot of lawyers, other
5 doctors, government officials, entertainers.

6 Q Any celebrities?

7 A Oh, yeah. BB King, a couple other people,
8 Flavor Flav.

9 Q So those people he took a little extra
10 time with them?

11 A They came in on Saturday. They were like
12 on a one-on-one basis and that was a select crew
13 that usually came in for them. Usually a nurse
14 anesthetist, they'd have -- last one I heard about
15 was just the charge nurse came in and I don't even
16 know if they used a tech or not. If they did it
17 wasn't me so I have no idea who it was.

18 Q Is it fair to say that over the time you
19 were, not just at that clinic but in your general
20 practice where you did this kind of thing for other
21 doctors at other locations, that you got a feel for
22 how long it took patients to recover from these kind
23 of procedures, things like that, after they were
24 done?

25 A Yes.

Donna J. McCord
CCR #337
(702) 671-3365

1 Q Typically when a patient had a procedure
2 done, and I'm talking about a colonoscopy type
3 procedure, how long did they typically recover out
4 in the recovery area before they were discharged or
5 let out of the facility?

6 A About ten to fifteen minutes.

7 Q Is that on average?

8 A Yeah.

9 Q How about with Dr. Desai's group?

10 A Oh, you mean -- oh, at other -- at
11 Southwest you wait 30 minutes before you're
12 discharged. You have to wait 30 minutes.

13 Q Why is that?

14 A It's just their degree of standard.

15 Q So is that because they had been given
16 medication or something along those lines?

17 A You've been given medication and they let
18 you wake up, you know, you throw the medication off
19 because everybody takes different amounts of
20 propofol so everybody wakes up differently. But I
21 had a colonoscopy done at Southwest Medical by
22 Southwest Medical Group after I started with Dr.
23 Desai and I was in there 30 minutes so --

24 Q Was that the way it was at Dr. Desai's
25 Shadow Lane clinic?

Donna J. McCord
CCR #337
(702) 671-3365

1 man that left, he just walked out of the building
2 because it was so many people in there, it was a
3 busy day, and he walked out and he was walking down
4 the street looking to catch the bus. I mean, he had
5 his clothes on but you're supposed to sit there
6 until the nurse releases you, the release nurse.
7 And he decided to get up and walk out the door. So
8 I don't even know if he knew that he had a
9 colonoscopy because the propofol acts differently on
10 everybody.

11 Q As far as the people that were, you know,
12 coming out of the recovery and so forth after the
13 procedures were done, did the doctors follow them
14 out and administer to them at the bedside?

15 A No.

16 Q Did the nurse anesthetist follow them out
17 and take care of them while they were in the
18 recovery room?

19 A No, they were too busy. They were getting
20 the next patient into the room and getting set to
21 go.

22 Q Was there a nurse or somebody that was
23 supposed to be out in the recovery area to help --

24 A The RN in the recovery room.

25 Q Was she pretty much the only one that

Donna J. McCord
CCR #337
(702) 671-3365

1 A No, that was about ten to fifteen minutes
2 and then they were getting you up.

3 Q So the patient leaves the room after the
4 procedure and within ten or fifteen minutes they're
5 heading for the door?

6 A Patient leaves the room, he goes out to a
7 recovery area, they put on a BP cuff, monitor him,
8 take his blood pressure, and I think it was three
9 blood pressures, and once his blood pressure was
10 normal they had it recorded, the majority of
11 patients were then put into their clothes and they
12 had whoever was taking them home was brought out and
13 they explained to them what happened. And it was a
14 nurse that explained everything that had happened to
15 them and talked to them so --

16 Q Ever an issue with that that you felt that
17 it was going too quickly, that they should have been
18 sticking around a little longer?

19 A There was one where because of the way the
20 medication acts in different individuals and some of
21 the individuals that we did at D's were, I mean,
22 they were borderline coming in because you don't
23 know if they didn't eat or didn't drink. Some of
24 them were -- one time we saw a guy after the
25 procedure drinking alcohol so -- but there was one

Donna J. McCord
CCR #337
(702) 671-3365

1 dealt with the patients in the recovery room?

2 A We had an RN and sometimes they put a tech
3 out there. Usually they'd keep a tech, maybe two
4 techs depending on how busy it was so they could --
5 because when we got up to that hundred stage, I
6 mean, it was like they were like flying. So they
7 would have like two techs and you'd go out and you'd
8 have to monitor their blood pressure and help them
9 put their clothes on. A lot of times they were
10 disoriented. They don't know where they're at or
11 what had happened but that's because of the
12 medication.

13 Q It's still get them out the door?

14 A Once they talked to them and, yeah, it's
15 up to the nurse to decide if they were safe to go.

16 Q Did you ever experience or see Dr. Desai
17 ever start a procedure before somebody put
18 anesthesia on a patient or given anesthesia to a
19 patient?

20 A No, not unless the patient had requested
21 not to have anesthesia.

22 Q What about an incident in which there was
23 a person who was having I think an upper endoscopy
24 and the nurse anesthetist was getting ready to give
25 the anesthesia and it didn't actually happen before

Donna J. McCord
CCR #337
(702) 671-3365

1 Desai was --

2 A That was at Southwest Medical, yeah. They
3 had a new nurse anesthetist and he wasn't used to
4 Dr. Desai's speed so he was just, you know, doing
5 his thing but he was a lot slower than everybody
6 was. And by the time he turned around and started
7 to do the procedure because the patient was already
8 in place and had the bite block in and, you know,
9 IV's already running because they start those on the
10 outside and bring them in, D thought the patient had
11 had the anesthesia so he put the scope down and we
12 did the EGD. It didn't hurt him but --

13 Q Patient react to it at all?

14 A Their eyes got a little bit big. But that
15 was just my job to calm them down so, you know, you
16 talk to them and tell them to breathe, just breathe,
17 because they have the feeling that -- you have the
18 feeling that you're suffocating, you can't breathe.
19 And then once you found out that you can actually
20 breathe through your nose then it's fine. And you
21 just take deep breaths, you tell them when to
22 breathe, to take a deep breath, don't hold your
23 breath. And you'll say, okay, when we're going to
24 do biopsies you're going to feel a tug but you won't
25 feel any pain. And you say, okay, we're taking it

Donna J. McCord
CCR #337
(702) 671-3365

143

1 finished. And usually in the afternoon it would be
2 either Dr. Carrol or Dr. Carrera finishing it up.

3 Q And as far as supplies are concerned, and
4 I'll start off with things like biopsy forceps, did
5 Dr. Desai ever tell you to reuse those things at any
6 time?

7 A Yes.

8 Q Okay.

9 A But that was because we would run out and
10 he asked could we reuse them and I said yes as long
11 as -- the thing with the biopsy forceps is that the
12 company only guarantees them for one bite. That's
13 all they guarantee the jaws for when you do that.
14 But they work more than that because some patients
15 you have to take three or four biopsies or five or
16 six biopsies depending on the doctor.

17 But to clean them you have to know
18 the person who's cleaning it because the forcep has
19 a little sharp tooth in it, a little spear, so they
20 have to know how to definitely how to clean it, make
21 sure there's no tissue in these two jaws that are
22 there, the alligator jaws, because they've got cuffs
23 in them so you have to make sure there's no tissue
24 in them. And then you put them in the sanitizer
25 with the scopes and you can clean them and then you

Donna J. McCord
CCR #337
(702) 671-3365

1 now. And sometimes you let them look at the monitor
2 and they can watch it and they thought it was pretty
3 neat.

4 Q Okay. So that happens on some patients
5 that actually prefer to have no anesthesia?

6 A Yeah, you have patients that didn't want
7 to take anesthesia because they didn't have a person
8 to take them home. You always had to have someone
9 to take you home and you couldn't let them go on the
10 bus, you couldn't let them go in a taxi because of,
11 I guess it was something with Medicare. Most of the
12 people that -- these were like Medicare, Medicaid
13 and stuff.

14 Q With respect to the difference between the
15 Burnham and the Shadow Lane clinics, was there a
16 preference in the staff as to which place they liked
17 to or wanted to work at?

18 A Yeah. The Burnham staff were -- they were
19 at the slower pace. They loved their clinic, they
20 loved their doctors because they had the same
21 doctors all the time. We had Desai always in the
22 morning and then you'd have -- another doctor would
23 start, you know, like 8:00 o'clock or 9:00 o'clock
24 coming from the hospital or something. And then you
25 would just run all the way through until you

Donna J. McCord
CCR #337
(702) 671-3365

144

1 can reuse them. But usually you only do that if it
2 was an emergency, we couldn't get anybody to
3 deliver. But usually with Dr. Desai you call
4 somebody up and somebody would be delivering or else
5 we would go to like Southwest and borrow a box of
6 forceps or two boxes or forceps and you pay them
7 back when you got your supply order in.

8 Q But he did at least at times tell you to
9 reuse that stuff?

10 A Yes.

11 Q As far as that was concerned, you had said
12 you left I think the clinic in August or rather
13 March 31st of '06, correct?

14 A Yes.

15 Q Never went back to the clinic?

16 A No.

17 Q You have fairly extensive training in your
18 background in doing this kind of work; is that
19 correct?

20 A Yeah, with that. I trained in that and
21 I've been in medical since 1965. I'm a retired
22 chief hospital corpsman, served most of my time
23 with, 16 years with Marines, three tours of combat,
24 four, went through a DEA. I'm a shooter.

25 Q Well, as far as your medical background

Donna J. McCord
CCR #337
(702) 671-3365

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1 and training, where did you get that?
 2 A Naval Hospital in San Diego, OR school. I
 3 was an OR tech. I was a navy transplant tech. I
 4 was an independent duty tech. I was a field medical
 5 tech. Independent duty means that I can go
 6 somewhere with X number of marines with a combat
 7 load without a doctor and I did that numerous times.
 8 Q And then you worked in endoscopy clinics
 9 in --
 10 A I worked in endoscopy after I got out of
 11 the service. I had cancer surgery in 1996 so when I
 12 came back from -- I was on light duty and it was
 13 limited light duty. So they said the only place you
 14 can really work would be the endo room. So I had
 15 already worked with the company doctor. I was still
 16 at Southwest. And so I learned all of the endo and
 17 I was one of the few techs that, you know, I could
 18 look at the scope and I could monitor and I could
 19 tell the doctor what part of the colon we were in.
 20 I got really good at it so pretty soon I was the
 21 only one and at one point I was -- just before I
 22 left I was up to like 400 cases a month as the only
 23 tech.
 24 Q So as far as your job at Southwest, or not
 25 at Southwest, but when you went to the Shadow Lane

Donna J. McCord
 CCR #337
 (702) 671-3365

1 actually using for their techs came from
 2 administration, you mean like clerical people?
 3 A Uh-huh.
 4 Q Had they had any background or training in
 5 doing the kind of work that you did?
 6 A No.
 7 Q And now you said as far as like even the
 8 reuse of biopsy forceps it was important to be at
 9 least cognizant enough to look to certain portions
 10 of this forcep, make sure it was clean and so forth
 11 if you were going to do that, right?
 12 A Yes.
 13 Q Was that a concern of yours that these
 14 people didn't have the training or knowledge or
 15 experience to be able to appreciate that and do it?
 16 A Yes.
 17 Q Did you voice this to anyone there?
 18 A Yes.
 19 Q What was the result of that?
 20 A I was told that I was not in charge of
 21 training, they had a nurse in charge of training and
 22 they would take care of it because I had already
 23 trained a couple people that were there and they
 24 were competent.
 25 Q Did you ever have discussions with Desai

Donna J. McCord
 CCR #337
 (702) 671-3365

1 clinic, did Dr. Desai recruit you to that clinic?
 2 A Yes.
 3 Q When you went to work for him what was
 4 your job role there initially?
 5 A It was supposed to be, I was supposed to
 6 help instruct these younger kids because they were
 7 getting people in from administration, the girls
 8 that were working over there, they were training
 9 them. They weren't getting the OR techs in. There
 10 was an OR tech school in town but their turn-out of
 11 people was marginal, if anything. Most of their
 12 techs never got OR jobs, they got endo jobs because
 13 you can train anybody to be an endo tech. So I was
 14 supposed to train the people to be endo techs and
 15 train them about sterility and how to run the
 16 sanitizer machines and the one sterilizer we had.
 17 But I was never given the opportunity to do it.
 18 Q Why was that?
 19 A Because when we would have the meetings
 20 the charge nurse never allowed me to do it.
 21 Q So if I understand you correctly, you have
 22 the experience and you would have done that role as
 23 far as a training person's concerned?
 24 A Yes.
 25 Q In the source of persons that they were

Donna J. McCord
 CCR #337
 (702) 671-3365

1 about any of this stuff?
 2 A No, because he never had time to talk to
 3 me about it.
 4 Q At some point you said you're not just in
 5 the room cleaning scopes, initially aren't you
 6 working somewhere else in the clinic?
 7 A Initially I was there to work in the room
 8 with the patient, with the doctor. And then I had a
 9 disagreement with Dr. Desai so we weren't talking
 10 literally. And so I became the clean tech so I was
 11 cleaning the scopes. So you had a room on each side
 12 and you had a clean room in the middle. And you
 13 clean the scopes and then you put them in the
 14 sanitizers and the one sterilizer and, well,
 15 actually it was a sanitizer, not a sterilizer, and
 16 you process them. So I was the process guy so that
 17 worked out pretty good. And if they needed me
 18 because of my ability to manipulate scopes from the
 19 outside from pressing on a patient's stomach
 20 because, you know, I knew where to press, if they
 21 needed me they would call me into a room.
 22 Q Now, as far as your, and I want to
 23 specifically ask you about Dr. Desai at this point,
 24 when you were with him in a room and you said you
 25 were, and I'm not talking about as the clean tech,

Donna J. McCord
 CCR #337
 (702) 671-3365

1 but when you were doing the procedures --
 2 A Uh-huh.
 3 Q -- these three to five-minute procedures
 4 that he was doing, when he would get to the end and
 5 the scopes would come out, was he ready to have that
 6 scope come out?
 7 A You had to be prepared for him to have the
 8 scope out because he was there and he was moving at
 9 the same time, he was moving away from the patient,
 10 and he would just hand it off and almost drop it.
 11 So you had to catch the scope because he would have
 12 it out. And sometimes he would -- when you do the
 13 last six inches of actually the rectum they pull the
 14 scope out and they come all the way to the anus and
 15 they push back in, they invert the scope so they can
 16 look back towards the anus to make sure they don't
 17 have any cancerous growths there or internal
 18 hemorrhoids, then they straighten the scope back out
 19 and then they can bring it back out. And so when he
 20 would bring it back out sometimes he would bring it
 21 out with about a little bit of speed so you had to
 22 know that he was bringing it out and you had to be
 23 prepared to catch the scope.
 24 Q Okay. Ever miss the scope?
 25 A I didn't, no.

Donna J. McCord
 CCR #337
 (702) 671-3365

1 Q Did others?
 2 A I've heard other people did, yes.
 3 Q Did you hear any yelling from Dr. Desai
 4 when something like that would happen?
 5 A Yes, because that's a \$24,000 scope.
 6 Q Okay.
 7 A And that's the business end of it. The
 8 main end of it is the distal end.
 9 Q Now, I want to ask you about some or talk
 10 to you about the reuse of biopsy forceps, things
 11 like that. Did Dr. Desai ever get upset about
 12 people using too many of anything; for example, like
 13 alcohol pads or too much lubricant, things like
 14 that?
 15 A Yeah. He was -- he had a meeting and they
 16 said that, I guess they were doing their, you know,
 17 cost analysis and all of a sudden he come up with
 18 this thing about overusing lubricant, overusing --
 19 he had them cutting the Chux up. Instead of being
 20 one big size he had them cutting them in half.
 21 Q And the Chux are the things --
 22 A Yeah.
 23 Q The protective plastic barrier?
 24 A Yes, it goes underneath the patient. And
 25 what else did he have them doing? He had them

Donna J. McCord
 CCR #337
 (702) 671-3365

1 doing -- you're supposed to wear gowns when you
 2 leave to go outside or like doctor coats. But he
 3 had the paper ones but he didn't want you to throw
 4 them away, you had to use them or reuse them.
 5 Q So if they were stained with any kind of
 6 debris, would that be a concern to him that --
 7 A Yeah. Sometimes he would come and look at
 8 them to see if they were hanging up. If they was
 9 hanging like in one room and he would look to see if
 10 they were, you know, if people were getting rid of
 11 them or too many masks or using too many gloves
 12 or --
 13 Q Did you in fact have to hide some gloves
 14 of your own?
 15 A Oh, yes.
 16 Q Why was that?
 17 A Because the biggest thing with cleaning
 18 the scopes is to protect yourself against hepatitis
 19 and HIV because the patients don't tell you if
 20 they've got it. So you need to put a serious
 21 barrier between yourself and the scopes that you're
 22 cleaning because you're dealing with contaminated
 23 scopes. So I would wear surgical gloves and then I
 24 would wear two sets of exam gloves and that way when
 25 I finished one part I could take the exam glove off

Donna J. McCord
 CCR #337
 (702) 671-3365

1 and then go to carry it to another station and then
 2 take that glove off and put two more gloves on and
 3 then start back doing what I was doing. But I
 4 always keep on the inner gloves unless they got wet.
 5 Then I would have to take those off. That was
 6 because I was an OR tech. The rest of the techs
 7 didn't really know anything about that.
 8 Q So what was the issue then with the
 9 gloves?
 10 A He said we were using too many gloves.
 11 We're using too many -- one time I was training a
 12 tech and we were using -- we both have extra large
 13 hands so we were using, instead of using my usual
 14 box and a half or two boxes a day I guess we got
 15 down to like four or five boxes and he was upset
 16 about that. I don't know how he found out we were
 17 using them but somebody was telling him. It wasn't
 18 us.
 19 Q So he was at least involved at the level
 20 of the supplies and so forth to even be worried
 21 about how many gloves you were using and things like
 22 that?
 23 A He was involved in all levels.
 24 Q Now, as far as that you mentioned the
 25 gloves, the lubricant. What about the -- you

Donna J. McCord
 CCR #337
 (702) 671-3365

1 mentioned the Chux which are those plastic, I think
 2 you said plastic lined pads?
 3 A That go underneath the patients, yes.
 4 Q And what's the purpose of one of those
 5 things?
 6 A The purpose of that is to keep them from
 7 soiling the gurney, soiling the sheet underneath
 8 them. If something happens, they do have an
 9 accident you can just contain it on that and take
 10 that out and put another one under them so you have
 11 a contained area.
 12 Q You mentioned those, you mentioned the --
 13 were they gowns or were they some sort of coat kind
 14 of thing that we're talking about?
 15 A They were paper coats, paper -- they're
 16 disposable. They use them in contaminated rooms.
 17 When you go in and visit a person you have the
 18 yellow ones or sometimes you have white ones. They
 19 have different colors. They're real thin but it's
 20 just to protect your outer garments against people
 21 breathing on you and stuff. They don't really work
 22 in a wet environment but --
 23 Q What about anything that might have gotten
 24 fecal material on it or anything else?
 25 A Yeah, then you were supposed to change out

Donna J. McCord
 CCR #337
 (702) 671-3365

1 but most of the time the techs in the room don't
 2 wear -- they wore scrubs. They didn't wear -- they
 3 didn't wear gowns. What they wore in the room, you
 4 wore a rubber apron but they were hot. So it's an
 5 actual apron, it's rubber and it ties behind. And
 6 it's a hundred percent impervious so nothing can go
 7 through it. So that's what people would actually
 8 wear in the room. But the people on the -- and in
 9 the clean room you have to wear that if you don't
 10 want to get wet so --
 11 Q Tell me about the issue regarding the
 12 lubrication that you had mentioned. You said that
 13 there was an issue of using too much. Did he
 14 institute any kind of policy or plan regarding that?
 15 A Yeah, when he was in the room he would
 16 monitor how much -- you had a four-by-four sitting
 17 there for him to lube the scope up with and he would
 18 look at the size of the dollop of lubricant you put
 19 on and he would say that's too much or, you know,
 20 that's okay. And then he would, you know, give you
 21 this little spiel about using too much.
 22 Q Was there anything about putting certain
 23 types of tubes that were partially used into rooms
 24 so that there couldn't be too much lubricant used?
 25 A No, I don't remember anything about that.

Donna J. McCord
 CCR #337
 (702) 671-3365

1 Most of the surgical lubricant, I mean, that was
 2 like, that's like pencils and papers. You go
 3 through so much of that a day. I mean, it's for the
 4 patients and it helps the doctor. I mean, some
 5 doctors actually use a whole big tube of lubricant
 6 per patient because they want it to be slipping and
 7 slide. And then there's other doctors that only
 8 need a little bit. So it's up to the doctor and
 9 where they learn that.
 10 Q Do you remember giving a statement to the
 11 police at one point during this whole investigation?
 12 A Yeah.
 13 Q And that was taped and you've actually --
 14 have you had a chance to review that statement
 15 before today?
 16 A Yeah.
 17 Q Do you recall being asked about the issue
 18 of the lubricant that I just talked about and saying
 19 that you had to make sure that the tubes were
 20 basically empty when you put them in the room so
 21 that the other doctors wouldn't use too much
 22 lubricant?
 23 A No, not empty when you put them in the
 24 room, you had to make sure they were empty before
 25 they were discarded.

Donna J. McCord
 CCR #337
 (702) 671-3365

1 Q Okay. So there was an issue with not
 2 throwing partial tubes away then?
 3 A Yeah. He wanted -- we went as far as to
 4 get, you had these tube rollers that you put on
 5 toothpaste and stuff and you take them and you can
 6 roll them so you can get the last little bit out of
 7 the tube. And we had those and we'd put them on so
 8 you would roll them up. And he would ask you
 9 where's your tube roller.
 10 Q And what about alcohol pads, was there any
 11 issue about that?
 12 A See, alcohol pads I didn't have anything
 13 to do with them. That was in the nursing
 14 anesthetist field because I didn't give shots or
 15 anything.
 16 Q What about the four-by-fours you mentioned
 17 and things like that?
 18 A Four-by-fours, yeah. He wanted you to --
 19 I mean, it's up to the tech to, you know, which
 20 doctor it is and what he feels comfortable with. So
 21 you know that if he gets -- he's going to use --
 22 hold the scope with two four-by-fours and then if
 23 they get dirty then you change them out and you get
 24 two more and, you know, you throw those in the bin.
 25 But he didn't want you putting all those on the fill

Donna J. McCord
 CCR #337
 (702) 671-3365

1 (sic) and one reason was that once you put them on
2 the fill you can't use them for anybody else. They
3 have to go, stay with that patient. So he only
4 wanted you to get a minimal amount and then if you
5 saw that he needed more or the doctor needed more,
6 usually it was just him, then you would have to go
7 back or have the nurse hand you more four-by-fours.

8 Q And as far as the glove issue, did you
9 ever hide any gloves so you could use them so he
10 didn't know about it?

11 A Yeah, all the time.

12 Q As far as the scopes and how they were
13 handled and after you moved to the clean room area,
14 are you with me now?

15 A Yes.

16 Q When you left the facility did you have
17 any concern that the people that were in the clean
18 room area were not trained sufficiently enough to do
19 the things that you were doing?

20 A Well, the people they put in there, I
21 didn't know them so I had no idea what training they
22 had and I found out through hearsay --

23 Q And I don't want you to get into what was
24 hearsay.

25 A I don't know what training they had.

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1 Q Okay. The things that you observed when
2 you were there as far as patients coming, or not
3 patients but people coming from administration into
4 the clean room area to start doing work and you not
5 being allowed to train them, that issue, do you
6 remember that?

7 A Yeah. You can only -- instead of having
8 them for a week you would only get them for like a
9 day. And then this is somebody who has, you know,
10 they don't even have a first aid card so they have
11 to learn all this about different solutions, when to
12 change the solutions in the machine, when to change
13 the water in the tub that they're washing the scopes
14 with, how much soap that goes in there to clean the
15 scopes and stuff because you had to do a hand
16 cleaning first and then you put them in the
17 sanitizing machine. But it was only one or two
18 people that I got to train and then the rest of them
19 would be in there like a half a day and then that
20 was it. And then they would take them out and
21 actually use them the majority of the time for
22 recovery. But then at a later date I heard they
23 were coming, you know, they were back cleaning so I
24 don't know.

25 Q Okay.

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1 And again I'm going to have the, as
2 far as that last comment --

3 A Take that out.

4 Q -- I'm going to have the Grand Jury
5 disregard that. It's a hearsay statement.

6 I have nothing further for this
7 witness, ladies and gentlemen.

8 THE FOREPERSON: Are there any questions
9 from the jury? None?

10 Okay. By law these proceedings are
11 secret and you are prohibited from disclosing to
12 anyone anything that transpired before us including
13 any evidence presented to the Grand Jury, any event
14 occurring or a statement made in the presence of the
15 Grand Jury or any information obtained by the Grand
16 Jury.

17 Failure to comply with this
18 admonition is a gross misdemeanor punishable by one
19 year in the Clark County Detention Center and a
20 \$2,000 fine. In addition you may be held in
21 contempt of court punishable by an additional \$500
22 fine and 25 days in the Clark County Detention
23 Center.

24 Do you understand this advisement?

25 THE WITNESS: Yes, I do.

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1 THE FOREPERSON: Thank you. You may be
2 excused now.

3 THE WITNESS: Thank you.

4 THE FOREPERSON: You're welcome.

5 MR. STAUDAHER: Ladies and gentlemen of
6 the Grand Jury, that concludes the presentation for
7 today. Are there any questions regarding any of the
8 law or issues pertaining to bias that have come up
9 since the presentation started this morning?

10 THE FOREPERSON: No.

11 MR. STAUDAHER: And I see that no Grand
12 Jury has said or indicated that there's any issues
13 regarding bias at this point. And as far as the
14 witnesses are concerned we'll just resume next
15 Thursday. And that concludes the presentation.
16 Thank you.

17 A JUROR: Thank you.

18 {Proceedings concluded.}

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RA 000288

1 REPORTER'S CERTIFICATE

2
3 STATE OF NEVADA)
4 COUNTY OF CLARK)
5

6 I, Donna J. McCord, CCR #337, do
7 hereby certify that I took down in Shorthand
8 (Stenotype) all of the proceedings had in the
9 before-entitled matter at the time and place
10 indicated and thereafter said shorthand notes were
11 transcribed at and under my direction and
12 supervision and that the foregoing transcript
13 constitutes a full, true, and accurate record of the
14 proceedings had.

15 Dated at Las Vegas, Nevada,
16 Wednesday, April 28, 2010.

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20 DONNA J. McCORD, CCR #337
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Donna J. McCord
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RA 000289

\$	70/19 71/2 74/16 75/20 101/20 101/22 103/18 104/18 108/12 115/2	101/13 101/14 102/23 103/5 106/7 107/18 109/3 109/6 109/21 110/11 110/19 111/23 116/1 117/8 120/10 121/11 125/9 127/23 128/17 128/25 129/3 129/6 130/17 136/14 137/2 137/6 137/9 138/1 140/22 146/15 148/1 148/3 148/23 148/25 149/21 150/9 150/10 150/11 150/18 152/7 152/16 152/21 152/25 153/14 153/23 154/11 154/21 154/22 154/25 155/17 155/18 156/10 156/11 156/16 157/10 158/11
\$2,000 [3] 26/16 124/21 159/20	28 [3] 3/4 61/17 161/16	above [3] 122/2 122/8 122/13
\$24,000 [1] 150/5	28th [1] 34/9	absolutely [1] 114/18
\$500 [3] 26/17 124/22 159/21	2nd [1] 39/16	acceptable [1] 123/25
'	3	access [4] 13/3 78/5 80/2 101/9
'06 [1] 144/13	30 [5] 83/11 128/18 131/13 137/11 137/23	accession [6] 10/22 16/19 16/24 17/1 20/20 23/6
-	30 minutes [1] 137/12	accessioned [1] 22/14
--oOo [1] 160/20	30402 [1] 16/17	accident [1] 153/9
0	31 [4] 85/25 86/5 86/21 109/13	accompanying [1] 7/1
09BGJ049A-C [1] 1/9	31st [1] 144/13	accordance [1] 54/8
1	32 [1] 85/24	according [5] 31/23 67/5 84/23 96/15 131/10
105 [7] 113/24 114/20 114/22 115/8 115/9 115/13 115/24	33 [1] 85/25	accurate [5] 18/15 67/1 85/4 89/22 161/13
10th [1] 47/14	337 [3] 1/25 161/6 161/19	accurately [1] 5/6
11 [1] 95/23	36 [3] 61/18 61/21 95/14	acquired [1] 33/3
115 [3] 110/16 113/23 114/21	3A [1] 1/22	across [9] 16/6 17/18 34/23 40/10 51/11 55/7 70/10 108/15 122/6
11th [1] 49/6	4	act [3] 5/25 27/13 125/18
12 [3] 4/4 13/18 135/14	40 [1] 83/12	actions [1] 61/13
12-27-2007 [2] 16/19 17/11	400 [1] 145/22	acts [2] 138/20 139/9
126 [1] 3/5	490 [1] 16/19	actual [9] 25/17 40/12 55/20 76/10 78/5 87/14 89/11 107/23 154/5
12839 [1] 20/20	5	actually [52] 8/21 9/1 13/10 18/14 20/7 20/12 21/14 29/16 31/25 33/14 35/13 37/5 39/4 40/5 47/10 52/10 58/13 59/11 63/25 65/15 70/1 70/11 70/14 71/24 73/8 75/5 78/15 78/16 86/13 89/7 89/10 92/15 94/5 94/6 94/21 103/2 105/23 108/3 110/14 114/7 126/19 135/6 140/25 141/19 142/5 147/1 148/15 149/13 154/7 155/5 155/13 158/21
13 [6] 4/4 4/5 4/6 56/10 59/2 76/18	50 [2] 116/24 134/14	acute [27] 29/24 32/15 32/20 32/23 32/25 33/1 33/8 33/13 33/14 33/18 34/7 37/13 45/1 102/14 102/25 103/8 103/13 103/24 104/16 104/16 109/15 111/18 112/13 120/1 120/7 120/12 120/16
13-1 [2] 121/22 121/25	50CC [2] 57/9 83/23	add [1] 86/8
13-2 [2] 121/24 122/16	55 [1] 116/24	addition [4] 26/16 70/19 124/21 159/20
15 [4] 1/17 2/1 5/1 135/17	56 [1] 4/5	additional [22] 9/11 11/16 15/9 15/15 22/17 26/17 46/14 48/14 68/4 83/3 88/14 96/2 96/6 102/5 102/20 103/11 104/1 113/24 116/8 117/14 124/22 159/21
15-minute [1] 86/22	5CC [1] 83/24	additionally [1] 62/4
16 [1] 144/23	6	address [1] 19/19
18 [10] 4/6 4/7 4/8 4/9 4/10 4/11 4/12 13/19 14/16 15/21	6-2 [1] 93/25	addressed [2] 24/5 110/4
19 [3] 4/7 18/21 18/21	60 [2] 93/25 120/24	adjusted [1] 116/22
1935 [1] 16/15	61 [2] 85/15 85/15	administer [1] 139/14
1965 [1] 144/21	63 [3] 57/6 57/11 85/23	administered [1] 77/22
1995 [1] 127/21	64 [1] 57/6	administration [3] 146/7 147/2 158/3
1996 [1] 145/11	65 [2] 121/24 121/24	administrator [1] 43/20
1:50 [1] 1/18	66 [2] 121/25 123/12	admit [1] 71/10
1A [2] 107/12 107/17	7	admitted [2] 59/19 79/14
1CC [1] 106/24	7-2 [4] 85/12 85/14 85/15 86/11 700 [2] 40/9 40/18	admonish [1] 73/3
2	74 [6] 76/15 76/17 76/25 81/20 81/21 81/21	admonition [3] 26/14 124/19 159/18
2-20-1935 [1] 16/15	75 [5] 76/16 81/19 82/1 134/22 134/23	advance [2] 44/4 44/10
20 [12] 4/8 18/22 33/19 42/16 131/13 131/14 131/16 133/24 133/24 135/12 135/14 135/17	76 [1] 60/19	advice [2] 7/4 36/6
20-1 [1] 60/18	7:30 [1] 135/13	advised [3] 5/23 27/11 125/16
20-2 [1] 82/2	8	
2003 [2] 126/24 127/21	85 [1] 135/5	
2006 [1] 126/25	8:00 [1] 142/23	
2007 [12] 16/19 17/11 18/3 18/4 29/17 31/6 31/7 67/5 67/5 127/5 127/5 127/5	9	
2008 [2] 8/5 29/16	90 percent [1] 85/24	
2010 [4] 1/17 2/1 5/1 161/16	9:00 [1] 142/23	
20CC [2] 53/15 57/10	9th [2] 39/18 39/22	
20s [1] 134/8	A	
21 [3] 4/9 18/22 87/24	A-R-M-O-U-R [1] 6/12	
21st [28] 18/4 37/21 50/13 50/14 55/19 56/2 57/5 57/12 63/12 67/5 74/16 75/21 84/10 84/10 84/17 84/19 84/19 84/21 84/22 85/20 101/19 101/24 102/4 102/6 103/18 104/17 108/12 115/2	abdominal [1] 33/4	
22 [4] 4/10 18/22 57/7 62/16	ability [2] 5/7 148/18	
22nd [2] 63/6 63/11	able [21] 39/17 50/11 50/14 55/18 61/8 62/20 63/15 65/4 66/17 71/13 84/12 98/21 102/18 103/10 103/23 104/4 105/11 109/8 112/17 117/12 147/15	
23 [4] 4/11 18/22 20/12 108/25	about [91] 5/16 12/3 15/20 17/8 27/4 31/24 32/22 33/14 34/7 34/20 35/9 35/9 35/12 36/12 38/4 40/20 44/11 44/12 44/25 50/20 51/3 51/17 52/10 54/6 54/21 56/16 57/3 57/15 64/25 71/7 74/20 83/19 84/6 86/19 93/24	
24 [5] 4/12 18/22 19/5 57/9 57/12		
25 [5] 26/18 42/16 42/18 124/23 159/22		
25-minute [1] 86/2		
25th [14] 18/3 37/20 55/19 67/4		

RA 000290

<p>A</p> <p>advisement [6] 6/6 26/20 27/19 124/25 125/24 159/24</p> <p>affiliated [1] 7/14</p> <p>AFORESAID [1] 1/4</p> <p>afraid [2] 133/9 136/1</p> <p>after [42] 14/8 24/5 25/1 25/15 45/10 45/14 48/8 53/17 54/16 57/3 59/24 72/7 91/6 94/23 94/25 95/4 95/6 95/10 95/14 95/22 95/23 95/24 96/3 96/7 97/2 98/4 107/6 107/20 108/6 109/10 113/8 119/12 120/10 120/19 122/23 136/23 137/22 138/3 138/24 139/12 145/10 157/13</p> <p>afternoon [3] 46/7 54/20 143/1</p> <p>afterward [1] 121/17</p> <p>again [12] 17/24 20/17 25/6 61/1 66/5 69/24 76/18 81/22 83/8 118/13 122/19 159/1</p> <p>against [3] 115/6 151/18 153/20</p> <p>age [2] 116/22 116/23</p> <p>AGNES [1] 2/11</p> <p>agree [1] 38/9</p> <p>ah [1] 133/19</p> <p>ahead [22] 5/10 7/5 15/18 19/2 56/21 57/2 61/7 61/25 62/12 63/14 65/13 68/13 69/10 73/12 77/8 78/11 78/25 87/18 90/8 113/9 113/10 116/14</p> <p>ahold [1] 37/15</p> <p>aid [2] 38/12 158/10</p> <p>air [2] 19/14 129/18</p> <p>alcohol [4] 138/25 150/13 156/10 156/12</p> <p>ALICE [1] 2/16</p> <p>aliquoted [1] 23/2</p> <p>all [100] 9/19 11/24 13/4 13/25 14/12 15/25 16/20 16/21 16/23 18/1 21/24 22/5 22/12 23/22 28/17 39/7 42/13 42/18 45/2 45/11 45/11 46/23 47/17 49/8 53/15 57/11 58/9 61/14 61/21 62/20 62/21 63/9 63/15 64/5 68/17 68/17 70/3 74/23 75/10 76/18 80/15 80/21 81/11 83/16 84/1 84/24 85/11 85/16 90/10 90/19 90/23 94/12 94/14 95/13 95/18 95/25 97/14 98/5 98/17 100/17 101/4 101/5 101/9 101/14 102/5 102/7 103/17 105/17 106/13 107/12 108/6 108/8 108/9 109/6 111/1 118/2 118/22 119/1 119/23 121/6 121/10 121/13 122/14 123/9 129/11 130/24 132/5 134/21 141/13 142/21 142/25 143/13 145/16 149/14 150/17 152/23 156/25 157/11 158/11 161/8</p> <p>alligator [1] 143/22</p> <p>allow [3] 30/15 30/17 78/21</p> <p>allowed [8] 62/15 64/18 65/17 84/16 112/14 118/6 146/20 158/5</p> <p>almost [1] 149/10</p> <p>along [9] 14/9 25/9 35/15 51/21 59/15 68/20 108/9 108/9 137/16</p> <p>already [14] 24/22 24/23 62/6 71/7 88/5 94/23 95/24 101/16 104/21 131/23 141/7 141/9 145/15 147/22</p> <p>also [22] 2/21 10/24 12/20 15/13 25/9 29/12 32/8 46/21 47/3 55/4 58/2 62/1 73/17 75/7 81/1 93/6 100/11 102/6 114/5 134/11 135/9 135/15</p> <p>although [2] 75/7 92/4</p> <p>always [6] 61/11 95/9 128/22 142/8 142/21 152/4</p> <p>among [2] 34/10 113/21</p> <p>amount [4] 54/4 83/21 105/22 157/4</p>	<p>amounts [2] 58/9 137/19</p> <p>analysis [10] 66/7 74/16 75/11 75/15 84/5 98/6 107/21 107/21 115/7 150/17</p> <p>anesthesia [33] 52/14 52/14 53/6 53/23 66/9 85/20 85/22 86/14 86/21 86/22 88/5 88/7 89/11 89/12 89/14 94/21 95/23 96/2 96/4 96/7 96/8 96/12 96/14 96/19 129/24 131/22 140/18 140/18 140/21 140/25 141/11 142/5 142/7</p> <p>anesthetist [5] 136/14 139/16 140/24 141/3 156/14</p> <p>angulation [2] 129/11 129/12</p> <p>ANNE [1] 2/19</p> <p>announcement [3] 72/9 103/16 113/16</p> <p>announcements [1] 122/23</p> <p>another [27] 6/25 10/16 11/8 14/22 15/10 23/3 31/22 34/2 51/3 53/21 63/3 63/4 73/5 82/18 83/6 92/1 92/13 93/22 95/13 96/1 102/21 120/15 131/5 131/14 142/22 152/1 153/10</p> <p>answer [2] 30/16 30/17</p> <p>anus [3] 130/9 149/14 149/16</p> <p>any [94] 10/7 11/11 15/15 22/10 22/17 23/9 23/15 23/24 24/3 24/6 24/18 24/18 24/19 26/4 26/8 26/9 26/11 29/8 31/17 34/23 35/2 35/17 40/23 46/1 48/9 52/13 52/15 54/13 54/25 55/1 56/20 62/17 68/7 68/11 70/5 70/5 70/9 72/2 72/22 74/10 74/13 76/12 86/17 89/16 91/25 94/5 99/24 101/21 105/4 105/11 105/19 106/4 106/8 106/20 107/19 108/7 108/15 109/18 110/8 110/12 113/6 114/14 115/6 115/17 116/3 116/12 117/12 119/6 123/24 124/9 124/13 124/14 124/16 127/6 135/24 136/6 141/25 143/5 147/4 148/1 149/17 150/3 151/5 154/14 156/10 157/9 157/17 159/8 159/13 159/13 159/15 160/7 160/7 160/12</p> <p>anybody [11] 42/9 43/25 44/18 59/5 112/24 119/5 123/7 133/13 144/2 146/13 157/2</p> <p>anymore [1] 113/20</p> <p>anyone [4] 26/7 124/12 147/17 159/12</p> <p>anything [34] 26/8 29/9 45/24 46/1 46/18 47/21 50/8 59/7 72/22 72/23 74/20 76/12 89/18 95/12 99/8 99/16 105/2 107/14 107/18 108/17 108/20 108/21 124/13 135/18 146/11 150/12 152/7 153/23 153/24 154/22 154/25 156/12 156/15 159/12</p> <p>anyway [2] 13/17 111/13</p> <p>anywhere [2] 117/6 128/13</p> <p>apparatus [1] 77/21</p> <p>apparently [1] 111/13</p> <p>appear [1] 67/6</p> <p>appears [2] 94/22 109/22</p> <p>appreciate [1] 147/15</p> <p>appropriate [2] 67/1 99/6</p> <p>April [5] 1/17 2/1 5/1 122/23 161/16</p> <p>apron [2] 154/4 154/5</p> <p>are [83] 5/23 7/25 9/13 9/23 10/23 11/3 13/4 14/8 14/11 16/22 18/19 18/23 21/24 22/5 22/6 22/12 23/17 24/6 25/6 26/4 26/6 26/7 32/14 33/6 34/22 36/3 37/24 43/23 48/17 51/6 51/7 55/1 55/2 81/8 83/19 90/23 91/22 93/8 93/24 96/20 98/1 98/1 100/20 100/23 105/17 108/3 108/19</p>	<p>109/7 109/18 110/2 110/8 110/17 111/21 113/6 115/10 115/12 115/16 116/10 121/3 122/5 123/2 123/4 124/9 124/11 124/12 125/16 125/16 129/5 129/15 135/6 135/7 135/9 136/2 143/3 143/21 150/21 153/1 157/14 159/8 159/10 159/11 160/7 160/14</p> <p>area [10] 77/23 91/12 123/23 137/4 138/7 139/23 153/11 157/13 157/18 158/4</p> <p>areas [7] 52/14 52/14 52/15 60/11 60/15 60/16 117/10</p> <p>aren't [2] 75/11 148/5</p> <p>arise [1] 55/1</p> <p>ARMOUR [7] 3/3 5/12 6/12 6/15 6/24 7/1 7/6</p> <p>arose [1] 57/24</p> <p>around [15] 36/15 51/7 52/9 75/23 93/9 93/15 106/16 106/19 107/4 117/3 119/22 120/9 129/13 138/18 141/6</p> <p>arrangements [1] 46/4</p> <p>arrive [1] 44/12</p> <p>arrived [5] 39/18 48/2 73/7 118/17 133/1</p> <p>arrow [1] 78/17</p> <p>as [193]</p> <p>ask [18] 15/19 15/23 30/17 31/24 34/20 35/9 35/9 35/11 35/13 56/10 56/18 70/14 119/24 119/25 127/22 148/23 150/9 156/8</p> <p>asked [6] 39/5 47/4 68/3 117/8 143/10 155/17</p> <p>asking [2] 38/11 66/10</p> <p>aspects [2] 49/20 62/7</p> <p>Assam [1] 39/12</p> <p>assembled [1] 42/13</p> <p>assess [1] 100/14</p> <p>assessment [1] 16/23</p> <p>assigned [5] 34/8 36/21 37/14 42/4 92/3</p> <p>assist [3] 38/14 42/2 42/3</p> <p>assistance [1] 38/11</p> <p>Assistant [1] 2/6</p> <p>assisted [1] 18/9</p> <p>associated [4] 35/18 41/11 114/9 127/6</p> <p>association [1] 63/17</p> <p>assume [16] 21/24 36/17 39/2 40/19 48/18 54/24 59/9 59/25 62/2 79/16 99/12 99/23 100/2 101/6 105/20 117/9</p> <p>assuming [1] 111/20</p> <p>assured [2] 134/21 134/23</p> <p>attached [2] 12/23 22/11</p> <p>attaches [1] 77/19</p> <p>attention [3] 8/3 29/15 126/18</p> <p>attorney [3] 2/22 7/2 97/4</p> <p>August [4] 84/19 84/22 126/24 144/12</p> <p>August 21st [2] 84/19 84/22</p> <p>author [2] 100/10 100/11</p> <p>authorship [1] 76/20</p> <p>automated [1] 94/13</p> <p>available [2] 25/14 100/4</p> <p>average [8] 30/21 30/23 51/25 85/24 116/23 128/6 131/8 137/7</p> <p>averaging [1] 135/5</p> <p>aware [6] 29/18 84/8 105/19 106/13 106/18 127/1</p> <p>away [6] 33/9 37/16 79/18 149/9 151/4 156/2</p>
---	--	--

<p>B</p> <p>bachelor's [1] 29/3</p> <p>back [55] 13/12 17/10 18/14 24/7 24/9 24/13 24/14 24/21 25/15 29/15 29/17 41/18 46/4 47/16 48/8 48/12 48/15 49/15 50/4 50/16 51/18 52/6 55/18 58/20 63/18 65/21 65/21 69/25 73/25 78/13 84/5 86/7 88/10 92/22 93/16 93/25 107/8 107/9 121/9 121/19 122/14 123/3 126/18 130/18 144/7 144/15 145/12 149/15 149/16 149/18 149/19 149/20 152/3 157/7 158/23</p> <p>back-to-back [1] 65/21</p> <p>background [12] 29/2 112/5 116/19 116/20 117/4 119/21 120/25 121/6 121/9 144/18 144/25 147/4</p> <p>backward [1] 78/17</p> <p>bacterial [1] 106/15</p> <p>bad [2] 107/6 133/24</p> <p>bag [4] 22/8 22/8 22/9 22/10</p> <p>bar [2] 12/20 21/2</p> <p>barrier [2] 150/23 151/21</p> <p>base [1] 25/19</p> <p>based [10] 31/8 37/7 57/13 65/8 84/13 86/12 89/20 89/22 90/4 90/6</p> <p>baseline [4] 120/22 121/20 122/7 123/4</p> <p>basic [1] 45/4</p> <p>basically [53] 28/24 35/2 36/23 37/12 37/19 37/24 40/15 44/7 44/10 44/23 45/21 46/18 47/20 49/12 52/6 52/8 52/18 54/3 60/21 62/17 64/1 64/21 72/15 74/21 78/7 81/14 82/8 82/11 82/18 82/23 86/8 86/21 88/6 88/16 88/19 88/25 89/6 89/25 90/10 94/2 94/10 94/25 95/3 95/18 100/22 102/8 115/3 121/7 122/1 122/4 122/12 123/3 155/20</p> <p>basis [4] 48/1 86/17 122/4 136/12</p> <p>bat [1] 97/9</p> <p>bathroom [1] 92/6</p> <p>BB [1] 136/7</p> <p>be [89] 5/12 5/18 5/21 7/3 7/4 8/21 8/24 10/1 13/16 16/1 21/11 22/17 22/18 22/25 23/2 23/16 25/13 26/16 26/22 27/6 27/9 34/23 35/3 40/11 45/5 53/2 54/11 56/17 61/12 65/3 65/14 66/12 67/3 68/9 68/10 69/21 79/11 80/12 81/1 81/23 82/18 83/10 93/8 95/6 99/20 104/2 104/4 104/5 104/6 104/20 105/11 106/12 106/17 106/18 109/14 112/17 117/17 121/18 124/21 125/2 125/11 125/14 131/3 131/14 133/5 133/11 133/12 133/13 133/14 133/17 135/13 139/23 143/1 144/4 145/14 146/5 146/13 146/14 147/8 147/15 149/7 149/22 151/6 152/20 154/24 155/6 158/19 159/20 160/1</p> <p>became [3] 9/2 99/14 148/10</p> <p>because [76] 17/12 35/7 40/12 60/18 64/5 64/7 68/21 69/16 70/23 71/3 75/12 80/6 81/10 86/9 86/22 87/1 88/24 89/17 95/8 103/20 105/6 106/25 110/17 114/2 114/10 115/21 116/5 116/23 117/23 118/4 121/5 121/10 121/17 123/9 129/12 133/9 133/18 134/21 135/12 135/20 135/20 137/15 137/19 138/19 138/22 139/2 139/9 140/5 140/11 141/7 141/9 141/17 142/7 142/10 142/20 143/9 143/14 143/18 143/22 146/6 146/12</p>	<p>146/19 147/22 148/2 148/18 148/20 149/8 149/11 150/5 151/17 151/19 151/22 152/6 155/6 156/14 158/15</p> <p>become [7] 8/10 9/1 28/25 29/18 29/22 84/8 100/17</p> <p>bedside [3] 95/7 96/17 139/14</p> <p>been [47] 5/5 6/16 13/24 28/4 28/13 28/15 28/16 28/18 29/7 29/11 31/11 47/13 47/14 49/5 51/16 54/12 55/20 56/9 71/1 71/15 71/19 75/22 80/16 81/22 84/3 84/22 94/22 101/1 105/21 106/9 107/4 107/15 111/17 111/23 113/24 114/13 118/23 119/2 122/15 126/8 126/16 128/9 130/14 137/15 137/17 138/17 144/21</p> <p>before [36] 1/4 5/17 6/24 26/8 27/5 29/16 30/16 30/17 39/21 40/2 43/25 56/8 67/6 72/8 83/3 96/1 103/10 114/12 115/18 115/21 117/5 119/24 121/12 124/13 125/10 130/21 133/1 137/4 137/11 140/17 140/25 145/21 155/15 155/24 159/12 161/9</p> <p>before-entitled [1] 161/9</p> <p>begin [1] 36/2</p> <p>beginning [8] 13/22 19/9 31/5 89/2 90/20 93/10 94/4 94/19</p> <p>behavior [1] 34/18</p> <p>behind [4] 87/6 112/22 132/10 154/5</p> <p>being [32] 30/20 52/10 58/6 61/23 64/2 64/3 64/16 67/13 67/17 67/23 70/18 71/9 72/18 74/3 74/8 79/21 79/23 80/2 82/23 82/25 96/19 96/20 106/20 106/23 121/3 123/5 123/10 135/7 135/8 150/19 155/17 158/5</p> <p>believe [12] 19/6 20/20 41/6 42/7 44/9 46/25 63/21 67/25 81/19 83/15 95/10 120/15</p> <p>believed [3] 16/1 108/8 108/14</p> <p>below [1] 122/6</p> <p>Berkeley [1] 29/6</p> <p>beside [7] 24/4 24/17 29/7 41/8 60/10 93/21 118/15</p> <p>besides [1] 44/19</p> <p>best [3] 5/7 88/3 89/8</p> <p>better [1] 121/5</p> <p>between [17] 30/3 30/24 32/15 32/23 41/22 56/3 66/17 71/13 85/25 92/9 93/16 110/15 131/22 132/15 135/17 142/14 151/21</p> <p>beyond [2] 116/8 121/17</p> <p>BIANCA [1] 2/13</p> <p>bias [2] 160/8 160/13</p> <p>big [10] 47/3 47/6 98/14 99/6 112/4 114/8 121/17 141/14 150/20 155/5</p> <p>biggest [1] 151/17</p> <p>bill [2] 19/15 117/21</p> <p>billed [1] 86/22</p> <p>billing [1] 86/21</p> <p>bin [1] 156/24</p> <p>bio [1] 7/20</p> <p>bio-terrorism [1] 7/20</p> <p>biohazard [1] 22/8</p> <p>biology [1] 29/3</p> <p>biopsies [3] 141/24 143/15 143/16</p> <p>biopsy [9] 63/20 63/24 64/5 64/6 64/8 143/4 143/11 147/8 150/10</p> <p>birth [4] 14/19 16/15 114/3 114/4</p> <p>bit [9] 29/17 49/16 50/16 77/1 111/19 141/14 149/21 155/8 156/6</p> <p>bite [12] 64/1 64/9 64/11 64/14 64/15 64/18 64/19 64/22 65/8 68/15 141/8 143/12</p> <p>bites [1] 64/21</p> <p>biting [1] 64/23</p>	<p>BLC [2] 51/13 51/19</p> <p>blips [1] 129/17</p> <p>block [3] 64/11 64/19 141/8</p> <p>blocks [7] 64/1 64/9 64/14 64/16 64/18 65/8 68/15</p> <p>blood [23] 9/14 22/19 22/21 23/12 34/16 34/24 35/3 35/4 78/13 78/21 78/22 81/13 88/13 96/4 103/20 104/4 113/12 113/17 123/7 138/8 138/9 138/9 140/8</p> <p>blowouts [1] 129/16</p> <p>board [1] 75/25</p> <p>BOB [2] 2/14 111/10</p> <p>body [1] 33/10</p> <p>book [1] 135/3</p> <p>books [1] 131/10</p> <p>borderline [1] 138/22</p> <p>borrow [1] 144/5</p> <p>boss [1] 37/4</p> <p>both [32] 6/9 8/7 18/3 18/11 22/3 27/22 31/13 32/20 34/10 35/19 35/22 42/3 55/12 63/9 64/4 67/4 67/8 67/16 68/18 69/12 71/9 74/15 74/22 84/25 93/4 93/7 94/18 94/24 102/9 122/5 126/2 152/12</p> <p>bottles [2] 53/1 53/14</p> <p>bottom [5] 68/24 85/15 86/11 90/13 96/3</p> <p>bowel [2] 130/13 130/13</p> <p>box [7] 90/19 91/3 91/16 91/19 91/20 144/5 152/14</p> <p>boxes [8] 23/16 90/23 91/16 91/18 96/11 144/6 152/14 152/15</p> <p>boy [1] 27/25</p> <p>BP [1] 138/7</p> <p>BRADLEY [1] 2/7</p> <p>break [4] 92/5 92/23 96/23 97/2</p> <p>breath [2] 141/22 141/23</p> <p>breathe [5] 141/16 141/16 141/18 141/20 141/22</p> <p>breathing [1] 153/21</p> <p>breaths [1] 141/21</p> <p>BRIAN [4] 3/4 25/13 27/24 28/3</p> <p>bring [8] 51/21 52/7 121/22 131/23 141/10 149/19 149/20 149/20</p> <p>bringing [1] 149/22</p> <p>broad [1] 98/25</p> <p>brought [6] 56/6 64/12 72/5 75/3 103/4 138/12</p> <p>building [5] 40/13 41/15 41/20 41/21 139/1</p> <p>buildings [1] 41/19</p> <p>bunch [3] 48/18 107/1 112/11</p> <p>Bureau [2] 42/24 44/15</p> <p>Burnham [8] 132/13 132/18 132/20 132/25 133/1 133/20 142/15 142/18</p> <p>burns [1] 106/25</p> <p>bus [2] 139/4 142/10</p> <p>business [4] 101/6 113/17 116/25 150/7</p> <p>busy [3] 139/3 139/19 140/4</p> <p>But that [1] 141/14</p> <p>buy [2] 124/3 124/3</p> <p>C</p> <p>C.C.R [1] 1/25</p> <p>CABILES [1] 2/8</p> <p>calculate [2] 105/15 109/4</p> <p>calculation [2] 105/17 109/9</p> <p>calculations [3] 33/23 81/16 83/13</p> <p>California [1] 29/6</p> <p>call [5] 36/17 96/22 136/3 144/3 148/21</p> <p>called [14] 10/22 11/10 14/21 15/10</p>
--	---	--

<p>C</p> <p>called... [10] 22/7 22/21 38/12 42/24 43/9 43/15 43/17 102/14 109/5 133/18</p> <p>calling [1] 103/17</p> <p>calm [2] 132/24 141/15</p> <p>came [34] 10/10 10/20 15/2 16/17 19/16 25/15 25/18 29/9 31/5 31/6 32/18 39/19 42/3 51/18 53/21 58/12 62/5 65/7 66/6 69/15 100/12 102/1 103/2 107/8 107/9 120/16 130/21 131/17 132/25 136/11 136/13 136/15 145/12 147/1</p> <p>camera [1] 94/13</p> <p>CAMP [1] 2/9</p> <p>Campbell [1] 97/21</p> <p>can [67] 9/7 9/9 9/9 9/10 11/15 14/16 16/5 16/7 16/12 18/22 19/3 19/5 22/20 30/2 32/22 38/13 43/10 54/24 56/5 57/3 59/6 63/19 68/25 69/1 70/23 77/1 78/12 78/14 82/18 82/19 90/15 91/22 92/17 92/21 97/13 100/25 105/15 105/24 105/25 106/1 106/1 106/4 106/16 109/4 111/20 112/12 114/17 115/13 118/24 124/1 124/3 124/3 131/14 141/19 142/2 143/25 144/1 145/5 145/14 146/13 149/15 149/19 153/9 154/6 156/5 156/6 158/7</p> <p>can't [11] 31/20 106/19 112/25 114/5 114/6 115/14 115/19 124/7 129/17 141/18 157/2</p> <p>cancer [2] 109/8 145/11</p> <p>cancerous [1] 149/17</p> <p>capacity [1] 7/23</p> <p>card [1] 158/10</p> <p>care [8] 30/7 100/4 101/2 112/3 121/4 122/24 139/17 147/22</p> <p>Carrera [2] 97/24 143/2</p> <p>Carrol [5] 44/23 72/5 97/23 103/4 143/2</p> <p>carry [1] 152/1</p> <p>case [44] 1/9 10/3 12/2 12/3 14/15 21/17 23/10 25/12 29/1 29/10 31/17 31/21 31/23 32/2 32/6 33/7 34/2 34/2 34/20 34/23 35/17 36/3 36/22 37/11 37/13 37/20 45/2 69/7 98/15 101/20 102/5 102/11 102/12 102/14 102/20 102/21 103/11 103/12 103/23 104/7 104/17 115/4 119/5 120/2</p> <p>cases [51] 29/19 29/24 30/1 30/3 30/12 30/24 31/3 31/10 32/14 32/18 33/24 34/5 34/7 34/8 35/23 36/4 36/7 36/20 37/18 37/24 44/24 44/25 45/1 46/21 101/12 101/15 101/16 101/18 102/2 102/3 102/25 103/2 103/8 107/19 108/3 110/12 110/12 110/15 111/22 113/20 113/23 117/16 119/24 120/1 120/13 121/6 122/17 123/3 123/9 131/12 145/22</p> <p>catch [3] 139/4 149/11 149/23</p> <p>categories [1] 16/22</p> <p>categorize [1] 84/12</p> <p>categorized [1] 22/4</p> <p>category [1] 17/19</p> <p>cause [1] 78/18</p> <p>causes [1] 81/7</p> <p>causing [2] 80/5 129/1</p> <p>caution [1] 86/23</p> <p>CCR [2] 161/6 161/19</p> <p>CDC [73] 8/1 8/16 8/22 8/24 9/10 11/12 12/5 12/11 12/15 12/15 12/22 12/24 13/1 13/2 13/13 13/24 14/6</p>	<p>14/9 14/12 15/6 15/8 15/11 17/4 17/5 17/8 17/10 18/25 19/1 19/9 19/19 20/23 21/6 21/8 21/15 22/22 22/23 23/5 23/14 24/5 24/20 25/8 25/9 25/18 36/5 36/17 37/3 37/5 37/7 37/9 37/12 38/7 38/13 39/5 39/14 39/16 41/23 42/1 42/23 44/2 44/16 47/25 48/2 48/8 48/22 51/20 69/19 84/7 100/13 103/21 104/3 107/8 107/12 107/21</p> <p>cecum [1] 129/12</p> <p>celebrities [1] 136/6</p> <p>center [19] 8/15 26/15 26/19 29/20 34/12 37/17 40/8 40/14 40/18 76/9 124/20 124/24 126/20 127/16 130/21 131/18 132/5 159/19 159/23</p> <p>centers [2] 35/8 76/23</p> <p>centrifuge [1] 22/20</p> <p>centrifuged [2] 22/18 22/25</p> <p>certain [7] 69/6 69/6 111/2 115/20 129/4 147/9 154/22</p> <p>certainly [2] 96/24 104/22</p> <p>CERTIFICATE [1] 161/1</p> <p>Certification [2] 42/25 44/16</p> <p>certify [1] 161/7</p> <p>challenge [4] 83/9 110/14 111/19 114/8</p> <p>challenges [1] 111/25</p> <p>chance [2] 54/17 155/14</p> <p>change [6] 40/2 133/5 153/25 156/23 158/12 158/12</p> <p>changed [2] 42/25 50/23</p> <p>charge [5] 12/7 136/15 146/20 147/20 147/21</p> <p>charged [1] 99/19</p> <p>chart [28] 15/10 17/4 46/1 46/15 47/10 47/16 47/20 47/23 48/18 48/21 48/23 49/9 49/11 49/12 49/15 50/3 50/9 51/10 51/12 51/22 56/19 56/25 67/20 76/9 86/13 87/20 88/23 89/5</p> <p>charting [2] 88/10 89/6</p> <p>charts [16] 46/17 46/19 46/22 46/24 47/7 47/8 48/19 50/5 51/7 84/20 85/23 88/1 89/23 90/6 96/4 108/17</p> <p>check [2] 96/4 96/11</p> <p>checked [4] 25/22 55/14 55/20 57/10</p> <p>chemicals [1] 106/15</p> <p>chief [1] 144/22</p> <p>CHRISTINE [1] 2/10</p> <p>chronic [8] 32/15 32/23 33/1 33/7 33/12 115/3 120/2 122/16</p> <p>Chux [3] 150/19 150/21 153/1</p> <p>clarify [1] 130/9</p> <p>CLARK [8] 1/2 26/15 26/18 124/20 124/23 159/19 159/22 161/4</p> <p>classified [3] 32/19 32/20 32/24</p> <p>clean [21] 53/22 53/22 58/16 58/16 77/16 77/17 77/17 131/14 143/17 143/20 143/25 147/10 148/10 148/12 148/13 148/25 154/9 157/13 157/17 158/4 158/14</p> <p>cleaned [3] 65/17 65/18 73/19</p> <p>cleaning [10] 47/5 52/15 73/20 143/18 148/5 148/11 151/17 151/22 158/16 158/23</p> <p>clear [3] 45/11 55/16 104/20</p> <p>clearly [2] 71/12 108/10</p> <p>clerical [2] 65/23 147/2</p> <p>clicked [1] 88/21</p> <p>client [1] 7/4</p> <p>Cliff [1] 44/23</p> <p>Clifford [1] 97/22</p> <p>clinic [101] 31/4 31/14 35/20 38/1 39/22 39/25 40/1 40/6 40/7 41/12</p>	<p>42/19 42/21 42/22 43/3 43/4 43/13 43/16 45/3 45/17 45/22 46/22 47/4 48/9 48/24 49/2 49/14 51/6 51/18 58/6 58/14 59/12 59/21 59/23 60/3 60/6 60/6 61/15 62/5 63/7 64/2 66/9 68/4 69/16 70/24 72/5 72/11 74/3 75/25 80/11 84/2 84/20 98/16 98/24 101/18 106/2 106/8 108/2 109/10 109/12 109/13 109/14 110/16 110/18 114/3 114/6 114/9 114/16 115/19 116/23 117/3 117/6 117/21 117/23 118/11 118/15 119/12 119/13 120/20 121/16 124/7 127/2 127/6 127/8 132/5 132/7 132/13 132/20 132/25 133/2 133/20 134/6 134/10 135/1 136/19 137/25 142/19 144/12 144/15 146/1 146/1 148/6</p> <p>clinical [1] 7/19</p> <p>clinics [5] 40/13 132/9 132/16 142/15 145/8</p> <p>clock [1] 89/1</p> <p>close [3] 15/22 75/15 89/24</p> <p>closely [2] 31/10 33/24</p> <p>closely-related [1] 33/24</p> <p>closer [4] 16/7 120/23 121/11 121/19</p> <p>clothes [3] 138/11 139/5 140/9</p> <p>cluster [8] 44/11 75/11 75/14 101/19 107/18 107/20 111/15 119/24</p> <p>clusters [9] 37/1 110/12 111/6 111/17 111/23 117/10 117/15 118/3 118/5</p> <p>CNA [1] 110/5</p> <p>coat [1] 153/13</p> <p>coats [2] 151/2 153/15</p> <p>code [8] 12/16 12/20 15/6 17/3 19/11 20/23 21/2 21/6</p> <p>Coffing [4] 2/23 7/2 87/11 97/4</p> <p>cognizant [1] 147/9</p> <p>collect [5] 9/21 10/2 10/23 22/20 48/14</p> <p>collected [10] 12/22 15/2 15/4 15/14 16/25 17/10 21/12 22/25 23/10 61/17</p> <p>collecting [3] 8/17 9/18 9/19</p> <p>collection [7] 8/6 9/25 11/14 15/5 16/18 16/23 17/1</p> <p>colon [3] 69/5 129/13 145/19</p> <p>colonoscopies [3] 40/21 68/17 128/18</p> <p>colonoscopy [9] 35/14 64/11 116/24 118/20 128/6 130/9 137/2 137/21 139/9</p> <p>colored [1] 33/5</p> <p>colors [1] 153/19</p> <p>column [10] 17/15 17/20 20/22 21/3 21/6 21/11 21/12 21/14 61/6 63/20</p> <p>combat [2] 144/23 145/6</p> <p>come [43] 9/12 22/7 22/11 22/14 22/19 24/7 24/9 24/14 30/14 32/14 34/5 38/3 38/11 39/14 39/15 41/24 42/1 42/8 46/4 49/4 55/7 59/10 70/10 74/17 80/18 82/12 83/17 83/23 94/12 103/19 105/10 108/15 110/12 111/14 113/17 133/16 133/18 149/5 149/6 149/14 150/17 151/7 160/8</p> <p>comes [11] 10/16 10/18 11/1 22/16 24/21 31/17 32/2 34/2 34/2 35/24 39/4</p> <p>comfortable [1] 156/20</p> <p>coming [19] 13/8 41/24 43/9 43/12 43/22 44/10 76/18 112/23 122/10 127/16 133/6 133/21 135/10 138/22 139/12 142/24 158/2 158/3 158/23</p> <p>comment [1] 159/2</p> <p>commercial [4] 9/7 15/1 15/3 16/17</p>
---	--	---

<p>C</p> <p>common [17] 34/10 35/18 36/3 37/1 45/6 55/8 55/11 62/14 62/21 64/3 68/16 69/22 69/25 92/7 107/13 123/19 123/23</p> <p>company [2] 143/12 145/15</p> <p>compare [3] 34/4 55/23 75/18</p> <p>comparing [3] 89/10 108/16 109/9</p> <p>comparison [1] 128/1</p> <p>competent [1] 147/24</p> <p>complete [1] 102/18</p> <p>completed [3] 19/17 19/18 72/8</p> <p>completely [1] 116/2</p> <p>comply [3] 26/13 124/18 159/17</p> <p>component [1] 8/14</p> <p>computer [5] 84/18 94/9 94/11 95/1 117/25</p> <p>concentration [1] 81/15</p> <p>concern [10] 54/6 54/7 57/20 61/11 64/23 74/3 98/19 147/13 151/6 157/17</p> <p>concerned [8] 18/20 63/13 69/18 100/1 143/3 144/11 146/23 160/14</p> <p>concerns [2] 62/14 65/16</p> <p>concluded [1] 160/19</p> <p>concludes [2] 160/6 160/15</p> <p>conclusion [1] 74/17</p> <p>conclusions [1] 108/18</p> <p>concurrent [1] 42/23</p> <p>conditions [1] 66/11</p> <p>conduct [1] 42/11</p> <p>conference [1] 51/10</p> <p>confident [1] 85/3</p> <p>confirm [2] 31/25 61/8</p> <p>confirmed [2] 45/2 108/10</p> <p>confusing [3] 40/11 40/12 94/3</p> <p>conjunction [1] 18/10</p> <p>connected [2] 41/18 108/3</p> <p>connection [3] 12/15 107/18 114/15</p> <p>connections [1] 114/16</p> <p>consideration [1] 74/10</p> <p>considered [3] 60/23 78/8 110/2</p> <p>consistent [2] 57/16 59/14</p> <p>CONSTANCE [1] 2/8</p> <p>constitutes [1] 161/13</p> <p>contact [9] 9/7 14/20 34/25 37/7 39/22 39/25 43/4 43/6 103/17</p> <p>contacted [1] 36/5</p> <p>contacting [1] 37/5</p> <p>contain [1] 153/9</p> <p>contained [6] 18/13 19/24 20/3 58/25 98/2 153/11</p> <p>container [1] 79/4</p> <p>contains [4] 17/24 20/11 21/7 23/7</p> <p>contaminate [2] 69/22 83/6</p> <p>contaminated [26] 54/11 78/19 78/22 79/1 79/16 79/17 79/24 80/1 80/10 80/11 80/17 80/21 80/24 81/2 82/7 82/11 82/15 82/16 82/24 83/4 83/6 92/12 92/13 104/23 151/22 153/16</p> <p>contamination [7] 54/13 77/4 78/14 78/20 80/3 80/5 83/12</p> <p>contaminations [1] 71/1</p> <p>contempt [3] 26/17 124/22 159/21</p> <p>continually [1] 81/24</p> <p>continue [6] 5/10 48/21 63/23 81/23 87/18 123/8</p> <p>continuing [2] 49/12 97/8</p> <p>control [4] 52/23 53/3 74/23 110/3</p> <p>conversation [1] 72/13</p> <p>copy [4] 13/11 25/9 56/17 60/25</p> <p>corpsman [1] 144/22</p> <p>correct [91] 11/21 12/1 14/7 14/13</p>	<p>14/14 16/3 17/21 17/23 18/5 19/8 19/21 19/22 20/13 20/14 21/1 21/4 21/19 21/21 21/22 22/1 23/23 31/19 32/17 38/5 40/22 41/14 50/18 50/24 51/5 52/11 52/12 53/12 53/19 55/3 55/22 55/25 58/24 59/3 59/4 59/8 59/13 62/10 62/11 63/6 65/12 67/19 69/9 70/19 71/20 72/1 75/19 75/20 76/4 76/20 76/24 77/6 77/7 78/2 78/7 79/19 80/8 80/22 85/8 85/9 86/6 87/17 90/7 91/8 91/10 93/5 98/2 99/17 99/18 99/22 99/25 100/7 100/16 100/18 100/19 101/7 101/8 105/3 113/18 113/19 117/10 119/14 119/20 120/2 120/5 144/13 144/19</p> <p>correcting [1] 55/1</p> <p>correctly [4] 11/18 92/24 111/20 146/21</p> <p>correspond [1] 14/2</p> <p>corroborate [1] 72/12</p> <p>corroborated [2] 70/10 71/25</p> <p>cost [1] 150/17</p> <p>could [46] 6/8 23/12 23/19 27/21 30/15 33/18 35/3 40/4 45/1 50/6 61/12 61/23 70/25 71/2 71/11 72/2 80/12 82/6 82/8 82/13 83/12 83/16 83/22 89/8 90/5 103/20 105/10 107/15 107/22 107/24 113/1 115/6 115/10 115/22 119/3 121/22 125/6 126/1 131/21 140/4 143/10 145/17 145/18 145/18 151/25 157/9</p> <p>couldn't [26] 81/10 87/9 89/17 104/6 107/17 111/2 111/3 114/2 114/22 115/24 118/1 119/8 123/23 129/8 129/8 129/11 129/13 132/19 133/10 133/12 133/13 133/13 142/9 142/10 144/2 154/24</p> <p>count [1] 133/23</p> <p>country [1] 71/17</p> <p>county [10] 1/2 26/15 26/18 30/23 37/25 124/20 124/23 159/19 159/22 161/4</p> <p>couple [14] 13/16 34/3 40/25 46/13 54/2 72/7 80/20 93/7 95/2 102/4 111/6 116/16 136/7 147/23</p> <p>court [6] 1/1 1/5 26/17 30/15 124/22 159/21</p> <p>cover [4] 92/4 93/14 118/25 119/1</p> <p>crafting [1] 18/8</p> <p>created [1] 12/15</p> <p>crew [1] 136/12</p> <p>criminal [5] 6/1 27/14 99/3 99/13 125/19</p> <p>CRNA [34] 52/22 53/9 62/19 63/3 63/3 63/10 72/14 72/15 86/15 88/6 90/11 90/16 90/16 90/18 90/18 92/17 92/25 92/25 93/3 93/6 93/10 93/11 93/13 93/16 97/12 97/12 97/17 97/17 97/18 97/19 97/19 110/6 110/7 112/23</p> <p>CRNAs [9] 59/17 62/24 63/7 63/9 90/15 92/3 92/8 112/19 127/13</p> <p>cross [1] 102/8</p> <p>cryovials [1] 21/13</p> <p>cuff [1] 138/7</p> <p>cuffs [1] 143/22</p> <p>curve [1] 129/13</p> <p>cutting [2] 150/19 150/20</p> <p>cycle [1] 82/19</p> <p>cycles [1] 83/8</p> <p>D</p> <p>D's [2] 132/1 138/21</p> <p>DA [1] 2/24</p>	<p>DA's [1] 99/16</p> <p>daily [1] 48/1</p> <p>damage [1] 33/10</p> <p>dark [4] 33/5 90/19 122/17 122/20</p> <p>data [3] 18/12 18/13 25/19</p> <p>date [19] 14/19 15/5 15/7 16/15 16/18 16/24 17/1 17/3 19/12 19/18 21/11 60/8 84/10 114/3 114/4 117/22 117/24 117/24 158/22</p> <p>Dated [1] 161/15</p> <p>dates [9] 15/14 18/3 36/11 36/13 36/14 37/19 45/4 117/21 127/4</p> <p>day [70] 36/9 37/18 38/2 43/21 45/20 45/23 46/2 46/3 46/5 46/21 47/7 47/9 47/10 47/11 47/13 47/17 47/20 47/21 49/4 49/5 49/7 49/8 49/8 50/13 52/3 53/15 53/18 54/16 56/4 56/24 57/9 60/7 64/18 66/13 70/22 75/16 75/18 80/15 89/14 93/4 94/3 101/23 104/2 106/2 106/7 106/9 106/10 106/21 107/4 109/12 110/25 112/14 118/2 118/2 131/12 132/4 133/6 133/21 133/24 134/17 134/18 134/18 135/2 135/5 135/13 139/3 152/14 155/3 158/9 158/19</p> <p>days [38] 26/18 36/8 46/24 46/25 48/4 48/22 50/5 51/19 52/3 52/4 55/14 55/19 55/21 57/14 62/9 62/10 67/4 67/8 70/4 70/4 72/17 74/4 74/22 75/6 76/2 102/13 104/19 106/17 110/11 110/13 111/2 111/14 114/18 114/24 114/25 115/2 124/23 159/22</p> <p>DEA [1] 144/24</p> <p>dealing [1] 151/22</p> <p>dealt [1] 140/1</p> <p>debris [1] 151/6</p> <p>December [3] 31/5 31/7 34/9</p> <p>December 28th [1] 34/9</p> <p>decide [1] 140/15</p> <p>decided [2] 39/24 139/7</p> <p>decisions [1] 73/7</p> <p>decrease [1] 121/19</p> <p>deep [2] 141/21 141/22</p> <p>Defendants [1] 1/12</p> <p>definitely [1] 143/20</p> <p>definition [1] 45/2</p> <p>degree [3] 29/3 29/4 137/14</p> <p>delay [1] 24/1</p> <p>delayed [1] 23/16</p> <p>deliver [1] 144/3</p> <p>delivering [1] 144/4</p> <p>delusional [1] 83/19</p> <p>demeanor [1] 133/4</p> <p>dental [1] 35/2</p> <p>department [1] 9/7</p> <p>departments [1] 38/16</p> <p>depending [3] 52/2 140/4 143/16</p> <p>depends [2] 128/10 129/23</p> <p>depict [1] 15/25</p> <p>depicted [4] 79/5 79/8 81/18 82/1</p> <p>Deputy [2] 2/4 2/22</p> <p>DESAI [32] 1/10 6/4 27/17 97/23 125/22 127/12 127/15 127/22 128/17 128/19 129/2 130/22 130/24 131/1 131/6 132/20 132/25 133/5 133/9 134/11 137/23 140/16 141/1 142/21 143/5 144/3 146/1 147/25 148/9 148/23 150/3 150/11</p> <p>Desai's [3] 137/9 137/24 141/4</p> <p>describe [2] 19/5 109/2</p> <p>described [4] 24/17 49/10 58/22 76/11</p> <p>Desert [2] 132/11 132/19</p> <p>designated [2] 50/7 97/11</p>
--	--	--

<p>D</p> <p>Detention [6] 26/15 26/18 124/20 124/23 159/19 159/22</p> <p>determination [5] 50/12 59/11 66/5 104/6 104/11</p> <p>determine [4] 81/16 84/9 100/5 118/18</p> <p>determined [3] 31/4 67/3 89/9</p> <p>determining [2] 85/4 89/20</p> <p>develop [2] 33/3 33/14</p> <p>developed [2] 103/13 110/20</p> <p>develops [1] 33/2</p> <p>device [1] 78/5</p> <p>diagnose [2] 111/19 111/20</p> <p>diagnosed [2] 30/1 113/12</p> <p>diagnosis [1] 21/14</p> <p>diagram [10] 56/19 76/12 77/2 77/3 77/25 79/16 93/21 93/22 93/25 107/25</p> <p>diagrams [2] 76/15 97/11</p> <p>dials [1] 37/3</p> <p>did [157] 8/10 8/20 8/23 10/3 10/5 10/6 10/9 12/4 12/8 12/13 13/7 13/9 13/10 13/14 16/19 18/17 18/18 23/21 23/24 24/3 29/17 39/19 40/3 41/1 41/3 41/8 43/15 43/25 44/1 44/5 45/8 45/14 45/15 46/1 46/4 46/6 46/17 47/10 47/25 48/21 48/23 49/4 51/21 52/13 52/16 54/17 55/4 55/7 57/25 58/2 58/3 58/8 58/11 59/25 60/3 62/17 67/6 68/7 68/11 70/9 70/14 70/16 72/6 72/22 73/6 73/8 74/4 74/7 74/13 74/17 75/11 75/14 76/5 83/13 84/7 84/11 84/24 85/2 85/6 85/10 89/9 89/10 89/12 89/19 91/25 93/3 93/4 100/10 101/14 101/21 103/24 106/8 106/11 106/20 106/22 107/8 107/9 108/3 108/15 112/20 112/20 112/22 113/20 117/11 117/13 117/20 118/17 119/4 119/9 119/11 119/17 120/20 121/5 121/18 122/11 126/19 127/12 127/15 127/18 128/19 129/2 129/4 129/19 130/1 130/6 131/1 132/5 132/9 133/4 135/11 136/2 136/4 136/16 136/20 137/3 138/21 139/13 139/16 140/16 141/12 143/4 144/8 145/1 145/7 146/1 147/5 147/17 147/25 150/1 150/2 150/3 150/11 150/25 151/13 154/13 157/8 157/16</p> <p>didn't [55] 33/20 36/8 36/10 36/15 40/1 47/21 54/12 59/20 64/8 66/15 68/22 70/20 74/6 74/20 80/23 86/17 89/17 93/12 98/22 102/16 105/10 107/3 107/14 109/11 112/24 113/2 114/3 114/13 114/14 115/17 117/15 117/18 117/19 117/23 119/7 119/8 132/23 135/21 138/23 138/23 140/25 141/12 142/6 142/7 147/14 149/25 151/3 152/7 154/2 154/3 156/12 156/14 156/25 157/10 157/21</p> <p>Diego [1] 145/2</p> <p>difference [5] 32/15 32/23 75/19 132/15 142/14</p> <p>differences [2] 56/3 91/23</p> <p>different [50] 17/20 21/25 36/8 41/19 42/14 48/13 51/16 53/12 60/14 60/22 62/8 62/9 63/3 63/4 65/18 65/19 65/24 66/1 68/19 69/1 73/16 74/22 75/7 75/21 76/2 76/2 78/9 84/22 86/12 87/19 87/23 87/25 91/7 94/1 97/12 98/11 99/2 102/1 107/10 107/11 107/15 108/11 114/25 124/5</p>	<p>131/24 131/25 137/19 138/20 153/19 158/11</p> <p>differently [3] 65/24 137/20 139/9</p> <p>difficult [1] 61/1</p> <p>dignitaries [1] 136/4</p> <p>dinner [1] 134/21</p> <p>DIPAK [5] 1/10 6/4 27/16 97/23 125/22</p> <p>dipping [1] 70/6</p> <p>direct [4] 8/3 16/12 29/15 126/18</p> <p>directed [3] 59/19 74/2 79/13</p> <p>direction [3] 72/25 74/14 161/11</p> <p>directly [1] 113/3</p> <p>director [1] 43/19</p> <p>dirty [1] 156/23</p> <p>disagreement [1] 148/9</p> <p>discard [1] 79/3</p> <p>discarded [1] 155/25</p> <p>discharged [2] 137/4 137/12</p> <p>disciplines [1] 42/14</p> <p>disclosing [3] 26/7 124/12 159/11</p> <p>discovered [1] 113/20</p> <p>discretion [1] 30/5</p> <p>discussed [1] 101/17</p> <p>discussing [1] 37/9</p> <p>discussion [2] 54/21 101/13</p> <p>discussions [2] 54/23 147/25</p> <p>disease [20] 7/21 29/13 30/9 31/12 32/1 32/5 33/1 33/15 34/21 57/21 68/9 78/10 80/13 81/7 83/1 108/23 111/9 112/13 112/15 121/1</p> <p>diseases [2] 29/5 61/23</p> <p>disgruntled [1] 72/10</p> <p>disoriented [1] 140/10</p> <p>display [5] 15/18 19/3 56/21 57/1 60/24</p> <p>displayed [2] 20/9 61/5</p> <p>disposable [2] 64/2 153/16</p> <p>disposed [1] 58/19</p> <p>disregard [5] 6/1 27/14 86/25 125/19 159/5</p> <p>distal [1] 150/8</p> <p>DISTRICT [28] 1/1 1/5 2/22 7/3 7/9 7/15 7/22 7/23 8/14 9/13 9/15 9/22 12/3 28/12 28/18 29/18 30/9 36/1 40/10 44/2 44/19 97/5 99/20 101/7 102/8 102/17 103/19 119/15</p> <p>divergence [1] 75/8</p> <p>diverticulitis [1] 129/15</p> <p>diverticulum [1] 129/16</p> <p>Division [1] 43/2</p> <p>do [146] 5/15 5/20 6/6 6/7 6/24 7/6 7/6 7/10 7/10 7/23 8/2 9/1 9/24 10/3 11/11 11/12 11/23 13/3 13/6 14/1 14/2 14/4 14/8 22/3 22/3 22/3 23/8 23/9 24/21 24/25 24/25 26/20 26/21 27/3 27/8 27/19 27/20 28/10 28/10 30/6 30/11 30/13 30/21 31/12 31/18 32/2 32/7 34/3 34/4 34/14 36/18 36/21 37/10 38/6 38/9 39/7 39/14 40/14 40/23 40/23 42/9 42/19 43/7 44/21 44/21 45/15 46/15 47/17 47/18 47/23 47/25 48/8 48/25 49/13 50/14 52/5 56/2 56/8 57/4 57/25 58/8 59/19 59/20 69/2 69/12 74/5 79/13 82/21 84/16 85/16 85/21 95/3 98/8 98/9 98/10 98/22 99/10 100/24 101/2 101/11 103/20 103/22 104/4 105/4 105/16 107/8 109/9 110/23 111/3 115/6 117/13 117/16 118/22 123/18 124/6 124/7 124/25 125/1 125/8 125/13 125/24 126/14 126/14 128/6 128/10 129/19 131/12 141/7 141/24 143/13 144/1 146/17 146/20 147/11</p>	<p>147/15 149/12 153/8 155/10 155/17 156/13 157/18 158/5 158/15 159/24 159/25 161/6</p> <p>doctor [22] 6/22 29/25 30/5 31/1 63/3 63/4 88/20 89/5 94/12 95/1 131/5 142/22 143/16 145/7 145/15 145/19 148/8 151/2 155/4 155/8 156/20 157/5</p> <p>doctor's [2] 40/15 112/11</p> <p>doctors [14] 72/6 102/22 111/19 128/1 128/3 130/25 136/5 136/21 139/13 142/20 142/21 155/5 155/7 155/21</p> <p>doctors' [1] 109/24</p> <p>document [7] 4/4 4/6 18/7 18/14 56/16 57/3 59/5</p> <p>documented [1] 67/13</p> <p>documents [11] 13/10 13/11 13/19 13/21 18/23 18/24 46/16 47/4 48/13 100/17 101/4</p> <p>does [10] 14/5 15/25 19/18 21/17 32/6 39/14 39/15 91/16 95/16 119/18</p> <p>doesn't [9] 68/24 68/25 83/11 106/14 116/9 118/13 118/25 119/1 119/7</p> <p>doing [46] 11/19 33/10 44/7 45/5 48/17 48/23 49/9 49/11 50/3 51/8 51/10 51/12 51/13 51/14 59/19 62/15 75/23 79/14 80/3 94/14 94/15 95/18 98/5 98/6 99/12 100/2 113/1 113/3 132/4 133/10 133/11 133/12 133/23 135/15 141/4 144/18 147/5 149/1 149/4 150/16 150/25 151/1 152/3 152/3 157/19 158/4</p> <p>dollars [1] 100/21</p> <p>dollop [1] 154/18</p> <p>don't [44] 9/24 16/21 33/22 42/18 44/4 51/13 74/19 80/18 80/20 85/17 93/5 99/7 105/7 105/12 106/4 109/8 110/22 111/14 111/22 111/22 115/4 115/16 116/3 133/23 134/4 135/4 135/21 135/22 136/15 138/22 139/8 140/10 141/22 149/16 151/19 152/16 153/21 154/1 154/9 154/25 157/23 157/25 158/10 158/24</p> <p>done [37] 13/5 15/15 22/18 24/6 24/22 24/23 31/16 35/20 42/24 53/7 59/21 60/5 66/7 70/18 71/19 74/11 76/3 81/22 88/21 89/5 89/6 94/12 96/7 98/6 103/6 116/3 116/5 116/6 120/19 130/14 135/7 135/8 136/24 137/2 137/21 139/13 146/22</p> <p>DONNA [4] 1/25 5/4 161/6 161/19</p> <p>door [9] 40/16 41/17 41/18 43/8 46/22 117/5 138/5 139/7 140/13</p> <p>dose [3] 58/17 58/21 81/6</p> <p>doses [2] 81/8 83/24</p> <p>double [1] 70/6</p> <p>down [34] 37/19 43/12 44/22 50/15 54/20 61/4 61/5 63/21 63/25 64/20 64/21 64/22 76/8 86/15 89/1 90/11 102/1 112/8 119/13 119/19 120/20 120/23 121/16 122/14 123/4 130/8 130/11 135/19 135/25 139/3 141/11 141/15 152/15 161/7</p> <p>download [1] 59/6</p> <p>downstairs [2] 45/16 134/4</p> <p>Dr [46] 39/12 42/2 42/2 44/22 49/21 50/1 50/17 51/4 58/14 60/1 72/5 79/11 97/22 97/23 97/24 97/24 103/4 127/12 127/15 127/22 128/16 128/19 129/2 130/22 130/24 131/1 131/6 132/20 132/25 133/5 133/9 134/11 137/9 137/22 137/24 140/16 141/4 143/2 143/2 143/5 144/3 146/1 148/9</p>
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D Dr... [3] 148/23 150/3 150/11 draw [4] 54/2 58/16 58/20 103/20 drawer [1] 107/2 drawn [2] 77/20 82/7 draws [1] 9/14 drew [2] 53/22 82/14 drink [2] 133/14 138/23 drinking [2] 133/14 138/25 drop [1] 149/10 drug [1] 34/25 duly [4] 5/5 6/16 28/4 126/8 duration [1] 85/22 during [15] 23/15 48/17 54/21 58/5 59/15 60/23 70/3 72/13 74/12 84/6 98/15 127/11 130/22 131/1 155/11 duties [1] 36/25 duty [4] 145/4 145/5 145/12 145/13	ensure [2] 23/14 23/19 entertainers [1] 136/5 entire [5] 23/8 37/25 80/5 106/2 106/7 entities [1] 41/15 entitled [4] 61/6 76/22 100/9 161/9 entity [4] 9/15 10/1 11/12 126/23 environment [1] 153/22 Epi [2] 15/13 38/12 Epidemic [1] 42/7 epidemiologic [1] 98/9 epidemiologist [11] 25/11 28/11 28/15 28/16 28/21 28/23 28/25 39/4 39/6 39/9 39/12 epidemiology [13] 9/4 9/6 9/23 9/25 14/23 16/16 17/7 18/11 24/16 25/4 25/10 29/13 109/5 equation [1] 105/12 equipment [14] 63/20 63/20 63/24 64/2 64/6 64/23 64/24 65/16 68/19 68/21 69/19 78/15 94/16 95/25 ERNEST [4] 1/10 6/4 27/17 125/22 error [1] 65/23 errors [2] 25/23 109/23 especially [1] 129/14 ESQ [2] 2/22 2/23 essentially [3] 33/20 41/9 82/24 establish [1] 81/10 evaluate [2] 58/11 61/14 evaluated [2] 69/16 105/24 even [22] 29/16 33/16 66/16 71/2 72/24 84/25 94/21 96/17 104/22 111/3 111/20 111/21 115/4 116/4 116/9 133/14 133/24 136/15 139/8 147/7 152/20 158/10 evening [1] 46/8 event [4] 26/9 31/9 124/14 159/13 eventually [3] 52/16 99/14 100/17 ever [22] 7/24 11/12 51/23 55/7 70/10 98/16 106/8 108/15 117/5 126/19 129/19 130/1 132/9 133/1 138/16 140/16 140/17 143/5 147/25 149/24 150/11 157/9 every [13] 10/18 34/20 63/2 65/2 78/24 98/15 98/23 111/5 118/10 129/10 129/21 129/21 132/21 everybody [10] 38/19 44/5 84/4 106/18 109/11 133/18 137/19 137/20 139/10 141/5 everyday [2] 48/24 60/5 everyone [4] 59/22 62/23 86/4 120/1 everything [8] 71/14 88/18 94/4 108/8 108/9 108/13 132/23 138/14 evidence [12] 26/9 30/8 58/4 72/12 72/21 74/13 74/19 75/1 75/4 108/15 124/14 159/13 Ex [1] 19/14 exact [1] 106/3 exactly [5] 75/13 99/4 99/5 105/7 115/14 exam [2] 151/24 151/25 EXAMINATION [3] 6/20 28/8 126/12 Examined [1] 3/2 example [9] 8/1 15/24 16/5 17/22 34/16 80/15 85/7 94/2 150/12 except [3] 35/19 86/4 120/1 excused [3] 26/23 125/3 160/2 exhibit [14] 13/18 13/18 14/15 14/16 15/21 17/25 19/4 20/6 20/12 56/10 56/18 59/2 76/18 81/22 exhibits [4] 4/1 4/3 13/16 18/19 exist [2] 119/8 123/22 exited [1] 87/11 expect [5] 37/25 66/13 75/14 117/3	122/3 expected [2] 95/3 121/9 experience [6] 29/2 131/6 131/8 140/16 146/22 147/15 experiences [1] 123/25 expert [1] 123/22 expertise [1] 38/13 explain [3] 44/5 73/21 105/16 explained [3] 44/23 138/13 138/14 explaining [1] 45/5 explains [2] 77/3 85/12 explanation [1] 91/25 exposed [3] 35/3 81/17 101/1 Express [1] 23/17 expressed [1] 59/20 extensive [2] 62/7 144/17 extra [3] 135/25 136/9 152/12 eyes [1] 141/14
E each [17] 12/21 17/19 18/1 18/24 20/10 31/23 41/17 44/6 46/20 55/17 63/2 66/13 75/16 92/4 104/12 132/1 148/11 earlier [3] 14/3 89/3 107/25 early [1] 66/14 ease [1] 30/15 easier [1] 76/14 easily [2] 68/19 106/1 easy [1] 135/20 eat [1] 138/23 education [1] 29/7 effect [2] 70/17 83/20 EGD [4] 130/3 130/7 130/11 141/12 EGDs [1] 64/9 egregious [1] 94/2 eight [2] 70/4 96/6 EIGHTH [1] 1/1 EIS [2] 42/4 42/6 either [15] 9/12 10/15 12/5 16/1 18/2 23/25 33/7 43/25 45/10 59/18 74/20 92/8 99/19 104/11 143/2 EKG [1] 88/13 Eladio [1] 97/24 elderly [2] 129/14 129/15 else [16] 29/9 42/9 44/18 54/11 71/14 73/14 74/4 95/25 99/16 105/2 109/11 144/4 148/6 150/25 153/24 157/2 emailing [1] 37/12 emergency [1] 144/2 employee [2] 14/21 14/21 employees [3] 8/17 61/18 134/22 empty [3] 155/20 155/23 155/24 enables [1] 24/13 end [20] 63/21 88/7 88/9 88/13 88/17 89/3 95/10 95/24 96/2 96/9 96/17 98/8 100/19 104/15 122/12 126/24 149/4 150/7 150/8 150/8 ended [4] 53/24 94/25 95/14 96/12 endo [6] 135/8 145/14 145/16 146/12 146/13 146/14 endoscope [3] 61/6 65/15 68/15 endoscopes [1] 73/16 endoscopic [5] 34/11 35/10 35/20 35/22 69/2 endoscopies [3] 40/20 64/10 68/17 endoscopy [19] 8/15 29/20 34/11 35/8 35/14 37/17 40/8 40/13 40/18 69/4 118/20 126/20 127/16 130/21 131/17 132/4 140/23 145/8 145/10 engaged [1] 34/17 enough [9] 34/1 59/22 69/4 104/9 114/10 128/12 129/9 147/9 157/18	facility [12] 8/17 10/20 11/3 19/16 36/4 44/21 61/19 67/17 127/13 132/6 137/5 157/16 fact [9] 35/19 61/3 62/6 67/22 72/19 74/15 78/16 119/6 151/13 factor [3] 34/10 73/14 116/9 factors [11] 31/25 32/9 32/13 34/19 34/21 35/18 35/21 36/3 110/22 114/15 115/17 failed [1] 129/7 Failure [3] 26/13 124/18 159/17 fair [2] 34/1 136/18 fairly [3] 62/7 85/3 144/17 faithfully [1] 5/5 false [3] 6/3 27/16 125/21 familiar [3] 13/20 53/12 56/11 far [33] 9/12 10/10 18/19 21/23 25/1 34/15 49/18 54/5 63/13 68/2 100/1 101/12 107/7 117/7 127/22 128/16 132/3 132/16 139/11 143/3 144/11 144/25 145/24 146/23 147/7 148/22 152/24 156/3 157/8 157/12 158/2 159/2 160/13 fast [4] 127/24 128/5 130/6 135/23 faster [6] 70/24 128/2 128/4 128/10 131/18 132/2 February [1] 8/19 fecal [1] 153/24 Fed [1] 19/14 Fed-Ex [1] 19/14 Federal [1] 23/17 feed [1] 64/20 feel [3] 136/21 141/24 141/25 feeling [2] 141/17 141/18 feels [1] 156/20 fell [1] 85/25 fellowships [1] 131/12 felt [1] 138/16 female [2] 72/14 72/15 females [2] 129/14 129/15 few [5] 15/20 43/17 48/15 70/22 145/17 field [3] 40/4 145/4 156/14 fifteen [3] 137/6 138/1 138/4 figure [16] 82/2 85/12 86/11 88/1 89/25 90/3 90/5 99/8 105/18 106/5 107/17 118/5 118/12 121/21 121/22 121/25 figuring [2] 66/25 111/1 fill [3] 105/11 156/25 157/2 final [4] 56/13 71/6 103/12 107/21 find [22] 31/13 56/5 56/23 56/24 74/13 83/14 87/21 89/19 98/17 99/3 101/14 104/9 111/2 111/5 112/12	

RA 000296

<p>F</p> <p>find... [7] 112/15 117/12 117/14 118/10 119/4 119/6 119/8</p> <p>finding [3] 118/3 122/25 123/4</p> <p>findings [2] 100/24 108/10</p> <p>fine [9] 16/10 18/6 26/16 26/18 124/21 124/23 141/20 159/20 159/22</p> <p>finger [2] 16/12 77/12</p> <p>finish [2] 30/16 30/17</p> <p>finished [4] 88/21 95/19 143/1 151/25</p> <p>finishing [1] 143/2</p> <p>first [63] 5/5 6/9 6/16 8/11 9/19 15/20 15/24 16/4 16/8 16/11 16/14 17/2 19/20 20/22 27/22 28/4 31/1 31/5 43/7 43/15 43/18 46/9 47/3 47/7 47/9 47/9 47/11 50/8 50/17 52/16 52/17 53/6 53/18 61/10 69/12 69/14 70/21 70/22 79/6 79/8 81/10 82/4 85/16 85/18 85/19 90/13 91/5 92/21 92/23 92/25 93/15 94/18 107/11 118/17 122/20 126/2 126/8 130/12 131/3 132/5 134/13 158/10 158/16</p> <p>first one [1] 69/12</p> <p>Fischer [8] 42/3 50/1 50/20 51/1 54/18 58/14 60/1 79/11</p> <p>five [11] 43/3 44/12 45/9 97/19 104/16 128/8 128/13 129/3 143/15 149/3 152/15</p> <p>five-minute [2] 129/3 149/3</p> <p>flag [3] 37/22 112/4 112/14</p> <p>Flav [1] 136/8</p> <p>Flavor [1] 136/8</p> <p>flip [1] 56/10</p> <p>flow [2] 13/11 78/13</p> <p>flows [1] 52/8</p> <p>flush [4] 69/23 69/24 70/7 129/9</p> <p>flying [1] 140/6</p> <p>focus [2] 47/6 47/23</p> <p>focused [1] 98/13</p> <p>follow [6] 32/7 34/15 116/18 123/1 139/13 139/16</p> <p>follow-up [1] 123/1</p> <p>followed [1] 59/22</p> <p>following [8] 5/6 17/25 39/17 46/5 48/3 48/6 48/13 106/10</p> <p>follows [3] 6/18 28/6 126/10</p> <p>foot [3] 70/20 70/25 117/6</p> <p>forcep [2] 143/18 147/10</p> <p>forceps [6] 143/4 143/11 144/6 144/6 147/8 150/10</p> <p>foregoing [1] 161/12</p> <p>Foreperson [6] 2/3 2/4 6/16 28/4 112/18 126/8</p> <p>form [13] 4/7 4/8 4/9 4/10 4/11 4/12 9/14 10/25 18/25 19/8 19/17 19/18 31/18</p> <p>formal [2] 39/6 39/13</p> <p>forms [1] 12/25</p> <p>formulate [1] 54/24</p> <p>forth [8] 13/4 32/9 57/15 93/16 117/9 139/12 147/10 152/20</p> <p>Forty [1] 45/9</p> <p>Forty-five [1] 45/9</p> <p>forward [3] 68/13 93/18 113/22</p> <p>found [28] 60/7 65/3 65/23 70/17 72/24 73/19 86/15 93/23 94/2 100/22 102/5 102/9 102/10 102/12 102/21 104/2 105/25 108/9 108/20 109/12 109/22 113/25 117/17 120/13 135/14 141/19 152/16 157/22</p> <p>four [28] 30/24 57/10 57/11 64/18 80/9 83/2 90/16 90/18 93/6 93/10</p>	<p>94/17 97/19 97/22 106/12 106/17 107/6 115/1 116/21 119/22 143/15 144/24 152/15 154/16 154/16 156/16 156/18 156/22 157/7</p> <p>four-by-four [1] 154/16</p> <p>four-by-fours [4] 156/16 156/18 156/22 157/7</p> <p>four-year [1] 115/1</p> <p>fours [4] 156/16 156/18 156/22 157/7</p> <p>fourth [1] 102/12</p> <p>frail [1] 136/1</p> <p>frame [2] 30/25 111/16</p> <p>fraud [3] 6/2 27/15 125/20</p> <p>freezer [3] 15/17 23/19 23/21</p> <p>Friday [1] 48/5</p> <p>front [5] 12/17 20/2 22/10 53/9 61/1</p> <p>frozen [5] 23/3 23/4 23/5 23/13 23/17</p> <p>full [3] 47/11 49/8 161/13</p> <p>further [7] 26/2 109/16 113/6 116/12 123/14 124/9 159/6</p> <p>future [2] 100/15 101/1</p> <p>fuzzy [1] 114/15</p> <p>G</p> <p>gap [1] 93/10</p> <p>gaps [2] 93/7 93/7</p> <p>garbage [1] 79/7</p> <p>garments [1] 153/20</p> <p>gastro [1] 46/22</p> <p>gastroenterology [1] 41/12</p> <p>gastrointestinal [1] 40/15</p> <p>Gastrostomy [1] 41/5</p> <p>gave [8] 43/11 45/16 70/11 87/15 89/2 89/7 89/13 134/21</p> <p>Gayle [4] 42/2 50/20 50/24 54/18</p> <p>Geez [1] 8/4</p> <p>general [6] 11/19 98/25 110/3 113/21 128/2 136/19</p> <p>generally [6] 68/25 69/5 92/3 92/8 112/15 118/1</p> <p>generated [1] 88/17</p> <p>generic [2] 97/13 97/15</p> <p>genetic [21] 62/1 62/4 62/7 62/9 66/6 66/15 74/15 74/19 75/10 75/15 101/24 101/25 103/22 104/5 107/7 107/21 108/16 110/18 110/22 111/3 114/17</p> <p>genetically [5] 103/24 114/22 115/9 115/12 115/15</p> <p>genotype [4] 107/12 107/13 107/15 107/17</p> <p>gentlemen [5] 5/9 73/2 97/1 159/7 160/5</p> <p>get [63] 6/24 7/24 9/9 9/9 11/1 11/2 22/19 24/12 25/1 29/18 30/11 31/21 32/3 32/10 32/11 36/18 36/21 36/25 37/15 39/17 43/10 44/1 45/14 45/17 49/15 50/15 62/2 66/19 77/1 77/13 78/12 78/14 80/20 80/23 81/14 92/11 97/2 97/9 98/24 103/19 106/8 109/7 112/7 116/24 119/18 120/25 122/4 122/24 129/11 139/7 140/13 144/2 145/1 149/4 150/11 154/10 156/4 156/6 156/23 156/23 157/4 157/23 158/8</p> <p>gets [4] 11/7 23/5 119/13 156/21</p> <p>getting [13] 12/10 83/24 117/17 118/19 119/24 122/10 138/2 139/19 139/20 140/24 146/7 146/9 151/10</p> <p>GI [3] 127/10 127/11 127/20</p> <p>girls [1] 146/7</p> <p>give [13] 5/16 5/24 10/21 11/16 27/4 27/12 61/2 97/13 125/9 125/17 140/24 154/20 156/14</p>	<p>given [9] 83/16 83/21 83/23 106/24 107/16 137/15 137/17 140/18 146/17</p> <p>giving [2] 25/2 155/10</p> <p>glitch [1] 84/15</p> <p>glove [4] 52/24 151/25 152/2 157/8</p> <p>gloves [11] 151/11 151/13 151/23 151/24 152/2 152/4 152/9 152/10 152/21 152/25 157/9</p> <p>go [79] 5/10 7/5 15/18 18/21 19/2 24/5 33/12 36/6 37/10 42/18 44/21 45/25 47/16 47/18 47/21 47/25 48/8 50/4 50/17 52/13 55/18 56/8 56/18 56/21 57/2 59/6 60/3 61/7 61/25 62/12 63/13 65/13 68/13 68/13 68/24 69/10 69/25 71/5 73/12 73/25 77/8 78/11 78/25 83/11 83/20 84/5 87/18 90/8 98/4 98/8 98/9 100/13 108/24 112/16 113/9 113/10 116/14 121/9 131/4 132/21 132/23 134/22 134/24 135/19 139/21 140/7 140/15 142/9 142/10 144/5 145/5 151/2 152/1 153/3 153/17 154/6 155/2 157/3 157/6</p> <p>goal [1] 98/14</p> <p>God [3] 5/19 27/7 125/12</p> <p>goes [20] 12/12 14/12 19/7 39/13 42/21 60/21 61/5 68/20 68/23 73/6 77/20 83/11 87/7 93/25 106/25 122/11 122/16 138/6 150/24 158/14</p> <p>going [60] 5/10 8/3 8/21 10/17 11/14 13/15 13/23 15/18 15/22 15/23 16/8 18/20 19/2 19/4 29/15 40/5 46/15 46/16 47/23 48/11 50/6 52/3 56/17 56/18 58/13 59/23 60/8 60/24 63/18 73/2 74/5 75/23 76/8 77/12 78/1 78/9 79/12 83/10 86/23 94/22 95/25 97/2 111/13 112/7 112/16 112/16 120/18 121/13 126/18 128/11 130/10 130/11 132/16 138/17 141/23 141/24 147/11 156/21 159/1 159/4</p> <p>gone [8] 18/14 31/13 63/9 66/3 104/24 105/20 107/6 122/14</p> <p>good [3] 75/2 145/20 148/17</p> <p>gosh [1] 31/20</p> <p>got [51] 18/21 34/1 36/13 36/14 38/1 43/18 43/25 44/8 45/21 53/6 56/16 60/5 60/25 78/1 79/15 80/7 88/19 91/1 91/9 92/25 94/11 98/7 98/7 104/12 105/13 107/10 107/12 107/20 114/3 115/19 117/21 117/23 122/25 123/8 133/24 134/14 134/20 134/23 136/21 140/5 141/14 143/22 144/7 145/10 145/20 146/12 146/12 151/20 152/4 152/14 158/18</p> <p>gotten [5] 64/7 75/24 76/1 104/25 153/23</p> <p>government [1] 136/5</p> <p>gowns [3] 151/1 153/13 154/3</p> <p>GRAND [37] 1/4 2/1 2/21 4/3 5/10 5/17 6/17 15/19 15/21 19/3 26/2 26/9 26/11 26/11 27/5 28/5 56/9 56/17 56/22 59/2 60/25 63/19 73/2 86/24 87/12 117/8 124/14 124/16 124/16 125/10 126/9 159/4 159/13 159/15 159/15 160/6 160/11</p> <p>graph [7] 85/19 86/11 86/14 94/8 96/5 122/6 122/15</p> <p>graphs [1] 90/15</p> <p>gray [1] 122/21</p> <p>gross [3] 26/14 124/19 159/18</p> <p>group [9] 9/16 41/13 47/1 47/3 75/10 90/10 130/25 137/9 137/22</p> <p>grouping [2] 7/25 80/19</p> <p>groupings [1] 75/8</p>
--	---	--

G groups [2] 18/11 69/8 growth [1] 106/15 growths [1] 149/17 guarantee [1] 143/13 guarantees [1] 143/12 guess [8] 18/20 73/15 121/10 121/24 130/8 142/11 150/16 152/14 gurney [1] 153/7 gut [1] 129/17 guy [2] 138/24 148/16	24/10 28/12 28/18 29/5 29/14 29/17 30/7 30/9 35/25 38/15 40/10 43/1 44/2 44/19 46/23 66/11 86/9 97/5 98/13 98/19 99/1 99/6 99/11 99/20 100/4 100/9 100/23 100/25 101/2 101/7 102/8 102/16 103/19 111/4 111/9 112/8 119/15 hear [3] 109/5 111/23 150/3 heard [3] 136/14 150/2 158/22 hearing [1] 38/19 hearsay [4] 87/2 157/22 157/24 159/5 heart [1] 96/5 held [5] 26/16 112/21 124/21 130/2 159/20 help [11] 5/19 27/7 38/9 46/15 47/23 51/21 100/14 125/12 139/23 140/8 146/6 helped [2] 13/23 100/10 helps [1] 155/4 hemorrhoids [1] 149/18 Hep [7] 115/18 116/10 116/19 116/20 121/2 121/5 121/14 hepatitis [60] 8/7 12/4 17/13 19/11 21/18 21/18 29/19 29/24 30/12 31/21 32/8 32/15 32/21 32/24 32/25 33/1 33/4 33/17 33/18 34/7 34/21 35/1 36/4 37/13 61/12 61/20 61/21 66/10 66/12 67/13 67/17 72/11 76/22 81/3 81/9 81/12 102/7 102/14 103/13 109/15 111/18 112/1 112/9 113/12 114/11 115/3 115/16 116/8 117/2 117/4 118/16 118/21 118/22 120/21 122/3 122/3 123/5 123/7 127/1 151/18 heplock [1] 78/5 her [5] 5/7 50/23 51/1 54/2 110/4 here [39] 5/23 7/4 12/3 14/17 15/9 15/22 16/9 16/14 20/25 26/25 27/11 41/24 56/17 62/13 69/11 77/13 77/23 78/17 78/18 79/2 82/4 82/21 82/22 83/2 86/1 86/11 87/21 90/9 91/16 91/22 92/15 92/18 94/7 100/9 108/19 119/3 121/6 122/6 125/16 hereby [1] 161/7 hey [1] 65/9 hide [2] 151/13 157/9 high [1] 37/15 higher [1] 117/1 him [22] 25/15 58/15 72/14 73/5 127/18 127/23 128/6 128/7 128/20 129/19 129/23 133/18 135/22 138/7 141/12 146/3 148/24 149/7 151/6 152/17 154/17 157/6 him but [1] 141/12 his [16] 7/1 7/4 73/5 73/7 73/7 88/21 103/4 103/5 103/7 103/9 130/25 133/18 138/8 138/9 139/5 141/5 hit [2] 97/9 134/24 HIV [7] 17/13 21/18 61/21 112/6 112/7 122/3 151/19 hold [2] 141/22 156/22 holding [1] 80/18 hole [1] 64/20 home [4] 45/25 138/12 142/8 142/9 hospital [4] 132/11 142/24 144/22 145/2 hot [1] 154/4 hour [6] 43/13 45/9 89/13 91/22 91/23 96/10 hours [6] 91/24 91/24 102/4 106/12 106/17 107/6 how [79] 8/10 12/12 19/13 22/3 28/13 29/22 30/21 31/4 32/24 39/15 45/8 45/18 46/20 47/25 49/1 49/23 51/20	52/8 52/8 55/14 55/15 55/19 55/23 56/1 57/15 61/15 73/7 73/18 77/3 81/12 81/13 81/17 91/25 94/1 98/8 98/9 100/21 100/25 101/14 104/12 105/8 105/12 105/13 105/14 105/16 105/16 105/25 106/19 107/9 108/2 108/2 111/13 114/7 122/1 122/2 122/4 123/6 123/23 126/16 127/18 128/5 128/18 131/9 133/4 133/15 133/21 134/5 136/22 137/3 137/9 140/4 143/20 143/20 146/15 152/16 152/21 154/16 157/12 158/14 however [1] 58/25 Hubbard [7] 52/22 53/9 72/16 80/15 82/6 97/18 109/21 huge [1] 118/4 huh [4] 91/2 130/6 147/3 149/2 Human [1] 21/20 hundred [8] 75/12 81/5 134/24 134/24 135/1 135/3 140/5 154/6 hung [1] 102/15 hurt [1] 141/12
H H-A-W-K-I-N-S [1] 126/5 had [219] hadn't [1] 103/9 half [9] 43/13 82/14 82/15 89/13 96/10 135/13 150/20 152/14 158/19 hall [1] 51/11 hand [8] 5/14 18/8 27/2 52/25 125/7 149/10 157/7 158/15 handle [2] 49/1 69/13 handled [3] 22/5 74/24 157/13 handling [2] 11/23 21/23 hands [2] 10/12 152/13 hanging [2] 151/8 151/9 happen [8] 33/20 82/14 92/15 112/12 112/13 118/13 140/25 150/4 happened [22] 37/8 52/19 53/20 53/25 72/17 74/18 82/20 87/6 93/9 93/15 98/24 99/5 99/10 105/7 105/16 110/25 111/6 118/12 119/12 138/13 138/14 140/11 happening [5] 59/11 70/12 71/24 100/15 105/5 happens [7] 10/15 35/25 39/2 52/8 78/16 142/4 153/8 hard [1] 91/21 has [15] 20/12 26/3 30/5 32/1 32/8 50/23 85/21 93/19 97/3 106/12 106/17 110/12 143/18 158/9 160/12 have [227] having [12] 5/5 6/16 28/4 31/10 36/3 82/25 92/6 120/24 126/8 132/22 140/23 158/7 HAWKINS [4] 3/5 126/5 126/7 126/14 he [103] 7/3 7/4 7/4 58/18 72/7 72/14 72/19 73/6 73/7 73/8 93/12 103/6 103/7 103/9 127/24 128/2 128/9 128/10 129/21 130/2 130/4 130/6 131/3 131/4 131/4 132/21 132/22 133/1 133/14 133/15 133/16 134/20 134/21 134/23 135/15 135/16 135/16 135/17 135/19 135/21 135/23 135/24 136/1 136/9 138/6 139/1 139/3 139/3 139/4 139/7 139/8 139/8 141/3 141/4 141/5 141/6 141/11 143/10 144/8 148/2 149/4 149/4 149/5 149/8 149/8 149/9 149/10 149/11 149/12 149/19 149/20 149/22 150/15 150/15 150/17 150/19 150/20 150/25 150/25 151/2 151/3 151/7 151/9 152/10 152/15 152/16 152/19 152/23 154/13 154/15 154/15 154/17 154/19 154/20 156/3 156/8 156/18 156/20 156/21 156/25 157/3 157/5 157/9 he'd [2] 129/22 133/10 he's [3] 7/2 38/19 156/21 head [1] 56/5 heading [1] 138/5 health [55] 7/3 7/9 7/13 7/15 7/18 7/22 7/23 8/13 9/13 9/15 9/22 11/9 12/3 15/5 16/25 17/6 17/12 17/17	help [11] 5/19 27/7 38/9 46/15 47/23 51/21 100/14 125/12 139/23 140/8 146/6 helped [2] 13/23 100/10 helps [1] 155/4 hemorrhoids [1] 149/18 Hep [7] 115/18 116/10 116/19 116/20 121/2 121/5 121/14 hepatitis [60] 8/7 12/4 17/13 19/11 21/18 21/18 29/19 29/24 30/12 31/21 32/8 32/15 32/21 32/24 32/25 33/1 33/4 33/17 33/18 34/7 34/21 35/1 36/4 37/13 61/12 61/20 61/21 66/10 66/12 67/13 67/17 72/11 76/22 81/3 81/9 81/12 102/7 102/14 103/13 109/15 111/18 112/1 112/9 113/12 114/11 115/3 115/16 116/8 117/2 117/4 118/16 118/21 118/22 120/21 122/3 122/3 123/5 123/7 127/1 151/18 heplock [1] 78/5 her [5] 5/7 50/23 51/1 54/2 110/4 here [39] 5/23 7/4 12/3 14/17 15/9 15/22 16/9 16/14 20/25 26/25 27/11 41/24 56/17 62/13 69/11 77/13 77/23 78/17 78/18 79/2 82/4 82/21 82/22 83/2 86/1 86/11 87/21 90/9 91/16 91/22 92/15 92/18 94/7 100/9 108/19 119/3 121/6 122/6 125/16 hereby [1] 161/7 hey [1] 65/9 hide [2] 151/13 157/9 high [1] 37/15 higher [1] 117/1 him [22] 25/15 58/15 72/14 73/5 127/18 127/23 128/6 128/7 128/20 129/19 129/23 133/18 135/22 138/7 141/12 146/3 148/24 149/7 151/6 152/17 154/17 157/6 him but [1] 141/12 his [16] 7/1 7/4 73/5 73/7 73/7 88/21 103/4 103/5 103/7 103/9 130/25 133/18 138/8 138/9 139/5 141/5 hit [2] 97/9 134/24 HIV [7] 17/13 21/18 61/21 112/6 112/7 122/3 151/19 hold [2] 141/22 156/22 holding [1] 80/18 hole [1] 64/20 home [4] 45/25 138/12 142/8 142/9 hospital [4] 132/11 142/24 144/22 145/2 hot [1] 154/4 hour [6] 43/13 45/9 89/13 91/22 91/23 96/10 hours [6] 91/24 91/24 102/4 106/12 106/17 107/6 how [79] 8/10 12/12 19/13 22/3 28/13 29/22 30/21 31/4 32/24 39/15 45/8 45/18 46/20 47/25 49/1 49/23 51/20	however [1] 58/25 Hubbard [7] 52/22 53/9 72/16 80/15 82/6 97/18 109/21 huge [1] 118/4 huh [4] 91/2 130/6 147/3 149/2 Human [1] 21/20 hundred [8] 75/12 81/5 134/24 134/24 135/1 135/3 140/5 154/6 hung [1] 102/15 hurt [1] 141/12 I I'll [9] 19/4 30/16 50/4 51/1 60/17 61/3 76/17 82/3 143/4 I'm [46] 7/8 7/12 8/3 13/15 15/18 15/19 15/22 15/23 16/8 18/20 19/2 19/4 20/8 20/8 28/11 29/15 36/23 51/2 51/16 56/9 56/18 60/24 63/12 63/18 67/25 73/2 76/8 77/11 81/21 84/6 86/23 105/21 115/8 119/17 123/22 126/15 126/18 128/17 130/13 130/17 137/2 144/21 144/24 148/25 159/1 159/4 I've [7] 28/15 28/16 29/11 56/16 71/7 144/21 150/2 I.D [2] 20/18 21/3 idea [4] 89/7 105/4 136/17 157/21 identified [29] 4/3 15/1 34/9 35/22 36/7 37/11 44/11 44/24 52/24 59/18 61/22 62/2 66/14 67/16 71/15 71/21 97/14 101/19 101/20 101/23 101/24 103/1 103/12 103/14 103/22 119/5 120/25 122/17 123/9 identifier [10] 10/19 11/16 14/23 15/3 15/6 15/10 17/4 23/7 97/13 97/15 identifiers [4] 10/21 11/20 14/3 14/6 identifies [2] 17/9 21/14 identify [12] 14/20 19/13 30/3 98/15 98/18 98/21 101/21 102/2 102/19 103/10 112/17 118/6 identifying [1] 121/6 Ihsan [1] 39/12 immediately [1] 39/14 Immunodeficiency [1] 21/20 IMPANELED [1] 1/4 impervious [1] 154/6 implying [1] 119/18 important [1] 147/8 impression [1] 55/7 improper [1] 69/18 inaccuracies [1] 25/23 inaccuracy [1] 87/15 inches [1] 149/13 incidence [2] 116/19 116/20 incident [2] 119/23 140/22 incidents [1] 111/15 include [3] 14/5 33/4 34/24 included [4] 14/11 19/14 20/1 22/9 includes [2] 7/18 25/8 including [6] 26/8 51/24 61/18 101/5 124/13 159/12 incomplete [1] 114/6

incorporating [1] 25/2	interested [1] 53/4	IV's [1] 141/9
incorrectly [1] 87/8	intern [2] 2/24 97/3	J
incubation [3] 120/6 120/8 121/18	internal [1] 149/17	January [9] 8/4 8/4 8/5 29/16 39/16
independent [2] 145/4 145/5	internally [1] 25/3	39/18 47/15 49/6 126/19
independently [1] 29/25	Internet [1] 59/6	jaundice [1] 33/4
INDEX [2] 3/1 4/1	interpret [1] 24/22	jaws [3] 143/13 143/21 143/22
indicate [1] 116/7	interpretation [2] 24/18 24/24	Jeff [1] 97/21
indicated [2] 160/12 161/10	interrupt [1] 38/17	job [7] 28/23 36/25 121/5 127/9
indicates [1] 91/5	intervening [1] 80/20	141/15 145/24 146/4
indication [3] 50/9 91/15 106/8	interview [6] 32/12 55/4 66/9 102/15	jobs [2] 146/12 146/12
individual [2] 32/6 101/2	102/18 102/19	JOSEPH [1] 2/4
individually [1] 22/6	interviewed [1] 55/5	jostle [1] 135/18
individuals [10] 14/1 33/17 33/19	interviewing [1] 59/17	JUDICIAL [1] 1/1
67/23 98/1 100/14 104/14 119/10	intravenous [1] 34/25	July [15] 18/3 36/10 37/20 67/4 70/19
138/20 138/21	introduced [1] 104/25	71/2 74/16 75/20 101/20 101/22
industry [1] 131/7	invert [1] 149/15	103/18 104/18 108/12 115/2 127/5
infect [2] 84/3 105/23	investigate [2] 30/2 73/8	July 25th [5] 37/20 70/19 101/20
infected [34] 16/1 18/2 33/12 61/12	investigated [2] 31/23 102/10	104/18 115/2
62/3 62/23 64/5 66/2 66/4 66/6 67/7	investigation [69] 5/17 5/24 8/12 8/15	June [1] 122/24
67/8 67/10 78/24 90/24 91/6 91/12	12/14 12/16 13/23 27/5 27/12 31/4	JUROR [1] 110/10
98/15 98/16 101/22 104/13 107/24	31/13 31/16 31/18 32/5 32/6 33/25	JURORS [1] 2/1
108/6 109/14 110/17 112/1 112/4	36/7 36/24 37/11 40/3 42/5 42/7	jury [42] 1/4 2/21 4/3 5/10 5/17 6/17
114/7 117/5 117/19 118/11 118/14	42/12 42/13 42/15 42/23 44/6 45/6	15/19 15/21 19/4 20/10 26/2 26/5
120/4 121/2	47/12 51/14 51/15 56/14 58/4 58/10	26/9 26/11 26/12 27/5 28/5 56/10
infecting [1] 81/24	59/10 59/16 60/9 60/23 61/20 65/9	56/17 56/22 59/2 60/25 63/19 73/2
infection [12] 33/3 52/23 53/3 71/15	66/8 70/9 71/25 72/8 73/6 73/7 74/11	76/14 86/24 87/12 109/19 116/13
73/22 74/23 74/25 92/1 110/3 112/1	74/13 84/8 86/9 87/5 98/10 98/13	117/8 124/14 124/16 124/17 125/10
112/6 120/7	98/20 99/1 99/3 99/14 99/15 100/1	126/9 159/4 159/9 159/13 159/15
infections [6] 85/10 91/9 93/15 93/19	100/3 100/10 100/23 101/10 101/17	159/16 160/6 160/12
120/16 120/21	108/17 111/4 125/10 125/17 155/11	just [98] 13/17 14/9 15/23 15/23
infectious [7] 29/5 29/13 60/12 68/9	investigations [3] 38/15 98/12 100/20	16/21 17/18 17/22 18/21 20/24 25/2
72/3 81/6 81/8	investigative [3] 30/9 34/4 100/6	28/24 30/4 30/14 31/20 31/21 33/23
infield [1] 108/16	investigator [3] 32/3 37/14 99/21	38/17 38/17 41/20 42/9 43/7 44/2
informal [1] 39/5	investigators [6] 31/12 34/3 34/6	44/20 45/4 45/17 46/16 49/25 51/2
information [50] 11/6 11/7 11/10	34/8 36/21 46/14	52/3 52/16 54/13 56/10 56/12 56/20
11/13 16/6 18/1 19/24 20/19 22/13	involve [2] 12/4 121/13	57/1 58/22 69/4 70/22 73/25 76/9
22/15 24/11 25/7 25/18 25/19 25/19	involved [22] 7/24 8/5 8/10 8/24 12/3	77/11 77/25 79/6 82/10 83/3 83/8
26/11 31/8 35/24 38/6 44/25 45/5	24/6 24/18 25/12 25/17 29/8 29/11	83/13 83/18 83/23 84/1 84/2 85/8
47/22 48/14 54/25 56/20 58/25 59/9	29/18 29/22 32/3 36/18 36/25 39/22	87/7 87/20 89/17 90/11 93/25 94/15
59/15 61/2 65/8 68/4 70/10 77/5	62/22 76/19 119/16 152/19 152/23	95/2 104/21 106/6 107/16 108/10
84/13 87/1 87/4 96/6 98/10 100/5	involving [4] 6/4 8/21 27/16 125/22	108/13 111/18 112/5 112/12 112/16
102/23 103/5 103/18 107/7 107/10	is [244]	115/15 116/10 116/16 117/15 119/8
107/11 107/16 114/10 117/15 124/16	isn't [2] 69/4 99/13	121/5 121/13 123/10 123/21 123/24
159/15	isolate [1] 7/21	130/7 133/19 135/7 136/15 136/19
initial [11] 42/17 43/4 43/5 43/6	issue [23] 50/16 53/3 54/14 60/10	137/14 139/1 141/4 141/15 141/16
44/20 46/13 84/7 95/20 101/16	64/14 71/19 74/1 76/10 84/15 95/8	141/21 142/25 145/21 148/4 149/10
122/18 123/1	106/14 106/18 107/5 119/9 138/16	153/9 153/20 155/18 157/6 160/14
initially [10] 32/2 36/14 50/6 82/20	152/8 154/11 154/13 155/17 156/1	K
99/15 107/11 122/15 146/4 148/5	156/11 157/8 158/5	KANTILAL [4] 1/10 6/4 27/17 125/22
148/7	issues [19] 24/4 32/9 52/23 52/25	keep [9] 10/17 13/23 13/25 22/4
initiate [1] 10/15	54/25 57/24 66/19 66/20 66/24 66/25	82/19 132/19 140/3 152/4 153/6
initiated [2] 9/14 88/19	69/13 71/19 73/20 74/24 86/16 101/3	KEITH [6] 1/11 6/5 27/17 58/14 97/17
injected [3] 81/2 82/24 82/25	110/3 160/8 160/12	125/23
injection [10] 69/12 69/19 71/6 74/23	it [328]	kept [2] 60/8 72/14
76/10 77/21 78/14 78/15 108/22	it's [57] 7/13 10/22 10/24 11/10 11/25	kids [1] 146/6
118/7	15/21 17/3 18/15 20/10 21/17 22/8	kind [48] 9/16 10/17 12/5 18/1 20/10
injections [1] 83/16	30/5 30/7 38/12 54/9 55/12 56/25	31/9 37/5 40/23 45/17 46/17 52/2
inner [1] 152/4	57/1 60/18 68/21 73/9 77/21 78/7	56/20 58/8 58/9 59/20 63/4 68/20
instance [1] 84/9	78/9 79/17 81/5 81/19 85/20 87/2	70/6 71/23 76/11 76/12 81/7 91/21
instances [2] 11/15 78/4	87/24 91/21 94/10 94/13 94/15 98/16	94/4 95/19 98/10 98/14 100/15
instead [3] 150/19 152/13 158/7	98/18 99/2 105/9 106/16 107/13	100/21 104/12 105/12 105/15 105/23
institute [1] 154/14	114/15 116/10 121/7 122/7 122/13	108/13 110/25 114/15 116/4 122/7
instruct [1] 146/6	137/14 140/13 140/14 141/20 153/19	128/19 129/5 130/14 136/20 136/22
insurance [3] 6/2 27/15 125/20	154/4 154/5 154/6 155/3 155/8	144/18 147/5 151/5 153/13 154/14
integral [1] 8/14	156/19 159/5	kinds [2] 98/11 128/25
integrity [1] 23/18	item [9] 35/13 61/10 62/13 63/24	King [1] 136/7
intention [1] 100/2	63/25 65/14 68/14 71/6 108/25	knew [9] 36/11 36/15 37/19 55/14
intentional [3] 74/1 75/2 103/6	items [5] 62/19 64/4 64/12 69/11	55/15 59/23 117/22 139/8 148/20
intentionally [4] 72/7 72/11 72/22	71/7	know [96] 8/20 8/23 15/21 24/1 31/21
75/23	its [2] 69/4 78/21	34/13 41/3 43/22 44/4 49/1 51/2
interacting [1] 11/12	itself [6] 24/19 52/11 67/24 71/25	51/13 51/19 51/19 51/20 53/11 56/2
interaction [1] 127/12	98/2 101/6	56/2 56/15 60/25 61/1 68/8 72/3 74/2
	IV [9] 69/15 69/20 69/23 70/7 70/20	
	70/25 71/4 78/5 131/23	

K know... [72] 76/11 81/12 81/13 93/3 98/7 99/9 99/14 100/8 104/23 105/6 105/7 105/12 108/18 112/3 112/7 112/10 114/13 115/16 115/17 115/22 116/10 117/19 117/20 119/13 119/17 121/11 122/2 123/18 123/22 123/25 124/1 127/18 129/23 131/7 131/15 133/15 133/17 134/5 135/4 135/10 135/21 135/22 136/16 137/18 138/23 139/8 139/11 140/10 141/4 141/8 141/15 142/23 143/17 143/20 145/17 148/20 149/22 150/16 151/10 152/7 152/16 154/19 154/20 156/19 156/21 156/24 157/10 157/21 157/25 158/9 158/23 158/24 knowledge [1] 147/14 known [6] 46/24 81/8 81/9 118/16 121/1 128/9 Kruiger [1] 97/21	left [16] 21/2 48/3 48/6 50/2 53/24 71/23 77/9 81/14 90/2 90/20 93/12 106/10 139/1 144/12 145/22 157/16 leftover [1] 53/7 lend [1] 7/4 length [2] 69/1 89/21 lengths [1] 91/15 Leone [1] 97/18 less [3] 83/10 83/10 131/21 let [13] 20/24 56/23 56/24 61/15 76/25 83/14 86/8 97/8 137/5 137/17 142/1 142/9 142/10 let's [7] 56/1 56/8 62/16 76/9 87/20 90/25 121/21 lets [1] 104/12 letter [1] 39/7 letters [1] 12/17 level [6] 32/3 33/10 119/21 121/9 121/19 152/19 levels [1] 152/23 licensing [3] 42/24 43/2 44/15 lidocaine [3] 106/24 107/1 107/4 light [4] 33/5 35/24 145/12 145/13 light-colored [1] 33/5 like [69] 19/6 24/2 29/9 32/9 34/14 34/18 38/4 46/2 47/19 49/16 50/8 51/8 53/2 59/7 62/22 65/8 68/11 81/6 83/24 84/25 86/25 88/1 89/21 96/9 96/22 100/11 107/6 109/2 112/6 112/25 115/21 115/24 119/3 121/7 130/3 131/11 131/12 131/16 132/17 133/17 133/19 133/23 135/5 135/10 136/11 136/23 140/6 140/6 140/7 142/12 142/23 143/4 144/5 145/22 147/2 147/7 150/4 150/11 150/12 150/13 151/2 151/9 152/15 152/21 155/2 155/2 156/17 158/8 158/19 liked [1] 142/16 likely [14] 64/13 71/14 72/20 73/22 74/25 75/2 76/5 83/18 83/25 93/8 109/7 109/14 110/17 115/19 limited [1] 145/13 LIMS [1] 11/10 Linda [7] 52/21 53/9 72/16 80/15 82/6 97/18 109/21 line [13] 17/8 35/13 43/18 69/23 90/11 90/12 90/14 108/13 122/5 122/8 122/17 122/20 122/21 lined [2] 54/1 153/2 lines [7] 35/15 63/25 69/15 90/9 91/21 92/16 137/16 link [2] 110/15 114/23 linked [8] 31/10 38/1 40/16 63/10 68/21 115/9 115/12 115/15 links [4] 30/3 37/1 63/25 66/17 liquid [1] 22/21 LISA [1] 2/9 list [16] 19/19 35/5 61/10 97/14 97/20 97/21 102/5 102/6 102/17 103/9 110/16 111/1 114/2 114/6 117/23 118/22 listed [10] 19/11 20/2 21/9 86/13 87/14 87/24 94/5 102/24 103/7 103/9 listing [1] 19/25 lists [7] 17/25 19/11 19/12 19/14 19/16 20/21 102/10 literally [1] 148/10 little [25] 16/7 28/24 29/17 31/11 40/11 40/12 43/11 49/16 50/16 53/24 77/1 111/19 122/13 129/17 135/25 136/2 136/9 138/18 141/14 143/19 143/19 149/21 154/21 155/8 156/6 living [3] 7/7 28/10 126/14 load [2] 123/6 145/7	loads [1] 134/12 local [3] 25/11 35/20 38/15 located [2] 40/7 40/9 location [2] 19/16 127/9 locations [1] 136/21 log [3] 12/25 14/18 88/24 logs [2] 13/4 47/5 long [15] 28/13 45/8 47/25 69/4 91/20 106/1 106/19 126/16 128/5 129/23 130/15 131/9 136/22 137/3 143/10 longer [4] 91/20 93/7 97/5 138/18 look [30] 13/19 16/9 31/22 32/8 32/12 34/22 35/6 36/2 45/6 46/17 47/22 48/18 55/19 57/2 58/2 62/17 70/14 74/7 84/24 92/16 116/21 118/24 119/9 142/1 145/18 147/9 149/16 151/7 151/9 154/18 looked [15] 58/9 60/12 60/15 60/16 61/8 65/10 65/22 73/13 73/17 85/6 88/25 96/9 105/22 108/5 117/9 looking [23] 14/17 19/6 20/7 20/15 34/13 34/15 34/20 47/2 47/7 49/20 50/5 51/7 64/1 65/15 66/16 77/2 105/25 108/1 108/2 122/1 122/16 123/6 139/4 looking at [1] 47/2 looks [1] 19/6 lot [23] 62/2 86/15 87/25 90/2 109/21 109/22 110/25 111/22 113/1 120/25 121/13 122/22 123/1 123/4 123/10 124/4 129/17 131/18 132/18 136/3 136/4 140/9 141/5 lots [2] 46/16 46/16 LOUISE [1] 2/5 lounge [2] 133/14 133/16 loved [2] 142/19 142/20 low [1] 134/8 lower [4] 28/24 32/3 69/1 69/6 lube [1] 154/17 lubricant [9] 150/13 150/18 152/25 154/18 154/24 155/1 155/5 155/18 155/22 lubrication [1] 154/12 lunch [2] 93/8 93/9 lung [1] 109/7 Lynette [1] 97/20 LYONAIS [1] 2/10
		M M-E-L-V-I-N [1] 126/4 ma'am [1] 5/14 machine [2] 158/12 158/17 machines [1] 146/16 made [20] 12/15 25/14 26/10 37/14 39/3 39/5 39/22 43/3 43/4 45/11 72/8 73/4 94/6 103/16 108/7 108/19 108/20 109/22 124/15 159/14 main [3] 43/18 129/9 150/8 maintain [4] 23/13 23/18 23/18 23/21 maintains [1] 14/23 major [8] 31/24 34/20 53/2 54/12 54/14 66/25 114/14 115/17 majority [5] 111/25 114/1 117/16 138/10 158/21 make [29] 11/24 25/22 33/22 38/23 39/6 39/25 43/6 46/4 50/11 55/1 69/4 76/14 78/21 81/16 99/6 100/3 100/3 104/6 104/10 104/21 108/3 110/15 118/12 143/20 143/23 147/10 149/16 155/19 155/24 man [1] 139/1 manage [1] 121/14 managed [2] 37/15 121/3

<p>M</p> <p>management [7] 11/7 20/19 22/15 24/11 25/7 60/7 123/5 manager [2] 7/8 7/11 manipulate [1] 148/18 manner [2] 73/18 89/16 manufacturer's [1] 54/9 manufacturing [1] 123/18 many [26] 19/13 30/21 49/23 51/20 55/14 55/15 55/20 55/23 56/1 61/15 86/12 114/7 122/1 122/2 122/4 122/10 128/18 133/21 134/5 139/2 150/12 151/11 151/11 152/10 152/11 152/21 March [3] 126/24 126/24 144/13 March 31st [1] 144/13 marginal [1] 146/11 marines [2] 144/23 145/6 marked [4] 13/17 13/18 56/9 59/2 markings [1] 91/22 masks [1] 151/11 master's [1] 29/4 match [7] 11/24 89/10 89/12 103/24 114/2 114/5 115/5 matched [3] 11/3 84/24 108/8 matches [4] 62/4 62/9 75/12 97/16 matching [1] 103/22 material [3] 12/6 22/22 153/24 MATHAHS [6] 1/11 6/5 27/18 58/14 97/17 125/23 mathematically [1] 83/18 matrix [1] 34/14 matter [4] 61/3 73/4 73/10 161/9 maximum [1] 120/8 may [23] 5/21 13/16 26/16 26/22 27/9 35/10 40/10 44/9 51/15 74/11 104/5 104/5 105/1 111/17 111/23 114/12 122/12 122/24 124/21 125/2 125/14 159/20 160/1 maybe [7] 29/16 33/19 41/4 45/9 72/9 135/17 140/3 McCord [4] 1/25 5/4 161/6 161/19 McDowell [1] 97/20 me [30] 13/20 16/20 20/24 30/15 37/4 44/20 51/24 52/3 56/7 56/20 56/23 56/24 57/3 61/15 72/7 76/25 83/14 86/8 87/20 94/7 97/8 103/5 136/17 146/20 148/3 148/17 148/21 148/21 154/11 157/14 mean [21] 30/21 33/18 41/24 50/7 53/11 56/1 89/13 89/18 91/17 95/16 117/9 119/7 137/10 138/21 139/4 140/6 147/2 155/1 155/3 155/4 156/19 Meana [1] 16/15 meaning [1] 81/6 means [4] 99/23 109/3 116/5 145/5 meant [1] 100/13 mechanism [3] 72/3 74/8 92/11 Medicaid [1] 142/12 medical [17] 16/16 32/11 35/1 35/5 41/12 46/21 112/3 124/7 127/20 128/9 130/20 137/21 137/22 141/2 144/21 144/25 145/4 Medicare [2] 142/11 142/12 medication [6] 80/12 137/16 137/17 137/18 138/20 140/12 medications [1] 69/14 medium [1] 128/2 meet [6] 39/19 39/24 41/23 41/24 42/8 43/10 meeting [12] 39/21 42/15 42/17 43/14 43/21 44/20 45/8 45/14 45/21</p>	<p>46/13 59/25 150/15 meetings [2] 8/16 146/19 Melissa [1] 42/2 MELVIN [3] 3/5 126/4 126/7 member [5] 62/5 62/15 64/17 72/10 117/8 members [7] 61/21 64/15 71/10 72/10 75/25 79/13 86/20 memory [1] 57/2 mention [1] 109/1 mentioned [11] 14/3 88/5 106/7 109/21 113/23 152/24 153/1 153/12 153/12 154/12 156/16 met [2] 60/6 72/7 metal [1] 77/19 methods [1] 102/1 MICHAEL [2] 2/17 2/22 mid [1] 36/10 middle [6] 31/6 64/22 90/11 92/16 122/6 148/12 might [10] 8/24 11/19 23/16 31/22 63/2 68/9 76/13 80/17 80/19 153/23 military [1] 136/3 million [1] 109/13 minimal [1] 157/4 minimum [1] 120/9 minor [1] 53/1 minute [7] 86/2 86/22 96/23 129/3 129/20 130/5 149/3 minutes [33] 45/9 85/24 85/25 86/5 86/21 94/17 94/20 94/23 94/23 94/25 95/2 95/4 95/6 95/10 95/14 95/22 95/23 96/1 96/3 96/7 128/8 128/13 128/18 131/13 131/15 131/16 131/21 137/6 137/11 137/12 137/23 138/1 138/4 misdemeanor [3] 26/14 124/19 159/18 miss [6] 6/22 6/23 6/24 7/1 7/6 149/24 missed [1] 111/24 misspoke [1] 7/13 mistakes [1] 108/19 mix [3] 62/24 62/24 68/18 mixing [1] 78/18 MMWR [1] 100/12 mode [2] 57/21 61/7 model [1] 106/4 modes [1] 60/22 moment [3] 15/23 74/1 76/9 Monday [1] 48/5 money [3] 6/3 27/15 125/21 monitor [10] 94/18 94/24 95/5 95/14 133/15 138/7 140/8 142/1 145/18 154/16 monitoring [3] 95/17 96/13 96/18 monitors [1] 88/11 month [7] 38/4 41/4 120/9 120/14 134/14 134/17 145/22 months [5] 36/12 120/9 120/10 120/12 121/17 morbidity [1] 14/24 more [25] 22/2 40/12 57/8 62/2 67/22 80/16 86/5 109/7 109/13 111/9 111/15 112/13 120/25 121/13 122/22 123/1 123/10 128/18 131/25 143/14 152/2 156/24 157/5 157/5 157/7 morning [4] 46/7 46/9 142/22 160/9 most [17] 33/11 37/6 45/24 51/23 78/4 90/4 94/2 107/13 116/25 117/3 117/19 136/2 142/11 144/22 146/11 154/1 155/1 mouth [4] 64/19 65/1 68/23 130/11 move [9] 49/16 61/3 63/18 63/18</p>	<p>70/23 78/23 82/3 92/6 92/9 moved [8] 17/18 84/1 112/19 113/2 119/2 134/3 134/4 157/13 moves [1] 52/9 moving [5] 93/16 112/24 113/3 149/8 149/9 MR [3] 6/21 87/11 126/14 Mr. [1] 28/10 Mr. Labus [1] 28/10 much [26] 47/17 48/24 66/15 81/12 81/14 81/17 93/6 105/8 105/12 105/13 105/14 122/14 123/6 128/22 129/2 133/15 139/25 150/13 154/13 154/16 154/19 154/21 154/24 155/3 155/21 158/14 Mukherjee [1] 97/25 multiple [6] 11/20 54/3 57/17 57/18 70/1 106/16 mutation [1] 75/12 my [16] 29/12 30/16 36/24 37/4 46/14 51/23 56/5 77/12 87/9 120/18 133/23 141/15 144/22 148/18 152/13 161/11 myself [1] 42/23</p> <p>N</p> <p>name [14] 6/9 7/1 11/4 11/5 14/19 16/14 20/22 22/13 27/22 43/1 50/23 102/17 102/25 114/4 names [6] 14/1 14/9 14/11 102/9 103/8 126/2 nationwide [2] 35/8 71/20 nausea [1] 33/4 Naval [1] 145/2 navy [1] 145/3 near [2] 117/6 122/12 neat [1] 142/3 necessarily [3] 59/22 84/6 87/14 necessary [1] 87/4 need [15] 16/7 22/18 42/14 57/2 61/4 69/3 69/24 99/10 100/24 101/1 110/23 110/24 111/8 151/20 155/8 needed [12] 17/12 23/20 46/15 58/17 69/25 92/4 92/5 92/10 148/17 148/21 157/5 157/5 needle [21] 53/22 58/16 58/18 58/19 58/19 69/17 69/24 77/17 77/18 78/1 78/13 79/3 79/9 79/17 79/20 79/21 79/23 80/2 83/4 83/5 124/5 needles [5] 58/12 69/13 123/19 123/20 124/3 needs [2] 7/5 22/17 negative [4] 61/22 118/21 122/5 122/11 neglect [3] 6/2 27/14 125/20 neither [1] 64/12 Nellis [1] 131/15 NEVADA [39] 1/2 1/7 1/16 5/1 7/2 7/9 7/13 7/15 7/18 7/20 7/22 8/8 8/13 9/13 9/15 9/22 11/9 15/5 16/25 17/6 17/12 17/16 24/9 28/12 28/18 29/1 29/20 32/25 34/12 37/17 40/9 44/18 71/21 97/5 121/7 126/20 130/22 161/3 161/15 never [17] 33/13 69/25 70/24 71/3 103/12 112/2 112/3 121/8 134/5 134/22 134/23 135/21 144/15 146/12 146/17 146/20 148/2 new [18] 53/21 58/19 77/17 79/20 79/21 79/23 80/1 104/17 112/1 123/3 123/9 134/4 134/6 135/10 135/15 135/19 135/22 141/3 newly [3] 33/2 33/12 122/17 news [1] 109/6</p>
---	---	--

<p>N</p> <p>next [32] 5/11 19/23 19/25 21/6 21/11 21/12 30/18 35/25 40/16 41/17 46/22 48/15 53/20 55/6 62/18 63/14 63/24 65/14 68/14 79/20 79/25 81/24 81/25 81/25 82/9 83/2 106/21 107/4 112/22 122/8 139/20 160/14</p> <p>nice [2] 107/15 132/23</p> <p>nine [4] 23/22 28/16 28/17 119/24</p> <p>no [70] 1/9 1/25 14/11 24/21 24/23 25/23 31/23 35/21 39/23 42/11 42/20 44/20 46/3 50/9 50/9 56/5 62/21 63/16 64/6 66/2 68/11 69/22 70/8 70/13 71/1 71/2 72/12 72/21 72/23 74/6 74/12 75/1 75/4 78/9 81/15 85/12 97/5 105/6 105/9 105/14 105/18 106/11 108/20 109/16 110/21 112/2 113/10 114/11 115/6 116/8 127/7 132/21 134/18 136/17 138/1 139/15 139/19 140/20 142/5 143/21 143/23 144/16 147/6 148/2 149/25 154/25 155/23 157/21 160/10 160/11</p> <p>nobody [1] 61/22</p> <p>non [2] 104/16 109/14</p> <p>non-acute [1] 104/16</p> <p>non-clinic [1] 109/14</p> <p>none [7] 26/5 75/24 116/2 116/15 124/10 128/21 159/9</p> <p>normal [8] 36/24 79/3 94/15 122/2 122/8 122/9 122/13 138/10</p> <p>normally [1] 121/1</p> <p>nose [1] 141/20</p> <p>not [94] 7/3 8/4 8/23 8/23 9/23 24/3 28/20 32/7 32/16 33/1 34/16 35/10 39/23 44/2 51/16 52/14 52/24 53/3 57/15 58/11 58/22 59/22 64/5 64/22 67/25 68/11 68/21 70/8 71/20 73/3 73/9 73/21 73/22 74/18 78/23 79/10 81/3 81/5 81/6 82/10 83/25 84/6 84/19 85/20 87/13 87/15 89/19 95/11 98/15 98/17 99/3 99/8 99/15 99/19 99/23 101/21 102/25 103/24 104/8 105/1 105/19 106/2 106/11 106/16 106/20 108/20 111/5 112/7 112/10 112/16 115/15 116/5 118/2 118/9 118/19 119/15 119/17 121/1 123/22 131/6 136/16 136/19 140/20 140/21 145/24 147/20 148/4 148/15 148/25 155/23 156/1 157/18 158/2 158/4</p> <p>note [1] 52/20</p> <p>notes [6] 34/4 88/21 95/3 109/24 109/25 161/10</p> <p>nothing [15] 5/18 6/18 26/2 27/6 28/6 70/17 72/24 73/14 95/25 116/5 123/14 125/11 126/10 154/6 159/6</p> <p>notice [1] 33/11</p> <p>notification [1] 8/18</p> <p>notified [3] 9/5 9/6 111/18</p> <p>notify [1] 111/7</p> <p>now [80] 5/17 8/20 9/12 11/11 17/24 18/6 18/7 18/19 20/6 20/10 21/23 23/8 24/4 27/5 32/14 37/7 37/18 38/1 39/13 40/6 41/23 42/18 43/6 45/10 47/9 48/17 51/1 54/5 54/16 54/23 56/9 56/15 57/24 58/22 59/24 60/10 60/24 62/16 63/18 66/19 67/22 70/3 73/25 76/8 77/25 79/1 79/2 80/5 80/10 82/16 82/17 84/5 86/7 87/4 91/15 93/21 97/2 98/20 99/12 101/12 110/11 111/12 114/11 115/16 120/24 121/3 121/11 121/14 125/3 125/10 127/22 128/25 134/10 142/1 147/7 148/22 150/9 152/24 157/14 160/2</p>	<p>number [68] 10/22 10/24 11/4 11/4 11/8 11/8 12/18 12/23 13/18 13/19 14/16 14/16 14/22 15/7 15/7 15/9 15/10 16/16 16/19 16/24 17/2 19/13 19/15 20/19 20/21 20/25 21/8 21/12 34/19 34/22 40/17 47/4 47/6 55/13 56/3 56/10 56/24 58/11 59/2 60/14 65/22 66/10 71/16 76/18 77/9 77/13 77/21 79/2 81/10 81/23 82/4 82/5 82/11 82/13 82/21 83/2 84/25 87/19 87/23 98/21 102/24 103/7 121/10 121/12 122/18 123/2 123/3 145/6</p> <p>numbered [1] 12/18</p> <p>numbers [13] 11/3 11/13 11/24 12/10 12/17 12/20 13/25 14/6 14/10 16/20 105/11 105/17 132/3</p> <p>numerous [2] 29/11 145/7</p> <p>nurse [20] 88/8 88/9 88/25 89/4 94/18 94/24 131/22 136/13 136/15 138/14 139/6 139/6 139/16 139/22 140/15 140/24 141/3 146/20 147/21 157/7</p> <p>nurse's [1] 88/24</p> <p>nurses' [1] 109/25</p> <p>nursing [1] 156/13</p> <p>NVC [7] 12/17 12/23 14/6 15/7 17/3 19/10 21/8</p> <p>NVC-1 [1] 17/3</p>	<p>99/16 102/13 112/11</p> <p>officers [1] 42/4</p> <p>offices [2] 41/18 41/22</p> <p>official [1] 39/3</p> <p>officials [1] 136/5</p> <p>oh [7] 20/8 92/24 133/22 136/7 137/10 137/10 151/15</p> <p>okay [81] 7/16 8/25 9/21 12/8 14/12 15/18 16/4 17/14 18/6 18/17 20/15 21/5 21/10 24/4 24/25 25/22 30/18 30/19 31/8 31/15 36/20 38/3 38/23 39/21 41/11 47/1 51/25 56/15 56/23 57/5 57/13 59/24 60/24 61/25 63/13 63/22 65/7 65/13 65/14 68/2 70/9 71/23 73/25 74/7 76/8 77/15 78/11 79/25 80/9 81/5 86/19 87/18 87/22 87/23 90/4 90/9 90/22 91/9 92/20 95/21 98/4 111/10 115/8 116/15 117/7 127/8 128/16 129/19 134/10 134/19 141/23 141/25 142/4 143/8 149/24 150/6 154/20 156/1 158/1 158/25 159/10</p> <p>old [1] 136/2</p> <p>older [2] 117/1 117/2</p> <p>once [14] 22/24 35/24 36/20 39/13 44/1 44/8 69/23 129/10 129/21 132/21 138/9 140/14 141/19 157/1</p> <p>one [176]</p> <p>one and [1] 145/21</p> <p>one-on-one [1] 136/12</p> <p>ones [15] 41/6 43/3 65/20 69/6 69/6 73/21 73/22 101/17 115/12 117/12 117/20 117/22 151/3 153/18 153/18</p> <p>ongoing [2] 111/9 121/4</p> <p>only [33] 20/11 32/7 33/13 35/21 49/7 52/24 54/10 63/7 64/9 64/10 64/17 72/4 72/15 73/6 101/20 110/18 111/14 114/16 116/6 131/20 133/23 135/12 139/25 143/12 144/1 145/13 145/21 145/22 155/7 157/3 158/7 158/8 158/17</p> <p>OEEMR [1] 14/22</p> <p>oOo [1] 160/20</p> <p>open [3] 9/23 24/12 80/16</p> <p>operations [2] 7/12 7/17</p> <p>opportunity [1] 146/17</p> <p>order [14] 12/6 18/21 28/25 61/14 67/2 67/2 86/10 86/12 88/1 88/2 89/25 94/5 110/23 144/7</p> <p>ordered [2] 24/10 122/1</p> <p>organ [1] 34/24</p> <p>organization [2] 10/8 113/15</p> <p>originally [1] 121/20</p> <p>other [85] 8/1 9/24 10/11 11/2 11/17 18/19 28/21 28/22 32/9 35/8 35/18 37/18 40/23 40/25 41/2 41/6 41/17 47/4 47/6 49/9 50/21 51/6 51/9 52/3 54/19 57/24 58/15 59/14 59/17 60/11 63/1 66/11 68/20 71/16 72/2 72/4 72/21 72/22 73/15 75/1 75/18 79/12 80/13 82/15 84/21 85/10 90/15 92/4 93/14 98/11 100/4 100/11 101/21 104/8 108/21 110/8 110/12 110/13 110/20 110/21 111/17 114/20 114/22 115/8 115/13 115/24 117/8 117/10 117/12 117/22 118/17 127/13 128/1 132/9 135/9 135/16 135/16 136/4 136/7 136/20 136/21 137/10 150/2 155/7 155/21</p> <p>others [1] 150/1</p> <p>our [52] 9/3 9/5 11/3 11/6 14/23 15/6 17/2 17/7 18/10 19/16 20/18 22/15 23/7 23/16 23/19 24/11 24/14 24/16 25/6 25/10 29/25 30/2 31/4 31/12</p>
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<p>O</p> <p>our... [28] 31/24 33/24 34/6 39/4 39/6 42/12 45/2 47/23 52/17 56/14 60/5 60/23 71/14 72/8 74/12 89/2 97/2 97/3 98/14 100/20 102/13 108/10 108/18 110/16 111/7 118/25 122/7 122/23</p> <p>out [105] 11/23 17/22 21/25 23/25 31/13 33/19 38/11 38/14 39/14 39/14 39/15 39/19 40/4 41/24 41/24 42/1 42/3 42/8 48/4 51/16 52/13 55/2 55/14 55/20 57/10 60/18 61/9 62/4 62/20 63/16 64/4 65/5 66/4 67/1 68/18 71/13 72/18 73/14 73/23 76/25 82/9 83/5 86/7 89/19 90/1 90/1 90/5 96/16 99/8 100/12 101/14 103/7 104/9 105/18 106/5 106/17 107/18 111/1 113/16 117/17 118/5 118/12 119/2 128/11 129/9 132/20 135/14 135/15 137/3 137/5 138/6 138/12 139/1 139/3 139/7 139/12 139/14 139/16 139/23 140/3 140/7 140/13 141/19 143/9 145/10 146/10 148/17 149/5 149/6 149/8 149/12 149/14 149/18 149/19 149/20 149/21 149/22 152/16 153/10 153/25 156/6 156/23 157/22 158/20 159/3</p> <p>outbreak [22] 8/7 8/12 10/4 12/4 12/14 16/2 29/19 36/24 38/14 42/11 42/13 53/3 53/4 54/24 64/13 65/3 73/21 74/11 76/22 108/23 111/7 127/1</p> <p>outbreaks [2] 35/7 71/16</p> <p>outer [1] 153/20</p> <p>outlier [1] 86/1</p> <p>Outpatient [1] 76/23</p> <p>outset [1] 67/14</p> <p>outside [4] 15/1 141/10 148/19 151/2</p> <p>outward [1] 112/2</p> <p>over [51] 13/19 16/9 42/18 42/21 43/9 43/12 43/13 43/16 43/22 44/1 44/1 44/10 48/15 48/21 79/20 79/25 81/22 81/22 83/8 83/8 83/10 84/1 85/24 92/22 93/13 106/10 108/24 109/13 114/25 123/6 123/8 126/17 128/6 128/19 131/16 131/21 132/10 132/12 132/21 132/23 133/6 133/20 134/10 134/12 134/22 134/24 135/15 135/19 135/20 136/18 146/8</p> <p>overall [3] 46/23 98/18 123/2</p> <p>overlap [1] 63/8</p> <p>overlapped [1] 89/15</p> <p>oversee [2] 7/12 7/17</p> <p>overusing [2] 150/18 150/18</p> <p>overview [2] 45/18 45/22</p> <p>own [5] 51/14 101/2 103/7 131/23 151/14</p>	<p>paper [3] 151/3 153/15 153/15</p> <p>papers [1] 155/2</p> <p>paperwork [2] 22/10 39/7</p> <p>parallel [1] 51/15</p> <p>parented [1] 49/17</p> <p>PARKER [2] 2/11 2/12</p> <p>part [27] 8/12 9/1 9/3 9/16 11/8 21/15 31/15 31/16 49/19 58/10 59/10 66/9 78/8 85/16 85/17 85/19 96/13 98/20 100/5 101/6 121/3 121/4 123/5 130/12 130/12 145/19 151/25</p> <p>partial [2] 49/7 156/2</p> <p>partially [1] 154/23</p> <p>participated [1] 8/16</p> <p>participating [1] 7/3</p> <p>particle [1] 81/7</p> <p>particular [26] 12/2 14/15 17/25 18/14 25/12 29/10 30/20 35/17 42/4 46/21 64/24 77/2 77/25 79/16 80/4 85/13 86/16 86/25 88/23 90/17 94/3 94/19 103/15 104/7 106/14 119/9</p> <p>partnered [1] 49/18</p> <p>passed [1] 96/11</p> <p>passing [1] 80/3</p> <p>past [5] 14/21 71/18 118/19 126/20 129/2</p> <p>Pat [1] 5/12</p> <p>patient [89] 12/21 14/20 16/16 17/13 20/18 21/3 32/12 43/19 45/23 52/7 52/8 53/6 53/18 53/18 53/21 53/23 54/10 55/17 57/7 58/17 58/17 61/11 61/24 64/16 64/16 64/21 66/1 66/3 66/6 67/4 68/8 69/15 70/2 70/20 73/23 73/23 74/22 77/22 78/24 80/17 81/11 82/23 85/7 85/8 85/22 86/4 86/13 88/3 89/7 91/1 91/6 91/13 93/11 93/17 96/16 98/17 98/23 101/23 101/25 104/8 104/17 104/24 107/24 108/6 109/11 110/24 111/2 115/5 128/11 129/11 131/13 131/23 134/12 135/22 137/1 138/3 138/6 139/20 140/18 140/19 140/20 141/7 141/10 141/13 148/8 149/9 150/24 155/6 157/3</p> <p>patient's [8] 14/18 20/22 22/13 32/11 46/23 90/21 129/24 148/19</p> <p>patients [108] 6/2 13/24 15/25 16/1 18/2 18/2 18/3 23/22 27/15 54/1 55/15 55/23 56/4 57/6 57/9 57/11 57/14 57/15 57/18 61/13 62/3 62/9 63/8 64/5 65/19 65/20 65/21 66/2 66/6 66/12 66/14 66/16 66/18 67/7 67/12 67/16 70/21 70/22 71/13 75/7 80/20 80/23 81/24 82/9 82/10 82/12 84/2 84/25 85/11 85/23 86/10 86/12 88/2 89/25 90/10 102/6 103/7 103/17 104/13 104/14 104/15 104/18 107/23 108/7 109/13 109/14 111/1 113/21 114/23 114/25 117/4 118/14 118/16 118/16 118/17 120/4 121/14 125/20 129/4 129/5 132/3 132/16 133/21 134/14 135/1 135/5 135/6 135/7 135/8 135/9 135/10 135/12 135/14 135/15 135/17 135/20 135/24 136/22 138/11 140/1 142/4 142/6 143/14 151/19 153/3 155/4 158/2 158/3</p> <p>patients' [3] 67/8 67/10 67/11</p> <p>PATRICIA [3] 3/3 6/11 6/15</p> <p>pause [1] 70/11</p> <p>pay [1] 144/6</p> <p>penalize [1] 99/7</p> <p>pencils [1] 155/2</p> <p>pending [4] 5/17 24/12 27/5 125/10</p> <p>people [102] 25/2 33/11 33/14 35/1</p>	<p>35/9 36/9 36/9 37/4 37/20 38/14 40/11 42/1 42/14 42/16 42/18 42/22 43/10 43/17 45/25 46/12 49/8 49/9 51/6 51/9 51/13 51/21 51/24 52/4 61/14 61/16 62/3 66/4 66/10 73/17 80/13 81/17 90/24 92/6 97/12 97/14 98/18 98/21 99/7 101/1 101/21 102/24 106/13 107/24 109/6 109/9 110/17 110/19 110/20 112/1 112/11 114/1 114/5 114/7 114/19 115/13 116/3 116/6 116/6 116/10 116/24 117/19 118/24 119/4 120/24 121/1 121/11 122/4 122/15 122/21 122/22 122/24 123/4 123/10 131/25 133/19 135/4 136/7 136/9 139/2 139/11 142/12 146/7 146/11 146/14 147/2 147/14 147/23 150/2 150/12 151/10 153/20 154/7 154/8 157/17 157/20 158/3 158/18</p> <p>per [4] 64/18 64/18 119/22 155/6</p> <p>percent [10] 75/12 81/5 85/24 115/22 115/25 116/4 116/9 116/21 117/4 154/6</p> <p>percentage [1] 105/4</p> <p>performance [3] 5/25 27/13 125/18</p> <p>performed [6] 7/19 9/8 15/14 21/15 46/20 57/6</p> <p>period [10] 23/1 36/16 38/4 48/22 58/5 89/14 115/1 120/8 121/18 131/2</p> <p>periodically [1] 50/4</p> <p>periods [1] 93/8</p> <p>person [43] 7/1 11/25 19/17 31/25 32/4 32/8 33/2 33/7 35/14 37/16 37/16 44/6 62/21 62/22 63/2 65/2 67/3 67/6 71/3 72/19 72/22 72/23 73/5 74/2 91/5 93/14 95/19 95/24 97/16 98/23 102/15 103/13 104/1 104/24 105/13 114/19 118/11 119/6 129/14 140/23 142/7 143/18 153/17</p> <p>person's [2] 120/10 146/23</p> <p>personally [2] 58/23 99/20</p> <p>personnel [1] 67/17</p> <p>persons [4] 6/1 27/14 125/19 146/25</p> <p>pertaining [4] 5/25 27/12 125/18 160/8</p> <p>PH [1] 41/1</p> <p>phase [4] 33/8 33/13 84/7 120/7</p> <p>phone [1] 37/2</p> <p>photos [1] 94/14</p> <p>physical [1] 33/6</p> <p>physician [9] 62/13 62/19 95/6 95/11 96/16 97/22 97/23 97/23 97/24</p> <p>physicians [6] 9/24 61/18 67/23 97/22 103/3 127/13</p> <p>pick [2] 15/24 16/4</p> <p>picked [2] 17/22 121/10</p> <p>picks [1] 37/2</p> <p>picture [3] 80/9 98/14 99/6</p> <p>piece [9] 9/20 9/20 54/14 64/24 65/15 77/18 77/19 79/8 85/13</p> <p>pieces [3] 68/20 86/16 106/5</p> <p>place [10] 8/11 51/16 65/24 69/23 103/15 134/4 141/8 142/16 145/13 161/9</p> <p>placed [7] 11/6 22/20 23/3 64/19 68/10 79/21 79/23</p> <p>placement [1] 69/15</p> <p>placements [1] 41/5</p> <p>placing [1] 41/1</p> <p>Plaintiff [1] 1/8</p> <p>plan [1] 154/14</p> <p>planning [1] 8/18</p> <p>plastic [4] 77/18 150/23 153/1 153/2</p> <p>players [1] 45/12</p>
--	---	---

<p>P</p> <p>please [9] 5/13 6/8 27/1 27/21 96/23 97/16 113/10 125/6 126/1</p> <p>plug [1] 94/10</p> <p>plus [5] 91/23 91/23 91/24 104/18 120/24</p> <p>pocket [1] 22/10</p> <p>point [25] 8/25 9/2 11/19 34/1 37/5 37/23 39/24 48/25 51/7 52/11 71/22 72/24 73/10 77/12 78/9 93/18 98/4 108/14 113/15 122/13 145/21 148/4 148/23 155/11 160/13</p> <p>pointed [1] 74/13</p> <p>pointing [1] 78/17</p> <p>pole [1] 28/24</p> <p>police [4] 99/16 99/21 99/24 155/11</p> <p>policies [3] 68/3 68/7 68/11</p> <p>policy [1] 154/14</p> <p>poor [1] 129/8</p> <p>population [9] 105/5 116/19 116/21 116/22 116/23 117/1 117/2 117/3 119/10</p> <p>port [1] 78/5</p> <p>portion [6] 22/9 22/21 23/2 73/1 77/12 90/25</p> <p>portions [1] 147/9</p> <p>position [3] 13/3 28/14 129/25</p> <p>positive [24] 9/4 61/23 66/12 67/13 67/18 68/1 103/21 104/2 104/13 110/20 114/1 114/11 114/12 115/16 115/18 116/10 117/18 118/15 118/20 118/25 119/6 119/7 122/5 122/11</p> <p>positives [3] 119/4 122/18 123/1</p> <p>possibility [2] 74/8 75/4</p> <p>possible [11] 33/22 57/21 60/12 65/5 65/10 72/3 72/18 81/1 81/23 83/18 104/22</p> <p>possibly [4] 71/2 92/13 104/8 114/9</p> <p>post [1] 52/14</p> <p>post-anesthesia [1] 52/14</p> <p>potential [13] 57/20 64/25 66/14 66/16 72/4 73/14 73/20 74/1 76/2 87/7 107/23 110/24 115/5</p> <p>potentially [7] 78/18 79/15 80/12 80/25 81/17 83/9 83/17</p> <p>practice [12] 49/20 55/9 59/18 67/24 76/11 79/3 79/10 82/5 103/3 118/7 123/20 136/20</p> <p>practices [4] 40/2 71/7 108/22 111/12</p> <p>pre [3] 12/19 52/14 66/9</p> <p>pre-anesthesia [2] 52/14 66/9</p> <p>pre-labeled [1] 12/19</p> <p>prefer [1] 142/5</p> <p>preference [1] 142/16</p> <p>prefill [2] 106/23 107/1</p> <p>prefilled [3] 80/24 82/8 82/11</p> <p>prep [4] 70/20 70/25 71/4 129/7</p> <p>preparation [4] 7/24 8/6 13/7 52/15</p> <p>prepared [2] 149/7 149/23</p> <p>prepped [1] 128/11</p> <p>preprinted [3] 12/19 21/7 22/16</p> <p>presence [4] 26/10 116/7 124/15 159/14</p> <p>present [6] 2/1 2/21 33/6 33/9 48/22 102/22</p> <p>presentation [4] 5/11 160/6 160/9 160/15</p> <p>presented [5] 26/9 33/17 59/1 124/14 159/13</p> <p>presenting [1] 72/6</p> <p>press [1] 148/20</p> <p>pressing [1] 148/19</p>	<p>pressure [5] 88/13 96/5 138/8 138/9 140/8</p> <p>pressures [1] 138/9</p> <p>pretenses [3] 6/3 27/16 125/21</p> <p>pretty [10] 47/17 48/24 68/19 122/14 127/24 130/6 139/25 142/2 145/20 148/17</p> <p>prevent [5] 54/25 74/4 100/14 100/25 111/9</p> <p>previous [2] 119/6 120/22</p> <p>previously [1] 103/1</p> <p>primarily [1] 132/8</p> <p>primary [1] 118/8</p> <p>print [1] 24/15</p> <p>printed [2] 25/8 84/20</p> <p>prior [9] 28/17 46/25 67/9 67/10 67/18 118/19 119/4 122/11 127/16</p> <p>priority [2] 37/15 118/4</p> <p>probably [8] 42/16 50/4 51/1 56/11 57/1 74/18 83/25 121/11</p> <p>probe [1] 41/1</p> <p>problem [7] 24/1 53/2 54/12 82/14 106/3 132/11 132/22</p> <p>problems [5] 23/15 23/24 24/3 55/2 112/9</p> <p>procedurally [1] 88/4</p> <p>procedure [67] 15/14 17/7 35/11 35/22 37/16 40/23 41/2 46/19 46/20 47/8 49/21 49/23 50/10 50/16 50/21 52/11 52/17 52/19 53/6 53/24 57/8 58/15 64/22 67/9 67/10 67/18 68/14 68/16 69/2 69/20 70/23 79/12 85/21 88/9 88/10 88/12 88/18 89/2 89/4 89/8 90/12 90/13 90/14 90/21 91/19 91/20 91/21 94/15 94/20 94/22 94/25 95/11 96/10 110/2 114/12 115/4 117/20 117/24 118/1 120/11 131/9 137/1 137/3 138/4 138/25 140/17 141/7</p> <p>procedures [51] 34/11 35/1 35/2 35/5 35/20 36/8 37/20 40/14 40/19 40/25 45/3 45/4 46/19 47/5 47/19 49/1 49/8 49/11 49/17 49/24 52/21 53/5 54/22 57/6 57/8 62/21 62/23 66/21 67/2 67/11 68/2 68/7 68/22 89/21 92/21 93/4 101/22 109/10 109/11 110/16 110/17 127/24 128/16 128/19 129/19 130/2 132/17 136/23 139/13 149/1 149/3</p> <p>proceed [1] 7/5</p> <p>proceeding [2] 91/10 93/19</p> <p>proceedings [8] 1/20 5/7 26/6 124/11 159/10 160/19 161/8 161/14</p> <p>process [26] 9/1 9/2 10/7 11/14 11/22 12/7 24/17 38/10 38/12 54/5 57/22 59/16 73/21 76/13 81/18 98/5 98/6 98/9 99/12 100/6 103/23 120/19 123/18 129/1 148/16 148/16</p> <p>processed [1] 10/8</p> <p>processing [3] 7/25 11/22 73/16</p> <p>produce [3] 12/6 13/10 33/21</p> <p>produced [2] 88/12 90/2</p> <p>product [1] 54/8</p> <p>products [1] 35/4</p> <p>profession [1] 29/12</p> <p>program [1] 121/8</p> <p>prohibit [1] 106/15</p> <p>prohibited [3] 26/7 124/12 159/11</p> <p>prone [1] 129/16</p> <p>proper [1] 129/24</p> <p>properly [1] 65/18</p> <p>property [3] 6/1 27/14 125/19</p> <p>propofol [33] 53/7 55/13 57/16 58/16 58/18 58/21 60/11 71/13 74/25 77/16</p>	<p>77/17 77/20 80/2 80/23 81/2 81/14 82/24 83/7 83/15 83/21 104/23 105/8 105/13 105/14 105/25 106/9 106/11 106/14 106/20 106/24 112/21 137/20 139/9</p> <p>protect [4] 99/10 100/24 151/18 153/20</p> <p>protective [1] 150/23</p> <p>protocol [1] 31/24</p> <p>protocols [1] 47/5</p> <p>provide [3] 38/12 38/13 123/20</p> <p>provided [2] 19/9 21/8</p> <p>provider [3] 32/11 61/12 63/2</p> <p>providers [4] 30/8 62/24 100/4 121/14</p> <p>provides [1] 24/24</p> <p>public [31] 7/13 7/18 9/24 11/9 15/5 16/25 17/6 17/12 17/16 24/10 29/5 29/14 59/5 72/9 86/9 98/13 98/18 99/1 99/6 99/11 100/3 100/9 100/18 100/20 100/23 100/24 103/16 111/4 111/8 111/8 113/16</p> <p>publications [2] 29/8 100/11</p> <p>pull [1] 149/13</p> <p>puncture [1] 69/17</p> <p>punishable [6] 26/14 26/17 124/19 124/22 159/18 159/21</p> <p>purchase [1] 124/1</p> <p>Purdue [1] 29/4</p> <p>purpose [6] 48/11 54/23 74/12 103/15 153/4 153/6</p> <p>purposes [4] 30/10 78/10 87/9 111/7</p> <p>push [1] 149/15</p> <p>put [41] 6/25 14/8 18/8 19/4 22/11 24/14 25/6 58/19 67/2 76/13 78/12 86/10 86/11 88/1 88/21 89/25 103/15 107/1 107/25 112/14 121/8 129/17 138/7 138/11 140/2 140/9 140/17 141/11 143/24 148/13 151/20 152/2 153/10 154/18 155/20 155/23 156/4 156/7 157/1 157/20 158/16</p> <p>putting [3] 18/11 154/22 156/25</p> <p>Q</p> <p>quantity [1] 104/4</p> <p>Quest [2] 16/18 17/10</p> <p>question [5] 30/16 30/18 40/6 119/25 120/18</p> <p>questioning [1] 97/8</p> <p>questions [14] 15/20 26/4 70/14 90/2 109/17 109/18 110/9 113/6 116/12 117/7 124/10 127/23 159/8 160/7</p> <p>quick [2] 45/17 45/21</p> <p>quickly [1] 138/17</p> <p>quite [1] 111/13</p> <p>R</p> <p>racketeering [3] 6/3 27/16 125/21</p> <p>radar [1] 112/16</p> <p>raise [3] 5/13 27/2 125/6</p> <p>Ralph [1] 97/19</p> <p>ran [2] 131/20 134/14</p> <p>Ranadev [1] 97/25</p> <p>range [8] 86/2 113/25 120/12 120/14 120/24 122/8 129/3 129/20</p> <p>rate [3] 75/13 96/5 132/17</p> <p>rates [2] 117/1 120/20</p> <p>rather [2] 49/18 144/12</p> <p>ratio [2] 122/7 122/19</p> <p>react [1] 141/13</p> <p>read [3] 16/20 16/21 61/2</p> <p>ready [4] 56/16 129/24 140/24 149/5</p> <p>real [2] 114/16 153/19</p> <p>reality [1] 86/18</p>
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