

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
John D. McLeod, Administrative Law Judge

Case No. 09-ALJ-07-0332-CC

Trident Medical Center, LLC, d/b/a
Berkeley Medical Center, ...Appellant/Respondent,

v.

South Carolina Department of Health and
Environmental Control and Roper St. Francis
Hospital-Berkeley d/b/a Roper St. Francis Hospital,

Of Whom South Carolina Department of Health and
Environmental Control is the Respondent, and

Roper St. Francis is the Respondent/Appellant.

Case No. 09-ALJ-07-0333-CC

Trident Medical Center, LLC, d/b/a
Berkeley Regional Medical Center, ...Appellant/Respondent,

v.

South Carolina Department of Health and
Environmental Control, and Roper St. Francis
Hospital-Berkeley, Inc. d/b/a Roper St. Francis
Hospital-Berkeley,

Of Whom South Carolina Department of Health and
Environmental Control is the Respondent, and

Roper St. Francis is the Respondent/Appellant.

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(caption continued from cover page):

Case No. 09-ALJ-07-0336-CC

CareAlliance Health Services and Roper
St. Francis Hospital-Berkeley, ... Respondents/Appellants,

v.

South Carolina Department of Health and
Environmental Control and Trident Medical
Center, LLC Respondents,
Of whom Trident Medical Center, LLC is the Appellant.

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Project Summary

The Roper St. Francis Mount Pleasant Hospital will:

1. Provide enhanced access to care
2. Establish the necessary healthcare resources to respond to significant population growth
3. Provide a not-for-profit, community-based alternative

00106

ROPER
ST FRANCIS
HEALTHCARE

49



Our Mission:

Healing all people with compassion,
faith and excellence.

001062



50

Slide 1

Good afternoon. I'm David Dunlap, President and Chief Executive Officer of Roper St. Francis Healthcare. I'd like to thank Chairman Whiteside and members of the DHEC project review committee for this opportunity to present our project to you today.

I believe that following our presentation you will agree there is a real need for two hospitals East of the Cooper.

At this time, I'd like to introduce the Chairman of the Roper St. Francis Healthcare Board, Dr. James Ravenel, the President of the Medical Society, Mr. John Jordan, and the Board Chairman of the Bon Secours St. Francis Hospital, Admiral James Flatley. Our senior executive team is here today, along with our attorneys and consultants, and I will introduce them as they present.

In addition, we have several people who could not be here today but have taped messages of support. I will introduce each as they appear in the presentation.

001063

Trident_09388

Slide 2

As in most cities, the downtown area of Charleston, also known as the peninsula, was the center of commerce and health services for many years.

Over time, populations have dispersed to outlying areas and commercial activities and healthcare services followed.

Charleston is no exception to this pattern; however, it has been much slower in deploying health services to the suburban areas.

As you can see from the map 1,110 acute care beds or 62% are still located on the peninsula. While there has been a re-distribution of beds in response to population growth and migration to the North and West Ashley areas, it has not occurred East of the Cooper, which has only 100 beds, or 6% to service 17% of the population.

001064

Trident_09389

Slide 3

In addition to acute care beds, there is also a maldistribution of operating rooms. As you can see on the map, 68 remain on the Peninsula, as compared to 9 operating rooms East of the Cooper- an area with approximately three times the population.

001065

Trident_09390

Slide 4

In an emergency quick, easy access is of utmost importance. The Peninsula has 65 emergency treatment bays versus 8 treatment bays East of the Cooper to support the population of nearly 100,000 people.

001066

Trident_09391

Slide 5

At this time I would like to introduce a taped message of support from the Honorable William Alston, Mayor of the Town of Awendaw, a community located to the north of our proposed site.

001067

Trident_09392

Slide 7

In 2004 we conducted an analysis to identify the most effective use of Roper Hospital's existing licensed beds.

As a result, the decision was made to redistribute 98 beds. Thirteen acute care beds will be transferred to St. Francis Hospital, and 85 beds to our proposed Mount Pleasant Hospital.

001068

Trident_09393

Slide 8

The proposed Mount Pleasant Hospital is critically important to Roper St. Francis Healthcare. We believe it will accomplish the following objectives:

First, to provide enhanced access to care for existing Roper St. Francis patients living East of the Cooper

Second, to establish the necessary healthcare resources to respond to significant population growth

And finally, to provide a not-for-profit, community-based alternative for residents East of the Cooper

001069

Trident_09394

Slide 9

And now its my pleasure to introduce someone who has been a strong supporter of this project from the very first day we announced our plans, the Honorable Harry Hallman, Mayor of the Town of Mt. Pleasant.

001070

Trident_09395

Slide 11

As previously mentioned, our first objective is to provide enhanced access for our patients living East of the Cooper. As you can see, the number of inpatients from the East Cooper area using our facilities has continued to grow during the last five years. In fact, 25% of residents needing inpatient care choose our facilities despite the travel time.

001071

Trident_09396

Slide 12

During the past five years, the number of surgery patients coming to our hospitals from the 7-zip code area has grown by 12%. We expect this trend to continue.

001072

Trident_09397

Slide 13

This growth trend becomes even more apparent in our outpatient volumes, which have grown by 31% since 2000.

As you can see by the number of patients already choosing Roper St. Francis Healthcare, a new hospital in the area will provide the enhanced access this community needs and wants.

001073

Trident_09398

Slide 14

In addition to the patients, this project would not be successful without the support of the more than 700 physicians on our medical staff, **more than 170 who live in the Mount Pleasant area.**

At this time I'd like to introduce Dr. Brian Cuddy, a Neurological Surgeon and Mt. Pleasant resident, to share a physician perspective on this project.

001074

Trident_09399

Slide 16

Our second objective is to create the necessary resources to respond to the area's tremendous population growth. The Town of Mt. Pleasant, consisting of two zip codes, has averaged an 8% annual growth rate for the past fourteen years.

The primary service area for the new hospital, a slightly larger 7 zip code area, is projected to grow more than 20% over the next five years, compared to Charleston County's projected 2.8% growth rate.

001075

Trident_09400

Slide 17

Because of natural and man-made barriers, Mt. Pleasant has evolved into a bi-centric community with distinct population pockets located to the north and south of the Towne Centre shopping district.

A 2004 Department of Transportation study shows that 45,000 cars per day travel from the Cooper River Bridge to the 526 Interchange and traveling on northwards, 48,000 cars per day now travel from 526 to Highway 41.

001076

Trident_09401

Slide 18

We are fortunate to have such a beautiful, historic city in our state which last year attracted 4.7 million visitors staying an average of 3.8 nights.

The population figures we've cited don't even begin to take into account the impact of tourism on our coastal community.

The impact of tourists on our daily population represents an increase of nearly 60,000 people. **This number is equal to the population of the City of Greenville visiting us each day.** It is also important to note many of these visitors need and use healthcare services during their stays.

001077

Trident_09402

Slide 19

In addition to existing residents and tourists visiting our area, a recent Post & Courier article noted that 113,000 new homes are either planned, permitted or under construction in the Tri-County area.

If the current population trends hold true, this will translate into an additional 269,000 people in the Lowcountry.

This further illustrates the urgent need to redistribute beds and services now.

001078

Trident_09403

Slide 20

Given the population growth, urban sprawl, and geographic barriers in our communities, traveling even short distances can take a considerable amount of time.

It is important to note that existing hospitals in the Charleston area are separated by 6-7 miles, making the location of our new Mt. Pleasant Hospital consistent with the distances between existing hospitals in our area. For example Summer Medical Center is 6.2 miles from Trident Medical Center. Roper is 6.5 miles from East Cooper Hospital and our new site is 6.3 miles from East Cooper Hospital.

001079

Trident_09404

Slide 21

The healthcare consulting firm Richardson/Knapp & Associates was hired to conduct an independent service demand analysis and financial feasibility analysis.

Mark Richardson has 26 years of experience with a focus on strategic business planning. At this time, I will turn the presentation over to Mark.

001080

Trident_09405

Slide 22

Thank you Mr. Dunlap. I would like to take the next few minutes to highlight some notable distinctions in the number of acute care beds per 1,000 population throughout the four regions of the state.

The average number of beds in the Lowcountry (Region IV) falls well below the Upstate (Region I) and the PeeDee (Region III), and is in fact below the state average of 2.63 beds.

001081

Trident_09406

Slide 23

To further analyze the situation, we looked at a sample of cities and towns across the state and calculated the number of acute care beds per 1,000 population.

As noted in this chart comparably sized cities, which are bolded, have anywhere from 2.5 to almost 10 times the number of beds per 1,000 population than currently exist in the Town of Mount Pleasant.

In addition, cities such as Greer and Florence have higher bed ratios and more than one hospital provider in town.

001082

Trident_09407

Slide 24

This next slide summarizes the four options DHEC has as it relates to the two projects presented today to the committee.

If DHEC approves both projects, the number of beds per 1,000 population in the Mt. Pleasant area in 2009 when both hospitals would be operational would remain below both the state average and the average for two comparably sized cities- Greenville and Rock Hill.

It is apparent from this chart that the Mount Pleasant area is in dire need of additional acute care beds and hospital services to support its growing population.

001083

Trident_09408

Slide 25

Each step of the methodology used to forecast patient volumes and bed need is outlined in the application. At this time I would like to mention several factors that provide me with a high level of confidence in the volume forecasts.

#1 The Population: The area East of the Cooper has seen tremendous growth in recent years and now houses 17% of the Tri-county's population yet only 6% of the acute care beds. The Peninsula, on the other hand, houses less than 6% of the area's population, with 62% of the total number of acute care beds. In addition to the large population base, the Mt. Pleasant Hospital's primary service area is projected to grow by 4% annually as compared to the state's overall projected 1% annual growth rate.

#2 The Forecast is Conservative: As the population grows and the age of the population increases, use rates increase as well. However, in this analysis I held the use rate constant in an attempt to paint a very conservative picture. In addition, neither part-time residents nor tourists were factored into the projections.

#3 Physician Support: Roper St. Francis Healthcare has submitted 184 letters from physicians practicing in the area, expressing their strong support for the project.

Combined, these three factors largely contribute to both the reasonableness and achievability of the volume forecasts.

001084

Slide 26

The application submitted on behalf of Roper St. Francis Healthcare documents the need for the proposed 85-bed relocation.

This project will reposition underutilized acute care beds to an area with strong volume and population growth without resulting in an unnecessary duplication of services.

This will be accomplished with no net gain in the number of licensed hospital beds in the Tri-County.

In addition, the project will offer residents East of the Cooper a much-needed choice in healthcare providers.

001085

Trident_09410

Slide 27

I'll be glad to answer any specific questions the committee members may have as it relates to the service demand analysis at the conclusion of this presentation.

Now, I'll ask my partner, Rick Knapp, to come up and discuss the financial feasibility of the project.

001086

Trident_09411

Slide 28

Thank you Mark. Highlights of the financials, including average costs and charges, gross and net revenues, are covered in the project review summary sheets.

I would like to discuss two factors relative to the financial projections. As Mark mentioned, the volume projections were quite conservative. Conservative volume projections translate into a conservative financial pro-forma. Even so, the proposed hospital will exceed the break-even point in year 2 of operations on a stand alone basis.

Another point I'd like to highlight is that the projected revenues for the Mt. Pleasant Hospital were based on the existing charge structure at Roper and St. Francis hospitals. This charge structure is significantly below the current market rates as will be shown in an upcoming slide.

Gross charges tend to be a starting point for negotiations on actual reimbursement levels. The significance of the proposed charge structure is shown in this next slide.

001087

Trident_09412

Slide 29

Because East Cooper is a for-profit hospital, both its net income per adjusted discharge before and after taxes is reflected on this graph. Based on the proformas submitted in both applications, the Mt. Pleasant Hospital will earn \$1,157 per adjusted discharge, whereas East Cooper Hospital will earn \$3,093 per adjusted discharge on a pre-tax basis.

A study released in December of 2005 by the Institute for Health & Socio-Economic Policy found that of the nation's top 100 Most Expensive Hospitals, 43 were affiliated with Tenet Healthcare Corporation. Tenet has approximately 2% of the hospitals in the country, yet 43% of the most expensive hospitals.

I, too, will be glad to answer any questions the committee may have at the conclusion of the presentation. Thank you.

001088

Trident_09413

Slide 30 DAVID DUNLAP

Thank you Mark and Rick. This brings us to our third and final objective, which is central to our mission as a not-for-profit, community-based provider.

When we began planning for this project we knew it was important to ask the community what they wanted. In the spring of 2005 we commissioned an independent public relations firm to conduct a survey of 500 area residents. That survey showed:

- 96% favor a choice of hospitals in Mt. Pleasant
- and East Cooper residents rank Roper St. Francis Healthcare the highest of all area hospitals for quality of care.

These same themes of choice and quality have been reaffirmed in recent months as we've talked to more than 2,000 people at professional and civic group meetings in the community.

001089

Trident_09414

Slide 31

Dr. Strait Fairey, a long-time family physician practicing in Mt. Pleasant, knows first hand the real need for choice in healthcare.

At this time I would like to share his message of support.

001090

Trident_09415

Slide 33

As Dr. Fairey states, choice in healthcare is good. Here is one reason why. Look at the disparity in charges per patient day. These have been severity-adjusted to ensure an apples to apples comparison. For the sake of comparison, we'll look at St. Francis Hospital and East Cooper Hospital. There is a 31% variance in the charge per patient day.

In fact, East Cooper Hospital ranks fifth among the top 10 most expensive hospitals in South Carolina, charging patients almost four times what it costs the hospital to care for them.

As part of our mission we strive to provide high quality care at a reasonable price. Roper and St. Francis hospitals have the same charges, and that same charge master will be extended to our Mt. Pleasant hospital.

This is just one example where we believe choice is important to the community.

001091

Trident_09416

Slide 34

In addition, we believe this project achieves the following goals of the Certificate of Need Program -- to promote cost containment, to best serve public needs, and to ensure high quality services.

001092

Trident_09417

Slide 35

Not only do we serve the community by providing value for their healthcare dollars, we also give back as part of our not-for-profit mission.

Service to the community is an important part of who we are and what we do everyday, as demonstrated by our investment in community outreach. In 2004 we spent an additional \$29 million beyond the \$52 million in uncompensated care.

001093

Trident_09418

Slide 36

In addition to investing in our community, a majority of our net income is reinvested into maintaining and modernizing our facilities, and acquiring state-of-the art technologies and equipment.

This is a demonstrated, long-term commitment by our organization.

In reviewing the capital expenditures on healthcare in Charleston over the past four years, Roper St. Francis Healthcare has spent in excess of \$144 million on upgrades to our facilities, whereas East Cooper Hospital, the most profitable hospital in all of Charleston, spent only \$2.5 million.

The obvious lack of growth and reinvestment by East Cooper Hospital has led to their proposed need to replace a 20 year old facility in its entirety.

001094

Trident_09419

Slide 37

The question I urge the committee to consider is, "Does Tenet have the ability to be the sole provider of healthcare for the growing East Cooper area in the long run?"

Our ability to move forward on this project is clear. At this time, I'd like to introduce our Chief Financial Officer, Bret Johnson.

001095

Trident_09420

Slide 38

Thank you, David. Chairman Whiteside and members of the Project Review Committee, Roper St. Francis Healthcare stands ready to fund this important project.

We are a financially strong health care system and, as David mentioned, clearly have the ability to fund our proposed hospital East of the Cooper.

This ability is evidenced by our credit rating. As this slide illustrates, Roper St. Francis Healthcare maintains a strong investment grade credit rating. We have been rated "A3" by Moody's Investor Services, and "A-" by Standard and Poor's. Both of these ratings carry a stable outlook. We've discussed our plans to construct a hospital East of the Cooper with both rating agencies and, to date, have received only positive feedback.

001096

Trident_09421

Slide 39

Roper St. Francis Healthcare's financial strength is also evidenced by how we compare to our peers. The metrics that appear on this slide compare Roper St. Francis Healthcare's 2005 performance to the most recently available Moody's data for Median "A" rated hospitals.

As you can see, our operating margin and operating cash flow margin are well above industry medians. The same is true of our liquidity position, as measured by days cash on hand.

Our ability to fund our debt, as measured by a multiple of debt to cash flow, is right in line with industry medians.

001097

Trident_09422

Slide 40

The funding picture for Tenet is not so clear. As noted in their most recent 10Q, Tenet is experiencing poor operating performance, tremendous pressure on liquidity, and has access to capital but at a very high cost.

Across the country, Tenet has committed to fund numerous new and replacement facilities costing hundreds of millions of dollars.

Generally speaking, companies like Tenet have four sources for funding such projects. They are cash flows from operations, issuing stock, incurring debt or using cash currently on hand. A brief look at each of these funding sources calls into question Tenet's ability to fund new and replacement facilities.

001098

Trident_09423

Slide 41

As this slide illustrates, based on Tenet's operating performance for the nine months ended September 2005, their operating cash flow of \$164 million was not even adequate to fund debt service, which was in excess of \$300 million. This is before considering the capital and strategic requirements of their existing 69-hospital facilities. While there were \$400 million in non-recurring losses recorded by Tenet in 2005, it is a fair conclusion that Tenet's cash flow from operations for the next several years will be used to fund debt service and the capital needs of its existing facilities.

This fact is further supported by Tenet's disclosure in its most recent 10Q that operating performance would probably not improve in the near term.

001099

Trident_09424

Slide 42

In terms of issuing stocks and bonds, it should be noted that since October 2002, Tenet's stock price has declined 84% to \$8.40 per share, significantly lessening Tenet's ability to raise funds through the equity markets.

As for Tenet's ability to incur additional debt- Tenet currently maintains a debt-to-equity ratio of approximately 78% and carries a non-investment grade of a B-, commonly referred to as a junk bond credit rating. As a result, the coupon rate of interest on its two most recent bond issues was in excess of 9%. Given the earnings pressures on public companies like Tenet, its difficult to conceive that a hospital funded with 9% debt could achieve a return on investment acceptable to Wall Street.

001100

Trident_09425

Slide 43

Lastly, Tenet is struggling to maintain adequate cash reserves. Not only is the need to fund operating losses, debt service, and capital requirements draining available cash, but analysts predict the ongoing investigations and civil law suits could cost Tenet over a billion dollars.

Tenet sums up their liquidity position very well in this disclosure, which appeared in their most recent 10Q.

It clearly implies the intent to preserve cash and available capital resources until operations improve and the legal issues have been resolved. It's a good strategy for Tenet to consider these new and replacement facilities. However, in all likelihood, it will be several years at best before funding is reasonably available.

Thank you for your time.

001101

Trident_09426

Slide 43 DAVID DUNLAP

And while we have respect for the management of East Cooper Hospital, it certainly calls into question the future financial viability of its parent company.

East Cooper Hospital's ability to finance a replacement hospital is questionable and certainly not borne out by their reinvestment in the twenty years they have been the sole hospital in East Cooper.

On the other hand, Roper St. Francis Healthcare has justified the need for its relocation of beds and stands committed and ready to make this project a reality.

001102

Trident_09427

Slide 44

We do know that the:

- tourists will continue to visit
- the community will continue to age, as already 36% of Charleston County's population is 45 years of age and older and
- the population East of the Cooper is growing rapidly -- to more than 100,000 people by 2009 with close to half living north of the Town Centre

The question is will they have access to healthcare services if we fail to act now?

001103

Trident_09428

Slide 45

We've received hundreds of letters of support, and know you won't be able to read them all. For that reason, I'd like to take the next few minutes to share excerpts from two representative letters.

Mr. James Dooley states,
I write in support of expanded services and access to the excellent care my family has received from Roper and St. Francis associates, physicians, and caregivers.

I write wearing several hats; a 28 year resident, homeowner, business owner, parent, grandparent and an appointed member of the Mt. Pleasant Planning commission.

I am actively involved in the community and am concerned that our community is growing at a pace that will compromise citizens' access to downtown medical facilities. Emergency vehicles need to be more accessible to a population which is migrating northward up Highways 17 and 41.

001104

Trident_09429

Slide 46

Another letter reads, just last week I was a patient at Roper's downtown hospital for the first time. I had a renal arteriogram to determine if my kidney function was preventing the stabilization of my blood pressure... My husband and I both can vouch for the care I had and would choose Roper again. How great to have it in the neighborhood caring for us and our daughter, son-in-law and two precious granddaughters who live just a few minutes from us. What a comfort to know such competent health care is nearby, not just for us but for the many young families who have chosen Highway 17 North for their home.

Sincerely,
Dr. and Mrs. John Turchi

001105

Trident_09430

Slide 47

The passion for this project is really evident in these letters. At this time I'd like to introduce Senator Glenn McConnell, President Pro Tempore of the Senate, another strong supporter of our project. While his schedule did not permit him to join us here today, he graciously agreed to tape this message of support.

001106

Trident_09431

RECORD 007375

Slide 49

In conclusion, it is our strong belief that the proposed hospital will:

Provide enhanced access to care for existing Roper St. Francis Healthcare patients living East of the Cooper

Secondly, it will establish the necessary healthcare resources to respond to significant population growth

And finally, provide a not-for-profit, community-based alternative for East Cooper residents

001107

Trident_09432

Slide 50

At Roper St. Francis Healthcare our mission is healing all people with compassion, faith and excellence.

For generations people of the Lowcountry have put their faith in us and we, along with our extraordinary team of employees and physicians, hope to bring this same mission of healing to our new Mount Pleasant Hospital.

Thank you for your time and careful consideration of this project.

001108

Trident_09433

RECORD 007377



March 1, 2006

Re: Roper St. Francis Mount Pleasant Hospital

Ms. Mary Fechtel
S.C. DHEC, Bureau of Health Facilities
1777 St. Julian Place Suite 201
Columbia, South Carolina 29204

Dear Ms. Fechtel:

I am submitting this letter to clarify information presented by East Cooper Regional Medical Center (ECRMC) at the project review committee meeting held on January 18, 2006 with respect to Roper St. Francis Mount Pleasant Hospital's Certificate of Need application.

Assertion #1:

It is too early and too far out for another hospital in Mt. Pleasant

Response:

- o The Town of Mt. Pleasant (2 zip codes) has averaged an 8% annual growth rate for the past 14 years.
- o The primary service area (PSA) (7 zip codes) is projected to grow by more than 20% over the next five years compared to Charleston County's projected 2.8% growth.
- o ECRMC used the same PSA population (and included one additional zip code) and projected growth to support its need for additional beds. It appears ECRMC is trying to have it both ways.
- o The Mayor of Mt. Pleasant, Mr. Harry Hallman, has been a vocal supporter of this project. In his *State of the Town Address 2006*, Mayor Hallman stated, "I believe that there is not only room for both in Mount Pleasant, I think, given our growth and our geography, it's imperative that we have two hospitals serving the greater East Cooper area."

001161

~~Roper Hospital~~

~~Ron Secours St. Francis Hospital~~

~~Roper Berkeley Day Hospital~~

~~Roper Rehabilitation Hospital~~

Trident_09484

RECORD 007378

- o The proposed location in the Carolina Park development is adjacent to the site of Wando High School. It is doubtful the School Board would select a site "too far out" for the only public high school that serves Mt. Pleasant. In addition, Wal-Mart recently announced it will build a 200,000 sq ft Super Center approximately one mile from Carolina Park. Finally, as demonstrated in our application, the majority of projected population growth will occur in northern areas of Mt. Pleasant.

Assertion #2:

The Roper St. Francis Mount Pleasant Hospital will not improve access

Response:

- o In its application, ECRMC agreed that the increasing traffic congestion and limited road access are making travel to downtown increasingly difficult. They went on to say that providing greater bed capacity will permit a large number of patients to remain in the Mount Pleasant community for care.
- o The area East of the Cooper has 1.02 beds per 1,000 population (versus the Peninsula with 32.95 beds per 1,000 population). As shown in our presentation, comparably sized cities to the Town of Mount Pleasant have anywhere from 2.5 - 10 times the number of beds per 1,000 population.
- o Mt. Pleasant and adjoining areas are not well-served by the one existing provider as demonstrated by: (1) the independent survey conducted by Rawle Murdy, a local public relations firm, of 500 area residents. This survey documents they want the following: a choice in local hospital providers (96% response rate), access, and value for their healthcare dollars. These residents ranked RSFH the highest overall in quality of care. In addition, the more than 2,000 people we've spoken to at professional and civic group meetings in the community have reaffirmed these same themes of choice and quality in recent months. (2) The area's 65% out-migration rate for inpatient care speaks loudly to the need for an alternative choice to ECRMC.

001162

- o The Roper St. Francis Mount Pleasant Hospital will have the same charge structure as both Roper St. Francis Healthcare (RSFH) member hospitals. As a result, it will increase accessibility to affordable healthcare, as there is a 31% variance in severity-adjusted charge per patient day between St. Francis Hospital (which offers a similar complement of care/services) and ECRMC, as graphed on slide 33 of our project review presentation.
- o ECRMC's projected net revenue per adjusted patient day for 2009-2011 is approximately 90% above that projected for the Roper St. Francis Mount Pleasant Hospital.

Assertion #3:

The need methodology and projections are seriously flawed

Response:

- o Roper St. Francis Mt. Pleasant Hospital's 33% in-migration rate assumption was stated to be unreasonably high. ECRMC's actual experience is that 46.5% of patients came from areas beyond its PSA. Furthermore, ECRMC projected a 41% in-migration rate—both considerably higher than our assumption.
- o ECRMC deemed holding the use rate constant "inappropriate", and assumed a 1% per year use rate growth in all of its forecasts. Had this same use rate increase been used in our methodology, the required market shares would be even less than presented in our model with even less of an adverse impact than proposed by ECRMC.
- o ECRMC stated a 4.0 length of stay (LOS) was appropriate and that the 4.68 LOS assumption was overstated¹. However, upon examination of ECRMC's LOS, its assumption is a 4.9 LOS excluding obstetrics and burn (ECRMC application base stamp page 672).
- o Physician support for the project was stated to be lacking. Physician support is clearly demonstrated by the 187 letters of support included in the application. Adequate physician staffing will not be an issue, as more than 170 physicians practicing at RSFH hospitals reside in the Mt. Pleasant area.

¹ As stated in the application, the 4.68 LOS was based on the actual experience of Bon Secours St. Francis Hospital, which offers a similar complement of care/services.

001163

- o The DRGs included in the methodology were modeled after Bon Secours St. Francis Hospital, which offers a similar complement of care/services.

Assertion #4:

This project duplicates other RSFH projects that relied on this patient population to justify bed expansions

Response:

Roper Hospital

- o The need for Roper's new patient tower was predicated on the following 3 factors: inadequate space for growth of cardiac, ambulatory, emergency, and imaging services; accessibility issues; and age/condition of the existing patient tower. The application neither specifically addressed nor relied on the Mt. Pleasant area population to justify the need to relocate existing beds to the new tower.

Bon Secours St. Francis Hospital

- o The demonstrated need for the 63-bed expansion was based on daily census trends, wait times in admission from the ED and PACU, the recent ED expansion, and the growth in discharges.
- o Service area demographics were based on 14 area zip codes including one in Mt. Pleasant (29464). Patient origin (2005) documents that only 2.3% of patients were from 29464, negating ECRMC's argument that the Mt. Pleasant population was used to justify the bed expansion and a hospital in Mt. Pleasant will adversely impact SFH's utilization. In fact, BSSFH experienced an 82% occupancy rate in 2005, and a 2.5% growth in admissions.

Assertion #5:

The project will result in a significant adverse impact on ECRMC

Response:

- o Currently, 25% of the area residents choose our hospitals for inpatient care despite the travel time.

001164

- o Our model assumes that for 2011 we will serve 3,239 patients from the PSA, of which 1,388 are "re-positioned" RSFH patients. 1,851 would be from the market currently served by other providers. The model shows that from 2003-2011 non-RSFH nonspecialty volume ages 15+ will grow by +1,676 patients, largely offsetting the market patients to be treated by the Roper St. Francis Mount Pleasant Hospital.
- o Further, with ECRMC only capturing 35% market share of the PSA and with 6,171 non-RSFH patients forecast for 2011 there are over 4,000 patients ($6,171 * 65\%$) served by other providers (other than RSFH or ECRMC). The Roper St. Francis Mount Pleasant Hospital could tap into this portion of the local market and not impact ECRMC at all.
- o ECRMC asserted two contradictory positions. On one hand it stated that our proposed site 6 miles away is too close and will result in a significant adverse impact, and yet its hospital was constructed 6 miles from Roper Hospital. On the other hand, the proposed site was stated to be so remote a location (too far out) that physicians will not drive that far. If that were the case, no adverse impact would be expected.

Assertion #6:

The project is not consistent with the 2004-2005 State Health Plan

Response:

- o In at least two other cases DHEC has determined the construction of a satellite hospital in the same county is consistent with State Health Plan standards. In 2005 a CON was issued to The Village Health Center, a new 48-bed hospital in Greer that Spartanburg Regional Medical Center will build via the transfer of existing licensed beds. In addition, Loris Healthcare System was approved in August 2005 to build Seacoast Medical Center, a 50-bed hospital in Little River.
- o This project will reposition underutilized acute care beds to an area with strong volume and population growth without resulting in an unnecessary duplication of services.

001165

- o This project will achieve the following CON Program goals: to promote cost containment, to best serve public needs, and to ensure high quality healthcare services are delivered to residents (and visitors) East of the Cooper.

Assertion #7:

This project will result in decreased versus enhanced competition

Response:

- o Roper St. Francis Mount Pleasant Hospital's PSA is projected to grow more than 4% annually over the next five years. A continuation of the monopoly that ECRMC has enjoyed for the past twenty years as the only provider located in this service area will only serve ECRMC's shareholders and not area residents.
- o With no local competitive pressure in the PSA, ECRMC has no market incentive to enhance services, improve quality, or offer a cost effective pricing strategy. As shown in our project review presentation, ECRMC has not reinvested in its facilities, equipment, technology or the community. In terms of pricing strategies, it should be noted that (1) gross charges tend to be a starting point for negotiations on actual reimbursement levels and (2) ECRMC ranks 5th among the top 10 most expensive hospitals in South Carolina.
- o In addition to physician and community letters of support, we've submitted letters from insurance companies, related entities, and businesses supporting our application to become a lower cost provider in this community.

I trust this information serves to clarify that which was presented by East Cooper Regional Medical Center at the project review committee meeting. Should you need any clarification or additional information, please contact me at (843) 965-8234.

Sincerely,

Shannon Cantwell

Ms. Shannon Cantwell
Roper St. Francis Healthcare
69 Barre Street
Charleston, SC 29401

001166

Roper St. Francis Healthcare

Mt. Pleasant Hospital CON Application

**Memorandum to DHEC Regarding the Feasibility of
Tenet's Proposed Replacement Hospital Facility**

March 6, 2006

001171

Trident_09494

RECORD 007384

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001172

Executive Summary:

This memorandum focuses on two specific matters pertaining to the feasibility of Tenet's Certificate of Need application for a replacement hospital in Mt. Pleasant, South Carolina.

#1 - Tenet Proposes to Place a Significant Financial Burden on the Residents and Employers of the Mt. Pleasant Community:

- The construction of a new and/or replacement hospital facility by a public company experiencing financial difficulties creates an unusual set of fiscal circumstances in which the costs associated with the applicant's, (1) elevated cost of capital, and (2) need to generate a high, risk-adjusted rate of return for investors, must be passed on to the community in which the facility is constructed. This issue is further exacerbated when such a facility is constructed in a community that does not house competing hospital facilities.
- Tenet is projecting that this project will generate an annual EBITDA margin of approximately 28%, an amount apparently necessary to cover its elevated cost of capital and meet the earnings expectations of its investor base.
- Tenet is clearly using rate leverage, not operational efficiency, to drive their high projected EBITDA margins:
 - Tenet's projected net revenue per patient day for 2009 through 2011 is nearly double that projected for the Roper St. Francis Healthcare Mt. Pleasant Hospital;
 - Tenet must generate a compound annual growth rate in net revenue per adjusted discharge of approximately 7.18% between 2005 and 2009 to meet the level of net revenue projected for their replacement facility, which equates to annual increases to the commercially insured population of Mt. Pleasant of approximately 11.42%;
 - Tenet's replacement facility is projected to generate between \$1.0 and \$1.2 million in net revenue per bed between 2009 and 2011, when the current average net revenue per bed in South Carolina for facilities with 101 to 150 beds is approximately \$614,000.

Unfortunately, of the multiple drivers of margin available to Tenet, the use of rate is the most disadvantageous to the citizens of Mt. Pleasant since they, in essence, foot the bill of such a strategy.

001173

#2 -- Because Tenet's Securities Filings do not Discuss the Proposed Replacement Facility in Mt. Pleasant, Tenet Should Clarify for DHEC its Plans for the Funding and Timing of the Mt. Pleasant Facility:

- Although Tenet's filings with the Securities and Exchange Commission discuss capital investments that Tenet has planned for Louisiana, Florida, Mississippi, and California, Tenet makes no mention of the large financial commitments (approximately \$430 million) it has made in its Certificate of Need applications for new and replacement facilities in South Carolina and Texas.
- A review of Tenet's Certificate of Need applications suggests that Tenet boasts a robust capital agenda for new and replacement facilities. A review of reports from ratings agencies and independent analysts, however, indicates a different view of the feasibility of such an agenda by Tenet within the next two-to-three years. In fact, public statements by Tenet's own senior management may call into question Tenet's ability to adequately fund capital for the organization, a sign that they may be unable to engage in an ambitious capital program in the short term.
- Tenet's promises regarding its ability to fund its proposed capital projects expressed in its Certificate of Need applications must be reconciled with concerns regarding Tenet's liquidity expressed in Tenet's securities filings, public statements by Tenet's management, and commentary provided by industry analysts. Furthermore, the lack of specificity in Tenet's securities filings regarding the funding of the South Carolina and Texas projects, combined with concerns regarding Tenet's liquidity, raises concerns that Tenet is overcommitted on capital projects.
- The unclear public record on Tenet's proposed capital investment program raises serious questions about whether Tenet is really committed to replacing its Mt. Pleasant facility or whether Tenet is posturing with an intent to preserve its position as the sole hospital provider located East of the Cooper.

001174

Introduction:

This memorandum is being offered as follow-up to certain analyses presented to DHEC's Project Review Committee on January 18, 2006, regarding the feasibility of Tenet's proposed replacement hospital facility in Mt. Pleasant, South Carolina.

This memorandum focuses on two specific matters pertaining to the feasibility of Tenet's Certificate of Need application for a replacement hospital in Mt. Pleasant, South Carolina.

First, Tenet proposes to place a significant financial burden on the residents and employers of the Mt. Pleasant community as it seeks to produce a rate of return that will cover its cost of capital and meet the earnings expectations of its investor base. This burden is clearly illustrated in the projections contained in Tenet's Certificate of Need application.

Second, because Tenet's securities filings do not discuss the proposed replacement facility in Mt. Pleasant nor the ambitious capital program advanced by Tenet elsewhere in South Carolina and Texas, there are serious questions about whether Tenet really plans to replace its Mt. Pleasant facility under the timeframe discussed in Tenet's CON application.

The balance of this memorandum contains a brief recap of analyses presented on January 18, 2006 to the Project Review Committee and further discussion and supporting analyses pertaining to the two issues noted above.

Brief Recap of Analyses Presented to Project Review Committee:

This section of the memorandum is not intended to be an exact excerpt of comments made at Project Review. Instead, this section seeks to reiterate the more significant comments made at Project Review concerning Tenet's financial condition and present them in further context to the additional analyses contained in this memorandum.

Generally speaking, companies like Tenet have five sources for capital funding. They are cash flows from operations, issuing stock, incurring debt, non-recurring sales of assets (such as one-time sales of facilities), and finally, using cash currently on hand. A brief look at each of these funding sources calls into question Tenet's ability to fund new and replacement facilities in El Paso, Texas, Rock Hill, South Carolina and Mt. Pleasant, South Carolina within the timeframes committed to by Tenet.

001175

A review of Tenet's most recent 10-Q quarterly filing with the SEC indicates that Tenet is experiencing financial difficulties, having incurred a loss of \$432 million through September 30, 2005. The 10-Q also discloses uncertainties regarding Tenet's liquidity, stating that if Tenet's "results of operations continue to deteriorate, and/or . . . if claims, lawsuits, settlements or investigations are resolved in a materially adverse manner, there could be substantial doubt about [Tenet's] liquidity." Tenet reported that its operating cash flow through the first nine months of 2005 deteriorated from the same period during 2004, dropping from \$208 million in 2004 to \$148 million in 2005 (after excluding an income tax refund in the amount of \$537 million). Tenet attributed the deterioration in operating cash flow "primarily to [its] reduced operating results, higher interest payments and reduced collections on accounts receivable." Elsewhere in the September 30, 2005 10-Q, Tenet explained that its operating performance was impacted by declining patient volumes at its facilities and the significant amount of litigation and governmental investigations in which Tenet is involved, as well as certain industry trends. Tenet predicted that "significant improvement in operating performance [would not] be achievable in the remainder of 2005," and that it would "continue to face many of the same challenges in improving its operating performance" in 2006.

In reviewing the September 30, 2005 10-Q, we note that Tenet's operating cash flow through September 2005 of \$148 million was not even adequate to fund its projected debt and lease cash requirements for 2005, which were in excess of \$300 million; and this is before considering the routine and strategic capital needs of its existing 69 hospitals. If we assume a modest annual routine and strategic capital budget of \$7 million per facility, Tenet would need to generate an additional \$483 million in operating cash flow to recapitalize adequately its existing facilities to ensure that they remain competitive in their respective marketplaces and continue to meet the health care needs of the communities they serve. In recent statements from its senior management, Tenet admits that their operating performance will probably not improve in the near term.

Despite the issues raised by the September 30, 2005 10-Q filing, Tenet has indicated in its Certificate of Need application that a source of funding for the Mt. Pleasant replacement hospital will be cash flow from operations. Given that Tenet's operating cash flow appears from its securities filings inadequate to fund its debt and lease cash requirements and the routine capital needs of its existing facilities, it is unclear how Tenet will be able to use cash flows from operations to fund the replacement facility in Mt. Pleasant, as well as the new and replacement facilities in El Paso and Rock Hill.*

In terms of stock and bonds, it should be noted that Tenet's stock traded at \$8.11 per share as of February 24, 2006, a decrease of 83.8% from October 1, 2002, which may make a stock offering by Tenet an unattractive financing alternative. As for Tenet's ability to incur additional debt, it should be understood that Tenet is already highly leveraged (as compared to comparable non-profit hospitals as discussed below) and carries a credit rating of B-, commonly referred to as a "Junk Bond" rating.

001176

* For further analysis, see below, where we analyze the feasibility of Tenet passing along the cost of its capital to the communities served by these new and replacement facilities.

Additionally, in an effort to preserve liquidity, Tenet has structured its existing debt such that no significant payments of principal are due until 2011, an important point to consider as we discuss Tenet's need to preserve liquidity later on.

As of September 30, 2005, Tenet carried a debt-to-capitalization ratio of 78% versus the same ratio for median non-profit hospitals rated "A" by Moody's Investor Services of 37.7% (2004 data). Due to Tenet's continuing financial difficulties and highly leveraged balance sheet, the coupon rate of interest on its two most recent debt offerings was in excess of 9%. Because it does not appear that Tenet's financial performance has improved materially since these notes were issued, it seems likely that any debt issued to fund new and replacement facilities in the near term would be at similar rates.

With regard to the non-recurring sale of facilities or other assets, Tenet's September 30, 2005 10-Q does not reveal any intent to make further substantial divestitures. Therefore, it does not appear that any divestitures are planned to fund the proposed replacement hospital in Mt. Pleasant.

Lastly, Tenet's September 30, 2005 10-Q filing suggests that Tenet may be depleting its existing cash reserves to fund debt and lease obligations and the capital needs of its existing 69 hospitals. As of September 30, 2005, Tenet held unrestricted cash of approximately \$1.5 billion, much of which was accumulated through the divestiture of approximately twenty-three hospital facilities. The adequacy of this remaining cash reserve is being challenged by Tenet's operational and debt service demands (noted above), as well as uncertainties arising from ongoing investigations and civil lawsuits, which some analysts predict could cost Tenet more than a billion dollars. Tenet's need to preserve liquidity is further supported by the fact that Tenet has refinanced its debt structure to avoid having to repay any material portion of principal until 2011. We further note that certain of this debt carries a coupon rate in excess of 9%, which would ordinarily make it the target of accelerated prepayment, not principal deferral. Because of the cash flow difficulties that Tenet has experienced, and the uncertainties related to lawsuits and investigations that Tenet must take into account when managing its cash reserves, DHEC should inquire as to whether Tenet plans to use any material portion of its current cash on hand to fund new and replacement facilities in the near term.

In concluding this section of the memorandum, we believe that it is evident that uncertainties exist regarding the feasibility of the three projects committed to by Tenet, regardless of which source of capital is ultimately utilized.

001177

Tenet Proposes to Place a Significant Financial Burden on the Residents and Employers of the Mt. Pleasant Community:

As noted above, the construction of a new and/or replacement hospital facility by a public company facing financial difficulties creates an unusual set of fiscal circumstances in which the costs associated with the applicant's, (1) elevated cost of capital, and (2) need to generate a high, risk adjusted rate of return for investors, must be passed on to the community in which the facility is constructed. This issue is further exacerbated when such a facility is constructed in a community that does not house competing hospital facilities. This section of the memorandum seeks to illustrate the extraordinary financial burden Tenet proposes to place on the residents and employers of Mt. Pleasant by analyzing and contrasting the financial information contained in both the Roper St. Francis Healthcare and Tenet Certificate of Need applications.

In Tenet's CON application, the financial projections clearly demonstrate that the proposed replacement hospital will provide a level of return sufficient to cover both the high cost of capital used to fund the project as well as provide a boost to shareholder value. Unfortunately for the citizens of Mt. Pleasant, the projections also define who will bear that cost. To further illustrate, data from Tenet's CON application has been used to answer the following questions:

- What level of margin is Tenet projecting this project to generate?
- What is driving the project's projected level of margin (i.e., efficient operations, effective cost containment, use of rate to drive top line results, etc.)?
- Are the underlying assumptions used to generate the projected results financially feasible?

What level of Margin is Tenet Projecting this Project to Generate?

As noted earlier, Tenet may debt finance this project. Also noted earlier, Tenet's interest rate on any near-term issuances of debt would likely be in excess of 9%. Therefore, high project margins are required by Tenet to cover the high cost of capital needed to fund the project and provide an acceptable boost in shareholder value. Indeed, sufficient margins have been projected by Tenet as outlined in the following table:

	EBITDA Margin %	
Tenet - ECRMC (Projected 2009)	28.3%	001178
Tenet Healthcare (2004)	4.6%	
HCA, Inc (2004)	16.9%	
Triad Hospitals (2004)	13.8%	
Universal Health Services (2004)	12.4%	
S & P Median "A" Rated Hospitals (2004)	10.7%	

What is Driving the Project's Projected Level of Margin?

Generally speaking, three of the most common drivers of hospital margins are:

- Level of utilization of hospital assets, sometimes referred to as throughput;
- Effectiveness of cost containment strategies;
- Use of rate leverage to increase revenue.

In analyzing each of the above, the following is noted when comparing Tenet's projected results to available benchmark data:

Utilization of assets as measured by projected inpatient occupancy rates:

	<u>Tenet – ECRMC (Budget 2005)</u>	<u>Tenet – ECRMC (Projected 2010)</u>	<u>Benchmark Median *</u>	<u>Benchmark Top Quartile *</u>
Occupancy %	55.4%	58.7%	61.5%	67.4%

* Source - Solucient Action O-I 12 month period ending 9/30/05

Cost as measured by projected operating expense per adjusted discharge:

	<u>Tenet – ECRMC (Budget 2005)</u>	<u>Tenet – ECRMC (Projected 2010)</u>	<u>Benchmark Median *</u>	<u>Benchmark Top Quartile *</u>
Operating Expense Per Adjusted Discharge	\$6,934	\$9,431	\$5,934	\$5,242

* Source - Solucient Action O-I 12 month period ending 9/30/05

Use of rate as measured by net revenue per adjusted discharge:

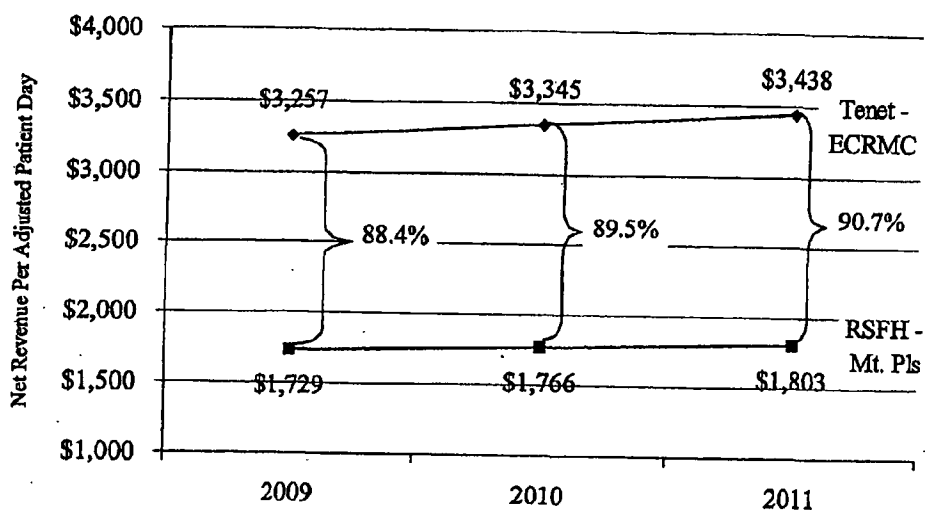
	<u>Tenet – ECRMC (Budget 2005)</u>	<u>Tenet – ECRMC (Projected 2010)</u>	<u>Benchmark Median *</u>	<u>Benchmark Top Quartile *</u>
Net Revenue Per Adjusted Discharge	\$10,838	\$14,792	\$6,787	\$7,717

* Source - Solucient Action O-I 12 month period ending 9/30/05

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Conclusion: Tenet is clearly using rate to generate the high margins required by this project. Unfortunately, of the three drivers of margin noted above, the use of rate is the most disadvantageous to the citizens of Mt. Pleasant since they, in essence, foot the bill of such a strategy.

To further depict (1) the cost of such a strategy to the citizens of Mt. Pleasant, and (2) the need for choice in the Mt. Pleasant community for hospital services, the following graph has been included which compares the projected net revenue per patient day for the proposed Tenet hospital to that of the proposed Roper St. Francis Healthcare hospital:



Are the assumptions used to generate the projected results financially feasible?

The following table illustrates the amount of revenue Tenet's proposed replacement hospital would need to generate at various projected EBITDA margins and desired internal rates of return assuming an overall project cost of \$157 million:

Tenet ECRMC - Required Revenue (\$ in Millions)

		Tenet Required IRR %					
		25.00%	26.00%	27.00%	28.00%	29.00%	30.00%
Projected EBITDA Margin %	25.00%	\$157.00	\$163.30	\$169.60	\$175.80	\$182.10	\$188.40
	26.00%	\$151.00	\$157.00	\$163.00	\$169.10	\$175.10	\$181.20
	27.00%	\$145.40	\$151.20	\$157.00	\$162.80	\$168.60	\$174.40
	28.00%	\$140.20	\$145.80	\$151.40	\$157.00	\$162.60	\$168.20
	29.00%	\$135.30	\$140.80	\$146.20	\$151.60	\$157.00	\$162.40
	30.00%	\$130.80	\$136.10	\$141.30	\$146.50	\$151.80	\$157.00

001180

This next table mirrors the proceeding table, but analyzes the revenue need on a per bed basis:

Tenet ECRMC - Required Revenue per Bed (\$ in Millions)

		Tenet Required IRR %					
		25.00%	26.00%	27.00%	28.00%	29.00%	30.00%
Projected	25.00%	\$1.12	\$1.17	\$1.21	\$1.26	\$1.30	\$1.35
EBITDA	26.00%	\$1.08	\$1.12	\$1.16	\$1.21	\$1.25	\$1.29
Margin	27.00%	\$1.04	\$1.08	\$1.12	\$1.16	\$1.20	\$1.25
%	28.00%	\$1.00	\$1.04	\$1.08	\$1.12	\$1.16	\$1.20
	29.00%	\$0.97	\$1.01	\$1.04	\$1.08	\$1.12	\$1.16
	30.00%	\$0.93	\$0.97	\$1.01	\$1.05	\$1.08	\$1.12

Given Tenet's projected EBITDA margins of approximately 28%, along with projected revenue per bed of approximately \$1,007,000 in 2009, climbing to \$1,207,000 in 2011, Tenet appears to be projecting an internal rate of return on this project of between 25% and 30%. While this is probably a necessary rate of return for a public company facing financial difficulties, consideration should be given to the financial impact of such a facility on the community it serves, particularly given what we know about how this margin will be generated.

This next table illustrates the average and median net revenues generated on a per bed basis by South Carolina hospitals:

Revenue per Bed Metrics

<i>South Carolina Statistics¹</i>	Average	Median
All Facilities	\$604,655	\$629,601
Below 50 Beds	\$417,257	\$337,230
Between 51-100 Beds	\$510,438	\$412,828
Between 101-150 Beds	\$614,437	\$621,469
Between 151-200 Beds	\$650,072	\$640,353
Over 200 Beds	\$812,307	\$775,506

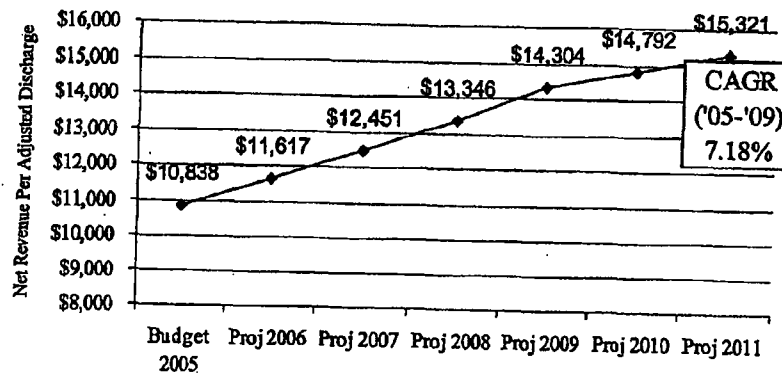
Notes:

¹ Per ahd.com database (excludes long-term care, behavioral care and rehab)

As can be seen in the above table, Tenet's projected revenue per bed is well above hospital norms for South Carolina.

001181

In analyzing the feasibility of Tenet's net revenue projections, consideration must be given to where Tenet's Mt. Pleasant hospital is today, and what sort of rate increases must occur in order for them to achieve their long-term projected results. To assist in this analysis, the following graph contains Tenet's projected net revenue per adjusted discharge for 2005, 2009, 2010 and 2011 as provided in their CON application. Years 2006 through 2008 have been added assuming a steady compounding of the necessary increase in net revenue per adjusted discharge to bridge the gap between 2005 and 2009.



As the graph shows, Tenet is projecting a compound annual growth rate in net revenue per adjusted discharge between 2005 and 2009 of 7.18%. In terms of what this means for the Mt. Pleasant community, let's compute the resulting increases to the commercially insured residents of Mt. Pleasant given the following assumptions:

<u>Payer Mix</u>		<u>Annual % Increase in Reimbursement</u>
Commercial	55.0%	Solved for below 2.0% 2.0% 2.0% 2.0%
Medicare	30.0%	
Medicaid	10.0%	
Self Pay	3.0%	
Other	2.0%	
<u>100.0%</u>		

001182

Solve For Needed Annual Increase in
Commercial Reimbursement

$$.55 (X) + .45 (2.0\%) = 7.18\%$$

$$.55 (X) + .9\% = 7.18\%$$

$$0.55 (X) = 6.28\%$$

$$X = 6.28 / .55$$

$$X = 11.42\%$$

As the above calculation illustrates, for Tenet to achieve the net revenue projections contained in its CON application, annual increases to the commercially insured population of Mt. Pleasant would need to approximate 11.42%. Not only is it doubtful that such increases are feasible, it is unconscionable to expect to pass such costs onto the residents and employers of the Mt. Pleasant community for the sake of shareholder value.

Because Tenet's Securities Filings do not Discuss the Proposed Replacement Facility in Mt. Pleasant, Tenet Should Clarify for DHEC its Plans for the Funding and Timing of the Mt. Pleasant Facility:

The following evidence the lack of clarity in the current public record concerning Tenet's plans for capital investment:

- Although Tenet's filings with the Securities and Exchange Commission discuss capital investments that Tenet has planned for Louisiana, Florida, Mississippi, and California, Tenet makes no mention of the large financial commitments (approximately \$430 million) it has made in its Certificate of Need applications for new and replacement facilities in South Carolina and Texas.
- A review of Tenet's Certificate of Need applications suggests that Tenet boasts a robust capital agenda for new and replacement facilities. A review of reports from ratings agencies and independent analysts, however, indicates a different view of the feasibility of such an agenda by Tenet within the next two-to-three years.
- Public statements by Tenet's own senior management may call into question Tenet's ability to adequately fund capital for the organization, a sign that it may be unable to engage in an ambitious capital program in the short term.

001183

Further discussion of each of the above bullets is provided in the paragraphs below:

Disclosure of Capital Commitments in South Carolina and Texas not Available in Tenet's Securities Filings:

In its most recent 10-Q filing for the period ended September 30, 2005, Tenet disclosed plans to repair fourteen facilities in Florida damaged by Hurricane Wilma, repair or rebuild six facilities in the Gulf area damaged by Hurricane Katrina, and continue funding the approximately \$300 million needed for facilities in California to meet seismic requirements. Not disclosed in the 10-Q were additional commitments Tenet has made to construct new or replacement facilities in El Paso, Texas, Rock Hill, South Carolina and Mt. Pleasant, South Carolina. Tenet's timeline is to have each of these three facilities complete by the end of 2009, which suggests that funding would likely be secured within the next twelve-to-eighteen months. The combined cost of these facilities is estimated at approximately \$430 million. It is unclear how each of these projects will be funded in light of Tenet's current financial condition.

The unclear public record on Tenet's proposed capital investment program raises serious questions about whether Tenet is really committed to replacing its Mt. Pleasant facility or whether Tenet is posturing with an intent to preserve its position as the sole hospital provider located East of the Cooper.

Indications of Feasibility from Ratings Agencies and Analysts:

The following quote was taken from an S&P Research Report dated October 17, 2005:

"Tenet's current financial policy is influenced by its minimal financial cushion, weak cash flow, and low operating margins. The company must focus on improving cash flow and credit protection measures. Acquisition efforts, share repurchases, and significant debt issuance are not viable strategies, at least for the next couple of years."

The following was taken from a Morningstar report dated October 24, 2005:

"On the operational front, we think Tenet's three-year-old turnaround effort is flailing. Admissions are still falling, and we expect the firm to post a loss for the third consecutive year in 2005."

The message from these investment analysts appears to be that Tenet should focus on its existing 69 core facilities before pursuing debt issuances to fund new and replacement facilities. Importantly, Tenet appears to endorse this strategy as well based on comments made on March 2, 2006 by Tenet CEO, Trevor Fetter, during Tenet's Q4 2005 Earnings Call (see below).

001184

Public Statements by Tenet's Own Senior Management:

The following quote from Robert Shapard, Tenet CFO, appeared in a November 2005 issue of HFM Magazine:

"Today we are not generating sufficient cash to support the company's capital needs."

Additionally, a December 10, 2005 article appearing in the El Paso Times indicated that Tenet's plans to build the El Paso facility hinged on an \$8 million property tax break from the city and county. In the article, it was indicated that without the tax break, Tenet might decide not to go ahead with the project, in part because of losses the company suffered in New Orleans.

Lastly, and of significant importance, during its Q4 2005 Earnings Call on March 2, 2006, Tenet appears to reassure the investor community of its focus on improving core operations. Prepared remarks from that call include the following statements by Trevor Fetter, Tenet's CEO:

"A number of you have expressed concern that our levels of capital expenditures are too low. But its hard to compare one company to another, and even harder to compare Tenet in 2005 to Tenet in prior years. The reason is that we have changed the nature of what we spend our capital dollars on. Leading up to 2003, it used to be concentrated on large multi-year construction projects, including new hospitals, new wings and towers. Now we target our spending to support our quality and growth initiatives in our core hospitals...Equipment and technology will be the focus of our investments in 2006."

Additionally, Tenet presents forecasted financial information for which the "...forecasted level of interest expense assumes the company's level of outstanding debt in 2006 remains constant with the current level."

Tenet's prepared remarks appear to send a strong message to the investor community of the company's intent to spend available capital on equipment and technology in core operations, not on multi-year construction projects including new hospitals. Once again, Tenet makes no mention of its commitments to construct new and replacement facilities in South Carolina and Texas.

As the above discussion illustrates, Tenet's promises regarding its ability to fund its proposed capital projects expressed in its Certificate of Need applications must be reconciled with concerns regarding Tenet's liquidity expressed in Tenet's securities filings, public statements by Tenet's management, and commentary provided by industry analysts. Furthermore, the lack of specificity in Tenet's securities filings regarding the funding of the South Carolina and Texas projects, combined with concerns regarding Tenet's liquidity, raises concerns that Tenet is overcommitted on capital projects.

001185

ROPER ST. FRANCIS HEALTHCARE

**Roper St. Francis Healthcare
Mt. Pleasant Hospital CON Application**

**Presentation to DHEC Offering Further Evidence
of the Need for Choice in the Mt. Pleasant
Community**

February 27, 2006

001186

Topics

This presentation focuses on two specific matters pertaining to the feasibility of Tenet's Certificate of Need application for a replacement hospital in Mt. Pleasant, South Carolina:

- #1 - Tenet proposes to place a significant financial burden on the residents and employers of the Mt. Pleasant community; and
- #2 - Parties should seek to clarify Tenet's disclosures regarding capital commitments.

001187

ROPER ST. FRANCIS HEALTHCARE

2

What is Driving the Financial Burden Tenet Proposes?

The construction of a new and/or replacement hospital facility by a financially ailing public company creates an unusual set of fiscal circumstances in which the costs associated with the applicant's, (1) elevated cost of capital, and (2) need to generate a high, risk adjusted rate of return for investors, must be passed on to the community in which the facility is constructed. This issue is further exacerbated when such a facility is constructed in a community that does not house competing hospital facilities.

001188

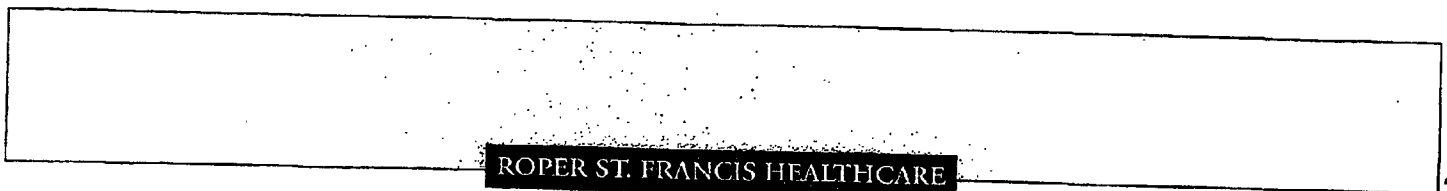
ROPER ST. FRANCIS HEALTHCARE

3

Tenet ECRMC Projected EBITDA Margin

	<u>EBITDA Margin %</u>
Tenet - ECRMC (Proj 2009)	28.3%
Tenet Healthcare (2004)	4.6%
HCA, Inc (2004)	16.9%
Triad Hospitals (2004)	13.8%
Universal Health Services (2004)	12.4%
S & P Median "A" Rated Hospitals (2004)	10.7%

001189



ROPER ST. FRANCIS HEALTHCARE

4

What is Generating High Margins?

	Tenet - ECRMC		Benchmark Data	
	<u>Projected 2010</u>	<u>Budget 2005</u>	<u>Median *</u>	<u>Top Quartile *</u>
Occupancy %	58.7%	55.4%	61.5%	67.4%

	Tenet - ECRMC		Benchmark Data	
	<u>Projected 2010</u>	<u>Budget 2005</u>	<u>Median *</u>	<u>Top Quartile *</u>
Operating Expense Per Adjusted Discharge	\$9,431	\$6,934	\$5,934	\$5,242

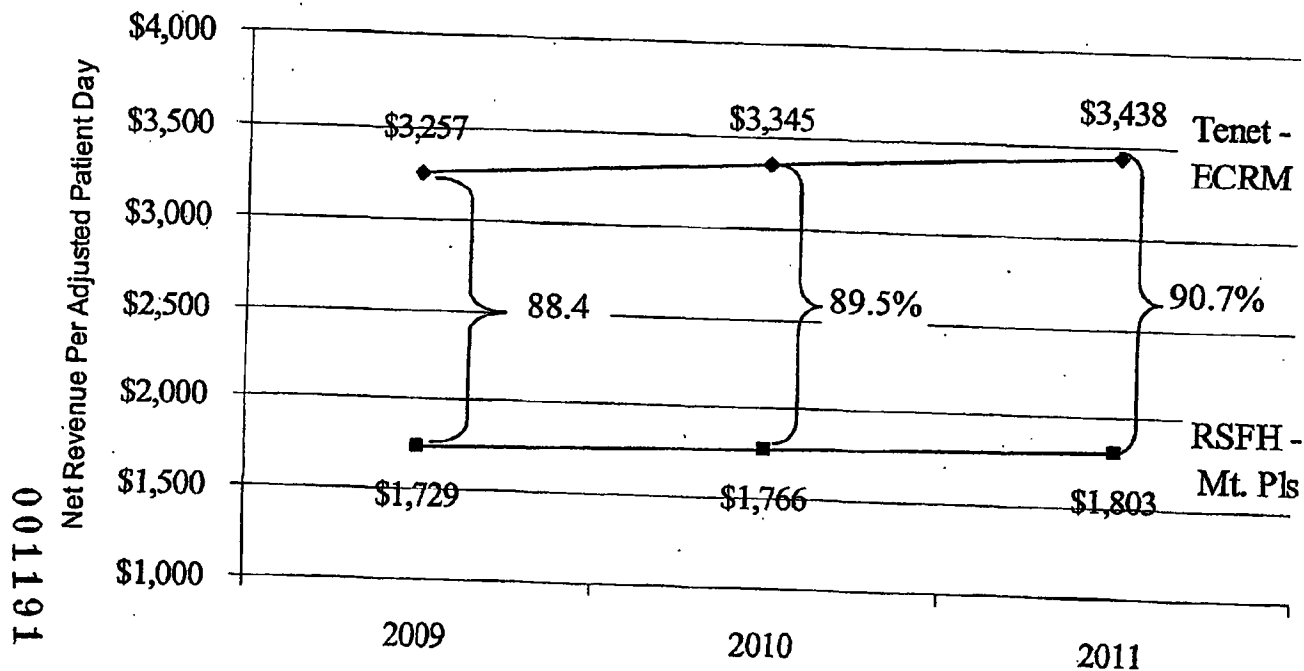
	Tenet - ECRMC		Benchmark Data	
	<u>Projected 2010</u>	<u>Budget 2005</u>	<u>Median *</u>	<u>Top Quartile *</u>
Net Revenue Per Adjusted Discharge	\$14,792	\$10,838	\$6,787	\$7,717

* Source - Solucient Action Q-I 12 month period ending 9/30/05

ROPER ST. FRANCIS HEALTHCARE

5

Tenet vs. RSFH Net Revenue Projections



ROPER ST. FRANCIS HEALTHCARE

Tenet ECRMC Projected IRR & Revenue Per Bed

Tenet ECRMC - Required Revenue per Bed (\$ in Millions)

Projected EBITDA Margin %		Tenet Required IRR %					
		25.00%	26.00%	27.00%	28.00%	29.00%	30.00%
	25.00%	\$1.12	\$1.17	\$1.21	\$1.26	\$1.30	\$1.35
	26.00%	\$1.08	\$1.12	\$1.16	\$1.21	\$1.25	\$1.29
	27.00%	\$1.04	\$1.08	\$1.12	\$1.16	\$1.20	\$1.25
	28.00%	\$1.00	\$1.04	\$1.08	\$1.12	\$1.16	\$1.20
	29.00%	\$0.97	\$1.01	\$1.04	\$1.08	\$1.12	\$1.16
	30.00%	\$0.93	\$0.97	\$1.01	\$1.05	\$1.08	\$1.12

001192

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7

Revenue Per Bed Benchmarks

Revenue per Bed Metrics

South Carolina Statistics ¹

	<u>Average</u>	<u>Median</u>
All Facilities	\$604,655	\$629,601
Below 50 Beds	\$417,257	\$337,230
Between 51-100 Beds	\$510,438	\$412,828
Between 101-150 Beds	\$614,437	\$621,469
Between 151-200 Beds	\$650,072	\$640,353
Over 200 Beds	\$812,307	\$775,506

Notes:

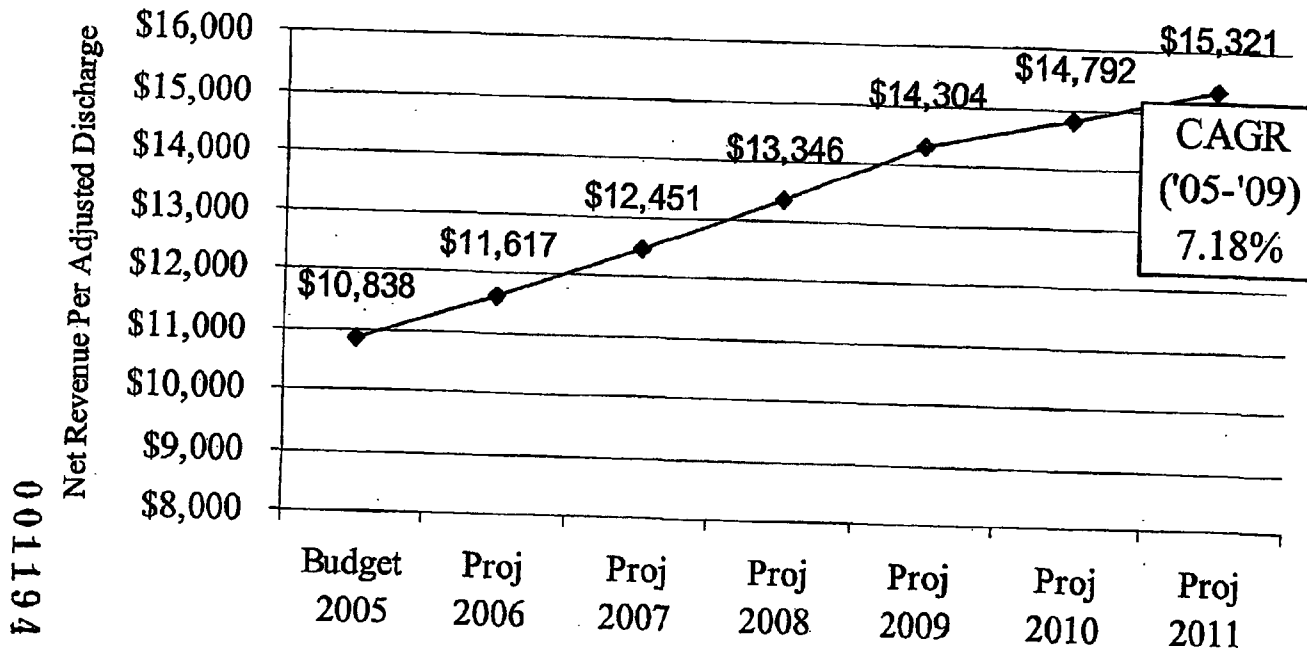
¹ Per ahd.com database (excludes long-term care, behavioral care and rehab.)
Fiscal year 2004 data.

001193

ROPER ST. FRANCIS HEALTHCARE

8

Revenue Growth Required to Achieve Projections



ROPER ST. FRANCIS HEALTHCARE

Computed Increase Required From Commercially Insured

<u>Payor Mix *</u>		<u>Annual % Increase in Reimbursement</u>	Solved for	<u>Solve For Needed Annual Increase in Commercial Reimbursement</u>	
Commercial	55.0%			$.55 (X) + .45 (2.0\%) = 7.18\%$	
Medicare	30.0%	2.0%		$.55 (X) + .9\% = 7.18\%$	
Medicaid	10.0%	2.0%		$0.55 (X) = 6.28\%$	
Self Pay	3.0%	2.0%		$X = 6.28 / .55$	
Other	<u>2.0%</u>	2.0%		$X = 11.42\%$	
	<u>100.0%</u>				

001195

* Estimates by RSFH with guidance from information available at www.ahd.com

ROPER ST. FRANCIS HEALTHCARE

10

Support for EBITDA margins appearing on slide 4

- 1) EBITDA margin for Tenet ECRMC (Proj. 2009): CON Revised Attachment J, 2009 EBITDA of \$39,950,498 divided by net revenue of \$140,924,290 equals projected EBITDA margin of 28.3%
- 2) S&P median "A" rated hospitals Taken from S&P Commentary Report "U.S. Not-For-Profit Health Care 2004 Median Ratios." All health care median ratio 10.7%
- 3) The following EBITDA margin percentages were calculated below using each company's Form 10-K filed with the Securities Exchange Commission for fiscal year 2004:

	—millions—			thousands
	Tenet	HCA	Triad	Universal
Net operating revenues	9,919	23,502	4,450.2	3,938,320
Income (loss) from continuing operations	(1,797)	1,246	138.0	170,006
Income taxes	184	727	85.3	101,137
Interest expense	333	563	113.7	43,405
Depreciation and amortization	388	1,250	186.4	155,514
Impairment of long-lived assets & goodwill	1,236	12	-	-
Loss from early extinguishment of debt	13	-	-	-
Restructuring charges	36	-	-	-
Costs of litigation and investigations	74	-	-	-
Minority interests	(3)	168	5.4	20,216
Gains on sales of facilities, etc.	(10)	-	-	-
Refinancing transaction costs	-	-	76.0	-
ESOP expense	-	-	10.3	-
Interest income	-	-	(2.6)	-
Adjusted EBITDA*	454	3,966	612.5	490,278
Adjusted EBITDA %	4.6%	16.9%	13.8%	12.4%

* Adjusted EBITDA as per shown in 10-K for HCA and Triad.
Tenet and Universal did not include this calculation in the notes to their 10-K's.

Note regarding EBITDA:

EBITDA is not considered a measure of financial performance under U.S. generally accepted accounting principles ("GAAP"), and the items excluded from EBITDA are significant components in understanding and assessing financial performance.

Since EBITDA is not a measure determined in accordance with GAAP and is thus susceptible to varying calculations, EBITDA, as presented, may not be comparable to other similarly titled measures of other companies.

001196

Support for percentages appearing on slide 5

		Projected 2010	Budget 2005
1) Occupancy %	Taken directly from Tenet ECRMC CON Revised Attachment J	68.7%	55.4%
2) Operating expense per adjusted discharge	Calculated below from numbers appearing in Tenet ECRMC CON Revised Attachment J:		
	Total Controllable Expenses	\$ 99,085,431	\$ 58,150,293
	Less - Provision for Bad Debts	(13,137,915)	(4,961,324)
	Add:		
	Depreciation and Amortization	7,703,621	2,786,433
	Interest Expense	4,885,788	4,885,788
	Total Expenses	98,546,925	60,861,190
	divided by Adjusted Discharges	10,449	8,777
	Operating Expense per Adjusted Discharge	\$ 9,431	\$ 6,934

Note: Expenses do not include federal and state taxes
or non-controllable expenses to promote a conservative
comparison to the benchmark data

3) Net revenue per adjusted discharge	Calculated below from numbers appearing in Tenet ECRMC CON Revised Attachment J:		
	Net Revenue	\$ 154,563,707	\$ 95,126,883
	divided by Adjusted Discharges	10,449	8,777
		\$ 14,792	\$ 10,838

001197

Support for required revenue per bed calculations appearing on slide 7

The table below calculates various revenue per bed requirements given various EBITDA margins and IRR percentages, along with assumptions about project cost and total beds. The formula contained in each cell is project cost multiplied by IRR % divided by EBITDA margin with the resulting amount then divided by total beds. The table illustrates that Tenet, with its projected EBITDA margins during 2009 through 2011 of approximately 28% is projecting an IRR on this project of between 25% and 30%. To generate this level of return, ECRMC must generate between \$1 million and \$1.2 million per bed during 2009 through 2011. Slide 8 compares this level of revenue per bed to South Carolina norms.

Total Beds - Tenet ECRMC 140
 Assumed Project Cost of (In millions): \$ 157.0

<i>Tenet ECRMC - Required Revenue per Bed (All Amounts in Millions)</i>								
		Tenet Required IRR %						
		25.0%	26.0%	27.0%	28.0%	29.0%	30.0%	
Projected EBITDA Margin %	25.0%	\$ 1.12	\$ 1.17	\$ 1.21	\$ 1.26	\$ 1.30	\$ 1.35	
	26.0%	\$ 1.08	\$ 1.12	\$ 1.16	\$ 1.21	\$ 1.25	\$ 1.29	
	27.0%	\$ 1.04	\$ 1.08	\$ 1.12	\$ 1.16	\$ 1.20	\$ 1.25	
	28.0%	\$ 1.00	\$ 1.04	\$ 1.08	\$ 1.12	\$ 1.16	\$ 1.20	
	29.0%	\$ 0.97	\$ 1.01	\$ 1.04	\$ 1.08	\$ 1.12	\$ 1.16	
	30.0%	\$ 0.93	\$ 0.97	\$ 1.01	\$ 1.05	\$ 1.08	\$ 1.12	

001199

Trident_09521

Support for net revenue per bed amounts appearing on slide 8

Mean and median net revenue per bed for South Carolina facilities was calculated using the table information contained in the table was obtained from www.ahd.com and represents fiscal year 2004 data. In the table that ECRMC's 2004 net revenue per bed was \$848,053. In their CON, they project net revenue per bed of approximately \$1,007,000 in 2009 and \$1,207,000 in 2011, well above South Carolina norms. Also note the modest occupancy projections appearing on slide 5.

South Carolina Statistics:

	Average	Median
All Facilities	\$ 604,656	\$ 629,601
Below 50 Beds	417,257	337,230
Between 51-100 Beds (w/o ECRMC)	510,438	412,828
Between 101-150 Beds	814,437	621,469
Between 151-200 Beds	650,072	640,353
Over 200 Beds	812,307	775,608

001200

Hospital Name	Beds	City	State	ZIP	NPR	Discharges	Patient Days
Charleston Memorial Hospital	20	Charleston	SC	29401	4,523,784	284	6,317
Carolinas Hospital System - Lake City	22	Lake City	SC	29560	17,004,156	991	5,826
Allendale County Hospital	25	Fairfax	SC	29827	8,557,818	541	4,462
Barnwell County Hospital	28	Barnwell	SC	29912	12,344,142	1,175	5,149
Regency Hospital of Florence	28	Florence	SC	29501	9,300,142	276	8,821
Williamsburg Regional Hospital	28	Kingsree	SC	29556	11,879,016	1,495	5,293
Armed Healthsouth Rehabilitation Hospital	30	Anderson	SC	29621	9,963,621	698	9,892
Intermedical Hospital Of South Carolina Inc.	35	Columbia	SC	29201	8,283,322	165	7,923
Clarendon Memorial Hospital	38	Manning	SC	29102	28,513,932	3,132	11,890
Kindred Hospital - Charleston	39	Charleston	SC	29401	11,183,754	343	10,785
Abbeville County Memorial Hospital	40	Abbeville	SC	29820	18,776,338	1,266	4,348
EDGEFIELD COUNTY HOSPITAL	40	EDGEFIELD	SC	29824	8,368,248	812	8,221
Hilcrest Hospital	43	Simpsonville	SC	29881	37,593,211	1,960	9,839
McLeod Medical Center - Darlington	49	Darlington	SC	29532	7,062,347	860	9,430
Fairfield Memorial Hospital	50	Winnabro	SC	29180	9,130,615	747	3,468
Waccamaw Community Hospital	54	Murrells Inlet	SC	29578	50,552,446	4,165	16,801
Cr... Memorial Hospital	55	Pickens	SC	29671	19,880,033	1,351	6,088
Al... Hospital	58	Greer	SC	29652	40,368,612	3,272	17,165
Br... County Hospital	60	Bamberg	SC	29903	22,913,718	1,683	6,805
Ch... General Hospital	59	Cheraw	SC	29520	29,699,014	2,916	10,498
Chester Regional Medical Center	64	Chester	SC	29708	26,421,013	1,795	7,931
Hampton Regional Medical Center	68	Vamville	SC	29944	10,816,540	1,009	3,766
Laurens County Hospital	76	Clinton	SC	29325	44,632,134	2,981	14,484
Palmetto Health Baptist Eastley	79	Eastley	SC	29840	60,917,333	5,504	20,094
MacLeod Medical Center - Dillon	79	Dillon	SC	28536	31,453,774	4,101	13,678
Newberry County Memorial Hospital	80	Newberry	SC	29108	27,922,210	2,989	12,742
Hilton Head Regional Medical Center	93	Hilton Head Island	SC	29928	79,683,499	5,226	21,852
Marlboro Park Hospital	94	Bennettsville	SC	29512	23,956,853	1,753	6,217
East Cooper Regional Medical Center	100	Mount Pleasant	SC	29484	84,805,285	6,193	22,802
Mary Black Healthcare	103	Spartanburg	SC	29307	107,738,170	6,207	28,417
Loris Community Hospital	105	Loris	SC	29569	65,254,193	4,782	17,829
Wallace Thomson Hospital	107	Union	SC	29379	31,411,129	3,639	16,083
Marion County Medical Center	110	Mullins	SC	29574	65,015,098	7,376	32,685
Kershaw County Medical Center	113	Camden	SC	29020	65,959,549	6,201	26,419
Carolina Pines Regional Medical Center	116	Hartsville	SC	29550	79,797,929	8,574	37,623
Oconee Memorial Hospital	122	Seneca	SC	29672	109,274,757	7,089	36,743
Colleton Medical Center	123	Walterboro	SC	29488	42,740,732	4,965	25,335
Upstate Carolina Medical Center	125	Gaffney	SC	29340	39,677,972	4,669	18,180
Bon Secours Saint Francis Hospital	141	Charleston	SC	29414	99,726,945	8,790	43,462
Georgetown Memorial Hospital	142	Georgetown	SC	29440	94,745,251	7,360	38,910
Beaufort Memorial Hospital	153	Beaufort	SC	29902	99,548,022	9,575	45,520
Conway Medical Center	160	Conway	SC	29528	110,471,611	10,341	36,991
Springs Memorial Hospital	172	Lancaster	SC	29720	108,211,485	7,334	31,512
Aiken Regional Medical Centers	197	Aiken	SC	29802	124,122,783	9,978	45,742
Guomey Regional Medical Center	210	Sumter	SC	29150	164,369,135	11,314	64,630
Grand Strand Regional Medical Center	219	Myrtle Beach	SC	29572	150,072,299	11,023	52,303
Self Regional Healthcare	250	Greenwood	SC	29648	232,715,353	13,607	67,468
Regional Medical Center of Orangeburg	251	Orangeburg	SC	29118	151,763,199	9,178	51,672
Piedmont Medical Center	268	Rock Hill	SC	29732	207,356,585	15,800	61,019
Saint Francis Hospital	268	Greenville	SC	29601	193,768,891	14,178	74,116
Edgington Medical Center	282	West Columbia	SC	29169	316,958,911	19,137	100,610
Carolinas Hospital System	284	Florence	SC	29505	166,165,639	14,168	76,378
... Hospital	304	Columbia	SC	29204	236,297,478	15,697	79,408
... Health Baptist	321	Columbia	SC	29220	246,915,801	21,311	90,531
... Medical Center	349	Charleston	SC	29408	284,800,379	20,291	101,649
McLeod Regional Medical Center	388	Florence	SC	29506	380,094,660	25,087	125,626
Armed Health	398	Anderson	SC	29621	287,626,818	20,432	93,345
Topper Hospital	414	Charleston	SC	29401	252,979,073	15,693	91,166
Spartanburg Regional Medical Center	422	Spartanburg	SC	29303	460,433,563	28,650	133,858
Medical University of South Carolina	459	Charleston	SC	29425	497,724,058	25,822	144,551
Palmetto Health Richland	575	Columbia	SC	29203	430,633,814	24,855	170,097
Greenville Memorial Medical Campus	744	Greenville	SC	29605	647,552,988	35,542	222,128

Trident_09522

RECORD 007412

Support for revenue growth projections on slide 9

Net revenue per adjusted discharge for years 2005, 2009, 2010 and 2011 calculated from data contained in Tenet ECRM CON Revised Attachment J, as follows:

	2005	2009	2010	2011
Net Revenue	\$ 95,126,883	\$ 140,924,290	\$ 154,563,707	\$ 168,934,777
Divided by Adjusted Discharges	8,777	9,852	10,449	11,026
Net Revenue per Adjusted Discharge	<u>\$ 10,838</u>	<u>\$ 14,304</u>	<u>\$ 14,792</u>	<u>\$ 15,321</u>

Net revenue per adjusted discharge for years 2006, 2007 and 2008 calculated using computed compound annual growth rate necessary to bridge above 2005 and 2009 projected amounts:

Computation of CAGR 2005 through 2009 (see formula embedded in cell D28) 7.18%

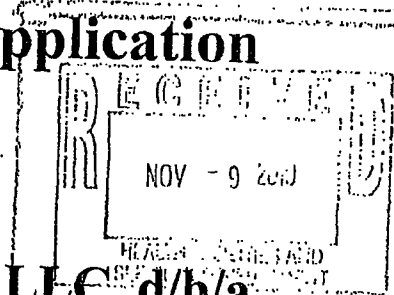
Calculation of 2006, 2007 and 2008 net revenue per adjusted discharge:

	2006	2007	2008
Previous Years Net Revenue per Adjusted Discharge	\$ 10,838	\$ 11,817	\$ 12,451
Multiplied by 1 Plus CAGR Above	7.18%	7.18%	7.18%
Net Revenue per Adjusted Discharge	<u>\$ 11,617</u>	<u>\$ 12,451</u>	<u>\$ 13,348</u>

001201

Certificate of Need Application

Submitted by:



**Trident Medical Center, LLC, d/b/a
Summerville Medical Center**



For

The Addition of 30 Acute Care Beds

November 2010

000001

**APPLICATION FOR CERTIFICATION OF NEED
FOR A HEALTH FACILITY OR SERVICE**

Proposal Prepared By:

Name: Louis F. Caputo

Title: Chief Executive Officer

Organization: Summerville Medical Center

Address: 295 Midland Parkway

City: Summerville **State:** SC

Zip Code: 29485 **Telephone Number:** 843-832-5101

The Applicant hereby certifies that the information contained in this Application, including all assurances and attachments, are correct to the best of his knowledge and belief.

Signature: Louis F. Caputo

Date: Nov. 8, 2010

Please copy all correspondence related to this application to:

Andrea Brisbin, Esq.
Parker Poe
200 Meeting Street
Charleston, SC 29401-3156

Daniel Sullivan
Sullivan Consulting Group
2090 Bethany Way
Alpharetta, GA 30004

Forward to:

**Bureau of Health Facilities and Services Development
S.C. Department of Health and Environmental Control
2600 Bull Street, Columbia, S.C. 29201**

000002

**APPLICATION FOR CERTIFICATION OF NEED
FOR A HEALTH FACILITY OR SERVICE**

NOTE: A "complete" application shall include a written narrative report by the applicant (Regulation 61-15, Section 202).

PART A - QUESTIONNAIRE (Page 1)

1. Name of Facility

Trident Medical Center, LLC d/b/a Summerville Medical Center

2. Address, City, County, State, Zip Code

295 Midland Parkway, Summerville, SC 29485

3. Type of Facility (Circle)

☒ **A. Hospital**

☐ **B. Nursing Home**

☐ **C. Psychiatric
Facility**

☐ **D. Rehabilitation**

☐ **E. Substance
Abuse Facility**

☐ **F. Ambulatory
Surgery Facility**

☐ **G. Other (Specify)** _____

4. Purpose of Review (Circle)

☐ **A. New Facility**

☐ **B. Change of
Licensure**

☒ **C. Addition to Existing Facility**

☒ **D. Renovation of Existing Facility**

☐ **E. Change of Services**

☐ **F. Other (Specify)**

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PART A - QUESTIONNAIRE (Page 2)

5. Management

A. Name of Administrator Louis Caputo	B. Address, City, State, Zip Code 295 Midland Parkway Summerville, SC 29485
C. Telephone 843-832-5000	D. Name of Licensee Trident Medical Center, LLC

6. Ownership or control of the facility (attach a list of names and addresses of the owners of the facility, indicating percent of ownership of each owner, the person responsible for the proposal, and the attorney(s) representing the proposal). Circle the appropriate information regarding ownership.

A. Individual	B. Partnership	C. Corporation	D. Proprietary
E. Non-Profit	F. Government (Specify) _____	G. Other (Specify) _____	

7. Is the Proposed Site of the Property?

A. Owned	B. Leased	C. Length of Site Lease _____
D. Option	E. Length of Option _____	
F. Name and Address of Owner(s) of Real Property		

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PART A - QUESTIONNAIRE (Page 3)**8. Total Bed Capacity for Which Application is Made:****Existing Facilities**

	New Facility Only	Existing Beds	# Gained or Lost	Bed Total
Type of Beds				
A. Medical/Surgical		74	27	109
B. Obstetrics		12	(5)	7
C. Pediatrics				
D. Substance Abuse				
E. Psychiatric				
F. Rehabilitation				
G. Nursing Care				
H. RTC's				
I. ICU/CCU		8		8
J. Other: Step Down			8	8
K. TOTAL		94	30	124

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PART A - QUESTIONNAIRE (Page 4)

9. Construction and Site	
(1) Type of Construction Renovation/Expansion	B. Number of Buildings One C. Number of Stories Three
D. Size of the Site in Acres N/A	E. Square Footage of the Facility Project Affects: New Construction: 50,138 s.f. Renovation: 1,867 s.f.
F. Anticipated Date of Beginning Construction July 1, 2011	G. Anticipated Date of Licensing or Project Completion July 1, 2013
10. Zoning of Construction Site Commercial	
11. Costs (Provide Estimated Cost Statement from Either the Architect or Engineer) Included in Attachment B	
A. Land Cost Not applicable	B. Construction Cost \$16,368,774
C. Architect's Fee \$1,174,293	D. Equipment Costs 1) Fixed Equipment: 2) Movable Equipment: \$4,552,672
E. Financing Cost During Construction: \$1,066,190	
F. Other Costs: Contingency \$3,799,627	G. Total Project Cost \$26,961,556
H. Construction and Equipment Cost: \$20,921,446 1) Per Square Foot: \$402.30 2) Per Bed: \$697,382	

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- (11) Demonstrate that the proposed project is needed or projected as necessary to meet an identified need of the public. This shall address at a minimum: identification of the target population; the degree of unmet need; projected utilization of the proposed facility or service; utilization of existing facilities and services; past utilization of existing similar services within the facility; and justification that the proposed project will not unnecessarily duplicate existing entities. The applicant must show all assumptions, data sources, and methodologies used. The applicant must use population statistics consistent with those generated by the State Demographer, State Budget and Control Board.

Summerville Medical Center (SMC), a 94-bed acute care hospital located in Summerville, is part of the Trident Health System, which is the principal provider of health care services in Dorchester and Berkeley Counties as well as northern Charleston County. SMC was established in 1993 to serve primarily the needs of Dorchester County residents. SMC grew out of a freestanding emergency department and outpatient center constructed in 1989 to become an important component of the health care systems for Dorchester County and surrounding areas. This application seeks the addition of 30 additional acute care beds to address the increasing demand for inpatient services in the service area as well as the current and projected occupancy levels for SMC. The proposed beds will include 22 medical/surgical beds and 8 Step Down beds, which will result in the following bed distribution for SMC.

Licensed Bed Unit	Current Beds	Proposed Beds	# Gained
ICU	8	8	0
Step Down	0	8	8
Medical/Surgical	74	96	27
OB (Post Partum)	7	7	0
OB (LDRP)	5	0	(5)
Total Licensed Beds	94	124	30
Non-Licensed Capacity			
Level II Special Care Nursery	3	3	0
Well Baby	10	10	0

The creation of an 8-bed Step Down Unit is an important component of this project since currently SMC only has 8 intensive care unit (ICU) beds to address the needs of patients requiring a higher acuity of care. As a consequence, at times when SMC's ICU is full, it must transfer patients requiring a higher level to another facility. With the additional beds, SMC will be able to transition patients in the ICU to the Step Down as their conditions improve providing the capability to serve a broader range of patients.

Trident Medical Center (TMC) is also part of Trident Health System. TMC is a regional referral center located in northern Charleston County. The original CON application for TMC was filed by HCA in 1972 as a replacement facility for two small county hospitals in Berkeley and Dorchester Counties. TMC's role as a replacement facility for the two existing hospitals was expressly recognized by the governing bodies of the two then-existing hospitals by their

agreement to cease operations of their respective facilities and endorse the construction of what was then called North Trident Regional Hospital. The facility was also approved to serve the growing population of Northern Charleston County, which was distant from the hospitals clustered in downtown Charleston.

Trident Health System has remained focused on its initial mission of meeting the needs of Charleston, Berkeley, and Dorchester Counties through bed expansions and service additions over the years. In 2009, Trident Health System received approval to develop a 50-bed hospital in Moncks Corner in Berkeley County. The Berkeley Medical Center will address the needs of Berkeley County residents for accessible care. This proposed 30-bed expansion for SMC also advances this mission by ensuring that adequate bed capacity will be available to Dorchester County residents in the future.

The 2008-2009 South Carolina Health Plan identifies a need for 24 additional beds at SMC in 2013. An excess of beds is calculated in the aggregate for Charleston, Berkeley, and Dorchester Counties. In this case, the following criterion is applicable to the project:

- d. If a county indicates a surplus of beds, then no additional beds will be approved unless an individual hospital in the county indicates a need for additional beds. Should an individual hospital indicate a need for additional beds, then a maximum of the actual projected bed need or up to 50 additional beds may be approved for that hospital to allow for the construction of an economical unit at either the existing hospital site or another site, if the existing hospital is relocating or has relocated in whole or in part to that site. The hospital requesting the addition must document the need for additional beds beyond those indicated as needed by the methodology stated above, based on historical and projected utilization, as well as projected population growth or other factors demonstrating the need for the proposed beds. Additional beds will only be approved for the specific hospital indicating a need.*

Consistent with this criterion, SMC is requesting the addition of 30 acute care beds, six more than identified under the need methodology, because this will provide for the construction of an efficiently designed unit. This request for six beds beyond the number calculated under the methodology is supported by the historical and projected utilization growth at SMC and other factors, as demonstrated in the following sections.

Target Population

SMC's service area is centered in Dorchester County but includes contiguous ZIP Codes in Charleston, Berkeley, and Colleton Counties. The primary service area encompasses 80% of all discharges from SMC in 2009 while the secondary service area represents another 14% of SMC discharges. Table 1 presents the 2009 patient origin by ZIP Code for SMC.

The estimated 2010 population and the projected 2016 population of the service area are presented in Table 2. Population projections from the South Carolina Budget and Control Board, Office and Research and Statistics (ORS) are not available at the ZIP Code level. As a result, ZIP Code population was obtained from Claritas, Inc., a national provider of demographic data.

The Claritas projections are somewhat higher than the ORS projections, but Claritas projections reflect more recent information. The following table compares the 2010 population estimates and the 2015 population projections for Berkeley, Charleston, and Dorchester Counties obtained from Claritas and ORS.

Comparison of Claritas and ORS Population Projections

County	Claritas		ORS		% Difference	
	2010	2015	2010	2015	2010	2015
Berkeley	176,145	193,398	162,370	172,940	-7.8%	-10.6%
Charleston	354,316	373,770	339,140	347,910	-4.3%	-6.9%
Dorchester	133,535	151,732	122,170	131,530	-8.5%	-13.3%

Source: Claritas; S.C. Budget and Control Board, Office of Research and Statistics

The population of SMC's primary service area is expected to increase from 245,301 in 2010 to 279,408 in 2015. The population of the secondary service area is projected to increase from 226,867 to 240,182 over this period. The fastest growing segment of this population is the age cohort age 65 and older. In the primary service area, the 65 and older population is projected to increase by 7.19% annually, more than three times the growth rate for the total population. In the secondary service area, the 65 and older population is projected to increase by 3.52% annually, which again is more than the three times the rate of increase in the total population.

This aging of the population in the SMC service area has important implications in planning for hospital capacity in the future. Older individuals utilize hospital services at a significantly higher rate than younger residents. According to data obtained from ORS for 2009, the rate of discharges per 1,000 population in the SMC service area was 307.9 for residents age 65 and older compared with a rate of 120.4 discharges per 1,000 for the total population.

Figure 1 presents the service area of SMC and the other providers in the Tri-county area. SMC is well positioned to address the needs of residents of this service area assuming that sufficient bed capacity is available. This project will ensure that SMC will be able to accommodate growth in demand for hospital services over the next several years.

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Table 1
Summerville Medical Center
2009 Patient Origin by ZIP Code

Service Area	Zip Code	City	SMC Discharges	% of Total
Primary	29445	Goose Creek	301	5.5%
Primary	29485	Summerville	1,341	24.5%
Primary	29483	Summerville	1,567	28.6%
Primary	29472	Ridgeville	232	4.2%
Primary	29437	Dorchester	73	1.3%
Primary	29456	Ladson	495	9.0%
Primary	29420	North Charleston	193	3.5%
Primary	29418	North Charleston	166	3.0%
Primary	29484	Summerville	24	0.4%
Subtotal Primary Service Area			4,368	79.8%
Secondary	29488	Walterboro	54	1.0%
Secondary	29479	Saint Stephen	18	0.3%
Secondary	29477	Saint George	72	1.3%
Secondary	29474	Round O	15	0.3%
Secondary	29471	Reevesville	17	0.3%
Secondary	29448	Harleyville	52	0.9%
Secondary	29461	Moncks Comer	187	3.4%
Secondary	29436	Cross	34	0.6%
Secondary	29435	Cottageville	58	1.1%
Secondary	29431	Bonneau	24	0.4%
Secondary	29414	Charleston	26	0.5%
Secondary	29407	Charleston	22	0.4%
Secondary	29406	Charleston	97	1.8%
Secondary	29405	North Charleston	23	0.4%
Secondary	29404	Charleston AFB	17	0.3%
Secondary	29059	Holly Hill	36	0.7%
Secondary	29048	Eutawville	35	0.6%
Subtotal Secondary Service Area			787	14.4%
Total Service Area			5,155	94.1%
In-Migration			322	5.9%
Total			5,477	100.0%

Source: SMC internal records

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Table 2
Summerville Medical Center Service Area Population
2010

Zip Code	City	Under 15	15-44	45-64	65+	Total
Primary Service Area						
29445	Goose Creek	13,426	26,962	13,740	4,471	58,599
29485	Summerville	10,022	19,651	12,973	4,930	47,576
29483	Summerville	13,196	25,590	16,462	6,259	61,507
29472	Ridgeville	1,398	4,709	2,567	966	9,640
29437	Dorchester	439	961	708	320	2,428
29456	Ladson	4,760	9,361	5,659	1,859	21,639
29420	North Charleston	4,933	8,443	4,846	1,391	19,613
29418	North Charleston	5,563	10,709	5,967	2,060	24,299
Subtotal Primary Service Area		53,737	106,386	62,922	22,256	245,301
Secondary Service Area						
29488	Walterboro	4,868	8,722	5,919	3,364	22,873
29479	Saint Stephen	1,721	2,816	1,771	930	7,238
29477	Saint George	1,265	2,745	1,851	1,066	6,927
29474	Round O	419	762	586	297	2,064
29471	Reevesville	310	654	423	226	1,613
29448	Harleyville	492	1,021	683	340	2,536
29461	Moncks Comer	5,762	10,569	7,514	3,455	27,300
29436	Cross	969	1,695	1,292	652	4,608
29435	Cottageville	736	1,414	1,179	513	3,842
29431	Bonneau	1,366	2,375	1,684	830	6,255
29414	Charleston	6,255	12,220	8,973	3,632	31,080
29407	Charleston	5,809	14,635	9,245	6,028	35,717
29406	Charleston	6,810	12,650	5,797	3,227	28,484
29405	North Charleston	6,363	13,669	7,113	4,093	31,238
29404	Charleston AFB	1,323	2,431	431	45	4,230
29059	Holly Hill	1,260	2,342	1,625	841	6,068
29048	Eutawville	869	1,690	1,394	841	4,794
Subtotal Secondary Service Area		46,597	92,410	57,480	30,380	226,867
Total Service Area		100,334	198,796	120,402	52,636	472,168

Source: Claritas, Inc.

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Table 2 (continued)
Summerville Medical Center Service Area Population
2016

Zip Code	City	0-14	15-44	45-64	65+	Total
Primary Service Area						
29445	Goose Creek	14,833	28,048	15,924	6,999	65,731
29485	Summerville	11,520	21,714	15,203	7,466	55,860
29483	Summerville	15,066	27,929	18,663	9,494	71,091
29472	Ridgeville	1,514	4,824	2,638	1,290	10,260
29437	Dorchester	489	1,029	743	435	2,693
29456	Ladson	5,183	9,610	6,434	2,858	24,057
29420	North Charleston	5,658	9,209	6,083	2,231	23,159
29418	North Charleston	6,135	10,716	6,760	2,990	26,576
Subtotal Primary Service Area		60,397	113,069	72,440	33,757	279,408
Secondary Service Area						
29488	Walterboro	4,916	8,674	5,805	3,961	23,349
29479	Saint Stephen	1,888	2,947	1,677	1,176	7,683
29477	Saint George	1,377	2,830	1,917	1,328	7,450
29474	Round O	421	768	560	347	2,095
29471	Reevesville	329	654	456	291	1,729
29448	Harleyville	551	1,089	707	437	2,783
29461	Moncks Corner	6,562	11,494	7,941	4,639	30,620
29436	Cross	1,068	1,846	1,219	848	4,978
29435	Cottageville	714	1,354	1,122	640	3,828
29431	Bonneau	1,596	2,580	1,726	1,132	7,029
29414	Charleston	6,959	12,167	9,783	5,020	33,898
29407	Charleston	6,181	14,030	9,173	7,004	36,372
29406	Charleston	7,557	13,010	6,533	3,976	31,066
29405	North Charleston	6,793	13,903	6,896	4,672	32,257
29404	Charleston AFB	1,269	2,278	650	47	4,236
29059	Holly Hill	1,297	2,250	1,492	935	5,972
29048	Butawville	937	1,682	1,293	960	4,868
Subtotal Secondary Service Area		50,407	93,543	58,924	37,398	240,182
Total Service Area		110,800	206,602	131,327	71,092	519,533

Source: Claritas, Inc.

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Table 2 (continued)
Summerville Medical Center Service Area Population
Compound Annual Growth Rate, 2010-2016

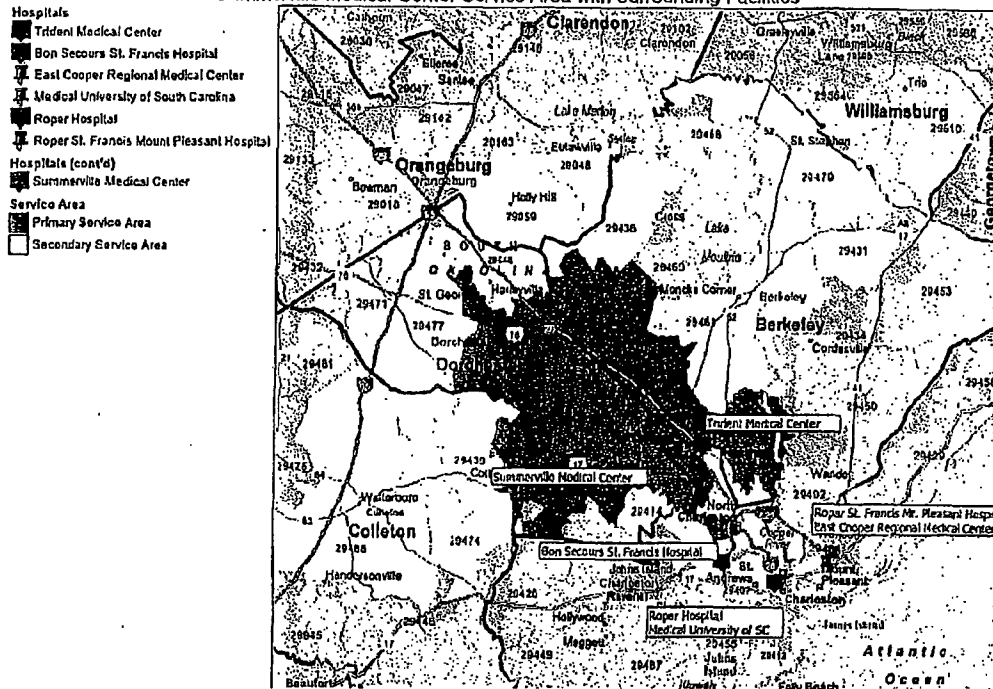
Zip Code	City	0-14	15-44	45-64	65+	Total
Primary Service Area						
29445	Goose Creek	1.68%	0.66%	2.49%	7.75%	1.93%
29485	Summerville	2.35%	1.68%	2.68%	7.16%	2.71%
29483	Summerville	2.23%	1.47%	2.11%	7.19%	2.44%
29472	Ridgeville	1.34%	0.40%	0.46%	4.93%	1.04%
29437	Dorchester	1.80%	1.14%	0.81%	5.23%	1.74%
29456	Ladson	1.43%	0.44%	2.16%	7.43%	1.78%
29420	North Charleston	2.31%	1.46%	3.86%	8.19%	2.81%
29418	North Charleston	1.65%	0.01%	2.10%	6.41%	1.50%
Subtotal Primary Service Area		1.97%	1.02%	2.38%	7.19%	2.19%
Secondary Service Area						
29488	Walterboro	0.16%	-0.09%	-0.32%	2.76%	0.34%
29479	Saint Stephen	1.55%	0.76%	-0.91%	3.99%	1.00%
29477	Saint George	1.43%	0.51%	0.59%	3.73%	1.22%
29474	Round O	0.10%	0.13%	-0.76%	2.62%	0.25%
29471	Reevesville	1.01%	0.00%	1.25%	4.30%	1.16%
29448	Harleyville	1.92%	1.07%	0.58%	4.27%	1.56%
29461	Moncks Corner	2.19%	1.41%	0.92%	5.04%	1.93%
29436	Cross	1.64%	1.43%	-0.96%	4.49%	1.29%
29435	Cottageville	-0.49%	-0.72%	-0.83%	3.76%	-0.06%
29431	Bonneau	2.63%	1.39%	0.41%	5.31%	1.96%
29414	Charleston	1.79%	-0.07%	1.45%	5.54%	1.46%
29407	Charleston	1.04%	-0.70%	-0.13%	2.53%	0.30%
29406	Charleston	1.75%	0.47%	2.01%	3.54%	1.46%
29405	North Charleston	1.09%	0.28%	-0.51%	2.23%	0.54%
29404	Charleston AFB	-0.69%	-1.08%	7.09%	0.87%	0.02%
29059	Holly Hill	0.49%	-0.67%	-1.42%	1.79%	-0.27%
29048	Eutawville	1.26%	-0.08%	-1.25%	2.23%	0.26%
Subtotal Secondary Service Area		1.32%	0.20%	0.41%	3.52%	0.96%
Total Service Area		1.67%	0.64%	1.46%	5.14%	1.61%

Source: Claritas, Inc.

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Figure 1

Summerville Medical Center Service Area with Surrounding Facilities



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Economic Development in the Service Area

Dorchester County has seen continued economic growth despite the economic challenges that the country and region face. There are a number of significant projects in and near Dorchester County that will have a positive impact on Dorchester's future economic and population growth.

A development that will have a regional impact on the SMC service area is the announced plan by Boeing to break ground on a 584,000-square-foot expansion near its existing factory near the Charleston Airport in North Charleston, which is short distance from SMC's location. Work on the first locally made 787 Dreamliner is expected to begin in 2011 with the potential to create 3,800 new jobs in the area. Site work is underway for this facility.

Another development that will impact growth in Dorchester County for many years to come is the recent announcement by MeadWestvaco of the plans for the East Edisto project. In December 2009, the paper products manufacturer rolled out its regional master plan for East Edisto revealing how the 78,000 acres, or 120 square miles, are likely to be developed over the next 50 years. That acreage, which includes the Watson Hill tract on S.C. 61, is on the eastern edge of the Edisto River and stretches from Adams Run in Charleston County to Givhans in Dorchester County.

Clemson University Restoration Institute (CURI) announced that a new wind turbine drive train testing facility that will be constructed at CURI's research campus on the former Navy base in North Charleston. The \$98 million new facility will be capable of full-scale highly accelerated testing of advanced drive train systems for wind, and 90% of the wind turbine manufacturers in the world are expected to use it for testing their units. Because of the size of these units, it is expected that many new wind turbine manufacturers will start locating facilities in an around the CURI facility.

- In anticipation of this, wind power suppliers have already started locating in the vicinity. IMO Group USA, a German-based manufacturer of slew drives and slew rings for wind turbines is an example, and will open its first U.S. operation in Dorchester County. The company expects to create 190 new jobs, and invest \$47 million

In Jedburg, a growing community along the Dorchester-Berkeley County border, major plans for new large-scale distribution and manufacturing facilities, totaling approximately 17 million square feet were announced. Four commercial real estate companies — and a few smaller players as well — are planning to build these facilities on parcels of land located just off Exit 194 on Interstate 26 in Berkeley County. Investors include Trammell Crow Carolinas Development Inc., and Ross Perot Jr.'s Hillwood Development Co, both based in Dallas, the Rockefeller Group out of New York; and Johnson Development Associates from Spartanburg. One of the very few large sites in the country that can accommodate industrial uses, have good access to the interstate systems and are priced competitively.

- MeadWestvaco Corp. has partnered with the Rockefeller Group in that company's plans to build about 2.7 million square feet of distribution space in the Jedburg area. Their first project is TBC Corporation, one of the largest marketers of automotive replacement tires will

be opening a 1.1 million sq. ft., \$52 million distribution center in a new 400-acre industrial park and they expect to create 120 new jobs.

- Hillwood Development, the Ross Perot Jr. company, bought 750 acres in the Jedburg area for a distribution center that is expected to create 3,000 jobs within 10 years, to be called the Charleston Trade Center. Increasing Charleston's warehouse space will allow the state to better handle the flood of goods that are expected to arrive after 2014, when expansions of the Port of Charleston and the Panama Canal are scheduled for completion
- Johnson Development Associates constructed its first building designed specifically for American LaFrance fire trucks, garbage trucks, and rescue units. The company plans to consolidate all of its operations to its Berkeley County headquarters and production facility, allowing the company to streamline production of three distinct product categories thus gaining manufacturing efficiency.
- Johnson leased its second, speculative building to Continental Terminals, a distribution company servicing Starbucks Coffee Co.
- Piggly Wiggly serves as an anchor in the Jedburg commerce park, with a 615,650 square feet warehouse and distribution facility serving more than 100 stores throughout S Carolina and southeastern Georgia. The site can accommodate future growth and Piggly Wiggly is contemplating moving its corporate headquarters to this site..

The Palmetto Commerce Park, which is located 4 miles from SMC, offers additional growth opportunities:

- Mercedes Vans - DaimlerChrysler has been at this site since 2005, initially hiring 220 workers, but with a potential of hiring up to 1,800, to build Sprinter vans.
- Cummins Turbo Technologies is consolidating its two facilities in the Charleston area, which together employ about 530 people, at Palmetto Commerce Park. As part of the consolidation, the Palmetto site will be expanded by more than 83,000 square feet to accommodate an additional assembly line, bringing the total size of the facility to more than 207,000 square feet. The transition to the Palmetto site is expected to be completed by October 2010.
- Boeing selected Palmetto Commerce Park as the site for its new fabrication facility for 787 aircraft's interior parts, including stowbins, closets, partitions, class dividers, floor-mounted stowbins, etc. The park is 10 miles from the main Boeing final assembly plant for the 787. Construction of the facility is expected to begin in the fourth quarter of 2010, becoming operational with 150 employees the following year.

According to the Dorchester County Economic Development website, over the past year there were several other new businesses announcing plans in Dorchester County:

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June 15, 2010	ArborGen to Invest \$14.3 Million and Create 25 New Jobs in Dorchester County
March 9, 2010	The IMO Group to Locate New Operations in Dorchester County and Create 190 New Jobs
January 21, 2010	Geocycle LLC Expands Facility in Dorchester, South Carolina
September 2, 2009	Dorchester County Breaks Ground on QuickJobs Center
July 13, 2009	Global Recovery LLC Announces New Facility in Dorchester County
July 8, 2009	Metalworx Inc. Announces New Facility in Dorchester County

These projects will bring additional residents to the SMC service area as well as employees who will have health care needs. The expansion of SMC will ensure that sufficient bed capacity is available to meet these future needs.

Growth at SMC

SMC has ongoing development efforts that will result in more inpatient admissions in the future. Among changes that will positively affect utilization are the recruitment of the following physicians to its medical staff:

- 3 new OB/GYN physicians
- New Bariatric surgeon to initiate a comprehensive program
- New Urologist
- 2 new Orthopedic surgeons
- New Cardiologist
- New gastroenterologists (with plans for 2 to 3 more)
- Addition of 3 to 4 primary care physicians per year
- 2 "house call" physicians who will actually visit patients in their homes as well as coordinate care with other physicians

In addition, SMC will be opening an Advanced Wound Care Program in early 2011 with hyperbaric therapy that will enhance the vascular and general surgery services at SMC. A medical group affiliated with Trident Health System recently was awarded a contract with TriCare, the managed care organization for the CHAMPUS program. This contract will have a significant, positive impact on SMC's utilization for obstetrics as well as other medical and surgical services.

These new physicians and services will drive increases in inpatient and outpatient services at SMC. Additional inpatient capacity is necessary to ensure that these future needs can be accommodated.

Unmet Need

There is an unmet need for additional acute care beds at SMC. The 2008-2009 South Carolina Health Plan identified a need for 24 additional beds at SMC in 2013. As discussed above, the

growth in SMC's service area as well as the expansion of SMC's services will require new bed capacity to address future demand.

1. Historical Utilization

The utilization of acute care beds in 2008 and 2009 in the Charleston area is presented in Table 3. Despite the economic problems that have negatively affected hospital utilization in the region, state, and nation, the two Trident Health Care System facilities have maintained their occupancy rates over the past two years. The Trident hospitals have among the highest occupancy rates of area hospitals.

Table 3
Charleston Area Hospitals
2008 and 2009 Inpatient Utilization

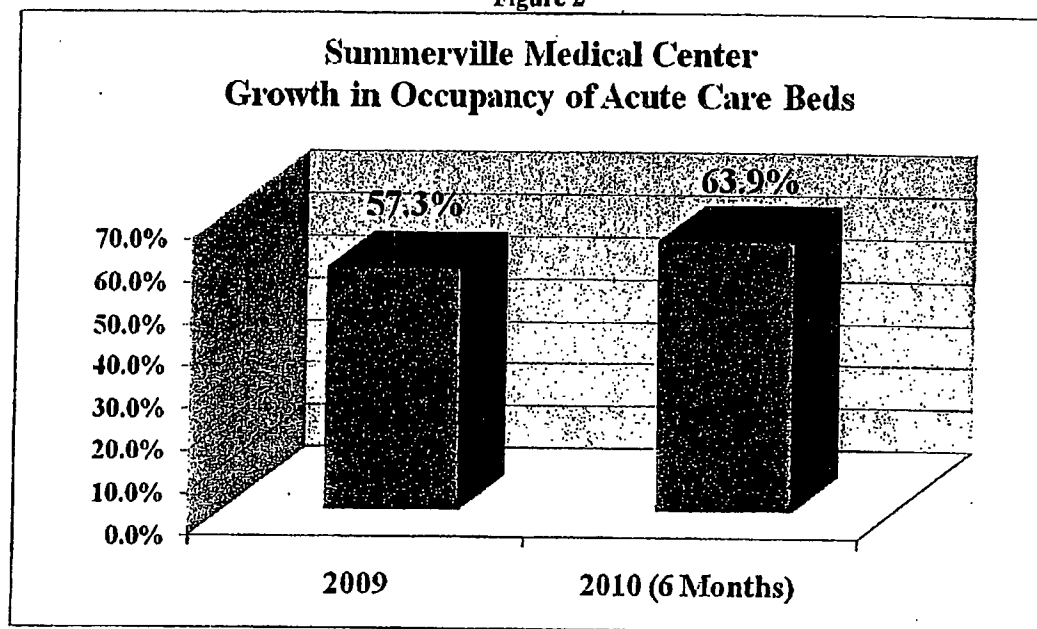
Licensed Beds		
Hospital	2008	2009
Summerville Medical Center	94	94
Trident Medical Center	296	296
Roper Hospital	440	453
Bon Secours St. Francis	204	204
Medical University of SC	689	689
East Cooper Regional Medical Center	106	106
Patient Days		
Hospital	2008	2009
Summerville Medical Center	20,907	20,787
Trident Medical Center	72,132	71,117
Roper Hospital	94,935	91,815
Bon Secours St. Francis	34,729	35,376
Medical University of SC	161,990	158,716
East Cooper Regional Medical Center	18,026	16,966
Average Daily Census		
Hospital	2008	2009
Summerville Medical Center	57.1	57.0
Trident Medical Center	197.1	194.8
Roper Hospital	259.4	251.5
Bon Secours St. Francis	94.9	96.9
Medical University of SC	442.6	434.8
East Cooper Regional Medical Center	49.3	46.5
Occupancy %		
Hospital	2008	2009
Summerville Medical Center	60.8%	60.6%
Trident Medical Center	66.6%	65.8%
Roper Hospital	59.0%	55.5%
Bon Secours St. Francis	46.5%	47.5%
Medical University of SC	64.2%	63.1%
East Cooper Regional Medical Center	46.5%	43.9%

Source: Joint Annual Reports of Hospitals

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Figure 2 presents SMC's occupancy rate of its 94 acute care in 2009 and for the first six months of 2010. This chart demonstrates that SMC experienced gains in utilization in recent months as a result of the overall growth in the area as well as the internal changes it has made to expand its medical staff and service offerings.

Figure 2



2. Projected Utilization

Given the foregoing analysis, SMC's utilization was projected over the period from 2010 and 2016 to determine its ability to utilize efficiently the requested 30 beds. The projections were based on the following assumptions.

- The project will be completed in 2013. The first three years of operation were assumed to be the fiscal years ending June 30, 2014, 2015, and 2016.
- Data was obtained from ORS regarding the number of total acute care discharges (excluding normal newborns) by ZIP Code in 2009 in SMC's primary and secondary service areas. Rates of discharges per 1,000 population were calculated for four age groups based on the ORS discharges and 2009 Claritas population estimates. These discharge rates are presented in Table 4. Discharge rates were assumed to remain constant over the projection period.
- The 2009 discharge rates were applied to the Claritas population projections by age group for the year 2010 to 2016 to project the total number of discharges in each year. These projected discharges are summarized in Table 5. The primary service area utilization is projected to increase at a faster rate than the secondary service area discharges. The primary service area

is expected to gain approximately 5,600 discharges annually between 2010 and 2016. The total service area will see a gain of 8,500 discharges annually over that same period.

- SMC's market share for 2009 was calculated for each ZIP Code in its service area. These market shares were adjusted in 2010 to increase by 2% in SMC's primary service area to reflect the significant growth that has occurred at SMC in 2010 year to date. These 2010 market shares were assumed to remain unchanged for 2011 and 2012. The opening of the 30 additional beds, including 8 Step Down Beds, in July 2013, is expected to allow SMC to experience modest growth in market share in its core Dorchester County ZIP Codes. Specifically, market shares in ZIP Codes 20437, 29483, 29484, and 29485 were projected to increase by 0.5% annually through 2015 and then remain at 2015 levels in 2016. For all other ZIP Codes in SMC's primary and secondary service areas, market shares were assumed to remain unchanged. These market share projections are presented in Table 6.
- Also shown in Table 6 is that 5.88% of SMC's discharges in 2009 were patients who resided outside of the SMC service area. This in-migration percentage was held constant over the projection period.
- Table 7 presents SMC's projected discharges by ZIP Code for 2010 through 2016. Total discharges are projected to increase from an annualized 6,244 in 2010 to 7,747 in 2016.
- Table 8 presents the projected utilization of the 94 existing beds and 30 proposed beds at SMC. Given that all of the beds being added are for Medical/Surgical patients and no obstetric beds are being added, it was assumed that the average length of stay (ALOS) at SMC would increase with the opening of these new beds. In addition, the aging of the population will also result in an upward trend in ALOS. The average length of stay is projected to increase from 3.7 days historically to 4.0 days in 2016.

Based on all of these assumptions, the 124 beds at SMC were projected to reach an occupancy rate of 68.5% in 2016. At this level of utilization, these 30 additional beds can be efficiently utilized while providing some additional capacity to accommodate growth beyond the projection period. These projections clearly document the need for this project.

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Table 4
Summerville Medical Center Service Area Age Group Specific Use Rate
2009

Service Area	Zip Code	City	0-14	15-44	45-64	65+	Total
Primary	29445	Goose Creek	86.4	67.4	92.2	296.3	94.0
Primary	29485	Summerville	94.3	77.4	86.3	293.0	104.8
Primary	29483	Summerville	106.5	88.1	112.4	318.5	120.9
Primary	29472	Ridgeville	86.3	52.2	135.8	362.6	109.4
Primary	29437	Dorchester	85.8	98.9	143.8	310.0	136.6
Primary	29456	Ladson	131.3	106.4	118.1	327.7	133.0
Primary	29420	North Charleston	77.8	75.8	83.1	274.1	91.4
Primary	29418	North Charleston	102.7	82.7	102.0	292.0	108.9
Primary	29484	Summerville	-	-	-	-	-
Subtotal Primary Service Area			97.8	79.7	102.0	309.0	109.2
Secondary	29488	Walterboro	111.3	103.7	164.7	404.1	164.3
Secondary	29479	Saint Stephen	70.2	92.0	149.4	403.2	140.0
Secondary	29477	Saint George	95.4	81.3	147.3	379.0	146.3
Secondary	29474	Round O	95.6	107.8	177.8	297.4	152.0
Secondary	29471	Reevesville	71.7	87.2	117.3	416.1	136.7
Secondary	29448	Harleyville	136.8	90.1	160.5	430.1	162.6
Secondary	29461	Moncks Corner	108.1	98.9	126.9	302.3	133.6
Secondary	29436	Cross	87.1	101.8	146.4	346.9	145.1
Secondary	29435	Cottageville	133.8	113.1	162.4	417.3	171.4
Secondary	29431	Bonneau	66.2	82.0	112.1	296.5	114.3
Secondary	29414	Charleston	100.0	74.1	73.4	253.0	99.2
Secondary	29407	Charleston	112.0	79.0	105.3	269.1	122.6
Secondary	29406	Charleston	125.5	110.9	151.0	288.2	142.2
Secondary	29405	North Charleston	98.4	95.0	176.9	268.1	136.9
Secondary	29404	Charleston AFB	57.8	44.0	12.5	67.3	45.6
Secondary	29059	Holly Hill	106.1	101.4	145.6	348.7	147.9
Secondary	29048	Eutawville	109.5	102.9	148.1	304.0	152.0
Subtotal Secondary Service Area			104.5	91.6	131.0	306.9	132.4
Grand Total Service Area			100.9	85.3	116.0	307.9	120.4

Source: Claritas, Inc., South Carolina Budget and Control Board Office of Research and Statistics

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Table 5
Summerville Medical Center
Projected Total Discharges for Service Area

ZIP Code	City	2010	2011	2012	2013	2014	2015	2016
Primary Service Area								
29445	Goose Creek	5,569	5,734	5,909	6,094	6,289	6,495	6,714
29485	Summerville	5,030	5,211	5,402	5,602	5,812	6,033	6,267
29483	Summerville	7,504	7,751	8,010	8,283	8,569	8,870	9,187
29472	Ridgeville	1,065	1,087	1,109	1,133	1,157	1,182	1,209
29437	Dorchester	334	342	350	358	367	376	385
29456	Ladson	2,899	2,972	3,049	3,130	3,215	3,305	3,400
29420	North Charleston	1,808	1,873	1,941	2,014	2,090	2,170	2,255
29418	North Charleston	2,667	2,728	2,791	2,858	2,928	3,002	3,079
29484	Summerville	143	143	143	143	143	143	143
Primary Service Area Total		27,019	27,841	28,705	29,613	30,570	31,577	32,638
Secondary Service Area								
29488	Walterboro	3,780	3,815	3,850	3,887	3,925	3,964	4,004
29479	Saint Stephen	1,019	1,036	1,053	1,071	1,089	1,108	1,128
29477	Saint George	1,021	1,040	1,060	1,081	1,102	1,124	1,147
29474	Round O	315	316	318	320	322	324	326
29471	Reevesville	223	228	233	238	244	249	255
29448	Harleyville	415	424	434	444	454	464	475
29461	Moncks Corner	3,667	3,757	3,850	3,946	4,046	4,149	4,257
29436	Cross	672	684	697	710	724	739	754
29435	Cottagesville	664	669	674	679	685	691	698
29431	Bonneau	720	739	759	779	801	823	846
29414	Charleston	3,108	3,179	3,253	3,331	3,412	3,496	3,585
29407	Charleston	4,402	4,441	4,481	4,521	4,563	4,607	4,651
29406	Charleston	4,063	4,135	4,209	4,285	4,362	4,442	4,524
29405	North Charleston	4,281	4,309	4,338	4,368	4,399	4,430	4,462
29404	Charleston AFB	192	190	189	188	187	186	185
29059	Holly Hill	901	902	903	904	906	907	909
29048	Eutawville	731	735	740	744	749	754	759
Total Secondary Service Area		30,174	30,600	31,040	31,496	31,969	32,458	32,964
Total Service Area		57,193	58,440	59,745	61,110	62,538	64,035	65,602

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Table 6
Summerville Medical Center
Historical and Projected Market Shares

		Historical		Estimated	Projected						
Zip Code	City	SMC	Total	Market	SMC	SMC	SMC	SMC	SMC	SMC	
		2009	2009	Share	2010	2011	2012	2013	2014	2015	2016
Primary Service Area											
29445	Goose Creek	301	5,403	5.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%
29485	Summerville	1,341	4,849	27.7%	29.7%	29.7%	29.7%	30.2%	30.7%	31.2%	31.2%
29483	Summerville	1,567	7,257	21.6%	23.6%	23.6%	23.6%	24.1%	24.6%	25.1%	25.1%
29472	Ridgeville	232	1,044	22.2%	24.2%	24.2%	24.2%	24.2%	24.2%	24.2%	24.2%
29437	Dorchester	73	326	22.4%	24.4%	24.4%	24.4%	24.9%	25.4%	25.9%	25.9%
29456	Ladson	495	2,826	17.5%	19.5%	19.5%	19.5%	19.5%	19.5%	19.5%	19.5%
29420	North Charleston	193	1,743	11.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%	13.1%
29418	North Charleston	166	2,606	6.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%
29484	Summerville	24	143	16.8%	18.8%	18.8%	18.8%	19.3%	19.8%	20.3%	20.3%
Subtotal Primary Service Area		4,368	26,054	16.8%	18.8%	18.8%	18.8%	19.1%	19.4%	19.6%	19.6%
Secondary Service Area											
29488	Walterboro	54	3,746	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%
29479	Saint Stephen	18	1,003	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%
29477	Saint George	72	1,001	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%
29474	Round O	15	313	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%
29471	Reevesville	17	218	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
29448	Harleyville	52	406	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%
29461	Moncks Corner	187	3,577	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%
29436	Cross	34	660	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%
29435	Cottageville	58	659	8.8%	8.8%	8.8%	8.8%	8.8%	8.8%	8.8%	8.8%
29431	Bonneau	24	701	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%
29414	Charleston	26	3,037	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%
29407	Charleston	22	4,364	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
29406	Charleston	97	3,991	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%
29405	North Charleston	23	4,252	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
29404	Charleston AFB	17	193	8.8%	8.8%	8.8%	8.8%	8.8%	8.8%	8.8%	8.8%
29059	Holly Hill	36	900	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
29048	Eutawville	35	727	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%
Subtotal Secondary Service Area		787	29,748	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%
Total Service Area		5,155	55,802	9.2%	10.3%	10.4%	10.4%	10.6%	10.8%	11.0%	11.1%
In-Migration		322									
Total		5,477									

000040

Table 7
Summerville Medical Center
Historical and Projected Discharges

		Historical	Projected						
		SMC	SMC	SMC	SMC	SMC	SMC	SMC	SMC
Zip Code	City	2009	2010	2011	2012	2013	2014	2015	2016
Primary Service Area									
29445	Goose Creek	301	422	434	447	461	476	492	508
29485	Summerville	1,341	1,494	1,548	1,604	1,692	1,784	1,882	1,955
29483	Summerville	1,567	1,771	1,829	1,890	1,996	2,108	2,226	2,306
29472	Ridgeville	232	258	263	269	274	280	286	293
29437	Dorchester	73	81	83	85	89	93	97	100
29456	Ladson	495	566	580	595	611	627	645	664
29420	North Charleston	193	236	245	254	263	273	284	295
29418	North Charleston	166	223	228	234	239	245	251	258
29484	Summerville	24	27	27	27	28	28	29	29
Subtotal Primary Service Area		4,368	5,078	5,238	5,405	5,654	5,916	6,193	6,407
Secondary Service Area									
29488	Walterboro	54	54	55	56	56	57	57	58
29479	Saint Stephen	18	18	19	19	19	20	20	20
29477	Saint George	72	73	75	76	78	79	81	83
29474	Round O	15	15	15	15	15	15	16	16
29471	Reevesville	17	17	18	18	19	19	19	20
29448	Harleyville	52	53	54	56	57	58	59	61
29461	Moncks Corner	187	191	195	200	205	210	216	221
29436	Cross	34	35	35	36	37	37	38	39
29435	Cottageville	58	58	59	59	60	60	61	61
29431	Bonneau	24	25	25	26	27	27	28	29
29414	Charleston	26	27	27	28	29	29	30	31
29407	Charleston	22	22	22	23	23	23	23	23
29406	Charleston	97	99	101	102	104	106	108	110
29405	North Charleston	23	23	23	23	24	24	24	24
29404	Charleston AFB	17	17	17	17	17	16	16	16
29059	Holly Hill	36	36	36	36	36	36	36	36
29048	Eutawville	35	35	35	36	36	36	36	37
Subtotal Secondary Service Area		787	799	812	826	840	854	869	885
Total Service Area		5,155	5,877	6,050	6,231	6,493	6,770	7,062	7,292
In-Migration		322	367	378	389	406	423	442	455
Total		5,477	6,244	6,428	6,620	6,899	7,193	7,504	7,747

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Table 8
Summerville Medical Center
Projected Utilization

	2010	2011	2012	2013	2014	2015	2016
Discharges	6,244	6,428	6,620	6,899	7,193	7,504	7,747
Average Length of Stay	3.7	3.7	3.7	3.8	3.9	4.0	4.0
Patients Days	23,103	23,784	24,494	26,216	28,053	30,016	30,988
Average Daily Census	63.3	65.2	67.1	71.8	76.9	82.2	84.9
Acute Care Beds	94	94	94	124	124	124	124
Occupancy %	67.3%	69.3%	71.4%	57.9%	62.0%	66.3%	68.5%

No Unnecessary Duplication

This project will not result in the unnecessary duplication of health care resources. As demonstrated in the foregoing analysis, the proposed 30 beds are projected to be well utilized once they become operational. In addition, SMC is uniquely positioned to address the needs of its primary service area residents. Absent the approval of this project, SMC would have insufficient capacity to serve the growing population in its service area and residents would be forced to travel to more distant or less preferred facilities. Rather than duplicate services, this project will enhance access to care.

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**Attachment D:
Financial Information**

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Financial Projections

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Exhibit 1A (Page 1 of 3)

Project: Trident Health System - 30 Bed addition (Summerville)
 m: Health System Total

	Projection 2010	2011	Projected 2012	2013	2014	2015
REVENUES						
Inpatient Revenue	\$ 967,292,000	\$ 1,064,021,200	\$ 1,170,423,320	\$ 1,273,387,756	\$ 1,384,986,536	\$ 1,505,805,894
Outpatient Ancillary	\$ 588,345,000	\$ 647,179,500	\$ 711,897,450	\$ 783,087,195	\$ 861,395,915	\$ 947,535,506
Total Patient Revenue	\$ 1,555,637,000	\$ 1,711,200,700	\$ 1,882,320,770	\$ 2,056,474,951	\$ 2,246,382,451	\$ 2,453,341,400
Other Operating Income	\$ 10,569,000	\$ 10,569,000	\$ 10,569,000	\$ 10,569,000	\$ 10,569,000	\$ 10,569,000
Total Revenues	\$ 1,566,206,000	\$ 1,721,769,700	\$ 1,892,889,770	\$ 2,067,043,951	\$ 2,256,951,451	\$ 2,463,910,400
DEDUCTIONS						
Medicare CY Contractuals	\$ 522,795,000	\$ 581,608,789	\$ 648,877,099	\$ 714,978,212	\$ 787,291,232	\$ 866,317,393
Medicaid CY Contractuals	\$ 60,532,000	\$ 71,709,661	\$ 84,515,278	\$ 98,158,072	\$ 112,491,136	\$ 128,652,922
Champus CY Contractuals	\$ 74,723,000	\$ 85,588,415	\$ 97,880,498	\$ 111,391,451	\$ 126,808,871	\$ 143,735,850
Prior Year Contractuals	\$ (2,497,000)	\$ -	\$ -	\$ -	\$ -	\$ -
HMO/PPO Discounts	\$ 367,543,000	\$ 407,492,816	\$ 451,777,739	\$ 498,829,199	\$ 550,698,069	\$ 608,350,467
Charity	\$ 24,234,000	\$ 26,641,047	\$ 29,288,798	\$ 31,868,132	\$ 34,656,356	\$ 37,666,591
Other Deductions	\$ 106,977,000	\$ 117,602,510	\$ 129,290,572	\$ 141,558,874	\$ 154,949,615	\$ 169,559,112
Total Deductions	\$ 1,154,307,000	\$ 1,290,643,237	\$ 1,441,629,983	\$ 1,596,703,940	\$ 1,766,895,279	\$ 1,952,282,335
Total Net Revenue	\$ 411,899,000	\$ 431,126,463	\$ 451,259,787	\$ 470,260,011	\$ 490,256,171	\$ 511,628,065
EXPENSES						
Salaries and Wages	\$ 97,049,000	\$ 100,445,715	\$ 103,961,315	\$ 107,190,667	\$ 110,479,773	\$ 113,792,546
Contract Labor	\$ 1,005,000	\$ 1,040,175	\$ 1,076,581	\$ 1,108,729	\$ 1,141,784	\$ 1,175,742
Employee Benefits	\$ 23,455,000	\$ 24,275,925	\$ 25,126,582	\$ 25,902,654	\$ 26,693,605	\$ 27,489,376
Supplies	\$ 64,392,000	\$ 67,397,821	\$ 70,546,256	\$ 73,610,223	\$ 76,851,619	\$ 80,332,765
Professional Fees	\$ 6,599,000	\$ 6,907,042	\$ 7,229,598	\$ 7,543,704	\$ 7,875,892	\$ 8,232,650
Contract Services	\$ 22,691,000	\$ 23,371,730	\$ 24,072,882	\$ 24,664,708	\$ 25,268,514	\$ 25,883,745
Repairs and Maintenance	\$ 7,501,000	\$ 7,726,030	\$ 7,957,811	\$ 8,153,591	\$ 8,353,343	\$ 8,556,882
Rents and Leases	\$ 4,866,000	\$ 4,983,720	\$ 5,083,394	\$ 5,157,161	\$ 5,230,888	\$ 5,304,358
Utilities	\$ 4,172,000	\$ 4,297,160	\$ 4,383,103	\$ 4,447,319	\$ 4,511,546	\$ 4,575,602
Insurance	\$ 4,040,000	\$ 4,120,800	\$ 4,203,216	\$ 4,259,741	\$ 4,316,901	\$ 4,371,475
Bad Debts	\$ 68,723,000	\$ 75,757,867	\$ 83,287,150	\$ 90,959,788	\$ 99,327,722	\$ 108,448,477
Investment Income	\$ (216,000)	\$ (211,680)	\$ (211,680)	\$ (211,680)	\$ (211,680)	\$ (211,680)
Taxes-Non Income	\$ 10,986,000	\$ 11,205,720	\$ 11,429,834	\$ 11,449,431	\$ 11,682,600	\$ 11,920,432
Other Operating Expenses	\$ 7,478,000	\$ 7,627,560	\$ 7,780,111	\$ 7,894,338	\$ 8,008,605	\$ 8,122,587
Total Expenses	\$ 322,781,000	\$ 338,945,585	\$ 355,924,152	\$ 372,130,374	\$ 389,630,112	\$ 407,994,957
EBDIT	\$ 69,138,000	\$ 92,180,878	\$ 95,335,635	\$ 98,129,637	\$ 100,726,059	\$ 103,633,108
CAPITAL & OTHER						
Depreciation	\$ 15,258,000	\$ 15,715,740	\$ 16,187,212	\$ 16,672,829	\$ 17,173,013	\$ 17,688,204
Amortization	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other Non-Operating Expense	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Interest Expense	\$ (23,036,000)	\$ (24,111,321)	\$ (25,237,304)	\$ (26,299,917)	\$ (27,418,229)	\$ (28,613,481)
Management Fees	\$ 28,756,000	\$ 30,098,331	\$ 31,503,904	\$ 32,830,371	\$ 34,226,367	\$ 35,718,408
Minority Interest	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Capital & Other	\$ 20,978,000	\$ 21,702,760	\$ 22,453,812	\$ 23,203,282	\$ 23,981,151	\$ 24,793,131
PreTax Income	\$ 68,160,000	\$ 70,478,128	\$ 72,881,823	\$ 74,928,355	\$ 76,744,907	\$ 78,839,977

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Exhibit 1A (Page 2 of 3)

Project: Trident Health System - 30 Bed addition (Summerville)
 Form: Project Incremental Proforma - After Conversion

	2013	Projected 2014	2015
REVENUES			
Inpatient Revenue	\$ 14,077,898	\$ 31,225,681	\$ 52,027,544
Outpatient Revenue	\$ -	\$ -	\$ -
Total Patient Revenue	\$ 14,077,898	\$ 31,225,681	\$ 52,027,544
Other Operating Income	\$ -	\$ -	\$ -
Total Revenues	\$ 14,077,898	\$ 31,225,681	\$ 52,027,544
DEDUCTIONS			
Medicare CY Contractuals	\$ 6,748,782	\$ 15,165,822	\$ 25,575,279
Medicaid CY Contractuals	\$ 1,004,910	\$ 2,258,227	\$ 3,808,220
Champus CY Contractuals	\$ 384,689	\$ 864,471	\$ 1,457,823
Prior Year Contractuals	\$ -	\$ -	\$ -
HMO/PPO Discounts	\$ 2,036,307	\$ 4,576,976	\$ 7,716,817
Charity	\$ 333,192	\$ 748,747	\$ 1,262,669
Other Deductions	\$ 588,565	\$ 1,340,378	\$ 2,287,690
Total Deductions	\$ 11,098,445	\$ 24,953,623	\$ 42,108,498
Total Net Revenue	\$ 2,981,453	\$ 6,272,060	\$ 9,919,046
EXPENSES			
Salaries and Wages	\$ 409,294	\$ 886,187	\$ 1,471,222
Contract Labor	\$ 5,533	\$ 11,477	\$ 17,883
Employee Benefits	\$ 102,324	\$ 221,547	\$ 367,806
Supplies	\$ 371,419	\$ 770,434	\$ 1,200,479
Professional Fees	\$ 38,059	\$ 78,946	\$ 123,013
Contract Services	\$ 130,360	\$ 270,408	\$ 421,343
Repairs and Maintenance	\$ 42,954	\$ 89,099	\$ 138,833
Rents and Leases	\$ 27,901	\$ 57,876	\$ 90,181
Utilities	\$ 23,446	\$ 48,635	\$ 75,782
Insurance	\$ 27,539	\$ 57,125	\$ 89,011
Bad Debts	\$ 609,573	\$ 1,352,072	\$ 2,252,793
Investment Income	\$ -	\$ -	\$ -
Taxes-Non Income	\$ 209,000	\$ 209,000	\$ 209,000
Other Operating Expenses	\$ 41,375	\$ 85,823	\$ 133,729
Total Expenses	\$ 2,038,778	\$ 4,138,627	\$ 6,591,076
EBDIT	\$ 942,674	\$ 2,133,433	\$ 3,327,970
CAPITAL & OTHER			
Depreciation	\$ 1,623,283	\$ 1,623,283	\$ 1,623,283
Amortization	\$ -	\$ -	\$ -
Other Non-Operating Expense	\$ -	\$ -	\$ -
Interest Expense	\$ -	\$ -	\$ -
Management Fees	\$ 208,702	\$ 439,044	\$ 694,333
Minority Interest	\$ -	\$ -	\$ -
Total Capital & Other	\$ 1,831,985	\$ 2,062,327	\$ 2,317,616
PreTax Income	\$ (889,311)	\$ 71,106	\$ 1,010,354

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Exhibit 1A(Page 3 of 3)**Project: Trident Health System - 30 Bed addition (Summerville)****m: New Health System Total - After Conversion****REVENUES**

Inpatient Revenue

Outpatient Ancillary

Total Patient Revenue

Other Operating Income

Total Revenues

Budget 2010	2011	Projected 2012	2013	2014	2015
\$ 967,292,000	\$ 1,064,021,200	\$ 1,170,423,320	\$ 1,287,485,652	\$ 1,416,212,217	\$ 1,557,833,438
\$ 588,345,000	\$ 647,179,500	\$ 711,897,450	\$ 783,087,195	\$ 861,395,915	\$ 947,535,506
\$ 1,555,637,000	\$ 1,711,200,700	\$ 1,882,320,770	\$ 2,070,552,847	\$ 2,277,608,131	\$ 2,505,368,944
\$ 10,569,000	\$ 10,569,000	\$ 10,569,000	\$ 10,569,000	\$ 10,569,000	\$ 10,569,000
\$ 1,566,206,000	\$ 1,721,769,700	\$ 1,892,889,770	\$ 2,081,121,847	\$ 2,288,177,131	\$ 2,515,937,944

DEDUCTIONS

Medicare CY Contractuals

Medicaid CY Contractuals

Champus CY Contractuals

Prior Year Contractuals

HMO/PPO Discounts

Charity

Other Deductions

Total Deductions

\$ 522,795,000	\$ 581,608,789	\$ 648,877,099	\$ 721,726,994	\$ 802,457,054	\$ 891,892,672
\$ 80,532,000	\$ 71,709,661	\$ 84,515,278	\$ 99,162,982	\$ 114,749,363	\$ 132,461,142
\$ 74,723,000	\$ 85,588,415	\$ 97,880,498	\$ 111,776,140	\$ 127,473,342	\$ 145,193,673
\$ (2,497,000)	\$ -	\$ -	\$ -	\$ -	\$ -
\$ 367,543,000	\$ 407,492,816	\$ 451,777,739	\$ 500,865,506	\$ 555,274,045	\$ 614,067,284
\$ 24,234,000	\$ 26,641,047	\$ 29,288,798	\$ 32,201,324	\$ 35,405,103	\$ 38,929,260
\$ 106,977,000	\$ 117,802,510	\$ 129,290,572	\$ 142,147,439	\$ 156,289,993	\$ 171,846,802
\$ 1,154,307,000	\$ 1,290,643,237	\$ 1,441,829,983	\$ 1,607,880,385	\$ 1,791,648,900	\$ 1,994,390,833

Total Net Revenue

\$ 411,899,000	\$ 431,126,463	\$ 451,259,787	\$ 473,241,462	\$ 496,528,231	\$ 521,547,111
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EXPENSES

Salaries and Wages

Contract Labor

Employee Benefits

Supplies

Professional Fees

Contract Services

Repairs and Maintenance

Rents and Leases

Utilities

Insurance

Bad Debts

Investment Income

Taxes-Non Income

Other Operating Expenses

Total Expenses

\$ 97,049,000	\$ 100,445,715	\$ 103,961,315	\$ 107,599,961	\$ 111,365,960	\$ 115,263,768
\$ 1,005,000	\$ 1,040,175	\$ 1,076,581	\$ 1,114,262	\$ 1,153,281	\$ 1,193,625
\$ 23,455,000	\$ 24,275,925	\$ 25,125,582	\$ 26,004,978	\$ 26,915,152	\$ 27,857,182
\$ 64,392,000	\$ 67,397,821	\$ 70,546,255	\$ 73,981,642	\$ 77,622,053	\$ 81,633,244
\$ 6,599,000	\$ 8,907,042	\$ 7,229,596	\$ 7,581,763	\$ 7,954,838	\$ 8,355,663
\$ 22,691,000	\$ 23,371,730	\$ 24,072,882	\$ 24,795,068	\$ 25,538,920	\$ 26,305,088
\$ 7,501,000	\$ 7,726,030	\$ 7,957,811	\$ 8,196,545	\$ 8,442,442	\$ 8,695,715
\$ 4,886,000	\$ 4,983,720	\$ 5,083,394	\$ 5,185,062	\$ 5,288,764	\$ 5,394,539
\$ 4,172,000	\$ 4,297,160	\$ 4,383,103	\$ 4,470,765	\$ 4,560,181	\$ 4,651,384
\$ 4,040,000	\$ 4,120,800	\$ 4,203,216	\$ 4,287,280	\$ 4,373,026	\$ 4,460,486
\$ 68,723,000	\$ 76,757,867	\$ 83,287,150	\$ 91,569,361	\$ 100,879,794	\$ 110,701,270
\$ (216,000)	\$ (211,680)	\$ (211,680)	\$ (211,680)	\$ (211,680)	\$ (211,680)
\$ 10,986,000	\$ 11,205,720	\$ 11,429,834	\$ 11,668,431	\$ 11,891,600	\$ 12,129,432
\$ 7,478,000	\$ 7,627,560	\$ 7,780,111	\$ 7,935,713	\$ 8,094,428	\$ 8,256,316
\$ 322,761,000	\$ 338,945,585	\$ 355,924,162	\$ 374,169,151	\$ 393,668,739	\$ 414,586,032

EBDIT

\$ 89,138,000	\$ 92,180,878	\$ 95,335,625	\$ 99,072,311	\$ 102,859,492	\$ 106,961,079
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CAPITAL & OTHER

Depreciation

Amortization

Other Non-Operating Expense

Interest Expense

Management Fees

Minority Interest

Total Capital & Other

\$ 15,258,000	\$ 16,715,740	\$ 18,187,212	\$ 18,296,112	\$ 18,796,296	\$ 19,311,487
\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
\$ (23,036,000)	\$ (24,111,321)	\$ (25,237,304)	\$ (26,299,917)	\$ (27,418,229)	\$ (28,613,481)
\$ 28,756,000	\$ 30,098,331	\$ 31,503,904	\$ 33,204,510	\$ 34,791,259	\$ 36,670,809
\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
\$ 20,978,000	\$ 21,702,760	\$ 22,453,811	\$ 23,200,704	\$ 23,969,327	\$ 24,738,815

PreTax Income

\$ 68,160,000	\$ 70,478,128	\$ 72,881,823	\$ 73,871,607	\$ 76,690,165	\$ 79,592,264
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Assumptions to Financial Projections

1. Utilization – The utilization of Trident Health System as a whole is expected to grow by approximately 2% annually without the addition of 30 beds to Summerville Medical Center (SMC). The incremental utilization projections for SMC following the addition of the proposed 30 beds are presented in Table 8 of the application and were determined by measuring the projected growth from 2013 in 2014, 2015, and 2016.
2. Patient Revenues – The gross patient revenues per adjusted admission were projected to increase by 8% annually for Trident Health System.
3. Deductions from Revenues - Deductions from revenue for Trident Health System are based on current reimbursement policies by Medicare, Medicaid, and CHAMPUS; current adjustment rates for Third Party Payors, and expected levels of charity care. It is assumed that the overall deduction percentages will increase annually by approximately 1.1%.
4. Salaries, Wages, and Benefits - Salaries, wages, and benefits are expected to increase based on growth in utilization and projected annual wage increases of 3.5%.
5. Other Expenses - Other expenses are expected to increase, depending on the category, by 2% to 4% annually.
6. Bad Debt Expenses - Bad Debts were projected at 4.4% of gross patient revenue.
7. Depreciation Expense – Depreciation expense was based on historical levels and expected future capital purchases. For the proposed project, the incremental depreciation expense was based on the estimated useful lives of the assets proposed to be added.
8. Interest Expense – Interest expense reflects expected allocations from HCA for interest expense accrued for the organization. Because this project is proposed to be funded with cash reserves, no incremental interest expense has been assumed.
9. Management Fees – Management fees were assumed to 7% of net revenue in each year.

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Accountant's Statement

000079

Life is a gift. Live it well.®

Trident Health System

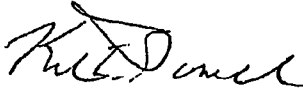
November 8, 2010

Ms. Beverly Patterson, Director
Bureau of Health Facilities and Services
South Carolina DHEC
2600 Bull Street
Columbia, South Carolina 29201

Dear Ms. Patterson:

I, Karl Gorrell, Chief Financial Officer of Trident Health System, hereby certify that I have reviewed the assumptions, calculations, and other information contained in the financial projections provided in the Certificate of Need application for the addition of 30 acute care beds to Summerville Medical Center. To the best of my knowledge, these projections are correct and based on reasonable assumptions.

Sincerely,



Karl Gorrell
Chief Financial Officer

000080

Trident
Medical Center

9330 Medical Plaza Drive Charleston, SC 29406

Ms. Beverly Patterson, Director
Bureau of Health Facilities and Services
South Carolina DHEC
2600 Bull Street
Columbia, South Carolina 29201

Manpower Budget

000081

Projected Manpower Budget for 30 Bed Addition			
	2013	2014	2015
RN	5.0	10.6	19.2
PST & PCT	1.3	2.7	4.8
Direct Patient Care Total	6.3	13.3	24.0
Administrative Support	0.2	0.4	0.6
EVS/Dietary	0.6	1.0	2.1
Pharmacy	0.2	0.6	0.8
Indirect Patient Care Total	1.0	2.0	3.5
Total	7.3	15.3	24.5

000082

6. a) Officers of Hospital Corporation of America

Jack C. Massey, Chairman
Thomas F. Frist, M. D., Vice Chairman and Chief Medical Officer
John A. Hill, President
Thomas F. Frist Jr., M. D., Executive Vice President
John C. Neff, Executive Vice President
Robert P. Brueck, Senior Vice President
Donald W. Fish, Secretary and General Counsel
Sam A. Brooks, Treasurer

b) Individual Responsible for Proposal

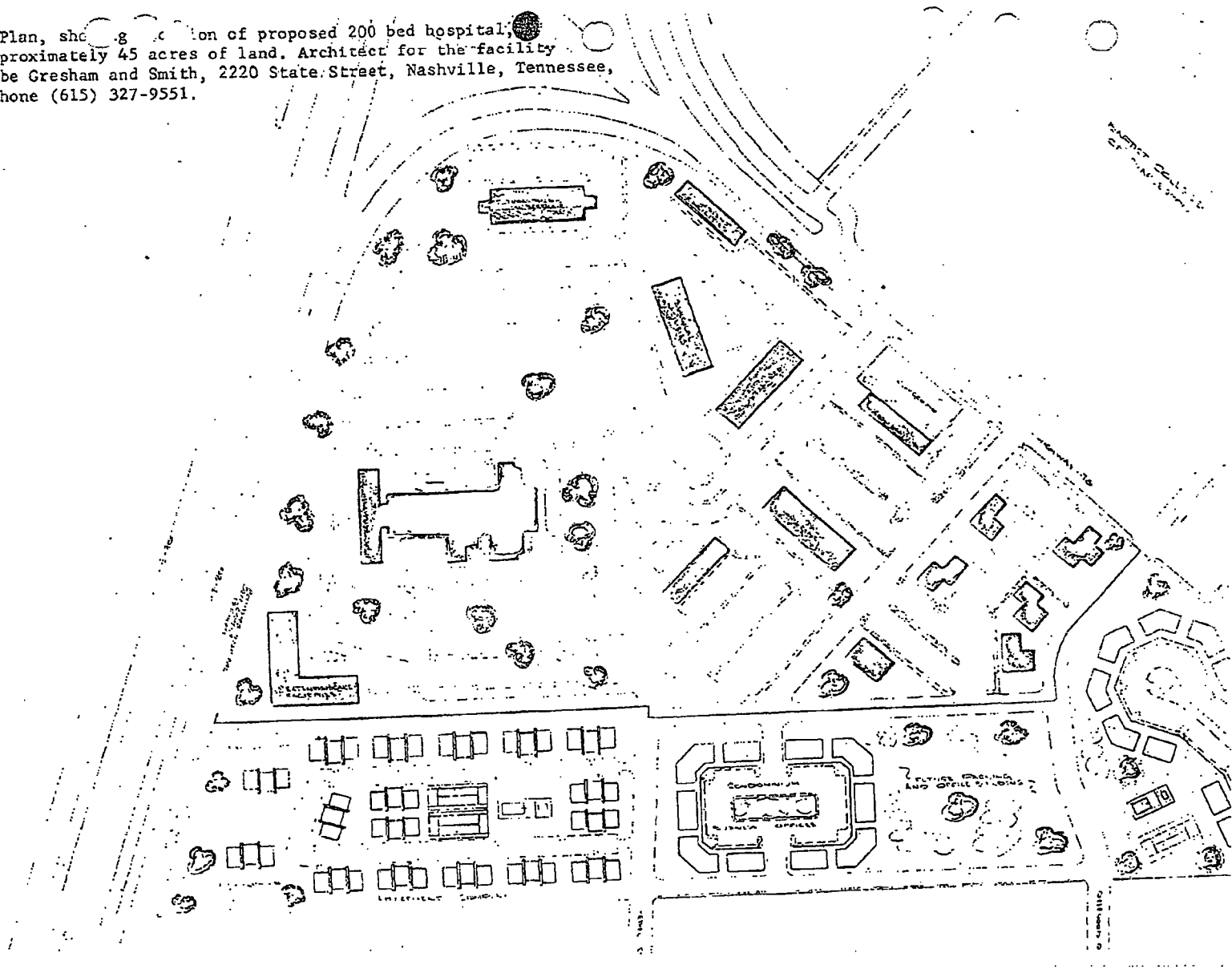
Thomas F. Frist Jr., M. D., Executive Vice President

c) Attorney Representing The Proposal

Donald W. Fish, Secretary and General Counsel

10. This is a proposal for a 200 bed regional hospital facility to serve Berkeley, Dorchester and the northern part of Charleston County. Existing hospitals in Berkeley and Dorchester Counties will be phased out as general, acute care hospitals.

at Plan, showing location of proposed 200 bed hospital,
 approximately 45 acres of land. Architect for the facility
 will be Gresham and Smith, 2220 State Street, Nashville, Tennessee,
 telephone (615) 327-9551.



SECTION I - QUESTIONNAIRE (Part 2)

TOTAL BED CAPACITY OF FACILITY FOR WHICH APPLICATION IS MADE:

	TYPE OF BEDS	NEW FACILITY ONLY	EXISTING FACILITIES				NUMBER OF BEDS IN MASTER PLAN
			EXISTING BEDS	BEDS GAINED OR LOST BY PROPOSAL	NEW CONFORMING BEDS	BEDS CHANGED TO CONFORMITY	
A.	Medical/Surgical	157					
B.	Maternity	20					
C.	Pediatrics	15					
D.	Chronic						
E.	Psychiatric						
F.	Nursing Care						
G.	Intermediate Care						
H.	C.C.U.	4					
I.	I.C.U.	4					
J.	Other (Specify)						
K.	TOTAL	200					

	NUMBER OF BEDS	EXISTING	UPON COMPLETION OF PROPOSAL
A.	Private		100 Private beds
B.	2-Bed Ward		92 semi-private beds
C.	3-Bed Ward		
D.	4-Bed Ward		
E.	5-Bed Ward		

10. Provide brief description of change of services or other change. Attach continuation sheet if necessary.
(see attached)

11. CONSTRUCTION AND SITE (Attach Plot Plan, Show Approximate Locations of Existing Buildings and Proposed Additions, Provide the Name, Addresses and Telephone Numbers of the Architect)

A. Type of Construction Fire Resistive	B. Number of Buildings 1	C. Number of Stories 5	D. Size of Site in Acres Approximately 45
E. Square Footage of Facility 142,119	F. Anticipated Date of Beginning Construction Immediately	G. Anticipated Date of Licensing Approximately two years after start of construction	

12. COSTS (Provide Estimate Cost Statement from Either the Architect or Contractor):

A. Land Cost \$600,000	B. Construction Cost \$6,315,000	C. Equipment Cost	
		(1) Fixed: \$450,000	(2) Movable: \$1,500,000
D. Architect's Fee \$300,000	E. Total Project Cost \$9,165,000	F. Construction and Equipment Cost (\$8,565,000)	
		(1) Per Square Foot: \$60.27	(2) Per Bed: \$42,825

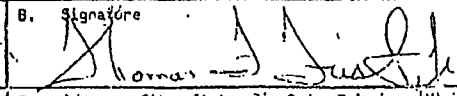
G. Is Federal Funding of This Project Anticipated?

☐ YES ☒ NO

13. ZONING: ZONING OF CONSTRUCTION SITE.

Site under consideration can be zoned for hospital facility

14. PROPOSAL PREPARED BY:

A. Type Name and Title Thomas F. Frist Jr., M. D. Executive Vice President	B. Signature 
C. Organization Hospital Corporation of America	D. Address, City, State, Zip Code, Telephone Number P.O. Box 550, Nashville, Tennessee 37202

1615 227-0551

Trident_10229

PROJECT NARRATIVEPart IA. Background

Hospital Corporation of America, based in Nashville, Tennessee is a publicly owned, corporate group of medical and surgical hospitals.

The Company was founded in August, 1968, by a group of Nashville's leading businessmen and physicians to combine the skills of business management and the resources of private capital, coupled with active participation of the medical profession in management, to serve the health care needs of America. Each of the founders has a background in the medical field and the business world, and is a well-financed, progressive business executive, dedicated to the total success of the Company.

The Company's growth has been carefully planned from the beginning and today HCA is the largest group of medical hospitals in the nation. It presently operates 48 hospitals, representing over 7,000 beds, in 14 states, has 13 other facilities under construction and a number of others in the planning stages.

HCA believes that it is vitally important that control of medical policy of member hospitals be determined and established at the local level by staff physicians. In all HCA facilities, local citizens constitute the majority of the boards of trustees, and they have broad management responsibilities for their individual units. HCA feels it appropriate that physicians will be adequately represented on this governing Board. The cooperation between physicians and administration results in achievement of HCA's most important goal - providing high quality medical care at the least possible cost.

Trident_10230

The facility HCA is proposing to build to serve the health care needs of the North Trident Community will be a five (5) story 200 bed, full-service medical and surgical hospital. The facility will include a four (4) bed Coronary Care Unit, four (4) bed Intensive Care Unit, emergency room, (24 hour physician staffed), 100 private rooms, and 92 semi-private beds programmed for medical, surgical and pediatric patients. The private rooms will measure 167 square feet (as compared to a 100 square foot minimum requirement) and 240 square feet for a semi-private room (as compared to a 160 square foot minimum requirement). The facility will also include six operating rooms, complete with piped-in oxygen, vacuum, nitrous oxide and nitrogen; an obstetrical pavilion; recovery room; four x-ray rooms, equipped with the most modern equipment; clinical laboratory; EKG; cafeteria and snack bar; pharmacy; physical therapy and inhalation therapy facilities.

Patient rooms will be fully carpeted and attractively decorated in order to create a pleasant atmosphere for patient rehabilitation. Each room will be equipped with numerous conveniences including telephone, color television with patient pillow speaker control, full bath with tub and shower, individual temperature control, electric beds, controlled humidity and a sophisticated nurse call system.

8. Site

Numerous parcels of land were examined to evaluate their general desirability and availability. The site HCA feels offers the best location to the largest number of residents of the North Trident Community and possessing some of the requisites necessary to insure the success of the 200 bed complex is presently owned by the City of Charleston. It consists of approximately 45 acres and lies in the southeast quadrant of Interstate 26 and U.S. 78 immediately south of the Baptist College.

Trident_10231

The site is moderately wooded over the entire tract and there are no houses or roads through the site. Based on opinion of engineers, the site drains well; public water and adequate sewerage facilities are available; and an adequate supply of power and natural gas are also available. The site is accessible from Interstate 26, U.S. 78 and the Deer Park Subdivision.

C. Services

HCA's proposed facility will be a complete 200 bed medical and surgical hospital and will include such general services as a Coronary Care Unit, Intensive Care Unit, Obstetrics and Pediatrics.

Ancillary services will include Clinical Laboratory, EKG, Emergency Room, Inhalation Therapy, Pharmacy, Physical Therapy, Recovery Room and Surgical Pavilion.

D. Professional Staff

1. Physicians

It will be essential to attract and recruit a good medical staff motivated to render the highest type medical care possible. We are confident that the present physicians in the North Trident Community can insure the quality of this medical complex, and we anticipate considerable interest from other physicians outside the North Trident Community as well.

A recent survey of twenty-four (24) physicians practicing in Dorchester, Berkeley and North Charleston area indicated that they would use a new facility in this area. It is also our belief that new doctors, establishing offices in close proximity to our new facility, will attract patients from the North Charleston area and

Trident_10232

admit them to our new facility.

2. Nursing Staff

Below are the projected nursing service positions by job title for a 200 bed hospital:

<u>Classification</u>	<u>No. Positions Projected</u>
Registered Nurses -----	41
Licensed Practical Nurses -----	35
Technicians -----	24
Nursing Aides -----	21
Male Nurse Assistants -----	16
Ward Secretary -----	<u>11</u>
Total	148

E. Personnel

Below are the total projected personnel needs by department for a 200 bed hospital:

<u>Department</u>	<u>No. Personnel Projected</u>
Administration & Fiscal Svcs.	33
Medical Records	10
Housekeeping	25
Dietary	30
Engineering	9
Pharmacy	5
Radiology	12
Laboratory	18
Inhalation Therapy & EKG	8
Central Supply	11
Nursing Service	<u>148</u>
Total	309

Recruitment of personnel for the proposed hospital complex will be carried out through classified advertising in the local newspapers and with medical placement service agencies.

F. Educational Activities

In-service education and training programs on a continual basis will be provided to assure consistent staff qualification to render maximum care to the patient's needs. Proven operational procedures and and cost control practices will be utilized to insure efficient, economical operation within highest care parameters. Education and training programs will include many of the following: licensed practical nurses, nursing technicians, nursing aides, operating room technicians, emergency room technicians, obstetric and pediatric nurse practitioners, orderlies and custodial personnel.

G. Financial Statement (see attached)

Hospital Corporation of America will finance the construction program by means of private funds. Ample funding will be provided to insure solvency. By no means will the taxpaying citizens of the community be called upon to help finance the project.

H. Professional Affiliations

The proposed medical facility, upon commencing operation, will seek membership in the American Hospital Association, South Carolina Hospital Association and any other health related agency deemed appropriate by the hospital administrator. After one (1) year of operation, the hospital administrator will request the Joint Commission on Accreditation of Hospitals to survey the facility for accreditation purposes.

Part II - Statement of Justification of Need

Trident_10234

1. MEDICAL FACILITIES IN CHARLESTON COUNTY

Charleston County had 247,650 residents according to the 1970 census. Of these, approximately 92,510 live in the area commonly referred to as North Charleston. About one quarter of Berkeley County's 56,200 residents live immediately adjacent to North Charleston. At this time there are no general acute care hospital beds, and no emergency care services in the area known as North Charleston.

Charleston County currently has eight hospitals--six serving civilians, and the Naval Hospital and Veterans Administration hospital serving active and retired servicemen and their dependents. With the exception of Baker Hospital, the remaining five civilian hospitals are located on the tip of the peninsula within the City of Charleston.

It is the opinion of the citizens of North Charleston that this distribution of acute care beds toward the tip of the peninsula is placing severe limitations on the delivery of health care in North Charleston, and that this condition will grow worse as the population center of Charleston County continues to shift to the North in the future. Many citizens have expressed their private dissatisfaction with the inconvenience of traveling to the tip of the peninsula for general medical care and emergency medical care.

2. MEDICAL FACILITIES IN BERKELEY AND DORCHESTER COUNTIES.

Berkeley and Dorchester Counties have one hospital each. The Berkeley facility is licensed for sixty beds, but has recently operated only thirty-seven. The Dorchester hospital is licensed for seventy-eight beds, and operates almost all of these. Both facilities are run-down and in need of replacement or major renovation. A recent study by the Dorchester County Hospital supports this, and Berkeley County residents

Trident_10235

are already exploring other uses of that facility "should a regional hospital be developed nearby".

Much discussion with the appropriate health providers and consumers in both counties has taken place during this study, and it appears that they would consider closing these facilities if a better alternative to delivering health care were developed. Although citizen groups in both counties are actively seeking solutions to their individual problems, all expressed a willingness to cooperate in developing an area-wide solution.

3. BED NEED DETERMINATION FOR NORTH TRIDENT COMMUNITY

The Charleston Area Comprehensive Health Planning Council recently conducted an in-depth study to determine the number of acute care beds needed for the entire Trident area. The Council examined admitting records and utilization patterns of thirteen (13) area hospitals - the ten (10) Trident area hospitals, along with Colleton, Orangeburg and Williamsburg county hospitals - to establish the pattern of where residents in each of the three (3) Trident counties went for care. These "patient origin" patterns were then combined with current population figures to determine a "population served" figure for each of the area hospitals.

While this process does not identify separately the future bed needs of the North Trident Community, it uses the assumption that the demand would be a product of most probable transfer actions. These assumptions were then modified to determine the minimum patient transfer situation to develop a minimum population to be served.

The results of the general acute care bed need analysis for the Trident area is given below. (A detailed breakdown of the data is given in Appendix A).

Trident_10236

Accountants' Report

ERNST & ERNST
Nashville City Bank and Trust Bldg.
Nashville, Tennessee 37201

Stockholders and Board of Directors
Hospital Corporation of America
Nashville, Tennessee

We have examined the consolidated financial statements of Hospital Corporation of America and subsidiaries as of December 31, 1971 and 1970. Our examinations were made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

We did not examine the consolidated financial statements of Ross Medical Corporation and its subsidiaries and the combined statements of Los Robles Hospital and affiliated corporations for the year ended December 31, 1970, these companies having been combined with Hospital Corporation of America in 1971 in transactions accounted for as poolings of interests. The aggregate contribution of these companies to the total assets, revenues and net income represented 14%, 20%, and 16%, respectively, of the consolidated restated totals. These statements were examined by other independent accountants whose reports thereon have been furnished to us.

In our opinion, based upon our examinations and, insofar as they relate to the year ended December 31, 1970, the reports of other independent accountants, the accompanying balance sheets and statements of income, stockholders' equity and changes in financial position present fairly the consolidated financial position of Hospital Corporation of America and subsidiaries at December 31, 1971 and 1970, and the consolidated results of their operations, and changes in stockholders' equity and financial position for the two years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Ernst & Ernst

Nashville, Tennessee
March 1, 1972

HOSPITAL CORPORATION OF AMERICA
Consolidated Statement of Income

For the Years Ended December 31, 1971 and 1970

		1970	
	1971	Restated for Poolings of Interests— Note 2	As Previously Reported
Operating revenues	\$116,199,000	\$ 90,499,000	\$ 70,819,000
Less provisions for contractual adjustments and doubtful accounts	<u>7,754,000</u>	<u>6,398,000</u>	<u>5,425,000</u>
	108,445,000	84,101,000	65,394,000
Costs and expenses			
Operating expenses	89,471,000	69,288,000	53,387,000
Depreciation and amortization	3,856,000	2,463,000	1,864,000
Interest	<u>3,417,000</u>	<u>2,577,000</u>	<u>1,753,000</u>
	96,744,000	74,328,000	57,004,000
	11,701,000	9,773,000	8,390,000
Other income	956,000	480,000	201,000
Other expense	<u>57,000</u>	<u>19,000</u>	<u>19,000</u>
INCOME BEFORE INCOME TAXES	12,600,000	10,234,000	8,572,000
Provision for income taxes (Note 3)			
Current	4,162,000	3,830,000	3,205,000
Deferred	<u>1,292,000</u>	<u>1,014,000</u>	<u>913,000</u>
	5,454,000	4,844,000	4,118,000
NET INCOME	<u>\$ 7,146,000</u>	<u>\$ 5,390,000</u>	<u>\$ 4,454,000</u>
Income per share of Common Stock assuming exercise of applicable warrants and employee stock options	\$1.14	\$.97	\$.92
Weighted average shares	6,280,505	5,553,870	4,859,758

(The accompanying notes to consolidated financial statements are an integral part of these statements.)

HOSPITAL CORPORATION OF AMERICA
Consolidated Balance Sheet

December 31, 1971 and 1970

		1970	
		Restated for Poolings of Interests— Note 2	As Previously Reported
ASSETS	1971		
CURRENT ASSETS			
Cash	\$ 11,464,000	\$ 8,094,000	\$ 7,374,000
Marketable securities at cost, which approximates market ..	6,148,000	495,000	495,000
Accounts receivable, less reserves for doubtful accounts and contractual adjustments of \$5,100,000 in 1971 and \$3,600,000 in 1970	16,472,000	14,869,000	10,840,000
Supplies at cost	4,527,000	3,238,000	2,614,000
Prepaid expenses	980,000	687,000	503,000
	<u>39,591,000</u>	<u>27,383,000</u>	<u>21,826,000</u>
INVESTMENTS AND OTHER ASSETS			
Cash restricted for construction	7,052,000		
Investments at cost, including land of \$2,557,000 in 1971 and \$1,460,000 in 1970	2,723,000	1,670,000	1,646,000
Deferred income tax benefits	595,000	696,000	518,000
Escrow deposits and other	840,000	1,083,000	360,000
	<u>11,210,000</u>	<u>3,449,000</u>	<u>2,524,000</u>
PROPERTY, PLANT AND EQUIPMENT, at cost (Note 4)			
Land	5,835,000	3,761,000	2,764,000
Buildings and improvements	76,043,000	40,806,000	30,407,000
Equipment	33,748,000	19,001,000	15,358,000
	<u>115,626,000</u>	<u>63,568,000</u>	<u>48,529,000</u>
Less accumulated depreciation	16,396,000	12,978,000	10,763,000
	<u>99,230,000</u>	<u>50,590,000</u>	<u>37,766,000</u>
Construction in progress (estimated cost to complete \$53,000,000 in 1971)	38,109,000	43,555,000	43,555,000
	<u>137,339,000</u>	<u>94,145,000</u>	<u>81,321,000</u>
INTANGIBLE ASSETS			
Cost in excess of net assets of purchased subsidiaries	1,117,000	1,117,000	1,117,000
Unamortized loan costs, being amortized over the terms of the loans	1,934,000	1,369,000	1,361,000
Preopening and other organizational costs, being amortized over five years	1,542,000	539,000	356,000
	<u>4,593,000</u>	<u>3,025,000</u>	<u>2,834,000</u>
	<u>\$192,733,000</u>	<u>\$128,002,000</u>	<u>\$108,505,000</u>

(The accompanying notes to consolidated financial statements are an integral part of these statements.)

LIABILITIES AND STOCKHOLDERS' EQUITY	1971	1970	
		Restated for Poolings of Interests— Note 2	As Previously Reported
CURRENT LIABILITIES			
Notes payable to banks.....	\$ 277,000	\$ 3,733,000	\$ 2,126,000
Accounts payable	3,102,000	3,267,000	2,220,000
Accrued liabilities	3,357,000	3,168,000	2,571,000
Medicare advances	462,000	1,223,000	786,000
Income taxes, including deferred taxes of approximately \$3,000,000 in 1971 and \$2,000,000 in 1970	4,429,000	3,718,000	3,379,000
	9,333,000	3,571,000	3,063,000
Current maturities of long term debt	<u>20,960,000</u>	<u>18,680,000</u>	<u>14,145,000</u>
LONG TERM DEBT (Note 4).....	95,238,000	61,679,000	55,170,000
DEFERRED CREDITS			
Deferred income taxes	2,903,000	1,712,000	1,193,000
Deferred Medicare income	1,388,000	522,000	505,000
	<u>4,291,000</u>	<u>2,234,000</u>	<u>1,698,000</u>
STOCKHOLDERS' EQUITY			
Common stock, \$1 par value, authorized 30,000,000 shares, outstanding 6,205,862 shares in 1971 and 5,695,117 in 1970 (Note 5)	6,206,000	5,695,000	5,004,000
Additional paid-in capital	42,715,000	23,497,000	18,271,000
Retained earnings (Note 4)	23,547,000	16,441,000	14,441,000
	<u>72,468,000</u>	<u>45,633,000</u>	<u>37,716,000</u>
Less Treasury stock, at cost, 40,206 shares	224,000	224,000	224,000
	<u>72,244,000</u>	<u>45,409,000</u>	<u>37,492,000</u>
COMMITMENTS AND CONTINGENCIES (Note 7)			
	<u>\$192,733,000</u>	<u>\$128,002,000</u>	<u>\$108,505,000</u>

HOSPITAL CORPORATION OF AMERICA
Consolidated Statement of Stockholders' Equity

For the Years Ended December 31, 1971 and 1970

	Common Stock	Additional Paid-In Capital	Retained Earnings	Treasury Stock
Balance, December 31, 1969, as previously reported.....	\$4,430,000	\$ 9,236,000	\$ 9,986,000	\$200,000
Acquisition of pooled companies during the year ended December 31, 1971	674,000	4,901,000	1,097,000	
Balance, December 31, 1969, as restated	5,104,000	14,137,000	11,083,000	200,000
Common stock sold in public offering.....	564,000	8,931,000		
Sale of stock by subsidiary prior to pooling of interests...	6,000	141,000		
Stock issued in poolings by subsidiary prior to acquisition ..	12,000	(19,000)		
Purchase of treasury stock by subsidiary			(32,000)	
Adjustments in acquisition costs of previously acquired subsidiaries—net	9,000	104,000		24,000
Capital donated to subsidiary prior to pooling of interests ..		291,000		
Costs incurred by subsidiary in pooling of interests prior to acquisition		(88,000)		
Net income			5,390,000	
Balance, December 31, 1970.....	5,695,000	23,497,000	16,441,000	224,000
Common stock sold in public offering.....	500,000	19,097,000		
Exercise of options and warrants.....	8,000	117,000		
Stock issued in earnings agreements of subsidiary prior to pooling of interests	3,000	(3,000)		
Capital donated to subsidiary prior to pooling of interests ..		7,000		
Net Income			7,146,000	
Dividends paid by subsidiary prior to pooling of interests ..			(40,000)	
Balance, December 31, 1971.....	<u>\$6,206,000</u>	<u>\$42,715,000</u>	<u>\$23,547,000</u>	<u>\$224,000</u>

(The accompanying notes to consolidated financial statements are an integral part of these statements.)

HOSPITAL CORPORATION OF AMERICA
Consolidated Statement of Changes in Financial Position

For the Years Ended December 31, 1971 and 1970

		1970	
	1971	Restated for Poolings of Interests— Note 2	As Previously Reported
SOURCE OF WORKING CAPITAL			
Operations			
Net income	\$ 7,146,000	\$ 5,390,000	\$ 4,454,000
Add expenses not requiring an outlay of working capital:			
Depreciation and amortization (Including deferred loan			
cost of \$87,000 in 1971 and 1970)	3,943,000	2,550,000	1,951,000
Deferred income taxes	1,292,000	794,000	575,000
Deferred income	866,000	438,000	422,000
Working Capital provided from operations	13,247,000	9,172,000	7,402,000
Additional long term borrowing	47,563,000	28,791,000	28,523,000
Common stock sold in public offerings (500,000 shares in 1971			
and 564,000 in 1970)	19,597,000	9,495,000	9,495,000
Exercise of options and warrants	125,000		
Capital donated to subsidiary prior to pooling of interests	7,000	291,000	
Other sources	382,000	499,000	330,000
	<u>80,921,000</u>	<u>48,248,000</u>	<u>45,750,000</u>
APPLICATION OF WORKING CAPITAL			
Additions to property, plant and equipment	48,061,000	40,493,000	38,958,000
Reductions in long term debt	14,004,000	3,063,000	2,950,000
Bond proceeds restricted for construction	7,052,000		
Additions to deferred debt costs and other intangible assets	1,313,000	563,000	475,000
Other applications	563,000	380,000	61,000
	<u>70,993,000</u>	<u>44,499,000</u>	<u>42,444,000</u>
Increase in Working Capital	9,928,000	3,749,000	3,306,000
Working Capital at Beginning of Year	8,703,000	4,954,000	4,375,000
Working Capital at End of Year	<u>\$18,631,000</u>	<u>\$ 8,703,000</u>	<u>\$ 7,681,000</u>
CHANGES IN COMPONENTS OF WORKING CAPITAL			
Increase in current assets:			
Cash	\$ 3,370,000	\$ 3,941,000	\$ 4,349,000
Marketable securities	5,653,000	233,000	233,000
Accounts receivable	1,603,000	878,000	115,000
Supplies	1,289,000	1,182,000	1,003,000
Prepaid expenses	293,000	100,000	99,000
	<u>12,208,000</u>	<u>6,334,000</u>	<u>5,799,000</u>
Increase (decrease) in current liabilities:			
Notes payable to banks	(3,456,000)	1,089,000	154,000
Accounts payable	(165,000)	(1,007,000)	38,000
Accrued liabilities	189,000	1,201,000	1,217,000
Medicare advances	(761,000)	(160,000)	(192,000)
Income taxes payable	711,000	100,000	67,000
Current maturities of long term debt	5,762,000	1,362,000	1,209,000
	<u>2,280,000</u>	<u>2,585,000</u>	<u>2,493,000</u>
Increase in Working Capital	<u>\$ 9,928,000</u>	<u>\$ 3,749,000</u>	<u>\$ 3,306,000</u>

(The accompanying notes to consolidated financial statements are an integral part of these statements.)

HOSPITAL CORPORATION OF AMERICA

Notes to Consolidated Financial Statements**(1) ACCOUNTING POLICIES**

The information presented on pages 40 and 41 of this annual report includes a summary of certain accounting policies of the Company and is an integral part of these financial statements.

(2) ACQUISITIONS

During 1971, the Company acquired, in poolings of interests transactions, Ross Medical Corporation and its subsidiaries, Los Robles Hospital and its affiliated corporations and McMinnville Hospital, Inc. in exchange for a total of 694,112 shares of the Company's common stock. Each of these companies operates hospitals and/or related facilities. The financial statements of the preceding year have been restated to include the accounts of the pooled companies. Aggregate revenues and net income of these companies for the periods prior to their acquisition included in the results of operations for the year ended December 31, 1971 were \$13,590,000 and \$985,000, respectively.

(3) INCOME TAXES

The provision for Federal income taxes for 1971 has been reduced for investment tax credits of \$360,000 applicable to the eight new hospitals opened during the year. Additional credits of \$91,000 and \$76,000 in 1971 and 1970, respectively, have also been applied to tax provisions.

(4) LONG TERM DEBT

At December 31, 1971 and 1970, long term debt, exclusive of current maturities, consists of the following:

	1971	1970
Notes under revolving credit and term loan agreement providing for borrowings until 1974 to a maximum of \$32,500,000 (increased in 1971 from \$30,000,000) at 1% above the prime rate. Borrowings are to be used for the construction of specific hospitals the capital stock of which has been pledged as collateral to the notes.....	\$26,976,000	\$21,183,000
Construction loans with interest ranging from the prime rate to 8½% and construction payables to be replaced by permanent financing.....	5,171,000	9,196,000
9½% Mortgage notes payable to insurance companies, due quarterly from 1973 to 1992. The proceeds of the borrowings, in aggregate amounts of \$27,000,000, will be used to reduce borrowings under the revolving credit and term loan agreement. The Company issued warrants to purchase 243,634 shares of its common stock at \$30 per share and is obligated to issue warrants to purchase an additional 39,866 shares upon the remaining takedowns.....	2,906,000	—0—
7¾% Mortgage notes payable to insurance companies due quarterly until 1991. The Company issued warrants to purchase 100,750 shares of its common stock at \$18 per share in connection with these notes.....	14,496,000	3,027,000
4¼% to 8½% Capitalized lease obligations underlying industrial revenue bonds, due in semi-annual payments until 1991. Payments are to be in amounts sufficient to pay bond interest and principal when due.....	16,342,000	3,807,000
5¼% to 9¼% Mortgage notes, due monthly in varying amounts through 1996.....	27,065,000	21,860,000
Other indebtedness.....	2,281,000	2,606,000
	<u>\$95,238,000</u>	<u>\$61,679,000</u>

Substantially all the Company's land, buildings and building improvements are pledged as collateral to the above debt. Current maturities of \$9,333,000 in 1971 includes approximately \$5,500,000 to be paid by the Company on construction loans when long term financing is drawn on hospitals scheduled to open in 1972.

Under the most restrictive covenants of the above loan agreements:

1. Consolidated current assets must be maintained in amounts of at least 125% of consolidated current liabilities.
2. Net working capital, as defined, must be maintained in amounts of at least 7% of operating revenues for the preceding year.
3. The Company may not obtain permanent financing in excess of 75% of hospital properties, as defined.
4. Dividends cannot be paid in excess of 50% of defined net income accumulated after January 1, 1971. Retained earnings of approximately \$3,500,000 are not restricted for the payment of dividends.

(5) COMMON STOCK AND STOCK OPTIONS

The Company has reserved 250,000 shares of its common stock for issuance to officers and employees under its qualified and non-qualified stock option plans. During 1971, the Company adopted a non-qualified plan under which 125,000 options to purchase the Company's common stock may be granted until 1991. Options under the non-qualified plan may be exercised after six months and before ten years from date of grant subject to individual restrictions contained in certain agreements. Prices are determined on an individual basis under the non-qualified plan whereas the qualified options must be granted at the market price at date of grant. Transactions during the two years ended December 31, 1971 were as follows:

	Number of Options	Price Per Option
Outstanding at December 31, 1969	11,350	\$30.50 to \$50.75
Granted during 1970	45,400	18.00 to 39.00
Outstanding at December 31, 1970	56,750	
Granted during 1971	82,100	18.38 to 41.50
Exercised (2,900) or expired during 1971	(5,250)	18.38 to 50.75
Outstanding at December 31, 1971	<u>133,600</u>	18.00 to 41.50

Options to purchase 95,300 shares were exercisable at December 31, 1971. An additional 5,667 shares are issuable in connection with options assumed in acquisitions and are excluded from the above transactions.

At December 31, 1971, options to purchase 92,600 shares and 98,600 shares are outstanding under the qualified and non-qualified plans of which 57,600 options exercisable under either plan would proportionately reduce the number of options exercisable under the other plan. The aggregate option prices to be received by the Company assuming exercise of options outstanding at December 31, 1971 is approximately \$3,500,000 after giving effect to a \$423,000 reduction for the exercise of certain non-qualified options granted in 1971. Compensation expense is being recognized for the difference between the market value at the date of granting either the qualified or the non-qualified alternative and the exercise price of the non-qualified option over ten years or in the year of exercise, if earlier. In 1971, \$97,000 was charged to operations.

In addition to the warrants issued to mortgage lenders as described in Note 4, the Company has outstanding at December 31, 1971, warrants to purchase 339,998 shares of common stock at \$5 per share expiring in June 1973.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

(6) SUBSEQUENT EVENTS

In January, 1972, The Health and Educational Facilities Board of the City of Athens, Tennessee sold \$4,400,000 of First Mortgage Revenue Bonds to finance construction of a hospital to be leased to and operated by the Company.

The Company has obtained commitments from a group of insurance companies for \$27 million of additional mortgage financing at 9 1/4 % extending for a twenty-year term.

In February, 1972, the Company agreed in principle to acquire three operating hospitals and one under construction which is scheduled to be opened in early fall of 1972. In connection with these transactions, approximately 600,000 shares of the Company's common stock are to be issued and certain liabilities are to be assumed. The acquisition of the three existing facilities will be accounted for as poolings of interests while the one under construction will be accounted for as a purchase. The inclusion of the results of operations of these companies with the operations of the Company for the year ended December 31, 1971 would increase revenues by approximately \$18,000,000, net income by approximately \$1,100,000 and income per common and common equivalent share by \$.06.

(7) CONTINGENCIES

The Company and its subsidiaries are defendants in lawsuits involving claims for personal injury damages which may exceed insurance coverage at the respective hospitals by an aggregate of approximately \$1,500,000. Special counsel for the Company are of the opinion that settlement of the lawsuits will not significantly exceed the limits of insurance coverage of the respective policies. In the opinion of management the outcome of the lawsuits will not have a material effect on the Company's financial statements.

TRANSFER AGENT

Third National Bank in Nashville, Tennessee
First National City Bank, New York, Co-Transfer Agent

REGISTRAR

Commerce Union Bank, Nashville, Tennessee
Bankers Trust Company, New York, Co-Registrar

CONSULTANTS

Auditors—Ernst & Ernst
Counsel—Waller Lansden Dortch & Davis
Public Relations—Holder, Kennedy & Company, Inc.

HOSPITAL CORPORATION OF AMERICA

242 - 25th Avenue, North
P. O. Box 550
Nashville, Tennessee 37202
615/327-5551

The chart is divided into three (3) sections: bed need for the North Trident area, bed need for the peninsula area and bed need for the Federal Government hospitals (Navy and Veterans Administration).

BED NEED BASED ON MINIMUM PATIENT TRANSFER CONDITIONS

	North Trident Area	Peninsula Hospitals	Federal Hospitals	Total
Population Served (Annual)	74,186	276,269	109,920	460,375
Projected Patient Days	80,714	308,869	231,821	621,404
Average Daily Census (P.D. $\div$ 365)	221	846	635	1,702
Bed Need (A.D.C. $\div$ 365)	260	995	747	2,002

4. Conclusion

Hospital Corporation of America feels that the development of a 200 bed facility is necessary to keep pace with the growing medical care needs of the residents of the north Trident area. The project will require the dedication and total effort of the entire medical community as well as other interested leaders in the area.

Our proposed facility, provided approval is granted, will offer the most modern equipment available for the services provided; strive for maximum patient comfort as well as the finest in health care; and provide the best possible service to physicians. It will be a complete hospital to the extent appropriate for the community and compatible with other hospitals in the area. The design will be such that additional beds can be added to meet the future health care needs of the area.

Based upon an exhaustive study conducted by the North Charleston Hospital Committee, the Committee concluded that a regional health care facility to

Trident_10246

serve Berkeley, Dorchester and the northern part of Charleston County is feasible.

Trident_10247

APPENDIX A

DETAILS OF THE BED NEED CALCULATION

Trident_10248

CHART I-A

CALCULATION OF CURRENT POPULATION SERVED

	ROPER	DORCHESTER CO.	BAKER	CHARLESTON CO.	MCLENNAN-BANKS	BERKELEY CO.	NAVAL HOSP.	V.A. HOSPITAL	MUSC HOSPITAL	ST. FRANCIS HOSPITAL	TOTALS
of Charleston Co. missions	28.11	0.50	5.72	8.49	1.84	0.06	19.00	5.76	14.30	15.91	99.7
77 Charleston Co. population Estimate	268.0										
population served"	75,341	1,340	15,330	22,760	4,930	160	50,920	15,440	38,330	42,645	196
of Dorch. Co. missions	15.37	34.60	2.92	0.62	0.83	0.23	10.06	3.25	12.90	8.15	88.92
77 Dorch. Co. population Estimate	38.5										
population served"	5,910	13,310	1,124	240	320	90	3,910	1,250	4,960	3,140	34,254
of Berkeley Co. missions	20.82	3.03	0.50	----	0.63	18.38	11.22	3.75	23.49	17.13	98.94
77 Berkeley Co. population Estimate	73.0										
population served"	15,200	2,210	366	----	460	13,410	8,190	2,740	17,150	12,500	72,226
of Colleton Co. missions	3.92	----	0.29	----	----	----	0.53	2.63	5.38	2.23	14.99
77 Colleton Co. population Estimate	26.2										
population served"	1,030	----	76	----	----	----	140	690	1,410	585	3,927
TAL POP. COUNTED FOR	97,481	16,860	16,895	23,000	5,710	13,660	63,160	20,120	61,850	58,875	
ADMISSIONS OF SP. ACCT. FOR	96.47	98.03	96.97	99.99	96.24	97.44	86.52	54.50	56.56	93.80	
TAL POP. RVED	100,765	17,200	17,420	23,000	5,930	14,020	73,000	36,920	109,350	62,770	

Trident 10249

Joint Exhibit 010-0024

RECORD 007473

CHART II-A
PATIENT ORIGINS WITHIN
CHARLESTON COUNTY

	ROPER	DORCHESTER CO.	BAKER	CHARLESTON COUNTY	MCLENNAN-BANKS	BERKELEY COUNTY	NAVAL HOSPITAL	MUSC HOSPITAL	V.A. HOSPITAL	ST. FRANCIS HOSP.
Charleston County Area										
Peninsula	8.7	16.7	11.1	40.3	38.5	0	2.1	31.2	31.7	19.2
West of Ashley	27.0	0	27.4	5.8	12.8	0	10.5	16.5	20.8	24.4
St. Islands	6.4	0	12.6	14.0	12.8	0	4.6	14.0	11.0	9.4
North Charleston	46.8	66.7	44.4	32.1	33.3	100.0	81.1	29.4	27.5	37.9
East of Cooper	11.1	16.7	4.4	7.8	2.6	0	1.8	8.9	9.0	9.0
TOTALS	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Trident_10250

CHART III-A: 1977 Population Served
(Based on "Most Probable" Patient Transfers).

	% of Chas. Co. To This Hospital from N. Chas.	Chas. Co. Population Served	N. Chas. Population Served	To New Hospital	Pop. of Berkeley County Served	To New Hospital	Pop. of Dorch. County Served	To New Hospital	For Each Hospital Total Pop. Served	Pop. Served By New Hosp.	Pop. Served by Cur- rent Private	Military Hospita Pop. Served	
ROPER	46.8	75,341	35,260	1/2 17,630	15,200	2/3 10,133	5,910	2/3 3,940	100,765	31,703	69,062	-0-	
DORCHESTER	66.7	1,340	894	1/2 447	2,210	2/3 1,473	13,310	100% 13,310	17,200	15,230	1,970		
BAKER	44.4	15,330	6,807	1/2 3,403	366	2/3 244	1,124	2/3 749	17,420	4,396	13,024		
CHARLESTON COUNTY	32.1	22,760	7,306	1/2 3,653	-----	-0-	240	2/3 160	23,000	3,813	19,187		
MCCLENNAN-BANKS	33.3	4,930	1,643	1/2 822	460	2/3 307	320	2/3 213	5,930	1,342	4,588		
BERKELEY COUNTY	100.00	160	160	2/3 107	13,410	100% 13,410	90	2/3 60	14,020	13,577	443		
NAVAL HOSPITAL	81.1	50,920	41,296	-- -0-	8,190	--- -0-	3,910	--- -0-	73,000	-0-	-0-	72,000	
MUSC HOSPITAL	29.4	38,330	11,269	1/3 3,752	17,150	1/2 8,575	4,960	1/2 2,480	109,350	14,807	94,543		
V.A. HOSPITAL	27.5	15,440	4,246	-- -0-	2,740	--- -0-	1,250	--- -0-	36,920	-0-	-0-	36,920	
ST. FRANCIS HOSPITAL	37.9	42,645	16,162	1/2 8,081	12,500	2/3 8,333	3,140	2/3 2,093	62,770	18,507	44,263		
TOTAL POPULATION SERVED		267,196	124,608		38,815		42,475		23,005	460,375	103,375	247,080	109,920

Trident 10251

CHART IV - A: 1977 Population Served
(Based on Minimum Patient Transfers)

	Ratio: North Chas. County Admissions vs. Total Chas. County Admissions	Charleston County Pop. Served	N. Chas. County Pop. Served	N. Chas. To New Hospital	Berk. Co. To New Hospital	Dorch. Co. to New Hospital	TOTAL POPULATION SERVED		
							New Hospital	Current Private Facilities	Fed. Gov't Hospitals
OPER	46.8	75,341	35,260	~~—~~	10,133	3,940	14,073	86,692	
DORCHESTER	66.7	1,340	894	$\frac{1}{2}$ 447	1,473	13,310	15,230	1,970	
AKER	44.4	15,330	6,807	~~—~~	244	749	993	26,427	
CHARLESTON COUNTY	32.1	22,760	7,306	~~—~~	-0-	160	160	22,840	
MCLENNAN-BANKS	33.3	4,930	1,643	~~—~~	307	213	520	5,410	
BERKELEY COUNTY	100.0	160	160	$\frac{2}{3}$ 107	13,410	60	13,577	443	
WALTON HOSPITAL	81.1	50,920	41,296	~~—~~	-0-	-0-	-0-	-0-	73,000
WISCONSIN HOSPITAL	29.4	38,330	11,269	$\frac{1}{3}$ 3,752	8,575	2,840	15,167	94,183	
W.A. HOSPITAL	27.5	15,440	4,246	~~—~~	-0-	-0-	-0-	-0-	36,920
T. FRANCIS HOSPITAL	37.9	42,645	16,162	$\frac{1}{4}$ 4,040	8,333	2,093	14,466	48,304	
TOTAL POPULATION SERVED		267,196	124,608	8,346	42,475	23,005	74,186	276,269	109,920 460,375

Trident 10252

Exhibit "A"		Trident Area - Restated Bed Inventory and Bed Need 11-20-72					
line	Hospital Unit	1 Beds 1972	2 Beds 1973	3 Beds 1974	4 Beds 1975	5 Beds 1976	6 Beds 1977
1	Medical University	461	461	470	470	470	470**
2	Roper Hospital	322 ✓	418	418	418	418	418
3	Saint Francis Xavier	252	252	252	252	252	252
4	Sub Total	1035	1131	1140	1140	1140	1140
5	North Charleston				*200	200	200
6	Sub Total	1035	1131	1140	1340	1340	1340
7	Charleston County Hospital	127	127	127	127	127	127
8	Baker Hospital	61	61	61	61	61	61
9	McLennon Banks	31	31	31	31	31	31
10	Sub Total	1254	1350	1359	1559	1559	1559
11	Dorchester County	76	76	76	-0-	-0-	-0-
12	Berkeley County	60	60	60	-0-	-0-	-0-
13	Sub Total	1390	1486	1495	1559	1559	1559
14	Shelled in beds 80% complete Saint Francis Xavier	82	82	82	82	82	82
15	Total	1472	1568	1577	1641	1641	1641
16(A)	Bed Need Per Pg.4-Plan (Annual increase prorated)	1190	1214	1239	1263	1288	1312
17(A)	Excess Beds Excluding Shelled in Beds	200	272	256	296	271	247
18(A)	Excess Beds Including Shelled in Beds	282	354	338	378	353	329
19(B)	Bed need Pg.4 Plan adj. for MUH newborn days included in need calculation by error	1157	1181	1206	1230	1255	1279
20(B)	Excess beds excl.shelled in bed	233	305	289	329	304	280
21(B)	Excess beds incl.shelled in bed	315	387	371	411	386	362

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RECORD 007477

BERKELEY-CHARLESTON-DORCHESTER

PROPOSED

TRIDENT REGIONAL HOSPITAL COMPLEX

SITE EVALUATION STUDY

Prepared by: Bob L. Robinson
Vice President Real Estate
Hospital Corporation of America

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NORTH TRIDENT REGIONAL HOSPITAL

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OBJECTIVES AND SCOPE

This report has been devoted to exploring the feasibility of developing and operating a Regional Medical Complex to serve the North Trident Regional Community. In this study of feasibility, considerable thought and evaluation has been directed toward the optimum size medical facility necessary to support the North Trident Community.

The primary consideration of this study has been to determine the site that will best accomplish the several objectives of the representative groups that have a demonstrated interest and need for the proposed facility as well as the economic aspects of its location.

Critical factors governing this investigation were:

1. Site selection to best serve the majority of the population without favor and prejudice and independent of personal preferences of special interests.
2. Location to permit maximum utilization by present physicians and be so located to attract new medical practitioners to broaden the scope of patient care in the community.
3. Examination of regional medical concept and define medically related ancillary services to be made a part of this development.
4. Investigate development costs as related to proposed and existing public utilities available at each site under consideration.
5. Labor force availability
6. Accessibility and public exposure
7. Select a site that offers amenities and space for expansion and implementation of health care programs that may be imposed by future governmental direction or encouragement.

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8. Select the site that best provides proximity to other medical specialties for maximum patient referral advantages and mutually compatible medical services.

The entire concept of feasibility for a venture of this magnitude requires testing of answers to questions that revolve around the strength of major economic considerations to insure that the project is viable and capable of keeping pace with the communities medical needs for years to come. The economic stability is a basic requirement to permit the operating entity to maintain and acquire the latest in sophisticated medical equipment to insure that patient care is not compromised due to poor site location resulting in a lower use. To select a site deficient in one major area could mean that the best medical care would be jeopardized at the expense of the patient, which HCA is unwilling to accept. The size of the facility required to meet the needs of the North Trident Community has been carefully determined.

The proper utilization and success of this hospital is dependent on a unified acceptance by the representative areas within the Trident Community. Fragmentation of support could result in the development of smaller, poorer equipped facilities severely limiting the delivery of extensive modern health care. This report has been devoted solely to the evaluation of one single facility as initially requested.

Data obtained for review and consideration was verified and expanded by consultation with professional organizations and individuals qualified in fields related to the type facility proposed. This information has been evaluated from experience and practical knowledge gained from developing similar projects.

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In general, we have investigated the various political subdivisions and their relation to each in establishing the major objectives to be made part of this study. Additionally, the guidance of the North Trident Regional Hospital Committee in setting out the area to be considered has served to establish the site location parameters and within the scope of this requirement we have made our evaluation to determine the project feasibility.

BASIC ASSUMPTIONS

There are certain basic assumptions that were made in the preparation of this study:

1. A certificate of need can be secured for a 200 bed acute care facility.
2. Additional beds can be added as required to meet the needs of the area.
3. Existing hospitals in Berkeley and Dorchester Counties will be closed upon opening of the proposed facility.
4. Scope of patient care is to be maximized.
5. Cost of patient care is to be minimized.
6. Consolidation of North Trident Regional Medical care will serve as a nucleus around which a major regional medical complex can grow and attract new practitioners in required specialties and sub-specialties.
7. Only certain medical staff members can professionally justify relocating immediately adjacent to the proposed hospital regardless of site selected. Those physicians engaged in primary health care may better serve patient care needs by remaining neighborhood oriented.
8. The entire development must be soundly based upon economic capability to justify the investment of considerable capital and effort.

Reliance upon these assumptions appears well grounded through prior studies of this subject and these factors have been applied throughout this investigative analysis as well.

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FIELD AND RESEARCH SOURCES

- () This investigation involved a careful analysis of the actual medical care needs as they now exist and can be forecast to exist within the next twenty years. Factual evaluation of the present population and correlation of the future service area population are considered primary controlling factors in locating the best site. Additionally, we must assess those trends that, in our studied judgment, affect changes in the dispensing of medical care services.

To obtain answers directly responsive to the details of the assignment, personal investigation of the potential sites and environment was accomplished and the general and specific regions were investigated to the extent necessary. Reliance was placed upon a number of agencies and resources; some of the more significant sources of primary data were:

() U.S. Statistical Abstract 1971
U.S. Department of Commerce

() Regional Planning Council
Berkeley-Charleston-Dorchester, S.C.

Charleston Area Comprehensive Health Planning
1069 King Street-Charleston, S.C.

Final Report, Acute Care Needs of the North Charleston Area
Charleston Area Comprehensive Health Planning/David M. Gioncolz and Associates

North Charleston Public Service Commission
Mr. Phil Floyd, Consulting Engineer

U.S. Corps of Engineers
334 Meeting St., Charleston, S.C.

Mayor Berlin Myers
Summerville, S.C.

Mayor Palmer Gaillard
Charleston, S.C.

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Mayor John Bourne
North Charleston, S.C.

Mr. Clyde Umphlett, County Supervisor
Berkeley County, S.C.

Mr. Gary LeCroy, Director Berkeley County Development Board
Berkeley County, S.C.

Mr. Cecil Clay, Chairman Site Committee
North Trident Regional Hospital Committee

Mr. Roy Winey, Superintendent of Public Works
Summerville, S.C.

Personal interviews and other similar methods of data gathering were employed to the extent deemed necessary for the assignment. Considerable time and attention was given to population trends, planned expansion of public utilities services and characteristics of sites that would affect planning and construction of the proposed facility.

DESCRIPTION OF NORTH TRIDENT COMMUNITY

The North Trident Community is an area North of Charleston, S.C. located in the coastal section of the state. The North Trident Community (N.T.C.) is composed of components of three (3) counties being portions of Berkeley-Dorchester and Charleston. The general economy of the N.T.C. is based on wood products, agriculture and manufacturing.

The identifiable population to be served by the proposed medical facility is shown to be 103,375 drawn from the component areas of each county represented in the N.T.C. and based on the bed need on most probable patients transfer conditions.¹ The projected population served for bed need based on minimum patient transfer conditions² is 74,186 in the N.T.C. major growth is anticipated in the area along either side and primarily to the east of the interstate.

1. Chart 1-Final Report, Acute Care needs, D.M.G. Report
2. Chart 2-Final Report, Acute Care needs, D.M.G. Report

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Substantial industrial, commercial and residential growth can be anticipated in this area if

○ suitable sewerage treatment facilities can be developed to accomodate the tremendous demand that will accompany such development. It is anticipated that sizeable apartment and townhouse type developments will be developed in the southern portion of the N.T.C. to house the great number of workers in the Charleston area desiring to live outside the immediate peninsula area with good access provided by the interstate. The Goose Creek area will also experience considerable development due to proposed availability of community services.

It is an area which will draw younger middle income population because of the potential in business and manufacturing growth. This in-migration of younger age groups with a good median income will pace the growth pattern of the N.T.C. This group will additionally maintain a continued high utilization of physician and hospital services. Living patterns ○ commonly tend to center on the purchase of services and goods within a reasonable distance of homes. This would especially apply to health care services and the concept of obtaining these at a major centralized source such as a regional medical complex.

Present major shopping facilities and proposed developments will greatly enhance the acceptance of the South portion of the N.T.C. as a growth oriented area and the potential in the area is considered excellent.

The anticipated center of population for the N.T.C. will be just north and east of the Baptist College located at the intersection of Highway 78 and Interstate 26.

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PREVIOUS MEDICAL NEED STUDY

There has been prepared a study titled "FINAL REPORT ACUTE CARE NEEDS OF THE NORTH CHARLESTON AREA" submitted to North Charleston Hospital Committee, North Charleston Public Service Commission. This report has been reviewed thoroughly to correlate the information presented with the objectives of this overall evaluation of sites for the proposed facility.

The bed need determination as developed in Section IV Methodology of the above mentioned report, developed information to establish the pattern of where the residents in each of the three Trident counties went for care. These "patient origin" patterns were then combined with current population figures to determine a "population served" figure for each of the area hospitals. As pointed out in the study these figures are independent of political and geographic subdivisions normally used in health facility planning exercises. This process did not identify separately the future bed needs of the N.T.C. but merely uses the assumption that the demand would be a product of most probable transfer actions. These assumptions were then modified to determine the minimum patient transfer situation to develop a minimum population to be served.

ESTIMATED BED NEED

By comparing data provided in the previous medical study and adjusting by application of experience of HCA hospitals, which experience an average patient stay less than the national average, we are able to arrive at the following bed need determination. Assuming an 85% occupancy we calculate a bed need of 274 beds for the proposed hospital as being the projected size required by 1977.

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PROJECTED PHYSICIANS SUPPORT REQUIREMENTS

The development of the proposed medical complex will be a major undertaking requiring the dedication and effort of the medical community as well as the other interested leaders in the area.

Those physicians initially involved in the planning and development of this facility must serve as advisors and planners for the community. Their thoughts and preferences will affect the practice of medicine for years to come. Active membership on the hospital board of trustees will preserve the community guidance and identity so necessary for the successful development and execution of this project.

HCA relies heavily on the guidance of Board Members as they serve to tailor the hospital to the particular needs of this community. More medical staff members will be required to support this planned facility and it will be essential to attract and recruit a good medical staff motivated to render the best patient care possible. The present physicians in the N.T.C. can insure the quality of this medical complex.

Physicians and para-medical services can be accommodated on this campus type development with participation various methods. Physicians can own their own land and office, lease land and office, or lease a complete office. The multiple choice opportunities permits greater response to the individual needs of the physicians desiring to locate near the hospital in the medical complex.

We are confident that substantial support will come from physicians now located in the area and we anticipate considerable interest from other physicians outside the N.T.C.

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SCOPE OF REGIONAL MEDICAL COMPLEX

With the strong governmental trend toward an expansion of public health insurance programs, new concepts of health care delivery, and expensive equipment required to provide the latest diagnostic and therapeutic treatment, we must of necessity focus our attention on the ultimate in providing quality health care on a regional basis. The N.T.C. deserves a regional medical complex offering the following services:

1. A fully equipped acute care hospital.
2. Individual and multi physician office buildings.
3. Pharmacies and optical shops.
4. Extended care facilities.
5. Brace shops and corrective appliances.
6. Short term surgery clinic.
7. Miscellaneous new medical services which may include such concept as Health Maintenance Organizations, Dental Operatory and Care Center, Eye Institute and Research facility, Pre-Ambulatory admission facility, transient housing, nurse and staff housing on campus, family living units either owner occupied or rental, related medical retail operations, i.e. uniforms, shoes, etc.

The development of a regional medical complex will require the utilization of these facilities to the maximum extent commensurate with the financial investment and medical skill and services available.

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MEDICAL RECRUITMENT

Physician recruitment today is highly competitive at both the urban and rural levels. The community which demonstrates proper organization, interest and a concentration of human resources to assist the physician in establishing his practice, will achieve positive results.

The practice trends of both residents and interns coming out of teaching hospitals today is toward corporate group practice or a formal, but independent, relationship between various specialty practitioners. Either system results in a closely established relationship of consultation and support for the medical management of patients. Additionally, group-like structures or formal independent practice relationships provide the necessary backup to each physician allowing more free time with guaranteed and competent coverage of patient needs.

With a concentration of health care delivery services in a comprehensive complex, N.T.C. can provide a setting that is extremely attractive to the physician who may wish to establish a practice on a solo, group or partnership basis, or who may be determined to relocate closer to his patient service area and hospital base.

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SITES EVALUATED AND FINDINGS

Numerous parcels of land were visited to evaluate their general desirability and availability. Of some 20 sites examined, 9 were selected as possessing some of the requisites necessary to insure the success of the proposed hospital complex.

Each site was evaluated on the basis of 8 major factors, with credit applied where certain amenities or intangible values could be assessed. Amenities included site orientation, land cover such as trees and natural soil stability and exposure from major thoroughfares. Intangible values include neighborhood growth that could be expected, future land use projection and protection that could be expected in an area without a formal zoning plan.

Attached as exhibit A are Engineering Reports for each site investigated and comments concerning the various factors considered. No site examined in the area established by the North Trident Regional Hospital Site Committee possessed all the requirements as of the date of inspection, but some, to the south of the intersection of I-26 and highway 78, did in fact offer more of the required factors than any of the final 9 sites reviewed. It is difficult to project a justification of a site as far north as we have considered due to the large tracts of land yet available and undeveloped lying south of highway 78. We have therefore restricted ourselves to consider only those lying in the prescribed area as furnished by the site selection committee.

SITE RECOMMENDED

The site offering the greatest potential for service to the N.T.C. has been determined to be that property owned by the City of Charleston and lying in the Southeast Quadrant of I-26 and Highway 78 immediately south of the Baptist College. The other sites are numbered in order of preference considering all the factors which HCA has found to be the

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most salient and desirable from past experience. Price of land was not considered a governing or overriding factor and even the offer of free land for this complex could not overshadow the deficiencies of several sites.

We are therefore recommending that the North Trident Hospital Complex be situated on the site recommended and this is done with the full faith and belief that the future growth and medical demands of the N.T.C. can best be served at this location. We realize that some may unknowingly let personal prejudice and preference attempt to guide their evaluation and selection of a site. We have approached this decision objectively with but one aim "to be fair and sincere in selecting the optimum site offering the best location to the largest number of the residents of the N.T.C." We feel we have accomplished this objective and selected the site that possesses the requisites that will permit immediate development bringing a modern medical facility to the area with the minimum delay at a time when medical care facilities are in need of considerable improvement.

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SITE STUDY REPORT

HOSPITAL CORPORATION OF AMERICA

The nine sites selected as possible locations for the new hospital were evaluated in respect to the following items:

1. Topo - general topographic features of the site.
2. Drainage - existing drainage conditions and drainage feasibility involved in site development.
3. Access - the accessibility of the site to major thoroughfares.
4. Water - the availability of public water facilities.
5. Sewer - the availability of public sewerage facilities and possibilities of on-site facilities.
6. Power - the availability of three phase high voltage power.
7. Gas - the availability of an adequate supply of natural gas (6 inch main or larger).
8. Stream - the availability of a flowing stream in which the effluent from which an on-site treatment plant can be discharged.

Based on the above criteria as discussed in the attached report, the following is the opinion of the Engineers as to the desirability of the sites for the hospital facilities:

Site number one is by far the most desirable site from all aspects considered. It drains well; public water is available on the site; adequate sewerage facilities will be available; accessibility to the site from two major highways; an adequate supply of power and natural gas are also available. A stream will not be necessary due to the availability of sewerage facilities. Another added feature that further strengthens the desirability of this site is the location of the North Charleston Fire Station only two blocks to the south.

All other sites have some of the desirable features listed above but not all of them. They are listed below in order of desirability.

2. Site No. 2
3. Site No. 7
4. Site No. 8
5. Site No. 6
6. Site No. 9
7. Site No. 4
8. Site No. 3
9. Site No. 5

SITE NO. 1

- Topo - The site is moderately wooded over the entire tract. There are no houses or roads through the site.
- Drainage - The site slopes gently away from U. S. 78 toward I-26. There are two depressions near the western boundary that extend several hundred feet into the property. These depressions become ditches near I-26 and are 10 feet to 15 feet below the average ground level and are 100 feet to 200 feet wide. They should add to the desirability of the site in that all of the property could very easily be drained into them, carrying the water under I-26 away from the site.
- Access - The site is very accessible from I-26, U. S. 78 and the Deer Park Subdivision. It would be desirable to have the I-26 cloverleaf completed to provide more direct access from the south. Visibility from I-26 and U. S. 78 will be very good.
- Water - A 24 inch diameter water main traverses the site, extending down Deerwood Drive, through the site to U. S. 78, then runs north along U. S. 78.
- Sewer - A 15 inch diameter sewer will be available under the North Charleston Public Service District unsewered area project. Completion of this line should be in mid 1974.
- Power - Three phase power is available on U. S. 78.
- Gas - A 6 inch diameter natural gas main is available on U. S. 78.
- Stream - There is no flowing stream available on this site.

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SITE NO. 2

- Topo - The site is very heavily wooded over the entire tract. It slopes to the east, with the eastern portion being low and boggy.
- Drainage - Drainage for this site will be to the east toward Goose Creek. Even though the eastern boundary becomes boggy there is enough relief across the site to provide adequate drainage by the construction of drainage ditches.
- Access - All access to the site would be from U. S. 78; however, it is only 2,500 feet $\pm$ to the I-26 interchange. It is doubtful that the facilities would be visible from I-26.
- Water - A 24 inch diameter water main is located along U. S. 78 just north of the site.
- Sewer - A 15 inch diameter sewer will be available under the North Charleston Public Service District unsewered area project. Completion of the 15 inch diameter sewer should be in mid 1974.
- Power - Three phase power is available on U. S. 78.
- Gas - A 6 inch diameter natural gas main is available on U. S. 78.
- Stream - There is no flowing stream available on this site.

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SITE NO. 3

- Topo - This site has some scattered wooded areas, but is primarily open land. It is all high ground and slopes away from the site on three sides. There are a few low income houses in the area on or near the site.
- Drainage - The topography of the site is such that drainage would be excellent. The center of the site, as best that could be determined is on a slight hill overlooking I-26. Drainage could be accomplished without extensive ditching.
- Access - The site is accessible only by a narrow dirt road. U. S. 78 lies approximately 2,500 feet to the west. There is a secondary road approximately 2,000 feet to the south that crosses I-26; however, there is no access to I-26 from this road. The facilities would be provided an excellent view from I-26, but access would be very expensive if not impractical from the interstate highway. It is doubtful that the site would be visible from U. S. 78 even though, with purchase of right-of-way adequate access could be provided from this highway.
- Water - There is a 24 inch diameter water main located along U. S. 78 and the secondary road (SC-8-62) to the south. Approximately 2,000 feet of addition line would be required to provide water to the site.
- Sewer - No existing public sewerage facilities are available near the site.
- Power - Three phase power is available approximately 2,500 feet to the east along U. S. 78.
- Gas - A 4 inch gas main is located approximately 2,500 feet to the east along U. S. 78; however, if additional capacity is required, this could be arranged with the gas company by tapping the high pressure gas main located near the site.
- Stream - There is no flowing stream available on or near this site. Without the availability of a stream any type treatment facility would be prohibitive unless fresh water was mixed with the effluent as a deluting agent.

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SITE NOS. 4 & 5

- Topo** - These two sites are very similar in topographic features and location and therefore, will be discussed together. The terrain in this area is generally flat, with a slight slope to the east. The area is scattered to moderately wooded. No houses are located on either site.
- Drainage** - Site No. 4 has a drainage ditch constructed by the highway department that extends from I-26, east, through the site. Both sites could be drained by constructing drainage canals.
- Access** - Access to both sites is presently very poor. A frontage road off of SC-8-62 serves site No. 4. Site No. 5 has no access from a state or county road. The sites are located along I-26, but a major interchange would be required to provide adequate access. The nearest direct access from I-26 is located approximately one mile north of Site No. 5. Visibility from I-26 would be very good for both sites.
- Water** - The closest public water supply to these sites is the 24 inch diameter main located approximately one mile to the west along U. S. 78.
- Sewer** - No existing public sewerage facilities are available near the sites.
- Power** - Three phase power is available approximately one mile west along U. S. 78.
- Gas** - A 4 inch gas main is available approximately one mile west along U. S. 78. As was the case with site No. 3, if additional gas was required this could be arranged by the gas company.
- Stream** - There is a very low flow in the drainage ditch through site No. 4. It would be doubtful that this stream could support the effluent from a treatment plant. No stream was observed on site No. 5.

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SITE NO. 6

- Topo - This site is moderately wooded over the entire tract. The terrain is rolling with several low areas traversing the site. Even though it contains some low areas, the grade differential is probably less than 10 feet.
- Drainage - Drainage of the site is presently poor; however, positive drainage away from the site could be accomplished by cleaning out and deepening the existing ditches. Storm water crosses under I-26 into Sawmill Creek which has been enlarged down stream approximately one and a half miles.
- Access - Access to the site is very good. The I-26 - U. S. 17-A interchange is located in the northwest corner of the tract. This is a complete clover leaf interchange, providing easy access from all directions. The site is visible from both I-26 and U. S. 17-A.
- Water - The city of Summerville has an 8 inch diameter water main located on U. S. 17-A, approximately 4,000 feet to the west. Under certain conditions they will extend their service beyond the city limits.
- Sewer - No public sewerage facilities are available near the site.
- Power - Three phase power is available along U. S. 17-A.
- Gas - Gas is available approximately 4,000 feet west of the site.
- Stream - The flow from the headwater of Sawmill Creek is very low through this site; however, it may be sufficient to support a sewerage treatment plant.

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SITE NO. 7

- **Topo** - This site is partially wooded with some open areas. The terrain is generally flat with a low area near the creek. There are no houses located on the site.
- **Drainage** - Positive drainage could be accomplished due to the creek being located in the tract without extensive canal construction.
- **Access** - The site is located approximately 2,200 feet from the I-26 - U. S. 17-A interchange. By construction of a frontage road along I-26 easy access could be provided. As was the case in site No. 6, the clover-leaf interchange provides easy access from all directions. Visibility from I-26 would be very good.
- **Water** - An 8 inch diameter water main from the city of Summerville is located approximately 4,000 feet to the northwest.
- **Sewer** - The closest public sewer is located approximately 4,500 feet to the northwest. This sewer is only 10 inches in diameter and would probably be inadequate to provide service for the site. If this sewer were used, a lift station on the site would be required.
- **Power** - Three phase power is available along U. S. 17-A, approximately 2,200 feet to the north.
- **Gas** - Gas is available approximately 4,000 feet to the northwest.
- **Stream** - Sawmill Creek passes through the site. The creek has a low flow. The flow would probably be adequate to receive the effluent from a treatment plant.

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SITE NO. 8

- Topo - This site is relatively flat with a slight slope to the north toward Sawmill Creek. Only a few patches of trees cover the area. The remainder of the tract is open land. There are no houses on the site.
- Drainage - Even though the site is relatively flat there is enough slope toward the creek to allow for adequate drainage. An easement would probably be required to accomplish this. There did not appear to be any low boggy area in the site.
- Access - Access would be good but less desirable than the access for site No. 7. Approximately 4,000 feet of frontage road would be required to provide access from the intersection of I-26 and U. S. 17-A. However, this clover-leaf intersection is convenient access for traffic from all directions. Visibility of the site from I-26 would be very good. It is doubtful that the site would be visible from U. S. 17-A.
- Water - The closest water main is an 8 inch diameter main located approximately 6,000 feet to the north on U. S. 17-A. This water line could be extended to the site.
- Sewer - No public sewer is available near the site. The location of the city of Summerville sewer main is too far away to consider as a discharge point.
- Power - Three phase power is available approximately 3,500 feet to the north along U. S. 17-A.
- Gas - Natural gas is available approximately 6,000 feet to the northwest along U. S. 17-A.
- Stream - A flowing stream is not available on the site. A sewer treatment effluent line approximately 1,000 feet long would be required to the nearest flowing stream; that being Sawmill Creek located north of the site.

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SITE NO. 9

- Topo - This site consist of farm land with some scattered wooded areas. The terrain slopes gently to the east. There is a relative large farm house with barns and a few smaller houses located within the site.
- Drainage - The slope of the land would provide adequate drainage to the east.
- Access - The site would have several hundred feet of frontage along U. S. 78. The site is local approximately 2,500 feet east of I-26 and over a mile from the nearest interchange. It would be impracticable, therefore, to consider access from I-26.
- Water - A 16 inch diameter water main is located along U. S. 78.
- Sewer - No public sewer is available within a mile of the site.
- Power - Three phase power is available along U. S. 78.
- Gas - A 4 inch gas main is available along U. S. 78. Additional capacity could be arranged with the gas company.
- Stream - No flowing stream was observed on the site. The nearest stream is located approximately 3,500 feet to the north.

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REVISED POPULATION PROJECTIONS FOR TRI-COUNTY AREA

	<u>1960</u>	<u>Jan. 1 1970 *</u>	<u>1975</u>	<u>1980</u>	<u>1985</u>
Peninsula City	62,925	46,100	62,819	66,442	70,678
North Charleston	76,255	84,000	107,483	116,042	125,156
St. Andrews	25,887	45,392	53,850	56,974	61,000
Johns Island	8,578	9,242	14,141	17,068	20,000
James Island	13,872	22,966	35,007	43,349	50,436
Moultrie	13,838	20,000	23,150	26,657	31,567
McClellanville	4,478	4,800	4,850	4,850	4,850
St. Pauls-Edisto	10,549	12,500	14,222	15,546	16,306
CHARLESTON COUNTY	216,382	245,000	315,522	346,928	379,993
BERKELEY COUNTY	38,196	55,660	65,000	77,485	96,696
DORCHESTER COUNTY	24,383	30,423	35,000	42,000	55,000
TRI-COUNTY TOTAL	278,961	331,083	415,522	466,413	531,689

1970 CENSUS POPULATIONS

City of Charleston	64,591
Goose Creek Town	3,706 - Area 16,300
Hanahan	9,227
Summerville Town	3,608 - Area 16,200

ESTIMATED URBAN POPULATION

Charleston County	218,000
Dorchester County	25,000
Berkeley County	16,000

Total Urban Population 259,000

SOURCE: Charleston County Planning Board and Market Research Department estimate
 *Although the totals for the county and city of Charleston are preliminary 1970 census figures, the smaller areas have been estimated

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1970
ECONOMIC PROFILE

Charleston Trident Area

	Popula- tion	House- holds	% White	% Male	Effective Buying Income*		Percent Households by Cash Income					
					Total (\$000)	Per House- hold	\$0- 2,999	\$3,000- 4,000	\$5,000- 7,999	\$8,000- 9,999	\$10,000- 14,999	\$15,000 +
Charleston Co.	271,200	72,300	68.4	50.0	631,598	8,736	25.4	15.1	21.8	12.5	25.2	8.5
Berkeley Co.	58,000	13,800	77.3	49.5	92,076	6,672	33.8	16.9	20.3	11.4	17.6	5.2
Worcester Co.	32,200	7,500	60.0	49.6	53,066	6,464	36.0	17.8	20.1	9.0	13.4	4.2
TRIDENT Charleston	361,400	93,600	67.9	49.9	776,740	8,250	27.5	15.6	21.5	12.1	23.1	7.7
Charleston SMSA	329,200	86,100	69.9	49.9	723,674	8,405	26.7	15.4	21.6	12.3	16.0	8.0
Columbia SMSA	329,100	82,900	72.9	51.0	828,631	9,996	21.3	15.6	23.2	12.7	17.7	9.5
Greenville SMSA	294,000	86,100	83.0	48.6	809,472	9,402	17.7	13.8	24.3	14.7	19.7	9.8
Savannah SMSA	200,400	58,700	60.5	48.0	504,911	8,602	21.8	15.6	23.5	13.6	16.9	8.6

*TRIDENT Area Figures are based on the 1970 Sales Management, Survey of Buying Power.

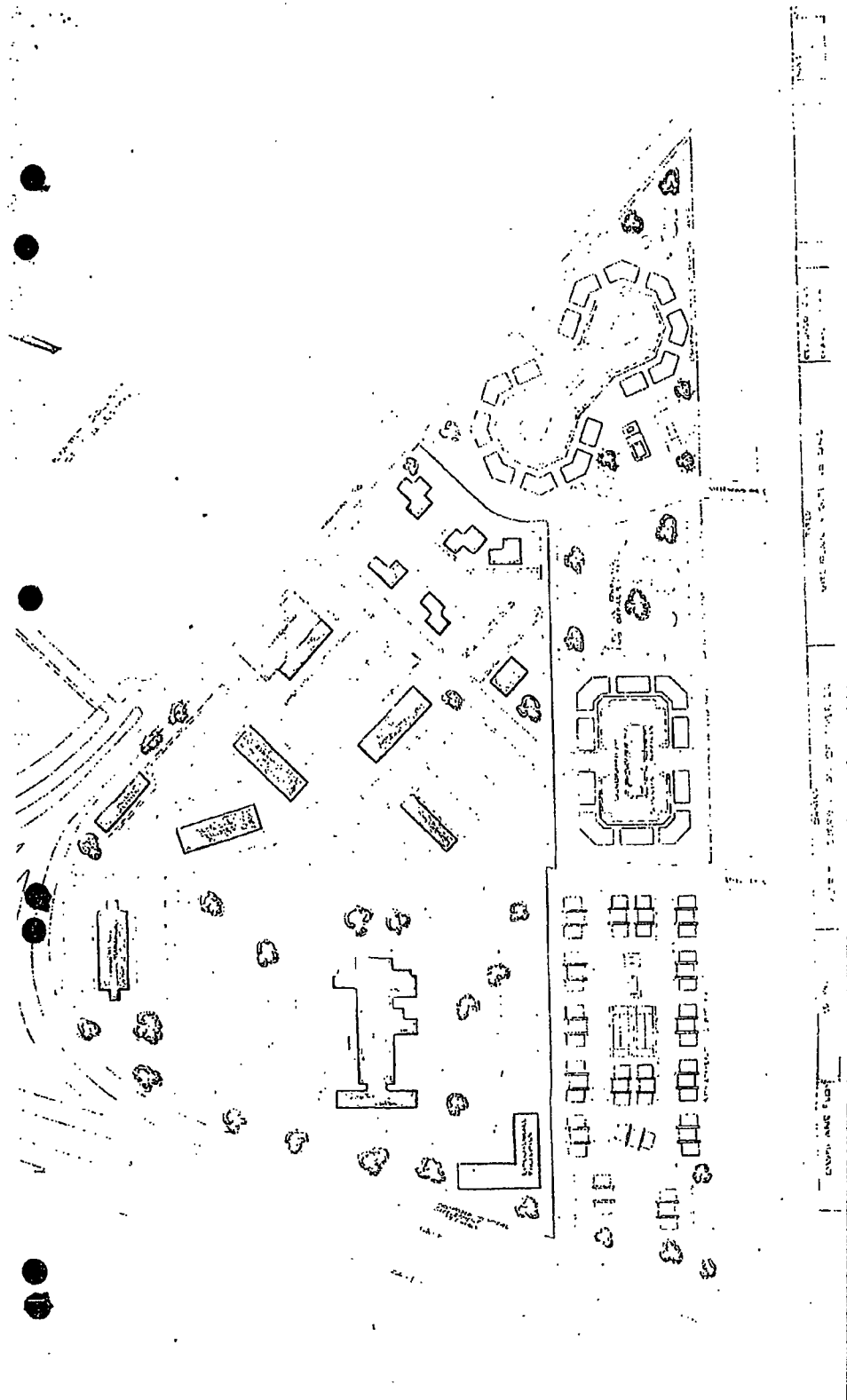
TRIDENT ECONOMY HISTORICAL SUMMARY

YEAR	POPULATION	EFFECTIVE BUYING INCOME	RETAIL SALES	HOUSEHOLD# INCOME
1950	217,708			\$2,258
1955	236,300	\$266,129,000	\$166,439,000	\$4,613
1960	271,700	\$327,961,000	\$221,822,000	\$4,809
1961	276,900	\$381,405,000	\$226,991,000	\$5,400
1962	282,800	\$409,192,000	\$219,877,000	\$5,931
1963	288,700	\$428,242,000	\$244,347,000	\$6,331
1964	294,600	\$477,009,000	\$252,501,000	\$6,322
1965	300,500	\$527,312,000	\$289,235,000	\$6,697
1966	306,400	\$571,423,000	\$337,551,000	\$7,243
1967	312,300	\$610,017,000	\$350,047,000	\$7,521
1968	318,200	\$652,129,000	\$365,994,000	\$7,877
1969	324,100	\$711,231,000	\$382,948,000	\$8,172
1970	330,000	\$776,740,000	\$483,693,000	\$8,250

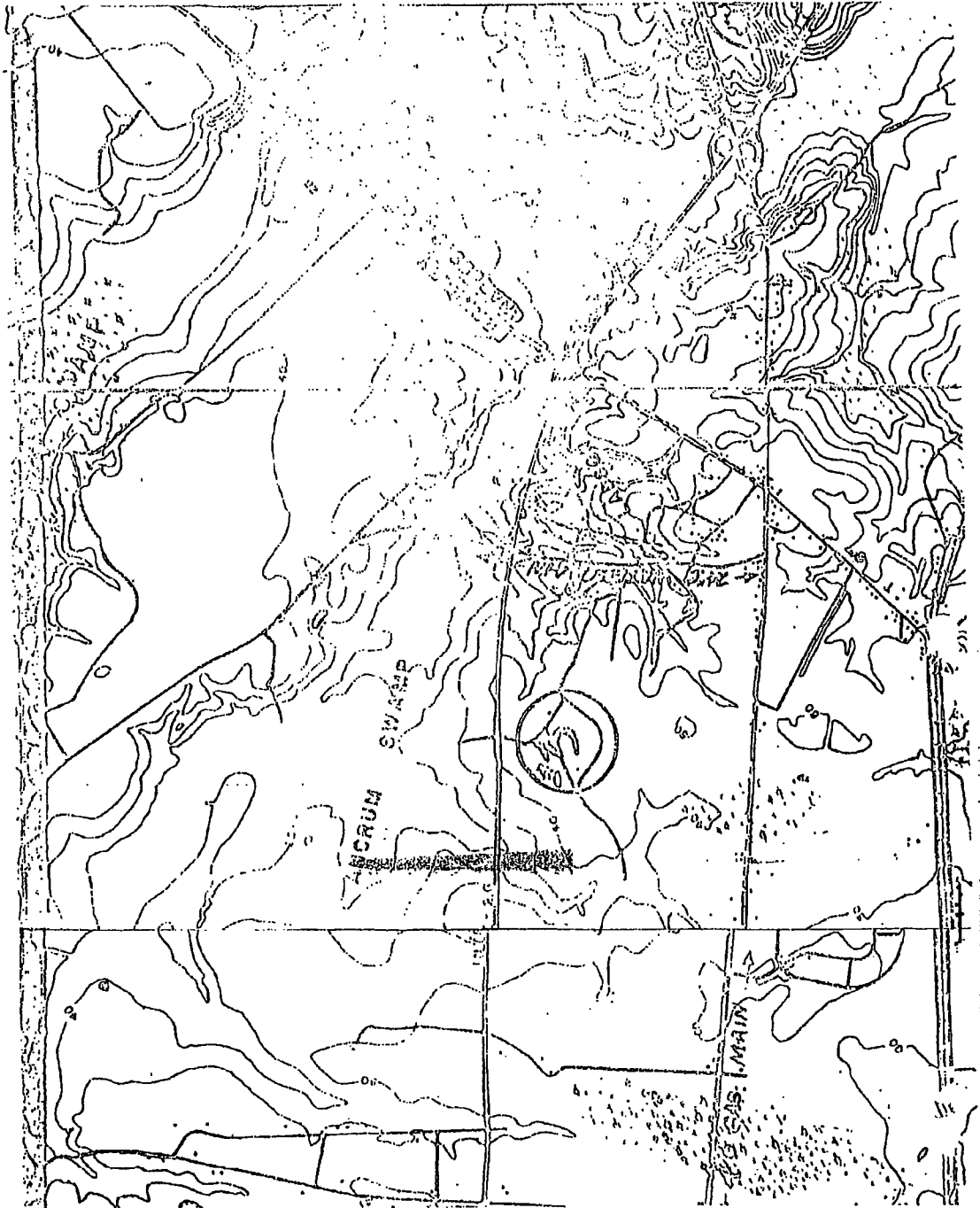
*Charleston County only.

SOURCE: U. S. Census 1950, 1970, Sales Management, Survey of Buying Power.
(NOTE: All figures are for 1 Jan. of year indicated)

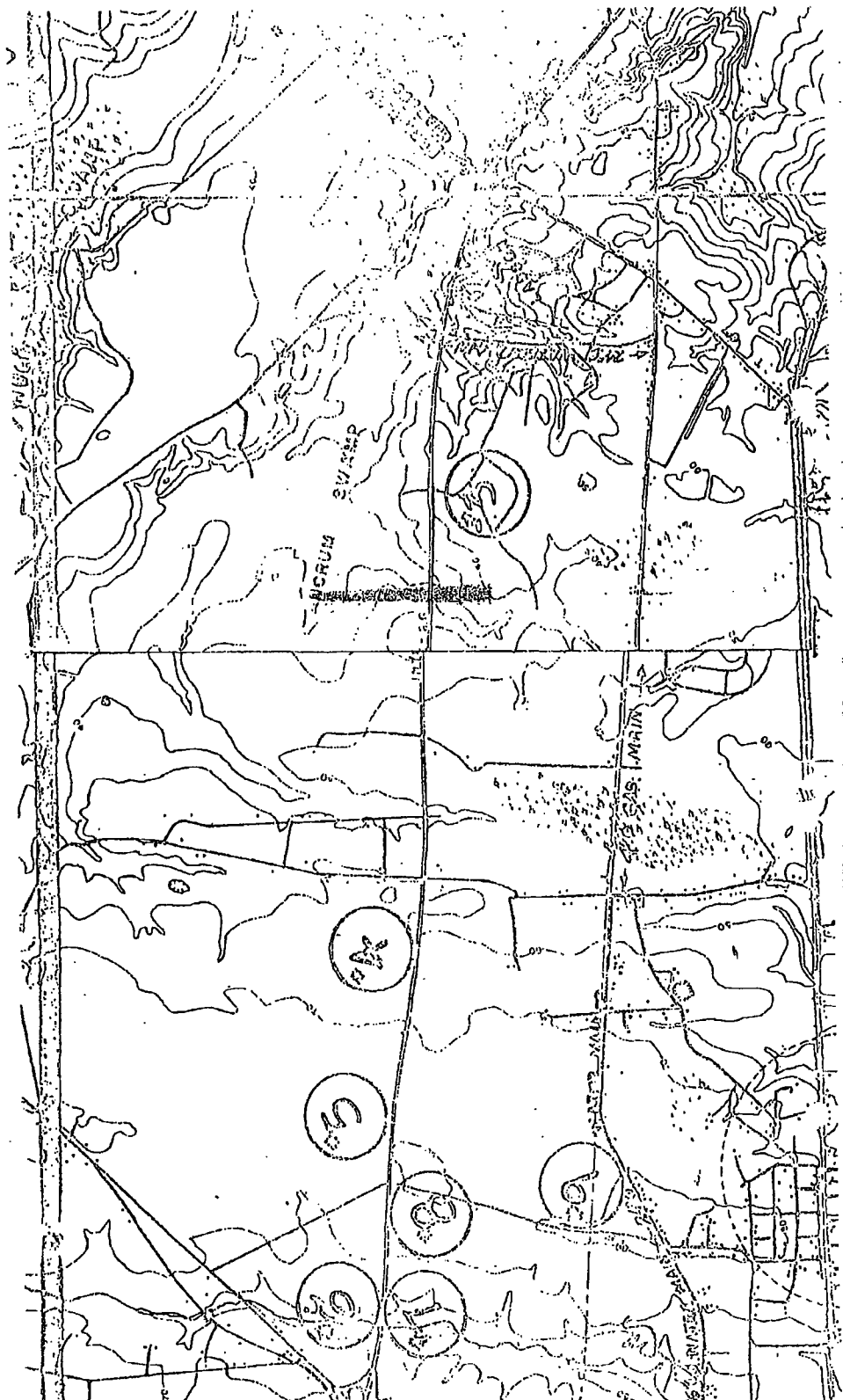
Trident_10279



Trident_10280



Trident_10281



Trident_10282

40 Per Cent Of Hospital Patients From North Area

123/172
Charleston Evening Post

By MARGARET W. GARRETT
Evening Post Staff Writer

The first phase of a hospital planning study indicates that 40 per cent of the patients treated in peninsular hospitals live in the North Charleston Public Service District.

The Charleston Area Comprehensive Health Planning program and the research firm of David M. Giancola and Associates are making a study of long-range hospital needs for Charleston, Berkeley and Dorchester counties.

The data collecting phase has been completed and the information will be submitted to other area planning groups for study and recommendations. The studies are being made primarily because of interest in a new hospital for North Charleston and the realization that such a hospital cannot be planned without consideration of all local facilities.

The preliminary study has indicated that:

Except for the Medical University Hospital and the VA Hospital, the hospitals in the three counties serve the residents of those counties plus about 12 per cent of the Colleton County residents.

Only 57 per cent of the Medical University Hospital patients and 51 per cent of the VA Hospital patients come from these four counties.

Charleston peninsular hospitals serve 73 per cent of Charleston County, 39 per cent of Dorchester County and 60 per cent of Berkeley County. The Naval Hospital serves 20 per cent of Charleston County, 10 per cent of Dorchester County and 12 per cent of Berkeley County. The VA Hospital serves six per cent for Charleston, three per cent for Dorchester and four per cent for Berkeley.

The Dorchester County Hospital serves 38 per cent of the county's residents and the Berkeley County Hospital

serves 20 per cent of that county's residents. The Charleston peninsular hospitals serve a larger percentage of those counties' people than do the respective hospitals in those counties.

Forty per cent of the patients admitted to voluntary peninsular hospitals live in the

North Charleston Public Service District.

The peninsula has 1,272 voluntary hospital beds existing or under construction. The current rate of utilization and the 1976 population projections indicate that 1,174 acute care beds are needed for the three-county area.

The further studies will help determine how the needed beds can be supplied for each area, where they should be located, and how the projected bed needs for Berkeley, Dorchester and North Charleston relate to the existing Berkeley and Dorchester facilities.

Says It's Feasible

*North Charleston Item
4/5/72*

Committee Recommends New Regional Hospital

The North Charleston Hospital Committee this week reported that a regional hospital serving North Charleston and Berkeley and Dorchester counties is feasible and recommended that health planning groups in the Trident area begin planning for such a facility.

In its first major report to the public since its formation several months ago, the committee said it had studied information provided it by a professional consulting firm and officials of the Charleston Area Comprehensive Health Planning group in addition to surveying physicians in the three-county area before arriving at a conclusion that a regional hospital would be feasible.

The committee further recommended that Charleston Area Comprehensive Health Planning (CACHP) help in convening a meeting with "appropriate representatives" in North Charleston, Berkeley and Dorchester counties in the near future to begin deliberations about the possibility of eventually building such a facility.

The report, however, did not include any information concerning actual construction and operations of a regional hospital. Nor did it include information about the possible location of such a facility, the types of services it would provide, the number of beds and sources of funds to construct the hospital.

The director of CACHP, David J. Keahley, said inclusion of such facts at this early date would have been "impossible" without long and lengthy deliberations by officials of the three counties and health planning officials.

The committee's major

regional hospital be included in the development of a three-county health plan, currently being developed by CACHP.

The committee, speaking in its report on what led to its conclusions, said the original charge of the committee was to study the feasibility of building a hospital in North Charleston.

"The study quickly grew beyond this scope as it became obvious that the most efficient and economical way to provide such services to the North Charleston residents was to either expand the services of the peninsula hospitals or promote a tri-county effort among Berkeley, Dorchester and North Charleston," the report stated.

The study evolved, the report stated, into a comprehensive patient origin analysis to determine where the residents of the three counties were going for care and to further determine if the suspected geographical and distributional imbalance in existing acute care general hospital beds truly existed. If a significant imbalance was documented, the report said, the end result would be to recommend several alternatives for correcting this situation.

The report said investigation showed that existing facilities in both Berkeley and Dorchester counties "are in need of replacement, or major renovation."

A recent study by the Dorchester County Hospital supported such a claim, the report said, and Berkeley County residents were already exploring other uses of that hospital (at Moncks Corner) "when a regional hospital is developed."

"This includes all the present

patients in the Trident area. This breakdown assumed, the report said, an altered role from acute care to specialty care for some beds on the peninsula.

The report also cited other support for its recommendations:

—nearly all physicians currently using the Berkeley and Dorchester facilities would use any new hospital in the North Trident area.

—a significant number of the physicians who are currently admitting patients from the North Trident area to the peninsula hospitals would begin to admit these patients to a new facility in the area.

—it is the opinion of many physicians from all over the three-county area who met recently that such a full service facility would attract new physicians to the area over a period of time.

Trident_10284

Keathley: New Hospital Still Must Be Justified

North Charleston Banner 4/5/72

The fact that a North Charleston hospital study group has pointed to the feasibility of a regional hospital serving the North Area and Berkeley and Dorchester counties in no way means that one actually will be built, a local health planning officer pointed out this week.

The hospital committee, charged several months ago with studying the feasibility of a hospital in North Charleston, recommended this week that health planners and government officials from the three-county Trident area begin deliberations on the future possibility of constructing a regional facility.

David U. Keathley, executive director of Charleston Area Comprehensive Health Planning which is charged with the overall health planning in Charleston, Berkeley and Dorchester counties, pointed out, however, that all the committee had actually done in its report was confirm that such a regional facility was feasible.

"They do not say that such a hospital is justifiable," Keathley said. "They say only that it is feasible. The committee is making a statement of feasibility. There is a big difference in that and justification."

"Justification" would mean that such a regional hospital were possible to build, Keathley said, and no one had determined yet if that was the case.

"What the report says is that the committee has determined the feasibility and that, now, it must get together with groups from the other two counties and with health planning groups

to determine if that feasibility is compatible with the overall needs of the Trident area," Keathley said.

Such things as administration, staff, a location and financing for a regional hospital could only be determined through a series of meetings between officials of the three counties, he said.

Keathley said the North Charleston Hospital Committee was making no recommendation that it be disbanded in favor of a larger three-county committee. It could conduct its meetings on a less-regular basis, he said, feeding its information into other groups and accepting information from them.

On the other hand, a larger committee encompassing leadership from all three areas may be created in the future, if a need for that is seen," he said. "But then you're getting into some pretty hard areas, such as legislation and so on."

There is no way to predict when—or even if—a regional hospital might be built, Keathley said.

"You can't predict it," he said. "If a decision was ever reached to build a hospital, it would take from two to two-and-a-half years from the time of the decision to build it, probably. And there is no telling how long it would take to get to the decision-making stage. You could spend six months just talking about financing."

One thing is certain, however, Keathley said. If a regional hospital is to be built for the tri-county area, it would have to be

(Continued On Page 10)

Keathley

(Continued From Page 1)

part of an overall Trident area, and statewide hospital plan.

"The state's franchising law governs the construction of hospitals, and if it isn't contained in a statewide plan, you can't get permission to build one. Without permission, you can't get the money to do it."

The News and Courier, Thurs., April 6, 1972 7-C
CHARI FAYON, S. C.

Regional Hospital Recommended

By L. L. McCONNELL
Staff Reporter

A regional hospital which would serve Berkeley, Dorchester and northern Charleston counties has been recommended by the North Charleston Hospital Committee.

The Charleston Area Comprehensive Health Planning Commission (CACHP) in a Wednesday morning meeting passed the regional hospital recommendation along to its health facilities committee where it will receive serious consideration, said David Keathley, CACHP director.

Simultaneously, the CACHP board of directors approved an agreement with the Berkeley-Charleston-Dorchester Regional Planning Commission which gives the CACHP responsibility for area health planning, Keathley said.

HASSLE ENDS

The agreement concludes a six-month hassle with the Regional Planning Commission and provides for a close association between the two groups to prevent duplication of efforts, Keathley said.

The report of an unofficial hospital committee formed last year recommended a regional general services facility as "feasible."

Keathley said the CACHP Board noted a gap between the "feasibility" and the "justification" of such a regional facility.

The CACHP's health facility committee will determine whether or not that gap can be bridged, he said.

"The next step is to see if the statistics can be put into reality," he said.

EXISTING FACILITIES

The hospital committee reported both existing facilities in Dorchester and Berkeley counties are "in need or replacement or major renovation....It appears that many decision makers in Berkeley and Dorchester counties agree that an efficient solution would be to close the existing Berkeley and Dorchester facilities and build one new hospital."

In 1977, about 2,000 beds will be needed in the Trident Area, according to data collected by and given to the committee.

As other support, the committee's report cited that "nearly all physicians using the Berkeley and Dorchester facilities would use any new hospital in the North Trident Area."

Further, some physicians admitting patients from the north into peninsular hospitals would begin admitting North Trident Area patients into a new facility.

New physicians would be attracted to the area "over a period of time" because of such a new facility, the report said.

The committee also suggested the CACHP assist it and the North Charleston Consolidated Public Service Commission in studying the hospital's possible justifications with representatives from the tri-county region.

"What we want to do is to figure out a way to solve everybody's needs at the same time," Keathley commented.

"There are a lot of things that have to be considered from here on out."

Trident_10286

Private Company Invited:5/17/72
North Charleston
Banner**Regional Hospital Group
Agrees To Hear Ideas**

A tri-county regional hospital committee has agreed to study a proposal whereby a private hospital corporation would build and operate a facility in the northern trident area.

Meeting for the first time last Thursday in North Charleston, the committee, composed of citizens from Berkeley and Dor-

chester counties and North Charleston, agreed to invite the Hospital Corporation of America to a May 18 meeting at Baptist College as a first step in its hospital planning.

Another private hospital firm, Hewett and Royer Consulting, is to be invited to a later meeting to discuss possibilities for

a regional hospital which would serve the North Area, along with Berkeley County and lower Dorchester County.

The 20-member committee, an outgrowth of separate committees in the three areas, was also expected to select permanent officers at its Thursday meeting and to arrive at by-laws

for future meetings and deliberations.

The committee is composed of 10 members from Charleston County and five each from Berkeley and Dorchester counties.

Named to the regional committee from North Charleston were Edward P. Blanton Jr., chairman of the North Charleston Hospital Committee; Max Ford, Arnold Lecqua, Cecil Clay, John Moon, Dr. Lloyd E. Varner, Robert N. King, and Sen. Allen R. Carter. Dr. William McCord, president of the Medical University of South Carolina, and Rev. Thomas W. Horton, head of the health facilities advisory committee of the Charleston Area Comprehensive Health Planning Group, were named from Charleston County.

Members from Berkeley County include Clyde Umphlett, county supervisor; Rep. Thomas A. Knight, Dr. Samuel O. Schuman, representing the Berkeley County Medical and Dental Association; F. Eugene Williams, representing the Berkeley County Hospital Board; and Gene Oliver Jr., representing the Berkeley County Health Advisory Committee.

Named from Dorchester County were Robert M. Bunch, Jr., Dorchester County Council; Rep. Carlyle McAlhany; Dr. G. S. Way, representing the Dorchester County Medical Society; Rev. C. R. Tapp, Dorchester County Health Advisory Committee; and Berlin Myers, representing the Dorchester County Hospital Board.

David U. Keathley, executive director of Charleston Area Comprehensive Health Planning which is assisting in the staff work of the regional committee, told committee members that the group had to consider two "critical points" in its future deliberations.

"You must come up with a regional hospital plan, one that is a consensus of all the people here," he said. "You must figure out such things as bed need, services, where it will be located and you must design its various roles. Secondly, you must beware of duplication of effort in designing the hospital. This committee must come up with all the particulars of a hospital,"

(Continued On Page 6)

Trident 10287

The News & Courier And Charleston Evening Post, Thurs., June 15, 1972 7-D

Hospital Plan Is Promising

By MARGARET W. GARRETT
Evening Post Staff Writer

A shortage of medical facilities of all types has long been a matter of concern for residents of the North Area.

A study released in April by the Charleston Area Comprehensive Health Planning manpower committee shows there are 19 physicians serving North Charleston and Charleston Heights. Only two of these, both general practitioners, have their offices within the boundaries of the new city.

The area presently has no general hospital nor any emer-

gency facilities and all non-military residents must come to the peninsular city or go to Berkeley or Dorchester County hospitals.

Although the U. S. Naval Hospital is located near the new city, its services are available only to active and retired military personnel and their dependents.

A committee has been formed recently, however, to study the feasibility of a community hospital to serve the North Area and Berkeley and Dorchester Counties. A preliminary report has determined that such a regional hospital is needed and that a significant number of persons now using

peninsular and other hospitals would be willing to go to a facility in this area.

The committee is in the process of determining whether the facility would be financially feasible, what services it should offer, how it would be operated, and where it should be located for the convenience of the greatest number of people.

If the hospital is built, it possibly would not be located within the North Charleston city boundaries, but it would be easily accessible to its residents.

The hospital project actually started as a plan for an emergency facility for the North

Area, since the only emergency room is located on the peninsula, but it was determined that there was a greater need than just an emergency room.

Backers of the regional hospital plan hope it will draw more physicians and other medical personnel to the North Area. The area's 19 physicians and 15 dentists must serve a population of about 100,000 persons. This is roughly one physician for every 5,000 persons and one dentist for every 6,500 persons.

The CACHP manpower report shows that 11 physicians are in general practice, one in family practice, one in ophthalmology, one in radiolo-

gy and three in pediatrics. In addition, two obstetricians in the peninsular city also have offices in the North Area, as do other specialists.

The 15 dentists, who also serve Goose Creek and Hanahan, are all in general practice. All dental specialists in the county are located either in Charleston or west of the Ashley.

The county's only private ambulance service has its headquarters on Elgin Street which is between the cities of Charleston and North Charleston. The only service for North Charleston will be this one or its own city police crashwagon.

July 19, 1972 Charleston Evening Post

Corporation To Be Asked To Build Hospital Here

By MARGARET W. GARRETT
Evening Post Staff Writer

The North Trident Regional Hospital Committee will ask a private hospital corporation to plan, build and operate a hospital in the North Area.

Dr. G. R. Way, Jr., of Summerville, committee chairman, said the group has studied a number of methods for building a hospital to serve Berkeley and Dorchester counties and the North Area and has concluded that the proprietary method is the preferred way.

The Hospital Corporation of America, which operates hospitals in several southeastern states, will be asked to proceed with definite plans for construction of the regional facility.

Members of the local committee have visited hospitals operated by the corporation in other cities and Way said it has been fully investigated. Physicians, citizens and planning groups in cities where its hospitals are located have rated it highly for reputation, responsiveness and willingness to work with the community, and quality of patient care, he said.

Before making its decision, the hospital committee explored the private ownership method, the nonprofit method

and the government method. Among the factors taken into account were the current difficulty of obtaining federal hospital construction funds and of establishing a bond program.

The committee also concluded that the proprietary method offered not only the most feasible financial approach but also the fastest

implementation of plans.

If the corporation accepts the offer, it will work with the local committee to draw up detailed plans which will be reviewed by the Charleston Area Comprehensive Health Planning program and by the franchising office of the State Board of Health.

If the Board of Health determines that the plans are satisfactory and, do not

conflict with present facilities and overall planning for the area, it will issue a certificate permitting construction to proceed.

This procedure is required under a new state law passed to provide coordinated planning in the health field.

The concept of a profit-making hospital is new to the

HOSPITAL

Continued From Page 1-A

area where present hospitals are either nonprofit or government operated. A spokesman for the Comprehensive Health Planning said the committee was impressed with the ability of the Hospital Corporation of America to make its profits without compromising the quality of patient care in its existing facilities.

The corporation would set up a local board of directors to handle regular operational activities so that the hospital would have an immediate responsibility to the community it would serve.

Regional Hospital Group Appointments Underway

The North Charleston Hospital Committee last week heard a formal final report on a feasibility study concerning a regional tri-county hospital and named three members to membership on a proposed group that would work to make such a facility a reality.

David Keathley, executive head of Charleston Area Comprehensive Health Planning, the planning agency in charge of health planning and study in the Charleston-Berkeley-Dorchester area, told the committee that he hoped, a tri-county committee could be functioning by mid-May.

"But first, of course, we must design the committee and say who is to be involved here," Keathley told the committee.

"Then, we must get representatives from Berkeley and Dorchester counties.

"The study phase of a regional hospital is over, and we are now ready to get down to the hard work of actually finding

out where and how a regional hospital can be built," Keathley said.

A professional consulting firm and CACHP recently completed a study of hospital needs in the northern trident area that showed a regional hospital was feasible. The North Charleston Hospital Committee and the North Charleston Public Service Commission approved the recommendations.

After going over the detailed final report again last Thursday night, the committee named its chairman, Edward P. Blanton Jr., its vice chairman, Lloyd Varnar, and member Max Ford to the expanded tri-county committee.

Blanton said early this week, however, that additional appointments to the expanded group might be made from the North Charleston Hospital Committee, because no one had yet determined how much representation on the tri-county com-

(Continued On Page 8)

Hospital

(Continued From Page 1)

mittee North Charleston was entitled to.

"There may be a problem of equal representation," Blanton said. "I think North Charleston, being the largest in population, should have equal representation on the new committee."

Blanton said he meant by equal that North Charleston should have as many members as Berkeley and Dorchester counties combined.

"I think we have as much population as the other two counties combined," Blanton said. "We have about 99,000 population up here, and Berkeley has something like 50,000 while Dorchester has about 30,000."

While Blanton said he saw no "large problems" about structuring the new committee, he said he was "concerned" about its makeup. He said there had been some suggestions that the new committee be composed of 20 members, with 10 coming from North Charleston, five from Berkeley County and five from Dorchester County, with a neutral chairman.

Wednesday, July 19, 1972

No. 5

10 CENTS PER COPY 44 PAGES

Regional Facility

Hospital Corporation Asked To Build Here

A local planning group has requested one of the nation's largest private hospital development corporations to begin work toward building a new facility that would serve North Charleston, Berkeley County and lower Dorchester County.

The North Trident Regional Hospital Development Committee approved a motion at its meeting last week to invite the Hospital Corporation of America to begin planning in conjunction with it and the Charleston J.A. & A. Comprehensive Health Planning Agency.

The motion by the committee was adopted at a meeting during which officials of the three areas discussed different methods which would have brought a new regional hospital into being.

The committee, by its action, turned down proposals for the time being at least that the three areas involved in hospital planning finance and build a hospital with public funding. It decided to turn to the proprietary hospital plan under which Hospital Corporation of America would build and operate the hospital on a profit-making basis.

Hospital Corporation of America is based in Nashville, Tenn., is the nation's largest proprietary hospital organization. Founded in 1923, when it acquired rights to 11 hospitals, HCA has since grown and operates 42 hospitals totaling 10,000 beds across the nation. It has a net worth of \$1 billion and is listed on the New York Stock Exchange.

Under a formal arrangement, HCA would acquire land, administer, near the junction of Charleston, Berkeley and Dorchester counties, construct a hospital and staff it and leave normal day-to-day decision-making to a board of directors composed of local citizens.

As the project proceeds, franchising, you would have control over the planning of the hospital, and once Hospital Corporation states in its certificate of need what it wants to do, it cannot deviate from that. Hospital Corporation was the first prospective hospital builder to present a program to the regional committee several weeks ago, and there

was some opposition to allowing a private corporation to come into the community to build and operate a facility after the presentation. That opposition apparently vanished after several members of the regional group visited HCA hospitals in Home and Macon, Ga., several days ago.

Dr. Lloyd Verner, a North Charleston physician, said

HCA hospitals in other Georgia cities were superb operations in every respect. I can tell this committee that in both hospitals they had the Cadillac of equipment, Verner said. They were concerned with what the doctors wanted. The doctors seemed well pleased. Verner said the approval of the committee was a relief. (Continued on Page 3)

The regional hospital committee has also studied the availability of several plots of land in the vicinity of the Baptist College and Auditorium north but has made no decision on land acquisition. Committee members were quick to point out that their invitation to HCA to begin preliminary work to build a regional hospital did not necessarily mean that the corporation would eventually do so.

Hospital Corporation of America must correlate its planning with hospital needs of the area expressed by CACHP and the state must also pass on HCA's plans before they can be put into effect.

Hospital Corporation of America has expressed an interest in building a hospital here, said CACHP Director David Keathley during the committee meeting, but it doesn't necessarily mean they will do so in the final analysis. They will have to make some decisions, and so will this committee.

Keathley also said the regional hospital committee would play a major role in the decision-making process if HCA goes ahead with planning to build a hospital. The committee, in conjunction with CACHP, would have much input, he said, into decisions about services of a new hospital, its location and

The state, as master on fact, would look askance at anything Charleston J.A. & A. Comprehensive Health Planning was not in agreement with, and Comprehensive Health Planning would look askance at anything this committee wasn't in agreement with, Keathley said.

Allowing Hospital Corporation to build a regional hospital would, in no way mean that the hospital committee was surrendering its authority to dictate certain services and arrangements in the hospital, he added.

You would have a lot of control, Keathley pointed out. As the project proceeds to franchising, you would have control over the plan.

You would have a lot of control, Keathley pointed

Trident 10291

RECORD 007515

Page 2 July 19, 1972
The North Charleston Banner
-Hospital-

(Continued From Page 1)
hospitals was worried before-
hand that HCA might be cut-
ting necessary costs in order
to make a profit.

"We found, however, that
where most hospitals would
pay three people \$60 a week
to do a particular job, HCA
would pay two people \$75
a week to do it better," Var-
ner said. "They had two em-
ployees per bed in their hos-
pitals where the average is
more like three or three and
a half, but the difference was
that their hospital adminis-
trators knew about the opera-
tions of the hospital, and
those two people were work-
ing all the time. In most
hospitals, you have three peo-
ple per bed, and everyone's
usually standing around."

There had also been con-
cern expressed on the re-
gional committee that HCA
might not include such ser-
vices as an emergency room
or obstetrics care, because
both departments are notori-
ously money-losing propo-
sitions for hospitals.

Varner said, however, that
at one HCA hospitals, doctors
had asked for OB services
and were told by HCA of-
ficials to prove its necessity.
When the doctors did so, the
service was added by HCA.

"In every case, we found
they had done everything
they had promised, or
more," Varner said. "Never
had they done less than they
promised."

Keathley said he had check-
ed on HCA operations with
health planners in other
states and had received en-
thusiastic endorsements in
every case.

"In all instances, they
(HCA) appear to be cutting
waste in their operations," he
said. "There didn't appear to
be any cutback in services.
You just can't knock Hospital

Corporation for quality care
and responsibility to pa-
tients."

Sen. Allen R. Carter of
North Charleston pointed out
at the meeting that the com-
mittee would have to be sure
to insist on some plan with
HCA under which indigents
in the three - county area
would be cared for.

Dr. G. S. Way, chairman
of the committee, told Car-
ter that HCA had said it
would provide indigent care
on a per diem arrangement
with the counties.

"You must, of course,
make a distinction between
those who just won't pay and
those who can't, but Hospital
Corporation won't be turning
away indigents at this hos-
pital," Way said.



Trident_10306

South Carolina State Board of Health

J. MARION SIMS BUILDING

COLUMBIA 29201

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SECRETARY AND STATE HEALTH OFFICER

July 23, 1973

IF WE DO NOT HEAR FROM YOU WITHIN TEN (10) DAYS FROM THE ABOVE DATE, WE WILL ASSUME THAT YOU RECOMMEND APPROVAL OF THIS PROJECT.

TO: Office of Comprehensive Health Planning

FROM: Mr. Coney

REF: Project Notification and Review

Control No. 09-0002

 No Comments
 Request conference prior to making comments
 X Comments as follows

Concur, A Certificate of Need was issued for this project on December 22, 1972.

IF WE DO NOT HEAR FROM YOU WITHIN TEN (10) DAYS FROM THE ABOVE DATE, WE WILL ASSUME THAT YOU RECOMMEND APPROVAL OF THIS PROJECT.

Signature: _____
Person making the above report

Director, Division of Planning and Programs
Title

Trident 10410

RECEIVED

MAY 11 2009

Parker, Pos, Adams
& Bernstein, L.L.P.

SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

DECISION ON REMAND TO THE DHEC BOARD

In Re: Remand from the Administrative Law Court to the DHEC Board pursuant to ALC Orders Dated March 9, 2009, and March 23, 2009, Regarding Whether the Transfer of Licensed Acute Care Hospital Beds for the Purpose of Establishing a New Hospital is Consistent with the 2004 – 2005 South Carolina Health Plan

Board Docket No. 07-RFR-112

Appearances: Nancy S. Layman, Esquire, for South Carolina Department of Health and Environmental Control

M. Elizabeth Crum, Esquire, and Pamela A. Baker, Esquire, for Palmetto Health d/b/a Palmetto Health Baptist Parkridge

David B. Summer, Jr., Esquire, and Faye A. Flowers, Esquire, for Newberry County and Lexington County Health Services District, Inc. d/b/a Lexington Medical Center

This matter comes before the South Carolina Board of Health and Environmental Control ("Board") on remand from the Administrative Law Court in order for the Board to determine the narrow issue of whether the transfer of licensed acute care beds from an existing hospital in order to create a new hospital is consistent with the 2004 – 2005 South Carolina Health Plan, including the "Plan Transfer Standard."

On October 20, 2006, Palmetto Health d/b/a Palmetto Health Baptist Parkridge (Parkridge) applied to the South Carolina Department of Health and Environmental Control ("Department"/ "DHEC") for a Certificate of Need ("CON") to construct a new 76-bed acute care hospital in northwest Richland County by transferring 76 licensed acute care beds from Palmetto Health Baptist Hospital ("PHB") in downtown Columbia to Parkridge. The Department approved the CON on August 27, 2007, under the 2004 – 2005 South Carolina Health Plan ("Plan").

Parkridge was challenged by both Lexington County Health Services District, Inc. d/b/a Lexington Medical Center ("LMC") and Newberry County Memorial Hospital ("NCMH").¹ Petitioners requested that the DHEC Board hold a Final Review Conference regarding the Department's approval of the CON. The Board declined both requests on September 17, 2007. Subsequently, on November 13, 2007, Petitioners LMC and NCMH filed Petitions for Administrative Review with the Administrative Law Court ("ALC"), arguing that the Court should reverse the Department's finding because, among other reasons, the Plan provides for the transfer of beds between existing hospitals only, not between an existing hospital and a proposed undeveloped hospital.

On December 12, 2008, after extensive discovery, Petitioners filed a Motion for Summary Judgment and Respondent Parkridge filed a Motion for Partial Summary Judgment. At the December 22, 2008, hearing on the Motions the ALC denied both Motions; however, on January 6, 2009, the Court issued a written Order granting Petitioners' Motion for Summary Judgment and denied Respondent Parkridge's Motion for Partial Summary Judgment. Following that Order, the Department joined in Parkridge's Motion to Alter or Amend Order Granting Summary Judgment. Parkridge filed additional Motions, including an Alternative Motion to Alter or Amend Order Granting Summary Judgment, requesting that the matter be remanded to the DHEC Board for interpretation of the State Health Plan. Petitioners responded to all Motions. On January 27, 2009, the Court suspended its January 6, 2009, Order granting Summary Judgment until it could make a decision on the Respondents' Motions.

On March 9, 2009, the Court issued an Order denying both the Petitioners' and the Respondents' Joint Motion to Alter or Amend Order Granting Summary Judgment; however, the

¹ On January 6, 2009, the Administrative Law Court ordered that Newberry County ("NC") be substituted to replace NCMH as Petitioner.

Court ordered that Palmetto's Alternative Motion to Alter or Amend Order Granting Summary Judgment be granted. The Court also vacated its January 6, 2009, Order and remanded the matter to the DHEC Board. The Order reads as follows: "Specifically, the DHEC Board must hold a final review conference within sixty days of the date of this Order to provide its interpretation of whether the 2004 – 2005 State Health Plan allows for the approval of a CON application for the transfer of licensed general acute hospital beds to establish a new hospital facility." The Court further ordered that any party could appeal the DHEC Board's decision regarding its interpretation of the Plan to the Administrative Law Court pursuant to S.C. Code Ann. §§ 1-23-600 and 44-1-60.

The ALC then clarified and modified its March 9, 2009, Order by issuing a March 23, 2009, Order in which the Court:

- 1) Gave the Board 30 days after the final review conference to report its interpretation of whether the Plan Transfer Standard allows the approval of a CON application for the transfer of licensed inpatient hospital beds for the purpose of establishing a new hospital facility;
- 2) Retained jurisdiction regarding the remaining issues in the case; and
- 3) Gave any party the opportunity to amend its Petition or Answer to address any issues raised by the Board's interpretation within 30 days of receipt of the Board's interpretation.

At its April 9, 2009, meeting, the Board heard argument from Petitioners and Respondents regarding the issue remanded by the ALC.

Having reviewed the submissions by all parties in this matter and having heard the sworn testimony of witnesses and their representatives, the Board concludes that the 2004 -2005 South Carolina Health Plan, which includes the Plan Transfer Standard, allows for the approval of a CON application for the transfer of licensed general acute care hospital beds to establish a new hospital facility. Specifically, Department staff properly interpreted and applied the 2004 – 2005

South Carolina Health Plan in approving the transfer of 76 acute care hospital beds from Palmetto Health Baptist Hospital in downtown Columbia to create Palmetto Health Baptist Parkridge, a new hospital to be constructed in northwest Richland County.

Nancy S. Layman, Chief Attorney for Health Regulation, presented the Department's case to the Board. She stated that by statute (S.C. Code Ann. §§ 44-7-110 - 300) DHEC, with the assistance of the Health Planning Committee, prepares a state health plan at least once every two years. By regulation, opportunity is afforded for "public review and comment, including regional public hearings, before adoption or revision of the plan" by the DHEC Board. S.C. Code Ann. § 44-7-180(C). Thereafter, to be approved, all CON applications must comply with the applicable state health plan, the project review criteria and other regulations. At issue in this case is the 2004 - 2005 South Carolina Health Plan, specifically, Section G.1.(A) General Hospitals (Plan, pp. II-4 - II-19). The Plan was approved by the Board on October 14, 2004. Prior to the approval of the Plan there had been neither requests for modification of the acute care hospital bed methodology nor objections to the ability of hospitals to create satellite facilities.

DHEC representative, Les Shelton, Senior Planner, who has been with the Department more than 20 years, addressed the Board. Mr. Shelton stated that the Department's position has been to allow hospitals to relocate or replace themselves and to transfer beds from an existing facility to create a new hospital as long as no additional beds were added. Since 1987 the Department has approved at least 11 other satellite hospitals, either through the transfer of licensed beds from an existing hospital or through the transfer of additional institutional bed need, or a combination of both methods. In two additional cases, a new hospital was created by consolidating and then closing the two existing hospitals. The Department has also approved the

transfer of different categories of beds between hospitals, e.g., general, psychiatric and rehabilitation beds.

Mr. Shelton further stated that Standard G.1.(A)(4)(h) (Plan, p. II-8-9), incorporated into an amended version of the 1994 South Carolina Health Plan and contained in each Plan thereafter to the present, addresses the transfer or exchange of beds between affiliated facilities. The standard (or Plan Transfer Standard) was added to create more flexibility in the CON process, in particular to allow affiliated facilities, which might otherwise be denied a CON under the Plan, to transfer beds or services across county or service area lines. He added that although the Department has not made CON approval for a new hospital contingent on this bed transfer standard, Palmetto referenced the standard in its CON application. New hospitals have been approved both before and after the 1994 Plan, and no Plan has prohibited the transfer of beds to establish a new hospital.

Mary Fechtel, DHEC Assistant Deputy Commissioner for Health Regulation, who has been with the Department for over 20 years as both CON reviewer and Director of the Certificate of Need program, also addressed the Board. She stated at the Final Review Conference that she had reviewed over 300 CON applications, including numerous bed transfer applications. She said that the Department determined that the transfer of beds from one hospital to another, regardless whether the hospital was in existence or yet to be constructed, was consistent with the bed need methodology of the Plan. Ms. Fechtel added that the bed transfer standard was applicable to create new facilities, as long as there was no increase in the number of beds. However, she stated, the standard was part of the section of the Plan on General Hospitals and the entire section had to be read as a whole.

M. Elizabeth "Liz" Crum, Esquire spoke to the Board on behalf of Parkridge. She emphasized that the Department had consistently permitted the transfer of licensed acute care beds to create a new hospital and that other applications for the transfer of licensed acute care beds were pending. She added that it was "good health planning" to move unused beds to a location where there was increased population. PHB is in the process of converting semi-private hospital rooms to private rooms, which are currently the industry standard for inpatients. PHB could not use all its licensed beds at its present location and, therefore, filed a CON to transfer 76 of them to Parkridge, to be located in the growing area of northwest Richland County. Ms. Crum argued that the inability of a hospital to transfer its unused beds to a new hospital would produce an absurd result, with older hospitals forced to keep adding beds at their present facilities.

David B. Summer, Jr., Esquire, spoke on behalf of LMC and NC. Mr. Summer argued that the "bed transfer exchange section" of the Plan does not apply when the facility receiving the beds does not exist. Applying rules of statutory construction, he said that the Board needed to look at the plain language of the Plan and to read each section of the Plan as a whole, rather than considering a particular clause in isolation, in order to avoid absurd results.

Mr. Summer stated that Plan Section G.1.(A)(4)(h), pp. II-8 - II-9, which provides, in part, that "affiliated hospitals may wish to transfer beds between themselves in order to serve their patients in a more efficient manner," cannot be applicable to Parkridge. He called attention to each requirement under (h) to point out its inapplicability to Parkridge since the hospital does not exist. He added that a surplus number of licensed hospital beds exists throughout the State, and allowing PHB to create a hospital anywhere, when it does not use the beds it has, is absurd.

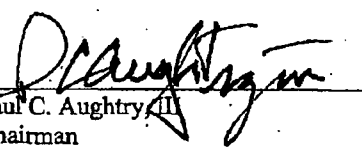
Speaking on behalf of NC was Mr. Lynn Beasley, CEO of Newberry County Memorial Hospital. Mr. Beasley stated that there were an excess number of hospital beds in the Midlands area and asked the Board to overturn the staff decision approving Parkridge.

The Department's August 27, 2007, letter approving Parkridge noted that PHB had been continuing to modernize and renovate its existing facilities in downtown Columbia and that by converting to private rooms, the hospital had lost access to approximately 20% of its bed capacity. The approval letter also stated that "... transfer of these existing licensed beds within the Palmetto Health System is consistent with the hospital bed need standards in the current 2004 - 2005 South Carolina Health Plan. This concept of transferring existing licensed beds from an existing hospital to create a new satellite hospital has been previously demonstrated in other rapidly growing communities in South Carolina, including Anderson, Charleston, Georgetown, Greenville, and Spartanburg."

Chapter I of the 2004 - 2005 South Carolina Health Plan provides guidance on interpreting the Plan (p. I-6): "The criteria and standards set forth in the Plan speak for themselves, and each section of the Plan must be read as a whole." The section of the Plan on General Hospitals (G.1.(A), p. II-4 - II-19) provides the definitions of terms in the section, including (1) "Definitions," (2) "Bed Capacity," and (3) "Inventory." The fourth section, "Narrative: General Hospital Beds," describes bed need methodology and how it is calculated. That section contains 10 sub-sections (a) through (j), including (h), the "Plan Transfer Standard." The Plan Transfer Standard was added originally to provide flexibility for facilities that wished to transfer beds across county lines. More recently, some applicants have referred to the provision when applying to the Department for a CON to transfer beds from an existing facility in order to construct a new hospital within the same county. Read as a whole, the General

Hospital section of the Plan recognizes that changes in the health care delivery system may call for the transfer of unused beds at one facility to a new facility constructed to receive them.

Accordingly, the Board has determined that the 2004 – 2005 South Carolina Health Plan, which includes the Plan Transfer Standard, allows for approval of a CON application for the transfer of licensed general acute care hospital beds to establish a new hospital.


Paul C. Aughtry, III
Chairman
Board of Health and Environmental Control
For the Board

May 8, 2009

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
John D. McLeod, Administrative Law Judge

Case No. 09-ALJ-07-0332-CC

Trident Medical Center, LLC, d/b/a
Berkeley Medical Center, ...Appellant/Respondent,

v.

South Carolina Department of Health and
Environmental Control and Roper St. Francis
Hospital-Berkeley d/b/a Roper St. Francis Hospital,

Of Whom South Carolina Department of Health and
Environmental Control is the Respondent, and

Roper St. Francis is the Respondent/Appellant.

Case No. 09-ALJ-07-0333-CC

Trident Medical Center, LLC, d/b/a
Berkeley Regional Medical Center, ...Appellant/Respondent,

v.

South Carolina Department of Health and
Environmental Control, and Roper St. Francis
Hospital-Berkeley, Inc. d/b/a Roper St. Francis
Hospital-Berkeley,

Of Whom South Carolina Department of Health and
Environmental Control is the Respondent, and

Roper St. Francis is the Respondent/Appellant.

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SC Court of Appeals

RECORD 007527

Case No. 09-ALJ-07-0336-CC

CareAlliance Health Services and Roper
St. Francis Hospital-Berkeley, ... Respondents/Appellants,

v.

South Carolina Department of Health and
Environmental Control and Trident Medical
Center, LLC Respondents,
Of whom Trident Medical Center, LLC is the Appellant.

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that the Record on Appeal contains all material
proposed to be included by any of the parties and not any other material.



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SC Court of Appeals

Columbia, South Carolina

July 17, 2013

RECORD 007528