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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM THE ADMINISTRATIVE LAW COURT
The Honorable S. Phillip Lenski, Administrative Law Judge

Appellate Case No. 2015-000056
Lower Court Docket No. 11-ALJ-07-0575-CC

Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center
d/b/a Fort Mill Medical Center ..... Respondent,

v.

South Carolina Department of Health and Environmental Control
and The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas
Medical Center-Fort Mill ..... Respondents,

Of whom The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas
Medical Center-Fort Mill, is ..... Appellant.

RECORD ON APPEAL - VOLUME VI OF XVII

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9. The patient is assessed and monitored to detect effects of medications; including both expected therapeutic effects as well as adverse reactions. For example: after administration of pain medication, the patient is assessed for pain relief as well as level of alertness and respiratory status within the specified time frame.

Documentation:

1. Documentation is done in blue or black ink.
2. Medications are documented on the Medication Administration Record (MAR) as they are given. (see attached)
3. The site of parenteral medications are documented on the MAR. (see attached)
4. Qualifying information such as blood sugar, blood pressure or pulse shall be documented on the MAR. (see attached)
5. When a medication is not given at the time ordered or is refused by the patient, an asterisk (*) shall is placed on the MAR and the reason is documented in the patient's narrative nursing record. If a patient refuses the medication, write refused beside the time. The physician is notified when a patient refuses ordered medications.
6. An explanation for the use of any PRN medication is written in the narrative nursing record of the patient chart. If the medication is for pain, the location, quality and pain scale shall be documented.
7. Response to PRN medications is documented in the narrative nursing record within 1 hour of administration.
8. An explanation for holding medications is documented in the nurse's notes.
9. Heart rate is documented on the MAR whenever beta blockers, calcium channel blockers, or digoxin is given.

Cross Reference(s):

Smith and Duel, Clinical Nursing Skills
Insulin Administration policy
Order Transcription policy
Pain policy
Medications From Home
Investigational/Experimental Drugs
SQ Morphine pumps

Attachment(s):

MAR
Unacceptable Symbols

Reference(s):

Nursing Procedures (3rd edition) (1999) Springhouse: Springhouse, PA

SC DHEC (2001). Drug control. Amendment R.61-4 controlled substances. Columbia, SC. Office of the DHEC Commissioner.

Institute for Safe Medication Practices. (2002). *Special issue: do not use these dangerous abbreviations or dose designations*. Retrieved April 23, 2002 from http://www.ismp.org/msaarticles/specialissuetable.html

Clinical Nursing Skills references for routes of administration:

Buccal, Sublingual Medications	CNS 409
Ear Drops	CNS 406-407
Eye Drops	CNS 404-405
Intradermal Injection	CNS 385-386
Intramuscular Injection	CNS 394-397
Rectal, Suppositories and Ointments	CNS 413-414
Subcutaneous Injection	CNS 386-388
Transdermal	CNS 401-402
Vaginal	CNS 414-415
Z-Track Injection	CNS 398-399

Piedmont Medical Center	Policies and Procedures	Page: 1 of 4
	SUBJECT: Medication Administration Record	Original Date: 1983
		Reviewed: 4/95, 3/96, 7/97, 7/00
		Revised: 1/03

Policy Statement(s):

Medication orders are correctly transcribed onto the Medication Administration Record (MAR) and medication administration is clearly documented.

Responsibility:

RN, LPN
Unit Secretary
Registered Pharmacists

Definition(s):

N/A

Equipment/Supplies:

Patient's chart and orders
Black pen
Addressograph or labels
Medication Administration Records (either computer-generated or hand-written)

Procedure:

1. Admission Medication Orders

   A. Height, weight, and allergy information must be entered into the Administrative Data screen in the computer prior to the dispensing of medications by the Pharmacy. **Exception:** Emergency situations.
      1) All allergies and the reaction(s) experienced by the patient are entered into the computer.
      2) If the patient has no known drug allergies, "NKDA" is entered.

   B. Medication orders are forwarded to the Pharmacy as soon as the patient is admitted.
      1) Patient identification information is present (i.e., imprinted, hand-written, or labeled) on the order sheet.
      2) The admitting diagnosis is also forwarded to the Pharmacy.

   C. Medication orders must include:
      1) Patient's name
      2) Medication name with additive (if appropriate)
      3) Dosage
      4) Route of administration
      5) Frequency of administration

6) If ordered "prn", indication for medication to be administered
7) Time, date, and ordering physician
8) Signature of person taking the order (i.e., nurse, pharmacist, or physician)

D. The Pharmacy generates Medication Administration Records within two (2) hours of receiving the orders, providing the required information (i.e., allergies) has been provided.
1) Expiration dates are included as appropriate and adjusted when new orders are written.
2) If a specific number of doses of the drug are to be administered, the scheduled time slots are numbered.

Documentation:

1. MAR Verification

A. The MAR is verified by an RN against the physician's orders on admission, transfer of the patient to or from the critical care units, post-op, with each newly printed MAR, and after new medication orders are received.

B. MAR's are generated daily between 2400 and 0600.

C. Scheduled medication administration times are identified, beginning at 0700.

D. When new orders are received, the person transcribing them onto the MAR includes the following information:
1) Medication name with additive (if appropriate)
2) Dosage
3) Route of administration
4) Frequency of administration
5) If ordered "prn", indication for medication to be administered
6) Time, date, and ordering physician
7) Initials of the person transcribing the order and the RN validating the order in the left-hand margin of the page to the left of the entry and signatures of each at the top of the page.

E. If the MAR is multiple pages, "page x' of "y" is displayed. Each page is to be initialed in the lower right-hand corner by the RN verifying the accuracy and completeness of the MAR.

F. If the MAR is recopied, it must be checked and signed by two nurses. "Recopied", along with the signature of the person recopying the form and the date, is noted at the top of the form.

2. MAR Documentation:

A. All medications administered to the patient are to be documented on the MAR including IV fluids, IV medications, IV fluid boluses, and heparin and saline flushes.

1) **Exception:** Medications administered during a code or in a procedural area are documented on the appropriate forms.
2) **Exception:** Medications to be administered by Respiratory Therapy personnel are identified on the MAR with a message "See RT Flowsheet". RT document medication administration on the RT Flowsheet.

B. If a scheduled medication is given as ordered, the nurse enters his/her initials next to the scheduled time slot.

C. If a scheduled medication is not given as ordered, an asterisk (*) is placed in the scheduled time slot and an explanation is placed on the back of the MAR.

D. The site of administration is documented if appropriate (i.e., IM or SC injections) and circled on the MAR next to the time administered.

E. PRN medications are documented on the MAR with the time and the dose administered (if determined by the nurse) as appropriate.

F. All persons charting on the MAR must include their initials and signature in the boxes provided for ease of identification.

3. Discontinuation of Medications:

A. If a medication is discontinued, "D/C'd" is written across the page in the appropriate slot with the nurse's initials, the date discontinued, and the entry is "yellowed out" with a highlighter.

B. When a patient goes to surgery or is transferred to or from a critical care area, all medications are automatically discontinued.
1) The orders may be rewritten by the physician.
2) The physician may also indicate which medications are to be reordered by checking "yes" or "no" on the Active Medication Summary as desired.
3) "Resume previous medications" is not an acceptable order.

Cross Reference(s):

Medication Administration Policy

Attachment(s):

N/A

Reference(s):

N/A

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Piedmont Medical Center	**Policies and Procedures**	Page 1 of 4
	SUBJECT: SITE/SIDE Identification Policy for Operative/Invasive Procedures	Original Date: 8/10/99
		Revised: 5/03, 6/03, 6/04
		Reviewed: 10/00

Policy Statement(s):

This procedure is followed for identifying the correct patient, procedure and anatomical site/side prior to all operative and invasive procedures.

Responsibility:

Registered Nurse, Physician, Surgical Technologists, CV Technicians and all other healthcare workers in the surgery or procedural areas, nursing units, and Emergency Department.

Definition(s):

Surgical/procedural site: the part of the body, i.e. extremity, etc. That is the intended site for surgery/invasive procedure.

Equipment/Supplies:

Permanent markers in any color except black.

Procedure:

A. Verification:

1. For scheduled operative/invasive procedures, the proposed site/side must be clearly identified on the scheduling form. Illegible forms will be rejected. The words "right" and "left" must be completely spelled out. Abbreviations will not be accepted. In all cases, the terms "right" and "left" shall refer to the patient's right and the patient's left.

2. The physician or Licensed Independent Practitioner (LIP) shall discuss the operative/invasive procedure with the patient before anesthesia/moderate sedation. The patient shall verbalize agreement of the correct procedure and surgical site, and the discussion and patient verbalization shall be documented on the consent form.

3. All relevant documentation including the consent form, History & Physical and diagnostic data shall be verified by the pre-procedural nurse/procedural team. If there are any discrepancies or uncertainties, the pre-procedural nurse/procedural team shall call the surgeon/physician for clarification prior the start of the procedure.

4. Communication barriers *(sight and hearing impairments, a non-English speaking patient, as well as well as the patient's emotional status)* shall be addressed by all caregivers so that the patient is able to fully participate in preoperative discussions. Measures taken to address communication barriers shall be documented in the medical record.

B. Pre-procedural:

1. Before the patient enters the OR or the procedure room, the pre-procedural nurse shall ask the patient to state (not confirm) their name and one other patient identifier, (i.e., full social security number or birth date). For non-verbal patients, the pre-procedural nurse will confirm the patient's name and on other patient identifier, (i.e., full social security number or birth date) by matching the wrist band against the medical record. In all cases, two patient identifiers will be used. The patient or designated decision maker will mark the correct side, site, and level where appropriate with a surgical marker. for patients under 18, the child may be allowed to identify the site; however, the parent or legal guardian must always verify the site. If the patient or the designated decision maker is unable to mark the site, the physician or the physician designee will mark the site with his/her initials. For purposes of this policy, physician designee includes the following types of licensed independent practitioners (LIP): the attending surgeon, fellow, resident, nurse practitioner or physician assistant.

2. The pre-procedural nurse will ask the patient/responsible adult to mark the site to enhance the reliability of the process. If the patient is unable to verify the procedural site/side, the patient's legal representative shall work with the person performing the procedure to identify the procedural site/side. If the patient's legal representative is not available, then the person performing the procedure shall mark the procedural site/side. If the patient/legal representative refuses marking of the site, the site will be reconfirmed verbally, and refusal and reconfirmation shall be documented in the medical record. **WOUND OSTOMY CONTINENCE NURSE WILL MARK OSTOMY SITE WHEN REQUESTED BY PHYSICIAN.**

3. The surgeon or LIP performing the procedure is ultimately responsible for the verification process.

4. To improve the adherence of the site marking, it is recommended that the area first be wiped with isopropyl alcohol prior to marking. After the skin is dry, the procedural site/side will be marked with a "yes" using a surgical marking pen.

5. To prevent confusion, the non-operative/procedure sites or sides are not to be marked, unless required for another aspect of care.

6. The method of marking and type of mark shall be consistent throughout the organization.

7. The procedural site mark, as described in this policy, must be visible to the procedural team after the surgical prep and draping has been applied. The visibility of the mark shall be documented in the procedural record. . The visibility of the mark shall be documented in the procedural record. In the case of multiple level surgeries such as spinal surgery, the surgeon/physician is to mark the levels to be operated on either by written means or the use of radiology in the procedural area.

8. Prior to performing the procedure, the surgical/procedural team will take a moment ("time-out"). "Time-out" must be immediately performed before starting the procedure. The "time-out"

process shall be conducted in the location where the procedure will be done and shall involve the entire operative team. The team shall verbally verify the following:

- Correct patient identity
- Correct side and site
- Agreement on the procedure to be done
- Correct patient position
- Availability of correct implants and any special equipment or special requirements.

All components of the above process shall be completed and documented on the verification checklist (see Attachment A) prior to the start of the procedure.

C. SCOPE:

This policy shall apply to the Medical Staff and all personnel in any area where operative and invasive procedures are performed including, but not limited to, bedside procedures, OR, ER, Critical Care, Interventional Radiology and Cardiac Catheterization lab (except when catheter/instrument insertion site is not predetermined). The Medical and Hospital Staff will be responsible for implementing and ensuring compliance with this policy.

- This policy applies to operative and invasive procedures involving right/left distinction (laterality), multiple structures, or levels. These sites include, but are not limited to the following examples:

  1. Any procedure on an extremity
  2. Multiple structures (such as fingers and toes)
  3. Spinal procedures (In addition to pre-operative skin marking of the general spinal region, special intra-operative radiographic techniques are used for marking the exact vertebral level).
  4. Unilateral procedures on the eyes, ears, sinuses, mouth, face or neck
  5. Thoracotomies and thoracoscopies
  6. Procedures involving the joints
  7. Inguinal hernia repairs
  8. Unilateral procedures involving the breast, ureters, kidneys, ovaries and testicles.
  9. Chest tubes
  10. Any procedure that relies on radiologic studies.

- "Time-out" – The "time-out" process shall be conducted in the location where the procedure will be done and shall involve the entire operative team.

- While site/side marking for dental procedures is exempt, documentation of the operative tooth name(s) or marking of the operative tooth (teeth) on the dental radiographs or dental diagram is required.

- Site/side marking is not required for the following procedures including those performed through or immediately adjacent to a natural body orifice.

1. Single organ cases (i.e., Cesarean section, cardiac surgery)
2. Cardiac Catheterization procedures (**ONLY** when catheter/instrument insertion site is not predetermined. For example arterial lines, PA catheters, central lines)
3. Mediastinoscopies
4. Interventional radiological procedures, i.e. angiographies, Cat scan guided procedures/biopsies
5. Abdominal surgeries, i.e. Cholecystectomies, Exploratory laparotomies, Laparoscopies, Splenectomies, Ventral Hernia repairs
6. Procedures on the larynx and trachea
7. Tonsillectomies
8. Transurethral procedure
9. Anal and transanal procedures
10. GI endoscopies
11. Bronchoscopies
12. Procedures on the genitalia (excluding testicles)

- Routine "minor" procedures such as venipuncture, peripheral IV line replacement, insertion of an NG tube, or Foley catheter insertion are not within the scope of this policy.

Documentation:

Document site verification(s) and marking in the designated area(s) on the pre-op checklist and operating room record.

Cross Reference(s):

Pre-procedure checklist policy

Attachment(s):

N/A

Reference(s):

JCAHO (2004) joint Commission Hospital Accreditation Standards. Oakbrook Terrace, Illinois:JCAHO>
American College of Surgeons
American Academy of Orthopaedic Surgeons Report of the Task Force on Wrong-Site Surgery 9/97; revision 2/98

Piedmont Healthcare System	Policies and Procedures	No. 4:10.08
	Subject: Standard Concentrations of Intravenous Medications	Page 1 of 2
		Original Date: 1/2003
		Revised:
		Reviewed

POLICY: Piedmont Healthcare System will encourage the use of standard concentrations for commonly used intravenous medications whenever possible.

PURPOSE: To provide standardized, safe and effective procedure for administration of possible high-risk medications to our patients.

PROCEDURE:
5% Dextrose in Water will be the standard base solution unless stated otherwise. 0.9% Sodium Chloride can be an alternative if Dextrose is undesirable.

I. All physician orders for *Insulin* drips will be prepared with 100 Units of Regular insulin in 100ml of 0.9% Sodium Chloride with a final concentration of 1 Unit/ml.

II. All physician orders for *Heparin* drips will be filled with commercially available premixed Heparin infusion bags containing 25,000 Units of Heparin in 250ml with a final concentration of 100 Units/ ml.

III. All physician orders for *Potassium Chloride* infusions will be filled with standard concentrations of premixed solutions as available. If the concentration desired is not commercially available, the bag will be admixed in the pharmacy by trained personnel. Concentrated potassium chloride vials will only be stocked in the pharmacy.

IV. All physician orders for *Pavulon® (Pancuronium)* drips will be prepared with 100mg in 100ml for a final concentration of 1mg/ ml.

VI. All physician orders for *Versed® (Midazolam)* drips will be prepared with 100mg in 100 ml for a final concentration of 1mg/ ml.

VII. Commercially available premixed bags of *Dobutrex® (Dobutamine)* 500mg in 250ml and *Dopamine* 400mg in 250ml will be used for all physician orders for these medications unless more concentrated solutions are needed.

VIII. All physician orders for *Levophed® (Norepinephrine)* drips will be prepared by adding 4mg of Norepinephrine to 250ml for a final concentration of 16 micrograms/ml.

IX. All physician orders for *Tridil® (Nitroglycerin)* drips will be prepared by adding 50mg of Nitroglycerin to 250ml for a final concentration of 200 micrograms/ ml.

X. All physician orders for *Nipride® (Nitroprusside)* drips will be prepared by adding 50mg of Nitroprusside to 250ml for a final concentration of 200 micrograms/ ml.

XI. Commercially available premixed bags of *Magnesium Sulfate* in 20gm/500ml will be used for physician orders in L&D and OB. Orders for Magnesium riders will be prepared by adding 1gm, 2gm, or 3gm to 50ml of standard base solution.

X. All physician orders for *Cardizem® (Diltiazem)* drips will be prepared by adding 125mg (25ml) of Diltiazem to 100ml for a final concentration of 1mg/ ml.

XII. All physician orders for *Cordarone® (Amiodarone)* drips will be prepared by adding 450mg of Amiodarone to 250ml in glass bottle with a final concentration of approximately 1.8mg/ ml. For recommended administration of 1mg/ min for the initial 6 hours the rate would be 33ml/ hr. For the remainder of the infusion at 0.5mg/ min, the rate would be 17 ml/ hr.

XIII. Other standardized concentrations, see attached table.

Piedmont Medical Center	Policies and Procedures	No. 4.10.08A
	SUBJECT: Standard Concentrations of Intravenous Medications: Drip Reference-Appendix A	Original Date:1/2003
		Revise:
		Reviewed: 07//03

Drug	Std Fluid	Std Drip	Final Volume	Std Conc	Max Conc
Alprostadil	D5W, NS	250 mcg in 250ml	Various	1 mcg/ml	1 mcg/ml
Alteplase	SW	100mg in 100ml	100ml	1mg/ml	1mg/ml
Amiodarone	D5W	Infusion: 450mg in 250ml	250ml	1.8mg/ml	1.8mg/ml
Bretyllium	D5W, NS	2 gm in 500ml	500ml	4mg/ml	10mg/ml
Diltiazem	D5W, NS	125 mg(25ml) in 100ml	125ml	1mg/ml	1mg/ml
Dobutamine	D5W, NS	500mg(40ml) in 210ml	250ml	2000mcg/ml	5000 mcg/r 8000 mcg/r
Dopamine	D5W, NS	400mg in 250ml 800mg in 250ml	250ml	1600mcg/ml 3200mcg/ml	6400mcg/r
Drotrecrogin	NS	Varied	100ml	100mcg/ml 200mcg/ml	200mcg/ml
Epinephrine	D5W, NS	1mg in 250ml	250ml	4mcg/ml	80mcg/ml i
Eptifibatide	Premixed	75mg in 100ml	100ml	0.75mg/ml	0.75mg/ml
Esmolol	D5W, NS	2.5gm in 250ml	250ml	10mg/ml	10mg/ml
Famotidine	D5W, NS	20mg in 10ml	10ml	2mg/ml	10mg/ml
Fenoldopam	D5W, NS	10mg in 250ml 20mg in 500ml	250ml 500ml	40mcg/ml 80mcg/ml	200mcg/ml
Fentanyl	NS	Infusion: 1000mcg in 100ml	100ml	10mcg/ml	50mcg/ml
Furosemide	NS	250mg(25ml) in 225ml	250ml	1mg/ml	1mg/ml
Heparin	D5W	25,000units in 250ml	250ml	100units/ml	100units/m
Insulin, Regular	D5W, NS	100units in 100ml	100ml	1unit/ml	1unit/ml
Isoproterenol	D5W, NS	1mg in 250ml	250ml	4mcg/ml	20mcg/ml
Labetolol	D5W, NS	200mg(40ml) in 160ml	200ml	1mg/ml	3.75mg/ml
Lidocaine	D5W, NS	2gm in 500ml	500ml	4mg/ml	8mg/ml in 1
Lorazepam	D5W	50mg(25ml) in 25ml	50ml	1mg/ml	1mg/ml
Magnesium Sulfate	D5W, NS	1gm in 50ml 2gm in 100ml	50ml 100ml	20mg/ml	40mg/ml
Midazolam	D5W, NS	100mg(20ml) in 80ml	100ml	1mg/ml	1mg/ml
Milrinone	D5W	20mg in 100ml	100ml	200mcg/ml	400mcg/ml

Piedmont Medical Center	Policies and Procedures	No. 4.10.08A
	SUBJECT: Standard Concentrations of Intravenous Medications: Drip Reference-Appendix A	Original Date:1/2003
		Revise:
		Reviewed: 07//03

Morphine	D5W	100mg(2ml) in 98ml	100ml	1mg/ml	10mg/ml
Nitroglycerin	D5W, NS	50mg(10ml) in 240ml	250ml	200mcg/ml	800mcg/ml
Nitroprusside	D5W, NS	50mg in 250ml	250ml	200mcg/ml	800mcg/ml
Norepinephrine	D5W, NS	4mg in 250ml	250ml	16mcg/ml	128mcg/ml
Octreotide	D5W, NS	500mcg in 100ml	100ml	5mcg/ml	10mcg/ml
Pancuronium	D5W, NS	100mg in 100ml	100ml	1mg/ml	1mg/ml
Pantoprazole	D5W, NS	40mg in 100ml	100ml	0.4mg/ml	0.4mg/ml
Phenylephrine	D5W, NS	10mg in 250ml	250ml	40mcg/ml	2.5mg/ml
Procainamide	D5W, NS	2gm in 500ml	500ml	4mg/ml	16mg/ml
Propofol	Premixed	1000mg in 100ml	100ml	10mg/ml	10mg/ml
Ranitidine	D5W, NS	150mg in 250ml	250ml	0.6mg/ml	2mg/ml
Theophylline	D5W, NS	400mg in 500ml	500ml	0.8mg/ml	1.6mg/ml i
Vecuronium	D5W, NS	100mg in 100ml	100ml	1mg/ml	1mg/ml

Piedmont Medical Center	Policies and Procedures	No. 4:24:08
	SUBJECT: Unacceptable Abbreviations/Symbols Monitoring and Reporting	Original Date:05/12/03
		Revise: 07/ 28/03
		Reviewed:

Policy Statement:
The Medical Executive Committee has adopted a list of dangerous abbreviations that should be avoided in physician orders. The pharmacy department will monitor all physician orders and report to medical staff instances that an unacceptable abbreviations is used.

Responsibility:

Pharmacist

Procedure:

1. Upon review of the orders, pharmacist will document occurrence of unacceptable abbreviation by filling out medication event tracking form.
2. The pharmacist will write a verbal order for placement on the chart denoting a clarification
3. Reminder letter will be sent to medical staff member detailing occurrence.

Reference(s):
Tenet Partnership for Change Medication Safety Policy: Avoiding Medication Errors Related to Dangerous Abbreviations.

		8-1
Piedmont Medical Center	**Policies and Procedures**	Page 1 of 1
	SUBJECT: Abbreviations	Original Date: 3/2002
		Reviewed: 9/04
		Revised: 6/03, 9/05

Policy Statement(s):

1. Piedmont Medical Center only allows acceptable abbreviations to be used in order to reduce the risk of errors in interpretation.

2. Piedmont Medical Center recognizes only the abbreviations listed in the Stedman's Acronyms and Symbols 1999, as acceptable abbreviations to be utilized in documentation with the exception of the list of unacceptable abbreviations. (Attachment A)

3. As pre-printed orders are updated, reviewed or revised, all unacceptable symbols and abbreviations shall be replaced with acceptable language.

4. When new pre-printed orders are developed, unacceptable symbols and abbreviations shall not be used.

5. The Forms Committee shall not approve the use of any form that utilizes unacceptable symbols and abbreviations.

Attachment(s):

Attachment A: Unacceptable Abbreviations

Reference(s):

Williams and Williams, Stedman's Abbrev. Abbreviation, Acronyms, and Symbols, (1999)
http://www.jcaho.org

ABBREVIATIONS AND SYMBOLS

Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for "0" (zero), the Number 4 (four) or "cc"	Write "unit"
IU (international unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "international unit"
Q.D., QD, qd, q.d. (daily) QOD, Q.O.D., qod, q.o.d. (every other day)	Mistaken for each other Period after the Q mistaken for I and the O mistaken for I	Write "daily" Write "every other day"
MS MS04 MgS04	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" Write "magnesium sulfate"
Trailing Zero (X.0)* Lack of Leading Zero (.X)	Decimal point is missed	Write X mg Write 0.X mg

The zero rules above apply to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed orders

Exception: A "trailing zero" may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Piedmont Medical Center	Policies and Procedures	Page 1 of 3
	SUBJECT: Infusion Control Devices Priority Ranking	Original Date: 2/98
		Revised: 7/00, 1/03
		Reviewed: 11/02, 1/04

Policy Statement(s):

In order to assure the safe and accurate administration of parenteral fluids and drug therapy the following guidelines will be used when there is a limited supply of IV pumps.

Responsibility:

RNs
Equipment Room personnel

Definition(s):

N/A

Equipment/Supplies:

IV Infusion Pump

Procedure:

1. IV pumps shall be used as indicated on the priority ranking chart.
2. IV pumps shall be removed from a running intravenous infusion whenever a higher priority infusion requires a pump and there are no unused pumps available.
3. When it is necessary to remove an IV pump from a patient for a higher priority infusion:
   A. Bottle shall be labeled for the appropriate rate and time for infusion
   B. IV solution administration sets designed to control and or restrict volume shall be applied (i.e., dial-a-flow)
   C. IV pumps are cleaned between patients with a hospital approved disinfectant solution.
4. When requesting IV pumps, nursing staff shall notify the equipment room of the priority level of the infusion to be delivered.
5. In the event that no IV pump is available from the equipment room for a priority 1 charge nurses evaluate all pumps in service on that unit for priority 2 infusions. The pumps used for priority 2 infusions shall be returned to the service elevator area for cleaning and dispersal.
6. The equipment room staff shall notify the nursing supervisors/directors in the event that unit charge nurses are unable to release enough pumps to meet priority 1 infusion needs.
7. The equipment room staff and nursing supervisors/directors shall contact those departments with stored pumps and have them released into immediate use for priority 1 infusions until rental pumps

can be procured. (Stored pumps are located in CVICU, Cath Lab, Labor and Delivery, and PACU).

8. The equipment room staff and nursing supervisors/directors shall notify the VP for Patient Care Services (or the equipment director in the absence of the VP) to approve rental of infusion pumps due to release of stored pumps for priority 1 infusions.

9. Once rental pumps are received, all pumps borrowed from specialty areas are to be returned to the respective specialty areas.

10. Priority 1 infusions must be on a pump. Priority 2 infusions are recommended but not required to be on a pump.

Priority 1	Priority 2
Amicar	
ALL Pediatric/Neonatal Infusions	Central IV access when patient in specialty units.
Aminophylline	
Chemotherapeutic agents	IV fluids with or without additives
Antiarrythmics – Bretylium, Cardizem, Esmolol, Lidocaine, Pronestyl	Narcan
Dopamine	Peripheral TPN
Dobutamine	
Heparin	Blood Products
Insulin	Antibiotic Therapy
Central IV access when patient is on Med-Surg floor	
Potassium boluses	
Total Parenteral Nutrition (TPN)/Intralipids	
Isuprel	
Levophed	
Epinephrine	
Mag sulfate	
Neosynephrine	
Mannitol	
Narcotics	
Nitroglycerine	
Nipride	
Pitressin/Pitocin	
Thrombolytic Agents	
Priority 1	**Priority 2**
Milrinone/Primacor	
Propofol	
Ritadrine	
3% Sodium Chloride	
Hydrochloric Acid	
Neuromuscular Blocking Agents	

Documentation:

N/A

Cross Reference(s):

N/A

Attachment(s):

N/A

Reference(s):

Cahill, M. et. al. (1996). Nursing Procedures.2nd edition. Springhouse Corp.: Springhouse, PA.
CDC Guidelines, 1998
JCAHO (1999) Sentinel Events Alerts

Piedmont Medical Center	Policies and Procedures	Page: 1 of 2
	SUBJECT: Clinical Alarms	Original Date: 7/03
		Reviewed
		Revised:

Policy Statement(s):

It is the policy of this institution to assure that all clinical alarms and medical equipment alarm systems utilized for patient care are properly operational and alarms are activated when the appropriate settings are in use.

Responsibility:

Technical Support Services (TSS)
Engineering
Staff operating equipment

Procedure:

1. Routine preventive maintenance and testing of clinical alarms and alarm systems associated with medical equipment will be performed by the Engineering/TSS Department:

   A. The Engineering/TSS staff will inventory all equipment/devices that are equipped with an alarm that is designed to elicit a response.
      1) This includes all medical (patient care) equipment such as ventilators, infusion pumps, anesthesia gas monitors, hemodynamic monitors, etc., as well as safety and security alarms such as infant abduction alarms, patient bed alarms, etc.
      2) Each piece of medical equipment/device to be utilized for patient care will be inventoried for risk.
      3) Each safety/security alarm throughout the institution will be inventoried for risk.

   B. Assess each device and assign a risk score based on inherent risk of the device (or safety/security system) failing to alarm or failing to draw the attention of staff (staff do not respond to alarm).
      1) Risk scoring will be assigned: Low – being no risk to patient to High – being **serious risk** including possible death to the patient (See Addendum A)

   C. Testing of all equipment/devices and safety/security systems will be performed starting with devices with the highest risk potential. Testing is designed to ensure the alarming mechanism (audible, visual, both) is functioning according to the manufacturer's specifications.

   D. Functional testing - periodic activation of the alarm on the device/equipment in a patient care area for equipment on the inventory list.

   E. The functional test is conducted on a piece of equipment/device that is not in use on a patient.

   F. Upon conclusion of the operational testing, periodic functional (human factor) testing will be conducted quarterly on all high-risk equipment where user has access to adjust the alarms. All results shall be reported to Hospital PI (See Addendum B for Audit Tool.)

G. For High Risk scored equipment:
   1) An environmental assessment of the alarm will be performed to assure the alarm can be heard within an appropriate distance and with competing noise within the unit where the medical device/equipment is being used.
   2) High-risk equipment where the volume may be adjusted by the user shall be "tagged" by TSS with the established range.
   3) The clinical manager/director/CNS/educator/medical staff representative and TSS representative establish the alarm parameters and adjustments. Refer to N.P. Vital Signs.

H. Patient care staff is responsible to confirm that alarm volumes are set at range designated on the monitor tag on equipment where volume may be adjusted by user.

2. Staffing on all patient care units will consider the amount and complexity of medical equipment/devices utilized for patient care to assure sufficient staff is available to assess, operate, hear and respond appropriately to clinical alarms at all times. The staffing ratio will be appropriate to the complexity of the medical equipment/devices in use and the acuity of the patient.

3. All staff who utilize or maintain medical equipment/devices with clinical alarm systems will be properly oriented to the equipment/devise and the alarm and trained on its use.

   A. Patient care staff must demonstrate both physical knowledge of the operational aspects of the equipment/device and alarm, and the physiological aspects as to why alarms become activated related to the specific equipment/device in use for the patient.

   B. Engineering/TSS staff must demonstrate physical knowledge of the mechanical aspects of the equipment/device alarm system.

   C. All staff using and/or maintaining medical equipment/devices with related alarm systems must be assessed and proven competent to operate the equipment/device and manage its associated alarm mechanism prior to use of that equipment/device.

Department: _____
Date: _____
Auditor: _____

PIEDMONT HEALTHCARE SYSTEM
ALARM VOLUME AUDIT WORKSHEET

Ventilator Alarm at Maximum Level

ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___
ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___
ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___
ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___
ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___
ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___
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ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___
ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___
ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___

Max Level Total Yes: _____ *+ Total Audited* _____ *= Percent Compliance* _____

Tagged Total Yes: _____ *+ Total Audited* _____ *= Percent Compliance* _____

Bedside Monitor: **Type monitor/range to be set:**

1) _____/_____
2) _____/_____
3) _____/_____

MONITOR/ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___
MONITOR/ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___
MONITOR/ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___
MONITOR/ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___
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MONITOR/ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___
MONITOR/ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___
MONITOR/ROOM: _____ Y ___ N ___ Tagged: Y ___ N ___

Range Set Total Yes: _____ *+ Total Audited* _____ *= Percent Compliance* _____

Tagged Total Yes: _____ *+ Total Audited* _____ *= Percent Compliance* _____

Central Station: **Type monitor/range to be set:** _____/_____

Station # 1 Y ___ N ___ Tagged: Y ___ N ___
Station # 2 Y ___ N ___ Tagged: Y ___ N ___
Station # 3 Y ___ N ___ Tagged: Y ___ N ___

Station # 4 Y ___ N ___ Tagged: Y ___ N ___
Station # 5 Y ___ N ___ Tagged: Y ___ N ___
Station # 6 Y ___ N ___ Tagged: Y ___ N ___

Range Set Total Yes: _____ *+ Total Audited* _____ *= Percent Compliance* _____

Tagged Total Yes: _____ *+ Total Audited* _____ *= Percent Compliance* _____

ATTACHMENT O

CHARITY CARE POLICY (UPDATED)

Charity Care Policy

I. POLICY:

The determination of Charity Care generally should be made at the time of admission, or shortly thereafter. However, events after discharge could change the ability of the patient to pay. Designation as Charity Care will only be considered after all payment sources have been exhausted. The co-pay amount will be pursued for all charity accounts with the exception of deceased and homeless patients with no other guarantor. Patient account transactions for Charity Care must be posted in the month the determination is made.

The flat rate "co-pay" amount is based on patient type. Emergency patients and outpatients are required to pay $100 flat rate and inpatients are required to pay $200 per day, with a $2,000 cap.

In the event the account has been assigned as Bad Debt to SOS/CFC as part of the monthly SOS journal entry, it will reverse the PA recovery that was given on an account determined to be Charity Care.

Note: EMPLOYEES OF TENET SHOULD NOT, AT ANY TIME, INDICATE OR SUGGEST TO THE PATIENT THAT HE/SHE WILL BE RELIEVED OF THE DEBT BY WAY OF A WRITE-OFF TO CHARITY CARE UNTIL THE DETERMINATION HAS BEEN MADE.

II. SCOPE:

All Tenet Patient Accounting Platforms

III. PURPOSE:

To define Charity Care and to distinguish Charity Care from accounts assigned to Bad Debt. Additionally, to establish policies and procedures to ensure consistent identification, accountability, and recording of charity at all Tenet entities and facilities.

IV. DEFINITIONS:

Charity Care represents all healthcare services that are provided to patients who are financially unable to satisfy their debts, resulting from a determination of a patient's inability to pay, not their willingness to pay. Hospital charges for patient accounts identified as Charity Care at the time of admission or service are not recognized by the facility as net revenue or net receivables. If patient accounts are identified as Charity Care subsequent to the facility recognizing the charges as revenue, an adjustment is required to appropriately classify the revenue and any Bad Debt expense previously recorded.

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RECORD 002477

Charity Care will be classified into four categories:

A. Charity Care – Statutory

Statutory Charity Care will be defined by facility participation in various Federal, State, and/or County uncompensated care programs. Criteria for such Charity Care must comply with governmental guidelines and/or State or County regulations. Statutory Charity Care also includes any Charity Care obligations as defined in contractual agreements documenting the acquisition of the facility. Each patient who appears eligible for Statutory Charity Care determination and requests such determination must complete a Confidential Medical and Financial Assistance Application (hereafter referred to as the Confidential Financial Application—or, as application—as illustrated in *Exhibit B*). The patient/guarantor must complete all areas of the application and attest to the accuracy of the information by signing the application. The application will be processed in accordance with the Tenet Charity Care Program Policy and Procedures.

Each facility may need to have a number of Statutory Charity Care accounts to provide for the separation and identification of Charity Care by specific program and/or obligation. Statutory Charity Care will generally be identified at the time of admission by the facility, Tenet Financial Assistance Center (TFAC), or while the patient is in-house; however, it may also be identified after discharge.

The following accounts have been added to the Acute Chart of Accounts:

1. 5950-3934 Charity Discount - Statutory I/P
2. 5950-4934 Charity Discount - Statutory E/R
3. 5950-6934 Charity Discount - Statutory O/P

B. Charity Care – Non-Statutory

Non-Statutory Charity Care is defined as patient Charity Care meeting Tenet's Charity Care criteria; however, there may not be State or County programs in which the facility participates or where the facility does not have specific obligations to provide Charity Care. TFAC will determine eligibility for Non-Statutory Charity Care. The determination will be performed after the Confidential Financial Application is submitted for processing. An effort will be made to secure a signed application, but this may not be possible in all cases and will not prevent an account from being qualified by TFAC as Charity Care.

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RECORD 002478

The following account descriptions have been revised in the Acute Chart of Accounts:

1. 5950-3935 Charity Discount - Non-Statutory I/P
2. 5950-4935 Charity Discount - Non-Statutory E/R
3. 5950-6935 Charity Discount - Non-Statutory O/P

C. Charity Care – Medicaid Denied Stays/Care, Non-Covered Services

Medicaid Charity Care will be defined as a category of patients who qualify for Medicaid, pursuant to governmental guidelines and/or State or County regulations, but where an outstanding patient balance exists, excluding waivers of deductibles and co-payments, unless otherwise documented and compliant with Tenet Regulatory Compliance Policy guidelines. Medicaid Charity Care also includes any Charity Care obligations as defined in contractual agreements documenting the acquisition of the facility.

Each patient who appears to be eligible for Medicaid Charity Care determination will not be required to complete a Confidential Financial Application due to the fact that Medicaid eligibility, in itself, is deemed to meet the requirements of Charity and, therefore, meets Tenet's criteria for Charity Care.

Under the Tenet Medicaid Charity Care Policy definition, these patients are eligible for Charity Care write-offs. Charges not billable or "un-billable" to the patient may not be claimed as Charity Care where it is not allowed by State law/regulation. Billable charges related to denied days, denied days of care, non-covered services, and any denied treatment authorizations will be included as Medicaid Charity Care. In addition, Medicare patients who have Medicaid coverage for their co insurance deductibles for which Medicaid will not make any additional payment, and for which Medicare does not ultimately provide Bad Debt reimbursement, will also be included as Charity Care.

At no time shall a facility claim Charity Care attributed to Medicaid billable charges as either Statutory or Non-Statutory Charity.

The following account descriptions have been revised in the Acute Chart of Accounts:

1. 5950-3940 Medicaid Denied Days I/P
2. 5950-4940 Medicaid Denied Services E/R
3. 5950-6940 Medicaid Denied Services O/P

D. Charity Care – Catastrophic Medically Indigent

For patients whose family income to the Federal Poverty Guidelines (FPG) ratio is greater than the designated threshold allowance (Tenet, State, or local-specific), but less than 300% of the FPG, the patient may be considered for the Catastrophic Medically Indigent category. The determination for this is completed after comparing the patient's gross income, income to FPG ratio, and amount of hospital charges as follows:

1. **Income/FPG Ratio**—Gross income to FPG ratio is greater than 200% or less than or equal to 300%.
2. **Income Limit**—Gross family income is not to exceed two times the FPG for a family of six (2003 Guidelines $24,680 x 2 = $49,360).
3. **Charges > 2 Times Income**—Total hospital charges for a patient for the preceding six months is more than twice the family's total gross annual income.
4. **Unable to Pay**—It is determined the patient is unable to pay.

The following account descriptions have been revised in the Acute Chart of Accounts:

1. 5950-3941 Catastrophic Medically Indigent Discount - I/P
2. 5950-4941 Catastrophic Medically Indigent Discount - E/R
3. 5950-6941 Catastrophic Medically Indigent Discount - O/P

V. PROCEDURE:

The hospital Financial Counselor or MEP Patient Advocate will attempt to identify potential Statutory and Non-Statutory Charity Care at the time of admission or while the patient is in-house. At the time of Charity identification, the financial class will be changed to Charity Care, the co-pay will be collected based on admission type, and a 100% Charity Care allowance should be taken for these patients. At the time of the financial class change, the patient's account will be assigned to TFAC and the Confidential Financial Application should be forwarded to TFAC for review and processing. Additionally, all CFC-, MEP-, and Early Out-assigned patient accounts—post-discharge—that qualify to be reviewed for Charity Care should be forwarded to TFAC. Completed Charity Care packets will be forwarded to the respective facility. TFAC will also retain the Charity Care packets, including applications for Charity Care, appropriate back-up documentation, and recommendations for possible retrospective audit by the Business Office and/or Tenet Audit Services.

A. Factors to be Considered

Factors to be considered in determining eligibility for Charity Care must include comparing the patient's gross income to the annually published FPG, or an equivalent thereof. The patient's gross income information may be obtained from a Confidential Financial Application, but is not required. This information may be obtained through verbal means from the patient/guarantor and documented by a MEP Patient Advocate, Financial Counselor, Financial Assistance Coordinator, or other specifically designated Tenet employee.

Other factors may include, but are not limited to, the following:

1. The patient's employment status, credit status, and capacity for future earnings.
   a) Patients who are unemployed and do not qualify for a government program
   b) Patients who have no credit established and no Bad Debt collection accounts
   c) Patients with a lack of revolving credit account(s) information
   d) Patients with a lack of revolving bank accounts(s) information
   e) Patients with delinquencies reported on open trade line accounts
2. The previous exhaustion of all other available resources.
3. International patients are considered on a case-by-case basis for ER treatment and/or ER admission only.
4. Catastrophic illness.

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RECORD 002481

VI. MEP PROCEDURE:

The MEP Patient Advocate should screen patients for potential linkage to Government/County programs. During the screening process, the Advocate should secure a Confidential Financial Application. The application is to be used for potential Charity Care determination only in the event MEP is unable to obtain eligibility for the patient for Government Programs reimbursement. For potential linkage to Government/County programs, the Patient Advocate will:

A. Change the financial class and assign the account to MEP within five days from date of discharge, thereby, netting the account to expected governmental reimbursement.

B. Make a final determination as to whether linkage will prevail within an additional 25 days from the assignment date, totaling no more than 30 days from date of discharge.

C. Return the account to the facility for assignment by the Business Office to Early Out for Self-Pay if it is determined that program linkage will not prevail within the additional 25 days from assignment date, and there are no other payment or third-party payment sources. Those meeting the financial guidelines for Charity Care will be assigned by the Business Office to TFAC with the appropriate financial class. The co-pay should be collected by the hospital's Financial Counselor, Business Office representative, or TFAC representative.

If, during the initial interview with the patient, it is revealed that there is no viable source of payment and the patient will not qualify for any governmental programs, the Patient Advocate will:

A. Offer the patient a Confidential Financial Application form.

B. Assist the patient in completing a Confidential Financial Application, which will document the patient's financial need.

C. Obtain the patient's signature on the Confidential Financial Application and forward the application to the Financial Counselor or TFAC, as deemed appropriate.

D. Refer the patient to the hospital Financial Counselor for collection of the co-pay.

MEP Processing for Charity Care

For those accounts that remain in MEP past 30 days from assignment with no government program linkage and that meet the financial criteria for Charity Care, MEP should have gathered all substantial information to enable the facility to affect Tenet's Charity Care Policy. Included in the Charity Care packet is a Confidential Financial Application. If the MEP representative has exhausted all efforts to secure all necessary verifications, the application for Charity Care should be submitted to TFAC for review and finalization without the verifications.

MEP is required to notify the Business Office of the inability to obtain eligibility, or the potential qualification for Charity Care classification, and to return the account to the Business Office.

The Business Office is required to update the plan ID and financial class for assignment to TFAC.

TFAC will further assess the application.

VII. FINANCIAL COUNSELOR PROCEDURE:

Patients assessed by a Financial Counselor to have no third-party coverage and/or benefits available will:

A. Be offered the facility flat rate or Prompt Pay Discount Program where allowed by State law/regulation.

B. Be assessed for Charity Care in the event he or she is unable to pay the facility flat rate or Prompt Pay Discount Program amount (as applicable to State law/regulation), and meets the income/asset and other guidelines set forth by the Charity Care Policy.

The Financial Counselor will take the appropriate steps as outlined below:

A. For patients who appear to meet the income guidelines set forth in this policy for Charity Care, the account should be updated with the financial class of Charity on the facility system, at which time, a 100% Charity Care reserve should be taken and the co-pay amount should be collected. The patient account is then assigned to TFAC for review follow-up and a final Charity Care recommendation. The Financial Counselor should forward the Confidential Financial Application to TFAC.

B. Patients who do not qualify for Charity Care should be treated as a Self-Pay. and standard A/R collection procedures will apply.

VIII. TENET FINANCIAL ASSISTANCE CENTER:

All accounts assigned to TFAC that are potentially Charity Care will be evaluated within 25 days. During the assessment period, the account's financial class may be changed to Charity Care on the facility's system and a 100% reserve taken.

Those accounts that do not meet the financial guidelines, which were assigned to TFAC for Charity Care assessment, will have the financial class changed to Self-Pay on the facility's system and will be assigned to Early Out.

For patient accounts meeting the Charity Care guidelines:

A. The TFAC Financial Assessment Coordinator will gather all substantial information to enable the facility to affect Tenet's Charity Care Policy.

B. The Charity Care packet should include a Confidential Financial Application. a Credit Bureau Report, and any other documents that substantiate the patient's financial need for Charity consideration. Where the patient is unable to complete a written Confidential Financial Application, verbal attestation is acceptable.

The amount of information to support a Charity Care recommendation will vary depending on TFAC's ability to effectively obtain the information from the patient or family.

When TFAC is unable to obtain hard-copy documentation from the patient or family, but all indications—from the information received verbally or in writing at the time of service (or soon thereafter)—are that the patient would qualify for Charity Care, then TFAC will complete a Confidential Financial Application recommending Charity Care. The application will include:

1. A Credit Bureau Report or summary
2. An analysis that supports the recommendation for a Charity Care adjustment

C. The Financial Assessment Coordinator will attempt to secure supporting documentation. Income and/or assets may be verified by attaching any one or more of the following:

1. Credit Bureau Report (including the lack thereof)
2. IRS tax returns
3. Payroll stubs
4. Declarations
5. Verbal attestation
6. Other forms used to substantiate the need for Charity Care consideration

D. The Financial Assessment Coordinator will apply FPG guidelines by using the FPG table (refer to *Exhibit A*), which is updated annually. The patient's family size is used to determine whether monthly or annual income falls at, below, or exceeds 200% of the FPG. Where State law/regulation does not allow for consideration of Charity up to 200% of the FPG, the State law/regulation will take precedent and be enforced.

1. If the family gross income falls below, or is at the designated income of the FPG ratio threshold, the patient's account will be considered for Charity Care adjustment at 100% minus the co-pay amount

   Note: Tenet Policy's ratio is 200%, which is influenced by State law/regulation.

2. For patients whose family income to the FPG ratio is greater than the designated threshold allowance (Tenet, State, or local-specific), but less than 300% of the FPG, the patient may be considered for a Catastrophic Medically Indigent discount. The calculation for this is completed after comparing the patient's gross income, income to the FPG ratio, and the amount of hospital charges as follows:

   a) **Income/FPG Ratio**—Gross income to FPG ratio is greater than 200% or less than or equal to 300%.

   b) **Income Limit**—Gross family income is not to exceed two times the FPG for a family of six (2003 Guidelines $24,680 x 2 = $49,360).

   c) **Charges > 2 Times Income**—Total hospital charges for a patient for the preceding six months is more than twice the family's total gross annual income.

   d) **Unable to Pay**—It is determined the patient is unable to pay.

      Note: All four of the above criteria must be met for consideration as Catastrophic Medically Indigent.

3. If the co-pay was not collected at the time of service, the Financial Assistance Coordinator will attempt to collect the amount before the Charity Care packet is submitted.

E. The Financial Assistance Coordinator will complete a Confidential Financial Application that indicates there are no other payment sources and the patient meets the income of the FPG guidelines.

F. TFAC is to review the application for Charity Care for appropriateness and completeness. Initialing the application indicates that it has been reviewed and meets the requirements for submission to the facility for Charity Care consideration and administrative adjustment.

G. If the TFAC representative has exhausted all efforts for those patients who meet Government Programs or Charity Care criteria, but are unable to complete the required applications and documentation (e.g., unable to contact the patient, unable to provide sufficient documentation, etc.), and/or have a potential change in future circumstances and recovery, then the account will not be recommended for a Charity Care allowance.

H. Those patients who do not meet the guidelines for Charity Care will have their accounts changed back to Self-Pay, and standard A/R follow-up will begin.

At all times, the Collection, Support, and Management staff of TFAC are required to input complete documentation on the account of all actions taken and all information received from the patient. It is the responsibility of the TFAC Operations management to ensure adherence to this policy.

IX. DOCUMENTATION:

A. Confidential Financial Application

In order to qualify for Charity Care, Tenet requests each patient or family to complete the Confidential Financial Application. This application allows the collection of information about income and the documentation of other requirements as defined below. Pending the completion of the application, the patient should be treated as a Charity Care patient in accordance with Tenet's Charity Care Policy as set forth here. The patient's account will have the financial class changed to Charity Care on the facility's HIS system.

In cases where the patient is unable to complete the written application, verbal attestation is acceptable if it is not disallowed by State law/regulation.

A Confidential Financial Application completed by the patient may not be required for patients who are deemed to be already eligible for other Federal, State, and County Assistance Programs. Such programs include, but are not limited to Medicaid, County Assistance Programs, MIA, MSI, AFDC, Food Stamps, and WIC.

1. **Family Members**—Tenet will require patients to provide the number of family members in their household.

   a) Adults—To calculate the number of family members in an adult patient's household, include the patient, the patient's spouse and/or legal guardian, and all of their dependents.

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b) Minors—To calculate the number of family members in a minor patient's household, include the patient, the patient's mother/father and/or legal guardian, and all of their other dependents.

2. **Income Calculation**—Tenet requires patients to provide their household's yearly gross income.

   a) Adults—The term "yearly income" on the application means the sum of the total yearly gross income of the patient and the patient's spouse.

   b) Minors—If the patient is a minor, the term "yearly income" means the income from the patient, the patient's mother/father and/or legal guardian, and all of their other dependents.

3. **Expired Patients**—Expired patients may be deemed to have no income for purposes of the Tenet calculation of income. Although no documentation of income and no Confidential Financial Application are required for expired patients, the patient's financial status will be reviewed at the time of death by TFAC to ensure that a Charity Care adjustment is appropriate. The co-pay will be waived if no other guarantor appears on the patient account.

4. **Homeless Patients**—Patients may be deemed homeless once verification processes have been exhausted by TFAC. The co-pay will be waived if no other guarantor appears on the patient account.

B. Income Verification

Tenet requests patients to attest to the income set forth in the application. In determining a patient's total income, Tenet may consider other financial assets and liabilities of the patient, as well as, the patient's family income, when assessing the ability to pay. If a determination is made that the patient has the ability to pay their bill, such determination does not preclude a reassessment of the patient's ability to pay upon presentation of additional documentation. Any of the following documents are appropriate for substantiating the need for Charity Care:

1. **Income Documentation**—Income documentation may include IRS W-2 form, Wage and Earnings Statement, paycheck stub, tax returns, telephone verification by employer of the patient's income, signed attestation to income, bank statements, or verbal verification from patient.

2. **Participation in a Public Benefit Program**—Public Benefit Program documentation showing current participation in programs, such as Social Security, Workers' Compensation, Unemployment Insurance, Medicaid, County Assistance Programs, AFDC, Food Stamps, WIC, or other similar indigence-related programs.

3. **Assets**—All liquid assets should be considered as a possible source of payment for services rendered. For patients with no source of regular income (employment, SSI, disability, etc.) other than liquid assets, those assets would be the patient's income source and should be measured against the FPG.

C. Information Falsification

Information falsification will result in denial of the Charity Care application. If, after a patient is granted financial assistance, the hospital/SOS finds material provision(s) of the application to be untrue, Charity Care status may be revoked and the patient's account will follow the normal collection processes.

D. Revenue Classification

It will be the responsibility of each Business Office to maintain the integrity of account classification on the hospital patient accounting system. Prior to month-end close, TFAC is responsible for providing detailed reports listing critical changes in account class between Self-Pay and Charity for any A/R account assigned to TFAC. The Business Office is required to use those reports to update the changes in the patient accounting system prior to the month-end.

Critical changes in account class are defined as:

1. Any account originally assigned to TFAC as Self-Pay that is re-classed as a result of meeting the criteria for Charity Care

2. Any account originally assigned to TFAC as Charity that is re-classed to Self-Pay as a result of denying Charity Care

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E. Denied Charity Care Recommendations

In the event the CFO denies a patient's application for Charity Care, documentation is to be placed in the facility collection system as to the reason for the rejection of the recommendation. The CFO is also to indicate on the Confidential Financial Application the reason for denial and the date of the denial. The packet is then to be forwarded to TFAC for review. After an initial review and discussion with the CFO, for those patient accounts where disagreement still prevails, and the accounts that meet Tenet guidelines for Charity Care as set forth here, a denial summary will be sent to the respective Tenet Regional Vice President of Finance by TFAC for resolution. For those patient accounts that the Regional Vice President of Finance has denied that have met the Tenet Charity Care guidelines as set forth here, a denial summary will be sent to the respective Tenet Divisional Senior Vice President of Finance for conference and resolution.

F. Custodian of Records

TFAC will serve as the custodian of records for all Charity Care documentation for all accounts identified by SOS, MEP, and CPFS.

G. Reservation of Rights

It is the policy of Tenet and the hospital to reserve the right to limit or deny financial assistance at their sole discretion.

1. **Non-Covered Services**—It is the policy of Tenet and the hospital to reserve the right to designate certain services that are not subject to the hospital's Charity Care Policy.

2. **No Effect on Other Tenet Regions/Hospital Policies**—This policy shall not alter or modify other Tenet policies regarding efforts to obtain payments from third-party payers, patient transfers, emergency care, State-specific regulations, State-specific requirements for Statutory Charity Care classification, or programs for uncompensated care.

X. EXHIBIT A – FEDERAL POVERTY GUIDELINES:

2004 Federal Poverty Guidelines (FPG) are as follows:

Size of Family	48 States Gross Yearly			Alaska Gross Yearly			Hawaii Gross Yearly		
	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG
1	$9,310	18,620	27,930	$11,630	23,260	34,890	$10,700	21,400	32,100
2	12,490	24,980	37,470	15,610	31,220	46,830	14,360	28,720	43,080
3	15,670	31,340	47,010	19,590	39,180	58,770	18,020	36,040	54,060
4	18,850	37,700	56,550	23,570	47,140	70,710	21,680	43,360	65,040
5	22,030	44,060	66,090	27,550	55,100	82,650	25,340	50,680	76,020
6	25,210	50,420	75,630	31,530	63,060	94,590	29,000	58,000	87,000
7	28,390	56,780	85,170	35,510	71,020	106,530	32,660	65,320	97,980
8	31,570	63,140	94,710	39,490	78,980	118,470	36,320	72,640	108,960
Each additional person, add	3,180	6,360	9,540	3,980	7,960	11,940	3,660	7,320	10,980

XI. EXHIBIT B – CONFIDENTIAL FINANCIAL APPLICATION:

Confidential Medical and Financial Assistance Application

Facility:	Acct. #:	Patient Name	SSN	DOB
Patient Address:				
Patient Home Phone:		Patient Work Phone:		

SECTION A

MEDICAL ASSISTANCE SCREENING – *Please circle answer "Y" for yes or "N" for no.*

1. Is the patient under age 21 or over age 65? Y / N
2. Is the patient a single parent of a child under age 21? Y / N
3. Is the patient a caretaker or guardian of a child under 21? Y / N
4. Is the patient a married parent of a minor child? *If yes, does the patient have a 30-day incapacitation?* Y / N
5. Is the patient pregnant, or was the admission pregnancy-related? Y / N
6. Will the patient potentially be disabled for 12 months? Y / N
7. Is the patient a Victim of Crime? Y / N
8. Does the patient have a "COBRA" or insurance policy that the premium has lapsed? Y / N

SECTION B

FINANCIAL ASSISTANCE SCREENING

Total Number of Dependent Family Members in Household _____

(Include patient, patient's spouse and/or legal guardian, and any children the patient has under the age of 18 living in the home. If the patient is a minor, include mother/father and/or legal guardian, and all other children under the age of 18 living in the home.)

Estimated Gross Annual Household Income $_____ (see page 2)

Calculate Income to FPG Ratio: Gross Annual Income ÷ FPG Based on Family Size

_____ ÷ _____ = _____%

Type of Service: Circle one ER OP IP

Service Date _____ to _____

Co-Pay Amount $_____

Tenet Healthcare Corporation

Size of Family	48 States Gross Yearly			Alaska Gross Yearly			Hawaii Gross Yearly		
	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG
1	$9,310	18,620	27,930	$11,630	23,260	34,890	$10,700	21,400	32,100
2	12,490	24,980	37,470	15,610	31,220	46,830	14,360	28,720	43,080
3	15,670	31,340	47,010	19,590	39,180	58,770	18,020	36,040	54,060
4	18,850	37,700	56,550	23,570	47,140	70,710	21,680	43,360	65,040
5	22,030	44,060	66,090	27,550	55,100	82,650	25,340	50,680	76,020
6	25,210	50,420	75,630	31,530	63,060	94,590	29,000	58,000	87,000
7	28,390	56,780	85,170	35,510	71,020	106,530	32,660	65,320	97,980
8	31,570	63,140	94,710	39,490	78,980	118,470	36,320	72,640	108,960
Each additional person, add	3,180	6,360	9,540	3,980	7,960	11,940	3,660	7,320	10,980

In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Responsibility Party:		Relationship to patient
SSN:	DOB	
Home Address:		Phone #
Work Address:		Phone #
Gross Income:	Check One - Hourly Daily Weekly Monthly Yearly	
	Hours Per Week:	
If income is $0/unemployed, what is your means of support?	Check One - Living on Savings/Annuity Live with parent/family/friends Homeless Shelter	

SPOUSE

Responsibility Party:		
SSN:	DOB	
Home Address:		Phone #
Work Address:		Phone #
Gross Income:	Check One - Hourly Daily Weekly Monthly Yearly	
	Hours Per Week:	

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HOMELESS AFFIDAVIT

I, _____, herby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others.
Patient/Guarantor Initials _____

ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in the denial of this Application. Additionally, in accordance with state statute, providing false information to defraud a hospital for obtaining goods or services is a misdemeanor, and in accordance with statue, may be punishable by imprisonment and a fine. I also understand that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Tenet Charity Care programs is a "Payer of Last Resort" and hereby assign all benefits due from any liability action, personal injury claims, forth settlements, and any and all insurance benefits which may become payable or fitness or injury for which Tenet's or its subsidiaries provided care.

_____ _____

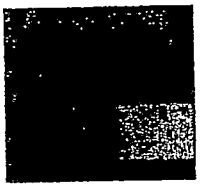
PATIENT/GUARANTOR SIGNATURE DATE

OFFICE USE ONLY

Family Size:	Account Number(s)	Balance	Patient Type (Inpatient, Outpatient, ER)
Gross Annual Family Income:			
FPG based on Family Size:			
Current Hospital Charges:			
Income/FPG:			
Income X 2:			
Recommendation:			
_____	_____	_____	
Prepared by		Date	Unit
_____	_____	_____	
Approved or Denied by		Date	Title

ATTACHMENT P

TENET'S COMPACT WITH UNINSURED PATIENTS



TENET'S COMPACT WITH UNINSURED PATIENTS

- Patients without insurance at Tenet hospitals will be treated fairly and with respect during and after their treatment, and regardless of their ability to pay for the services they receive.

- Tenet hospitals will provide financial counseling to uninsured patients. This will include help in understanding and applying for local, state and federal health care programs such as Medicaid.

- After uninsured patients* receive treatment at Tenet hospitals and are provided with financial counseling, they will be offered discounted pricing for the services provided at rates equivalent to the hospital's current managed care rates, which are substantially discounted from retail or "gross" charges.

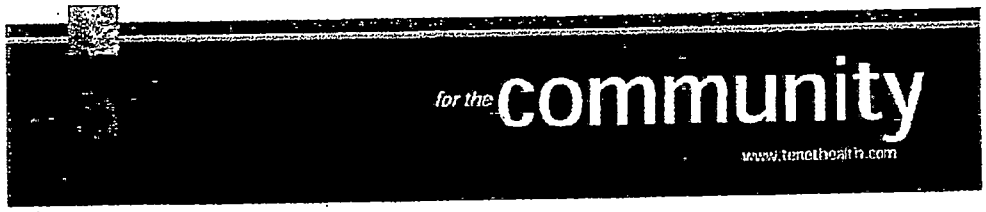
- All patients without insurance at Tenet hospitals will be offered reasonable payments and payment schedules and, subject to their acceptance of the offer, will be billed at discounted local market rates. Whenever possible, this will occur before the patients leave the hospital, as part of the financial counseling process.

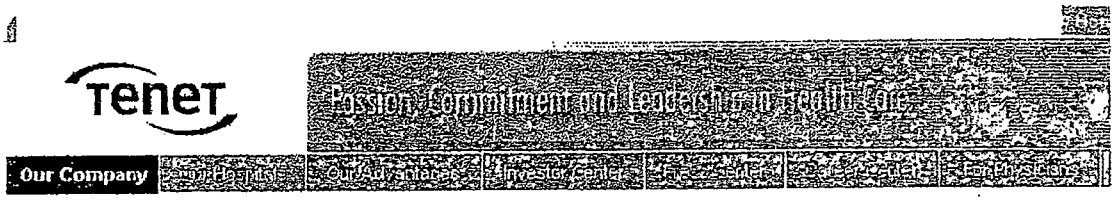
- Tenet hospitals will not pursue legal action for non-payment of bills against any patient who is unemployed or without other significant income. Before taking legal action for non-payment, our hospitals will assure that the patient is not eligible for any assistance program and does not qualify under the hospitals' charity care policy. Nor will our hospitals pursue legal action if the only recovery available would be to place a lien on the patient's home.

* Patients will not be considered "Uninsured Patients" if they reside outside of the United States and travel to the United States for the purpose of receiving specialized medical care.

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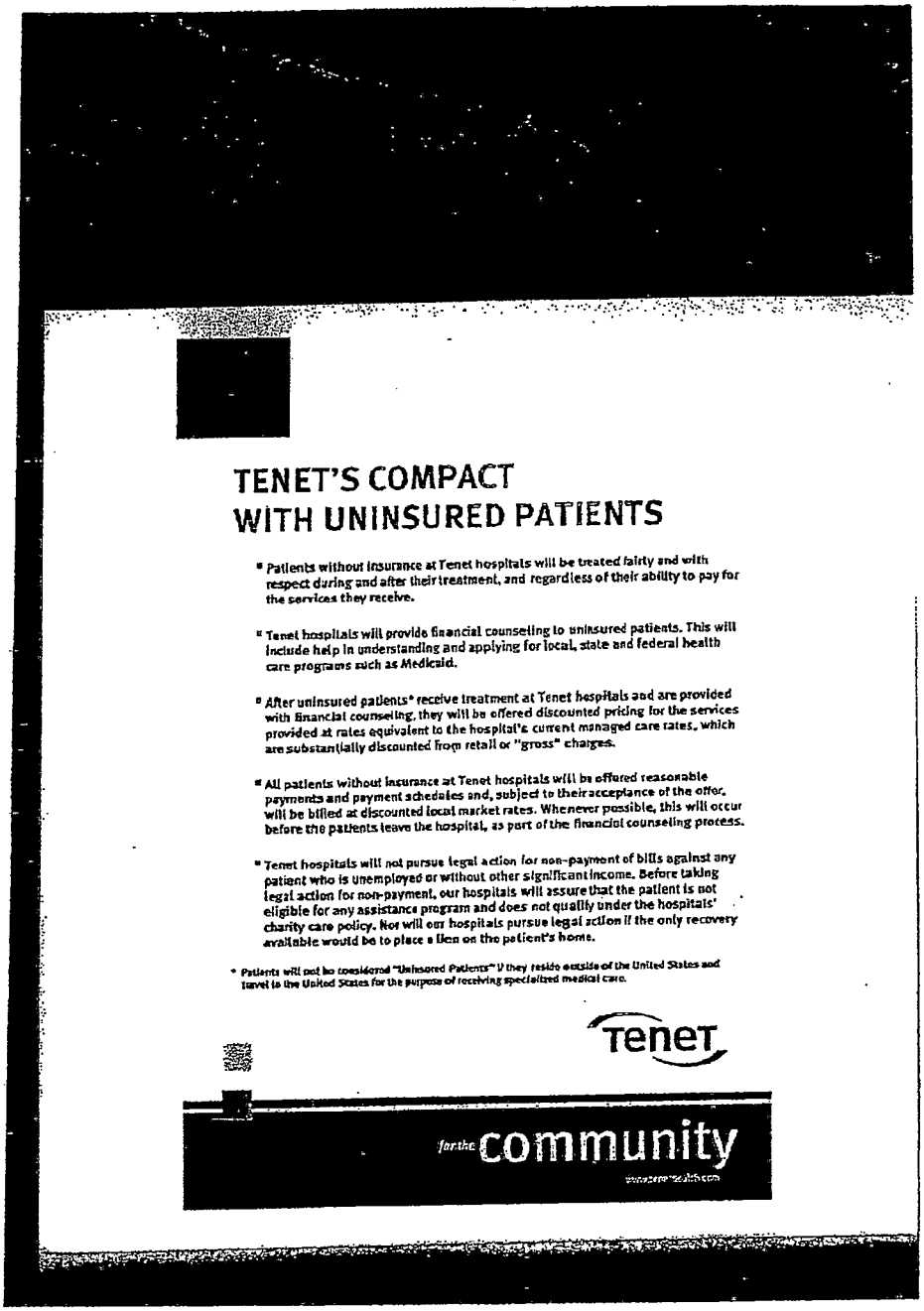
Tenet's Compact With Uninsured Patients

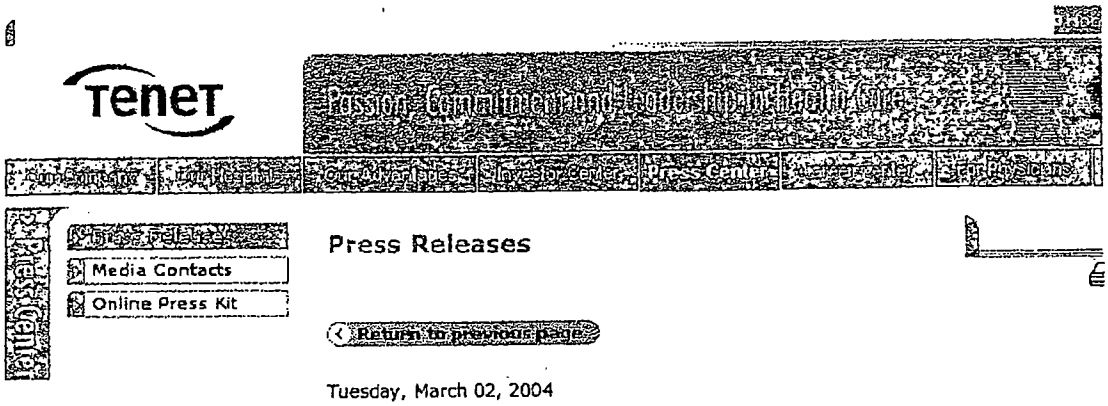
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- Patients without insurance at Tenet hospitals will be treated fairly and with respe after their treatment, and regardless of their ability to pay for the services they r
- Tenet hospitals will provide financial counseling to uninsured patients. This will ir understanding and applying for local, state and federal health care programs suc
- After uninsured patients* receive treatment at Tenet hospitals and are provided counseling, they will be offered discounted pricing for the services provided at ra to the hospital's current managed care rates, which are substantially discounted "gross" charges.
- All patients without insurance at Tenet hospitals will be offered reasonable paym payment schedules and, subject to their acceptance of the offer, will be billed at local market rates. Whenever possible, this will occur before the patients leave tl part of the financial counseling process.
- Tenet hospitals will not pursue legal action for non-payment of bills against any unemployed or without other significant income. Before taking legal action for nc our hospitals will assure that the patient is not eligible for any assistance prograr not qualify under the hospitals' charity care policy. Nor will our hospitals pursue the only recovery available would be to place a lien on the patient's home.

*Patients will not be considered "Uninsured Patients" if they reside outside of the United travel to the United States for the purpose of receiving specialized medical care.

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TENET'S COMPACT
WITH UNINSURED PATIENTS
▪ Patients without insurance at Tenet hospitals will be treated fairly and with respect during and after their treatment, and regardless of their ability to pay for the services they receive.
▪ Tenet hospitals will provide financial counseling to uninsured patients. This will include help in understanding and applying for local, state and federal health care programs such as Medicaid.
▪ After uninsured patients* receive treatment at Tenet hospitals and are provided with financial counseling, they will be offered discounted pricing for the services provided at rates equivalent to the hospital's current managed care rates, which are substantially discounted from retail or "gross" charges.
▪ All patients without insurance at Tenet hospitals will be offered reasonable payments and payment schedules and, subject to their acceptance of the offer, will be billed at discounted local market rates. Whenever possible, this will occur before the patients leave the hospital, as part of the financial counseling process.
▪ Tenet hospitals will not pursue legal action for non-payment of bills against any patient who is unemployed or without other significant income. Before taking legal action for non-payment, our hospitals will assure that the patient is not eligible for any assistance program and does not qualify under the hospitals' charity care policy. Nor will our hospitals pursue legal action if the only recovery available would be to place a lien on the patient's home.
* Patients will not be considered "Uninsured Patients" if they reside outside of the United States and travel to the United States for the purpose of receiving specialized medical care.
Tenet
for the community



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Tuesday, March 02, 2004

Tenet to Implement Discounts for Uninsured Patients

Mar. 2, 2004 – Tenet Healthcare Corporation (NYSE: THC) said today that it will impler care-style discount pricing for uninsured patients at its hospitals, subject to state laws a regulations. The discounts will be phased in during the second quarter this year and wil effect by June 30.

The company took the action after Tommy Thompson, secretary of the U.S. Department Human Services, stated on Feb. 19 that nothing in the Medicare program rules or regula hospitals from providing discounts to uninsured and underinsured patients who cannot a hospital bills. HHS's Office of the Inspector General also publicly expressed its view that authority prohibits or restricts hospitals from offering discounts to uninsured patients wh to pay their hospital bills.

In January 2003, Tenet became the first major hospital operator to offer to discount its uninsured patients when it unveiled its innovative five-point "Compact With Uninsured P that time, however, the company said it could not implement the pricing discount until i advisory opinion from the OIG that the proposed discount would comply with applicable and regulations. In light of the OIG's recent public pronouncement, the company has d withdraw its request for this advisory opinion.

Other provisions of Tenet's Compact, including certain limits on the company's legal effc unpaid hospital bills, have been in effect for more than a year.

"Offering a discount to our uninsured patients is simply the right thing to do, and we are to be able to implement this policy we first proposed more than a year ago," said Trevor Tenet's president and chief executive officer. "We are grateful for Secretary Thompson's support. Our Compact With Uninsured Patients represents a groundbreaking approach t help solve one of our nation's most pressing problems. The problem of the uninsured re all Americans and requires a national solution. But we are committed to doing whatever being a leader in addressing all issues facing health care today, and we will be known fo dedication to quality in patient care."

The amount of the discounts will be within the current range of local managed rates cun by each hospital, and therefore will vary from hospital to hospital. They will be offered t uninsured patients who receive treatment in Tenet hospitals nationwide, regardless of th level. However, the discount will not apply to deductibles or co-pays owed by patients u Medicaid or other federal health care programs. The phase-in timing is needed because substantial training and other implementation efforts that must take place to assure tha functions properly. The discount pricing will not be available in Texas, where state law c permit it. Until the discount pricing policy is fully implemented, Tenet will continue to w the past to assure that uninsured patients are offered financial counseling and reasonab plans.

Specifically, Tenet's Compact With Uninsured Patients states that:

- Patients without insurance at Tenet hospitals will be treated fairly and with respe

after their treatment, and regardless of their ability to pay for the services they r

- Tenet hospitals will provide financial counseling to all uninsured patients. This w in understanding and applying for local, state and federal health care programs s Medicaid.
- If uninsured patients receive treatment at Tenet hospitals, they will be offered di pricing for the services provided at rates comparable to the hospital's current ma rates.

- All patients without insurance at Tenet hospitals will be offered reasonable paym payment schedules and, subject to their acceptance of the offer, will be billed at local market rates. Whenever possible, this will occur before the patients leave t part of the financial counseling process.
- Tenet hospitals will not pursue legal action for non-payment of bills against any p unemployed or without other significant income. Before taking legal action for nc our hospitals will assure that the patient is not eligible for any assistance prograr not qualify under the hospitals' charity care policy. Nor will our hospitals pursue the only recovery available would be to place a lien on the patient's home.

Although the uninsured discount is new, the Compact puts in writing other assistance efforts that Tenet hospitals have been making for a number of years.

For instance, Tenet has been a leader in helping uninsured patients understand and app government health care programs, such as Medicaid. Many such patients are often una are eligible for government programs. In fact, about 50,000 uninsured patients in Tene the past 12 months were qualified for such programs because of the company's efforts t Medical Eligibility Program. More than 300 financial counselors work directly with patien hospitals to provide information and assistance.

Tenet Healthcare Corporation, through its subsidiaries, owns and operates acute care hc related health care services. Tenet's hospitals aim to provide the best possible care to e who comes through their doors, with a clear focus on quality and service. Tenet can be World Wide Web at www.tenethealth.com.

# # #

Certain statements in this release may constitute forward-looking statements. They are management's current expectations and could be affected by numerous factors and are various risks and uncertainties. Certain of those risks and uncertainties are discussed in Company's filings with the Securities and Exchange Commission, including the Company report on Form 10-K and quarterly reports on Form 10-Q. Do not rely on any forward-l statement, as we cannot predict or control many of the factors that ultimately may affec achieve the results estimated. We make no promise to update any forward-looking stat whether as a result of changes in underlying factors, new information, future events or

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Tuesday, January 28, 2003

Tenet Pledges Fair Treatment, Discount Prices for Uninsured
Written Statement of Commitments Offers Innovative Solutions

SANTA BARBARA, Calif. – Jan. 28, 2003 – Offering its own innovative solutions to th faced by hospital patients without insurance, Tenet Healthcare Corporation (NYSE: THC) unveiled a unique "Compact With Uninsured Patients" that includes an offer of managed pricing for the uninsured and certain limits on the company's legal efforts to collect unpa bills.

Tenet's written statement of commitments regarding fair treatment of uninsured patient to be a first in the hospital industry. The Compact With Uninsured Patients represents a Tenet's strategy to offer solutions for the realities of today's health care environment. T will be distributed to patients in Tenet hospitals once regulatory approval for the pricing received.

"We have heard the many voices in our communities seeking innovative answers for the the uninsured, and this Compact is a major step in the right direction," said Jeffrey C. B. Tenet's chairman and chief executive officer. "Tenet is only one member of a very large we intend to demonstrate our leadership on this and other issues. Most of us in this ind been troubled for years by regulations and practices that meant uninsured patients – th to afford their care – often receive the largest bills and are subject to collection efforts if pay. The Compact is Tenet's own solution to this challenge, and we hope others will join effort."

Specifically, Tenet's Compact With Uninsured Patients states that:

- Patients without insurance at Tenet hospitals will be treated fairly and with respe after their treatment, and regardless of their ability to pay for the services they r
- Tenet hospitals will provide financial counseling to all uninsured patients. This w in understanding and applying for local, state and federal health care programs s Medicaid.
- After uninsured patients receive treatment at Tenet hospitals and are provided w counseling, they will be offered discounted pricing for the services provided at ra to the hospital's current managed care rates, which are substantially discounted "gross" charges. (This proposal requires regulatory approval, which Tenet is see
- All patients without insurance at Tenet hospitals will be offered reasonable paym payment schedules and, subject to their acceptance of the offer, will be billed at rates. Whenever possible, this will occur before the patients leave the hospital, i financial counseling process.
- Tenet hospitals will not pursue legal action for non-payment of bills against any p unemployed or without other significant income. Before taking legal action for nc our hospitals will assure that the patient is not eligible for any assistance prograr not qualify under the hospitals' charity care policy. Nor will our hospitals pursue the only recovery available would be to place a lien on the patient's home.

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JOINT-B-PMC-001.0317

RECORD 002501

In a related development, Tenet announced that it has reached agreement to settle and lawsuits coordinated by Consejo de Latinos Unidos and filed by individual plaintiffs again company and some of its hospitals in Southern California. The lawsuits basically allegec hospitals' billing and collection practices for uninsured were unfair under California law. settlements were not disclosed.

As part of its new pricing strategy, Tenet had announced in December that it hoped to o pricing to uninsured patients at rates equivalent to a hospital's current managed care ra the proposed discount pricing is unique in the industry and may involve a number of imp and state laws, the company is seeking an interpretative opinion from federal regulators program complies with applicable federal laws before implementing it. Tenet expects to formal request for this opinion within the next two weeks.

Although the uninsured discount is a new proposal, the Compact puts in writing other as efforts that Tenet hospitals have been making for a number of years.

For instance, Tenet has been a leader in helping uninsured patients understand and app government health care programs, such as Medicaid. Many such patients are often una are eligible for government programs. In fact, about 50,000 uninsured patients in Tene the last 12 months were qualified for such programs because of the company's efforts u Medical Eligibility Program. More than 300 financial counselors work directly with patien hospitals to provide information and assistance.

The company said its decision not to pursue legal action for non-payment against unemp and not to place liens on a home if that is a patient's only asset are part of its commitm uninsured patients with fairness and respect.

"We believe this commitment is simply the right thing to do," Barbakow said. "We stror that those who have an ability to pay for their health care should do so. But pursuing le collect from unemployed patients or those who truly have no assets other than their hor something Tenet hospitals will do."

Tenet Healthcare Corporation, through its subsidiaries, owns and operates 114 acute car with 27,851 beds and numerous related health care services. Tenet and its subsidiaries approximately 115,000 people serving communities in 16 states. Tenet's name reflects business philosophy: the importance of shared values among partners - including emplo physicians, insurers and communities - in providing a full spectrum of health care. Tene on the World Wide Web at www.tenethealth.com.

# # #

Certain statements in this release may constitute forward-looking statements. They are management's current expectations and could be affected by numerous factors and are various risks and uncertainties. Certain of those risks and uncertainties are discussed in Company's filings with the Securities and Exchange Commission, including the Company report on Form 10-K and quarterly reports on Form 10-Q. Do not rely on any forward-lo statement, as we cannot predict or control many of the factors that ultimately may affec achieve the results estimated. We make no promise to update any forward-looking stat whether as a result of changes in underlying factors, new information, future events or

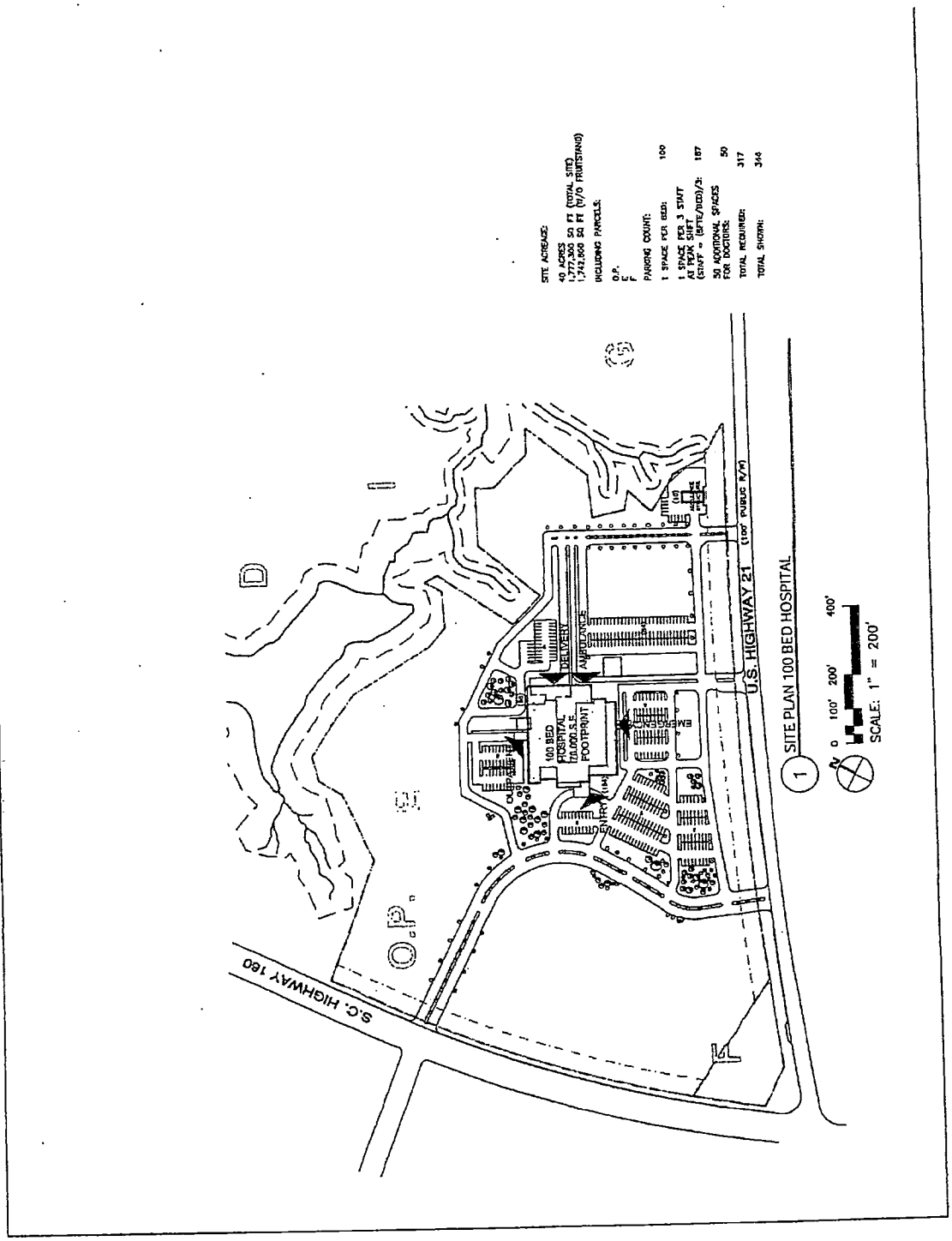
Return to previous page

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ATTACHMENT Q

SITE PLAN



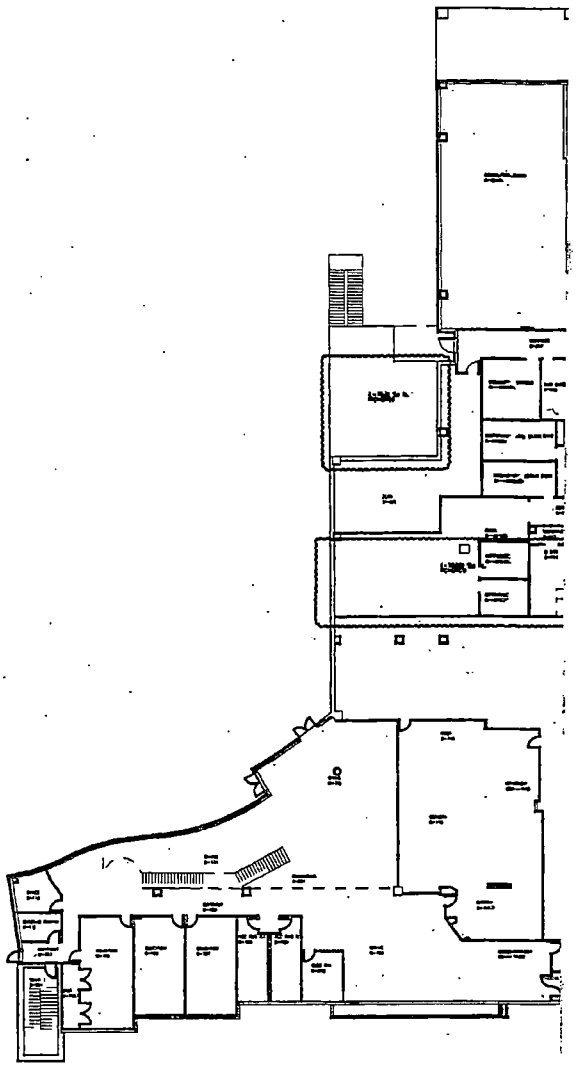
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JOINT-B-PMC-001.0322

RECORD 002506

ATTACHMENT R

SCHEMATIC PLANS (REVISED)



GROUND FLOOR - FLOOR PLAN

8' 0 8' 16' 24'

GS&P

Design Services For The Built Environment

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Columbus
Dallas
Fort Lauderdale
Jackson
Jacksonville
Knoxville
Louisville
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FT. MILL MEDICAL CENTER

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REVISION		
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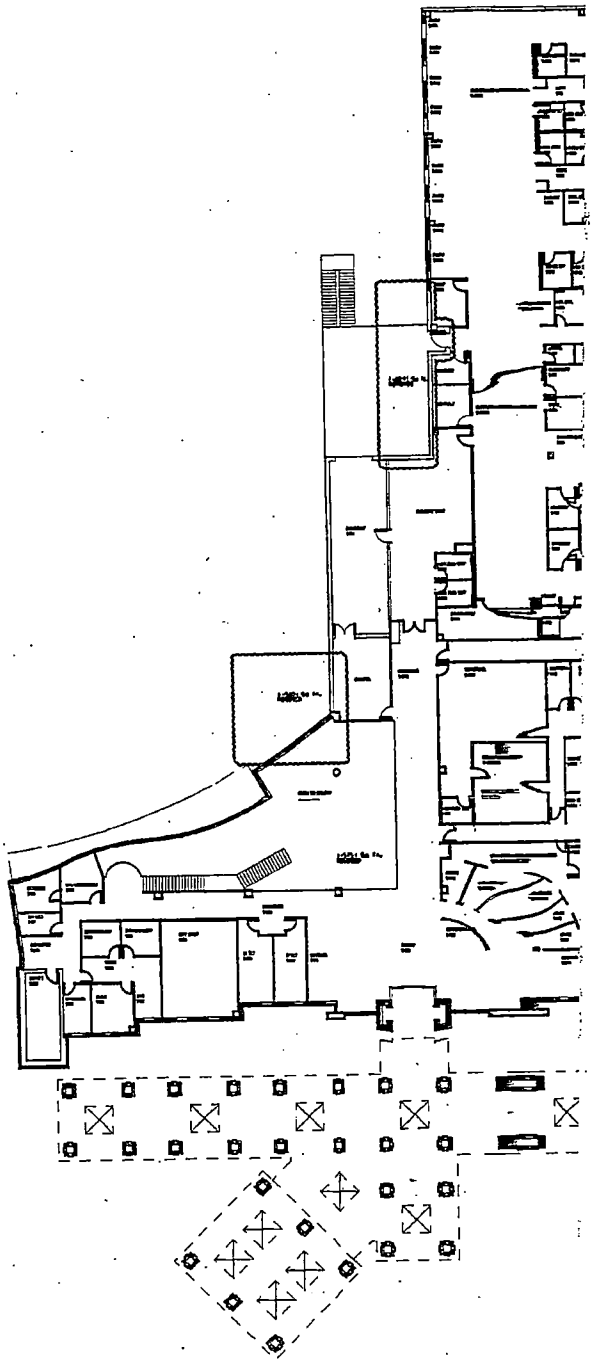
GROUND FLOOR PLAN

A2.0

FILE: 3782AM00.dgn
PROJECT#:
DATE: 9/17/2010

Pied.Supp.CON.0305

JOINT-B-PMC-001.0325



FIRST FLOOR - FLOOR PLAN

8' 0 8' 16' 24'

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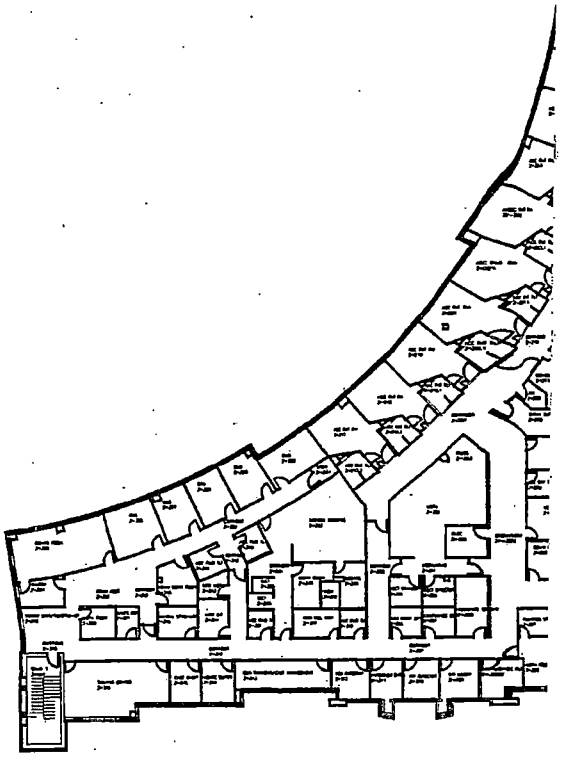
A2.1

FILE: 0702_AM01.dgn
PROJECT:
DATE: 8/17/2010

Pied.Supp.CON.0306

JOINT-B-PMC-001.0326

RECORD 002510



SECOND FLOOR - FLOOR PLAN

8' 0 8' 16' 24'

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No.	Date	Revision

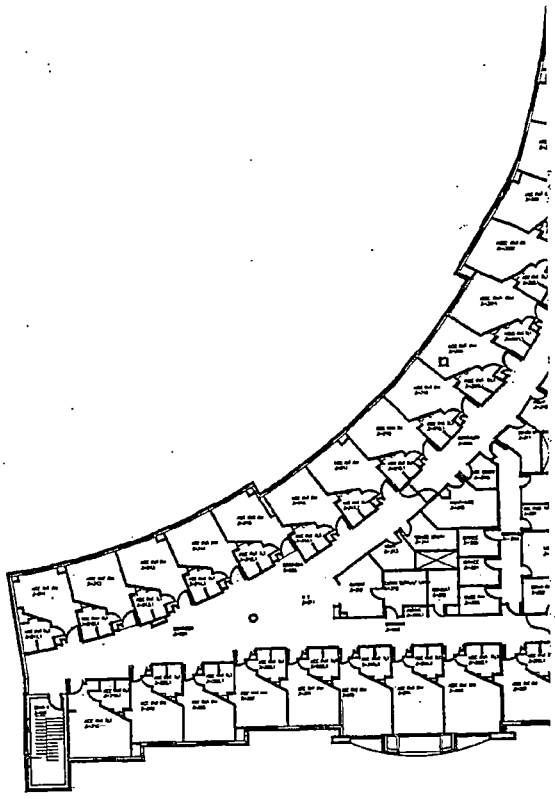
SECOND FLOOR PLAN

A2.2

FILE: 3782AM02.dgn
PROJECT:
DATE: 9/17/2010

Pied.Supp.CON.0307

JOINT-B-PMC-001.0327



THIRD FLOOR - FLOOR PLAN

6' 0 8' 15' 24'

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THIRD FLOOR PLAN

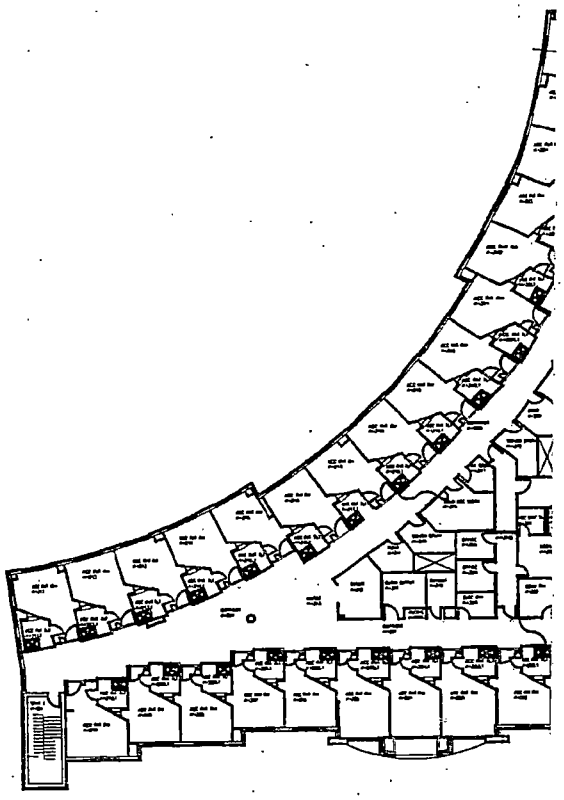
A2.3

FILE 3782_sm03.dgn
PROJECT
DATE 9/17/2010

Pied.Supp.CON.0308

JOINT-B-PMC-001.0328

RECORD 002512



FOURTH FLOOR - FLOOR PLAN

6' 0 8' 16' 24'

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REVISION		
No.	Date	Revision

FOURTH FLOOR PLAN

A2.4

FILE: 6782_AMD4.dgn
PROJECT:
DATE: 9/17/2010

Pied.Supp.CON.0309

JOINT-B-PMC-001.0329

RECORD 002513

EXTRA LARGE MAPS

PAGES 310-314

Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center d/b/a Fort Mill Medical Center

As Per December 9, 2009 Order from Judge Matthews,
Administrative Law Court

Updated Informtation - 10/4/2010
Volume 2 of 2 BS 315 - 421

2

ATTACHMENT S

ZONING

TOWN OF FORT MILL

April 27, 2005

Charles Miller
222 South Herlong Avenue
Rock Hill, SC 29732

Re: Proposed Tenet Healthcare Facility
Hwy 21 and Hwy 160

Dear Mr. Miller:

This letter is to inform you that the Town of Fort Mill completed annexation of the above referenced property on April 18, 2005. The property was annexed into the town limits under the Highway Commercial (HC) zoning designation. This zoning district allows the construction and operation of the hospital facility proposed by Tenet.

We welcome you to the Town of Fort Mill and we will be glad to answer any questions you have. Thank you for your efforts to bring additional healthcare opportunities to our town.

Sincerely,

David E. Hudspeth
Town Manager

P.O. BOX 159 • 112 CONFEDERATE STREET • FORT MILL, SOUTH CAROLINA 29715
TELEPHONE (803) 547-2116 • FAX: (803) 547-2126

ATTACHMENT T

DOCUMENTATION OF UTILITY ACCESSIBILITY FOR THE PROPOSED SITE

YORK COUNTY NATURAL GAS AUTHORITY

979 WEST MAIN STREET
P. O. BOX 11907
ROCK HILL, SOUTH CAROLINA 29731-1907

TELEPHONE (803) 329-5255 FAX (803) 329-0998

December 29, 2004

Mr. Stefan Magura
Piedmont Medical Center
222 S. Herlong Avenue
Rock Hill, South Carolina 29732

Re: Natural Gas Service

Dear Mr. Magura:

York County Natural Gas Authority has the capability and willingness to provide, operate and maintain service to the proposed medical center located at the intersection of Hwy. 160 and Hwy. 21 By-pass in Fort Mill, South Carolina.

If you have any questions, please call me at 803-327-7162.

Sincerely,

Jimmy Sprouse
Business Development Manager

ENGINEERING DEPARTMENT

Post Office Box 148, 6 South Congress Street, York, South Carolina 29745-0148
Tel: (803) 684-8571 • Fax: (803) 684-8596

January 12, 2005

Mr. Charles Miller
Chief Executive Officer
Piedmont Medical Center
222 South Herlong Avenue
Rock Hill, South Carolina 29732

Re: Water/Sewer Availability – Piedmont Hospital Expansion
US Highway 21 at Highway 160 (Northwest Quadrant)

Dear Mr. Miller,

Please be advised that water and sewer service from York County is available in the area of the above referenced project. An engineer or architect must submit plans, specifications, and flow calculations to York County for approval. When the plans are approved, tap fees will be calculated based on the proposed plans.

Prior to the submission of plans and specifications, the engineer or architect must formally submit a request for York County's willingness and capability letter. This letter shall include projected sewer flows for the new facility as per the SCDHEC Regulations (unit contributory loading sheet).

All fees must be paid in full before a commitment to provide service will be issued or construction begins. If you have any questions regarding this subject, please do not hesitate to contact us at (803) 684-8571.

Sincerely,

Thomas A. Bach
Acting County Engineer

cc: Diane Simpson, Assistant County Manager

YORK COUNTY GOVERNMENT CORRESPONDENCE IS PRINTED ON RECYCLED PAPER.

ATTACHMENT U

LETTERS OF SUPPORT

SEE SUPPLEMENTAL LETTER NOTEBOOKS
SUBMITTED WITH APPLICATION

ATTACHMENT V

GOVERNING BOARD APPROVAL

RESOLUTION

I certify that the following resolution was adopted by the Board of Governors of Amisub of South Carolina, Inc., d/b/a Piedmont Medical Center and was enacted in accordance with the bylaws of said Corporation and recorded in its minutes at a meeting of said Board at which a quorum was present on the 30th day of September, 2005.

WHEREAS, there has been presented documentation of the need for the development of a 100-bed hospital to be located in the area known as Fort Mill, SC. The hospital will increase the efficiency of the care delivered in the service area and will increase convenience for patients who would normally receive hospital services outside the defined service area.

WHEREAS, after full discussion, the Board approved the submission of a Certificate of Need Application for the development of a hospital at a cost of approximately $125,000,000.

NOW, THEREFORE, it is hereby:

RESOLVED, that Amisub of South Carolina, Inc., d/b/a Piedmont Medical Center Board of Governors approves the request to submit a Certificate of Need Application as presented by management and hereby directs that said Application be executed on behalf of the Corporation.

IN WITNESS WHEREOF, I have hereunto subscribed my name this 30th day of September, 2005.

Secretary, Board of Governors

ACTION BY WRITTEN CONSENT
OF THE SOLE DIRECTOR
OF
AMISUB OF SOUTH CAROLINA, INC.
a South Carolina corporation

I, Caitlin Larsen, the sole director of Amisub of South Carolina, Inc., a South Carolina corporation (the "Corporation"), doing business as Piedmont Medical Center (the "Hospital"), by my signature below, do hereby adopt the following resolutions effective as of September 29, 2005 by written consent pursuant to the Bylaws of the Corporation and the laws of the State of South Carolina:

WHEREAS, the Corporation has demonstrated a need for the development of a 100-bed hospital to be located in the area known as Fort Mill, South Carolina, at a cost of approximately $125,000,000.; and

IT IS HEREBY RESOLVED, that the Board of Directors of the Corporation approves the request to submit a Certificate of Need Application as presented by management and hereby directs the Application to be executed on behalf of the Corporation.

IN WITNESS WHEREOF, the undersigned has affixed her signature as of September 29, 2005.

Caitlin Larsen, Sole Director

dkj/SC/BdResos/AmiSC

ATTACHMENT W

SUPPORTING INFORMATION

ARTICLES



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Article published February 23, 2010

Tenet's 2009 results best in seven years

By Vince Galloro
Posted: February 23, 2010 - 2:45 pm ET

Tenet Healthcare Corp., Dallas, said 2009 produced its best financial performance in seven years, but cautioned that 2010 would be a transition year typified by higher spending on labor and information technology.

Tenet recorded fourth-quarter profits of $21 million compared with a fourth-quarter loss of $33 million in 2008. Revenue increased 3.9% to $2.26 billion. For the full year, Tenet reported net income of $181 million vs. a profit of $25 million in 2008. Revenue increased 5% to $9.01 billion. Control of labor and supply expenses helped fuel an operating margin of 6% for the full year compared with 3.6% in 2008.

The company plans to spend $70 million on IT capital goods and another $40 million on training in 2010 on electronic health record and computerized physician order-entry systems. Tenet had planned to invest in these systems anyway, but accelerated its timetable to keep up with the deadlines under the healthcare IT provisions of 2009's stimulus law, said Trevor Fetter, Tenet's president and CEO.

Through 2014, Tenet expects to spend a total of $560 million on health IT and to reap $320 million in incentive payments as well as operating efficiencies that it cannot quantify yet, according to a securities filing.

What do you think? Post a comment on this article and share your opinion with other readers. Submit your comments to Modern Healthcare Online at mheditorial@modernhealthcare.com. Please be sure to include your hometown and state, along with your organization and title.



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Article published May 4, 2010

Tenet reports strongest 1Q operating earnings in seven years

By Vince Galloro
Posted: May 4, 2010 - 5:15 pm ET

Tenet Healthcare Corp., Dallas, reported its best operating margin in any quarter in seven years and its best first-quarter operating earnings in that period, as cost control and higher pricing and acuity offset lower volume.

Tenet recorded net income of $88 million for the quarter, compared with $178 million in 2009's first quarter. The year-ago quarter, however, included a $134 million pre-tax gain from the early repayment of debt. Revenue increased 3.4%, to $2.34 billion. Earnings before interest, taxes, depreciation and amortization (EBITDA) were $298 million for the quarter, up 7.2% compared with 2009's first quarter; the EBITDA margin was 12.7%, up from 12.3% a year ago.

Admissions declined 2% and adjusted admissions declined 1.1%, comparing the quarters in both cases, Tenet said. A study of Tenet's market share in several key states found that it was improving slightly in most, with only a small decline in North Carolina, said Steve Newman, chief operating officer.

"We've clearly put all of the cleanup and all of the legacy issues behind us. We're operating the company where we're building volume, getting fair and appropriate pricing and controlling costs," Tenet President and CEO Trevor Fetter said. Volume remains the top challenge, he added.

What do you think?

Share your opinion. Send a letter to the Editor or Post a comment below.

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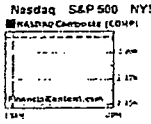
After-Hours Movers 5/24: NBIX, OSIS, NCR, SUNH, DF Higher; CIMT, AIR, DRH, PVH Lower

Trading Radar for 05/25: TiVo (TIVO), AutoZone (AZN), Trina Solar (TSL), Dycom (DY), Danaos (DAC) Report

Unusual 11 Mid-Day Movers 05/24: ODSY, QMM, SEED, CCIX, RPC, GTIV Up; JAV, TRMA, DWA, DDD, HAUP Down

Market Snapshot

Nasdaq S&P 500 NYSE



Nasdaq	2160.05	
-53.50	(-2.42%)	
S&P 500	1049.66	
-23.99	(-2.23%)	
NYSE	6518.46	
-148.28	(-2.22%)	

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Trader Talk

JPMorgan Says Tenet Healthcare (THC) Will See More Favorable Impact from Healthcare Reform; Upgrades to Overweight

May 24, 2010 3:41 PM EDT

Shares of Tenet Healthcare (NYSE: THC) have jumped more than 3.5% today on the heels of a morning upgrade from an analyst at JPMorgan . The firm now rates THC shares an Overweight, up from Neutral previously. JPMorgan also raised its price target on the stock from $7 to $8.

The firm believes that Tenet shares are beginning to look attractive given a 15% sell-off over the last several weeks of trading. JPMorgan feels that Tenet will see a more favorable impact from healthcare reform than others in its sector and further, expanding healthcare coverage to more urban areas will also benefit Tenet.

With shares of Tenet last trading around $5.56 today, the firm's new price target suggests potential upside of about 43% from where the stock is trading.

Tenet Healthcare Corporation , an investor-owned health care services company, operates general hospitals and related health care facilities .

Related Categories

Trader Talk
Upgrades

Stocks Mentioned

THC 5.36
-0.18 -3.25%
Volume: 271,867
Track THC

Related Entities

- JPMorgan

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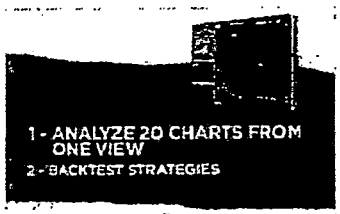
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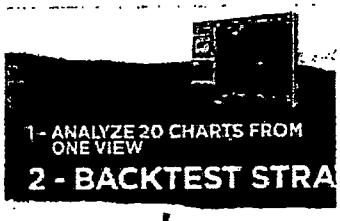


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More News related to THC

- J.P. Morgan Upgrades Tenet Healthcare (THC) to Overweight
- Raymond James Upgrades Tenet Healthcare (THC) to Strong Buy
- Tenet Management to Speak at Bank of America Merrill Lynch Health Care Conference on May 11, 2010
- Tenet Shareholders Elect Nine Directors

More News related to THC



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More News related to Trader Talk

- Allied Irish Banks (AIB) and Bank of Ireland (IRE) Lead Financials Down Pre-Market
- Germany Seeks To Expand Naked Short Selling Ban On All German Stocks

Bloomberg Businessweek
Available on the iPad

THE ASSOCIATED PRESS July 1, 2010, 2:45PM ET

Wells Fargo analyst upgrades Tenet to 'outperform'

INDIANAPOLIS

Hospital operator Tenet Healthcare Corp. may wind up with higher earnings before interest, taxes, depreciation and amortization than both the company and Wall Street expect, according to a Wells Fargo analyst.

THE OPINION: Analyst Gary Lieberman upgraded the Dallas company's stock to "outperform" from "market perform." He said in a research note that California will likely implement provider fees in the second half of this year, and that should generate about $100 million in the financial measure known as EBITDA for Tenet, which is assuming a $30 million benefit.

Lieberman also noted that Tenet shares have dropped 20 percent in the last month, which he attributes at least partially to an overreaction to news that Tenet was considering the acquisition of a large Australian company.

"While we agree that the acquisition would have been misguided, we think that management likely learned a valuable lesson and should focus on growth opportunities that offer clearer accretion potential," Lieberman wrote.

Tenet operates 49 acute care hospitals and 59 outpatient centers in 11 states, mostly in the southeastern United States.

THE STOCK: Down 7 cents, or 1.7 percent, to $4.27 in afternoon trading Thursday.



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Article published August 3, 2010

Tenet reports higher 2Q earnings

By Gregg Blesch
Posted: August 3, 2010 - 9:00 am ET

Tenet Healthcare Corp., Dallas, reported net income of $35 million for the second quarter of 2010, compared with a $14 million loss in the same quarter in 2009.

Tenet President and CEO Trevor Fetter said in a news release that the positive results could be attributed to accomplishing 3.3% growth in operating revenue amid declines in admissions and outpatient visits in the quarter ended June 30. "This progression demonstrates our ability to address the challenges presented by the continuing soft macroeconomic environment to produce meaningful growth in value," Fetter said.

Specifically, the company cites higher acuity among patients with commercial insurance and an improved commercial payer mix. Admissions declined 2% and outpatient visits dipped nearly 1%.

Tenet recorded earnings before interest, taxes, depreciation and amortization (EBITDA) of $268 million, a margin of 11.6% and an increase of 8.9% over the $246 million EBITDA figure tallied in the second quarter of 2009.

Meanwhile, Tenet announced a private placement of $600 million in senior unsecured notes maturing in 2020. Proceeds will pay for a buyback of notes due in 2013.

What do you think?

Share your opinion. Send a letter to the Editor or Post a comment below.

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Tenet Healthcare Ranked Most Cash-Rich Healthcare Facility Company

Written by Rachel Fields | September 10, 2010

More

Tenet Healthcare has been ranked the most cash-rich company in the healthcare facilities industry by Cash Equivalents, a measure that compares the cash cushion of companies in the same industry, according to a *My Smart Trend* report.

Tenet ranked first with CE of $713M, followed by Community Health with CE of $548.75 million, Health Management Associates with CE of $253.03 million, LifePoint Hospitals with CE of $189.7 million and VCA Antech with CE of $193.76 million.

Read the *My Smart Trend* report on the most cash-rich healthcare facilities.

Read more recent news on hospital finance:

-California Insurer PacifiCare Faces $99B In Fines From Regulators

-Study Finds Medical Malpractice Accounts for 24 Percent of Healthcare Spending

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Ambulatory Surgical Centers of America is a leader in surgery center development and turning around failing facilities. Since 1991, its founders have helped physician-owners operate successful facilities. ASCOA currently owns and manages 34 facilities across the country with 14 others in development. For more information, visit www.ascoa.com or call (866) 982-7262.

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Piedmont Medical Center - Fort Mill Service Area

2009

Hospital Name	29704	29707	29708	29710	29715	29717	29726	29730	29732	29742	29743	29745	Grand Total
Piedmont Medical Center	202	78	343	771	755	71	112	3,681	2,636	133	57	1,646	10,485
Piedmont Medical Center	60.5%	8.7%	24.3%	32.1%	34.4%	54.6%	70.4%	71.5%	65.5%	57.8%	42.2%	64.2%	53.4%
North Carolina Hospitals	103	773	1,032	1,586	1,343	31	26	1,286	1,256	41	47	815	8,339
North Carolina Hospitals	30.8%	86.7%	73.2%	66.1%	61.2%	23.8%	16.4%	25.0%	31.2%	17.8%	34.8%	31.8%	42.5%
Subtotal	305	851	1,375	2,357	2,098	102	138	4,967	3,892	174	104	2,461	18,824
Total	334	892	1,410	2,401	2,194	130	159	5,150	4,023	230	135	2,563	19,621
Market Share PMC & NC Providers	91.3%	95.4%	97.5%	98.2%	95.6%	78.5%	86.8%	96.4%	96.7%	75.7%	77.0%	96.0%	95.9%

2017

Hospital Name	29704	29707	29708	29710	29715	29717	29726	29730	29732	29742	29743	29745	Grand Total
Piedmont Medical Center	219	91	409	880	895	79	130	4,166	3,104	146	62	1,865	12,046
Piedmont Medical Center	60.5%	8.7%	24.3%	32.1%	34.4%	54.6%	70.4%	71.5%	65.5%	57.8%	42.2%	64.2%	53.2%
NC Providers	111	901	1,230	1,811	1,592	34	30	1,456	1,479	45	51	924	9,665
NC Providers	30.8%	86.7%	73.2%	66.1%	61.2%	23.8%	16.4%	25.0%	31.2%	17.8%	34.8%	31.8%	42.7%
Proposed NC Provider Fort Mill Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0
Proposed NC Provider Fort Mill Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Subtotal	330	992	1,639	2,692	2,488	113	160	5,622	4,584	190	113	2,789	
Total	361	1,040	1,681	2,742	2,602	144	184	5,829	4,738	252	147	2,904	22,623

2017													
Percent from Piedmont	50%	16%	45%	80%	55%	85%	85%	75%	60%	85%	85%	95%	67%
Percent from NC Providers	50%	85%	55%	20%	45%	15%	15%	25%	40%	15%	15%	5%	33%
Hospital Name	29704	29707	29708	29710	29715	29717	29726	29730	29732	29742	29743	29745	Grand Total
Piedmont Medical Center	158	10	30	757	172	59	108	3,175	2,316	105	45	1,606	8,540
Piedmont Medical Center	48.0%	1.0%	1.8%	28.1%	6.9%	52.1%	67.9%	56.5%	50.5%	55.3%	39.7%	57.6%	37.8%
NC Providers	61	440	749	1,751	963	26	25	1,123	973	33	39	877	7,060
NC Providers	18.3%	44.4%	45.7%	65.1%	38.7%	23.4%	15.9%	20.0%	21.2%	17.4%	34.4%	31.4%	31.2%
Proposed NC Provider Fort Mill Hospital	82	496	820	135	1,244	3	5	1,124	1,146	6	3	195	5,259
Proposed NC Provider Fort Mill Hospital	25.0%	50.0%	50.0%	5.0%	50.0%	3.0%	3.0%	20.0%	25.0%	3.0%	3.0%	7.0%	23.2%
Subtotal	330	992	1,639	2,692	2,488	113	160	5,622	4,584	190	113	2,789	21,711
Total	361	1,040	1,681	2,742	2,602	144	184	5,829	4,738	252	147	2,904	22,623
Impact to PMC (Cases) 2017 with & without	60	81	379	124	723	20	21	991	789	40	17	260	3,505
Contribution Per Case (for CMI < 2.0)	$4,044	$3,915	$3,915	$4,044	$3,915	$4,044	$4,044	$3,915	$3,915	$4,044	$4,044	$4,044	
Total Impact	$243,573	$317,335	$1,483,795	$500,670	$2,831,990	$80,285	$85,677	$3,881,376	$3,087,906	$163,010	$69,094	$1,050,241	$13,794,952

Source: SC Office of Research and Statistics and Polaris.

Note: As ZIP Code 29716 is a post office box, this ZIP Code was combined with 29715.

Similarly, ZIP Code 29703 was combined with 29710, and 29731 & 29733 were combined with 29730.

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YORK COUNTY CONTRACT

SIXTH ADDENDUM TO AGREEMENT
BY AND AMONG
AMERICAN MEDICAL INTERNATIONAL, INC.,
AMISUB OF SOUTH CAROLINA, INC., AND
YORK COUNTY, SOUTH CAROLINA

August 25, 1995

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SIXTH ADDENDUM TO AGREEMENT
BY AND AMONG AMERICAN MEDICAL INTERNATIONAL, INC.,
AMISUB OF SOUTH CAROLINA, INC., AND
YORK COUNTY, SOUTH CAROLINA

THIS SIXTH ADDENDUM TO AGREEMENT made and entered into this 25th day of August, 1995, by and among AMERICAN MEDICAL INTERNATIONAL, INC., a corporation organized under the laws of the State of Delaware (herein referred to as "AMI Parent"), AMISUB OF SOUTH CAROLINA, INC., a corporation organized under the laws of the State of South Carolina (herein referred to as "AMI"), and YORK COUNTY, SOUTH CAROLINA, a political subdivision of the State of South Carolina (herein referred to as "York County"),

W I T N E S S E T H:

WHEREAS, AMI Parent, AMI, the Trustees of York General Hospital and York County entered into an agreement on or about December 8, 1980 (herein referred to as the "Prior Agreement"), pursuant to which the Trustees of York General Hospital and York County leased and sold certain property and assets to AMI Parent and its subsidiary corporation, AMI, for the operation of a hospital in York County, South Carolina; and

WHEREAS, York County has succeeded to all rights and interests and assumed all liabilities of the Trustees of York General Hospital under the Prior Agreement; and

WHEREAS, AMI Parent and AMI constructed and operate a hospital in York County, South Carolina, known as Piedmont

Medical Center (the "Hospital"), pursuant to the terms and conditions of the Prior Agreement; and

WHEREAS, the Prior Agreement has been amended and modified by a First Addendum thereto dated June 16, 1989, a Second Addendum thereto dated April, 1992, a Third Addendum thereto dated April, 1995, a Fourth Addendum thereto dated June, 1995, and a Fifth Addendum thereto dated as of July 1, 1995 (the Prior Agreement, as amended and modified, being referred to herein as the "Agreement"); and

WHEREAS, York County has performed its obligations under the Agreement; and

WHEREAS, in order to induce York County to waive the purchase option granted in the Prior Agreement, as modified by the five prior Addenda thereto, and in order to ensure the continuing provision of high quality, cost effective health care to the citizens of York County without cost to York County, AMI and AMI Parent have proposed to undertake various obligations expanding upon, or in addition to, those contained in Sections 3 and 4 of the Prior Agreement; and

WHEREAS, certain of the provisions of Sections 3 and 4 of the Prior Agreement are no longer applicable, having been satisfied by performance or superseded by the passage of time and changing circumstances;

NOW, THEREFORE, for and in consideration of the premises, the mutual promises contained herein, the sum of ten dollars ($10.00) paid by each party to the other, and of other good and valuable consideration, the receipt, adequacy and sufficiency of which is hereby acknowledged by each party

hereto, the undersigned parties, intending to be legally bound, hereby agree as follows:

Section 1. Sections 3 and 4 of the Agreement are hereby amended to read as follows:

"Section 3. Operation of the Hospital; Ambulance Service, Indigent Care and Related Matters. The parties hereto agree that it is their objective under and through this Agreement to establish and make available to the citizens of York County a secondary/tertiary medical facility serving as a regional medical center for upstate South Carolina. In order to achieve this objective, AMI undertakes the following commitments in connection with the operation of the Hospital and the provision of health care services in York County:

3.1. Hospital Services. (a) General. During the term of this Agreement, AMI shall provide in York County at a minimum (i) all health care services previously provided by the former York General Hospital, (ii) all health care services authorized in the Certificate of Need for the Replacement Hospital and (iii) all other services required to be provided by this Agreement.

(b) New Services and Facilities. In addition to the services and related facilities set forth in 3.1(a), above, and subject to required regulatory approval, the granting of which will be pursued expeditiously in good faith by AMI, AMI agrees to provide the following services and/or complete the following facilities on or before the respective dates set forth below:

(i) Expansion of cardiac services and installation of cardiovascular surgical services including the

construction of two operating suites, perfusion space, anesthesia space, expanded recovery room space, and adequate support and office space at a cost of approximately $3,900,000, to be completed on or about December 31, 1997, or within twenty-four (24) months of receipt of a Certificate of Need therefor.

(ii) A second heart catheterization laboratory at a cost of approximately $1,450,000, to be completed on or about December 31, 1997, or within twenty-four (24) months of receipt of a Certificate of Need therefor.

(iii) Neurosurgical services facilities including adequate operating room(s) and related equipment at a cost of approximately $3,500,000, to be completed on or about July 31, 1998, or within thirty-two (32) months of receipt of a Certificate of Need therefor.

(iv) Intensive care and monitored bed capacity (rooms) adequate to support the development of cardiovascular and neurosurgical services at a cost of approximately $3,800,000, to be completed on or about December 31, 1997, or within twenty-four (24) months of receipt of a Certificate of Need therefor.

(v) A new hospital emergency room with adequate treatment bays to allow for ambulance cases, emergent walk-ins, non-emergent "fast track", and private physician exam space at a cost of

approximately $3,000,000, to be completed on or about April 30, 1997, or within sixteen (16) months of receipt of a Certificate of Need therefor.

(vi) A free-standing psychiatry pavilion for up to twenty-six (26) patients to improve clinical services and provide for outpatient psychiatric programming at a cost of approximately $2,400,000, to be completed on or about April 30, 1997, or within sixteen (16) months of receipt of a Certificate of Need therefor.

(vii) Expansion of the clinical laboratory at a cost of approximately $200,000, to be completed on or about December 31, 1996.

(viii) Complete facility renovations (decor) on 4B nursing unit (39 beds) at a cost of approximately $160,000, to be completed on or about December 31, 1996.

(ix) Equipment (technology) upgrades:

(A) Purchase or lease of a CT scanner at a cost of approximately $860,000, to be acquired on or about February 28, 1996.

(B) Purchase or lease of nurse call system at a cost of approximately $350,000, to be acquired on or about January 31, 1997.

(C) Purchase laboratory hematology analyzer at a cost of approximately $150,000, to be acquired on or about February 28, 1996.

(D) Purchase vascular laboratory ultrasound at a cost of approximately $222,200, to be acquired on or about February 28, 1996.

(c) Emergency Room Service. AMI shall provide at no expense to York County an emergency room sufficiently staffed on a twenty-four hour basis by qualified physicians who will administer emergency medical care. Care to persons with emergency medical conditions will be furnished at Piedmont Medical Center to all parties regardless of their ability to pay or place of residence. AMI will continue the Hospital's current program of providing emergency room services to Winthrop University students. Emergency room physicians and ambulance service staff shall coordinate their respective functions in order to insure the highest quality life-saving skills. For purposes of this Section 3.1(c), the term "emergency medical condition" shall have the meaning ascribed thereto by the Federal Emergency Medical Treatment and Active Labor Act, 42 U.S.C. Section 1395dd and the corresponding regulations thereunder, 42 C.F.R. Section 489.24(b), or any successor statutory and/or regulation provisions, such definition currently being as follows:

Emergency medical condition means-

(i) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in-

(A) Placing the health of the individual(or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part; or

(ii) With respect to a pregnant woman who is having contractions-

(A) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

(ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Such term shall include, at a minimum, those conditions listed in Classes I, II and III of the current Triage Criteria of Piedmont Medical Center attached hereto as Schedule 3.1(c). Each person who comes to the emergency room at the Hospital seeking care shall be afforded an appropriate medical screening to determine whether that person has an emergency medical condition, and each such person shall be classified as to the level of severity of condition in accordance with the Hospital's triage criteria. AMI's agreement to provide emergency care at no cost to York County and without regard to a patient's ability to pay shall not preclude AMI's seeking or obtaining payment or reimbursement from any other source which may be available therefor.

(d) Medical/Surgical Beds. AMI shall maintain at least two hundred forty-eight (248) medical/surgical beds and twenty (20) psychiatric beds at the Hospital. On or before May 31, 1999, all medical/surgical beds in the Hospital shall be in

private rooms. For purposes of this Section 3.1(d), the term "medical/surgical beds" means all licensed beds at the Hospital other than psychiatric, rehabilitation, sub-acute, intensive care or general observation beds. Within one hundred eighty (180) days following any date on which the daily census at the Hospital has averaged eighty-five percent (85%) of the then available bed capacity at the Hospital for a period of twelve (12) months, AMI shall prepare and present to York County an estimate of future medical/surgical bed requirements at the Hospital necessary to comply with the terms of this Agreement. In the event such estimate indicates that patient demand will exceed available bed capacity, such estimate shall be accompanied by a proposal, including a schedule, for the filing of a request for a certificate of need and/or such other action as shall be necessary to provide such bed capacity as shall be shown to be required in such estimate, at the time such estimate shall project such capacity shall be needed.

(e) Pricing. AMI acknowledges that, in addition to the securing of the highest quality health care for the citizens of York County, a major objective of York County in entering into this Agreement is that such care be provided on a cost-effective basis at prices favorably comparable to those paid for similar services provided by comparable acute-care hospitals in the same general geographical area. York County acknowledges that the pricing of, and charging and reimbursement for, health care services and the market therefor and other factors relating thereto, including the reporting thereof, is a complex process and but one of a

number of related major management responsibilities of the governing body of AMI and the administration of the Hospital. Both parties understand that cost-effective, competitive pricing for services provided at the Hospital is essential to the provision of quality health care services to the citizens of York County, to the continuing economic well being of the Hospital and to the ability of AMI to meet its obligations hereunder. AMI agrees to exert every effort to so conduct its operations and finances to maintain prices for services at the Hospital at reasonable, competitive levels vis a vis other hospitals in the "peer group" (as defined in Section 3.13(a)(xii) hereof) for which Medpar pricing information is provided pursuant to such Section 3.13(a)(xii). In the event such pricing information shall show that the average charge per case by the Hospital for "All Product Lines" is the highest in the peer group, AMI shall, within twelve (12) months following the delivery of such information to York County, present to York County, and implement a plan reasonably expected to fix or reduce its costs and/or charges for services such that the average charge per case for All Product Lines at the Hospital will be less than the highest in such peer group. If such average charge remains the highest in the peer group at the end of the second Medpar reporting period following the reporting period which first showed the Hospital's having the highest average charge, AMI shall not increase any charges for services at the Hospital until such time as there have been delivered to York County reports provided pursuant to Section 3.13(a)(xii) hereto which show

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the Hospital's average charge per case for All Product Lines being less than the highest of the peer group.

(f) Trauma Center. AMI agrees to obtain level 3 trauma center designation by July 31, 1996, subject to regulatory approval.

3.2. Ambulance Service. (a) AMI shall provide ambulance service at no expense to York County, which ambulance service shall respond to calls within the geographical limits of York County on a twenty-four hour basis, and which shall furnish transportation by ambulance to any hospital operating within the geographic limits of York County and all counties contiguous to York County. The skill levels of the staff and the equipment of the ambulance service shall be maintained in such a manner as to enable the service to provide "advanced life support" as defined in South Carolina Department of Health and Environmental Control Regulation Number 61-7, Section 306, as amended from time to time, or any successor provision of law or regulation. The principal objective of such service shall be to meet the needs of all citizens of York County rather than the sole needs of AMI or the Hospital. AMI shall operate the service in such a manner so as not to diminish the level of services presently available within York County or as required by this Agreement. The parties hereto understand that York County, in executing this Agreement, does not grant unto AMI an exclusive franchise to operate an ambulance service in York County; York County agrees that it will not grant an exclusive franchise to operate ambulance service in York County to any other person or entity. AMI shall not discontinue, abolish, diminish or

subcontract for ambulance service without the express written approval and consent of the York County Council.

(b) On or before April 1, 1996, AMI shall provide a second ambulance, with appropriate support facilities and staff, in western York County, such ambulance to be based in the City of York. Thereafter, AMI agrees to maintain at least two (2) ambulances based in western York County, staffed to provide advanced life support, twenty-four (24) hours a day, seven (7) days a week. When the population of western York County exceeds 47,500, AMI shall provide an additional quick response vehicle to serve western York County; when such population exceeds 57,500, AMI shall replace such quick response vehicle with an additional ambulance. Thereafter, AMI shall continue to provide an additional quick response vehicle with each population increase of 15,000 persons following the provision of an ambulance, and shall replace such quick response vehicle with an ambulance with each population increase of 10,000 persons following the provision of such quick response vehicle.

(c) AMI agrees to maintain at least four (4) ambulances and one (1) quick response vehicle based in eastern York County (with at least one (1) of such ambulances being based in the Fort Mill area) staffed to provide advanced life support, twenty-four (24) hours a day, seven (7) days a week. When the population of eastern York County exceeds 131,500, AMI shall provide an additional quick response vehicle to serve eastern York County; when such population exceeds 146,500, AMI shall replace such quick response vehicle with an additional ambulance. Thereafter, AMI shall continue to

provide an additional quick response vehicle with each population increase of 20,000 persons following the provision of an ambulance, and shall replace such quick response vehicle with an ambulance with each population increase of 15,000 persons following the provision of such quick response vehicle.

(d) AMI agrees to cooperate and coordinate with York County and the rescue squads operating in York County to determine the most cost effective, response oriented network of emergency medical care in York County to the end of maintaining response times for emergency care as low as possible. AMI agrees to so provide ambulance service such that average annual response times for ambulance service shall not be more than twelve (12) minutes for eastern York County, which shall, for purposes of this response provision include Newport, Bethesda, Oakdale, Tega Cay, Riverview, Flint Hill, Fort Mill and Lesslie Fire Districts and the City of Rock Hill, and not more than twelve (12) minutes for the City of York; not more than eighteen (18) minutes for the Clover/Lake Wylie area, which for purposes of this response provision shall include the Clover and Bethel Fire Districts; and not more than twenty (20) minutes for the western York County area, which for purposes of this response provision shall include the Bethany, Smyrna, Hickory Grove, Bullock Creek, Sharon, and McConnells Fire Districts and that portion of the York Fire District not encompassed within the corporate limits of the City of York, and the remainder of the western York County area. For purposes of this paragraph (d), "response time" means the period of time from receipt of a call by an

AMI operated unit to the arrival on the scene of the emergency by an AMI operated ambulance. Response times shall be established by the records maintained by York County for emergency medical service in the County. In the event any report delivered to York County pursuant to the provisions of Section 3.14(b)(ix) hereof, or other information available to York County, shall show noncompliance with any of the maximum average response times imposed by this paragraph (d), AMI shall, within six (6) months of the delivery of such report, provide York County an action plan to reduce such response time or times to comply with this paragraph (d). AMI shall implement such plan and shall so modify and/or operate its emergency response system such that monthly average response times shall meet the time limitations of this paragraph (d) not later than the end of the sixth (6th) month following delivery of such plan.

(e) For purposes of establishing population levels pursuant to this Section 3.2, the term "eastern York County" shall mean the geographical areas of York County so designated on the map appearing as Schedule 3.2(e)(1) attached hereto as lying on the eastern side of a line passing through York County at 81 degrees, 10 minutes west longitude, and the term "western York County" shall mean the geographical areas of York County so designated on the map appearing as Schedule 3.2(e)(1) attached hereto as lying on the western side of a line passing through York County at 81 degrees, 10 minutes west longitude. Response times for ambulance service pursuant to this Section 3.2 shall be as defined in Section 3.2(d) above and the respective geographical areas of York County for

which response times are designated under this Section 3.2 shall mean the geographical areas of York County so designated on the map appearing as Schedule 3.2(e)(2) attached hereto.

3.3. Indigent Care; Indigent Assistance Program. (a) During the twelve-month period ending May 31, 1996, AMI shall provide, at no cost to York County, medical care at Piedmont Medical Center to indigent residents of York County in an amount (based on AMI's schedule of rates and charges in effect from time to time) not less than Four Hundred Seventy-Five Thousand Dollars ($475,000). Thereafter, adjustments to such amount shall be made at the end of the initial twelve-month period and each subsequent twelve-month period (the "Adjustment Date(s)") as follows:

(i) The index used for computing the adjustment is the "Market Basket Index" as defined in Section 44-6-5, Code of Laws of South Carolina, 1976, as from time to time amended, or any successor or replacement provision of law, currently defined as the index used by the federal government on January 1, 1986, to measure the inflation in hospital inpatient prices for Medicare reimbursement. If the Market Basket Index ceases to be calculated in substantially the same manner, a similar Market Basket Index or some similar index must be developed by the parties using substantially the same methodology as used by the federal government in calculating the Market Basket Index to measure inflation in hospital inpatient prices for Medicare reimbursement, and such substantially similar index shall be used by the

parties thereafter in the administration of this Agreement.

(ii) The percentage for the adjustment at the end of the initial twelve-month period shall be determined by dividing the Market Basket Index for the date nearest the initial Adjustment Date by the Market Basket Index for July 1, 1995. The percentage for the Adjustment at the end of each subsequent twelve-month period shall be determined by dividing the Market Basket Index for the date nearest the current Adjustment Date by the Market Basket Index for the immediately preceding Adjustment Date.

(iii) The initial adjustment shall be computed by multiplying the sum of Four Hundred Seventy-Five Thousand Dollars ($475,000) by the percentage determined pursuant to (ii), above. This adjustment and each subsequent adjustment shall produce an adjusted amount which shall continue until the next Adjustment Date. Each subsequent adjustment shall be computed by multiplying the adjusted amount for the immediately preceding twelve-month period by the percentage determined pursuant to (ii), above, for the current Adjustment Date.

The calculations required by this paragraph (a) shall be made by AMI and, absent manifest error, shall be binding on the parties hereto. York County may audit such information for compliance with the terms and provisions of this Agreement. The provisions of this paragraph (a) shall not limit AMI's obligation to provide emergency care to indigent persons at Piedmont Medical Center, notwithstanding that the minimum

dollar amount of indigent care services required by this paragraph (a) shall~~,~~ at any time, have been equaled or exceeded by AMI.

(b) AMI agrees to assume responsibility for payment of any amounts otherwise payable by York County to, or with respect to, the South Carolina Health and Human Services Finance Commission Medically Indigent Assistance Program, or any successor agency or program. AMI agrees, subject to any necessary governmental or regulatory approval, to serve, without cost to York County, as the designee of York County in connection with the administration of, and the making of payments to, such Program. In the administration of such Program, AMI shall comply with all applicable statutes and regulations relating thereto. AMI's obligation to fund and administer such Program shall continue only for so long as York County, absent the provisions of this paragraph (b), would otherwise be required to participate in, or make payments to, such Program. York County agrees to cooperate with AMI in order to ensure that payments by AMI under this paragraph (b) shall be no greater than payments otherwise required to be made by York County absent the provisions hereof.

(c) For purposes of this Agreement, the term "indigent" shall have the same meaning as the term "medically indigent" in Section 44-6-5(5), Code of Laws of South Carolina, 1976, as from time to time amended and the regulations relating to financial eligibility for the South Carolina Medically Indigent Assistance Program, including, particularly, Regulation Section 126-520,and any replacement or successor

provisions of the law or regulations, currently defined as meaning that such persons must meet all requirements for eligibility for assistance under the South Carolina Medically Indigent Assistance Program under regulations promulgated by the State Health and Human Services Finance Commission, Article 5, Subarticle 1, Regulations 126-500 through 126-520, and such persons must, at a minimum be:

(i) persons whose gross family income and size falls at or below the Federal Community Service Administration Guidelines and who meet certain qualifying criteria regarding real property allowance, qualifying services, residency requirements, and other sponsorship, and migrant or seasonal farmworkers who have no established domicile in any state for purposes of the State Medically Indigent Assistance Program; and

(ii) persons whose gross family income and size falls between one hundred (100) percent and two hundred (200) percent of the Community Service Administration Guidelines who meet certain other qualifying criteria regarding real property allowance, qualifying services, residency requirements and other sponsorship and whose medical bill is sufficiently large in relation to their income and resource to preclude full payment, so as to qualify for assistance under the South Carolina Medically Indigent Assistance Program. For purposes of this definition, the qualifying criteria for real property allowance shall permit ownership of up to fifty acres of farmland upon which the family has resided for at least twenty-five (25) years; and

(iii) persons who qualify for assistance through the South Carolina Medically Indigent Assistance Program under the non-financial eligibility requirements of Regulation 126-515 promulgated by the South Carolina Health and Human Services finance Commission; and

(iv) persons who qualify for assistance through the South Carolina Medically Indigent Assistance Program under the financial eligibility requirements of Regulation 126-520 promulgated by the South Carolina Health and Human Services Finance Commission.

(d) Any resident of York County who believes that he or she has been charged for medical services by AMI based upon an incorrect determination that such person is not indigent shall be entitled to have such determination reviewed by AMI and, following such review, shall be provided by AMI a written determination as to such person's qualification, or not, as "indigent", which determination shall advise the recipient thereof of his or her rights of appeal hereunder. Any person wishing to dispute any such written determination as to indigence with respect to the services required to be provided by AMI pursuant to subsection (a) of this Section 3.3, may, within thirty (30) days of the receipt thereof, but not after, seek further review of such determination by written request to the York County Community Health Board (or if such Board has been dissolved or merged into any other entity, to the Advisory Board established pursuant to Section 3.10 hereof) (the "Board"). Such request for review shall be accompanied by the written determination provided such person and by a written summary of the reasons why the person seeking review

believes that AMI's determination is incorrect. The Board shall provide AMI a copy of any request for review within five (5) business days of receipt thereof by the Board. AMI shall be entitled to provide the Board, in writing, with a response to any such request for review, including therewith such additional information or rebuttal as AMI feels appropriate. Not less than thirty (30) days following the receipt of a request for review hereunder, the Board shall provide AMI and the person seeking review a written determination as to such matter, either confirming or reversing the prior AMI determination as to indigence. A copy of such determination shall also be provided to York County. In connection with its review, the Board may, but shall not be required to, seek additional information, interview persons or conduct hearings in order to assist it in reaching a fair and accurate determination. AMI agrees to cooperate in any such fact finding efforts, and agrees to be bound by the determination of the Board. Pending the outcome of any review and/or appeal process hereunder, AMI shall suspend any and all actions with respect to the billing or collection of any amounts charged with respect to services provided to, or for the account of, the person seeking such review and/or appeal.

(e) Appeals with respect to determinations as to financial eligibility under the Medically Indigent Assistance Program shall be processed by AMI in accordance with South Carolina Code Regulation Section 126-510, as amended, or any replacement or successor provision of law or regulations. Copies of determinations by AMI as to the ineligibility of any person for such Program shall be provided to York County.

3.4. Medical Care for County Prisoners and Inmates.

(a) To the extent requested by York County, AMI shall provide inpatient and outpatient medical services to prisoners and inmates of the York County Prison and Detention Center (the "Detention Center") at a cost equal to the lesser of

(i) the least amount charged by AMI for services under any contract for managed care to which AMI is, at the time of the provision of such services, a party, or

(ii) AMI's cost of providing such services plus ten percent (10%) of such cost.

For purposes of this paragraph (a), "cost" shall be determined by utilizing the latest state-reported Medicaid cost-to-charge ratio as published by the South Carolina Health and Human Services Finance Commission.

(b) In order to assist York County in reducing its costs of operating the Detention Center, AMI agrees that it will, at the written request of York County, from time to time, sell to York County medical supplies for use at the Detention Center at AMI's cost if and to the extent permitted by law.

(c) AMI shall provide supervisory support to the staff of the Detention Center through the medical director of AMI's western York County urgent care center at no cost to York County.

3.5. Rural Healthcare Clinics. On or before December 31, 1996, AMI shall establish an urgent care/occupational medicine facility in western York County, subject to regulatory approval. Such facility shall provide urgent care for minor emergencies, occupational medicine, including physical examinations, occupational testing/screenings, care

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for on-the-job injuries and other similar health care services. Such facility shall be open and staffed between the hours of 8:00 a.m. and 8:00 p.m., seven (7) days a week, with staffing being provided by not less than two (2) licensed physicians (at least one (1) of whom shall be at the facility during all operating hours) and adequate support staff. In order to ensure responsiveness to community needs by this facility, there shall be established an advisory committee comprised of one (1) member of York County Council, three (3) residents of York County Council Districts 2 and/or 3 (as constituted on the date of delivery of this Sixth Addendum) appointed by AMI from a list of not less than five (5) nominees named by York County Council and one (1) representative of AMI. Such committee shall meet no less often than quarterly to discuss the need for services in western York County, the manner in which the western York County urgent care facility is meeting such needs and any changes which might be necessary or advisable with respect to the types of services provided or the manner in which services are provided in order to better meet the needs of the residents of western York County. AMI agrees to take into consideration any recommendations or requests made by the advisory committee in connection with its operation of the urgent care facility and its planning with respect thereto and provide a timely written response to any such recommendation or request.

3.6. Integrated Health Care Delivery System. In order to better provide for the health care needs of the citizens of York County and to maintain competitiveness in a managed care

environment, AMI shall continue to expand the vertical integration of services into its health care delivery system, including such possible services as primary care, home care, ambulatory diagnostics, pain management, rehabilitation and occupational medicine, and the expansion of York Family Medicine in the Town of York to enable the rotation of specialists and sub-specialists in western York County.

3.7. Reinvestment in York County Medical Services. AMI agrees that in the period beginning June 1, 1995, and ending May 31, 1998, it will make investments in land or depreciable or amortizable property located in York County, South Carolina, in an aggregate amount not less than Twenty-Three Million ($23,000,000) Dollars, provided that in the event AMI shall be relieved from the obligation to provide any facility or service described in Section 3.1(b) hereof as a result of the inability to obtain any regulatory approval required therefor, such amount shall be reduced by the estimated cost of such facility or service as set forth in said Section 3.1(b). Thereafter, in each period of twelve (12) months beginning June 1 of a year and ending on May 31 of the next succeeding year, beginning with the twelve-month period starting June 1, 1998, it will invest in land or depreciable or amortizable property located in York County, South Carolina, used for the purpose of providing the services required by this Agreement, an amount which, when added to the amount so invested by AMI in the preceding two (2) such twelve (12) month periods, would make the average thereof equal to or greater than the greater of (i) $4,000,000 or, (ii) one hundred eight percent (108%) of the average of the amounts

shown on the financial statements of AMI as depreciation or amortization for property, plant and equipment located in York County for the preceding three (3) such twelve (12) month periods, provided that in no such twelve (12) month period shall the amount actually so invested be less than $1,500,000. Notwithstanding the foregoing, in the event AMI's earnings before depreciation and amortization, as shown in the financial statements of AMI for the twelve (12) month period in question, are less than $4,000,000, the amount required to be reinvested as herein provided during such period shall not exceed an amount equal to fifty percent (50%) of such earnings before depreciation and amortization. Accounting terms used in this Section 3.7 shall be given meaning and applied in accordance with generally accepted accounting principals; depreciation and amortization shall be determined in accordance with American Hospital Association or some other nationally recognized standard therefor.

3.8. Physician Recruitment and Retention; Medical Staff; Staff Privileges. (a) AMI recognizes that, in order to effectively perform its obligations hereunder, the recruitment and retention of qualified physicians is critical. In order to ensure the provision of the highest quality services and the range of services necessary to establish the Hospital as a regional medical center for upstate South Carolina, AMI will diligently pursue the identification and recruitment of qualified physicians and in connection with such recruitment and the relocation and retention of such physicians will provide such economic and other incentives and support as is

consistent with federal and state regulations relating to such matters.

(b) AMI shall at all times establish and maintain policies with respect to medical staff privileges at the Hospital encouraging and enabling any and all qualified, appropriately licensed physicians (i.e. individuals with an M.D. or D.O. degree), dentists and podiatrists to join the active or courtesy medical staff of the Hospital without restriction; provided that AMI may enter into exclusive contracts for Hospital-based services for radiology, anesthesiology, pathology, neonatology, cardiovascular surgery, neurosurgery and emergency medicine.

3.9. Local Hospital Board. (a) AMI covenants and agrees that on or before December 31, 1995, the Rules and Regulations of the Governing Board of Piedmont Medical Center (the "Rules and Regulations") shall be amended in the following respects:

(i) The first paragraph of Article II thereof relating to the Roles and Responsibilities of the Governing Board of the Hospital (the "Governing Board") shall be amended to read as follows:

> "The governing board has the authority and responsibility for ensuring proper organization of the institution's Medical Staff and for monitoring the quality of care provided under the auspices of the institution. The governing board is responsible for the assurance of quality patient care provided by the institution (including the provision of adequate and appropriate staffing, monitoring and reviewing replacement hospital

equipment, and recommendations for changing services, procedures, and product lines to take into account medical and technological developments and advancements; establishing mechanisms to assure and achieve and maintain high quality medical practice and patient care; and periodic review and recommendations concerning pricing for institution services, procedures, and product lines)."

(ii) Section 1 of Article III of the Rules and Regulations relating to the composition of the governing Board shall be amended to provide that, of the voting membership of the Governing Board, one of such members shall be a resident of western York County and another of such members shall be selected from a list of not less than three (3) nominees submitted by York County Council.

(b) AMI and AMI Parent covenant and agree that no changes (whether initiated by AMI, AMI Parent, the Governing Board or any other person) shall be made to the Rules and Regulations which have the effect of diluting or eroding the role, powers, authority, responsibilities, functions or duties of the Governing Board from those in existence as of July 31, 1995, as modified as hereinabove provided, without the prior written approval of York County, which approval, York County agrees, will not be unreasonably withheld.

(c) AMI and AMI Parent further covenant and agree in connection with the Governing Board that no removal of fifty percent (50%) or more of the members of the Governing Board within a six (6) month period shall be effected, unless prior thereto any such proposed removal shall have been discussed

directly between the President and Chief Operating Officer of Tenet and the Chairman of York County Council. The Chairman and Vice Chairman of York County Council shall be invited to attend any meeting of the Board of Directors of AMI at which any such removal was to be considered or acted upon. Any such meeting shall be held at a location in York County, South Carolina, with sufficient notice so as to provide reasonable opportunity for the Chairman and Vice Chairman at York County Council to be in attendance at such meetings. In the event of any such removal, the positions of any Governing Board members removed pursuant to any such action shall be filled within three (3) months following the date of any such removal.

3.10. Hospital Advisory Board. AMI shall maintain a board of hospital advisors (the "Advisory Board") consisting of twelve members. Four members of the Advisory Board shall be representatives of the medical staff of Piedmont Medical Center, four members of the Advisory Board shall be representatives of the community and four members of the Advisory Board shall be representatives of AMI. The medical staff representatives shall be the Chief of Staff, the Vice Chief of Staff, the Immediate Past Chief of Staff and the Secretary-Treasurer of the medical staff of the Hospital. The four AMI representatives shall be selected by AMI and shall include the chief executive officer of Piedmont Medical Center. The four community representatives shall be selected by York County Council. All members of the Advisory Board shall serve staggered terms of four years. The Advisory Board shall establish its own rules of operation and procedure. The purpose of the Advisory Board shall be to insure that AMI is

continuously apprised of community interest and to provide the appropriate interface between the Hospital and the York County community.

3.11. AMI Scholarship Program. In each year during the term of this Agreement, there shall be awarded by AMI contributions for medical scholarships for York County residents which shall be used for the pursuit of education in a field which shall be related to medical care. For the fiscal year ending May 31, 1996, the amount to be awarded shall be Twenty Thousand Dollars ($20,000). Thereafter, adjustments to such amount shall be made at the end of the initial twelve-month period and each subsequent twelve-month period (the "Adjustment Data(s)") as follows:

(i) The index used for computing the adjustment is the Consumer Price Index for All Urban Consumers published by the U.S. Department of Labor, Bureau of Labor Statistics (the "CPI").

(ii) The percentage for the adjustment at the end of the initial twelve-month period shall be determined by dividing the CPI for the date nearest the initial Adjustment Date by the CPI for June 1, 1996. The percentage for the Adjustment at the end of each subsequent twelve-month period shall be determined by dividing the CPI for the date nearest the current Adjustment Date by the CPI for the immediately preceding Adjustment Date.

(iii) The initial adjustment shall be computed by multiplying the sum of Twenty Thousand Dollars ($20,000) by the percentage determined pursuant to (ii), above.

This adjustment and each subsequent adjustment shall produce an adjusted amount which shall continue until the next Adjustment Date. Each subsequent adjustment shall be computed by multiplying the adjusted amount for the immediately preceding twelve-month period by the percentage determined pursuant to (ii), above, for the current Adjustment Date.

The calculations required by this Section 3.11 shall be made by AMI and, absent manifest error, shall be binding on the parties hereto.

3.12. Continuing Education. AMI shall continue and further the health care educational opportunities and programs of York General Hospital, which programs shall include, but not be limited to the following:

(a) York Technical College Programs. AMI will participate in the following medically-related programs currently offered by York Technical College:

(i) Medical Lab Technology:

(ii) Nursing (Associate Degree);

(iii) Operating Room Technician;

(iv) Radiologic Technology.

(b) Winthrop University Programs. AMI will continue to support and participate in the dietician and medical social services programs offered by Winthrop University.

(c) AMI Programs. AMI will provide programs for the continued improvement in educational and skill levels of its employees. To this end, AMI will

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offer a variety of activities ranging from in-house seminars to programs of formal education presented by major universities. AMI will also provide programs of management training for hospital personnel, including administrators, directors of nursing, business office managers, and other hospital department heads.

3.13. Annual Report; Other Information. (a) On or before October 1 of each year beginning October 1, 1996, AMI shall provide to York County an annual report on the status of the Hospital, the state of its operations, its plans for the future, and its activities and progress in relation to its various undertakings pursuant to this Agreement. Such report shall include the following information:

(i) Annual financial statements of AMI for the fiscal year ending the preceding May 31, with a certificate as to the accuracy thereof by an officer of AMI Parent;

(ii) Actual depreciation on Hospital assets as reported to the Federal government in Medicare cost reports;

(iii) Calculations showing the amount required to be invested pursuant to Section 3.7 hereof and identified investments equalling or exceeding such amount;

(iv) Information concerning the number and nature of services provided to York County indigents and the cost of such services, and the amount of any payment to the Medically Indigent Care Program pursuant to Section 3.3 hereof;

(v) Services, administrative assistance and supplies provided in connection with the Detention Center pursuant to Section 3.4 hereof;

(vi) In addition to the information provided pursuant to (iii), above, a descriptive list of all equipment purchases for items having a cost basis in excess of $250,000;

(vii) Information relating to the number of patients served and the nature, level and scope of services provided in the Hospital emergency room;

(viii) Information as to physician recruitment activity;

(ix) Detailed information with respect to ambulance response times showing annual averages for each location;

(x) Information concerning the number of full-time employees at the Hospital for the preceding fiscal year;

(xi) Medicaid in-patient cost-charge ratios and Medicaid out-patient cost-charge ratios as reported to the South Carolina State Health and Human Services Finance Commission, division of Acute Care Reimbursement, annually;

(xii) The most recently reported Medpar information, summarized and shown on a comparative basis, on gross charges for cardiology, gynecology, medicine, neurology, oncology, orthopedics, psychiatry, pulmonary, surgery, urology, vascular surgery and all product lines, from the Medpar national data base with respect to a "peer group" comprising the Hospital and the following hospitals: Richland Memorial Hospital-Columbia, S.C., Carolinas

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Medical Center-Charlotte, N.C., Providence Hospital-Columbia, S.C., Baptist Medical Center-Columbia, S.C., Spartanburg Regional Medical Center-Spartanburg, S. C., Mercy Hospital-Charlotte, N.C., Gaston Memorial Hospital-Gastonia, N.C., Presbyterian Hospital-Charlotte, N.C., and Mary Black Memorial Hospital-Spartanburg, S. C.;

(xiv) Information concerning number and type of beds at the Hospital for the preceding fiscal year;

(xv) Information as to contributions for medical scholarships and activities with respect to medical education during the prior fiscal year;

(xvi) The summary results of any community or physician surveys conducted by AMI with respect to the Hospital or any services provided by AMI hereunder;

(xvii) A copy of the most recently issued Medically Indigent Assistance Fund Annual Guidelines and Annual Report;

(xviii) The status of any matter required to be addressed hereunder by way of an action plan or remedial action to achieve compliance with any of the terms hereof;

(xix) The filing by or against AMI, AMI Parent or Tenet of any bankruptcy, insolvency or similar or related action under any state or federal bankruptcy law; and

(xx) The loss of any license permit or other regulatory or other approval relating to the operation of the Hospital or the provision of any services hereunder or the filing or pendency of any action by any health

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care regulatory agency with respect to AMI, the Hospital or any service provided by AMI hereunder.

(b) AMI agrees to provide such other information as York County or the Advisory Board may from time to time reasonably request in order to verify information provided by AMI in order to determine compliance hereunder by AMI and enable them to meet their respective obligations hereunder or in connection herewith. York County agrees to notify AMI promptly of any request it receives for copies of information provided to York County or the Advisory Board pursuant to the provisions of this Section 3.13.

Section 3.14. Right of First Refusal; Assumption of Agreement by Successors. (a) Subject to the terms and conditions contained in this Section 3.14, York County is hereby granted a right of first refusal to purchase the Hospital. Except as provided in paragraph (b) hereof, in the event that an agreement for the sale of more than an eighty percent (80%) interest in (i) the Hospital or (ii) the voting securities of AMI, has, subject only to the provisions of this Section 3.14, been entered into, written notice thereof shall be provided to York County. Such notice shall set forth the identity of the proposed purchaser, the interest proposed to be conveyed and the consideration, or, if the consideration is other than cash, the fair market value of the consideration, allocable to the Hospital in the proposed transaction. York County shall have forty-five (45) days following receipt of such notice to notify AMI of its election to exercise the right of first refusal herein granted. Notice of exercise of the right of first refusal shall be accompanied by a non-

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pay to the Trustee and fees and expenses of the appraiser nominated by it, and each shall pay one-half of the fees and expenses of any additional appraiser or appraisers and one-half of all other costs and expenses incurred in connection with each additional appraisal.

4.4. Term of Agreement. Unless extended by written agreement of the parties hereto, this Agreement shall expire on July 1, 2045."

Section 2. Section 16.4 of the Agreement is hereby amended to delete therefrom the reference to, and address of, the "Trustees of the Hospital" and to substitute the following addresses for AMI and AMI Parent and York County:

If to AMI or AMI Parent, addressed to:

Piedmont Healthcare System
c/o President
222 S. Herlong Avenue
Rock Hill, South Carolina 29732

Tenet Healthcare Corporation
c/o Vice President for Southeast Region
1000 Abernathy Road
Building 400, Suite 1110
Atlanta, Georgia 30328

Tenet Healthcare Corporation
c/o Executive Vice President, Eastern Division
14001 Dallas Parkway
Suite 200
P. O. Box 809088
Dallas, Texas 75380-9088

If to York County, addressed to:

York County, South Carolina
c/o County Manager
P. O. Box 66
York, South Carolina 29745

Section 3. The options to purchase various assets contained in Section 14 of the Prior Agreement and the First and Second Addenda thereto, as modified and amended by the

SEVENTH ADDENDUM TO AGREEMENT BY AND AMONG TENET HEALTHCARE CORPORATION, AMISUB OF SOUTH CAROLINA, INC., AND YORK COUNTY, SOUTH CAROLINA

THIS SEVENTH ADDENDUM TO AGREEMENT made and entered into this 5th day of October, 2000, by and among TENET HEALTHCARE CORPORATION (formed as the result of a merger between American Medical International, Inc., and National Medical Enterprises, Inc.), a corporation organized under the laws of the State of Delaware (herein referred to as "AMISUB Parent"), AMISUB OF SOUTH CAROLINA, INC., (herein referred to as "AMISUB"), and YORK COUNTY, SOUTH CAROLINA, a political subdivision of the State of South Carolina (herein referred to as "York County"),

WITNESSETH:

WHEREAS, AMISUB Parent, AMISUB, the Trustees of York General Hospital and York County entered into an Agreement on or about December 9, 1980 (herein referred to as the "Prior Agreement") pursuant to which the Trustees of York General Hospital and York County leased and sold certain property and assets to AMISUB Parent and its subsidiary corporation, AMISUB, for the operation of a hospital in York County, South Carolina: and

WHEREAS, York County has succeeded to all rights and interests and assumed all liabilities of the Trustees of York General Hospital under the Prior Agreement; and

WHEREAS, AMISUB Parent and AMISUB constructed and operate a hospital in York County, South Carolina, known as Piedmont Medical Center (the "Hospital"), pursuant to the terms and conditions of the Prior Agreement; and

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WHEREAS, the Prior Agreement has been amended and modified by a First Addendum thereto dated June 15, 1989, a Second Addendum thereto dated April 1992, a Third Addendum thereto dated April, 1995, a Fourth Addendum thereto dated June, 1995, a Fifth Addendum thereto dated as of July 1, 1995, and a Sixth Addendum thereto dated August 25, 1995, (the Prior Agreement, as amended and modified, being referred to herein as the "Agreement"); and

WHEREAS, AMISUB and AMISUB Parent desire to amend the Prior Agreement, as amended and modified, in order to improve the quality of health care provided at the Hospital; and

WHEREAS, the parties have determined that the Prior Agreement, as amended and modified, should be further amended in the particulars and on the terms and conditions stated in this Seventh Addendum to the Agreement in order to serve the public interest, improve the quality of health care rendered at the Hospital and address emerging medical needs and changing circumstances in York County;

NOW, THEREFORE, for and in consideration of the premises, the mutual promises contained herein the sum of Ten Dollars ($10.00) paid by each party to the other and of other good and valuable consideration, the receipt, adequacy and sufficiency of which is hereby acknowledged by each party, the undersigned parties, intending to be legally bound, hereby agree as follows:

1. Section 3.1 (b)(vi) of the Agreement is hereby deleted.

2. Section 3.1 (b)(vii) of the Agreement is hereby amended to read as follows:
(b)(vii) - Renovation of the clinical laboratory at a cost of approximately Two Hundred Thousand Dollars ($200,000) to begin on or about January 1, 2002.

3. Section 3.1 (d) of the Agreement is hereby amended to read as follows:
(d) - Medical/surgical beds, AMISUB shall maintain, upon completion of the project described herein, at least two hundred ten (210) private and

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sixteen (16) semi-private medical/surgical beds and twenty (20) psychiatric beds at the Hospital. On or before December 31, 2002, or no later than twelve (12) months after completion of the Women's Tower as provided in paragraph 4 (x), complete renovations to the original hospital structure to create 166 private medical/surgical beds. Additionally, the Women's Tower will provide for the ability to add additional 28 private rooms that can be built out as demand dictates. For purposes of this Section 3.1 (d), the term "medical/surgical beds: means licensed beds at the Hospital other than psychiatric, rehabilitation, sub-acute, intensive care or general observation beds. Within on hundred eighty (180) days following any date on which the daily census at the Hospital has averaged eighty-five percent (85%) of the then available bed capacity at the Hospital for a period of twelve (12) months, AMISUB shall prepare and present to York County an estimate of future medical/surgical bed requirements at the Hospital necessary to comply with the terms of this Agreement. In the event such estimate indicates that patient demand will exceed available bed capacity, such estimate shall be accompanied by a proposal, including a schedule, for the filing of a request for a Certificate of Need and/or other such action as shall be necessary to provide such bed capacity as shall be shown to be required in such estimate, at the time such estimate shall project such capacity shall be needed.

4. Section 3.1 (b) of the Agreement is hereby amended by adding the following new subsection (x), relating to additional new projects not encompassed in the Hospital Agreement:

(x) – Complete construction of a new forty-four (44) bed women's tower at an estimated cost of Thirty-Four Million, Five Hundred Thousand Dollars ($34,500,000), which includes costs of renovating to private rooms with an estimated completion date of December 31, 2002, or within thirty-six (36) months of receipt of a Certificate of need, subject to regulatory approval.

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5. Section 3.10 of the Agreement is hereby deleted.

6. AMISUB Parent hereby jointly and severally guarantees all representations, warranties, agreements, covenants and obligations of AMISUB contained in this Seventh Addendum.

7. Except as herein modified, the Agreement is hereby ratified and confirmed.

8. Capitalized terms not otherwise defined in this Seventh Addendum shall have the meaning assigned thereto in the Agreement, if defined therein.

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IN WITNESS WHEREOF, the undersigned parties have caused this Seventh Addendum to Agreement to be executed under seal as of the date first above written.

TENET HEALTHCARE CORPORATION

BY: _____

Title: VP - Operations Southern States Region

Attest: _____

Title: Assistant Secretary - CCO

AMISUB OF SOUTH CAROLINA, INC.

BY: _____

Title: CEO

Attest: Elizabeth A DeMarco

YORK COUNTY, SOUTH CAROLINA

BY: _____

C. Michael Short, Vice Chairman
York County Council

Attest: _____

Al Greene
Acting County Manager

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EIGHTH ADDENDUM TO AGREEMENT BY AND AMONG TENET HEALTHCARE CORPORATION (FORMED AS A RESULT OF MERGER BETWEEN AMERICAN MEDICAL INTERNATIONAL, INC., AND NATIONAL MEDICAL ENTERPRISES,INC.),AMISUB OF SOUTH CAROLINA, INC., AND YORK COUNTY, SOUTH CAROLINA

THIS EIGHTH ADDENDUM to Hospital Agreement dated as of December 8, 1980, among American Medical International, Inc., AMISUB of South Carolina, Inc. and York County, South Carolina, as amended and modified from time to time, made and entered into this 7th day of June, 2004, by and among Tenet Healthcare Corporation, a corporation organized under the laws of the State of Delaware, and formed as the result of a merger between American Medical International, Inc., and National Medical Enterprises, Inc. (herein referred to as "AMISUB Parent"), AMISUB of South Carolina, Inc., (herein referred to as "AMISUB"), and York County, South Carolina, a political subdivision of the State of South Carolina (herein referred to as "York County"),

WITNESSETH:

WHEREAS, AMISUB Parent, AMISUB, the trustees of York General Hospital and York County entered into an agreement on or about December 9, 1980 (herein referred to as the "Prior Agreement") pursuant to which the trustees of York General Hospital and York County leased and sold certain property and assets to AMISUB Parent and its subsidiary corporation, AMISUB, for the operation of a hospital in York County, South Carolina; and

WHEREAS, AMISUB Parent and AMISUB constructed and operate a hospital in York County, South Carolina, known as Piedmont Medical Center (the "Hospital") pursuant to the terms and conditions of the Prior Agreement; and

WHEREAS, the Prior Agreement has been amended and modified by a First Addendum thereto dated June 16, 1989, a Second Addendum thereto dated April, 1992, a

Third Addendum thereto dated April, 1995, a Fourth Addendum thereto dated June, 1995, a Fifth Addendum thereto dated as of July 1, 1995, a Sixth Addendum thereto dated as of August 25, 1995, and a Seventh Addendum thereto dated October 5, 2000, (the Prior Agreement, as amended and modified, being referred to herein as the "Agreement"); and

WHEREAS, issues have arisen concerning the pricing provisions of Section 3.1(e) and other sections of the Agreement, as amended and modified; and

WHEREAS, AMISUB, AMISUB Parent and York County have determined that cost-effective competitive pricing for services provided at the "Hospital" is essential to the provision of quality health care services to the citizens of York County, to the continuing economic well-being of the "Hospital", and to the ability of AMISUB and AMISUB Parent to meet their obligations under the Agreement; and

WHEREAS, in order to resolve pricing and other issues under the Agreement, the undersigned parties desire to amend the Agreement, as previously amended and modified, by the execution and delivery of this Eighth Addendum to the Agreement.

NOW, THEREFORE, for and in consideration of the premises, the mutual promises contained herein, the sum of Ten Dollars ($10.00) paid by each party to the other, and of other good and valuable consideration, the receipt, adequacy and sufficiency of which is hereby acknowledged by each party hereto, the undersigned parties, intending to be legally bound, hereby agree as follows:

1. Section 3.1(e) of the Agreement, as amended and modified by the First, Second, Third, Fourth, Fifth, Sixth and Seventh addenda thereto, is hereby amended to read as follows:

(e) Pricing. (i) AMISUB and AMISUB Parent acknowledge that a major objective of York County in entering into this Agreement is that such care be provided on a cost-effective basis at prices favorably

comparable to those charged for similar services provided by comparable acute-care hospitals in the same general geographical area. York County acknowledges that the pricing of, and charging and reimbursement for, health care services and the market therefor and other factors relating thereto, including the reporting thereof, are complex and but a few of a number of related major management responsibilities of the governing body of AMISUB and AMISUB Parent in the administration of the "Hospital". AMISUB, AMISUB Parent and York County acknowledge and agree that cost-effective, competitive pricing for services provided at the "Hospital" is essential to the provision of quality health care services to the citizens of York County, to the continuing economic well-being of the "Hospital", and to the ability of AMISUB and AMISUB Parent to meet their obligations under this agreement. AMISUB and AMISUB Parent agree to exert every reasonable effort to so conduct their operations and finances to maintain prices for services at the "Hospital" at reasonable, competitive levels as and when compared to other hospitals in the "peer group" [as defined in Section 3.13(a)(xii) of the Agreement, as amended and modified] for which Medpar pricing information is provided pursuant to Section 3.13(a)(xii) of the Agreement, as amended and modified.

(ii) Effective with the Medpar reporting period beginning October 1, 2003, in the event Medpar pricing information submitted to or obtained by the "Hospital" shall, at any time, show that the Average Charge Per Case by the "Hospital" for "all product lines" is the highest in the peer group established and described in this Agreement, AMISUB and AMISUB Parent shall in no event more than fifteen (15) business days after receipt of such Medpar report or information:

(1) reduce its rates, charges and fees or otherwise demonstrate to the county that the rates, charges and fees currently utilized by the hospital reduce the Average Charge Per Case to levels which establish that the Average Charge Per Case by the "Hospital" for "all product lines" will be less than the highest in the peer group as reported in the first Medpar report that contains a full year of data reflecting the changes referred to herein; and

(2) maintain such reduced rates, charges and fees and not adjust rates, charges or fees so as to cause the Average Charge Per Case to increase over the prior period report until such time as there has been delivered to York County a report pursuant to Section 3.13(a)(xii) of this agreement, as amended and modified, which shows that the Hospital's Average Charge Per Case for all product lines is less than the highest of the peer group; and

(3) within forty-five (45) days of the receipt of such Medpar information provide York County, at the "Hospital's" expense, a report, from a qualified consultant, mutually agreed upon by the "Hospital" and York County, that the action taken in (1) above will, to the best of the consultant's ability to make such a determination, result in the Average Charge Per Case by the "Hospital" for "all product lines" being less than the next highest in the peer group designated and established in this Agreement on the first Medpar report that contains a full year of data reflecting the changes made in (1) above. Additionally, should the consultant determine that the action taken by the "Hospital" in (1), will not result in the "Average Charge Per Case" for "all product lines" being less than the next highest in the peer group as called for in (1) above, the "Hospital" will immediately, and in no event more than forty-five (45) days unless an extension is agreed to by county, work with the consultant to identify and implement those actions necessary to achieve the required result that the Average Charge Per Case by the "Hospital" for "all product lines" is less than the next highest in the peer group. York County shall respond to the hospital's designation of a proposed consultant by notification to the hospital that such proposed consultant is approved or disapproved within ten days of receipt from hospital of the name of a proposed consultant. The "Hospital" agrees to begin requesting the required Medpar data no later than April 1st of each year. AMISUB, AMISUB Parent, and York County acknowledge that the release of this information is subject to the control of the Centers for Medicare and Medicaid.

(4) York County, AMISUB and the "Hospital" all recognize that MedPar data is not available for over 12 months after each of the "Hospital"'s fiscal years ends. In order to provide more timely information to monitor the "Hospital"'s prices for services, the "Hospital" agrees to provide York County quarterly financial information, commencing with the first financial quarter after the date of this Eighth Addendum, to include: (1) Charge Description Master; (2) Report showing frequency of all charge items processed for inpatient Medicare services consistent with the data available in the Medpar report. These schedules will be prepared from Hospital internal billing data by quarter and show comparable information to that appearing in the annual MedPar data. York County acknowledges this information may not be reflective of the data appearing in the annual Medpar report and is to be used for informational purposes only.

York County, AMISUB and the "Hospital" agree that York County reserves the right, at its expense, to hire an outside consultant to test the data provided by the "Hospital" for reasonableness.

(iii) Should AMISUB and/or AMISUB Parent fail to perform their obligations under Section 3.1(e)(i) and/or (ii) of the Agreement, as amended and modified by this Eighth Addendum, within the time frame prescribed, York County, subject to the provisions of Section 4.1, shall be entitled to take whatever action at law or in equity may appear necessary or desirable to enforce performance and observance of the obligations, agreements and covenants of AMISUB and AMISUB Parent under this Agreement, as further amended by this Eighth Addendum. Additionally, if AMISUB and/or AMISUB Parent shall fail to substantially observe and perform the covenants, conditions or agreements in Section 3.1(e)(i) and/or (ii) above, AMISUB and AMISUB Parent shall, upon written demand by York County:

(a) within thirty (30) days of the receipt of such written demand adjust rates, charges and costs at the "Hospital" to the average of the Average Charge Per Case for hospitals in the peer group, based on the most recent MedPar report available, for "all product lines" for a period of twelve months or until receipt of the next Medpar report, whichever period of time is greater, showing that the Average Charge Per Case is no longer the highest in the peer group; and

(b) within thirty (30) days of the implementation of the provisions of Section 3.1(e)(iii)(a) above, submit a Charge Master Report to York County, which report is subject to audit and verification, at York County's expense, by York County or its agents, consultants or auditors, which shows that the rates, charges and costs at the "Hospital" have been reduced to the average of the Average Charge Per Case for "all product lines" for hospitals in the peer group based on the most recent Medpar report available for all product lines. If the "Hospital" has not reduced rates, charges and costs to the average of the Average Charge Per Case for hospitals in the peer group for all product lines within the thirty (30) day period provided in this subparagraph (b), AMISUB and AMISUB Parent shall, in addition to the actions required in (a) above, promptly pay to York County, upon York County's demand, the sum of one hundred thousand ($100,000.00) dollars per month, representing the amount of liquidated damages which the parties have agreed upon as compensation to York County until the "Hospital" adjusts, fixes

or reduces its rates, charges and fees to levels which establish that the Average Charge Per Case by the "Hospital" for all product lines will be less than the highest in the peer group for a period of not less than three consecutive months. The parties acknowledge and agree that the sum of one hundred thousand ($100,000.00) dollars per month for each month in which "Hospital" fails or neglects to adjust, fix or reduce the Average Charge Per Case at the "Hospital" for all product lines to less than the highest of the peer group represents a fair and equitable amount of compensation for delay, failure or neglect to adjust, fix or reduce the "Hospital's" Average Charge Per Case for all product lines to less than the highest in the peer group, in view of the impossibility or difficulty of ascertaining actual damages. The foregoing liquidated damages clause shall, however, be in addition to and not in substitution of any other rights or remedies which York County may have under this Agreement or otherwise against AMISUB and AMISUB Parent or the "Hospital".

2. (a) Section 3.7 of the Agreement, as previously amended and modified, is further amended by inserting the following new Section (b) immediately following the existing Section 3.7, and designating existing Section 3.7 of the Agreement as 3.7(a):

(b) AMISUB, AMISUB Parent and York County acknowledge and agree that the viability of community-based agencies which have no ownership relationship with the "Hospital" is essential to serve and improve the delivery of health care services in York County. In recognition of the vital services provided by community-based service agencies which are not directly related to the "Hospital", AMISUB and AMISUB Parent, in a continuing effort to improve the health status of the York County community, agree to contribute the following sums to the following York County community-based agencies:

(i) to Keystone, a not-for-profit substance abuse facility, to be applied to its capital campaign the sum of one hundred twenty-five thousand ($125,000) dollars to expand its York County residential treatment facility, to be paid in annual contributions of twenty-five thousand ($25,000) dollars a year for five years;

(ii) to the York County Hospice Agency, to be applied to the construction of a residential hospice facility in York County, the sum of one hundred twenty-five thousand ($125,000.00) dollars, to be paid in annual contributions of twenty-five thousand ($25,000) dollars a year for five years;

(iii) to North Central Family Clinic, a family medicine clinic which receives federal funding for treating Medicaid patients and others on a "sliding scale" the sum of three hundred fifty thousand ($350,000) dollars, to be paid in annual contributions of seventy thousand ($70,000) dollars per year for five years, provided, however, that North Central Family Clinic shall continue to provide prenatal care as a part of its clinical programming through the use of licensed midwives a minimum of sixty hours per week.

Section 3.11 of the Agreement is amended by adding the following provision at the end of Section 3.11.

> AMISUB and AMISUB Parent agree to endow fifteen (15) annual scholarships to York Technical College in its registered nursing and radiology technician programs for a period of five years without restrictions except for the requirement of a two-year commitment of post-graduate work at Piedmont Healthcare System with a projected cost of three thousand seven hundred fifty ($3,750) dollars per year per scholarship, with a maximum total commitment over a five-year period of two hundred eighty-one thousand two hundred fifty ($281,250) dollars.

3. Section 3.1(c), Emergency Room Service, of the Agreement, as previously amended and modified, is further amended by inserting the following new paragraph immediately following the existing Section 3.1(c):

> AMISUB and AMISUB Parent further agree that the "Hospital" will maintain its Joint Commission on Accreditation for Healthcare Organizations ("JCAHO") accreditation.

4. Section 3.13 of the Agreement, as previously amended and modified, is further amended by inserting a new Section (c) immediately following the existing section 3.13(b) as follows:

(c) In order to permit York County or its auditors, consultants, representatives or agents to monitor and determine the observance and performance of the covenants, conditions or agreements in this Agreement on the part of AMISUB and AMISUB Parent, AMISUB, AMISUB Parent and the "Hospital" hereby grant to York County, its

successors, auditors, consultants, accountants, attorneys and agents the right, upon reasonable notice, to inspect, examine, and review books, records and reports of AMISUB Parent, AMISUB and the "Hospital" reasonably necessary in order to determine compliance, observance and performance by AMISUB Parent, AMISUB and the "Hospital" of and with the covenants, conditions, provisions and agreements contained in the Agreement, as amended and modified. In the event AMISUB, AMISUB Parent, or the "Hospital" determines that any such request is not reasonably necessary to York County's ability to monitor or determine the observance or performance of the covenants, conditions, or agreements in this Agreement or is otherwise unreasonable, AMISUB, AMISUB Parent, or the "Hospital" shall provide written objection to York County, describing the specific grounds of objection. Within ten (10) days upon the County's receipt of said objection, the parties shall meet and attempt to resolve the issues. Should the parties be unable to resolve their differences at said meeting, they shall jointly retain a mutually agreeable consultant to determine whether the request at issue is reasonably necessary to York County's ability to monitor or determine the observance or performance of the covenants, conditions, or agreements in this Agreement and is otherwise reasonable. The provisions of this Eighth Addendum shall be cumulative and in addition to, and not in substitution for any other rights or remedies which York County may have under this Agreement or otherwise, and this provision shall not preclude or limit York County in the exercise of any other right or remedy under this Agreement or at law or in equity.

4. Guaranty by AMISUB Parent.

AMISUB Parent hereby jointly and severally guarantees all representations, warranties, agreements, covenants and obligations of AMISUB contained in this agreement.

5. Prior Agreement ratified and confirmed.

Except as modified herein, the Prior Agreement as amended and modified by the First, Second, Third, Fourth, Fifth, Sixth and Seventh addenda thereto, is hereby ratified and confirmed.

6. Miscellaneous provisions.

NINTH ADDENDUM TO AGREEMENT BY AND AMONG TENET HEALTHCARE CORPORATION (FORMED AS A RESULT OF MERGER BETWEEN AMERICAN MEDICAL INTERNATIONAL, INC., AND NATIONAL MEDICAL ENTERPRISES,INC.),AMISUB OF SOUTH CAROLINA, INC., AND YORK COUNTY, SOUTH CAROLINA

THIS NINTH ADDENDUM to Hospital Agreement dated as of December 8, 1980, among American Medical International, Inc., AMISUB of South Carolina, Inc. and York County, South Carolina, as amended and modified from time to time, made and entered into this ___ day of _____, 2006, by and among Tenet Healthcare Corporation, a corporation organized under the laws of the State of Delaware, and formed as the result of a merger between American Medical International, Inc., and National Medical Enterprises, Inc. (herein referred to as "AMISUB Parent"), AMISUB of South Carolina, Inc., (herein referred to as "AMISUB"), and York County, South Carolina, a political subdivision of the State of South Carolina (herein referred to as "York County"),

WITNESSETH:

WHEREAS, AMISUB Parent, AMISUB, the trustees of York General Hospital and York County entered into an agreement on or about December 9, 1980 (herein referred to as the "Prior Agreement") pursuant to which the trustees of York General Hospital and York County leased and sold certain property and assets to AMISUB Parent and its subsidiary corporation, AMISUB, for the operation of a hospital in York County, South Carolina; and

WHEREAS, AMISUB Parent and AMISUB constructed and operate a hospital in York County, South Carolina, known as Piedmont Medical Center (the "Hospital") pursuant to the terms and conditions of the Prior Agreement; and

WHEREAS, the Prior Agreement has been amended and modified by a First Addendum thereto dated June 16, 1989, a Second Addendum thereto dated April, 1992, a

Third Addendum thereto dated April, 1995, a Fourth Addendum thereto dated June, 1995, a Fifth Addendum thereto dated as of July 1, 1995, a Sixth Addendum thereto dated as of August 25, 1995, a Seventh Addendum thereto dated October 5, 2000, and a Eighth Addendum thereto dated June 4, 2004, (the Prior Agreement, as amended and modified, being referred to herein as the "Agreement"); and

WHEREAS, AMISUB has made application to the South Carolina Department of Health and Environmental Control (DHEC) for the purpose of granting a Certificate of Need to expand AMISUB by 64 beds to be located in the vicinity of Fort Mill, South Carolina, such facility to provide medical / surgical services, emergency room services open 24 hours a day / 7 days a week, inpatient / outpatient surgical services and all the necessary diagnostic and support services expected to provided for the successful support of those services, and

WHEREAS, the Fort Mill campus is a continuation of services provided by AMISUB and AMISUB is the contractual party to the Prior Agreement, the Fort Mill campus would operate under the Prior Agreement, as subsequently amended and modified, as applicable.

WHEREAS, opportunities have arisen for further improvement of services for the residents of York County under Section 3.2 and Section 3.5 of the Agreement, as amended and modified; and

WHEREAS, in order to expand and clarify the obligations and expectations under the Agreement, the undersigned parties desire to amend the Agreement, as previously amended and modified, by the execution and delivery of this Ninth Addendum to the Agreement which, unless extended by written agreement of the parties hereto, shall expire on July 1, 2045.

NOW, THEREFORE, for and in consideration of the premises, the mutual promises contained herein, the sum of Ten Dollars ($10.00) paid by each party to the other, and of other

good and valuable consideration, the receipt, adequacy and sufficiency of which is hereby acknowledged by each party hereto, the undersigned parties, intending to be legally bound, hereby agree as follows:

1. Section 3.5 of the Sixth Addendum of the Agreement, as amended and modified by the Seventh and Eighth addenda thereto, is hereby amended to read as follows:

a) AMISUB has established an urgent care/occupational medicine facility (Facility) in western York County, which provides urgent care for minor emergencies, occupational medicine, including physical examinations, occupational testing/screenings, care for on-the-job injuries and other similar health care services, and which currently is open and staffed between the hours of 8:00 a.m. and 8:00 p.m., Monday through Saturday and 1:30 p.m. on Sundays, except for Christmas, New Years, Easter and Thanksgiving in accordance with the guidance provided by the advisory committee established under the Sixth (6th) Addendum of the Agreement. York County and AMISUB have agreed that an evaluation of the community need for an expansion of hours of operation at this Facility is appropriate to determine how best to serve the residents of western York County in an efficient and cost effective manner. Therefore, effective no later than 300 days following the execution of this Ninth (9th) Addendum the Facility will be open between the

hours of 8:00 a.m. and 12:00 midnight Monday through Saturday and 1:30 p.m. and 12:00 midnight Sundays and AMISUB will implement this change as soon as possible after the execution of this Ninth (9th) addendum, the requisite full time professional staff are employed, and the Facility transitioned. Additionally, effective no later than three (3) full months following the extension of hours to 12:00 midnight the Facility will be open twenty-four hours each day, except that the Facility will be permitted to be closed between the hours of 12.00 midnight and 1:30 p.m. on Sundays. Additionally, the Facility will be permitted to be closed from 12:01 a.m. to 10:00 p.m. Christmas, New Years, Easter and Thanksgiving. Staffing of the Facility will be provided by not less than two (2) licensed physicians. AMISUB will use its best efforts to retain Board Certified or Board Eligible in Emergency Medicine physicians (at least one (1) of whom shall be at the Facility during all operating hours) and adequate support staff.

b) This evaluation shall continue for a period of not less than five (5) years from the first day the Facility begins operation "24 hours each day" as set forth in paragraph a) above. At the conclusion of that five (5) year period, AMISUB shall evaluate the performance of the Facility and may, at its sole discretion, adjust the hours of operation and/or levels of service as

AMISUB determines may be appropriate, but at no time shall the hours of operation or service be less than that which existed prior to the execution of this Ninth Addendum. Failure to make adjustments at the end of the five year period shall not preclude AMISUB from making adjustments at a later time should it determine that adjustments are appropriate.

c) In order to ensure responsiveness to community needs by this Facility, there shall be established an advisory committee comprised of one (1) member of York County Council, three (3) residents of York County Council Districts 2 and/or 3 (as constituted on the date of delivery of this Sixth Addendum) appointed by AMISUB from a list of not less than five (5) nominees for three (3) vacancies, four (4) nominees for two (2) vacancies, and three (3) nominees for one (1) vacancy named by York County Council and one (1) representative of AMI. Such committee shall meet no less often than annually to discuss the need for services in western York County, the manner in which the western York County urgent care facility is meeting such needs and any changes which might be necessary or advisable with respect to the types of services provided or the manner in which services are provided in order to better meet the needs of the residents of western York County. AMISUB agrees to take into consideration any recommendations or requests made by the

advisory committee in connection with its operation of the urgent care facility and its planning with respect thereto and provide a timely written response to any such recommendation or request.

2. Section 3.7 of the Sixth Addendum of the Agreement, as amended and modified by the Seventh and Eighth addenda thereto, is hereby amended to read as follows: AMI agrees that in the period beginning June 1, 1995, and ending May 31, 1998, it will make investments in land or depreciable or amortizable property located in York County, South Carolina, in an aggregate amount not less than Twenty-Three Million ($23,000,000) Dollars, provided that in the event AMI shall be relieved from the obligation to provide any facility or service described in Section 3.1(b) hereof as a result of the inability to obtain any regulatory approval required therefore, such amount shall be reduced by the estimated cost of such facility or service as set forth in said Section 3.1(b). Thereafter, in each period of twelve (12) months beginning June 1 of a year and ending on May 31 of the next succeeding year, beginning with the twelve-month period starting June 1, 1998, it will invest in land, depreciable or amortizable property, and depreciable property acquired by way of operating lease(s), such leases providing for the payment of ad vorem taxes to York County, shall belocated in York County, South Carolina, and used for the purpose of providing the service required by this Agreement, an amount which, when added to the amount so invested by AMI in the preceding two (2) such twelve (12) month periods, would make the average thereof

equal to or greater than the greater of (i) $4,000,000 or, (ii) one hundred eight percent (108%) of the average of the amounts shown on the financial statements of AMI as depreciation or amortization for property, plant and equipment located in York County for the preceding three (3) such twelve (12) month periods, provided that in no such twelve (12) month period shall the amount actually so invested be less than $1,500,000. Notwithstanding the foregoing, in the event AMI's earnings before depreciation and amortization, as shown in the financial statements of AMI for the twelve (12) month period in question, are less than $4,000,000, the amount required to be reinvested as herein provided during such period shall not exceed an amount equal to fifty percent (50%) of such earnings before depreciation and amortization. Accounting terms used in this Section 3.7 shall be given meaning and applied in accordance with generally accepted accounting principles; depreciation and amortization shall be determined in accordance with American Hospital Association or some other nationally recognized standard therefore.

3. Section 3.14 of the Sixth Addendum, Right of First Refusal; Assumption of Agreement by Successors is hereby amended to read as follows:

(a) Subject to the terms and conditions contained in this Section 3.14, York County is hereby granted a right of first refusal to purchase the Hospital. Except as provided in paragraph (b) hereof, in the event that an agreement for the sale of more than an eighty percent (80%) interest in (i) the Hospital or (ii) the voting securities of AMI, has, subject only to the provisions of this Section 3.14, been entered into, written notice thereof shall be provided to York County. Such notice shall set forth the identity

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DHEC AMISUB RECORD PAGE 898

Acceptability – 4a, 4b, 4c
The Fort Mill Town Council endorsed (via letter) more than one applicant. The York County Council extended and entered into new Amendments of the existing contract with PMC. Additionally, three (3) York County Council members met personally with the Department to endorse Piedmont Medical Center. York County Medical Society endorsed Presbyterian Healthcare System with 77 votes; however, this is only 21.0% of the 361 +/- physicians currently practicing in York County.

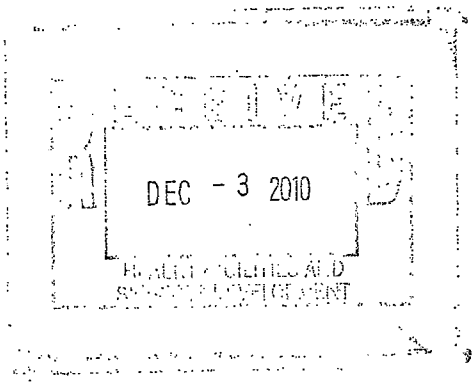
All of the applicants received letters of support and some opposition. Carolinas Hospital Systems and Presbyterian letters of support far outnumbered any of the four (4) competing applicants. Many letters received were form letters that were duplicated in large numbers. There were so many forms mass produced that letters of support lacked originality and meaningful dialogue and became a contest of "seeing who could produce the most." With this in mind, three of the applicants received adequate support, while Lake Wylie did not nearly reach the number of support letters generated by the other three. However, the Lake Wylie applicant does not have a facility presence in the greater Rock Hill – Charlotte area, so it is expected that there will not be familiarity with this applicant and that the other three applicants, who all have a presence in the Rock Hill – Charlotte area and serve the residents of York County, will generate a greater response. On that note, it is also expected that since PMC is the only provider of hospital services in York County and currently has a larger market share in the County, it would generate more negative response than any other provider, which was the case.

Adverse Impact on Other Facilities – 23a, 23b
Approval of FMMC will not negatively impact any of the other three applicants, as none have existing facilities in the State. Additionally, the nearby North Carolina facilities will not be impacted since PMC currently has a major market share in York County at this time, and particularly in the service area cited. The proposed facility is projected to serve an existing PMC patient base. PMC itself will remain well utilized with an expected occupancy of over 70.0% by the third year of operation of FMMC.

In contrast, should either of the competing three applicants be chosen to construct a new facility, their patient base would be siphoned from the existing utilization of PMC, which must continue to operate under the contract with York County to provide the following services, in addition to

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healthcare
affiliates



December 3, 2010

Beverly Brandt
Bureau of Health Facilities and Services Development
Division of Planning and Certificate of Need
South Carolina Department of Health and Environmental Control
2600 Bull Street
Columbia, SC 29201-1708

Re: Amisub of South Carolina, Inc. d/b/a Fort Mill Medical Center
As Per December 9, 2009 Order from Judge Matthews, Administrative Law Court
Fort Mill, South Carolina

Dear Ms. Brandt,

The following is response to your letter dated November 3, 2010, requesting additional information on the above referenced project.

1. **In reference to the Part A Questionnaire, please address the following:**
   - **Provide an estimated cost for the fixed and mobile equipment as shown in 11-D.**
   - **Indicate if land cost includes site and road improvements**
   - **Indicate if architect's fee included engineering and consulting fees**
   - **Indicate the total number of exam rooms in the Emergency Department**

Response: Section 11-D of Piedmont's updated application lists total equipment costs of $50,833,168. Of this amount, $31,119,011 is the cost of medical equipment; of that amount, approximately $12,019,817 is for fixed medical equipment and $19, 098,278 is for moveable medical equipment. These costs are not accurate, however, for two reasons. First, due to an oversight, Piedmont's projected medical equipment costs in the Updated Application are based on list prices. The projections fail to include the standard average discount of 22 percent that Piedmont receives though its group purchasing organization. Moreover, as further discussed in response to question 19, Piedmont's cost projections are inflated to 2014, while the other applicants appear to have based their costs on 2010 prices.

Piedmont's projected equipment costs, based on 2010 prices and including its standard average medical equipment discount of 22 percent, are $40,966,039.54. See **Attachment A** and **Figure 8.** Of this amount, $23,471,350 is for medical equipment. Fixed medical equipment costs are approximately $9,153,826 and moveable medical equipment costs are approximately $14,317,524.

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(p) 404.315.9011 (f) 404.315.1071

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9 River Place, Beaufort, SC 29906
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As a result of these and other revisions discussed in response to question 19, Piedmont is submitting **Attachment B** as a replacement for page 5 (Bates p. 8) of the Updated Application (Part A, section 9-11 of Questionnaire).

Land costs do not include site and road improvements. Those costs are included in construction costs. The architect's fee included engineering and consulting fees.

The proposed Emergency Department will have 13 general exam rooms, 1 psychiatric room, and 2 trauma bays.

2. **Is the square footage associated with the Central Energy plan included in the total sq ft of the project? Were costs associated with the design and construction of the Energy Plant factored into the Total Project Cost (TPC)?**

Response: The square footage associated with the Central Energy plant is included in the total sq ft of the project. The costs associated with the design and construction of the Energy Plant are factored into the Total Project Cost (TPC).

3. **Your narrative states that the revised CON application has excluded the initially proposed diagnostic catheterization lab yet the schematic drawing shows a room labeled as "cath lab". Will this be shelled in space? If so, has this cost been factored into your TPC? When do you propose initiating these services?**

Response: The space labeled "cath lab" on the schematic drawings is the space that was originally to be used for diagnostic cardiac catheterization services. Since the application was amended to delete this service, the space will be used for storage and/or support space until a different future use is determined. The space will be finished and the costs are included in the total project costs. A proposed cardiac catheterization service will be initiated at the Fort Mill Medical Center when the need for such a service is determined and compliance with the State Health Plan can be achieved. Appropriate approval from DHEC would be obtained prior to initiating such a service.

4. **Please expand on other services to be offered at Fort Mill Medical Center such as sleep lab, therapy, or rehab services. (p. 11)**

Response: Fort Mill Medical Center will be a full service acute care hospital with a complete array of clinical services, including but not limited to:

- Medical / Surgical Beds
- Critical Care Beds
- Newborn Nursery
- Emergency Room
- Surgical services (Inpatient and Outpatient):
  - General
  - Urology
  - Orthopedics
  - ENT
  - Vascular
  - GYN
  - Digestive Disease
  - Endoscopy
- Cardiology
- Infectious Disease
- OB (including C-Sections)
- Neonatology
- Pulmonology
- Oncology
- Full laboratory
- Complete Imaging services, including but not limited to:
  - 64-slice CT
  - 3.0T MRI
  - Special Procedures
  - Ultrasound
- R&F
- Respiratory Therapy
- Physical Therapy
- Speech Therapy
- Pulmonary Function Testing
- Vascular Lab

5. **In your primary and secondary service area analysis, were areas outside of York County considered? If so, identify which outlying counties and discuss the level of impact, if any, to your population projections.**

Response: Areas outside of York County were considered and included in the analysis; 10 percent of the projected utilization is assumed to come from residents from outside of York County. This includes Lancaster, Chester and other counties and areas.

6. **Indicate which ancillary or imaging services (i.e., mammo, ultrasound, endo, nuclear med) originally proposed in the initial application have been scaled down or modified and to what extent. Also, provide a rationale for the proposed change. (p. 28)**

Response: None of the ancillary or imaging services originally proposed in the initial application have been scaled down or materially modified.

7. **Provide any updates to the 2025 York County Comprehensive Plan since its April 2004 publication. Have any of these infrastructure and development changes been initiated? (p.28)**

Response: Representatives of the York County Planning & Development office indicate that the Open Space, Transportation, and Priority Investment Act sections of the 2025 Comprehensive Plan have been updated. They are provided in **Attachment C.** We have not been able to confirm the extent to which infrastructure and development changes have been initiated.

8. **Provide the source of NC inpatient data, which references the 8,339 residents that left the state to seek inpatient services in NC. Expand on reasons for out-migration and reduction in market share. What measures have been implemented by Piedmont to recapture lost market share? (p. 28)**

Response: In order to accurately size the York County market and accurately capture all residents, both South Carolina and North Carolina provider data was utilized. The South Carolina data source was the South Carolina Office of Research and Statistics. The North Carolina data was obtained from Thomson/Reuters. Thomson/Reuters is an outside company that contracts with the North Carolina Department of Health and Human Services to provide healthcare reporting and analytics systems. Both sources provide utilization data that is obtained from hospitals in each state through the reporting of annual utilization information to the respective entities.

Residents of the service area, particularly those in the northern portion of the county, are leaving the state to receive services in North Carolina. As a bedroom community of Charlotte, the Fort Mill/Tega Cay/Northern Rock Hill area residents generally orient north toward Charlotte, rather than south toward Rock Hill. They look to the greater Charlotte area for business, recreation, leisure, and community activities, as well as for the selection of healthcare services in the absence of convenient local options. The other factor that has increased the outmigration has been the change in referral patterns caused by the increased number of medical practices in York County owned by Carolinas Health System and Presbyterian.

This trend has increased since Piedmont first filed a CON to develop a hospital in that area in 2004/2005. The two competing providers in North Carolina, Presbyterian and Carolinas, have focused their attention and efforts on increasing their marketshare of this area. They have recruited physicians and increased their marketing efforts in order to garner a higher percentage of patients from that area.

Without a hospital location in the northern portion of the county, Piedmont will continue to lose patients to providers to the north. As discussed in the original CON application in 2004/2005, the proposed location of Fort Mill Medical Center will increase access to hospital services and enhance the geographic distribution of beds within York County, resulting in the recapture of many patients who currently travel out of state for care.

Piedmont has developed a physician recruitment plan to place 13 additional employed physicians in the service area, particularly the area near the proposed Fort Mill Medical Center. By increasing the supply of and access to physicians in the area, combined with the proposed Fort Mill Medical Center, Piedmont will reduce the number of residents leaving the county.

9. **In Revised Figure 13 and Revised Figure 14 on p. 29, please separate out data by source (i.e.- SC Office of Research and Statistics, Thomson Reuters, and Polaris). Explain your methodology for deriving the Total % of PMC market share for inpatient discharges.**

Response: In order to accurately assess the utilization of all residents of York County, information from both South Carolina and North Carolina providers was analyzed. As discussed previously, the source for South Carolina provider data is the South Carolina Office or Research and Statistics (SCORS). The North Carolina data source was Thomson/Reuters. A patient level database from both sources was

obtained that identified multiple variables including provider, DRG, Zip Code, County, admissions, etc. Information from both sources was combined to create a county-wide database for all residents of York County. Revised Figure 14 has an incorrect data source. Rather than listing Polaris (the data source for 2004 North Carolina Data), it should have referenced Thomson/Reuters and Claritas.

Revised CON Figure 13
Fort Mill Medical Center Service Area
Distribution of 2009 Inpatient Medical/Surgical and ICU Discharges

	Discharges				PMC
ZIP Code	PMC (a)	NC (b)	Other(a)	Total	Market Share
29707	35	561	31	627	5.6%
29708	228	737	27	992	23.0%
29715	540	1,004	64	1,608	33.6%
29730	2,692	1,054	141	3,887	69.3%
29732	1,944	954	113	3,011	64.6%
PSA	5,439	4,310	376	10,125	53.7%
SSA	2,148	2,147	251	4,546	47.3%
Total	7,587	6,457	627	14,671	51.7%

Source: (a) SC Office of Research and Statistics and (b) Thomson Reuters.
Note: As ZIP Code 29716 is a post office box, this ZIP Code was combined with 29715.
ZIP Code 29703 was combined with 29710, and 29731, 29733 and 29734 were combined with 29730.

The methodology to derive Piedmont market share for inpatient discharges was to divide the number of discharges that was reported for Piedmont Medical Center by SCORS by the combined total discharges for all resident who received inpatient services at any hospital, as reported by the SCORS and Thomson/Reuters.

10. Provide further explanation how redirection will be accomplished. (p. 30)

Response: Without a hospital location in the northern portion of the county, Piedmont will continue to lose patients to providers to the north. As discussed in the original CON application in 2004/2005, the proposed location of Fort Mill Medical Center will increase access to hospital services and enhance the geographic distribution of beds within York County, resulting in the recapture of many patients who currently travel out of state for care.

Fort Mill Medical Center's proposed market share of the service area not only includes the redirection of patients from Piedmont to the new facility, but it also considers the recapture of patients from the area who currently travel to North Carolina for care. It is reasonable to assume that the redirection of patients and the resulting market share levels proposed by Fort Mill Medical Center are achievable for the following reasons:

1. The facility's proximity to the patient population it proposes to serve makes it a more attractive alternative for patients who would normally seek care at Piedmont and North Carolina facilities.

2. The significant development underway in the Fort Mill and Tega Cay area has made it an attractive location for physicians who continue to establish offices in the area, and will be likely to refer to the new facility rather than to Piedmont or to North Carolina facilities.
3. The growth in resident population related to the substantial residential and commercial development underway creates the need for a facility that is dedicated to the service of the areas of Fort Mill and Tega Cay.
4. The strong support evidenced by the letters of support from physicians and community members.
5. Historical marketshare levels achieved by Piedmont Medical Center.

All of these factors, and Piedmont's positive historical market share in the service area, combine to create a market in which the proposed facility will be well-received immediately. The fact that many of the same physicians who currently admit patients to Piedmont will also be on staff at Fort Mill Medical Center will increase the public's awareness of the facility, as well as the services it offers and the quality of those services.

At the current time, physicians representing numerous specialties have offices in the Fort Mill area, including:

Cardiology	OB/GYN	Ophthalmology
Family Practice	Otolaryngology	Orthopedics
General Surgery	Pediatrics	Podiatry
Internal Medicine		

Plans call for an additional 13 physicians to be recruited by Piedmont to serve this area. These physicians will help retain the patient base of residents requiring acute care services.

Finally, Piedmont has an existing presence with the Piedmont Urgent Care Center and Piedmont Imaging Center in the Baxter Village area of Fort Mill. The Imaging Center opened in 2008, subsequent to the original Fort Mill Medical Center CON application.

With an increased presence in the north portion of the County, Piedmont will be able to recapture the patients out migrating to North Carolina and achieve a marketshare consistent with historical levels.

11. **Provide the figures that correspond with the respective percentages shown on Revised Figure 16. How much of the market share (% and #s) are attributed to redirection vs. inmigration. (p. 31)**

Response: The following figures provide the data that corresponds to the percentages shown in Revised Figure 16.

Figure 1
Fort Mill Medical Center Service Area
Distribution of 2004 Inpatient Medical/Surgical and ICU Discharges

ZIP Code	PMC	NC	Other	Total	PMC Market Share
29708	219	384	11	614	35.7%
29715	*801*	*895*	*55*	*1,751*	*45.7%*
29730	3,701	645	122	4,468	82.8%
29732	2,350	580	81	3,011	78.0%
PSA	*7,071*	*2,504*	*269*	*9,844*	*71.8%*
SSA	*2,296*	*1,777*	*182*	*4,255*	*54.0%*
Total	9,367	4,281	451	14,099	66.4%

Source: 2004 PMC Annual Market Share Report, and 2004 Inpatient North Carolina data; Solucient.
Note: Several ZIP Codes included Post Office Boxes. Those ZIP Codes combined with the associated area.
Note: Excludes: Obstetrics, Open Heart Surgery, Angioplasty, and Psychiatry.

Figure 2
Fort Mill Medical Center Service Area
Distribution of 2009 Inpatient Medical/Surgical and ICU Discharges

ZIP Code	Discharges PMC	NC	Other	Total	PMC Market Share
29707	35	561	31	627	5.6%
29708	228	737	27	992	23.0%
29715	540	1,004	64	1,608	33.6%
29730	2,692	1,054	141	3,887	69.3%
29732	1,944	954	113	3,011	64.6%
PSA	5,439	4,310	376	10,125	53.7%
SSA	2,148	2,147	251	4,546	47.3%
Total	7,587	6,457	627	14,671	51.7%

Source: SC Office of Research and Statistics and Thomson Reuters.
Note: As ZIP Code 29716 is a post office box, this ZIP Code was combined with 29715.
ZIP Code 29703 was combined with 29710, and 29731, 29733 and 29734 were combined with 29730.

Figure 3
Fort Mill Medical Center Service Area
Projected Inpatient Medical/Surgical and ICU Utilization

Area	2015 Total	2016 Total	2017 Total	2015 Admissions FMC	2015 Admissions PMC	2016 Admissions FMC	2016 Admissions PMC	2017 Admissions FMC	2017 Admissions PMC
PSA	11,903	12,228	12,563	3,056	5,518	3,697	5,511	4,351	5,393
SSA	5,283	5,418	5,555	140	2,502	169	2,567	199	2,626
York County (a)	17,186	17,646	18,118	3,196	8,020	3,866	8,078	4,549	8,019

Source: Claritas, SC Office of Research and Statistics and Polaris.
(a) For projections, York County = Service Area total
Note: As ZIP Code 29716 is a post office box, this ZIP Code was combined with 29715.
Similarly, ZIP Code 29703 was combined with 29710, and 29731 & 29733 were combined with 29730.
Excludes OB, OHS, cardiac Cath, and Psych.

The projected utilization at Fort Mill Medical Center was assumed to come from both a redirection of patients from Piedmont Medical Center, as well as those South Carolina patients historically going to North Carolina for care. Piedmont Medical Center's projected utilization also factored in both of these variables.

In 2009, Piedmont's market share of the service area was 53.8 percent. In the third year of operation of Fort Mill Medical Center (2017), Piedmont's market share is projected to be 48.8 percent. This represents a 5 percentage point reduction. Fort Mill Medical Center is projected to have a 27.7 percent market share. Therefore, approximately 18 percent of the Med/Surg and ICU admissions will be redirected from Piedmont's market share, with the remainder coming from redirection from North Carolina and market growth.

12. The Utilization Projections: MRI section on Page 37 references Figure 38, yet it is not listed. Please clarify or provide this table.

Response: The reference to Figure 38 referred to the figure in the original CON application, shown below.

CON Figure 38
2004 MRI Volumes
York County Providers

York County Provider	Units	Scans	Scans per Unit	Percent Capacity
Piedmont Medical Center	2	4,601	2,301	92.0%
Carolina Orthopedic Surgical Assoc.	1	2,079	2,079	83.2%
Carolinas Diagnostic Imaging	1	3,633	3,633	145.3%
Metrolina Neurodiagnostics Center	1	1,170	1,170	46.8%
Total	**5**	**11,483**	**2,297**	**91.9%**

Source: 2004 SC MRI Procedures by Facility; SC DHEC, Health Facilities and Services Development.

Since MRI utilization information is no longer collected or published by DHEC, the above information is the most recent volume data available for the market.

13. Provide the current and projected MRI utilization for Piedmont and projected utilization for FMC; indicate redirection from Piedmont to FMC. (p. 37)

Response: The following provides the last three years' MRI utilization information for Piedmont.

Figure 4

	2007	2008	2009
PMC	4,473	4,139	4,000
Piedmont East	1,002	1,134	369
Baxter Imaging			953
TOTAL	5,475	5,273	5,322

Source: Internal data

The following presents the projected MRI utilization at Fort Mill Medical Center. Consistent with the inpatient shift from Piedmont, it is assumed that approximately 18 percent of the volume will be redirected from Piedmont.

Figure 5

	2015	2016	2017
FMMC	821	998	1,166

Source: Internal data

14. Provide a 3 year projected data, inpatient and outpatient, for the following cases: outpatient, ED, surgical cases, endo, CT, MRI, mammo, nuclear med, etc. Indicate how many are redirected cases vs. in-migration. (p. 37)

Response: The following figure projects the outpatient utilization for various services at Fort Mill Medical Center. The volume that is expected to be redirected from Piedmont is consistent with the overall inpatient redirection and in-migration relationships identified in response to Question 11 above.

Figure 6
Fort Mill Medical Center
Detailed Volume Estimates

	2015	2016	2017	2018	2019
Admits:					
Total Admits	4,449	5,404	6,317	6,499	6,686
Visits:					
ER (OP)	18,580	22,879	27,494	29,100	30,776
OP Surgery	1,262	1,554	1,867	1,976	2,090
Other	27,618	34,007	40,868	43,256	45,748
Total	47,460	58,440	70,229	74,332	78,614
Other Referred OP Visits:					
Dept Description					
LABOR	346	420	491	505	519
VASCULAR SERVICES	399	485	567	583	600
PATHOLOGY	1,731	2,102	2,458	2,528	2,601
EKG	386	469	549	564	581
CATH LAB	468	568	664	683	703
EEG	64	77	91	93	96
RADIOLOGY	2,964	3,600	4,208	4,329	4,454
MAMMOGRAPHY	3,428	4,164	4,867	5,008	5,152
ULTRASOUND	1,857	2,256	2,637	2,713	2,791
CAT SCAN	2,247	2,730	3,191	3,283	3,377
ENDOSCOPY	1,995	2,423	2,833	2,914	2,998
INTERVENTIONAL RADIOLOGY	197	239	279	287	296
NUCLEAR MEDICINE	366	444	519	534	550
MRI	821	998	1,166	1,200	1,234
PHYSICAL THERAPY	210	256	299	307	316
OCCUPATIONAL THERAPY	45	55	64	66	68
SPEECH THERAPY	114	138	162	166	171
NUTRITIONAL SERVICES	27	33	39	40	41
OUTPATIENT OBSERVATION (NON-ED)	409	496	580	597	614
LABORATORY	4,236	5,145	6,014	6,188	6,366
OTHER	5,308	6,909	9,190	10,668	12,220
TOTAL VISITS OTHER	27,618	34,007	40,868	43,256	45,748

15. **Provide data/explanation to support "Piedmont Medical Center is currently very well utilized" when data shown in Figure 2, PMC Historical Utilization, p. 11, indicates a 2009 utilization of 57.1 %, which is a 18% decrease in utilization since 2003. (p. 39)**

Response: The reference to Piedmont's utilization refers to the historical utilization at the time of the original CON application. Since that time, utilization has declined as a result of several factors including reduced length of stay, increased observation patients, and increased outmigration to North Carolina. With approval of the proposed Fort Mill Medical Center, Piedmont is confident that utilization levels at both Piedmont Medical Center and Fort Mill Medical Center will be strong.

16. **Provide information to support "the vast majority of patients seeking care outside the state are not seeking specialized services in distant metropolitan areas ... " and "York County residents are traveling to NC for routine care out of convenience." (p. 44)**

Response: Based on the combined North Carolina and South Carolina utilization data, the majority of the residents who leave the state are traveling to Charlotte area providers and not Atlanta, Raleigh, or other cities. In 2009, of the 8,339 residents who left South Carolina for services, 8,054 (97 percent) went to one of the 14 Charlotte/Gaston area hospitals. Analysis of the DRG information shows that the vast majority of these patients were general acute care patients seeking services that would be provided by the proposed Fort Mill Medical Center. Using Presbyterian's criteria of a case mix greater than 2.0 as the threshold for specialized/high acuity patients, 7,540 or approximately 90 percent of the total admissions leaving the state had a case mix less than 2.0.

17. **B-17, Revised Figure 40, provide info re: how case mixes were adjusted; indicate and provide supporting data re: if hospitals are of similar size and services. (p. 48)**

Response: The concept of using case mix is a mechanism to adjust for the different complexity of cases treated by different facilities. The basis for the case mix is the Medicare Severity-Diagnosis Related Groups (MS-DRGs) case weights assigned by the Centers for Medicare & Medicaid Services (CMS). Patients are assigned to one of over 700 MS-DRGs (based on the principal and secondary diagnoses, age, procedures performed, the presence of co-morbidity and/or complications, discharge status, and gender). Each MS-DRG has a numeric weight reflecting the national "average hospital resource consumption" by patients for that MS-DRG, relative to the national "average hospital resource consumption" of all patients. A facility case mix index is then calculated by averaging the MS-DRG weight of patients discharged within the calendar year (the sum of the MS-DRG weights divided by the number of patients).

The "Medicare charge per discharge case mix adjusted", as indicated on Revised Figure 40 of the CON application, simply takes the total average charge per discharge and divides by the Case Mix index. This adjustment normalizes for patient acuity. By normalizing for patient acuity, the variation in the severity of illness and other factors are accounted for, allowing for a comparable analysis between facilities of different size and patient type.

18. Provide supporting info that "between 2003 and 2004, Piedmont lowered its rates by 13%." Indicate and support if further reductions have occurred. (p.48)

Response: In 2003, Piedmont Medical Center restructured its charge master and billing process. Through the process of adjusting charges for all inpatient and outpatient services, as well as changing the mechanism of billing for many services and departments, the overall impact was approximately a 13 percent facility wide reduction in gross charges.

The figure below provides the average Medicare inpatient charge per discharge case mix adjusted. The data shows that Piedmont's average Medicare inpatient charge declined approximately 12 percent from 2003 to 2004. During that same period, Carolinas Medical Center increased 3.2 percent and Presbyterian Hospital charges increased 11.5 percent. Overall, from 2001 to 2009, Piedmont's charges *decreased* nearly 5 percent or 0.6 percent annually, while CMC charges *increased* over 54 percent or 5.6 percent annually and Presbyterian Hospital's charges *increased* nearly 80 percent or 7.6 percent annually. In 2009, Piedmont's charges were less than those of both Carolinas Medical Center and Presbyterian Hospital.

Figure 7
Average Medicare Charge per Discharge
Case Mix Adjusted

										Change	
Facility	2001	2002	2003	2004	2005	2006	2007	2008	2009	'01-'09	Avg Annual
Piedmont Medical Center	$19,894	$20,755	$21,315	$18,858	$18,441	$18,666	$18,671	$18,692	$18,913	-4.9%	-0.6%
Carolina Medical Center	$12,539	$14,524	$15,537	$16,033	$16,869	$18,516	$18,259	$18,517	$19,319	54.1%	5.6%
Presbyterian	$10,599	$11,993	$12,919	$14,403	$15,169	$16,460	$17,888	$18,403	$19,028	79.5%	7.6%
Spartanburg	$12,590	$14,563	$16,011	$18,803	$21,429	$23,328	$25,504	$26,547	$26,842	113.2%	9.9%

Source: PMC internal info, MedPar data

19. On p. 50 and 64, explain "design and construction economies," relative to cost per square foot ($570 for FMC vs. $396.89 for PHFM) and per bed ($1,264,650 for FMC vs. $944,100.23 for PHFM).

Response: The three applicants have projected their capital costs in different ways. DHEC cannot make a comparable analysis of the applicants' projected costs without certain adjustments to make them more equivalent. The following identifies the areas of inconsistency.

Site and Road Development, Contingency, and IT Costs
Presbyterian's construction and equipment cost per square foot and per bed are unfairly lowered because they do not include site and road development costs, IT costs, or a contingency (Pres. Updated App. pp. 10, 13).

By contrast, Piedmont and CHS include IT costs in their equipment costs. They also include site/road development and contingency costs in their construction costs (**Attachment A**; Pied. Updated App. Bates pp. 8, 88; CHS Updated App. pp. 131, 161, 192).

Figure 8 in this response classifies costs the same way for all three applicants, so that DHEC can fairly compare them.

Capitalized Interest
If its application is approved, CHS intends to finance its project through cash reserves. (CHS Updated App. p. 249.) Presbyterian would also like to finance its project from cash reserves, but notes that bond financing is another option. (Pres. Updated App. pp. 44-45.) Piedmont intends to finance its project "through the most appropriate and cost-effective capital structure available at the time: utilizing existing cash reserves, existing lines of credit, or the issuance of debt and/or equity." (Piedmont Updated App. p. 211.)

Whether a project is financed internally or externally makes no difference, however, in projecting costs. Even internal financing requires imputed interest costs to be considered. Piedmont, therefore, included as part of its project costs capitalized interest of $8,962,851. (Piedmont Updated App. p. 8.) Neither CHS nor Presbyterian, however, included any capitalized interest in their project costs. For an appropriate comparison to be made of the three applicants, either:

a) all three applicants must *include* capitalized interest cost; or
b) all three applicants must *exclude* capitalized interest costs.

Since the other applicants did not include capitalized interest expense, **Attachment A** and **Figure 8** provide project costs that excludes this line item.

Inflation
CHS and Presbyterian's construction equipment and IT costs appear to be based on 2010 prices. By contrast, Piedmont's projected costs include inflation factors based on *2014* prices. A fair, direct comparison of the three applicants cannot be made unless either:

a) CHS and Presbyterian construction, equipment, and IT costs are inflated to 2014 prices; or
b) Piedmont's construction, equipment, and IT costs are de-inflated to 2010 prices.

Figure 8 de-inflates Piedmont's costs, so that DHEC may compare all three applicants based on 2010 pricing. As discussed in response to question 1, due to an oversight, Piedmont's Updated Application based medical equipment costs on list prices, failing to account for Piedmont's standard average group purchasing discount of 22 percent. **Figure 8, Attachment A** and **Attachment B** reflect this discount.

The Apples-to-Apples Comparison
As discussed above, a fair, apples-to-apple comparison of the three applicants' projected capital costs can be made only after certain adjustments are made. These adjustments are reflected in **Figure 8,** which demonstrates that Piedmont's costs compare favorably with CHS and Presbyterian. They are also reflected in **Attachment A** and **Attachment B,** a replacement for page 5 (Bates p. 8) of Piedmont's updated Application (Part A, section 9-11 of Questionnaire).

Inexpensive Medical Equipment May Not Lead to Efficiencies
Finally, it is important to recognize that the most efficient project is not necessarily the cheapest. The 16-slice CT, 1.5T MRI, and analog (rather than digital) equipment that Presbyterian proposes to use are undoubtedly cheaper than the equipment Piedmont would use, but they do not have the same capabilities as that proposed by Piedmont.

Figure 8
Capital Cost Comparison

	FMMC 2014 pp. 8, 12, 76, 87-89	FMMC 2010 Attachments A,B	CMC-FM 2010 pp. 131, 161	PH-Y 2010 pp. 10, 13
Land Cost	4,668,605	4,668,605	2,397,000	1,309,000
Construction	75,631,867 [1]	68,160,435 [1]	43,447,925 [4]	48,071,639 [6]
Equipment	50,833,168 [2]	40,966,040 [3]	29,910,940 [5]	23,162,359 [7]
A&E	5,260,735	4,849,059	3,345,495	3,155,014
Interest	8,962,851	0	0	0
Misc/Other	1,164,816	1,164,816	0	550,000
Sub-Total	*146,522,042*	*119,808,954*	*79,101,360*	*76,248,012*
- Interest	8,962,851	0	0	0
Total	**137,559,191**	**119,808,954**	**79,101,360**	**76,248,012**
Square Feet	221,895	221,895	140,000	152,240
Beds	100	100	64	64
Construction and Equipment per SF	$569.93	$491.79	$523.99	$467.91
Construction and Equipment per Be	$1,264,650	$1,091,265	$1,146,232	$1,113,031
Total Cost per SF	**$619.93**	**$539.94**	**$565.01**	**$500.84**
Total Cost per Bed	**$1,375,592**	**$1,198,090**	**$1,235,959**	**$1,191,375**

1 Includes a 5% contingency plus all site and road development.
2 Includes IT and all other FF&E costs. Medical Equipment is at list price.
3 Includes IT and all other FF&E costs. Medical Equipment is discounted.
4 This amount includes site development and a contingency. (CHS Updated App p. 192)
5 Includes IT and all other FF&E costs.
6 This amount includes site improvements ($2,901,474), road improvements ($1,910,109), and a contingency ($3,000,000). (See Pres. Updated App. p. 13.)
7 This amount contains FF&E ($20,162,359) and IT ($3,300,000). (Pres. Updated App. p. 13.)

20. P. 64, Attachment W, please provide a copy of the signature page for the 8th addendum, and the first page and signature page for the 9th addendum. Please provide a copy of the county area map mentioned in Schedule 3 .2(e)(1) of the initial contract.

Response: **Attachment D** provides the requested pages for the 8th and 9th addendums. Both documents in their entirety were submitted to DHEC as part of the original CON submission and additional information.

21. P. 347 mentions ambulance service furnishing transportation to "any hospital operating within the geographic limits of York Counties and all counties contiguous to York County." Indicate if this includes CMC Steele Creek and CMC Pineville.

Response: Section 3.2(a) of the Sixth Addendum to Agreement By and Among American Medical International, Inc., Amisub of South Carolina, Inc., and York County, South Carolina dated August 25, 1995 states:

AMI shall provide ambulance service at no expense to York County, which ambulance service shall respond to calls within the geographical limits of York County on a twenty-four hours basis, and which shall furnish transportation by ambulance to any hospital operating within the geographic limits of York County and all counties contiguous to York County.

The above would include all hospitals operating in Mecklenburg County, North Carolina, including CMC Pineville.

With regards to CMC Steele Creek, CMC Steele Creek is not a hospital and thus is not covered by the above referred obligation. However, should a patient request to go to CMC Steele Creek and in the judgment of the EMS Medical control physician, the patient would not be compromised by being taken to a facility with limited service capability, then Piedmont EMS will transport a patient to that facility.

22. Please provide the most recent copy of the Annual Report referenced on page 366.

Response: See **Attachment E**.

23. Please indicate if Amisub has had to adjust rates as described in section (iii) on page 380 of the Eighth Addendum; if yes, provide dates. Please indicate if Amisub has had to pay the sum of one hundred thousand dollars per month as described in section (iii) on pages 380 and 381 of the Eighth Addendum. If yes, provide dates and penalty amount(s).

Please indicate if the contributions were made as described in Section 3.7(a) of the Eighth Addendum on pages 381 and 382.

Response: Amisub has not adjusted rates as described in section (iii) on page 380 of the Eighth Addendum. Amisub has not paid any penalty amounts as outlined in the Eighth Addendum.

Contributions have been made as described in Section 3.7(a) of the Eighth Addendum on pages 381 and 382.

24. In reference to the pro formas provided in Attachment K, please address the following:

- **P. 213, Financial Projections, explain the difference between the line items "FTEs worked" vs. "FTEs paid" as shown on the Fort Mill Medical Center.**
- **Explain the column labeled "Start-up Period". For what time frame does this period consist?**
- **Please provide the following for each pro forma:**
- **Payor mix; descriptions of "Other" under "Deductions from Revenue", "other professional fees", "other fees and services", "Other Ctrl Expenses".**
- **Please provide separate pro forma for Piedmont Medical Center with and without Fort Mill Medical Center. These pro formas should be consistent with the format of the one provided in Attachment K and contain all applicable assumptions.**

Response: The variance between paid FTEs and worked FTEs represent vacation, sick, holiday and other nonproductive time. Paid FTEs represent the total number of full time equivalents that are required. Worked FTEs represents the staff actually on-site working/providing care.

The "Start-up" period represent the preopening period prior to actually admitting and treating patients at the new hospital. The expenses reflect the estimated costs to hire and staff the building prior to being fully operational.

The payor mix was held constant throughout the projection period. The following is the assumed payor mix for Fort Mill Medical Center and Piedmont Medical Center. The Fort Mill Medical Center payor mix was based on the 2009 County average, adjusted to reflect the Fort Mill market as well as Piedmont's experience.

Figure 9
Piedmont Medical Center
Payor Mix

Medicare	50.2%
Medicaid	13.9%
Commerical/Managed Care	25.7%
Self Pay/Charity/Other	10.2%

Source: PMC internal data

Figure 10
Fort Mill Medical Center
Payor Mix

Medicare	42.0%
Medicaid	14.0%
Commerical/Managed Care	34.0%
Self Pay/Charity/Other	10.0%

Source: PMC internal data

The following provides descriptions of the various categories in the Pro Formas:

Other Deductions: Tricare/Champus, Commercial Workers Comp, VA, Other Government, Commercial Discounts (non-managed care), etc.

Medical and Clinical Fees: Physician Fees (i.e., Intensivists, Hospitalists, ER Physicians), Medical Directorships, Outside Medical Services (i.e., Dialysis, Radiation Oncology), Outside Medical Testing (i.e., Reference lab).

Other Professional Fees: Consulting Services, Management Fees, Legal Fees, Audit Fees, Board of Director Stipends, Personnel Recruiter Fees.

Other Fees and Services: Contracted Departments (i.e., EVS and Food and Nutritional Services, BioMed, Admitting, I.T.).

Other Controllable Expenses: Utilization Review, Minor Equipment, Recruiting, Software, Advertising, Contributions, Freight, Postage, Dues/Subscriptions, Outside Training, Training/Development, Travel, Recruitment, other.

Attachment F provides a separate pro forma for Piedmont Medical Center with and without Fort Mill Medical Center. The pro forma without Fort Mill Medical Center assumes that one of the North Carolina applicants are approved.

25. **Each applicant is requested to identify any deficiencies, violations, and penalty actions cited by state and/or federal divisions (that are comparable to the SC Department of Health and Environmental Control's Certificate of Need Division, Division of Licensing, Bureau of Radiological Health and Bureau of Certification (Medicaid/Medicare), as well as any pending civil actions within the last three (3) years of operation. Please also include comparable information concerning TJC inspections. This information should include any health care facilities in which the applicant/owner has an ownership interest.**

    Additionally, address any civil actions against the licensee or affiliated entities.

Response: During the period requested, Piedmont has received two EMTALA citations that were favorably resolved without penalty. Piedmont is not party to any pending civil action filed by state or federal agencies.

We trust this information is sufficient for you to deem the application complete and initiate the review of this project. If you have any additional questions, please do not hesitate to contact me at 843.379.9372. I look forward to working with you as this project continues.

Sincerely,

David S. Levitt
Managing Partner

cc: Charles Miller, President/CEO

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Tenet

TENET HEALTHCARE CORPORATION

Construction and Design - Project Cost Estimate (PCE)

Facility: **Piedmont - Fort Mill**
Project: **New Hospital with 3.0T MRI**
Project No.: **000-00-000**
Prepared By: **KCP**
Date: **9/13/2010**

Revision: 1
Print Date: 11/29/2010 12:43
Inflation Rate: 0.00%
Cap Interest Rate: 0.00%

	CER Category	Budget
1	Professional Fees	$4,849,058.97
2	Construction	$68,160,435.00
3	Equipment/Furniture	$40,966,039.54
4	Permits and Fees	$264,816.00
5	Tests and Inspections	$525,000.00
6	Construction Administration	$375,000.00
7	Administration Other	$0.00
8	Project Administration	$0.00
9	Pre CER Expenditures (CIP)	$0.00
10	Capitalized Interest	$0.00
11	Land Purchase	$4,668,604.81
12	Other Substituted Funds	$0.00
	TOTAL PROJECT COST ESTIMATE INCLUDING CAPITALIZED INTEREST	**$119,808,954.32**

Project Manager's Comments:

This estimate does not include inflation beyond 2010 and no capitalized interest cost. Construction costs include all site and road development costs and a 5% contingency.

Proposed Durations (Post Approval Process)

0.	CER Approval Projected	11/15/2010
1.	Drawings Submitted to City/State	4/20/2013
2.	Agency Reviews Completed	6/16/2013
3.	Construction Start	7/16/2013
4.	Construction Completed	5/12/2015
5.	Construction Occupancy Date	7/9/2015
	PROJECT DURATION (From CER Approval)	**56 Months**

ATTACHMENT A

PROJECT COST SUMMARY

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ATTACHMENT B

REPLACEMENT PART A, PAGE 3 (BATES PAGE 8), CON APPLICATION

Part A - Questionnaire (Page 3) – The following reflect updated costs	
9. Construction and Site	
A. Type of Construction: New Construction	**B. Number of Buildings:** One
	C. Number of Stories: Five
D. Size of the Site in Acres: 16.75 acres	**E. Square Footage of Facility:** 221,895 Gross S.F.
F. Anticipated Date of Beginning Construction: July 2013	**G. Anticipated Date of Licensing or Project Completion:** Facility will be licensed July 2015
10. Zoning of Construction Site: Commercial	
11. Costs (Provide Estimated Cost Statement from Either the Architect or Engineer)	
A. Land Cost: $4,668,605	**B. Construction Cost:** $68,160,435
C. Architect's Fee: $4,849,059	**D. Equipment Costs:** $40,966,040 **1) Fixed Equipment:** $9,153,826 (medical)
E. Financing Cost During Construction:	**2) Movable Equipment** : $14,317,524 (medical)
F. Other Costs: (includes tests, inspections, and permitting): Other Costs - $1,164,816	**G. Total Project Cost:** $119,808,954 Increase from original submission is attributable to inflation and changes in technology/equipment costs.
H. Construction and Equipment Cost: **1) Per Square Foot:** $492 **2) Per Bed:** $1,091,265	

C

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ATTACHMENT C

OPEN SPACE, TRANSPORTATION, AND PRIORITY INVESTMENT ACT
SECTIONS OF THE 2025 COMPREHENSIVE PLAN

YORK COUNTY 2025 COMPREHENSIVE PLAN

PRIORITY INVESTMENT ELEMENT

November 2009



Prepared by the York County Department of Planning and Development

Introduction

According to the United States Census Bureau, York County's population increased from 164,614 in 2000 to an estimated 208,827 in 2007, which represents a 26.8% increase. This level of growth creates enormous demands on community facilities and infrastructure. As a local government with a commitment to serve its citizens, York County recently developed a Capital Improvement Plan to address the infrastructure demands from its unprecedented growth. In order to fund these improvements, significant budget requests should continue to be prioritized so that millage rate increases can be curtailed while the County's infrastructure is maintained, upgraded, and expanded.

In the 2008-2009 budget Capital Project Funds included nearly $228.9 million in appropriations for improvements and additions to county facilities, the 1997 and 2003 Pennies for Progress Programs, C-Fund projects, and water and sewer capital projects. By investing in these projects, the county will have the ability to support the existing population and offer adequate facilities for businesses and newcomers interested in relocating to York County. Although these measures require a level of investment beyond the status quo, meeting immediate needs and investing for future populations will be highly beneficial for long-term payoffs.

Purpose and Rationale

The Priority Investment Element is intended to analyze "the likely federal, state and local funds available for public infrastructure and facilities during the next ten years, and recommend[s] the projects for expenditure of those funds during the next ten years for needed public infrastructure and facilities such as water, sewer, roads, and schools" according to Section 6-29-510(D) of the 1976 South Carolina Code as amended by the Priority Investment Act.

By projecting capital improvement costs and available funds over the ten year planning horizon and coordinating with all "relevant and adjacent jurisdictions" as specified in the Act, substantial budget shortfalls should be reduced, interjurisdictional coordination should be improved, and opportunities to collaborate in cost saving ventures can be identified.

Organization

The York County budget includes three primary areas under "Capital Project Funds." These are capital facilities (building construction and improvements), water and sewer capital projects, and capital projects relating to transportation. Because these three categories constitute nearly all capital projects in the county budget, this plan is divided into sections focusing on each one.

York County is funded by several revenue sources and funding mechanisms to finance the planning, design, construction, and maintenance of capital projects. Impact /capacity fees are used to fund some water and sewer expansion projects, and user fees fund system maintenance, which can require equipment replacements and upgrades. Transportation projects are funded

primarily by revenue generated through a special sales tax and by state and federal grants made available in past years. Building construction and improvements are normally funded through the general fund and bond issues. Because each project category is funded through specific revenue streams, they are organized accordingly in this element.

In each of the following sections, all primary funding sources are described including past revenue levels. Where possible, projections regarding the availability of these funds have been made. Although the projected figures are as accurate as possible, the entries on the tables should be updated annually to reflect the most recent projections. Other less consistent funding sources are not included in revenue projections simply because their availability is unpredictable from one budget cycle to the next. These sources are also described briefly and may reference past allotments. However, this is not an indicator of what may be available in the future.

In addition to the funding sources dedicated to a specific type of capital expenditure, other funding sources with various allowable uses are included in a separate section that identifies general funding sources.

It is important to note that schools are not included in this plan, although the enabling Act includes them as an example of "needed public infrastructure." Schools in York County function as districts independent from the county government. Each school district in the county gains revenue from ad valorem taxation and sales tax. This includes a base school millage, a levy for bond retirement, and an additional 30 mils per district for a county wide tax. With funding gained through taxes, awarded grants, bonds and other revenue streams; school boards initiate and execute all elements of capital improvements relating to education.

General Revenue Sources

There are several sources of revenue available for funding capital projects. Some, like sewer and water impact /capacity fees, are dedicated to funding one particular type of capital projects. Other sources, like those found in this section, can be used to fund any number of different capital projects. Because of the structure of York County's capital improvement strategy, many of these general sources are used to fund capital building projects, although they can also be appropriated to supplement funding gaps where needed and to implement more ambitious projects in a shorter time period than what would normally occur under a pay as you go method.

Local and State Hospitality Tax
A combined $450,000 was generated last year by state and local accommodations taxes. Charged in addition to the standard 5% sales tax, the State Accommodations Tax is a 2% charge on the rental of transient accommodations. York County adds a fee in addition to the state sales tax and the State Accommodations Tax. This local accommodations tax is 3%. Through this formula, an additional 5% is taxed above the normal sales tax for all overnight lodging in York County. The revenue generated by these taxes must be spent on a limited scope of improvements aimed at increasing tourism and improving the experience of out-of-town guests. Some transportation and sewer projects are allowed under the condition that they serve tourism related improvements.

General Fund
A portion of building improvements and new facilities construction relies on appropriations from the general fund. The primary funding source of the York County general fund is property tax. Other key revenue sources contributing to the general fund include the State of South Carolina, fees for County services, fines, miscellaneous sales, and interest income.

General Obligation (GO) Bonds
General obligation bonds, backed by the "full faith and credit" of the county, are considered a safe investment for bond holders. The principal and interest of these bonds are paid through property taxes collected and other general revenue. South Carolina law limits jurisdictions from issuing bonds in excess of 8% of its total assessed property value. The county is currently servicing debt on $97.2 million in GO bonds with remaining principal and interest payments totaling $103.6 million. Approximately 65% of this was approved in October 2008 to fund Pennies for Progress projects, Department of Social Services improvements, and jail construction.

Revenue Bonds
Revenue bonds do not pledge the full faith and credit of the jurisdiction and are considered limited liability revenue bonds. Typically, pledges are made to dedicate one specific revenue source to repay these bonds. Revenue bonds are not included in the 8% general obligation debt

limit set by the State. The county is currently repaying $27 million in revenue bonds, with remaining principal and interest payments totaling $38.8 million.

Grants

Grants are discretionary contributions by a government or other organization to support a particular function. Most grants received by the county are for operations, but grants supporting capital improvements are not uncommon. There is no assurance that these monies will be available in the future. However, it is assumed that some capital improvements will continue to be funded with grant assistance. For this analysis, it has been assumed that the county will receive $500,000 grants for capital facilities improvements annually through the duration of the planning horizon. This is a conservative figure inferred from grant awards from previous years.

Capital Building Projects

Capital Building Projects

The Capital Projects Fund is used to finance all stages of building construction and renovations for County owned and operated facilities. Major projects for the 2009-2010 budget include jail and prison housing, courthouse renovations, a recycling center, and fire substations. Funding sources for these improvements primarily come from bond proceeds and appropriations from the general fund. The present capital projects plan outlines improvements three years into the future. The details of this plan are included in Table 1. Although these plans do not extend into the ten year planning horizon, the plan currently set forth is aggressive and may meet many of the county's current needs for the years to come.

Table 1: Capital Building Projects

PROJECTS	2009-2010	2010-2011	2011-2012	2012-2019	Total
Moss Justice Center					
Phase I - Parking Expansion (Public) - 200 Spaces	$ -	$ 1,131,841	$ -	$ -	$ 1,238,666
Phase II - Court Exp/ Reno - 53,700 sf exp./ 30,000 sf reno.	$ 529,294	$ 1,170,640	$ 16,217,376	$ -	$ 17,917,310
Phase II - Central Plant Expansion - 8,500 sf	$ -	$ 481,032	$ 4,589,045	$ -	$ 5,070,077
Phase IV - 128-Bed Jail Housing Expansion - 32,000 sf	$ 7,302,427	$ -	$ -	$ -	$ 7,302,427
Prison Housing	$ 329,393	$ -	$ -	$ -	$ 329,393
Probation / Parole Renovations	$ 215,090	$ -	$ -	$ -	$ 215,090
Security System and Construction	$ 480,423	$ -	$ -	$ -	$ 480,423
Total	**$ 529,294**	**$ 2,783,513**	**$ 20,806,421**	**$ -**	**$ 32,553,386**
Cultural and Heritage Museums					
Hightower Hall Improvement	$ 229,753	$ -	$ -	$ -	$ 229,753
McCelvey Renovations	$ 3,500,000	$ -	$ -	$ -	$ 3,500,000
Museum of Life and Environment	$ -	$ 1,000,000	$ -	$ -	$ 1,000,000
Total	**$ 3,729,753**	**$ 1,000,000**	**$ -**	**$ -**	**$ 4,729,753**
Rural Fire Board					
Aerial Replacement	$ -	$ 400,000	$ 400,000	$ -	$ 800,000
Fire Substations	$ 3,127,285	$ -	$ -	$ -	$ 3,127,285
Fire Training Renovation	$ 705,204	$ -	$ -	$ -	$ 705,204
Total	**$ 3,832,489**	**$ 400,000**	**$ 400,000**	**$ -**	**$ 4,632,489**
Other County Capital Projects					
Records Management/Computer Aided Dispatch	$ -	$ 166,666	$ 166,667	$ -	$ 333,333
Tax Software	$ -	$ 650,000	$ 650,000	$ -	$ 1,300,000
Heckle Building 3 Renovations	$ 302,445	$ -	$ -	$ -	$ 302,445
York DSS Building Renovations	$ 1,562,088	$ -	$ -	$ -	$ 1,562,088
DSS Building - Phase II	$ 813,642	$ -	$ -	$ -	$ 813,642
DSS Building - Phase I	$ 1,941,064	$ -	$ -	$ -	$ 1,941,064
Library Construction and Improvements / Land	$ 24,621	$ -	$ -	$ -	$ 24,621
Communications Building	$ 1,515,530	$ -	$ -	$ -	$ 1,515,530
Recycling Center	$ 4,724,093	$ -	$ -	$ -	$ 4,724,093
Total	**$ 10,883,483**	**$ 816,666**	**$ 816,667**	**$ -**	**$ 12,516,816**
Courthouse					
Interim Courthouse Renovation and Construction	$ 529,294	$ -	$ -	$ -	$ 529,294
Phase II - Courthouse Renovations	$ 4,828,350	$ -	$ -	$ -	$ 4,828,350
Total	**$ 5,357,644**	**$ -**	**$ -**	**$ -**	**$ 5,357,644**

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RECORD 002630

Projecting capital improvements past the 2012-2013 budgets is difficult in the current economic climate because there is limited predictability for future excess county revenues. Projections of future revenues are shown in Table 2. Most sources contributing to this fund are relatively uncertain from this point. Of course, scheduled bond proceeds will occur at increments throughout the next ten years. Grants and matching funds occurring in the past are expected to continue, but growth in these categories is limited or reduced based on a level of uncertainty in regards to their availability.

Table 2: Estimated Capital Fund Appropriations

	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
Grants	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000
Bonds - Current Fiscal Year	$ -	$ -	$ 20,806,421	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bond Proceeds - Prior Fiscal Years	$ 22,353,925	$ 3,312,807	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Appropriations	$ 6,659,324	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interest Income	$ 106,825	$ 25,000	$ 150,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Matching Funds	$ 51,412	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Funding Sources	$ 29,671,486	$ 3,837,807	$ 21,456,421	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000

Table 3: Overall Capital Building Project Totals

	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
Revenue	$ 29,671,486	$ 3,837,807	$ 21,456,421	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000
Capital Improvements	$ 29,671,486	$ 3,837,807	$ 21,456,421	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000
Excess Revenue over Expenditures	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

RECORD 002632

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Capital Building Projects Analysis

The County aims to implement a capital building improvement plan over the next three years totaling over $50 million. This plan addresses several facilities outlined in Table 1 and will be contributed to heavily by bond proceeds. Because these proceeds exceed the planned facility improvement costs, there will be surplus funds to fund new projects, complete existing and underfunded projects on the Pennies for Progress Program project list, or to roll into the subsequent year as fund balance.

Transportation

Needed transportation improvements in York County are identified and addressed by three entities: South Carolina Department of Transportation (SCDOT), the Rock Hill – Fort Mill Area Transit Study (RFATS), and the York County Government. The SCDOT both funds and implements projects. RFATS is responsible for prioritizing local improvement projects and distributing funding to the county and other municipalities for implementation. County specific capital projects are prioritized and funded through a capital projects sales and use tax known as the Pennies for Progress Program. Only the remaining projects included in the 1997 and 2003 Pennies for Progress Program are outlined in this element because they are the only long term capital projects initiative operated by the local government to fund transportation improvements. However, other organizations with separate prioritized projects lists are described in order to recognize them as funding contributors.

One Cent Sales and Use Tax – Pennies for Progress

The Pennies for Progress Program is York County's only true transportation capital improvements program. Although other transportation funding mechanisms exist such as C-Funds and the Rock Hill Fort Mill Area Transit Study, these programs identify and prioritize projects on an annual basis according to the funding amount available. The Pennies for Progress program outlines transportation improvement priorities over a multiyear period to be funded in order of priority using proceeds from a special sales tax levied in the county. The Pennies for Progress program began in November 1997 when a measure to fund local transportation infrastructure through a local capital projects sales tax to improve roads throughout the county was passed by referendum. Over six years the tax generated over $103.4 million in revenue and funded 14 projects with a total budget of $218 million. The remaining projects funded through this program can be found in Table 4.

1997 Pennies for Progress

Referendum Passed: 1997
Tax Expires: November 2003
Capital Through Tax: $103.4 million
Additional Capital Leveraged: $73.25 million to date
Number of Projects: 14
Program Duration: 1998 to 2012

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JOINT-B-PMC-001.0483

RECORD 002634

Table 4: Remaining 1997 Pennies for Progress Projects, funded

Project	Project Type	Project Name	2009-2010	2010-2011	2011-2012	2012-2013
97-006	Multi-lane Widening	SC Highway 274	$13,485,067	$ -	$ -	$ -
97-007	Multi-lane Widening	SC Highway 901 (SC Highway 72 to I-77)	$ 9,111,947	$ -	$ -	$ -
97-009	Multi-lane Widening	Cherry Road (York Ave. to Heckle Blvd.)	$ 4,215,864	$ 1,264,759	$ -	$ -
97-011	Multi-lane Widening	SC Highway 72/Albright Rd. (Black St. to	$ 2,174,886	$ 6,524,658	$1,631,165	$ -
97-012	Multi-lane Widening	SC Highway 5 Bypass	$ 5,762,159	$ 6,285,991	$6,285,991	$3,666,828
Totals			$34,749,923	$14,075,409	$7,917,156	$3,666,828

In November 2003 the Pennies for Progress Program was continued though a voter referendum. The continuation of the local option tax was intended to fund 25 projects totaling $173 million. Through a recent assessment of the 2003 Pennies for Progress Program, it has been discovered that the program needs an additional $169 million to complete the entire project list. This shortfall is due to a continued rise in construction material and right of way acquisition costs, as well as a limited construction workforce. These factors caused the costs to complete the planned improvements to increase significantly after the initial cost estimates and project list were developed. In addition, the economic downturn has significantly reduced funding available from federal and state sources through grants. Remaining projects to be completed with the available 2003 Pennies for Progress funding are shown in Table 5. Other unfunded projects are included in Table 6. York County continues to explore additional funding opportunities to help complete the 2003 Pennies for Progress projects.

2003 Pennies for Progress

Referendum Passed: 2003
Tax Expires: August 2011
Capital Through Tax: $173 million
Additional Capital Leveraged: $500,000 (to date)
Number of Projects: 25
Program Duration: 2004 to 2013

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JOINT-B-PMC-001.0485

RECORD 002636

Table 5: Remaining 2003 Pennies for Progress Projects, funded

Project Number	Project Type	Project Name	2009-2010	2010-2011	2011-2012	2012-2013
03-002		Intersection Improvements	$1,592,932	$1,006,688		
03-002d	Safety Improvements	SC Highway 55/Rhyne Road	$579,307			
03-002f	Safety Improvements	SC Highway 321/Ferguson Ridge Road/Ridge Road	$381,127	$381,127		
03-002g	Safety Improvements	Porter Road/Firetower Road	$507,385			
03-002i	Safety Improvements	SC Highway 324/Cameron Road/Gordon Road	$125,112	$625,561		
03-002		Intersection Improvements	$4,878,426	$6,098,033		
03-002d	Safety Improvements	SC Highway 55/Rhyne Road	$579,307			
03-002f	Safety Improvements	SC Highway 321/Ferguson Ridge Road/Ridge Road	$381,127	$381,127		
03-002g	Safety Improvements	Porter Road/Firetower Road	$507,385			
03-002i	Safety Improvements	SC Highway 324/Cameron Road/Gordon Road	$125,112	$625,561		
03-003		SC Highway 55 East of Clover	$4,381,137	$5,476,421	$3,285,852	
	Three-Lane Widening	Between Quinn Road and Green Pond Road east of Clover	$4,381,137	$5,476,421	$3,285,852	
03-004		Fort Mill Southern By-pass	$4,880,373	$19,521,492	$19,521,492	$7,320,560
	Two-Lane Alignment	Fort Mill Parkway near Brickyard Road and Banks Street (Phase I)	$4,880,373	$12,200,933	$7,320,560	
	Two-Lane Alignment	Springfield Parkway near it's intersection with SC Highway 160 (Phase II)		$7,320,560	$12,200,933	$7,320,560
03-005		SC Highways 49/211/97/ Nimitz Road Loop	$4,421,459	$5,895,278	$4,421,459	
	Safety Improvements	SC 321 South in York to SC Highway 5 at Nimitz Road	$4,421,459	$5,895,278	$4,421,459	
03-006		Tega Cay/Gold Hill Road Connector				
	Two-Lane Alignment	Beginning at Stonecrest Development and ending at Gold Hill Road				
03-007		SC Highway 274 Intersection Corridor	$3,227,032	$6,454,064		
03-007a	Safety Improvements	Adnah Church Road/SC Highway 161/ SC Highway 274	$700,000	$1,400,000		
03-007b	Safety Improvements	Adnah Church Road/ SC Highway 5/Eastview Road	$631,758	$1,263,516		
03-007c	Safety Improvements	Eastview Road/McConnell's Hwy/Falls Road	$631,758	$1,263,516		
03-007d	Safety Improvements	Falls Road/Robertson Road	$631,758	$1,263,516		
03-007e	Safety Improvements	Robertson Road/Neely Road	$631,758	$1,263,516		
03-008		US Highway 21	$1,255,534	$6,277,669	$6,277,669	$2,511,068
	Safety Improvements	I-77 to Sutton Road	$1,255,534	$6,277,669	$6,277,669	$2,511,068
03-009		Gravel Road Group 1	$2,101,319	$3,151,978		
	Gravel Road Paving	Cheek Rd, Mountainview Rd, Forestview Rd, et al	$2,101,319	$3,151,978		
	Gravel Road Paving	Ferguson Long Road				
	Gravel Road Paving	Ranger Road				
	Gravel Road Paving	Enon Church Road				
	Gravel Road Paving	Mission Road				
	Gravel Road Paving	Shillinglaw Road				
	Gravel Road Paving	Pamela Road				
	Gravel Road Paving	Sikes Road				
03-010		White Street Realignment and Railroad Crossing				
	Three-Lane	From Dave Lyle Boulevard to Constitution Boulevard				
03-011		McConnell's Highway	$1,105,556	$5,527,781	$5,527,781	
	Three-Lane Widening	Heckle Boulevard to SC Highway 324	$1,105,556	$5,527,781	$5,527,781	
03-012		Mount Gallant Road		$2,027,148	$5,067,869	$3,040,721
	Three-Lane Widening	Dave Lyle Boulevard to Anderson Road		$2,027,148	$5,067,869	$3,040,721
Totals			$24,558,272	$49,024,649	$31,901,190	$5,551,789

Table 6: Remaining 2003 Pennies for Progress Projects, unfunded

Project Number	Project Type	Project Name	Estimated Cost
03-013		SC Highway 557	$21,862,600
	Three-Lane Widening	Kingsbury Road to SC Highway 49	
03-014		Ebinport Road	$12,707,216
	Three-Lane Widening	Cherry Road to India Hook Road	
03-015		SC Highway 160	$4,689,507
		Springfield Parkway to Lancaster County Line	
03-016		Riverview Road	$8,722,527
	Intersection and Drainage Improvements	Eden Terrace to SC Highway 161	
03-017		SC Highway 72	$14,162,290
	Three-Lane Widening	SC Highway 901 to Rambo Road	
03-018		Gravel Road Group 2	$5,021,656
	Gravel Road Paving	Southbend Road	
	Gravel Road Paving	Calabash Road	
	Gravel Road Paving	Wilkerson Road	
	Gravel Road Paving	Canaan Church Road	
	Gravel Road Paving	Piedmont Springs Road	
	Gravel Road Paving	Montview Road	
	Gravel Road Paving	Carroll Falls Road	
	Gravel Road Paving	Burns Road	
	Gravel Road Paving	Turner Road	
	Gravel Road Paving	Traylor Road	
	Gravel Road Paving	Beersheba Road	
	Gravel Road Paving	Frontier Road	
	Gravel Road Paving	James Harvey Road	
	Gravel Road Paving	Longleaf Road	
	Gravel Road Paving	California Road	
	Gravel Road Paving	Garvin Road (part)	
	Gravel Road Paving	Arrow Road	
	Gravel Road Paving	Devinney Road	
	Gravel Road Paving	Nivens Road	
	Gravel Road Paving	Dunree Street	
	Gravel Road Paving	South Fork Road	
	Gravel Road Paving	Shady Oak Lane	
	Gravel Road Paving	Greenglen Road	
	Gravel Road Paving	Faires Road	
03-019		Mount Gallant Road	$24,429,003
	Three-Lane Widening	Celanese Road to Twin Lakes Road	
03-020		SC Highways 274/279	$24,975,667
	Three-Lane Widening	Pole Branch Road	
03-021		Ebenezer Road	$8,763,433
	Three-Lane Widening	Frank Gaston Boulevard to SC Highway 161	
03-022		Springhill Farm Road	$10,934,331
	Five-Lane Widening	SC Highway 51 to US Highway 21	
03-023		SC Highway 51	$11,408,674
	Five-Lane Widening	US Highway 21 to NC State Line	
03-024		Eden Terrace Road	$10,830,786
	Three-Lane Widening	Bradley Street to Anderson Road	
03-025		SC Highway 160	$5,003,129
		Gold Hill Road to Zoar Road	
		Program Management	
Totals			$163,510,820

The Priority Investment Act specifies that all capital projects to be implemented over a ten year planning horizon be recognized. Although the 2003 Pennies for Progress Program was originally planned to last through 2015, the present funding shortfall will likely lengthen the timeline based on available future funding. In order to account for all unfunded 2003 Pennies for Progress Program projects to be implemented, projects and their costs have been included in Table 6 in order of priority, but phasing details are not included. Implementation will be in order of priority as funding becomes available. If passed by voter referendum, a 2010 Pennies for Progress local capital projects sales tax could be a potential source of funding.

Congestion Mitigation and Air Quality Improvement Program Funds (CMAQ)

The CMAQ program, jointly administered by the Federal Highway Administration (FHWA) and the Federal Transit Administration (FTA), was reauthorized in 2005 under the Safe, Accountable, Flexible, and Efficient Transportation Equity Act: A Legacy for Users (SAFETEA-LU). Over the 5 year period from 2005 to 2009, the CMAQ program provided over $8.6 billion dollars in funds to State DOTs, Metropolitan Planning Organizations (MPO's), and transit agencies to invest in projects that reduce air pollutants emitted by transportation related sources. Usually requiring a 20% match from the receiving entity, funding is available for areas that do not meet the National Ambient Air Quality Standards (nonattainment areas) as well as former nonattainment areas that are now in compliance (maintenance areas). York County, as an RFATS community, is eligible for CMAQ funds due to its EPA nonattainment designation for ground-level ozone. The CMAQ funds are apportioned based on population in the nonattainment area and the classification level of air quality violation.

The CMAQ program granted approximately $2 million to RFATS in the 2008-2009 budget cycle. Although it is not mandated that SCDOT provide this funding to RFATS and other MPO's around the State, the level of funding from this resource is likely to increase, beginning with the 2011-2012 budget cycle, based on projected changes in the classification level of nonattainment in the Charlotte region. Projects to be funded through CMAQ are selected annually from the Long Range Transportation Plan (LRTP) based on immediate need and available funds. The amount used to implement projects in the unincorporated area of York County can vary widely based on these criteria. In the future, as regulations tighten and new areas become non-attainment, competition from other non-attainment areas will likely reduce funds available to the county.

Federal Highway Administration Grants (FHWA)

Although federal funds do not come directly to York County, it is the beneficiary of a significant amount of funding passed through the SCDOT stemming from the FHWA. The FHWA has been a valuable resource to the County in years past through the provision of multiple funding sources including TEA-21 funds, SAFETEA-LU funds, CMAQ funds, and other specially designated federal monies. The availability of funding has been, in part, due to the ability of York County to contribute matching funds made available through the Pennies for Progress program and C-Funds. Unfortunately, as more jurisdictions have begun similar infrastructure funding measures

and federal budgets diminish, competitiveness and the availability of these funds will likely reduce the amount of funds awarded to this county.

Rock Hill - Fort Mill Area Transit Study (RFATS)
RFATS is the MPO charged with creating and implementing policies regarding to regional transportation improvements. This group funds projects in the City of Rock Hill, the City of Tega Cay, the Town of Fort Mill, the Catawba Indian Nation, and half of eastern York County. Funded by SCDOT (Guideshare funds) and the FHWA via CMAQ funds, RFATS collects approximately $2.8 million dollars annually to be used directly on funding transportation related capital improvements. Projects are selected annually from applications submitted by each jurisdiction in the MPO, projects most commonly from the TIP, and awards are based on immediate need and available funds.

Transportation Enhancement Program
Transportation Enhancement funds are administered by two organizations. Funds for urban areas totaling $165,000 are distributed via RFATS. Funds to be used in rural areas are distributed by the Catawba Council of Governments in an amount up to $200,000. All funds, regardless of the distributor, are granted on a competitive basis for investments improving the transportation experience. These improvements may range from historic preservation, median landscaping, bicycle lanes, pedestrian facilities, and a wide variety of other projects that improve the aesthetic quality of the local transportation system. Jurisdictions are eligible for funds distributed by the COG every third year after they have been awarded, and the funding source will be available as long as SCDOT funds the Guideshare program. Funding through RFATS is available annually. York County will again be eligible for COG funds in the 2009/2010 fiscal year.

The South Carolina State Infrastructure Bank (SIB)
The State Infrastructure Bank provides financial assistance to major projects on a competitive basis through loans, grants, and other forms of aid for highway and transportation facilities recognized as being beneficial to the state or region. York County has received benefits from this fund in the past in support of the widening of I-77, 1997 Pennies for Progress projects, improvements to the Hwy 161/US 21 interchange, and the extension of SC Highway 5 west into Cherokee County. These funds are available on a highly competitive basis and annual availability cannot be projected.

C-Funds
The C-Fund Program is a statewide program for improving roads whereby each county is allocated a portion of funds generated by a tax on gasoline and diesel fuel. Distributed by the SCDOT, the funds are allocated on a competitive basis by a committee, referred to as the C-Funds Transportation Committee (CTC), designated by the state legislature. The funds reimburse the county for projects approved by the CTC and therefore cannot be used for all

transportation projects. Last year the County received $2.4 million in C-Funds for fiscal year 2009. Although the allocation is subject to change, it has been assumed by the engineering department that this level of funding will be available through the duration of the planning horizon. The C-Fund project list varies on an annual basis.

Miscellaneous Funds

In addition to the common funding sources previously described, other funding sources include federal and state grants, federal earmarks, and SCDOT matching funds. These sources contributed over $56.6 million toward the completion of the 1997 Pennies for Progress projects to date. Unfortunately, these funds are highly unpredictable and may become increasingly competitive based on the current economic climate and the increasing availability of local matching funds from the widespread popularization of local sales tax funding like the Pennies for Progress programs. Although they can provide a significant source of gap financing to county transportation infrastructure projects, these potential revenues are not included in recognized annual revenues that fund transportation improvements for this reason.

Table 7: Transportation Revenue

Funding Source	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
1997 Pennies for Progress Fund Balance	$ 27,920,423	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Prior Year Bond Proceeds Designated for 1997 PFP	$ 6,828,900	$ 9,671,100	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Grant/SIB/Federal Funds - 1997 PFP	$ -	$ 4,404,309	$ 7,919,156	$ 3,666,828	$ -	$ -	$ -	$ -	$ -	$ -
2003 Pennies for Progress Tax Collections - Current FY	$ 23,900,208	$ 24,314,605	$ 12,080,537	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2003 Pennies for Progress Fund Balance	$ 33,360,228	$ 57,412,208	$ 11,115,214	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Critical Needs Resurfacing Funds	$ 1,075,000	$ 1,161,000	$ 1,253,880	$ 1,354,190	$ 1,462,526	$ 1,579,528	$ 1,705,890	$ 1,842,361	$ 1,989,750	$ 2,148,930
RFATS (Guideshare)	$ -	$ -	$ 1,000,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Transportation Enhancement Program	$ 200,000	$ -	$ -	$ 200,000	$ -	$ -	$ 200,000	$ -	$ -	$ -
C Fund Fund Balance/Other Matching Funds	$ 598,707	$ 475,000	$ 475,000	$ 475,000	$ 475,000	$ 475,000	$ 475,000	$ 475,000	$ 475,000	$ 475,000
C-Fund - Current Year Collections	$ 2,400,000	$ 2,400,000	$ 2,400,000	$ 2,400,000	$ 2,400,000	$ 2,400,000	$ 2,400,000	$ 2,400,000	$ 2,400,000	$ 2,400,000
CMAQ Funds	$ 1,754,829	$ 1,900,000	$ 1,900,000	$ 1,900,000	$ 1,900,000	$ 1,900,000	$ 1,900,000	$ 1,900,000	$ 1,900,000	$ 1,900,000
Total Funding Sources	**$ 98,038,295**	**$ 101,738,222**	**$ 38,143,787**	**$ 9,996,018**	**$ 6,237,526**	**$ 6,354,528**	**$ 6,680,890**	**$ 6,617,361**	**$ 6,764,750**	**$ 6,923,930**

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Table 8: Planned Capital Improvements

Projects	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
1997 Pennies for Progress	$ 34,749,323	$ 14,075,409	$ 7,919,156	$ 3,666,828	$ -	$ -	$ -	$ -	$ -	$0
2003 Pennies for Progress	$ 57,260,436	$ 81,726,813	$ 23,195,751	$ -	$ -	$ -	$ -	$ -	$ -	$0
Critical Needs Resurfacing	$ 1,075,000	$ 1,161,000	$ 1,253,880	$ 1,354,190	$ 1,462,526	$ 1,579,528	$ 1,705,890	$ 1,842,361	$ 1,989,750	$ 2,148,930
RFATS (Guideshare)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Transportation Enhancement Program	$ 360,000	$ -	$ -	$ 200,000	$ -	$ -	$ 200,000	$ -	$ -	$ -
SC Infrastructure Bank (SIB	$ -	$ -	$ 1,000,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -
C-Funds	$ 2,400,000	$ 2,400,000	$ 2,400,000	$ 2,400,000	$ 2,400,000	$ 2,400,000	$ 2,400,000	$ 2,400,000	$ 2,400,000	$ 2,400,000
CMAQ Funds	$ 2,193,536	$ 2,375,000	$ 2,375,000	$ 2,375,000	$ 2,375,000	$ 2,375,000	$ 2,375,000	$ 2,375,000	$ 2,375,000	$ 2,375,000
Excess Revenue over Expenditures	**$ 98,038,295**	**$101,738,222**	**$ 38,143,787**	**$ 9,996,018**	**$ 6,237,526**	**$ 6,354,528**	**$ 6,680,890**	**$ 6,617,361**	**$ 6,764,750**	**$ 6,923,930**

Table 9: Overall Transportation Funding Totals

Overall	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
Funding	$ 98,038,295	$ 101,738,222	$ 38,143,787	$ 9,996,018	$ 6,237,526	$ 6,354,528	$ 6,680,890	$ 6,617,361	$ 6,764,750	$ 6,923,930
Projects	$ 98,038,295	$ 101,738,222	$ 38,143,787	$ 9,996,018	$ 6,237,526	$ 6,354,528	$ 6,680,890	$ 6,617,361	$ 6,764,750	$ 6,923,930
Excess Revenue over Expenditures	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

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Transportation Capital Projects Analysis

York County has numerous potential funding sources for its aggressive transportation improvement agenda. The capital improvements sales tax (Pennies for Progress) provides the majority of the funding for these initiatives and has been recognized as a model by other jurisdictions and states around the nation. Despite a high level recognition for the use of innovative funding techniques, capital projects relating to transportation in York County are presently underfunded though the 2014-2015 budget cycle because of shortfalls in the 2003 Pennies for Progress program. Created by unprecedented increases in material, construction, and right of way acquisition costs from the time of project estimation to implementation as well as other dynamics; this unforeseeable shortfall may be narrowed using miscellaneous funds including federal and state grants. Despite this predicament, over $340 million in transportation improvements will occur in the short-term as remaining 1997 and funded 2003 Pennies for Progress Projects are completed.

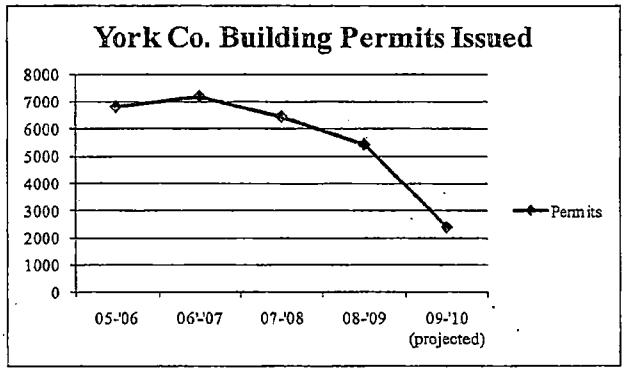
Other capital projects funded by CMAQ grants, C-Funds, and other sources will also be completed during this period. Any resulting surpluses will be allocated to fund projects selected annually based on available funding and immediate priorities as outlined in the State Long Range Transportation Plan, the RFATS Transportation Improvement Program, and local C-Fund priorities. Because some of these funds are divided between the unincorporated and incorporated portions of the county on a competitive basis, it is difficult to estimate the total amount of funding that will be invested in the unincorporated portion of the County. It can only be assumed that all projects using these funding sources will total $5.3 million annually. Including all projects funded by these sources, totaling over $20 million, capital investments likely to occur through the 2013-2014 budget cycle will top $360 million. Additional projects may be funded if sources such as the State Infrastructure Bank, earmarks or state matching funds are secured.

Water and Sewer

York County provides sewer and water service in areas of the county with some proximity to urban or suburban areas. The system is primarily funded through two sources, user fees and impact / capacity fees. User fees are charged with the intent to ensure consistent and adequate service by allowing moderate revenues to accrue, which funds maintenance of the system. These funds are used to pay for the required upgrades to pump facilities, replacement of lines, and other capital investments relating to maintaining and providing service.

Impact / capacity fees aid in funding the expansion of the water and sewer system to serve urbanizing areas of the county. Allowed by the South Carolina Development Impact Fee Act (Section 6-1-910, et seq.), impact / capacity fees are one time financial payments to a local government made to fund the development's proportionate share of necessary off-site capital improvements. In the 2008/2009 fiscal year York County collected $1.7 million in impact / capacity fees. Directly related to permitting activity, this funding source is variable from year to year. Permitting activity has dropped off significantly in the 2008-2009 fiscal year as illustrated by Figure 1. Projections for the 2009-2010 fiscal year are based on permitting activity from January through May 2009 and were projected for the remainder of the calendar year using monthly data trends from the previous four years.

Figure 1: Impact / Capacity Fee Projections



The reduction in impact / capacity fee revenue should not have a serious negative effect on system expansions planned for the future unless the system is already underserved in a particular area. As demands for housing and commercial taps decrease, the need to expand the system reduces proportionately.

Table 10 illustrates the planned future improvements to the sewer and water system. Although some projects will entail cost sharing between one or more municipalities, the total cost for each project is included in full until a cost sharing agreement is made. The 2009-2010 and 2010-2011 budgets show the substantial investments being made to upgrade and expand the system in the

short term, with costs waning significantly thereafter. Projects to be funded with user impact / capacity fees are designated.

Table 10: Sewer and Water Projects

Project Name	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	Total Overall
New Heritage Sewer Pump Station and Forcemain Upgrades	$ 1,200,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,200,000
River Pines Water System Replacement	$ 100,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 100,000
SC Route 51 Pump Station Abandonment Plan / Sewer Replacement at English Trails	$ 1,500,000	$ 1,761,600	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,261,600
Odor Control Study	$ 500,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 500,000
Elevated Water Storage Tank in the Lake Wylie Area (Mill Creek Commons) - 1.5 MG	$ 3,164,200	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,164,200
Catawba River Water Line Crossing Grey Rock Road to Hwy 21 Waterline Connection, and Hwy 160 BPS (3)	$ 5,639,000	$ 1,737,800	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,376,800
New Eastern Elevated Water Storage Tank - Flint Hill Road/Hwy 21 Area (site to be determined) - 1.5MG	$ 1,225,000	$ 2,500,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,725,000
New Eastern Elevated Water Storage Tank - Pleasant/Vista Road Area (site to be determined) - 1.5 MG	$ 200,000	$ 1,225,000	$2,500,000	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,925,000
New Water Line from Buster Boyd Bridge to River Hills Elevated Water Tank	$ 400,125	$ 1,518,750	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,918,875
River Hill's Elevated Water Storage Tank Improvements	$ 150,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 150,000
Catawba Elevated Water Storage Tank Improvements	$ 160,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 160,000
Force Main Replacement (Crowder's Creek Pump Station to the Proposed Little Allison Creek P.S.)	$ 758,000	$ 3,750,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,508,000
Manhole rehabilitation along Steele Creek	$ 222,500	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 222,500
Convert 30-inch C of RH Raw Waterline to Finished Waterline	$ 1,500,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,500,000
Water System Tie to the City of Rock Hill at Newport (Hwy 161 to Adnah Church Road) (1)	$ 213,950	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 213,950
Water System Tie to the Town of Clover along SC Route 557 (2)	$ 192,893	$ 283,666	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 476,559
Water Line Connection on Gold Hill Road (Fort Mill Northern Bypass to Steele Creek Bridge)	$ 29,160	$ 243,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 272,160
Water Line Connection on Pleasant Road (Whitley Road to Legacy Fort Mill Apartments)	$ 36,480	$ 304,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 340,480
Regional Study For County-Wide Utility Authority	$ 120,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 120,000
Big Allison Creek Pump Station and Force Main	$ 855,000	$ 5,907,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 6,762,000
Route 21 Booster Pump Station (2500 gpm) - To be located north of Gold Hill Road	$ 150,000	$ 300,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 450,000
Gold Hill Road Booster Pump Station (500 gpm) - To fill Tega City's Tank	$ 145,000	$ 225,500	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 370,500
Four Seasons at Gold Hill Road - Second Waterline Connection / Loop	$ -	$ 6,500	$ 54,000	$ -	$ -	$ -	$ -	$ -	$ -	$ 60,500
Knightsbridge Subdivision - Second Waterline Connection / Loop	$ -	$ 11,900	$ 99,000	$ -	$ -	$ -	$ -	$ -	$ -	$ 110,900
Blankinship Branch Sewer Outfall (Includes 1,600 LF of 12" Forcemain to Stockbridge PS)	$ -	$ 181,511	$1,296,510	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,478,021
Booster Pump Station at the Concord Road EST site.	$ -	$ 450,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 450,000
Hwy 49 Waterline to Allison Creek	$ -	$ -	$ 144,900	$1,207,500	$ -	$ -	$ -	$ -	$ -	$ 1,352,400
Steele Creek Pump Station Upgrades	$ -	$ -	$ 247,500	$ 577,500	$ -	$ -	$ -	$ -	$ -	$ 825,000
Inman Road Water Line Extension (From Hwy 161 to Parsley Dairy Development Entrance)	$ -	$ -	$ 28,680	$ 239,000	$ -	$ -	$ -	$ -	$ -	$ 267,680
River Hills Pump Station and Force Main Upgrades	$ -	$ -	$ -	$ 250,000	$ -	$ -	$ -	$ -	$ -	$ 250,000
Water System extension along Campbells Road (SC Route 274 to Parham Road)	$ -	$ -	$ -	$ 125,340	$1,044,500	$ -	$ -	$ -	$ -	$ 1,169,840
Water System Tie to the Town of Clover along SC Route 55 (2)	$ -	$ -	$ -	$ -	$ 147,207	$ 207,333	$ -	$ -	$ -	$ 354,540
Gravity outfall south west along Little Allison Creek from Hwy 274.	$ -	$ -	$ -	$ -	$ 139,740	$1,164,500	$ -	$ -	$ -	$ 1,304,240
Gravity outfall extension up Big Allison Creek from the Big Allison P.S.	$ -	$ -	$ -	$ -	$ -	$ 157,800	$1,315,000	$ -	$ -	$ 1,472,800
Sewer line rehabilitation study (New Heritage Area)	$ -	$ -	$ -	$ -	$ -	$ 210,000	$ 210,000	$ 210,000	$210,000	$ 840,000
Sewer line rehabilitation study (Ballivick, Melbourn, & Beacon Knoll S/Ds)	$ -	$ -	$ -	$ -	$ -	$ 210,000	$ 210,000	$ 210,000	$210,000	$ 840,000
Gravity outfall extension from the Crowders Creek PS up Crowders Creek to Hwy 557.	$ -	$ -	$ -	$ -	$ -	$ -	$ 228,000	$1,900,000	$ -	$ 2,128,000
Total	$18,461,308	$20,406,227	$4,370,590	$2,399,340	$1,331,447	$1,949,633	$1,963,000	$2,320,000	$420,000	$53,621,545

Partial Reimbursement Funding from the City of York (Amount to be Determined)
Partial Reimbursement Funding from the Town of Clover (Amount to be Determined)
These two projects (Projects 3 & 4) were included as part of Project 1P (Catawba River Waterline Crossing)

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Table 11: Net Sewer and Water Revenues

	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
Water / Sewer Charges	$14,246,500	$14,958,825	$15,706,766	$16,492,105	$17,316,710	$18,182,545	$19,091,673	$20,046,256	$21,048,569	$22,100,997
Less Operating Expenses	$ 9,141,010	$ 9,598,061	$10,077,964	$10,581,862	$11,110,955	$11,666,503	$12,249,828	$12,862,319	$13,505,435	$14,180,707
Net Total (Partially Reserved for Debt Payments)	**$5,105,490**	**$5,360,765**	**$5,628,803**	**$5,910,243**	**$6,205,755**	**$6,516,043**	**$6,841,845**	**$7,183,937**	**$7,543,134**	**$7,920,291**

Table 12: Overall Water and Sewer Funding Totals

Overall	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
Bond Proceeds - Current Year Proceeds	$ -	$20,406,227	$ 1,593,773	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Bond Proceeds - Prior Year Proceeds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Current Year Revenue	$ 711,976	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Appropriation of Retained Earnings	$17,749,332	$ -	$ 2,776,817	$ 2,399,340	$ 1,331,447	$ 1,949,633	$ 1,963,000	$ 2,320,000	$ 420,000	$ -
Capital Improvements	$18,461,308	$20,406,227	$ 4,370,590	$ 2,399,340	$ 1,331,447	$ 1,949,633	$ 1,963,000	$ 2,320,000	$ 420,000	$ -
Excess Revenue over Expenditures	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

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Sewer and Waste Capital Projects Analysis

The York County Engineering Department oversees facility and water / sewer capital improvement projects. These projects are funded primarily by the county with proceeds from impact / capacity fees and retained earnings, with some assistance through other sources including grants and partnerships. Capital projects relating to sewer and water have adequate funding through the duration of the planning horizon, and the projected retained earnings accruing over this period are sufficient to bridge any unforeseen financing shortfalls and to finance future improvements, maintenance, and expansion of the system. Major investments are planned in the near future to gain capacity needed to operate the system efficiently. After these investments are complete, the cost of capital improvements in subsequent years diminish significantly.

Coordination

The Act states that "The recommendation of those projects for public expenditure must be done through coordination with adjacent and relevant jurisdictions and agencies." Coordination for planned York County projects was achieved immediately after the adoption of the Priority Investment Element with written and certified notification to adjacent and relevant jurisdictions, school districts, public and private utilities, local and regional transportation agencies, and other public entities that could potentially be affected by or have interest in one or more of the projects recognized. All recipients of notification are included in Figure 2. Notifications included a list of all capital projects contained in this plan and the opportunity to make comments was extended.

Figure 2: Jurisdictions and Organizations Notified

Other County Departments
York County Engineering Department
York County Finance Department

Counties
Union County
Chester County
Mecklenburg County
Gaston County
Lancaster County

Jurisdictions
The Town of Smyrna
Catawba Indian Nation
The Town of Fort Mill
The City of Rock Hill
The City of Tega Cay
The Town of McConnells
The Town of Sharon
The Town of Hickory Grove
The Town of Clover
The City of York

State Agencies
South Carolina Department of Health and Environmental Control (SCDHEC)
South Carolina Department of Transportation (SCDOT)

Regional Agencies
Catawba Regional Council of Governments
Rock Hill – Fort Mill Area Transportation Study (RFATS)

Schools
York School District 1
Clover School District 2
Rock Hill School District 3
Fort Mill School District 4

Utilities
York Electric Cooperative
Comporium
The City of Rock Hill Utilities Department
Duke Energy

Linkage to CIP Plan

The Priority Investment Element provides an overview of information normally included in a complete Capital Improvement Plan (CIP). The Priority Investment Element summarizes capital projects indentified by county departments as necessary to maintain or improve current levels of service, provides preliminary cost estimates for each identified project, and describes potential funding sources. A formal CIP should prioritize all county projects, more extensively outline project costs through their implementation, and specifically identify all revenue sources that will fund a particular project.

Unlike the mandated five year update of the Comprehensive Plan, a CIP is updated on a yearly or bi-yearly basis to reflect progress toward implementation and to include the most up-to-date information for planned expenditures and revenues. Future updates to the CIP should include projects to be implemented through a ten year planning horizon, include projected costs, and reference the primary funding source for the project.

Goals and Implementation Strategies

The following goals were set forth for drafting the 2009-2010 York County Budget.

Goal PI-1: Provide a responsive and pro-active local government

- Maintain County infrastructure to preserve invested capital and extend useful lives on investments.
- Implement recommendations of the land use plan.

Goal PI-2: Provide high quality service and customer satisfaction at comparatively low millage/service rates.

- Maintain, renovate and expand County facilities in order to meet service needs generated by a growing population.
- Maintain County services at the current level and enhance services if justified, and if funding is available.

Goal PI-3: Maintain a strong fiscal position.

- Utilize financial planning to accommodate future capital needs.

Goal PI-4: Provide staff with the resources needed to effectively perform their duties.

- Provide for a competitive salary and benefit structure for County employees in order to attract and keep qualified staff to operate the County's programs and services.
- Support productivity with technology.

D

RECYCLED PAPER
RECYCLABLE

ATTACHMENT D

COUNTY CONTRACT SIGNATURE PAGES

TENET HEALTHCARE CORPORATION

By: _____
Reynold J. Jennings,
Chief Operating Officer

Attest: _____

Title: _____

AMISUB OF SOUTH CAROLINA, INC.

By: _____
Charles F. Miller
Chief Executive Officer

Attest: _____

Title: _____

YORK COUNTY, SOUTH CAROLINA

By: _____
Ada Chisolm-Perry, Vice Chairman
York County Council

Attest: _____
Alfred W. Greene
County Manager

APR 25 ...

Doc# 5536140.03

000788

NINTH ADDENDUM TO AGREEMENT BY AND AMONG TENET HEALTHCARE CORPORATION (FORMED AS A RESULT OF MERGER BETWEEN AMERICAN MEDICAL INTERNATIONAL, INC., AND NATIONAL MEDICAL ENTERPRISES,INC.),AMISUB OF SOUTH CAROLINA, INC., AND YORK COUNTY, SOUTH CAROLINA

THIS NINTH ADDENDUM to Hospital Agreement dated as of December 8, 1980, among American Medical International, Inc., AMISUB of South Carolina, Inc. and York County, South Carolina, as amended and modified from time to time, made and entered into this 5th day of June, 2006, by and among Tenet Healthcare Corporation, a corporation organized under the laws of the State of Delaware, and formed as the result of a merger between American Medical International, Inc., and National Medical Enterprises, Inc. (herein referred to as "AMISUB Parent"), AMISUB of South Carolina, Inc., (herein referred to as "AMISUB"), and York County, South Carolina, a political subdivision of the State of South Carolina (herein referred to as "York County"),

WITNESSETH:

WHEREAS, AMISUB Parent, AMISUB, the trustees of York General Hospital and York County entered into an agreement on or about December 9, 1980 (herein referred to as the "Prior Agreement") pursuant to which the trustees of York General Hospital and York County leased and sold certain property and assets to AMISUB Parent and its subsidiary corporation, AMISUB, for the operation of a hospital in York County, South Carolina; and

WHEREAS, AMISUB Parent and AMISUB constructed and operate a hospital in York County, South Carolina, known as Piedmont Medical Center (the "Hospital") pursuant to the terms and conditions of the Prior Agreement; and

WHEREAS, the Prior Agreement has been amended and modified by a First Addendum thereto dated June 16, 1989, a Second Addendum thereto dated April, 1992, a

agreement, notwithstanding any representation, written or oral, to the contrary, made by any person or entity.

(k) Multiple counterparts. This Ninth Addendum is executed in multiple counterparts, each of which shall be deemed an original, but all of which collectively shall constitute but one and the same agreement.

(l) Prior Agreements; entire agreement. All obligations of the parties, each to the other, relating to the subject matter of the Agreement, as previously amended or modified, or this Ninth Addendum, contained in any other document or agreement or based on any other communication prior to the execution of this Ninth Addendum are superseded by the Agreement, as amended and modified. The Agreement, as modified by the First, Second, Third, Fourth, Fifth, Sixth, Seventh, Eighth and this Ninth addenda, constitutes the entire agreement between the parties relating to the subject matter hereof.

IN WITNESS WHEREOF, the undersigned parties have caused this Ninth Addendum to Agreement to be executed under seal as of the date first above written.

TENET HEALTHCARE CORPORATION

By: _____

Title: Senior VP

Attest: _____

Title: _____

AMISUB OF SOUTH CAROLINA, INC.

By: _____
Charles F. Miller
Chief Executive Officer

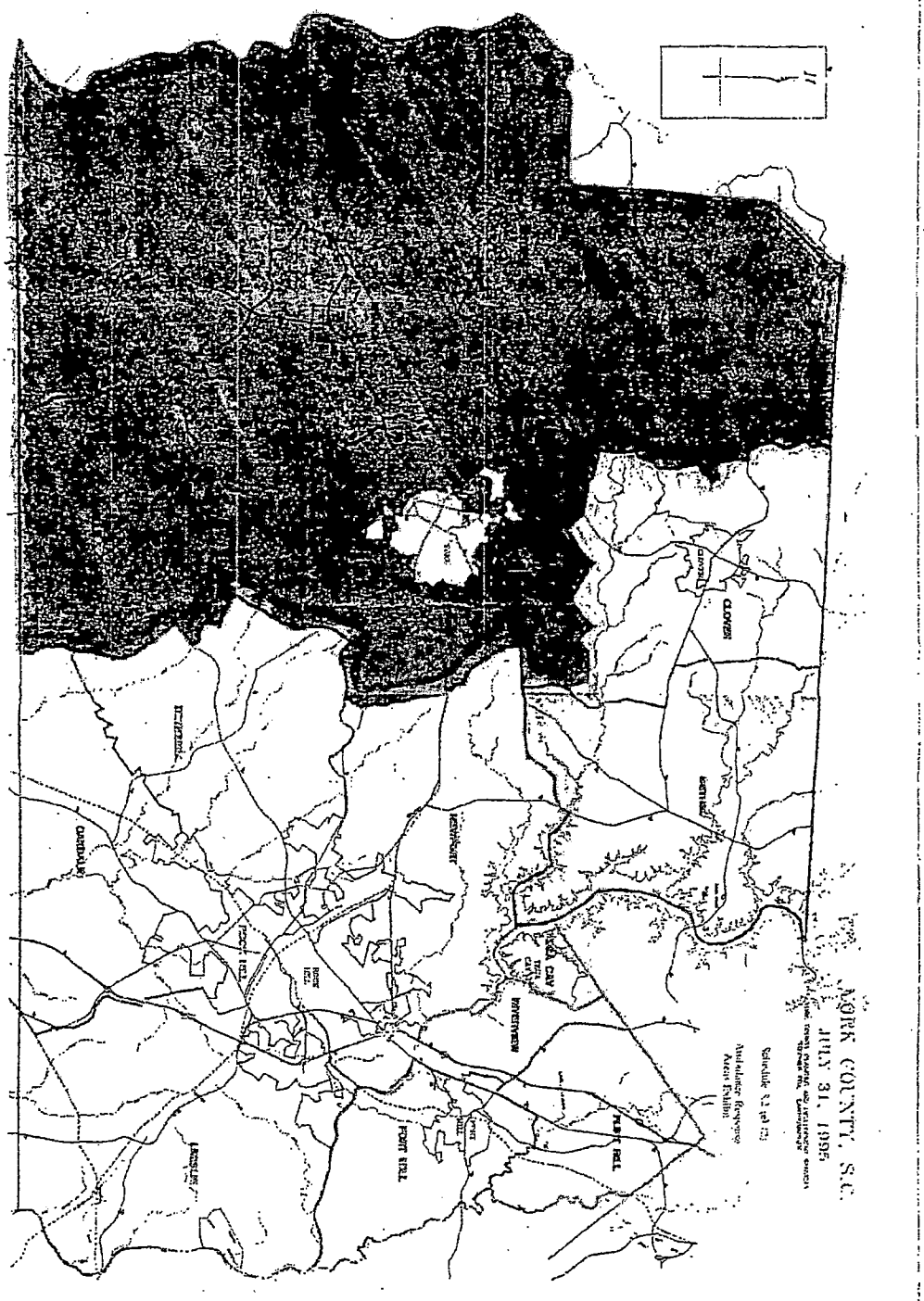
Attest: Carrie P. Newman

Title: Executive Assistant

YORK COUNTY, SOUTH CAROLINA

By: _____
T. Steve McNeely, Chairman
York County Council

Attest: _____
Alfred W. Greene
County Manager


N
YORK COUNTY, S.C.
JULY 31, 1995
CLOVER
BETHEL
KINGSMOUNT
CANDLELIGHT
ROCK HILL
RIDGEVIEW
FORT MILL
PLEASANT VALLEY
LANCASTER

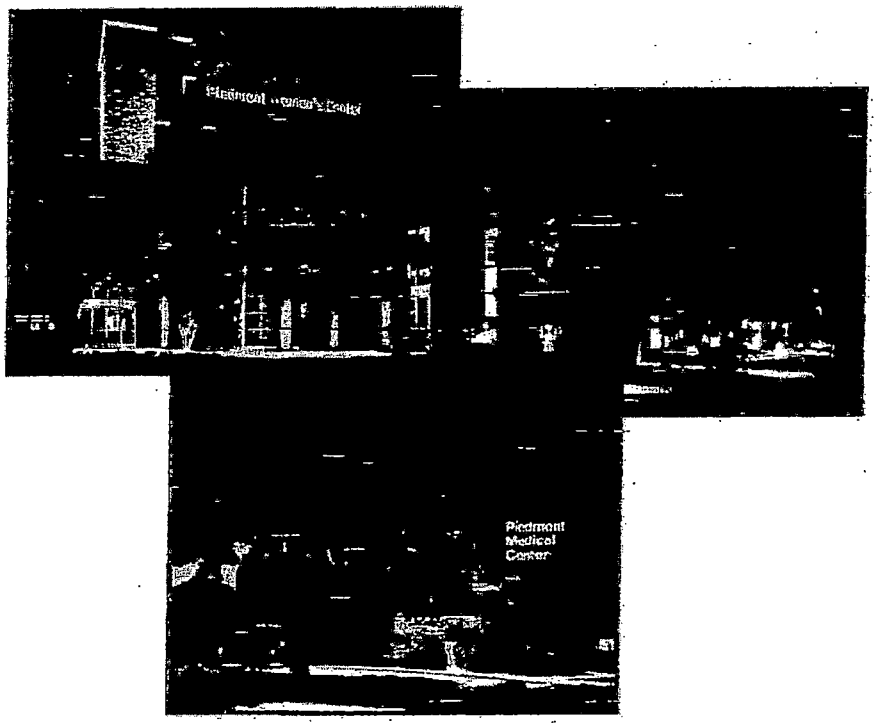
E

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ATTACHMENT E

ANNUAL REPORT

Piedmont Medical Center



York County Report 2009

Tenet Healthcare System

I have reviewed the attached 2009 Annual Report to York County Council and, to the best of my knowledge, believe it to be accurate in reporting on the operations of Piedmont Medical Center as required in the sixth addendum to the York County Contract dated August 1995.

_____

John Holland
Sr. Vice President Regional Operations

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Vision Statement

Piedmont Medical Center will be the leading resource for healthcare services in the upstate of South Carolina.

Board of Governors for 2009

Voting Members

Joe Robinson – Chair
Charles F. Miller, CEO – Secretary
Bill Alexander
Chantay Bouler
Michael Cowen, MD
Joseph Duschl [1] [2]
Alex Espinal, MD
John Hoitink, MD
Ted Matthews
Jay Shah, MD
Skip Tuttle [1] [3]
Karen Walto
James Welsh, MD

Non-Voting members

Sushil Singhi, MD – Chief of Staff
Dorcas Hinson – President, Volunteer Auxiliary
Claudia Douglass – Piedmont Senior Vice President, Operations and Chief Operating Officer
Mary Cline – Piedmont Vice President of Business Development
Don Currier – Piedmont Vice President, Human Resources
Mary Kaye Halterman – Piedmont Vice President – Patient Care Services and Chief Nursing Officer
Jawanna King – Piedmont Hospital Compliance Officer
Richard Patterson, MD – Chief Medical Officer
Jay Pennisson – Piedmont Vice President, Finance and Chief Financial Officer

[1] *Selected from York County nominees*
[2] *Resident - Western York County*
[3] *At-large member*

Advisory board members for 2009

Clergy:

Pastor James Barber	Rock Hill	Rev. Andy Barnett	Rock Hill
Rev. Dennis Buchanan	Rock Hill	Rev. Craig Butler	Rock Hill
Rev. Darryl Colston	Rock Hill	Rev. Roland Dry	Rock Hill
Rev. Warren Fowler	Richburg	Rev. Sally Franklin	Fort Mill
Rev. Carlos Gardner, Jr.	Lancaster	Father John Giuliani	Rock Hill
Rev. Alice Haynes	Rock Hill	Rev. Andrew Housley	Rock Hill
Rev. Sandra King	Rock Hill	Rev. Barry Lambert	Fort Mill
Rev. Robert Lindsay	Rock Hill	Rev. Charlie Mason, Jr.	Rock Hill
Rev. Alvin McLamb	Rock Hill	Rev. Tom McPhail	York
Rev. William Shytle	Rock Hill	Rev. Jesse Sims	Rock Hill
Rev. Kyle Sims	Smyrna	Rev. Jerry Sosebee	Rock Hill
Rev. David Stanford	Clover	Rev. Patricia Starr	Clover
Rev. Wallace Tinsley	York	Rev. Kenneth Walters	Rock Hill
Rev. John Warren	Fort Mill		

Retired Physicians:

Hal Anderson, MD	Rock Hill	George Bonham, MD	Rock Hill
John Boulware, MD	Rock Hill	David Cowan, MD	Rock Hill
Max Culp, MD	Rock Hill	L.D. Frederick, MD	Rock Hill
Dennis Gettelfinger, MD	Rock Hill	William Gregory, MD	Rock Hill
William Henry, MD	Fort Mill	Cloud Hicklin, MD	Chester
Hartwell Hildebrand, MD	Rock Hill	William Hull, MD	Rock Hill
Joel Huneycutt, MD	Lake Wylie	Matthew Johnson, MD	Rock Hill
Frank Kiser, MD	Rock Hill	Kenneth Laughlin, MD	Rock Hill
Francis Lemmon, MD	Rock Hill	Richard McCoy, MD	Rock Hill
Rion Rutledge. MD	Rock Hill	Robert Scoville, MD	Rock Hill
Frank Strait, MD	Rock Hill	Walter Tiedeman, MD	Rock Hill
W.B. Ward, MD	Rock Hill	Robert Wilson, MD	Rock Hill
Dianne West	Sharon		

Advisory board members for 2009, continued

Seniors:

Ricardo Bach	Lake Wylie	Joanne Cauthen	Rock Hill
Al Crouch	Rock Hill	Jennifer Davis	Rock Hill
Wendy Duda	Rock Hill	Robert Hope	Rock Hill
Helen Johnston	Fort Mill	Elizabeth Killian	Clover
Joan McMaster	Rock Hill	Bob Meeker	Lake Wylie
Otis Patton	Rock Hill	Jean Sherer	Rock Hill
Juanita Toatley	Rock Hill	Barbara Williams	Rock Hill

Western York County:

Debra Brown	Clover
Bill Whitesides	Smyrna
Joe Cox	York County Council
Thomas Smith	York County Council
Charles Miller	Piedmont Medical Center President and CEO

Women's Services:

Mary Ann Aberman	Rock Hill	Martha Bollinger	Rock Hill
Dorcas Hinson	Rock Hill	Elaine Copeland	Rock Hill
Phyllis Fauntleroy	Rock Hill	Sherry Glenn	Rock Hill
Beverly Kelly	Lake Wylie	Sue Kirsh (deceased 02/09)	Clover
Shirley MacMillan	Lake Wylie	Pam Morrell	Rock Hill
Barbara Robinson	Rock Hill	Kara Tipp	Rock Hill
Judy Tuttle	Rock Hill	Tammie Welch	Fort Mill
Dot Welchel	Blackstock	Gladys Whitesides	Smyrna
Pansy Yates	Rock Hill		

Annual Financial Statement FY '09 - Ending May 31, 2009

Funds Available	**2009** (000s)
Piedmont Medical Center received:	
For inpatient services	$332,485
For outpatient services	$239,028
Total revenue	**$571,514**
In Addition, the Medical Center Received,	
From Cafeteria Activity	
From Other Non-Patient Activity	$3,334
Total Non-Patient Revenue	**$3,334**
Piedmont did not receive full payment for services:	
From Government and Third-Party Payors	$281,596
From Those Unwilling to Pay	$26,292
From Those Unable to Pay	$20,574
From Compact with Uninsured Total	$11,107
Revenue Not Received	***$339,569***
Total Funds Available	**$235,278**
FUNDS APPLIED	
Piedmont Medical Center Applied Funds:	
To Pay Full- and Part-Time Employees	$68,310
To Provide Employee Benefits	$15,278
To Purchase Supplies, Utilities, Insurance and Other Expenses	$97,094[1]
To Pay Depreciation and Amortization	$10,316
To Pay Interest on Debt	$16,287
Total Expenses	***$207,286***
Pre-Tax Income	**$27,993**
Federal Inc Taxes	$6,340
State Inc Taxes	$906
State Franchise Taxes	$90
Property Taxes	$2,011
Business License Taxes	$175
Indigent Care Taxes	$7,602
Total Tax Expense	***$17,124***
After Tax Income	**$10,869**
Capital Expenditures	***$10,089***

(1) This amount includes corporate overhead.

Property Tax Payments Calendar Year 2008

School Operations	$927,304.24
School Debt Service	$325,021.90
City Operations	$533,407.49
County Operations	$255,518.97
County Debt Service	$55,448.09
Library	$25,723.39
Culture and Heritage	$16,577.31
York Tec College	$24,008.51
Unincorporated County Millage	$1,181.55
Special Fire District	$569.10
Total	**$2,164,760.54**

Depreciation Reported for Piedmont Medical Center

Medicare Cost Report (Ending April 30, 1996)	$2,957,674
Medicare Cost Report (Ending April 30, 1997)	$3,643,810
Medicare Cost Report (Ending May 31, 1998)	$4,326,446
Medicare Cost Report (Ending May 31, 1999)	$5,047,537
Medicare Cost Report (Ending May 31, 2000)	$5,040,228
Medicare Cost Report (Ending May 31, 2001)	$6,598,342
Medicare Cost Report (Ending May 31, 2002)	$7,343,714
Medicare Cost Report (Ending May 31, 2003)	$8,458,222
Medicare Cost Report (Ending May 31, 2004)	$7,940,379
Medicare Cost Report (Ending May 31, 2005)	$7,701,444
Medicare Cost Report (Ending May 31, 2006)	$7,307,246
Medicare Cost Report (Ending May 31, 2007)	$8,067,789
Medicare Cost Report (Ending May 31, 2008) [1] [2]	$8,788,613
Medicare Cost Report (Ending May 31, 2009) [1] [2]	$9,336,025

(1) Unaudited

(2) PMC book depreciation prior to corporate year-end adjustments. Excludes amortization (computer software and intangible).

Calculation of Required Minimum Capital Investment

AMI (Tenet Healthcare System) agrees that in the period beginning June 1, 1995, and ending May 31, 1998, it will make investments in land or depreciable or amortizable property located in York County, South Carolina, in an aggregate amount not less than $23,000,000.

Period ending	*Capital expended*
FY96 (June 1, 1995 - May 31, 1996)	$ 9,037,474
FY97 (June 1, 1996 - May 31, 1997)	$20,307,000
FY98 (June 1, 1997 - May 31, 1998)	$15,296,000
FY99 (June 1, 1998 - May 31, 1999)	$ 8,330,000
FY00 (June 1, 1999 - May 31, 2000)	$ 6,286,533
FY01 (June 1, 2000 - May 31, 2001)	$19,371,848
FY02 (June 1, 2001 - May 31, 2002)	$21,186,311
FY03 (June 1, 2002 - May 31, 2003)	$14,265,756
FY04 (June 1, 2003 - May 31, 2004)	$ 5,142,463
FY05 (June 1, 2004 - May 31, 2005)	$ 8,426,403
FY06 (June I, 2005 - May 31, 2006)	$12,573,989
FY07 (June I, 2006 - May 31, 2007)	$22,650,453 (A)
FY08 (June 1, 2007 - May 31, 2008)	$13,912,248
FY09 (June 1, 2008 - May 31, 2009)	$10,089,419
Total Capital Investment to Date	***$186,875,897***

Calculations for contract year ending May 31, 2009:

1) $4,000,000.00, or,
2) 108% of $8,730,809 (average of most recent three years' depreciation) = $9,429,274 but no less than $1,500,000

- Therefore required minimum capital for 2009 = $9,429,274
- Average actual capital spent (contract year ending May 31, 2009 and preceding two years)= 15,550,707

Obligation under paragraph 3.7 of the sixth addendum of the Agreement exceeded in 2009 by $660,146

(A) Includes land purchase of $8,581,257

Descriptive List of Capital "Equipment" Purchased (June 1, 2008 to May 31, 2009):

A. Cost basis greater than $250,000

Item	Capital Cost
34008756 Enterprise Wireless LAN	$289,226
34007720 Fort Mill Hospital Pre-design	$465,532
34008502 Piedmont Internal Medicine & Family Practice at York	$665,788
34007924 MediTech Upgrade	$1,627,288
34007808 The Imaging Center at Baxter Village	$5,048,423
Total:	***$8,096,258***

C. Cost basis greater than $100,000

Item	Capital Cost
34008505 Rock Hill Family Practice	$189,965
Total:	***$189,965***

Note: *This schedule does not include equipment valued under $100,000.*

Services to the Medically Indigent (June 1, 2008 - May 31, 2009)

A. York County Write-offs

1. 30 Outpatient accounts	$ 268,357

B. MIAP and Other Non Statutory Charity Write-Offs

1. 588 Inpatient accounts	$13,167,849
2. 780 Outpatient accounts	$ 2,340,596
3. Additional Charity Reserves	$ 4,797,093

A - B.	***Total Charity Care***	***$20,573,895***
	Other Uncompensated Care (Bad Debt Provision)	$26,291,962
D.	Compact with the Uninsured Discounts	$11,107,208

E. Indigent Care Taxes Paid

To State of SC	$7,165,472
To York County	$ 471,831
Total	*$7,637,303*

Calculation of required indigent services for June 1, 2008 - May 31, 2009:

$662,831 x (.97734) = $647,811

Note: CPI decreased -4.96 points or -2.3% (6/08, 218.815 and 5/09, 213.856) = .97734

Schedule of York County Resident Charity and Bad Debts

A. Charity

York County	$17,412,804
Other Counties or Unclassified	$3,161,091
All counties	$20,573,895

B. Bad debt *

York County	$23,960,356
Other Counties or Unclassified	$2,331,606
All counties	*$26,291,962*

*Bad debt provision based on account assignments to collection agency.

Services, assistance, and supplies provided to York County Detention Center

York County Detention Center Accounts

Patient Number	Total Charges	Expected Reimbursement
18567834	$ 408.00	$ 250.00
18729061	$ 895.30	$ 433.96
18885830	$1,292.55	$ 708.34
18898460	$1,327.60	$ 774.19
Total	*$3,923.45*	*$2,166.49*

Description of Emergency Department Services (June 1, 2008- May 31, 2009)

Total Volume: 59,789

Acuity levels of patients treated in the Emergency Department (based on charge levels):

Level from least to most severe	Volume
I	768
II	14,986
III	23,893
IV	12,144
V	5,998
Critical Care	110
0	1,890

Physicians joining Piedmont's staff June 1, 2008 through May 31, 2009

New Practitioner	Status	Specialty
Dharmendra Bhaskaran, MD	Active	Internal Medicine
Rene Herlong, MD	Consulting	Pediatric Cardiology
Graham Bullard, MD	Courtesy	Pain Management
Jimmy Antezana, MD	Active	Vascular Surgery
Brian Pope, MD	Courtesy	Family Practice
Robert McCammon, MD	Consulting	Radiation Oncology
Jerome Butler, MD	Consulting	Radiation Oncology
Brian Walker, DO	Courtesy	Family Practice
Paul Kim, MD	Courtesy	Neurosurgery
Geralyn Campi, MD	Active	Internal Medicine
Christopher Jones, MD	Active	Otolaryngology
Sally Wooten, MD	Active	Critical Care
Elizabeth Bumgarner, MD	Active	Pediatrics
Douglas Villaret, MD	Active	Otolaryngology
Daniel Bauer, MD	Active	Internal Medicine
Amsalu Bizuneh, MD	Active	Internal Medicine
Jared Browning, MD	Consulting	Telemedicine
John Chang, MD	Consulting	Telemedicine
Jeffrey Zorn, MD	Consulting	Telemedicine
Eugene Kim, MD	Active	Critical Care
Jeanea Hundley, MD	Active	Emergency Medicine
Sameer Vemuri, MD	Consulting	Physical Med/Rehabilitation
Stuart Jarrell, MD	Active	Neurosurgery
Chad Eller, MD	Active	Emergency Medicine
William Bragdon, MD	Courtesy	Psychiatry
Marial Cobb, MD	Consulting	Telemedicine
Darius Bulczack, MD	Consulting	Telemedicine
Dhawal Goradia, MD	Consulting	Telemedicine
David Wells, MD	Courtesy	Neonatology
Brian Erb, MD	Active	Nephrology
Shashank Mishra, MD	Courtesy	Family Practice
Jeremy Johnson, DO	Courtesy	Emergency Medicine
Anoma Gamage,MD	Courtesy	Family Practice
Jonathan Liu, MD	Courtesy	Family Practice
Dara Josiah-Howze, MD	Active	Psychiatry
Aydrian Thomas, MD	Courtesy	Family Practice
Wilkins, Thomas, MD	Courtesy	Emergency Medicine
Shepard, Jaime, MD	Consulting	Telemedicine
Angel Perez, MD	Courtesy	Psychiatry

Emergency Medical Services

Objective: Promote educational opportunities for agencies providing Emergency Medical Services for York County.

- Maintain physician medical control for all agencies providing emergency medical services.
- Working to bring more educational opportunities for EMS providers to York County through York Technical College and Piedmont EMS.

Objective: Promote community health education and safety programs.

- Continue as lead agency of York County Safe Kids program.
- Continue to conduct child passenger safety checks at EMS headquarters on Heckle Boulevard. Explore additional locations to conduct child passenger safety checks.
- Conduct a study to evaluate the need for pre-hospital public education in our community. Develop and provide programs to meet those needs.

Objective: Enhance the level of pre-hospital care given in York County.

- Conduct research to identify best practice in pre-hospital care.
- Enhance protocols to provide best practice.
- Develop at least one medical pilot program for pre-hospital care.
- Implement Automatic Vehicle Location System in conjunction with York County.

Emergency Medical Services (EMS) - Response Times (June 1, 2008-May 31, 2009)

Total EMS calls*:	15,230
Total Emergency Dispatches:	12,216 (80%)
Quick Response Unit	979

*Reconciled to York County Data

District	Total District Calls	Total Emergency Responses
Eastern York County	10,981	8,665
Clover/Lake Wyle	1,636	1,388
City of York	1,929	1,604
Western York County	684	559

District	Contract Response Provision (in minutes)	Average Response Times (in minutes)
Eastern York County	12	9:01
Clover/Lake Wylie	18	10:50
City of York	12	8:05
Western York County	20	16:30

York County Emergency Response Districts

Eastern York County (12 minutes)
Bethesda
City of Rock Hill
Flint Hill
Fort Mill
Lesslie
Newport
Oakdale
Riverview
Tega Cay

Western York County (20 minutes)
Bethany
Bullock
Hickory Grove
McConnells
Sharon
Smyrna
York Fire District (out of city)

City of York: 12 minutes

Clover/Lake Wylie & Bethel - Clover Fire District: 18 minutes

Projected population FY 2009	221,346	Next Trigger for New Equipment
Eastern York County	154,942	166,500
Western York County	66,403	72,500

Emergency Medical Services Equipment/Resource Allocation

I. As required by the contract, all ambulances operate as Advanced Life Support units, 24 hours a day, 365 days a year.

II. As required by the contract, Piedmont Medical Center is required to operate ambulance stations in Eastern York County and three ambulance stations in Western York County as follows:

Eastern York County:
One unit on Heckle Boulevard
One 12-hour unit on Heckle Boulevard
One Quick Response Unit at Heckle Boulevard
One unit on Black Street
Three EMS units in Fort Mill area-Tega Cay, Baxter and downtown Fort Mill
One unit at Exit 82/ Riverview Road
* *Approved for FY 09-additional 12-hour peek unit to Rock Hill area*

Western York County:
One unit at Piedmont West station
One unit in Sharon
One unit at Clover station
One 24-hour unit at Newport station
One 24 ALS Quick Response Vehicle (QRV) at Piedmont West

Employee Information as of May 31, 2009

	Full Time	Part Time	PRN
Piedmont Medical Center	1,118	108	238
Carolina Surgical Center	18	10	4
Totals	*1,136*	*118*	*242*

Medicaid Cost/Charge Ratios:

Inpatient:	28.23%
Outpatient:	32.94%

Contract Reporting Year Ending May 31, 2009

"Pricing"

As of the filing of this annual report, Amisub of South Carolina, d/b/a Piedmont Medical Center, is in full compliance with all requirements of Section 3.1 (e) Pricing as amended and modified by the First, Second, Third, Fourth, Fifth, Sixth, Seventh and Eighth addenda to the agreement between York County, South Carolina and Amisub.

Attached is the MedPar report reflecting Medicare inpatient charge data for the federal year beginning October 1, 2007 and ending September 30, 2008.

(A) Comparison of reported charge data between average charges 2007 to 2008 shows the following rates of increase among local hospital providers:

Piedmont Medical Center	2.3%
Carolinas Medical Center	2.0%
Carolinas Medical Center- Mercy (includes CMC-Pineville)	7.3%
Gaston Memorial	5.7%
Presbyterian Hospital	9.8%

MEDPAR DATA
Federal Fiscal Year October 1, 2007 Through September 30, 2008
Medicare Inpatient Data

Hospital Comparison using 2008 Medpar Data by Specialty

Inliers and Outliers	Carolinas Medical Center (340113)	Carolinas Medical Center-Mercy (340089)	Gaston Memorial Hospital (340032)	Mary Black Memorial Hospital (420083)	Palmetto Health Baptist-Columbia (420066)	Palmetto Health Richland Memorial (420018)	Piedmont Medical Center (420082)	Presbyterian Hospital/3466 3 (340063)	Providence Hospital/42082 6 (420020)	Spartanburg Regional Medical Center (420007)	Springs Memorial Hospital (420036)
CARDIOVASCULAR MEDICINE	$18,871.30	$16,625.30	$15,627.82	$27,345.46	$31,021.77	$30,717.26	$18,214.97	$16,720.09	$18,726.38	$28,846.80	$25,326.42
CATHEP	$48,696.50	$48,926.83	$46,413.91	$58,186.76	$42,085.91	$53,696.43	$44,888.97	$47,057.11	$50,286.78	$49,712.41	$50,668.37
DENTAL/ORAL	$24,832.77	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
DERMATOLOGY	$14,521.95	$13,490.67	$12,442.49	$23,160.07	$26,680.06	$29,322.65	$10,438.62	$14,879.42	$13,270.91	$26,341.54	$22,682.65
ENDOCRINOLOGY MEDICINE	$13,828.57	$12,576.12	$11,871.22	$23,443.74	$26,395.41	$23,428.37	$16,919.56	$13,954.11	$16,324.16	$26,510.68	$22,186.03
ENDOCRINOLOGY SURGERY	$26,446.04	$0.00	$25,625.06	$0.00	$36,962.94	$55,936.00	$23,616.28	$27,094.17	$19,470.06	$37,933.84	$0.00
ENT MEDICINE	$14,410.18	$10,837.68	$12,355.40	$0.00	$14,758.00	$20,661.65	$11,944.39	$11,052.60	$17,002.47	$24,980.43	$20,630.53
ENT SURGERY	$29,103.30	$0.00	$0.00	$0.00	$0.00	$51,295.12	$0.00	$0.00	$0.00	$40,217.69	$0.00
GASTROINTESTINAL MEDICINE	$19,834.17	$17,253.23	$15,348.15	$26,016.11	$27,717.20	$33,799.80	$19,779.17	$18,632.58	$17,728.27	$31,355.77	$27,168.93
GENERAL MEDICINE	$14,483.50	$12,445.00	$12,761.38	$15,695.12	$23,276.87	$20,183.49	$14,446.42	$12,650.58	$13,939.13	$23,041.59	$12,840.17
GENERAL SURGERY	$66,960.69	$55,636.66	$47,206.62	$63,932.62	$69,324.19	$138,377.60	$71,615.50	$57,662.13	$66,123.84	$100,391.21	$74,267.44
GYNECOLOGY	$20,541.91	$15,850.81	$13,762.70	$23,210.60	$34,005.99	$29,595.78	$19,597.92	$16,307.77	$20,849.62	$23,692.82	$37,255.59
HEMATOLOGY	$18,321.78	$20,212.38	$18,136.68	$29,872.91	$30,430.82	$30,141.09	$21,382.97	$21,614.09	$14,782.05	$26,045.35	$23,941.42
HIV INFECTIONS	$23,020.53	$28,181.50	$36,431.94	$0.00	$0.00	$83,837.00	$0.00	$28,845.00	$0.00	$0.00	$0.00
INFECTIOUS DISEASES	$40,619.26	$29,203.35	$29,061.46	$50,770.33	$61,250.56	$68,169.64	$52,064.77	$37,416.21	$40,421.43	$54,360.50	$58,224.22
MAJOR TRAUMA	$33,600.46	$0.00	$24,133.97	$0.00	$31,139.39	$48,371.59	$0.00	$18,229.03	$25,501.00	$42,154.69	$0.00
NEPHROLOGY	$18,806.00	$16,906.07	$15,774.82	$31,666.26	$32,444.26	$29,157.68	$24,204.36	$20,722.83	$23,456.90	$30,285.21	$30,562.74
NEUROLOGICAL MEDICINE	$22,423.80	$16,477.03	$15,771.50	$28,459.39	$32,380.97	$34,336.14	$19,618.03	$19,443.90	$16,788.35	$33,679.14	$33,959.53
NEUROSURGERY	$48,897.81	$32,763.26	$30,115.26	$25,801.86	$63,251.00	$76,431.69	$25,462.48	$36,167.66	$27,654.38	$50,800.35	$0.00
OBSTETRICS - DELIVERED	$14,906.15	$0.00	$8,354.46	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$13,556.20	$0.00
OBSTETRICS - NON DELIVERED	$0.00	$0.00	$0.00	$0.00	$0.00	$18,801.54	$0.00	$0.00	$0.00	$0.00	$0.00
ONCOLOGY MEDICINE	$25,829.50	$19,927.99	$19,885.47	$55,709.22	$50,367.77	$57,021.81	$25,831.10	$29,994.03	$23,988.17	$36,248.61	$40,755.30
ONCOLOGY SURGERY	$33,060.69	$30,066.50	$26,404.40	$25,025.60	$71,316.65	$51,476.57	$26,216.62	$33,761.51	$0.00	$55,655.66	$48,561.80
OPEN HEART	$100,544.46	$87,677.98	$71,684.64	$0.00	$0.00	$184,332.66	$72,725.03	$95,042.50	$84,679.01	$137,068.19	$0.00
OPHTHALMOLOGY	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$14,121.09	$0.00	$0.00	$0.00
ORTHOPEDIC MEDICINE	$18,544.73	$18,164.47	$12,636.93	$21,494.53	$27,330.24	$28,009.44	$17,354.31	$18,251.39	$14,224.98	$27,483.22	$21,317.59
ORTHOPEDIC SURGERY	$36,167.00	$39,211.94	$25,568.69	$49,651.40	$51,439.87	$54,312.90	$27,997.26	$28,004.59	$35,021.44	$48,009.69	$50,040.96
PLASTIC SURGERY	$33,971.49	$26,316.36	$26,669.17	$32,580.54	$60,990.60	$59,637.44	$66,476.69	$33,059.26	$34,773.14	$52,276.51	$26,714.71
POISONING/DRUG TOXICOMP. OF TX	$22,624.61	$16,850.64	$14,604.21	$12,905.05	$23,482.63	$27,695.68	$16,830.00	$17,805.22	$12,534.34	$32,049.89	$19,612.92
PSYCHIATRY	$12,830.72	$10,308.90	$10,530.28	$26,875.33	$29,744.12	$24,775.52	$13,750.43	$12,772.83	$13,261.15	$27,392.77	$0.00
PULMONARY MEDICINE	$27,237.37	$20,222.88	$18,019.88	$32,513.84	$40,878.83	$40,780.21	$27,122.02	$23,869.33	$28,659.49	$38,119.26	$35,292.09
SPINAL FUSION SURGERY	$64,892.43	$67,492.67	$29,911.38	$99,844.30	$78,918.61	$132,095.37	$45,735.46	$67,516.90	$35,699.08	$69,365.69	$0.00
SUBSTANCE ABUSE	$18,276.04	$6,609.27	$15,950.10	$0.00	$0.00	$35,704.88	$0.00	$15,784.40	$0.00	$35,009.25	$0.00
THORACIC SURGERY	$56,085.29	$54,751.68	$39,850.59	$0.00	$75,885.56	$78,954.53	$48,284.02	$49,760.91	$54,357.57	$88,745.52	$51,812.05
TRANSPLANT	$127,669.68	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
UROLOGY MEDICINE	$20,739.97	$15,281.82	$13,542.01	$23,178.02	$27,586.61	$28,401.31	$16,668.97	$16,600.75	$15,849.04	$26,067.38	$29,429.30
UROLOGY SURGERY	$29,298.59	$22,073.12	$23,681.89	$32,758.31	$37,384.70	$47,767.69	$20,130.55	$27,642.61	$69,849.33	$40,745.05	$27,903.33
VASCULAR SURGERY	$44,287.66	$36,736.24	$34,311.06	$46,962.65	$71,032.14	$71,832.08	$45,873.08	$50,372.15	$52,306.69	$85,390.06	$39,449.64
Total Average	$36,267.44	$25,710.28	$22,118.77	$37,030.25	$43,838.29	$53,821.16	$30,066.65	$29,339.56	$36,586.13	$44,954.40	$34,758.00
Average LOS	5.83	5.37	4.89	5.10	7.33	6.82	5.74	6.10	5.80	5.86	4.64
Rank	8	10	11	4	3	1	8	9	5	2	7

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Piedmont Medical Center Beds

Total licensed beds:	*288*
- Acute Medical/Surgical	251
- Psychiatric	17
-Non-operational	20
- Special Care Nursery Bassinets	10

2009 Scholarships and Education

A. Scholarships
Paid June 1, 2008-May 31, 2009

CAP Scholarships to York Technical College 9 Scholarships	$51,672
York Technical Community College York County Scholarship	$15,718
Winthrop University York County Scholarship	$15,718

A. Education support

1.	University of South Carolina – Nursing program support	$250,000
2.	York Technical College – Nursing program support	$ 55,255

Education support

3. Piedmont provides funding and support to the following programs:

♦ Various educational booklets	$ 5,238
♦ Community programs, including:	
Screenings, health fairs, wellness programs	$47,220
Additional on-site classes /support groups	$11,900

Total education support ***$452,721***

1. Piedmont provides community education through the following publications and events:

including Healthy Hometown Fort Mill and York events	$173,768
HealthBreak magazine	$183,229

Total community education ***$356,997***

Grand total education ***$809,718***

2. Piedmont Medical Center serves as a clinical practicum site for:

- Medical University of South Carolina
  - Nursing, Physician Assistant, Pharmacy
- University of South Carolina
  - Nursing, Pharmacy, Speech Pathology, Physical Therapy
- Winthrop University
  - Dietitian Training, Social Work, Program
- York Technical College
  - Nursing, Allied Health, Laboratory Technologists, Operating Room Technician, Emergency Medical Training
- Kaplan University: Nursing
- University of Phoenix: Nursing
- Walden University: Nursing
- University of South Dakota: RN Refresher Program

Community Donations

1. Hospice & Community Care/Hospice House	$82,249
2. Palmetto Volunteers in Medicine	$70,000
3. North Central Family Medical Center	$43,436
4. Keystone Substance Abuse Services	$37,500
5. Main Streets of Old Town Association	$15,000
6. Girls on the Run	$11,777
7. American Red Cross/York	$ 9,999
8. York County Safe Kids	$ 9,883
9. Move Fort Mill Forward Inc.	$ 8,500
10. Rock Hill Bicycle Club Inc.	$ 7,000
11. Arts Council of Rock Hill	$ 5,500
12. City of Rock Hill	$ 3,650
13. Carolina Motor Madness	$ 2,500
14. Fort Mill Rotary Foundation	$ 2,500
15. High Cotton Classic	$ 2,500
16. Tega Cay Lions Club	$ 2,500
17. York County – Pregnancy	$ 2,500
18. Good Folks of York County	$ 2,000
19. Nation Ford Land Trust	$ 2,000
20. United Way of York County SC	$ 2,792
21. Boy Scouts of America/Palmetto	$ 1,750
22. Culture & Heritage Foundation Inc.	$ 1,500
23. Piedmont Medical Center/Auxiliary	$ 1,300
24. American Cancer Society	$ 1,000
25. Catawba Care Coalition Inc.	$ 1,000
26. Family Connection of SC	$ 1,000
27. Harry Hampton Memorial Wildlife Fund	$ 1,000
28. March of Dimes/SC	$ 1,000
29. Individuals Caring for the Elderly	$ 700
30. City of Tega Cay	$ 580
31. Fort Mill YMCA	$ 500
32. Alexa Good ALS Foundation	$ 500
33. Sheriff's Foundation of York County	$ 500
34. York County Medical Society Alliance	$ 500
35. Young Life of York County	$ 500
36. NAACP	$ 400
37. Greater York Chamber	$ 350
38. Clover High School	$ 100
Total donations	**$337,966**
Grand total education and donations	***$1,147,684***

Piedmont Medical Center Physician Satisfaction Survey

The last survey was conducted during second quarter 2008.

Overall hospital rating = 71.6 percent

Piedmont Medical Center
Continuing Education Report, FY 2008-2009

During the fiscal year 2008, Piedmont Medical Center's Department of Education continued providing employees with diverse opportunities to enrich their knowledge and increase skill levels. With a staff that includes three staff educators and two diabetes/wound care educators, the department provided multiple educational offerings to employees and others from the surrounding community.

A variety of learning formats were available for Piedmont employees, including educational presentations, self learning modules (written), videos and computer assisted instruction. Additionally, the department uses Tenet's Educational library and maintains a membership with Mid-Carolina Area Health Educational Consortium.

Piedmont is an approved provider of Continuing Nursing Education by the South Carolina Nurses Association, an accredited approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. During the fiscal year 2008, the department provided 68 educational activities yielding 290 Continuing Education Contact Hours (CECH) to a total of 2,152 attendees. Programs included Basic Cardiac Rhythm Interpretation, Crisis Management, Nursing Research, Healthcare Statistics, Legal Aspects of Nursing, IV Therapy, Critical Thinking, Physical Assessment, Leadership Development, Documentation, Wound Assessment, Diabetes Management, Skin Care Prevention, Lactation Training, Hemodynamic Monitoring and Psychiatric Issues. Basic and Advanced levels of various programs were offered. The department also provided contact hours for the South Carolina Trauma Symposium.

In addition to various educational offerings, the department also sponsors and supports the Research Committee, Shared Governance program, the Hospital Clinical Ladder program, and the Nursing Awards promotion process. Throughout the year, the department supported four National Certification Review Programs: Certified Critical Care Nurse, Certified Medical Surgical Nurse, Certified Oncology Nurse and Certified Emergency Nurse. Various program offerings were available for Registered Nurses, Licensed Nurses, Nurse Technicians, Pharmacists, Radiology Technicians, Social Workers and Physical Therapists. International programs such as the Trauma Nursing Core course, Advanced Fetal Monitoring, Crisis Prevention Intervention and Crucial Conversations were offered throughout the year. Piedmont also updates and maintains an in-house medical library used by employees, physicians and students from a variety of disciplines.

Computer Assisted Instruction for all disciplines remained available through the Tenet Web site using .EDU and OPAL (Management Resource Tool). Available also online is an NCLEX RN review course to assist newly graduated nurses in preparing for their licensing examination and an online Critical Care course from the American Association of Critical Care Nurses. Nationally recognized continuing education credits were also provided through the Emergency Nurses Association, the American Association of Critical Care Nurses, the Association of Women's Health, Obstetric and Neonatal Nurses (AWOHN), and the Oncology Nurses Society.

The American Heart Association (AHA) recognizes Piedmont's Department of Education as a Community Training center. Piedmont provides all available courses in Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS) and Neonatal Resuscitation Courses (NRP).

During the fiscal year, the department provided training and verification to 1,291 Piedmont Medical Center employees and others in the surrounding medical community. Piedmont also sponsored three mass CPR training sessions for the community, teaching 554 individuals.

The department assisted in the coordination and facilitation of the mandatory 2008-2009 Ethics and Compliance general training from Tenet and provided Nursing orientation to all new staff.

The department coordinated the Annual Safety Skills fair attended by 1,465 employees. The fair included training on hand washing, fire safety, electrical safety, hospital codes, back safety, HAZMAT, JCAHO Patient safety goals, oxygen safety and nursing specific training to include the ParaSlyde, hand off communication and Accucheck blood sugar measurements.

The department participated in all of Piedmont's community activities and Healthy Hometowns providing CPR training and demonstration, blood sugar monitoring and heart and stroke education.

Medical Indigent Assistance Fund Guidelines

Financial Eligibility Requirements

Introduction: This chapter states the criteria used to determine if the applicant's income and resources are within the MIAF limits.

301 *Determining Financial Eligibility*

In determining eligibility for the MIAF, the income and resources of the applicant's family must be considered and measured against the appropriate standards. Spouses are responsible for spouses and parents are responsible for minor children.

302 *Family*

The first step is determining the amount of income and resources available to the applicants to establish the family composition. A family is defined as the applicant and dependents or legally responsible relatives who live in the same household.

Consideration must be given to the applicant's dependent status in determining the family composition.

A. If the applicant is legally or financially dependent upon someone else in the household, the family is composed of the following household members:

1. the applicant; and
2. the persons upon whom he/she is dependent (i.e., the responsible person); and
3. all persons related to the applicant by blood, marriage or adoption who are also legally or financially dependent upon the responsible person.

If the applicant is a minor child who lives in the home with a stepparent, the stepparent is considered a member of the family only if the stepparent claims the child as an income tax dependent.

If the applicant is an adult who is financially dependent upon someone else in the household, the applicant is considered a family member only if the person upon whom he/she is dependent is a relative; and both parties agree that one is financially dependent upon the other; and one could be claimed by the other as a dependent for income tax purposes, whether or not a return is filed.

B. If the applicant (e.g., adult) is not dependent upon someone else, the family is

composed of the following household members:

1. the applicant; and
2. the persons related to the applicant by birth, marriage, or adoption and who are legally or financially dependent upon the applicant.

If the applicant has stepchildren living in the home, the stepchildren are included as members of the family only if the stepparent claims them as income tax dependents.

Common Law Relationships. South Carolina law recognizes common law marriages. A legally binding common law marriage is an agreement between two people to be married. Both of the individuals must be legally free to marry and they must hold themselves out to the community as a married couple. To document that a common law marriage exists, verification must be obtained that substantiates the fact that both individuals are legally free to marry. Statements are obtained from each partner indicating when the couple began living together as husband and wife and a collateral statement indicating the couple is known to the community as husband and wife. In South Carolina, common law marriages between minors are recognized when the male is at least 14 years old and the female is at least 12 years old.

Unmarried Individuals Living Together. Unmarried individuals who live together, who do not have common children and do not claim to have a common law relationship are not considered members of the same family. Ordinarily the income and resources of one would not be attributed to the other since they are not legally or financially responsible for each other. However, if both parties agree that their income is mutually available, half of the total gross annual income is attributed to the applicant.

Pregnant Women Cases. The family composition for a pregnant woman applicant is as follows:

- the pregnant woman;
- the unborn child(ren);
- the father of the unborn child (if he resides in the home); and
- persons related to the applicant by blood, marriage or adoption who are also legally or financially dependent upon the applicant

Family Members Recently Deceased. When a member of the applicant's Family dies prior to the effective date of the application, the deceased individual is not considered a member of the family. Therefore, his income and resources are not considered in determining the applicant's eligibility unless such income and assets are available to the applicant and his family as of the effective date of the application.

When the applicant is deceased and death occurred within 30 days of the date of admission, his income is considered for only the thirteen weeks prior to the date of application and is not annualized.

When the applicant's family composition is questionable, prepare a summary of the family's circumstances and forward it to the Division of Eligibility for a determination of family size.

302.1 *Minors or Students Absent from Home*

To determine the family composition for an applicant who is a minor or a student absent from his parent(s) home, consideration must be given to the student's financial dependence upon the parent(s). Examples of such minors are students or children who choose not to live with their parent(s). For the purposes of the MIAF, an applicant who is a minor child or a student who is still financially dependent upon his/her parent(s) is considered a member of his parents(s)' household. If his/her parent(s) do not live in the same home, he/she is considered a family member in the home of the parent who holds legal custody.

A minor child is always considered a dependent of his parent(s) unless a court order exists which divests the parent(s) and the child of their rights, privileges and annuities, duties and obligations with respect to each other. If such a document exists, the child is not considered a member of the parent(s)'s family and the parent(s)' income and resources are not available to the minor child. A copy of the court order must be filed in the case record as documentation. For students over age eighteen (18), the parent(s) must be contacted to determine if the student Is financially dependent upon the parent(s), the student is not considered a member of their family and the parent(s)' income and resources are not available to the child.

303 *Income Standards*

Only those persons whose gross family income is equal to or less than one hundred percent of the poverty guidelines may qualify for full payment through the MIAF. Only those persons whose gross family income is between one hundred and two hundred percent of the poverty guidelines, may qualify for partial payment through the MIAF.

Refer to Table II, Table III, Table IV and Table V of this Chapter for Poverty Guidelines.

304 *Computation of Income*

The gross annual income of the individual and his family is measured against the annual poverty guidelines for the appropriate size family. Gross annual income should be representative of the family's average earnings. For this

reason, the method of calculating gross annual income will vary depending on the employment status of the family members. In all cases, the applicant must be carefully interviewed to determine his/her employment status. *(Refer to 306.2 for the treatment of income when a family member is self-employed.)*

304.1 *Methods of Verification and Computation*

The following describes methods of verifying and computing gross annual income based on the manner in which the income is received.

1. Fixed Income is a set benefit or a set income for work performed. An example is someone receiving Social Security benefits or a teacher. If the income is a fixed monthly amount, the income received in the preceding or current month must be verified. The verified monthly income is multiplied be twelve (12) to determine gross annual income. If the income is a fixed amount received semi-monthly, bi-monthly, etc., the income for the appropriate pay period must be verified and multiplied by the number of pay periods in a year.

2. Hourly/Salaried with Bonuses, Commission and Overtime is income received regularly and is based on the number of hours worked or a salary, which is subject to additional earnings due to overtime, commissions or bonuses. Income received in this manner is usually variable. Therefore, it must be verified for the thirteen (13) weeks prior to the effective date of the application. If income verification is available for thirteen (13) week period, the income received is multiplied by four (4) to determine gross annual income. If income verification is available for a longer period of time, the income received should be converted to an average weekly income and multiplied by fifty-two (52).

   If the applicant does not have thirteen (13) weeks of income (earned or unearned), verify the total amount of income received in the thirteen (13) week period and multiply by four (4) to determine the gross annual income.

3. Irregular Income is income which varies from week to week or month to month. An example is people who work odds jobs. The method for verifying and computing income is the same as stated in number 2 above.

4. Self-Employment Income is income derived from an individuals' own business. Examples are farmers, beauticians, "shade tree" mechanics, loggers, etc. In this situation, determine gross annual income based on income received in the thirteen (13) weeks prior to the effective date of application, multiplied by four (4). If the person does not report income on a weekly, bi-weekly, or monthly basis, determine gross annual income based on the prior year's income tax return. Deductions are allowed for self-employment income for the cost of doing business. Refer to Chapter 3 Section 306.2 for a list of allowed deductions.

For self-employed individuals who do not file income tax returns or maintain employment records, a signed affidavit regarding their earnings should be obtained. Refer to Transmittal Number 16 dated October 30, 1986.

5. Seasonal Income is income that is generally received only part of the year. If an individual or family has no other sources of income, the amount received during the most recent "season" must be verified and considered to be annual income. If an individual has other income, the amount received during the "season" is combined with the other income to determine gross annual income.

   Most recent season is defined as a season that occurred in the twelve (12) months prior to the effective date of the application.

   It should be noted for migrants work all during the year. Therefore, their income should be determined based on the method stated in number 2 on the previous page.

   Note: *If the earnings of the applicant and his/her family do not conform to the aforementioned description, contact the Division of Eligibility for assistance.*

   For non-emergency applications, income is verified based on the income received prior to the effective date of the application. For emergency admissions and retroactive applications, income is verified based on income received prior to the date of admission rather than the effective date of the application.

306 *Earned Income-Definition and Types*

Earned income includes all income in cash earned by an individual through the receipt of wages, salary, commissions, or profit from activities in which he/she is engaged as a self-employed individual or as an employee. This earned income may be derived from his/her own employment, such as a business enterprise or farming, or derived from wages or salary received as an employee.

306.1 *Earned Income Credit (EIC)*

The EIC is a provision of the Federal tax laws that allows the earnings of many individuals and couples who receive less than $22,370 per year to be supplemented either in advance or in a lump sum. The maximum credit is $1,384.00 per year. This supplement (Earned Income Credit) is counted as earned income.

306.2 *Computation of Income*

Self-employment income is allowed deductions for the cost of doing business. The applicant must provide a record of expenses incurred in the production of the income. Examples of self-employment are beauticians, makeup sales, etc. Allowable costs for

producing self-employment income are:

1. Identifiable costs of labor, such as salaries, employer share of Social Security, insurance, etc.;
2. Stock, raw materials, seed and fertilizer, feed for livestock used in producing income;
3. Rent and costs of maintenance for the business building;
4. Business telephone costs;
5. Costs of operating a motor vehicle when required in connection with the operation of the business;
6. Insurance premiums and taxes paid on the business;
7. Costs of feed for work livestock;
8. Costs of meals for children when day care is provided in the applicant's home;
9. and Interest paid to purchase income-producing property.

The following items are not considered as a cost of producing self-employment income:

1. Payments on the principle of the purchase price of income producing real estate and capital assets, equipment, machinery and other durable goods;
2. Net losses from previous providers;
3. Federal, state and local income taxes, money set aside for retirement purposes, and expenses are accounted for by the earned income deduction.
4. Costs of producing home produce intended for family consumption;
5. Family living expenses;
6. Personal debts;
7. Entertainment expenses'
8. Depreciation expense.

After the self-employment income is given the cost of doing business deduction, it is added to any other earned income.

306.3 *Border or Lodger Income*

The worker must verify and document the income received from the boarder or lodger and then exclude the verified actual costs incurred in providing room and/or board. Examples of costs incurred are the additional utilities, cost of food provided, laundry expenses, etc.

If the applicant is unable to provide records that substantiate the costs of providing lodging and/or board, a standard deduction of $60 monthly may be given for lodging and board and a standard $20 monthly may be given for lodging only. Any income received in excess of the standard amounts is added to other earned income prior to granting the standard earned income disregards.

After this exclusion, the remaining income is considered earned income and is added to other earned income.

307 *Verification*

All income must be verified and the method, amount and date of verification must be documented. The following documents that can be used to verify earned income:

1. Pay stubs;
2. Employee's W-2 Forms;
3. Wage tax receipts;
4. Federal income tax return;
5. Self-employment bookkeeping records;
6. Sales and expenditures records;
7. Employer's wage records;
8. Statements from employer; and
9. Employment Security Office.

The following are documents that can be used to verify other types of income:

1. Social Security award letter (changes in benefits will not always be reflected);
2. Benefit payment check;
3. Unemployment Compensation award letter;
4. Pensions award notice;
5. Veterans Administration award notice;
6. Correspondence on benefits;
7. Income tax records;
8. Railroad award letter;
9. Support and alimony papers evidenced by court order, divorce or separation papers, contribution check;
10. Social Security Administration records and letters;
11. Employment Security Commission;
12. Union records;
13. Workmen's Compensation records;
14. Veterans Administration records and letters;
15. Insurance company records;
16. Tax records;
17. Railroad Retirement Board records; and
18. Department of Social Services Letter of Notification

Note: *If the applicant claims to have no income, you may accept his/her statement; however, he should be carefully interviewed to determine how he obtains food, clothing, and shelter given such circumstances. This information should be included in the case record dictation. If you question the accuracy of his statement, you may request that the applicant go to the Employment Security Commission to obtain the most recent.*

Total countable resources include the business assets owned by a self-employed individual. Total countable resources must be within the limits described below:

1. **Home property.** The valve of a farm of 50 acres or less on which the applicant or his family resides and has resided for at least twenty-five (25) years is excluded from the resources computation. The equity value of home property other than a family form cannot exceed $35,000.00.

2. **Non-home real property and taxable personal property.** The applicant's or family's total equity interest in non-home real property and taxable personal property such as motor vehicles may not exceed $6,000.00.

3. **Household effects.** Household effects such as furniture, kitchen utensils, etc., are not considered in the resource computation.

4. **Liquid assets.** The applicant or family's total liquid assets may not exceed $500.00.

   For non-emergency admissions, the value of liquid assets must be determined as of the effective date of the application. For emergency admissions and retroactive determination, the value of liquid assets must be determined as of the date the applicant entered the hospital

   If an applicant claims that he/she nor his/her family members do not own any liquid assets, you may accept his statement. The case record should contain a notation that the applicant's statement was accepted.

   a) If the total value of all liquid assets owned by the applicant and his/her family members does not exceed the limit, the liquid asset test is met.

   b) An applicant with excess liquid assets may establish eligibility if he/she and/or other members of his/her family spend the excess amount over $500.00 toward payment of valid debts.

   For the purpose of meeting this spend-down requirement, valid debts are defined as:

   Rent or Mortgage Payment - The actual amount of rent or mortgage on the primary residence not to exceed maximum allowable deductions of $500.00 per month, per household.

   Utilities - The actual amount for utility bills (i.e., electric, gas, oil, kerosene, wood, etc.) not to exceed a maximum allowable deduction of $150.00 per month, per household.

Medical Expenses - The actual amount paid for the cost of medical care, i.e., doctor bills, hospital charges, durable medical equipment, prescription drugs, etc. for each family members which were incurred within thirty (30) days prior to the effective date of application or for the applicant, during the period of hospitalization for which assistance is requested.

The applicant must be advised that he/she must spend-down his excess liquid assets before he can qualify for assistance through the fund. The applicant should be advised that the spend-down of excess liquid assets must occur after the effective date of application in order for the expense to be deducted from excess resources and that spend-down may be accomplished in the following way:

The applicant must present paid receipts that verify that the excess amount was used toward the payment of these valid debts which were incurred within 30 days prior to the effective date of application or during the period of hospitalization for which assistance is requested. Spend-down must be accomplished within three (3) days of the effective date of the application. For retroactive applications, the spend-down must be accomplished within thirty (30) days of the date of verification that the value of liquid assets exceeded the limit, if the applicant still owns the excess liquid assets. If the applicant no longer owns the excess liquid assets, the excess amount must have been spent on valid debts in accordance with the above stated procedure.

309 *Non-Liquid Resources*

The equity interest of non-liquid resources must be considered in the resources computation. Equity interest is the value of the applicant's and/or his family's ownership interest in the resources less any legal indebtedness. To determine a person's equity interest in a non-liquid resource, the following factors must be considered:

1. **Ownership Interest.** The value of a person's interest in property must be considered. A person may have sole ownership. In this case, the equity value in the entire piece of property must be considered a resource and measured against the appropriate standard.

   If the person, jointly owns property with on or more other persons, only the equity value of the applicant's and/or his family's interest in the property is considered a resource and measured against the appropriate standards.

   In addition to joint or sole ownership of property, a person may own the right to use real property. These rights might be in the form of:

   - *Timber Rights* - Timber rights permit an individual to cut and remove freestanding trees from property owned by another as designated by contract with the person holding title to the land on which the timber stands. In this case, the value of the timber rights would be considered and measured against the appropriate standards.

- *Mineral Rights* - A mineral right is an ownership interest in certain natural resources such as coal, sulfur, petroleum, sand natural gas, etc. which are usually obtained from the ground. Only the value of the mineral right is considered a resource.

- *Remainder Interest/Life Estate* - A person may also hold a life estate or remainder interest in property. A life estate conveys upon an individual or individuals for his lifetime, certain rights in property. Its duration is measured by the lifetime of the tenant or of another person, or by the occurrence of some specific events, such as remarriage of the tenant. The owner of a life estate has the right of possession, the right to use the property, the right to obtain profits from the property and the right to sell his life estate interest. (However, the contract establishing the life estate may restrain one or more rights of the individual.) He does not have title to the property and he does not have the right to sell the property. He may not usually pass it on to his heirs in the form of an inheritance. See Table 1 in this chapter for the chart used to determine the value of a person's life estate interest in property. Where an individual owner conveys property to another person for life (life estate holder) and to a second person (the remainder man) upon the death of the life estate holder, both a life estate interest and a remainder interest have been created in the property. Upon the death of the life estate holder, the remainder man will hold full title in fee simple. An owner of real property may designate several individuals as remainder men who would hold ownership jointly or in common by will or agreement.

  Example: *Mr. Heath, who is now deceased, conveyed a life estate to his wife in home property that he owned in fee simple both before and after his marriage to Mrs. Heath. Mrs. Heath has the right to live there for the rest of her life. On her death, the property will pass to her two sons who own a remainder interest in the property. The will designated that the sons will then own the property as joint tenants.*

  The property is not considered a resource to the remainder man until the property is actually passed on to him.

- Unprobated Estates (Heir Property) - If an individual who owns property dies without making a will, and the estate has not been settled and the property is divided among heirs, the property is called intestate property. If an applicant is an heir, the value of such property must be developed. An heir would not be able to sell the property itself, but he would be able to sell his interest legally without court action and without permission of the other heirs.

  The South Carolina Law concerning Descent and Distribution was

changed by Act 539 of 1986. The new law is entitled Intestate Succession and Wills and is found at Section 62-2-101, et sec, S.C. Code of Laws, 1976, as amended. The law provides that the estate of an individual who dies intestate will be divided as follows:

- If the deceased has no children, the widow (er) inherits the entire estate.
- Regardless of the number of children surviving the deceased, the widow(er) inherits ½ of the estate and the remaining ½ is divided equally among the children of the deceased.
- If any of the children of the deceased are not living, but at least one child survives the deceased, the ½ of the estate, which is inherited by the children, is still divided as though all children survived the parent. The portion to which the child who dies before his parent was entitled, will then be divided amongst his/her heirs according to law.
- If there is no widow (er), the estate would then be divided equally among the children.
- If the deceased were a joint owner of any real property, that portion to which he/she is entitled by law would become a part of his estate and would be divided according to the provisions of the law.

Note: *Any situation, which is not covered in this section, should be referred to the Division of Eligibility.*

Evidence of ownership of property can be obtained by checking the deed, the will or property and tax records in the county Courthouse. A deed does not have to be recorded to be valid. Tax records can be used only as a guide to other resources of documentation, as the person(s) listed on the tax records is not necessarily the true owner. Adverse possession, which occurs when someone lives on a parcel of land, pays the taxes, and then claims ownership to the property, is not considered legal ownership unless legal title has been conferred by court order.

2. **Tax Assessed Value** - The tax-assessed value of the resource is the current market value established by the County Tax Assessor. In addition, the current market value of a motor vehicle may be established by using either the NADA book value or the current market value established by the County Tax Assessor. When using the NADA book to verify value, use only the current month's book and the listed "Trade-In" value. If the applicant wishes to rebut the current market value as established by the tax assessor's office or the NADA book, the following action is required:

Taxable Personal Property - The applicant may obtain an appraisal from a reputable dealer to establish a different value. If the county designee questions the reliability of the appraisal, he may require a second appraisal for another dealer.

Real Property - Rebuttal must be accomplished through an appeal to the assessor's office in the county where the property is located. A copy of the assessor's determination of value must be furnished to the designee. The value established by the assessor must be used.

2. **Legal Indebtedness** - Legal indebtedness is any legal encumbrance such as a note, mortgage or lien, which has been filed against the resource. It is the applicant's responsibility to provide verification of the current amount of the indebtedness. If the applicant fails to furnish verification of indebtedness, the tax-assessed value of the resource should be used in determining equity interest.

Examples of non-liquid resources are:

a) Real property;
b) Personal property, such as boats, vehicles, farm equipment and livestock. Personal property should not be confused with personal effects such as appliances, furniture, clothes and other similarly essential items of limited value that are necessary for day to day living, since personal effects are not counted.

309.1 *Real Property*

Real property is treated in the following manner:

1. *Home Property* - Home property is the applicant's principal place of residence. The home is defined as the home and all contiguous property. This includes all buildings on the contiguous property such as sheds, barns, garages, warehouses, or other houses. If the surrounding property is separated from the home by public rights of way, such as roads, the surrounding property is still considered contiguous to the home. However, if the surrounding property is separated from the home by intervening property owned by others, the surrounding land is not considered contiguous to the home. A mobile home is considered as home property if it is the applicant's principal place of residence. Equity interest in home property, which does not meet the family farm exclusion, must be applied toward the $35,000.00 home resources limitation.

2. *Non-home Property* - Non-home property is any property that is owned by the applicant and/or his family which is not contiguous to the home. The applicant's and/or his family's equity interest in non-home property must be applied toward the $6,000.00 resource limitation.

309.2 *Taxable Personal Property*

The value of the applicant's and/or his family's interest in taxable personal property must be applied toward the $6,000.00 resource limitation.

309.3 *Buildings*

In some instances, an applicant or his family may have an ownership interest in a building but not the land on which the building is located. In such cases, the value of the interest in the building must be applied toward the $6,000.00 resources limitation.

310 *Liquid Resources*

The value of the applicant's and/or his family's liquid resources must be applied toward the liquid asset resource limitation as found in Section 308.3. Examples of liquid resources are:

1. Cash on hand;
2. Checking or savings accounts in banks or other savings institutions, including credit unions;
3. Savings certificates;
4. The market value of stocks or bonds;
5. Trust accounts except when inaccessible;
6. Funds held in individual retirement accounts (IRS's). The entire cash value of the account, less the amount of any penalty for early withdrawal, is counted;
7. Pension funds that are available;
8. Federal and State Income Tax refunds;
9. Pre-need burial contracts; and
10. Cash value of life insurance. County cash value only for each family member who has life insurance with a total face value(s) greater than $5,000.00. A separate determination must be made for each family member. For each family member who owns life insurance, determine the total face value owned by the individual.
    (The owner is the insured unless otherwise stipulated in the policy.) If the total face value of all policies owned by the family member does not exceed $5,000.00, exclude the cash value of the family member's policies. If the total face value of all policies owned by the family member exceeds $5,000.00, exclude the first $1,500.00 of cash value and count the amount above $1,500.00 as liquid asset.

Note: *Term insurance does not have a cash value.*

310.1 *Jointly Owned Liquid Resources*

When accounts (e.g. savings or checking, stocks or bonds, etc.) are owned jointly and the applicant and/or his family have access to the entire amount in the account, the entire amount is counted toward the resource limit.

To determine whether the person has access to the entire amount, the worker will need

to determine if both signatures are needed for access to the resources or if only one signature is needed. One signature means the entire amount is accessible. When both signatures are needed, only a pro-rata s hare of the account is applied to the resource limit.

310.2 *Trusts*

If an applicant and/or a member of his family is the beneficiary of a trust and he has unrestricted access to the principal of the trust, the value of the principal is counted as a resource. The value of the trust principal is measured against the liquid asset resource limitation.

If the beneficiary of the trust does not have access to the trust and the trustee either does not have the authority or refuses to make the trust principal available to the beneficiary, the trust principal is not counted as a resource. If the applicant or family member does not have access to the trust principal, only the income and/or other benefits from the trust is counted.

310.3 *Burial Plots*

A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn or other repository, which is customarily and traditionally used for the remains of a deceased person. Burial plots owned by the applicant and/or his family are excluded from resources.

311 *Household Effects*

Clothing, household goods, personal effects and furnishings used for day-to-day living are excluded.

312 *Resources Verification*

All resources must be verified and the method, amount and date of verification must be documented. The following are documents that can be used to verify resources:

1. Bank statements;
2. Tax assessor records;
3. Real estate forms;
4. Insurance policies;
5. Insurance agencies;
6. Statement from other owner when there is joint ownership;
7. Current official correspondence received by the applicant;
8. Court Records - Deeds, Titles, etc., and
9. Current NADA Book.

Note: *If the applicant states that he/she and/or his/her family do not own*

real property or taxable personal property, the courthouse records must be searched to verify his/her statement. Courthouse records do not have to be searched in the name of minor children unless there is an indication that they own real and personal property. For reapplications which are filed within six (6) months of an MIAF eligible hospital stay, it is not necessary to re-verify (i.e., search of courthouse records) the ownership and value of real and personal property unless the applicant indicates that their circumstances have changed.

313 *Transfer of Resources*

An applicant and/or his/her family who transferred resources without receiving full compensation within three (3) months prior to the period of hospitalization for which the application for assistance is made, may not be eligible. The application must be denied if the uncompensated value in combination with other resources exceeds the appropriate resource limitation.

Although transfer of a resource without receipt of full compensation may result in ineligibility for MIAF for up to twelve (12) months, the person may establish eligibility if it is determined that he/she later receives full market value for the transferred resource. The person may establish that full compensation was received provided the resource is returned or the applicant receives fair market value for the transferred resource, and the proceeds are used for living and/or medical expenses of the applicant to the point that the resource is reduced to within the appropriate resource limitation.

The transfer resources policy applies to:

1. Transfers made by an applicant and/or his family, or on their behalf by a person acting for and legally authorized to execute a contract for the applicant and/or his family (such as legal representative, parent of minor child, holder of power or attorney, etc.);

2. Transfers of liquid and non-liquid resources (cash, bank accounts, etc. by giving to another individual, creation of irrevocable trusts, petitioning courts to set aside funds for a specific purpose, etc.);

3. Waiver or suspension of benefits to which the individual is legally entitled, e.g. inheritance, insurance settlement and proceeds of a loan.

The transfer of resources policy does not apply to:

1. Actions take by persons not listed in #1 above (for example, policy does not apply to withdrawal of funds by another person from a bank account jointly held with the eligible applicant unless the other person is the spouse or parent of the applicant);

2. A resource that is spent or used to repay a valid debt;

3. Valid loans made by an eligible individual or eligible spouse.

314 *Treatment of Cash Received to Replace/Repair Lost, Damaged or Stolen Resources*

Cash received from any source (e.g. insurance companies, Federal or State agencies, public or private organizations, other individuals) for the purpose of replacing or repairing a resource which is lost, damaged or stolen is not income but a resource that has changed form.

When it is determined that cash will be or is received for the purpose of replacing or repairing a resource, the total amount of such cash is excluded from the income computation for a period of six (6) months from the month of receipt. However, it is not excluded from resources it is counted as the resource it replaces would have been counted.

Cash which is received for personal injury, death or other purposes is not excluded from income or resources under this provision, even if the cash is received in conjunction with an/or from the same source as cash intended to replace or repair a resource.

Table I: FAMILY COMPOSITION CHART

RELATIONSHIP TO THE APPLICANT	WHERE LIVING	INCLUDED AS FAMILY MEMBER	VERIFICATION
Spouse (Includes common law)	In the home.	Yes	Applicant's Statement
Spouse	Separated and living out of the home for 30 days from effective date of the application.	No	Collateral statement from two (2) non-related family members. Example: Landlord or Neighbor
Minor Child	In the home.	Yes	Applicant's Statement
Minor Child (Applicant)	Out of the home.	Yes, unless all parental rights are terminated by court order.	Parental statement, if yes. Court order, if no.
Child over 18 years of age.	In the home or attending school.	Yes, if both parties agree that one is financially dependent on the other.	Written statement from both parties and case notes which verify that one could claim the other as a dependent for income tax purposes.
Other Relatives	In the home.	Yes, if both parties agree that one is financially dependent on the other.	Written statement from both parties and case notes which verify that one could claim the other as a dependent for income tax purposes
RELATIONSHIP TO THE APPLICANT	**WHERE LIVING**	**INCLUDED AS FAMILY MEMBER**	**VERIFICATION**
Other Relatives	In the home.	Yes, if both parties agree that one is financially dependent on the other.	Written statement from both parties and case notes which verify that one could claim the other as a dependent for income tax purposes.
Non-Relatives	In the home.	No, refer to Page 3 of this chapter for treatment.	Applicant's statement
Unmarried couple with common child	In the home.	Yes	Applicant's statement or birth record.

Table II:

Use this table when processing MIAF applications for hospital admissions on January 1, 1986 through April 30, 1986.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 5,250.00	$ 10,500.00
Two (2)	$ 7,050.00	$ 14,100.00
Three (3)	$ 8,850.00	$ 17,700.00
Four (4)	$ 10,650.00	$ 21,300.00
Five (5)	$ 12,450.00	$ 24,900.00
Six (6)	$ 14,250.00	$ 28,500.00
Seven (7)	$ 16,050.00	$ 32,100.00
Eight (8)	$ 17,850.00*	$ 35,700.00
For families with more than eight (8) persons, add $1,800 for each additional family member.		

Table III:

Use this table when processing MIAF applications for hospital admissions on or after May 1, 1986.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 5,380.00	$ 10,760.00
Two (2)	$ 7,240.00	$ 14,480.00
Three (3)	$ 9,120.00	$ 18,240.00
Four (4)	$ 11,000.00	$ 22,000.00
Five (5)	$ 12,880.00	$ 25,760.00
Six (6)	$ 14,760.00	$ 29,520.00
Seven (7)	$ 16,640.00	$ 33,280.00
Eight (8)	$ 18,520.00*	$ 37,040.00
For families with more than eight (8) persons, add $1,880 for each additional family member.		

Table IV:

Use this table when processing MIAF applications for hospital admissions after May 1, 1987.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 5,500.00	$ 11,000.00
Two (2)	$ 7,400.00	$ 14,800.00
Three (3)	$ 9,300.00	$ 18,600.00
Four (4)	$ 11,200.00	$ 22,400.00
Five (5)	$ 13,100.00	$ 26,200.00
Six (6)	$ 15,000.00	$ 30,000.00
Seven (7)	$ 16,900.00	$ 33,800.00
Eight (8)	$ 18,800.00*	$ 37,600.00
For families with more than eight (8) persons, add $1,900 for each additional family member.		

Table V:

Use this table when processing MIAF applications for hospital admissions on or after May 1, 1988.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 5,770.00	$ 11,540.00
Two (2)	$ 7,730.00	$ 15,460.00
Three (3)	$ 9,690.00	$ 19,380.00
Four (4)	$ 11,650.00	$ 23,300.00
Five (5)	$ 13,610.00	$ 27,220.00
Six (6)	$ 15,570.00	$ 31,140.00
Seven (7)	$ 17,530.00	$ 35,060.00
Eight (8)	$ 19,490.00*	$ 38,980.00
For families with more than eight (8) persons, add $1,960 for each additional family member.		

Table VI:

Use this table when processing MIAF applications for hospital admissions on or after May 1, 1989.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 5,980.00	$ 11,960.00
Two (2)	$ 8,020.00	$ 16,040.00
Three (3)	$ 10,060.00	$ 20,120.00
Four (4)	$ 12,100.00	$ 24,200.00
Five (5)	$ 14,140.00	$ 28,280.00
Six (6)	$ 16,180.00	$ 32,360.00
Seven (7)	$ 18,220.00	$ 36,440.00
Eight (8)	$ 20,260.00*	$ 40,520.00
For families with more than eight (8) persons, add $2,040 for each additional family member.		

Table VII:

Use this table when processing MIAF applications for hospital admissions on or after May 1, 1990

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 6,280.00	$ 12,560.00
Two (2)	$ 8,420.00	$ 16,840.00
Three (3)	$ 10,560.00	$ 21,120.00
Four (4)	$ 12,700.00	$ 25,400.00
Five (5)	$ 14,840.00	$ 29,680.00
Six (6)	$ 16,980.00	$ 33,960.00
Seven (7)	$ 19,120.00	$ 38,240.00
Eight (8)	$ 21,260.00*	$ 42,520.00
For families with more than eight (8) persons, add $2,140 for each additional family member.		

Table VIII:

Use this table when processing MIAF applications for hospital admissions on or after April 1, 1991.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 6,620.00	$ 13,240.00
Two (2)	$ 8,880.00	$ 17,760.00
Three (3)	$ 11,140.00	$ 22,280.00
Four (4)	$ 13,400.00	$ 26,800.00
Five (5)	$ 15,660.00	$ 31,320.00
Six (6)	$ 17,920.00	$ 35,840.00
Seven (7)	$ 20,180.00	$ 40,360.00
Eight (8)	$ 22,440.00*	$ 44,880.00
For families with more than eight (8) persons, add $2,260 for each additional family member.		

Table IX:

Use this table when processing MIAF applications for hospital admissions on or after April 1, 1992.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 6,810.00	$ 13,620.00
Two (2)	$ 9,190.00	$ 18,380.00
Three (3)	$ 11,570.00	$ 23,140.00
Four (4)	$ 13,950.00	$ 27,900.00
Five (5)	$ 16,330.00	$ 32,660.00
Six (6)	$ 18,710.00	$ 37,420.00
Seven (7)	$ 21,090.00	$ 42,180.00
Eight (8)	$ 23,470.00*	$ 46,940.00
For families with more than eight (8) persons, add $2,380 for each additional family member.		

Table X:

Use this table when processing MIAF applications for hospital admissions on or after April 1, 1993.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 6,970.00	$ 13,940.00
Two (2)	$ 9,430.00	$ 18,860.00
Three (3)	$ 11,890.00	$ 23,780.00
Four (4)	$ 14,350.00	$ 28,700.00
Five (5)	$ 16,810.00	$ 33,620.00
Six (6)	$ 19,270.00	$ 38,540.00
Seven (7)	$ 21,730.00	$ 43,460.00
Eight (8)	$ 24,190.00*	$ 48,380.00
For families with more than eight (8) persons, add $2,460 for each additional family member.		

Table XI:

Use this table when processing MIAF applications for hospital admissions on or after April 1, 1994.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 7,360.00	$ 14,720.00
Two (2)	$ 9,840.00	$ 19,680.00
Three (3)	$ 12,360.00	$ 24,720.00
Four (4)	$ 14,800.00	$ 29,600.00
Five (5)	$ 17,280.00	$ 34,560.00
Six (6)	$ 19,760.00	$ 39,520.00
Seven (7)	$ 22,240.00	$ 44,480.00
Eight (8)	$ 24,720.00*	$ 49,440.00
For families with more than eight (8) persons, add $2,480 for each additional family member.		

Table XII:

Use this table when processing MIAF applications for hospital admissions on or after April 1, 1995.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 7,470.00	$ 14,940.00
Two (2)	$ 10,030.00	$ 20,060.00
Three (3)	$ 12,590.00	$ 25,180.00
Four (4)	$ 15,150.00	$ 30,130.00
Five (5)	$ 17,710.00	$ 35,420.00
Six (6)	$ 20,270.00	$ 40,540.00
Seven (7)	$ 22,830.00	$ 45,660.00
Eight (8)	$ 25,390.00*	$ 50,780.00
For families with more than eight (8) persons, add $2,560 for each additional family member.		

Table XIII:

Use this table when processing MIAF applications for hospital admissions on or after May 1, 1996.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 7,740.00	$ 15,480.00
Two (2)	$ 10,360.00	$ 20,720.00
Three (3)	$ 12,980.00	$ 25,960.00
Four (4)	$ 15,600.00	$ 31,200.00
Five (5)	$ 18,220.00	$ 36,440.00
Six (6)	$ 20,840.00	$ 41,680.00
Seven (7)	$ 23,460.00	$ 46,920.00
Eight (8)	$ 26,080.00*	$ 52,160.00
For families with more than eight (8) persons, add $2,620 for each additional family member.		

Table XIV:

Use this table when processing MIAF applications for hospital admissions on or after May 1, 1997

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 7,890.00	$ 15,780.00
Two (2)	$ 10,610.00	$ 21,220.00
Three (3)	$ 13,330.00	$ 26,660.00
Four (4)	$ 16,050.00	$ 32,100.00
Five (5)	$ 18,770.00	$ 37,540.00
Six (6)	$ 21,490.00	$ 42,980.00
Seven (7)	$ 24,210.00	$ 48,420.00
Eight (8)	$ 26,930.00*	$ 53,860.00
For families with more than eight (8) persons, add $2,720 for each additional family member.		

Table XV:

Use this table when processing MIAF applications for hospital admissions on or after May 1, 1998.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 8,050.00	$ 16,100.00
Two (2)	$ 10,850.00	$ 21,700.00
Three (3)	$ 13,650.00	$ 27,300.00
Four (4)	$ 16,450.00	$ 32,900.00
Five (5)	$ 19,250.00	$ 38,500.00
Six (6)	$ 22,050.00	$ 44,100.00
Seven (7)	$ 24,850.00	$ 49,700.00
Eight (8)	$ 27,650.00*	$ 55,300.00
For families with more than eight (8) persons, add $2,800 for each additional family member.		

Table XVI:

Use this table when processing MIAF applications for hospital admissions on or after May 1, 1999.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 8,240.00	$ 16,480.00
Two (2)	$ 11,250.00	$ 22,120.00
Three (3)	$ 13,880.00	$ 27,760.00
Four (4)	$ 16,700.00	$ 33,400.00
Five (5)	$ 19,520.00	$ 39,040.00
Six (6)	$ 22,340.00	$ 44,680.00
Seven (7)	$ 25,160.00	$ 50,320.00
Eight (8)	$ 27,980.00*	$ 55,960.00
For families with more than eight (8) persons, add $2,820 for each additional family member.		

Table XVII:

Use this table when processing MIAF applications for hospital admissions on or after May 1, 2000.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 8,350.00	$ 16,700.00
Two (2)	$ 11,250.00	$ 22,500.00
Three (3)	$ 14,150.00	$ 28,300.00
Four (4)	$ 17,050.00	$ 34,100.00
Five (5)	$ 19,950.00	$ 39,900.00
Six (6)	$ 22,850.00	$ 45,700.00
Seven (7)	$ 25,750.00	$ 51,500.00
Eight (8)	$ 28,650.00*	$ 57,300.00
For families with more than eight (8) persons, add $2,900 for each additional family member.		

Table XIII:

Use this table when processing MIAF applications for hospital admissions on or after May 1, 2001.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 8,590.00	$ 17,180.00
Two (2)	$ 11,610.00	$ 23,220.00
Three (3)	$ 14,360.00	$ 29,260.00
Four (4)	$ 17,650.00	$ 35,300.00
Five (5)	$ 20,670.00	$ 41,340.00
Six (6)	$ 23,690.00	$ 47,380.00
Seven (7)	$ 26,710.00	$ 53,420.00
Eight (8)	$ 29,730.00*	$ 59,460.00
For families with more than eight (8) persons, add $3,020 for each additional family member.		

Table XIX:

Use this table when processing MIAF applications for hospital admissions on or after May 1, 2002.

POVERTY SCALE		
Family Size	**100% Gross Annual Income**	**200% Gross Annual Income**
One (1)	$ 8,860.00	$ 17,720.00
Two (2)	$ 11,940.00	$ 23,880.00
Three (3)	$ 15,020.00	$ 30,040.00
Four (4)	$ 18,100.00	$ 36,200.00
Five (5)	$ 21,180.00	$ 42,360.00
Six (6)	$ 24,250.00	$ 48,520.00
Seven (7)	$ 27,340.00	$ 54,680.00
Eight (8)	$ 30,420.00*	$ 60,840.00
For families with more than eight (8) persons, add $3,080 for each additional family member.		

Table XX

Use this table when processing MIAF applications for hospital admissions on or after May 1, 2003.

Poverty Scale

Family Size	100% Gross Annual Income	200% Gross Annual Income
1	$ 8,980.00	$ 17,960.00
2	$ 12,120.00	$ 24,240.00
3	$ 15,260.00	$ 30,520.00
4	$ 18,400.00	$ 36,800.00
5	$ 21,540.00	$ 43,080.00
6	$ 24,680.00	$ 49,360.00
7	$ 27,820.00	$ 55,640.00
8	$ 30,960.00	$ 61,920.00

For families with more than 8 persons, add $3,140 for each additional member.

Table XXI

Use this table when processing MIAF applications for hospital admissions on or after May 1, 2004.

Poverty Scale

Family Size	100% Gross Annual Income	200% Gross Annual Income
1	$ 9,310.00	$ 18,620.00
2	$ 12,490.00	$ 24,980.00
3	$ 15,670.00	$ 31,340.00
4	$ 18,850.00	$ 37,700.00
5	$ 22,030.00	$ 44,060.00
6	$ 25,210.00	$ 50,420.00
7	$ 28,390.00	$ 56,780.00
8	$ 31,570.00	$ 63,140.00

For families with more than 8 persons, add $3,180 for each additional member.

Table XXII

Use this table when processing MIAF applications for hospital admissions on or after May 1, 2005.

Poverty Scale

Family Size	100% Gross Annual Income	200% Gross Annual Income
1	$ 9,570.00	$ 19,140.00
2	$ 12,830.00	$ 25,660.00
3	$ 16,090.00	$ 32,180.00
4	$ 19,350.00	$ 38,700.00
5	$ 22,610.00	$ 45,220.00
6	$ 25,870.00	$ 51,740.00
7	$ 29,130.00	$ 58,260.00
8	$ 32,390.00	$ 64,780.00

For families with more than 8 persons, add $3,260 for each additional member.

Table XXIII

Use this table when processing MIAF applications for hospital admissions on or after May 1, 2006.

Poverty Scale

Family Size	100% **Gross Annual Income**	200% **Gross Annual Income**
1	$ 9,800	$ 19,600
2	$ 13,200	$ 26,400
3	$ 16,600	$ 33,200
4	$ 20,000	$ 40,000
5	$ 23,400	$ 46,800
6	$ 26,800	$ 53,600
7	$ 30,200	$ 60,400
8	$ 33,600	$ 67,200

For families with more than 8 persons, add $3,400 for each additional member.

Table XXIV

Use this table when processing MIAP applications for hospital admissions on or after March 1, 2007.

	Poverty Scale	
	100%	200%
Family Size	**Gross Annual Income**	**Gross Annual Income**
1	$ 10,210	$ 20,420
2	$ 13,690	$ 27,380
3	$ 17,170	$ 34,340
4	$ 20,650	$ 41,300
5	$ 24,130	$ 48,260
6	$ 27,610	$ 55,220
7	$ 31,090	$ 62,180
8	$ 34,570	$ 69,140

For families with more than 8 persons, add $3,480 for each additional member.

Table XXIV

Use this table when processing MIAP applications for hospital admissions on or after March 1, 2008.

	Poverty Scale	
	100%	200%
Family Size	**Gross Annual Income**	**Gross Annual Income**
1	$ 10,400	$ 20,800
2	$ 14,000	$ 28,000
3	$ 17,600	$ 35,200
4	$ 21,200	$ 42,400
5	$ 24,800	$ 49,600
6	$ 28,400	$ 56,800
7	$ 32,000	$ 64,000
8	$ 35,600	$ 71,200

For families with more than 8 persons, add $3,600 for each additional member.

Use this table when processing MIAP applications for hospital admissions on or after March 1, 2009.

Poverty Scale

Family Size	100% Gross Annual Income	200% Gross Annual Income
1	$ 10,830	$ 21,660
2	$ 14,570	$ 29,140
3	$ 18,310	$ 36,620
4	$ 22,050	$ 44,100
5	$ 25,790	$ 51,580
6	$ 29,530	$ 59,060
7	$ 33,270	$ 66,540
8	$ 37,010	$ 74,020

For families with more than 8 persons, add $3,740 for each additional member.

RECYCLED PAPER
RECYCLABLE

ATTACHMENT F

PIEDMONT MEDICAL CENTER PRO FORMA

Fort Mill Medical Center
Financial Projections
Years 1-5

Statistics	Start-up Period	Year 1 2015	Year 2 2016	Year 3 2017	Year 4 2018	Year 5 2019
Beds		100	100	100	100	100
Occupancy		42%	50%	58%	60%	62%
Admissions		4,312	5,118	5,946	6,117	6,293
Adjusted Admissions		7,840	9,433	11,108	11,581	12,071
Inpatient Days		15,244	18,214	21,258	21,870	22,500
Adjusted Patient Days		27,715	33,570	39,712	41,403	43,157
ADC		41.8	49.9	58.2	59.9	61.6
Adjusted ADC		75.9	92.0	108.8	113.4	118.2
ALOS		3.5	3.6	3.6	3.6	3.6
FTEs Worked		265	318	374	385	393
FTEs Paid		305	366	431	444	453
Gross Patient Revenues						
Inpatient Revenue		$82,955,056	$103,081,942	$125,121,805	$133,874,326	$143,239,103
Outpatient Revenue		$67,865,531	$86,908,385	$108,618,239	$119,563,160	$131,507,820
Total Gross Patient Revenue		$150,820,587	$189,990,327	$233,740,045	$253,437,486	$274,746,923
Deductions from Revenue						
Indigent/Charity		$4,524,618	$5,699,710	$7,012,201	$7,603,125	$8,242,408
Other		$73,574,553	$95,354,109	$120,283,889	$133,039,198	$147,000,029
Total Deductions		$78,099,171	$101,053,819	$127,296,090	$140,642,323	$155,242,437
Other Revenue		$218,652	$227,398	$236,494	$245,953	$255,791
Net Revenue		$72,940,068	$89,163,906	$106,680,449	$113,041,117	$119,760,277
Operating Expenses						
Salaries, Wages, and Benefits		$25,079,402	$31,031,646	$37,601,256	$39,928,923	$41,805,853
Supplies		$10,238,934	$12,429,421	$14,802,623	$15,695,143	$16,640,632
Med & Clinical Fees		$1,422,556	$1,711,566	$2,024,584	$2,143,342	$2,269,084
Other Prof Fees		$1,590,552	$1,708,048	$1,833,888	$1,886,304	$1,961,484
Other Fees & Services		$5,895,539	$6,585,132	$7,328,507	$7,846,799	$7,981,567
Utilities and Phones		$833,499	$877,620	$914,895	$946,033	$978,550
Repairs/Maint/Equip Rent		$1,999,946	$2,190,781	$2,395,983	$2,489,211	$2,586,971
Other Ctrl Expenses		$1,959,618	$2,146,604	$2,347,669	$2,439,017	$2,534,806
Prov for Bad Debt		$6,952,167	$8,555,692	$10,303,775	$10,986,249	$11,711,440
Total Controllable Expenses		$55,972,213	$67,236,511	$79,553,180	$84,171,021	$88,570,386
Non-Controlable Expenses		$7,999,541	$9,224,494	$9,514,384	$9,726,295	$9,943,512
Total Expenses	$2,089,950	$63,971,754	$76,461,004	$89,067,564	$93,897,316	$98,513,898
EBITDA	($2,089,950)	$8,968,314	$12,702,902	$17,612,884	$19,143,801	$21,246,379
Depreciation and Amortization		$7,358,824	$7,458,824	$7,558,824	$7,858,824	$8,108,824
EBIT	($2,089,950)	$1,609,491	$5,244,078	$10,054,061	$11,284,977	$13,137,555
Interest Expense		$10,391,282	$9,982,514	$9,546,174	$9,073,617	$8,561,839
Pretax Income	($2,089,950)	($8,781,791)	($4,738,436)	$507,887	$2,211,360	$4,575,716
Income Taxes at 38.25%	($799,405)	($3,359,035)	($1,812,452)	$194,267	$845,845	$1,750,211
Net Income	($1,290,544)	($5,422,756)	($2,925,984)	$313,620	$1,365,515	$2,825,505

Source: PMC Internal data.

Fort Mill Medical Center
CON Financial Pro Forma Assumptions

Summary
In general, financial assumptions were gathered from actual experience of Piedmont Medical Center in Rock Hill, SC and were adjusted for service mix. Base-line time period used in the pro forma was Fiscal Year 2009.

Volume
Inpatient volumes were derived through market research of the Fort Mill service area. Outpatient volumes were based on current outpatient to inpatient ratios experienced at Piedmont Medical Center. The growth rate for Years 1-3 was based on the population trends in the Fort Mill area (Source: SC State Budget and Control Board, Office of Research and Statistics) and market share shifts. A conservative growth rate of 2.8% was assumed in Years 4-5 based on demographic information located in Part B of application.

Revenue
Gross and Net Revenues were based on case mix adjusted averages from Piedmont Medical Center's actual experience. O.B. and General Acute services were weighted accordingly. Gross Revenues were inflated by 4% per year based on current trends for medical care services.

An assumption for charity care that represents three percent of gross revenue. The following table details indigent and charity care dollars for Years 1-5 (2015-2019).

Fort Mill Medical Center
Indigent/Charity Care as a Percent of Gross Patient Revenue

	Year 1 2015	Year 2 2016	Year 3 2017	Year 4 2018	Year 5 2019
Gross Patient Revenue	$150,820,587	$189,990,327	$233,740,045	$253,437,486	$274,746,923
Charity/Indigent	$4,524,618	$5,699,710	$7,012,201	$7,603,125	$8,242,408
% Of Gross Revenue	3.0%	3.0%	3.0%	3.0%	3.0%

Overall case mix was assumed at 1.0 compared to Piedmont Medical Center's overall case mix of 1.34.

Salaries
Salaries were based on Piedmont Medical Center's actual experience volume and case mix adjusted. In years 1 through 5 paid FTEs per adjusted average daily census (AADC) was assumed at approximately 4.0. Inflation was assumed at 3% per year.

Supplies
Supplies were based on Piedmont Medical Center's actual experience volume adjusted. Five percent of supplies was assumed to be fixed and ninety-five percent variable. Inflation was assumed at 2% per year.

Bad Debt
Bad debt was assumed at 9.5% of net patient revenues based on current experience at Piedmont Medical Center adjusted for a reduction in-patient out migration.

Other Controllable Expenses
All other controllable expenses (OCE) were based on Piedmont Medical Center's actual experience volume adjusted. Various Fixed/Variable assumptions were used based on expense category. Inflation was assumed at 2% per year.

Non Controllable Expenses
Non-controllable expenses (NCE) were based on Piedmont Medical Center's actual experience volume adjusted. Real and personal property taxes were assumed at approximately three million dollars. Of the remaining NCE, sixty percent was assumed to be fixed and forty percent variable. Inflation was assumed at 2% per year.

Taxes
An effective tax rate of 38.25% was assumed.

Cost of Capital
A cost of capital expense was imputed for the project based on an interest rate of 8% payable over 15 years.

Piedmont Medical Center
Income Statement

	Forecast					
	2015	2016	2017	2018	2019	2020
STATISTICS						
Acute Admissions	11,976	11,857	11,745	11,628	11,511	11,396
Psych Admissions	787	782	777	772	767	762
Total Admissions	12,763	12,639	12,524	12,400	12,278	12,158
Inpatient Patient Days	57,436	56,874	56,358	55,798	55,252	54,712
ALOS	4.5	4.5	4.5	4.5	4.5	4.5
Adjusted Admissions	20,563	20,361	20,173	19,972	19,775	19,580
Adjusted Patient Days	92,536	91,623	90,779	89,875	88,989	88,111
E/R I/P Admits	7,494	7,419	7,349	7,276	7,203	7,131
Hospital O/P Visits	114,997	113,847	112,775	111,647	110,531	109,426
GROSS REVENUE						
Inpatient Revenue	$407,700,690	$419,859,875	$432,692,642	$445,528,929	$458,816,068	$472,505,149
Outpatient Revenue	$249,149,586	$256,524,346	$264,273,230	$272,095,108	$280,150,314	$288,443,580
Gross Patient Revenue	$656,850,276	$676,384,221	$696,965,872	$717,624,037	$738,966,382	$760,948,729
Deductions from Revenue	$403,023,421	$421,783,492	$441,436,709	$461,352,138	$481,923,627	$503,132,051
Net Patient Revenue	$253,826,855	$254,600,729	$255,529,163	$256,271,899	$257,042,755	$257,816,678
Other Revenue	$2,257,082	$2,279,653	$2,302,450	$2,325,475	$2,348,730	$2,372,217
Net Operating Revenue	$256,083,937	$256,880,382	$257,831,613	$258,597,374	$259,391,485	$260,188,895
OPERATING EXPENSES						
Salaries Wages and Benefits	$83,882,207	$84,715,681	$85,614,015	$86,456,678	$87,316,464	$88,184,065
Supplies	$42,164,233	$42,583,187	$43,034,744	$43,458,317	$43,890,497	$44,326,605
Provision for Bad Debt	$23,144,685	$23,215,249	$23,299,906	$23,367,631	$23,437,920	$23,508,489
Other Controllable Expenses	$45,556,974	$46,126,272	$46,710,348	$47,292,971	$47,884,062	$48,482,441
Non Controllable Expenses / Corp Overhead	$25,722,019	$26,197,952	$26,685,545	$27,178,686	$27,681,569	$28,193,807
Total Operating Expenses	$220,470,118	$222,838,341	$225,344,558	$227,754,283	$230,210,512	$232,695,407
Operating Income	$35,613,819	$34,042,041	$32,487,055	$30,843,091	$29,180,973	$27,493,488
EBITDA	$35,613,819	$34,042,041	$32,487,055	$30,843,091	$29,180,973	$27,493,488
Operating Margin	13.9%	13.3%	12.6%	11.9%	11.2%	10.6%
Depreciation & Amortization	$11,729,802	$11,847,100	$11,965,571	$12,085,227	$12,206,079	$12,328,140
EBIT	$23,884,017	$22,194,941	$20,521,484	$18,757,864	$16,974,894	$15,165,348
Interest Expense	$15,978,601	$15,818,815	$15,660,627	$15,504,020	$15,348,980	$15,195,490
PRE TAX INCOME	$7,905,416	$6,376,126	$4,860,857	$3,253,844	$1,625,914	-$30,142
Income Tax	$3,023,822	$2,438,868	$1,859,278	$1,244,595	$621,912	-$11,529
NET INCOME	$4,881,595	$3,937,258	$3,001,579	$2,009,249	$1,004,002	-$18,613

generally accepted accounting principles. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the Company's financial position, results of operations, and cash flows. Accordingly, these financial statements are not designed for those who are not informed about such matters.

RECORD 002728
Pied.Supp.Con.0545
JOINT-B-PMC-001.0577

Piedmont Medical Center
Financial Forecast Assumptions

Summary
In general, financial assumptions were gathered from 2009 actual experience of Piedmont Medical Center in Rock Hill, SC. Base-line time period used in the forecast was January through December 2009.

Volume
Volumes were assumed to grow from historical levels at a rate of approximately 2.0 percent per year. Volumes were adjusted in 2015 to account for those patients from Fort Mill ZIP Codes who are currently being seen at Piedmont Medical Center and now will be seen at Fort Mill Medical Center.

Revenue
Gross and Net Revenues were based on same case mix as 2009. Gross Revenues were volume adjusted and inflated by 4-5 percent per year based on recent Hospital and Related Services CPI. Net Revenues were volume adjusted and inflated by 1.3 percent per year.

Salaries
Salaries were based on Piedmont Medical Center's actual 2009 experience volume adjusted. Inflation was assumed at 3.0 percent per year.

Supplies
Supplies were based on Piedmont Medical Center's actual 2009 experience volume adjusted. Inflation was assumed at 2.0 percent per year.

Bad Debt
Bad debt was based on same percent of Gross Revenue as Piedmont Medical Center's actual 2009 experience.

Other Controllable Expenses
All other controllable expenses (OCE) were based on Piedmont Medical Center's actual experience volume adjusted. OCE was assumed 75 percent variable and 25 percent fixed. Inflation was assumed at 1.5 percent per year.

Non Controllable Expenses
Non-controllable expenses (NCE) were based on Piedmont Medical Center's actual experience volume adjusted. Inflation was assumed at 2.0 percent per year.

Taxes
An effective tax rate of 38.25 percent was assumed.

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McNAIR

ATTORNEYS

Ariail Burnside Kirk

akirk@mcnair.net
T (803) 799-9800
F (803) 753-3278

February 8, 2011

Via Facsimile

Mr Jody Hamm
Freedom of Information Officer
South Carolina Department of Health
and Environmental Control
2600 Bull Street
Columbia, South Carolina 29201

Re: Request for Information Pursuant to the South Carolina Freedom of Information Act

Dear Mr Hamm:

Pursuant to the South Carolina Freedom of Information Act, S.C. Code Ann. §§ 30-4-10, et seq. (1976), I am writing to request a copy of the following bates numbered pages from various Certification of Need application updates submitted as per the December 9, 2009 Order from Judge Matthews, Administrative Law Court:

- Carolinas Medical Center—Fort Mill bates pages S-CHS-0422 through S-CHS-0448;
- Presbyterian Hospital York, LLC d/b/a Presbyterian Hospital Fort Mill bates pages:
  - PHY2010_001711 through PHY2010_001741, and
  - PHY2010_001989 through PHY2010_002266; and
- Anisub of South Carolina, Inc. d/b/a Fort Mill Medical Center bates pages Pied.Supp.CON.0393 through Pied.Supp.CON.0422.

I will be pleased to reimburse the Department for the costs of copying these documents Should you have any questions with respect to this FOIA request, please do not hesitate to contact me

Very truly yours.

Ariail Burnside Kirk

RECEIVED
FEB 0 9 2011
Freedom of
Information Office

McNair Law Firm, P.A.
The Tower at 1301 Gervais
1301 Gervais Street
11th Floor
Columbia, SC 29201

Mailing Address
Post Office Box 11390
Columbia, SC 29211

mcnair.net

Amisub of South Carolina, Inc d/b/a Fort Mill Medical Center

Request of January 4, 2011

Volume 1

(4)

547-618

4

D H E C
PROMOTE PROTECT PROSPER

C. Earl Hunter, Commissioner

Promoting and protecting the health of the public and the environment.

January 4, 2011

Mr. Charles Miller, President and CEO
Piedmont Medical Center
222 South Herlong Avenue
Rock Hill, SC 29732

Re: Amisub of South Carolina, Inc. d/b/a Fort Mill Medical Center
As Per December 9, 2009 Order from Judge Matthews, Administrative Law Court
Fort Mill, South Carolina

Dear Mr. Miller:

This is to acknowledge acceptance of your application for the above referenced project on December 3, 2010. As a result of this Department's review of the application, we find the following additional information is needed prior to the application being considered complete as required in Section 302 of Regulation No. 61-15. Please note that any referenced page numbers refer to Bates Stamped pages of the Department file.

In addition, note that the Department cannot replace pages of the original application or pages of the updated information submitted on October 4, 2010 with revised sections to include figures, tables, or pages. Any supplemental information received will be added to Department file in a sequential manner.

1. The market share you stated on page 0430 only provides a discussion of the market share for Piedmont Medical Center and Fort Mill Medical Center for 2017. Provide a breakdown of the market share percentage for both facilities for the first three years of operation for Ft. Mill Medical Center.

2. Is the proforma provided for Piedmont, as shown in Attachment F, inclusive of the Fort Mill Medical Center? The income statement provided on p. 0545 does not clearly indicate whether this is a consolidated budget or one not inclusive of the new hospital.

3. In your narrative about the proformas provided in Attachment F, you state that the proforma without Fort Mill Medical Center assumes that one of the North Carolina applicants are approved. Provide a discussion of the direct financial impact or implications that such a decision would have on Piedmont Medical Center.

4. Please indicate if any attempt has been made to quantify letters of support by the primary and secondary service areas as defined in the updated application. If so, please identify the number of support letters from the service area vs. the total.

Note that blank Bates stamped labels were not provided as requested.

Please provide all the requested information to this Office within thirty (30) days of the date of this letter. Pursuant to Section 302.2 of Regulation No. 61-15, Certification of Need for Health Facilities and Services, this application will be considered withdrawn if additional information has not been received by February 3, 2011.

Should you require further information, please contact me at (803) 545-4200.

Sincerely,

Beverly Brandt

Beverly A. Brandt, Chief
Bureau of Health Facilities and Services Development

Lisa D. Sanders, Health Planning Analyst
Bureau of Health Facilities and Services Development

cc: Stuart M. Andrews, Jr., Esquire
Ashley Biggers
M. Elizabeth Crum, Esquire
Barbara Freedy
David Levitt
Donald B. Meyer, Esquire
F. Del Murphy, Jr.

January 31, 2010

Ariail Burnside Kirk

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T (803) 799-9800
F (803) 753-3278

Beverly Brandt
Director, Bureau Health Facilities & Services
South Carolina Department of Health and Environmental Control
1777 St. Julian Place
Columbia, SC 29204

JAN 31 2011

Re: **The proposed Fort Mill Medical Center CON Application—Community Health System's attempts to acquire all outstanding shares of Tenet Healthcare Corporation**

Dear Beverly:

If Community Health Systems, Inc. ("CHS") acquires Tenet Healthcare Corporation ("Tenet") prior to a Department decision on the pending applications, we do not believe that, as a matter of law, the proposed Fort Mill Medical Center ("FMMC") certificate of need ("CON") application can be approved. If CHS acquires Tenet prior to a decision in this matter, this acquisition would constitute a substantial change in the project pursuant to S.C. Code Reg. 61-15, Section 310 and violates S.C. Code Ann. § 44-7-230(A) of the CON Act because the project would no longer be the one described in the application. Furthermore, if the Department were to approve Tenet and CHS acquires Tenet after Department approval and before FMMC is opened for patients, the CON would be voided pursuant to S.C. Code Ann. § 44-7-230(E).

Background Events

According to its website, CHS owns, operates or leases more than 126 hospitals in 29 states, with approximately 19,400 licensed beds. These hospitals include Marion Regional Healthcare Center (Mullins, SC), Carolinas Hospital System (Florence, SC), Marlboro Park Hospital (Bennettsville, SC), Chesterfield General Hospital (Cheraw, SC), Springs Memorial Hospital (Lancaster, SC), and Mary Black Health System (Spartanburg, SC).

While the proposed licensee is Amisub of South Carolina, Inc., "[t]he ultimate parent corporation of Amisub of South Carolina, Inc. is Tenet Healthcare Corporation." See FMMC Application, Pied.Supp.CON.00017.

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To date the following events have taken place in light of CHS's attempts to acquire Tenet:

- November 12, 2010—CHS offered to acquire all of the outstanding shares of Tenet for $6.00 per share in cash and stock.
- December 8, 2010—Tenet sent CHS a letter stating that the Tenet board is not interested in pursuing the CHS proposal.
- December 9, 2010—CHS sent a letter to Tenet and publicly announces it has made an offer to acquire Tenet for $6.00 per share, including $5.00 per share in cash and $1.00 per share in CHS common stock, which represents a premium of 40% over Tenet's closing stock price. The CHS letter to Tenet stated:

  > It remains our strong desire to reach an agreement with Tenet. However, we are committed to completing this transaction and will consider all alternatives necessary to do so. ...
  >
  > This transaction is a strategic priority for us and has the full attention of our management team and the unanimous support of our Board of Directors. ...
  >
  > I want to reiterate CHS's commitment to successfully completing this compelling transaction. By refusing to negotiate with us, you are delaying your shareholders' ability to receive the substantial financial and strategic benefits of this transaction. We stand ready to meet with you and your advisors to move this transaction forward without further delay.

- December 9, 2010 -- Tenet responded by issuing a press release confirming that it received an offer from CHS and that the Tenet board previously rejected an identical proposal describing the CHS proposal as "inadequate."

- December 10, 2010 -- A Shareholder Class Action law suit was filed by Tenet shareholder Max Katz in Dallas County, Texas against Tenet and the individuals serving on the Tenet Board of Directors. See Exhibit 1, Katz v. Fetter et. al.
- December 20, 2010—CHS announced that it intends to nominate directors for election at the 2011 Tenet Annual Meeting. Tenet's entire Board is up for reelection at the 2011 Annual Meeting.
- December 20, 2010—Tenet responded that it has yet to schedule a 2011 Annual Meeting.
- January 7, 2011—Tenet announced that its Board amended the Tenet bylaws to allow the Annual Meeting to be held on November 3, 2011 (a 6 month delay) and adopted a stockholder rights plan.
- January 7, 2011—CHS's responded: "Tenet shareholders should be deeply disappointed that their Board's response to a compelling 40% premium offer is a

double-barreled entrenchment strategy - facilitating a significant delay of their 2011 Annual Meeting and installing a poison pill. We are confident that Tenet shareholders will see these steps for what they are: the actions of a Board that is not working for them. Rather than resorting to delaying tactics, Tenet should engage with us in good-faith discussions to complete a mutually beneficial transaction."

- January 14, 2010—Tenet announced it has received notice from CHS of a slate of 10 nominees for the Tenet Board.
- January 14, 2010—CHS announced its Tenet Board nominees.

Application Project Changes Resulting from Takeover

"If an applicant amends his application during the review process, the department will determine whether or not the amendment is substantial and constitutes a new application." S.C. Reg. 61-15, § 310. We submit that even if FMMC were to notify the department of the acquisition of Tenet by CHS and amend the FMMC application accordingly, the amendment would be substantial and constitute a new application.

Acquisition of Tenet would invalidate a number of documents relied on by FMMC "for the project described in the application" to comply with CON regulatory requirements:

- The CON regulations require that the applicant identify the method of financing the project, including the start-up costs and provide documentation that the applicant can obtain financing. *See* Reg. 61-15 § 202.b(15). To comply with this requirement, FMMC submitted a letter from John Holland, Senior Vice President, Operations for Tenet has the funding and to certifying that Tenet is committed to providing the necessary funding, approximately $147 million, to develop FMMC. See Pied.Supp.CON.0211. CHS' hostile takeover attempts began after this letter was submitted. There is no evidence that this commitment is still valid in light Tenet's expenditures fighting CHS' hostile takeover attempts. Further, is Tenet were taken over by CHS, there would be no documentation of the method of financing, since Tenet is the only identified financing source.
- Attachments M, N, and O to the FMMC CON Application contain Tenet's required quality, patient safety, charity care, and uninsured policies which would be invalid upon takeover of Tenet by CHS as Tenet would no longer own and control FMMC. *See* Reg. 61-15 § 202.c(1)
- The CHS charges that would be in effect in York County have not been reviewed by the Department. FMMC submitted Piedmont Medical Center's charges in response to Reg. 61-15 § 202.b(16) and (17) in creating its projected charges and pro forma budgets. CHS's acquisition of Tenet may drastically change charges in effect at Piedmont rendering the CON submission inaccurate as to FMMC's charges and pro forma budgets.
- The Department has not reviewed CHS as part of Reg. 61-15 requirement regarding "Record of the Applicant".

- CHS has not provided the Part D assurances required by Regulation 61-15 Section 202.
- CHS has not submitted any documents supporting the FMMC CON application.

For the reasons discussed above, CHS's acquisition of Tenet would constitute a substantial change and thereby either: (1) constitute a new application prior to any DHEC decision; or (2) render any issued CON invalid as the project would not be the same "project described in the application."

A Certificate of Need is Nontransferable

The CON Act states as follows:

> A Certificate of Need is nontransferable. A Certificate of Need or rights thereunder may not be sold, assigned, leased, transferred, mortgaged, pledged, or hypothecated, and any actual transfer or attempt to make a transfer of this sort results in the immediate voidance of the Certificate of Need. **The sale or transfer of the controlling interest or majority ownership in a corporation, partnership, or other entity holding, either directly or indirectly, a Certificate of Need, results in the transfer and voidance of a Certificate of Need.**

S.C. Code Ann. § 44-7-230(E) (emphasis added). Specifically, the CHS's acquisition of Tenet after approval of the FMMC CON application would result in the voidance for the CON.

Tenet is well aware of the fact that any CON approved for FMMC would be voided pursuant to S.C. Code Ann. § 44-7-230(E) upon CHS' acquiring Tenet. During the summer of 2007, Tenet purchased Coastal Carolina Medical Center ("CCMC"). At the time DHEC had issued Coastal Carolina Medical Center a CON for MRI services(SC-06-46). In a June 28, 2007 letter to the Department, Tenet counsel stated:

> **Acknowledgement**. [Tenet HealthSystem Medical Inc.] acknowledges the change of ownership of PCH-Jasper, Inc. [CCMC] would void Certificate of Need SC-06-46 if the project were not fully implemented and the file closed prior to the closing of the transaction; however, I have been advised that PHC-Jasper has submitted the final completion report for the project and that on June 27, 2007, the Department closed its file on this matter.

Exhibit 2, June 28, 2007 letter to Victoria R. Tibshrany from Stuart M. Andrews, Jr. Tenet is essentially estopped from taking any position other than to acknowledge that the acquisition by CHS will void any CON issued for FMMC.

MCNAIR
ATTORNEYS

Please do not hesitate to contact me if you have any questions or if you need any additional information regarding this matter. We request that this letter be made a part of the official Department file for the above-referenced application.

Very truly yours,

Ariail Burnside Kirk

ABK:dh
Enclosures

cc: Ashley C. Biggers, Esquire
Douglas M. Muller, Esquire
Trudy H. Robertson, Esquire
Stuart M. Andrews, Esquire
Daniel J. Westbrook, Esquire



Filed
10 December 17 P4:14
John Warren
County Clerk
Dallas County

Cause No. CC-10-08884-C

MAX KATZ, Individually And On Behalf Of All Others Similarly Situated,	§	IN THE COUNTY COURT AT LAW
Plaintiff,	§	
v.	§	NO. 3
TREVOR FETTER, EDWARD A. KANGAS, JOHN ELLIS BUSH, BRENDA J. GAINES, KAREN M. GARRISON, EDWARD A. KANGAS, J. ROBERT KERREY, FLOYD D. LOOP, RICHARD R. PETTINGILL, RONALD A. RITTENMEYER, JAMES A. UNRUH and TENET HEALTHCARE CORPORATION,	§	
Defendants.	§	DALLAS COUNTY, TEXAS

SHAREHOLDER CLASS ACTION PETITION

Plaintiff Max Katz ("Plaintiff"), individually and on behalf of all other similarly situated public shareholders of Tenet Healthcare Corporation ("Tenet" or the "Company"), other than the defendants and their affiliates (the "Class"), brings the following Shareholders Class Action Petition against Tenet and its board of directors (the "Director Defendants," and together with Tenet, the "Defendants"). The allegations of the Complaint are based on the personal knowledge of Plaintiff as himself and his acts and on information and belief (including the investigation of counsel and review of publicly available information) as to all other matters.

DISCOVERY PLAN

1. This dispute involves complicated class action issues and requires that discovery be conducted on an expedited basis. Therefore, discovery will be conducted under a level 3 discovery control plan, as will be set by the Court pursuant to Tex. R. Civ. P. 190.4.

NATURE OF THE ACTION

2. This action arises from the Director Defendants' steadfast refusal to engage in negotiations with Community Health Systems, Inc. ("CHS") regarding a possible acquisition of Tenet at a premium price. The Director Defendants' actions are unreasonable, motivated purely by their own selfish interest in preserving their positions on Tenet's board of directors and constitute a breach of their fiduciary duties to Tenet's public shareholders.

3. Specifically, on November 12, 2010, CHS provided the Director Defendants with a proposal to acquire the Company for $6 per share, representing a price approximately 40% above the market price for Tenet common stock. Despite the premium offer (as well as the possibility that arm's-length negotiations could result in an even higher offer), the Director Defendants flatly refused to explore even the possibility of an acquisition by CHS and refused to meet with any CHS representatives.

4. Having been stiff-armed by a corporate board that refused to engage in any discussions with a willing buyer offering a significant premium to market prices, CHS went public on December 9, 2010 and disclosed the premium offer and the Director Defendants' failures to engage. The Director Defendants' response was to yet again flatly reject the premium offer without any discussions or negotiations with CHS.

5. Through this action, Plaintiff seeks injunctive and other equitable relief to require the Director Defendants to fulfill their fiduciary duties to the Company and the Class by fairly considering CHS's offer to acquire the Company at a premium price, including seeking increased consideration from CHS. Plaintiff also seeks injunctive relief against entrenching transactions that will not maximize shareholder value.

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JURISDICTION AND VENUE

6. This Court has jurisdiction over each Defendant named herein because each Defendant is either a corporation that conducts business in and maintains operations in Dallas County, or is an individual who has sufficient minimum contacts with Texas so as to render the exercise of jurisdiction by the Texas courts permissible under traditional notions of fair play and substantial justice.

7. Venue is proper in this Court because one or more of Defendants is either a domiciliary of, resides in or maintain executive offices in this County, a substantial portion of the transactions and wrongs complained of herein, including Defendants' primary participation in the wrongful acts detailed herein and aiding and abetting breaches of their fiduciary duties owed to Tenet shareholders occurred in Dallas County, and Defendants have received substantial compensation in Dallas County by doing business here and engaging in numerous activities that had an effect on this County.

THE PARTIES

8. Plaintiff is and was at all times relevant hereto, a shareholder of Tenet.

9. Defendant Tenet is a Nevada corporation headquartered at 1445 Ross Avenue, Suite 1400, Dallas, Texas 75202. Tenet is a health care services company whose subsidiaries and affiliates principally operate general hospitals and related ancillary health care businesses, including 49 acute care hospitals in 11 states and 64 outpatient centers. Tenet common stock is publicly traded on the New York Stock Exchange under the symbol "THC." Tenet is named herein as a necessary party in connection with equitable relief needed to address the actions the Director Defendants committed in violation of their fiduciary duties to Tenet's public shareholders.

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10. Defendant Trevor Fetter ("Fetter") is a director of Tenet and is the Company's President and Chief Executive Officer. Fetter originally joined Tenet in 1995, serving as an executive vice president, chief financial officer and a member of the office of the president. He left Tenet in February 2000 to serve as chairman and CEO of Broadlane, Inc., a hospital cost-management services company that was founded by Tenet and other health care providers. Fetter returned to Tenet in November 2002 as President, was named acting CEO in May 2003, and was appointed CEO in September 2003.

11. Defendant Edward A. Kangas ("Kangas") has been a director of the Company since March 2003 and Chairman since July 2003.

12. Defendant John Ellis Bush ("Bush") has been a director of the Company since April 2007.

13. Defendant Brenda J. Gaines ("Gaines") has been a director of the Company since March 2005.

14. Defendant Karen M. Garrison ("Garrison") has been a director of the Company since March 2005.

15. Defendant J. Robert Kerrey ("Kerry") has been a director of the Company since March 2001.

16. Defendant Floyd D. Loop ("Loop") has been a director of the Company since January 1999.

17. Defendant Richard R. Pettingill ("Pettingil") has been a director of the Company since March 2004.

18. Defendant Ronald A. Rittenmeyer ("Rittenmeyer") has been a director of the Company since June 2010.

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19. Defendant James A. Unruh ("Unruh") has been a director of the Company since June 2004.

20. Defendants Fetter, Kangas, Bush, Gaines, Garrison, Kerrey, Loop, Pettingill, Rittenmeyer and Unruh constitute the entirety of the Company's board of directors and are collectively referred to herein as the "Director Defendants."

21. By virtue of their position the directors of Tenet and/or their exercise of control and ownership over the business and corporate affairs of the Company, the Director Defendants have, and at all relevant times had, the power to control and influence and did control and influence and cause the Company to engage in the practices complained of herein.

22. Each Director Defendant herein is sued individually and in his/her capacity as a director of Tenet. The liability of each of the Director Defendants arises from the fact that they have engaged in all or part of the unlawful acts, plans, schemes, or transactions complained of herein.

THE DIRECTOR DEFENDANTS' FIDUCIARY DUTIES

23. Each of the Director Defendants owed and owes Tenet shareholders fiduciary obligations of due care, good faith, and loyalty and were and are required to: (1) use their ability to control and manage Tenet in a fair, just, and equitable manner; (2) act in furtherance of the best interests of the Tenet shareholders; (3) act to maximize shareholder value in connection with any change in ownership and control to the extent consistent with governing statutes; (4) govern Tenet in such a manner as to heed the expressed views of its public shareholders; (5) refrain from abusing their positions of control; and (6) not favor their own interests at the expense of the Company's public shareholders.

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24. The Director Defendants, separately and together, as they continue to refuse to negotiate with CHS, are knowingly or recklessly violating their fiduciary duties of good faith, care and disclosure owed to the Class.

SUBSTANTIVE ALLEGATIONS

25. CHS, which is headquartered in Nashville, Tennessee, is the largest publicly traded hospital company in the United States, operating 126 hospitals in 29 states. CHS common stock is traded on the New York Stock Exchange under the symbol "CYH."

26. On November 12, 2010, CHS provided the Director Defendants with a letter outlining CHS's proposal to acquire all of the outstanding shares of Tenet common stock for $6 per share, consisting of $5 per share in cash and CHS common stock valued at $1 per share. CHS's $6 offer price was approximately 40% higher than the market price of Tenet common stock that day.

27. The Director Defendants on December 6, 2010, responded to CHS's proposal. The Director Defendants flatly rejected the offer and rejected any effort to engage CHS in discussions with respect to the offer or any higher value offer that might be achieved through arm's-length negotiations. No one on the part of Tenet even bothered to pick up the phone and talk to someone at CHS.

28. With the bulk of the offer price in cash and CHS seeking an outright acquisition of the Company, the Director Defendants rightly recognized that a sale to CHS would end the Director Defendants' positions on Tenet's board and the valuable compensation that flows therefrom.

29. Indeed, Tenet's board of directors is extraordinarily well paid for the handful days of work a year devoted to board and committee meetings. Between 2006 (the first year Tenet began public reporting fees paid to its individual directors) and 2009, Tenet collectively paid its

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directors over $11.3 million for attending meetings maybe one day per month. (Tenet's board met just 7 times during 2009.) The Director Defendants have, between 2006 and 2009, received director fees consisting of cash and stock in the following amounts:

Director Defendant	2006-2009 Director Fees
Kangas	$1,788,735
Bush	$937,627 (Since April 2007)
Gaines	$1,261,092
Garrison	$1,227,092
Kerrey	$1,140,235
Loop	$1,421,787
Pettingill	$1,102,035
Rittenmeyer	n/a (joined board in June 2010)
Unruh	$1,217,357

30. Fetter, who was paid over $41 million between 2006 and 2009, certainly also recognized that he would lose his job if the Company was acquired.

31. With a fully financed premium offer already on the table, the Director Defendants have been offered a unique opportunity to maximize the value of Tenet common stock, notwithstanding the Director Defendants' personal financial reasons to reject any acquisition overture. Indeed, rather than take advantage of CHS's offer as a springboard to solicit and explore a better offer from CHS, the Director Defendants flatly rejected CHS's offer without any effort to determine whether better or different terms could be obtained.

32. The Director Defendants' failure to engage CHS or otherwise properly inform themselves of the offer lead CHS to go public and disclose the acquisition proposal directly to shareholders on December 9, 2010. CHS disclosed a new, December 9, 2010 letter to the Director Defendants, which stated in relevant part:

December 9, 2010

Board of Directors
Tenet Healthcare Corporation
1445 Ross Avenue
Dallas, Texas 75202

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Attention: Mr. Trevor Fetter
President and Chief Executive Officer

Ladies and Gentlemen:

We were surprised and disappointed by your flat rejection of a transaction that would provide a premium of approximately 40% to Tenet Healthcare Corporation shareholders. As you know, Community Health Systems, Inc. ("CHS") has offered to acquire all of the outstanding shares of Tenet at a price of $6.00 per share ($5.00 in cash and $1.00 in CHS stock). We are convinced this transaction would be very attractive to Tenet shareholders – and we do not understand how you could state in your letter of December 6 that our proposal does not offer "even remotely fair value" to Tenet shareholders.

Given your position, we have concluded it is now appropriate to publicly disclose our proposal. This will allow Tenet shareholders to decide for themselves if they prefer the substantial premium and high degree of certainty offered in this transaction – or would rather continue to accept the significant risk, especially in light of recent operating performance, that Tenet can achieve greater present value for shareholders through execution of its strategic plan in the years ahead.

The combination of CHS and Tenet is both financially and strategically compelling. At $6.00 per share, our proposal provides a 40% premium over Tenet's closing stock price today which is materially higher than the average premium paid in similar size transactions over the last five years. In addition to receiving a substantial cash premium, Tenet shareholders will share in the upside of the combination through the stock portion of the consideration, which will be based on a fixed exchange ratio. The total value of the transaction would be approximately $7.3 billion.

* * *

It remains our strong desire to reach an agreement with Tenet. However, we are committed to completing this transaction and will consider all alternatives necessary to do so. Our proposal is based on our analysis of publicly available information. As we have made clear to your advisors, we would welcome the opportunity to review any additional information you provide and are prepared to recognize any additional value you can demonstrate.

We do not believe there are any financial or regulatory impediments to your shareholders' timely realization of this substantial premium. The cash portion of the consideration would be financed with available cash on hand together with external debt financing. We have analyzed this combination in detail with our financial advisors at Credit Suisse and are highly confident that we can deliver a fully financed transaction. Prior to the execution of the definitive transaction agreements, we anticipate receiving financing commitments in an amount sufficient to fund the transaction. We have conducted a preliminary antitrust review and do not believe the combination would give rise to any significant

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antitrust issues. In addition, we do not expect the transaction would require approval by CHS shareholders.

This transaction is a strategic priority for us and has the full attention of our management team and the unanimous support of our Board of Directors. Accordingly, we and our financial and legal advisors at Credit Suisse and Kirkland & Ellis LLP are prepared to devote the resources necessary to complete our due diligence activities and negotiate and execute mutually acceptable definitive documentation in an expedited manner.

I want to reiterate CHS's commitment to successfully completing this compelling transaction. By refusing to negotiate with us, you are delaying your shareholders' ability to receive the substantial financial and strategic benefits of this transaction. We stand ready to meet with you and your advisors to move this transaction forward without further delay.

Sincerely,

/s/ Wayne T. Smith
Wayne T. Smith
Chairman of the Board, President and
Chief Executive Officer

33. CHS's Wayne Smith ("Smith") during a conference call later that day provided further detail of Tenet's refusal to engage in any discussions with CHS. According to Smith:

> [W]e would love to have had an opportunity to talk to Tenet and their Board about why we think this is strategically so compelling. We never got that far.
>
> * * *
>
> I would say that it's unfortunate that we weren't able to have a conversation about this... We're certainly hopeful that rational people prevail here, and that we have an opportunity to have discussions and have an opportunity to talk about this, and hopefully, work out a transaction that works both for the Tenet shareholders and for our shareholders.
>
> * * *
>
> [I]t's unfortunate and we're apologetic for the fact that we had to go public with this. If we had had the opportunity to discuss this face to face, I think we would have had a different result here. And we would have been able to work through this.

34. The Director Defendants responded to CHS's December 6, 2010 proposal by again flatly rejecting any acquisition discussions, to the harm of shareholders. The Director

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Defendants' unwillingness to engage in any discussions with CHS to explore whether a higher offer might be achieved has harmed and will continue to harm shareholders, as there unlikely to be any other potential suitors for Tenet. *The New York Times* reported the comments of Sam Goodyear, an analyst at Creditsights, that "I don't see an obvious competing bidder in terms of another strategic buyer." According to David Whelan at *Forbes*:

> Will another bidder enter the picture? At $7.3 billion the deal is out of the range of all but the very biggest private equity firms–which usually do not outbid strategic acquirers anyway. I'm guessing that the answer here is no. There's been plenty of time for other hospitals or buyout funds to buy Tenet in recent years.

CLASS ACTION ALLEGATIONS

35. Plaintiff brings this action on his own behalf and as a class action pursuant to Rule 42 of the Texas Rules of Civil Procedure on behalf of all shareholders of Tenet (except the Director Defendants herein and any person, firm, trust, corporation or other entity related to or affiliated with any of the defendants) and their successors in interest, who have been or will be adversely affected by the conduct of Defendants alleged herein.

36. This action is properly maintainable as a class action because:

(a) The Class is so numerous that joinder of all members is impracticable. As of October 27, 2010, there were over 485 million shares of Tenet common stock outstanding, likely owned by at least thousands of shareholders scattered throughout the United States;

(b) A class action is superior to other methods for the fair and efficient adjudication of the claims asserted herein, and no unusual difficulties are likely to be encountered in the management of this action as a class action. The likelihood of individual class members prosecuting separate claims is remote;

(c) There are questions of law and fact which are common to members of the Class and which predominate over any questions affecting any individual members. The common questions include, *inter alia*, whether the Director Defendants have fulfilled their

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fiduciary obligations to Tenet public shareholders and are capable of properly assessing CHS's proposals and whether Plaintiff and the other members of the Class would be irreparably damaged by the Director Defendants' wrongful conduct.

37. The Director Defendants have acted on grounds generally applicable to the Class with respect to the matters complained of herein, thereby making appropriate the relief sought herein with respect to the Class as a whole. To the extent the Director Defendants continue their refusal to consider and respond in good faith to reasonable acquisition offers or adopt defensive measures to make such an acquisition more difficult or costly to CHS or any other potential acquirer, preliminary and final injunctive relief on behalf of the Class as a whole will be entirely appropriate.

38. Plaintiff is committed to prosecuting this action and has retained competent counsel experienced in litigation of this nature. Plaintiff's claims are typical of the claims of the other members of the Class and Plaintiff has the same interests as the other members of the Class. Accordingly, Plaintiff is an adequate representative of the Class and will fairly and adequately protect the interests of the Class.

39. The prosecution of separate actions by individual members of the Class would create the risk of inconsistent or varying adjudications with respect to individual members of the Class, which would establish incompatible standards of conduct for the Director Defendants, or adjudications with respect to individual members of the Class which would, as a practical matter, be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests.

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FIRST CAUSE OF ACTION

(Against the Director Defendants for Breaches of Fiduciary Duties)

40. Plaintiff repeats and realleges the allegations set forth above as if fully set forth herein.

41. The Director Defendants owe the Class the utmost fiduciary duties of due care, good faith, and loyalty. The Director Defendants have failed to consider and respond in good faith to the acquisition offers by CHS to the detriment of Tenet and its shareholders. Despite the failure of their restructuring initiatives, the Director Defendants have given no indication of intent to conduct any legitimate negotiations with CHS.

42. The Director Defendants have a duty not to adopt, implement or maintain defensive measures designed to make the acquisition of Tenet unduly burdensome or expensive for a potential suitor. The Director Defendants are obligated to refrain from entering into any agreements that would either harm the Company or its shareholders or inhibit the Director Defendants' ability to maximize shareholder value. Given the substantial premium offered by CHS, there is no threat posed to Tenet or its shareholders by the offer.

43. As a result of the foregoing, the Director Defendants have breached their fiduciary duties to Tenet and its shareholders, including the obligations of loyalty, good faith and due care.

44. Absent relief in this action, Director Defendants' conduct will irreparably harm Class members who will be denied the opportunity to benefit from a value-maximizing transaction.

45. Plaintiff and the Class have no adequate remedy at law.

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PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays that the Court enter judgment:

A. Declaring that this action is properly maintainable as a class action and certifying Plaintiff as the representative of the Class as to Count I;

B. Preliminarily and permanently directing the Director Defendants to consider and respond in good faith to acquisition offers that would maximize value to the Class;

C. Preliminarily and permanently enjoining the Director Defendants from entering into any contractual agreements that inhibit the Director Defendants' ability to maximize shareholder value;

D. Preliminarily and permanently enjoining the Director Defendants from initiating any defensive measures which may render the acquisition of the Company unduly burdensome or expensive for a potential acquirer;

E. Ordering the Director Defendants to rescind or redeem the poison pill and/or declaring the poison pill invalid;

F. Awarding plaintiff the costs and disbursements of this action, together with reasonable attorneys' fees and expenses; and

G. Granting such other and further relief as the Court may deem just and proper.

JURY DEMAND

Plaintiff hereby demands a trial by jury on all issues triable by jury.

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Dated: December 17, 2010

BARON & BUDD, P.C.

By: _____
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Counsel for Plaintiff

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EXHIBIT
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June 28, 2007

RECEIVED
JUN 28 2007
HEALTH FACILITIES AND SERVICES DEVELOPMENT

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1777 St. Julian Place, Suite 201
Columbia, SC 29204

RE: Response to Request for Additional Information Concerning CON Exemption Request Related to Change of Ownership of PHC-Jasper, Inc. d/b/a Coastal Carolina Medical Center
Our File No. 05983/09034

Dear Ms. Tibshrany:

I am writing to respond to your request dated June 25, 2007 for additional information concerning the CON exemption request of Tenet HealthSystem Medical, Inc. ("THM") concerning the above-referenced matter ("CON Exemption Request").

1. Reimbursement Certification. Enclosed as Attachment A is a certification by Kristy Waters that, to the best of her knowledge, verifies government-sponsored reimbursement will not increase as a result of the change of ownership.

2. Acknowledgement. THM acknowledges the change of ownership of PHC-Jasper, Inc. would void Certificate of Need SC-06-46 if the project were not fully implemented and the file closed prior to the closing of the transaction; however, I have been advised that PHC-Jasper has submitted the final completion report for the project and that on June 27, 2007, the Department closed its file on this matter.

In addition, pursuant to our recent conversation, I am furnishing additional information concerning the ownership disclosure set forth in Exhibit 6(c) of THM's CON Exemption Request. In paragraph (c) of Exhibit 6, the complete title of the licensee's governing body is identified as the Governing Board. The Governing Board, along with the Board of Directors,

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will share responsibility for the business and affairs of PHC-Jasper, Inc. The Governing Board will have authority and responsibility for assuring proper organization of the hospital's medical staff and for assuring the quality of care provided under the auspices of the hospital. The Board of Directors will have responsibility for all other business and affairs of PHC-Jasper, Inc., except to the extent the Board of Directors delegates other such matters to the Governing Board. Elizabeth Lamkin will serve as the President of PHC-Jasper, Inc. Other officers of the corporation are identified in Attachment B to Exhibit 6. Caitlin Larsen will be the sole director of the Board of Directors. The Governing Board will be appointed by the Board of Directors after closing.

Finally, I am enclosing a substitute 2008 P&L proforma budget (Attachment B) that includes a management allocation fee inadvertently omitted from the original filing.

Thank you for your consideration of this information and documentation. Please advise should any further information be necessary.

Very truly yours,

Stuart Andrews by DJW

Stuart M. Andrews, Jr.

SMA:ckb
Enclosures

LEVITT
healthcare
affiliates

RECEIVED
FEB - 3 2011
HEALTH FACILITIES AND
SERVICES DEVELOPMENT

February 3, 2011

Ms. Beverly Brandt
Chief
Bureau of Health Facilities and Services Development
South Carolina Department of Health and Environmental Control
2600 Bull Street
Columbia, SC 29201-1708

Ms. Lisa D. Sanders
Health Planning Analyst
Bureau of Health Facilities and Services Development
South Carolina Department of Health and Environmental Control
2600 Bull Street
Columbia, SC 29201-1708

RE: Amisub of South Carolina, Inc. d/b/a Fort Mill Medical Center
As Per December 9, 2009 Order from Judge Matthews, Administrative Law Court
Fort Mill, South Carolina

Dear Ms. Brandt and Ms. Sanders:

The following is response to your letter dated January 4, 2011, requesting additional information on the above referenced project.

1. **The market share you stated on page 0430 only provides a discussion of the market share for Piedmont Medical Center and Fort Mill Medical Center for 2017. Provide a breakdown of the market share percentage for both facilities for the first three years of operation for Ft. Mill Medical Center.**

Response: The following figure provides the projected 2015-2017 Medical/Surgical and ICU marketshare for Piedmont Medical Center and Fort Mill Medical Center, consistent with the information presented on 0430.

Fort Mill Medical Center Service Area
Projected Medical/Surgical and ICU Marketshare

	2015 Market Share			2016 Market Share			2017 Market Share		
Area	FMC	PMC	Combined	FMC	PMC	Combined	FMC	PMC	Combined
PSA	25.7%	46.4%	72.0%	30.2%	45.1%	75.3%	34.6%	42.9%	77.6%
SSA	2.7%	47.4%	50.0%	3.1%	47.4%	50.5%	3.6%	47.3%	50.8%
York County	20.7%	52.0%	72.7%	24.4%	51.0%	75.3%	27.7%	48.8%	76.5%

Source: Claritas, SC Office of Research and Statistics and Thompson/Reuters.

1778 Emory Ridge Drive, Atlanta, GA 30329
(p) 404.315.9011 (f) 404.315.1071

9 River Place, Beaufort, SC 29906
(p) 843.379.9372 (f) 843.379.9373

cell 404.964.2658
david.levitt@comcast.net

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2. **Is the proforma provided for Piedmont, as shown in Attachment F, inclusive of the Fort Mill Medical Center? The income statement provided on p. 0545 does not clearly indicate whether this is a consolidated budget or one not inclusive of the new hospital.**

Response: The pro forma provided in **Attachment F** is for Piedmont Medical Center only and does not include Fort Mill Medical Center.

3. **In your narrative about the proformas provided in Attachment F, you state that the proforma without Fort Mill Medical Center assumes that one of the North Carolina applicants are approved. Provide a discussion of the direct financial impact or implications that such a decision would have on Piedmont Medical Center.**

Response: The approval of either of the Charlotte-area applications to build a satellite hospital in Fort Mill, the most affluent, fastest growing area of York County, would severely undermine, if not permanently compromise, the ability of Piedmont to continue to provide a full range of accessible, quality services to other residents of York County. Some effects of such a decision are measurable. Many of the effects, while not measurable, are no less significant. In fact, these considerations may well be more important than the short-term quantifiable impacts. They reasonably forecast a predictable process that is likely to erode the healthcare system on which a majority of the residents of York County rely.

Projected Loss of Patient Volume and Revenue
Piedmont projects that it will lose over 3,500 cases and some $13.8 million in net patient revenue by the third year of operation of a Fort Mill facility owned by either Carolinas or Presbyterian. (Pied.Supp.CON.0040-41, Figures A and D.) The reduction in patient volume represents a decline of 29 percent in Piedmont's market share in its primary and secondary service areas, which would be a reduction of 27 percent in 2009 admissions.

Patients who would be likely to shift their care from Piedmont to the new Fort Mill facility would include the following groups:

1. Patients from the Fort Mill and Tega Cay communities.
2. York County patients whose attending physicians are employed by an affiliate of Carolinas or Presbyterian that have been admitting or referring patients to Piedmont.
3. Other York County patients for whom drive time to the new Fort Mill hospital would not be significantly greater than the drive to Piedmont and would like to try the new facility.

Acknowledging its low market share of York County patients, Presbyterian concedes that it must take a substantial number of patients from Piedmont for its facility to succeed.

Carolinas, on the other hand, argues that it provides services to such a large number of York County residents in its Charlotte-area facilities, including CMC-Pineville, that it will be able to redirect these patients to its Fort Mill facility without any adverse effect on Piedmont.

There are two fundamental flaws in Carolinas' logic. The first is that since CMC-Fort Mill would have an open medical staff, it cannot control whether patients admitted would be those who have previously received their care from another Carolinas facility or from Piedmont. Fort Mill and Tega Cay patients who received services from Piedmont Medical Center in the past would be likely to move their care to the more convenient local hospital.

In addition, other York County patients whose physicians are employed by either Carolinas or Presbyterian but who have been admitted or otherwise referred to Piedmont due to preference for a local hospital would be likely to transfer their care to the new Fort Mill facility approximately 15 minutes from Piedmont Medical Center.

Finally, many York County patients – like consumers anywhere – would seek out services from the new facility simply because it would have the appeal of being a new facility. With the exception of a few sparsely populated areas in the southern and western quadrants of York County, the travel times to Piedmont and the new locations for the new facilities proposed by the other applicants are not materially different. Five to ten-minute drive time variances may be sufficient to effect patron choice of some restaurants or retail outlets, but not in the selection of hospital services.

For all of these reasons, a new Fort Mill-area hospital will be heavily utilized. The ownership of the facility will have little effect on the extent of that utilization. If Piedmont is the owner of that facility, it intends to create efficiencies and transfer beds and staff to the new hospital to manage the effect on its hospital in Rock Hill. If, on the other hand, either of the Charlotte-area systems is approved, it will result not only in the substantial loss of patient volume and revenue, but, as outlined below, in the erosion of the healthcare system on which the majority of the residents of York County rely.

The Triggering Effects of Substantial Patient and Revenue Losses

As Piedmont experiences the loss of patients, it will have no choice but to reduce costs to offset the loss in revenue due to the decline in utilization of hospital services. The cost reduction would take the form initially of the reduction or elimination of jobs and services. Over time, it would limit Piedmont's ability to continue to invest in new technology, upgrade its facilities, and establish new services. These constraints in turn would impede Piedmont's ability to recruit physicians to or retain physicians in York County, which would diminish its competitiveness. The disadvantage to which Piedmont would be put not only would drive even more York County patients to the new Fort Mill-area hospital, but would increase outmigration for tertiary and other specialty services to the Charlotte-area hospitals not available at the new Fort Mill area hospital. Outmigration for such high-end services would particularly weaken Piedmont's open heart surgery and neurosurgery programs.

The high utilization projected by the third year of operation by both Charlotte-area applicants would result in additional bed need being projected using the current standards in the Health Plan. It must be assumed, therefore, either CMC-Fort Mill or PH-Y would attempt to justify an

expansion of their new facility within their initial 3 year planning horizon. It would not be unreasonable to project that within its first decade of operation, the 64-bed hospital would become a 164-bed facility through two successive 50-bed additions authorized under the State Health Plan.

It is not hyperbole to expect this predictable cycle to fundamentally change the nature of Piedmont Medical Center. The establishment of a new hospital in northeastern York County by a provider other than Piedmont would substantially change Piedmont's payor mix. It would drain off commercially insured managed care patients who are heavily represented in the demographics of the Fort Mill, Tega Cay, and northern Rock Hill communities. This northeastern quadrant, in particular (ZIP Codes 29708 and 29715), comprises not only the wealthiest area in York County, but among the most affluent in the state.

The loss of managed care patients will necessarily increase Piedmont's percentage of Medicaid and Medicare patients who utilize its services. Because the reimbursement from government-sponsored programs generally do not cover the full cost of a hospital's services, Piedmont's ability to continue to meet its obligations under the contract with York County to provide a broad range of services to all residents of the county would be jeopardized.

The Reduction of Services

When a hospital is faced with an actual or potential patient volume loss, the first question management must ask itself is whether it can develop and implement a strategy to avoid or recover the lost market share. That was precisely what Piedmont did over a decade ago, when in 1999 it began plans to build a hospital in Fort Mill to serve the growing I-77 corridor and stem the outmigration of York County residents into Charlotte. If that strategy were thwarted by the approval of another provider, Piedmont would be forced to identify how it could reduce costs to offset the decline in patient revenue without further eroding its market share. Its options would be limited. Piedmont's contract with York County ("County Contract") requires the hospital to provide and maintain certain core services and facilities, none of which could be reduced or eliminated even if utilization declined. These contractual obligations, set forth in the Sixth Addendum to the County Contract, include:

- 24-hour county-wide ambulance services with mandatory response times and equipment standards that operate annually at approximately $4.8 million dollar loss;
- urgent care services in western York County at a loss of $800,00 to $900,000 annually;
- minimal levels of capital reinvestments that Piedmont consistently exceeds; and
- minimal levels of indigent care and discounts for medical services to inmates in York County custody that Piedmont consistently exceeds.

In addition, Piedmont is required under the County Contract to maintain certain tertiary and other specialty services that include the following:

- Open heart surgery
- Neurosurgery

- A minimum of two cardiac cath labs
- Minimal number of intensive care beds

The quality of these services is volume-dependent. As Piedmont's census is driven down, it would not be able to consider the closure of these advanced services. The consequence would be that Piedmont's open heart volume,[1] for example, could drop far below generally recognized and accepted standards that would jeopardize the quality of services it would provide to York County patients. Even with the declining number of open heart cases, which should be reasonably anticipated with the pending establishment of CMC-Pineville's open heart program, Piedmont would also be required to maintain a second cardiac cath lab even if utilization did not justify it.

After removing from consideration for potential cuts services that are required under the County Contract, Piedmont has identified the following services that it would likely reduce or eliminate to begin the process of offsetting losses of patient volume and associated revenues:

1. Neonatal services for high-risk newborns would be terminated and Piedmont's Level II Nursery designation relinquished due to its loss of a substantial number of deliveries to the new non-affiliated Fort Mill facility.
2. Piedmont's infusion center would be closed.
3. Piedmont's wound care center and hyperbaric chamber would be closed.
4. With the reduction in outpatient and inpatient surgeries, Piedmont would close the number of operating rooms necessary to reflect the decline in demand and eliminate a corresponding number of OR and nursing staff.
5. With the reduction in demand for services in the Emergency Department, Piedmont would reduce the number of bays it staffs and would lay off personnel as well.
6. With the reduction in patient admissions, projected by 2017 to be 27 percent below 2009 admissions, Piedmont would reduce the number of staffed beds, close nursing units and wings as necessary, and terminate clinical and administrative staff to correspond to the loss in patient volume and revenues.

The adverse consequences of the approval of either Carolinas or Presbyterian would extend not only to Piedmont, but to residents throughout York County. As a result of a process that would weaken Piedmont's tertiary services, reduce the utilization of its core services, compromise its ability to continue to invest and grow, and diminish its ability to compete for the recruitment of physicians and patients alike, the people of York County would be the losers and suffer the negative impact. Their valuable asset, protected vigorously by the County Contract, would be at risk of becoming a second-class facility, and an increasing number of York County residents would become dependent on North Carolina-based hospitals for their care.

[1] Notwithstanding the fact that the new Fort Mill facility would not offer open heart or other advance services, the operation of the new hospital would increase the owner's market share for all services in general and would increase outmigration for tertiary services in particular.

4. **Please indicate if any attempt has been made to quantify letters of support by the primary and secondary service areas as defined in the updated application. If so, please identify the number of support letters from the service area vs. the total.**

Response: The following summarizes the current letters of support.

Primary Service Area	1,797
Secondary Service Area	514
Service Area Total	2,311
TOTAL	2,481

Note that blank Bates stamped labels were not provided as requested.

Response: Additional blank Bates stamped labels are provided.

We trust this information is sufficient for you to deem the application complete and initiate the review of this project. If you have any additional questions, please do not hesitate to contact me at 843-379-9372. I look forward to working with you as this project continues.

Sincerely,

David S. Levitt
Managing Principal

cc: Charlie Miller

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[redacted]

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D H E C

PROMOTE PROTECT PROSPER

C. Earl Hunter, Commissioner

Promoting and protecting the health of the public and the environment.

February 24, 2011

Mr. Charles Miller, President and CEO
Piedmont Medical Center
222 South Herlong Avenue
Rock Hill, SC 29732

Re: Amisub of South Carolina, Inc. d/b/a Fort Mill Medical Center
As Per December 9, 2009 Order from Judge Matthews, Administrative Law Court
Fort Mill, South Carolina

Dear Mr. Miller:

This is to acknowledge acceptance of information on February 3, 2011 for the above referenced project. As a result of this Department's review of the application, we find the following additional information is needed. Please note that referenced page numbers refer to Bates Stamped pages of the Department file.

1. For further clarification, please provide budgets that are clearly labeled for the following: current budget for Piedmont Medical Center; projected budget for Fort Mill Medical Center; combined budget for Piedmont Medical Center and Fort Mill Medical Center; projected Piedmont Medical Center budget without Fort Mill Medical Center. A charity line item must be provided. All assumptions must be provided in detail. Please provide more explanation for "Deductions from Revenue." Please provide a breakdown of payor mix and average salary per FTE.

2. The income statements on Pied. Supp. Con. page 0216 and Pied. Supp. Con. page 0545 are substantially different. Please explain the differences in detail if both budgets are "stand alone" budgets for Piedmont Medical Center. Explain why there is no charity line item. Indicate if the budget on page 0545 assumes a CON has been issued for Fort Mill Medical Center.

3. Please indicate if the totals previously provided for the letters of support reflect having any duplicate letters subtracted from the total.

Please provide all the requested information to this Office within thirty (30) days of the date of this letter. Pursuant to Section 302.2 of Regulation No. 61-15, Certification of Need for Health Facilities and Services, this application will be considered withdrawn if additional information has not been received by March 26, 2011.

Should you require further information, please contact me at (803) 545-4200.

Sincerely,

Beverly Brandt

Beverly A. Brandt, Chief
Bureau of Health Facilities and Services Development

Lisa D. Sanders, Health Planning Analyst
Bureau of Health Facilities and Services Development

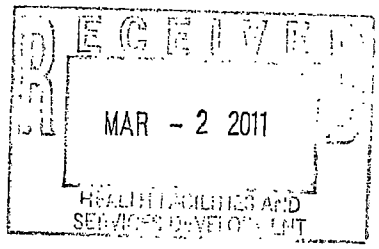
cc: Stuart M. Andrews, Jr., Esquire
Ashley Biggers
M. Elizabeth Crum, Esquire
Barbara Freedy
David Levitt
Donald B. Meyer, Esquire
F. Del Murphy, Jr.

Nelson Mullins

Nelson Mullins Riley & Scarborough LLP
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March 1, 2011



Via Email & U.S. Mail

Beverly A. Brandt, Bureau Chief
Division of Planning and Certification of Need
Bureau of Health Facilities & Services Development
South Carolina Department of Health & Environmental Control
1777 St. Julian Place, Suite 201
Columbia, SC 29204

Ashley C. Biggers, Esq.
South Carolina Department of Health & Environmental Control
2600 Bull Street
Columbia, SC 29201

RE: Fort Mill Medical Center CON Application
CHS Hostile Bid to Acquire Tenet

Dear Beverly and Ashley:

I am writing in response to Ariail Kirk's letter of January 31, 2011 concerning the proposed hostile takeover bid of Community Health Systems, Inc. ("CHS") to acquire Tenet Healthcare Corporation ("Tenet"). Presbyterian has built a house of cards of nothing more than speculation and wishful thinking. Its argument provides no basis in fact or in law for the Department's review of Piedmont's application to be affected in any material respect.

The Facts

CHS has publicly announced its proposal to acquire Tenet. The unsolicited offer was rejected out-of-hand by the Tenet board of directors. To further discourage CHS from continuing to press its failed hostile takeover bid, the Tenet board took measures to reduce substantially the value of the stock CHS seeks to purchase. The board meeting at which CHS will attempt to replace the Tenet board with its own slate of directors is not scheduled until November 2011. No events relating to the bid are scheduled in the interim.

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The Law

Presbyterian presses two legal grounds on which the Department should rely in disqualifying Piedmont. One provision, Section 310 of S.C. Code Reg. 61-15, would apply if the purchase occurred before the Department's decision to award the CON for the new York County hospital. The other, S.C. Code Ann. § 44-7-230(E), would apply after the Department's decision.

A. No Sale Will Occur Before the Department's Decision.

Presbyterian puts considerable effort into attempting to show that something that will never happen would violate Section 310. Although no evidence exists that CHS is likely at any time in the future to succeed in its efforts to buy a controlling interest in Tenet stock, the earliest point, based on the timeline in Ms. Kirk's letter, at which any action could be set in motion concerning the sale would be November 2011. Any sale itself would not occur until well into 2012, long after the Department has made its decision in this case.

B. No Sale Will Occur, If It Does At All, Within the Statutory Period After the Department's Decision.

Presbyterian next argues that if CHS were to acquire Tenet after the decision but before licensure, the transaction would violate S.C. Code Ann. § 44-7-230(E). Its legal position again is based on factual assumptions for which it has no support.

Nothing in the record would support a finding by the Department that Tenet is likely to be acquired at all, much less when the speculative sale might occur. Even assuming, however, that such a transaction were to occur, two key facts would control the outcome of the legal analysis, namely

1) whether there would be a change of controlling interest not in Tenet, but in Amisub of South Carolina, Inc. ("Amisub"), and

2) when the transaction would occur.

1. If There Were A Purchase, It Would Not Involve A Change of Controlling Interest in Amisub.

The only purchase that has been the subject of the speculated acquisition is the purchase of stock of Tenet Healthcare Corporation. No facts exist to support a finding that the purchase of Tenet Healthcare Corporation would change the ownership of Amisub. As the organizational chart attached as Exhibit A shows, Tenet Healthcare Corporation is four corporate levels removed from Amisub. The purchase of Tenet's stock therefore would not transfer the controlling interest in Amisub, the corporation that would hold the CON for Fort Mill Medical Center, and therefore would not violate Section 44-7-230(E).

2. **Even if a Sale of Amisub Occurred, It Would Not Take Place Until After Licensure.**

In the remote event that the forced purchase occurred, Tenet and CHS would structure the transaction in a manner that Amisub would be carved out, or separated, from the transaction for a period that would be sufficient to permit Fort Mill Medical Center to become licensed and operational. No prospective buyer would be willing to forego the opportunity to establish a new hospital in a vibrant, affluent market. Perhaps more importantly, no prospective buyer would be willing to relinquish the CON and concede the Fort Mill-Tega Cay market to Charlotte-area companies. As we have demonstrated, the adverse impact on Piedmont caused by the approval of Presbyterian or Carolina's applications would be substantial. Any potential buyer would be highly motivated to protect its prospective interests.

Conclusion

The Department's task in reviewing the three competitive application is difficult enough without injecting CHS's unlikely hostile takeover bid into the mix. No facts exist that support Presbyterian's speculation that a change of ownership is likely to occur either before or after the Department's decision that would violate Section 310 or Section 44-7-230(E).

Please let me know if I can address any questions the Department may have concerning this matter.

Very truly yours,



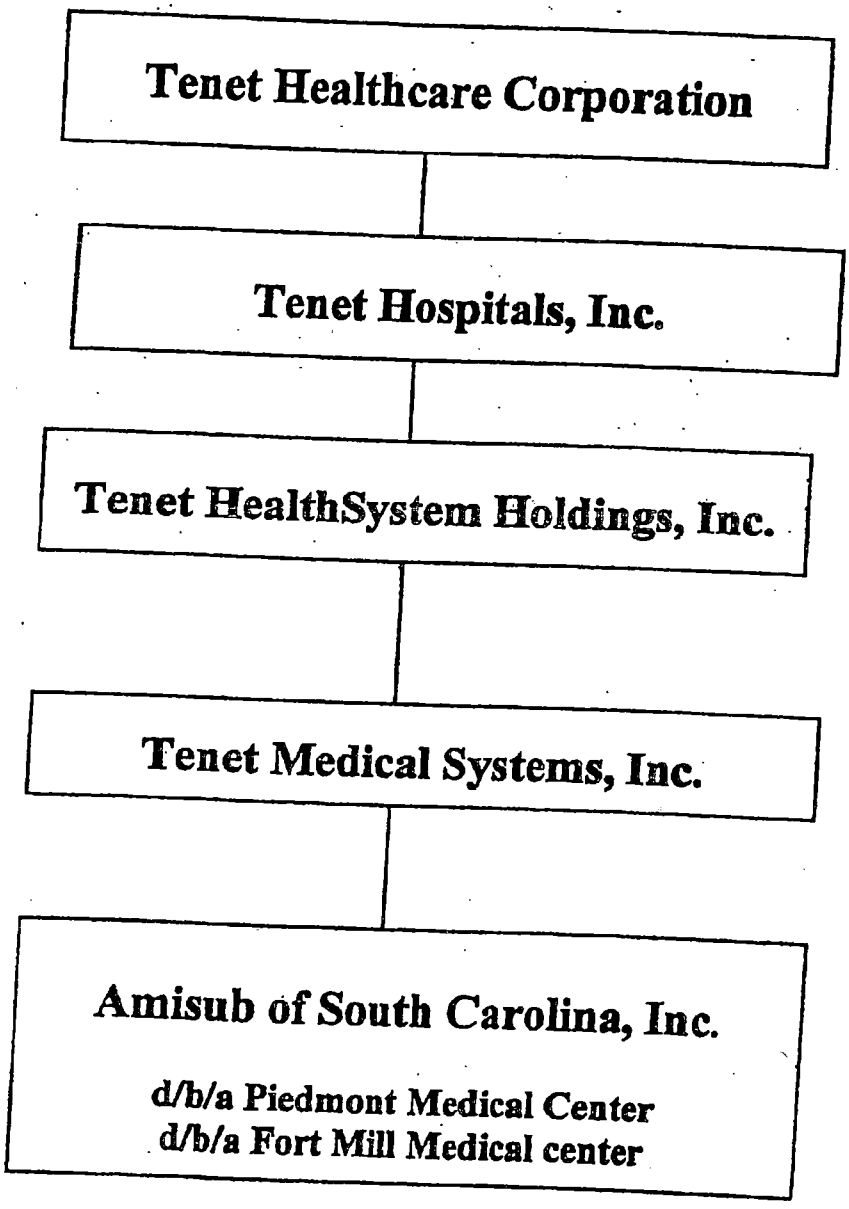
Stuart M. Andrews, Jr.

SMA:cks
Enclosure
cc: Ariail B. Kirk, Esq.
M. Elizabeth Crum, Esq.
Douglas M. Muller, Esq.
Trudy H. Robertson, Esq.

EXHIBIT A

Pied.Supp.CON
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CURRENT STRUCTURE



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Pied.Supp.CON
0582

TENET

JOINT-B-PMC-001.0617

RECORD 002768

Beverly Brandt - Re: FW: Fort Mill hospital matter - DHEC submissions - differences in Bates-stamp numbering

From: Beverly Brandt
To: Kirk, Ariail
Date: 3/22/2011 9:51 AM
Subject: Re: FW: Fort Mill hospital matter - DHEC submissions - differences in Bates-stamp numbering
CC: Biggers, Ashley

Thanks. Please note that the discrepancies are due to the fact that additional items have been added to the files - FOI requests, e-mails (such as this one), your submissions and our correspondences which have affected the Bates stamping. For example, we placed the February 3 letter from Carolinas re: Presbyterian in both the Carolinas and Presbyterian files. You are all welcome to make an appt. to come by and view our files. Trying to keep the files in order & complete has been quite a challenge and it has been difficult to come up with a plan that will work for the applicants and us, so I apologize for any confusion.

Therefore, our records indicate the following Bates stamps for your next responses for additional info:

1. Presbyterian - 2309
2. Carolinas - 854
3. Piedmont - 580

Please let me know if you have questions. Thanks.

Beverly

>>> "Kirk, Ariail" <AKirk@MCNAIR.NET> 3/21/2011 5:05 PM >>>
FYI

From: Doug Muller [mailto:dougmuller@mvalaw.com]
Sent: Monday, March 21, 2011 5:04 PM
To: Stuart Andrews; Kirk, Ariail
Cc: Baker, Pam; Blitch, E-Beth; Dan Westbrook; Leslie Sackett; Crum, Liz
Subject: RE: Fort Mill hospital matter - DHEC submissions - differences in Bates-stamp numbering

Thanks, Stuart.

Ariail's response was the same.

My thanks to you both for checking.

From: Stuart Andrews [mailto:stuart.andrews@nelsonmullins.com]
Sent: Monday, March 21, 2011 5:02 PM
To: Kirk, Ariail; Doug Muller; Crum, Liz
Cc: Baker, Pam; Blitch, E-Beth; Dan Westbrook; Leslie Sackett
Subject: RE: Fort Mill hospital matter - DHEC submissions - differences in Bates-stamp numbering

Doug, We don't have an explanation for the discrepancy, either. Our last bates number ends in 552 and we have provided you with a copy of all documents we have submitted to DHEC.

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Stuart

From: Kirk, Ariail [mailto:AKirk@MCNAIR.NET]
Sent: Monday, March 21, 2011 2:57 PM
To: 'Doug Muller'; Crum, Liz; Stuart Andrews
Cc: Baker, Pam; Blitch, E-Beth; Dan Westbrook; Leslie Sackett
Subject: RE: Fort Mill hospital matter - DHEC submissions - differences in Bates-stamp numbering

Doug,

The January 4, 2011 request for additional information from DHEC to PHY is numbered PHY2010_02239-02240. I do not know why the attached index shows this 2 page January 4, 2011 DHEC request for additional information as being numbered 2239 through 2302. The last page submitted by PHY is PHY2010_ 002290 as the pdf you attached shows.

Ariail

From: Doug Muller [mailto:dougmuller@mvalaw.com]
Sent: Monday, March 21, 2011 1:15 PM
To: Crum, Liz; Stuart Andrews
Cc: Kirk, Ariail; Baker, Pam; Blitch, E-Beth; dan.westbrook@nelsonmullins.com; Leslie Sackett
Subject: Fort Mill hospital matter - DHEC submissions - differences in Bates-stamp numbering

Liz and Stuart:

We are trying to resolve a discrepancy between the Bates-stamp numbers on the documents you have provided to us and the numbers shown on DHEC's list.

As you can see on DHEC's list (attached), PMC's last page is numbered 573 and Presbyterian's is numbered 2302. The list specifically notes that Carolinas' numbers do not match DHEC's numbers, but it does not do the same with PMC's and Presbyterian's numbers.

I've also attached pdf files that we received from your respective Feb. 3rd submissions. As you will see, PMC's last submitted page is numbered 0552 and Presbyterian's last submitted page is numbered 2290.

So, there are discrepancies between DHEC's last Bates-stamped number and your own (i.e. PMC 552 vs. PMC-DHEC 573, and Presbyterian 2290 vs. Presbyterian-DHEC 2302). I want to make sure we have a copy of everything you have submitted, as these numbers do not match up.

Can you please clarify whether this numbering difference is simply as a result of a numbering discrepancy between your Bates-stamp numbering and DHECs Bates-stamp numbering, or whether we are missing something?

Many thanks.

Douglas M. Muller
Attorney at Law

Pied.Supp.CON
0584

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dougmuller@mvalaw.com
www.mvalaw.com

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Pied.Supp.CON
0585

From: Beverly Brandt
To: Fort Mill Attorneys
Date: 3/23/2011 11:41 AM
Subject: Fwd: Re: FW: Fort Mill hospital matter - DHEC submissions - differences in Bates-stamp numbering
Attachments: Re: FW: Fort Mill hospital matter - DHEC submissions - differences in Bates-stamp numbering

FYI- I just realized this was not distributed to all parties. Thanks.

Beverly

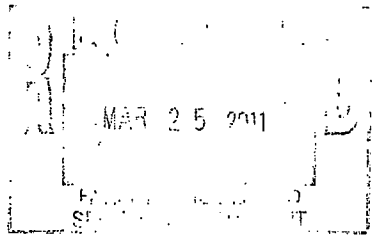
Pied.Supp.CON
0586

LEVITT

healthcare

affiliates

March 24, 2011



Ms. Beverly Brandt
Chief
Bureau of Health Facilities and Services
Development
South Carolina Department of Health and
Environmental Control
2600 Bull Street
Columbia, SC 29201-1708

RE: Amisub of South Carolina, Inc. d/b/a Fort Mill Medical Center
As Per December 9, 2009 Order from Judge Matthews, Administrative Law Court
Fort Mill, South Carolina

Dear Ms. Brandt and Ms. Sanders:

The following is response to your letter dated February 24, 2011, requesting additional information on the above referenced project.

1. **For further clarification, please provide budgets that are clearly labeled for the following: current budget for Piedmont Medical Center; projected budget for Fort Mill Medical Center; combined budget for Piedmont Medical Center and Fort Mill Medical Center; projected Piedmont Medical Center budget without Fort Mill Medical Center. A charity line item must be provided. All assumptions must be provided in detail. Please provide more explanation for "Deductions from Revenue." Please provide a breakdown of payor mix and average salary per FTE.**

Response: **Attachment 1** provides the 2011 Budget for Piedmont Medical Center, a five-year projected budget for Fort Mill Medical Center, a five-year projected budget for Piedmont Medical Center with Fort Mill Medical Center approval, a projection that combines Fort Mill Medical Center and Piedmont Medical Center through the projection period, and a projections for Piedmont Medical Center without Fort Mill Medical Center, assuming a North Carolina provider is approved. Assumptions for these projections are also provided.

Charity care was included in the "Deductions from Revenue" line item. The Pro Formas included in **Attachment 1** provide further breakout of the charity care in "Deductions from Revenue". The projected payor mix for the Fort Mill Medical Center and Piedmont Medical Center is presented below. The payor mix was held constant throughout the projection period. The following is the assumed payor mix for Fort Mill Medical Center and Piedmont Medical Center. The Fort Mill Medical Center payor mix was based on the 2009 County average, adjusted to reflect the Fort Mill market as well as Piedmont's experience.

Pied.Supp.CON
0587

1778 Emory Ridge Drive, Atlanta, GA 30329
(p) 404.315.9011 (f) 404.315.1071

9 River Place, Beaufort, SC 29906
(p) 843.379.9372 (f) 843.379.9373

cell 404.964.2658
david.levitt@comcast.net

Piedmont Medical Center
Payor Mix

Medicare	50.2%
Medicaid	13.9%
Commerical/Managed Care	25.7%
Self Pay/Charity/Other	10.2%

Source: PMC internal data

Fort Mill Medical Center
Payor Mix

Medicare	42.0%
Medicaid	14.0%
Commerical/Managed Care	34.0%
Self Pay/Charity/Other	10.0%

Source: PMC internal data

The average salary, wages and benefits per FTE at Fort Mill Medical Center is projected to be $82,277 in 2015.

2. **The income statements on Pied. Supp. Con. page 0216 and Pied. Supp. Con. Page 0545 are substantially different. Please explain the differences in detail if both budgets are "stand alone" budgets for Piedmont Medical Center. Explain why there is no charity line item. Indicate if the budget on page 0545 assumes a CON has been issued for Fort Mill Medical Center.**

Response: Both Piedmont Supp CON page 0545 and Piedmont Supp CON 0216 are "stand alone" budgets for Piedmont Medical Center. Piedmont Supp CON 0216 reflects PMC operations with approval of the proposed Fort Mill Medical Center. Piedmont Supp CON 0545 reflects PMC operations if a North Carolina applicant is approved and operational in the Fort Mill area. Charity care was included in "Deductions from Revenue". As stated in response to the previous questions, a charity care line item has been added to these projections.

3. **Please indicate if the totals previously provided for the letters of support reflect having any duplicate letters subtracted from the total.**

Response: We attempted to eliminate any duplicate letters of support from the tabulation previously provided. We are not aware of any duplicate letters included in the calculation. However, if supporters submitted multiple letters, Piedmont has provided those letters to DHEC.

In addition, 1,964 additional letters of support are also being provided to DHEC.

If you have any additional questions, please do not hesitate to contact me at 843-379-9372. I look forward to working with you as this project continues.

Sincerely,

David S. Levitt
Managing Principal

cc: Charles Miller, PMC

ATTACHMENT 1

PRO FORMAS

Pied.Supp.CON
0590

Pied.Supp.Con.0556

JOINT-B-PMC-001.0625

Piedmont Medical Center
2011 Budget

Admissions	13,776
Adjusted Admissions	22,596
Inpatient Patient Days	60,654
Adjusted Patient Days	99,401
Average Daily Census	166
Adjusted ADC	272
ALOS	4.40
Hospital O/P Visits	125,379
FTEs Worked	1,006
FTEs Paid	1,151
GROSS PATIENT REVENUES	
Inpatient Revenue	373,763,445
Outpatient Revenue	238,780,510
TOTAL GROSS PATIENT REVENUE	612,543,955
DEDUCTIONS FROM REVENUE	
Indigent/Charity	26,951,934
Other	332,176,576
TOTAL DEDUCTIONS	359,128,510
NET PATIENT REVENUE	253,415,445
Other Revenue	2,340,095
NET OPERATING REVENUE	255,755,540
Bad Debt	25,259,434
NET COLLECTIBLE REVENUE	230,496,106
OPERATING EXPENSES	
Salaries, Wages & Benefit	82,720,554
Supplies	39,091,411
Med & Clinical Fees	6,475,474
Other Prof Fees	3,583,894
Other Fees & Services	21,811,428
Utilities & Phones	2,765,671
Repairs/Maint/Equip. Rental	5,810,476
Other Ctrl Expenses	3,504,989
Total Controllable Expenses	165,763,897
Rent & REIT	883,123
Non-Cntrl/Overhead Expenses	21,733,958
Total Noncontrollable Expenses	22,617,081
Total Operating Expenses	188,380,978
EBITDA	42,115,128
Depr & Amortization	11,644,106
EBIT	30,471,022
Interest Expense	11,348,548
Investment Earn/Loss	(819)
PRETAX INCOME	19,122,474

Pied.Supp.CON
0591

Pied.Supp.Con.0557

JOINT-B-PMC-001.0626

Fort Mill Medical Center
Financial Projections
Years 1-5

Fort Mill Medical Center

Statistics	Start-up Period	Year 1 2015	Year 2 2016	Year 3 2017	Year 4 2018	Year 5 2019
Beds		100	100	100	100	100
Occupancy		42%	50%	58%	60%	62%
Admissions		4,312	5,118	5,946	6,117	6,293
Adjusted Admissions		7,840	9,433	11,108	11,581	12,071
Inpatient Days		15,244	18,214	21,258	21,870	22,500
Adjusted Patient Days		27,715	33,570	39,712	41,403	43,157
ADC		41.8	49.9	58.2	59.9	61.6
Adjusted ADC		75.9	92.0	108.8	113.4	118.2
ALOS		3.5	3.6	3.6	3.6	3.6
FTEs Worked		265	318	374	385	393
FTEs Paid		305	366	431	444	453
Gross Patient Revenues						
Inpatient Revenue		$82,955,056	$103,081,942	$125,121,805	$133,874,326	$143,239,103
Outpatient Revenue		$67,865,531	$86,908,385	$108,618,239	$119,563,160	$131,507,820
Total Gross Patient Revenue		$150,820,587	$189,990,327	$233,740,045	$253,437,486	$274,746,923
Deductions from Revenue						
Indigent/Charity		$4,524,618	$5,699,710	$7,012,201	$7,603,125	$8,242,408
Other		$73,574,553	$95,354,109	$120,283,889	$133,039,198	$147,000,029
Total Deductions		$78,099,171	$101,053,819	$127,296,090	$140,642,323	$155,242,437
Other Revenue		$218,652	$227,398	$236,494	$245,953	$255,791
Net Revenue		$72,940,068	$89,163,906	$106,680,449	$113,041,117	$119,760,277
Operating Expenses						
Salaries, Wages, and Benefits		$25,079,402	$31,031,646	$37,601,256	$39,928,923	$41,905,853
Supplies		$10,238,934	$12,429,421	$14,802,623	$15,695,143	$16,640,632
Med & Clinical Fees		$1,422,556	$1,711,566	$2,024,584	$2,143,342	$2,269,084
Other Prof Fees		$1,590,552	$1,708,048	$1,833,888	$1,896,304	$1,961,484
Other Fees & Services		$5,895,539	$6,585,132	$7,328,507	$7,646,799	$7,981,567
Utilities and Phones		$833,499	$877,620	$914,895	$946,033	$978,550
Repairs/Maint/Equip Rent		$1,999,946	$2,190,781	$2,395,983	$2,489,211	$2,586,971
Other Ctrl Expenses		$1,959,618	$2,146,604	$2,347,669	$2,439,017	$2,534,806
Prov for Bad Debt		$6,952,167	$8,555,692	$10,303,775	$10,986,249	$11,711,440
Total Controllable Expenses		$55,972,213	$67,236,511	$79,553,180	$84,171,021	$88,570,386
Non-Controllable Expenses		$7,999,541	$9,224,494	$9,514,384	$9,726,295	$9,943,512
Total Expenses	$2,089,950	$63,971,754	$76,461,004	$89,067,564	$93,897,316	$98,513,898
EBITDA	**($2,089,950)**	$8,968,314	$12,702,902	$17,612,884	$19,143,801	$21,246,379
Depreciation and Amortization		$7,358,824	$7,458,824	$7,558,824	$7,858,824	$8,108,824
EBIT	**($2,089,950)**	$1,609,491	$5,244,078	$10,054,061	$11,284,977	$13,137,555
Interest Expense		$10,391,282	$9,982,514	$9,546,174	$9,073,617	$8,561,839
Pretax Income	**($2,089,950)**	($8,781,791)	($4,738,436)	$507,887	$2,211,360	$4,575,716
Income Taxes at 38.25%	($799,406)	($3,358,035)	($1,812,452)	$194,267	$845,845	$1,750,211
Net Income	**($1,290,544)**	($5,422,756)	($2,925,984)	$313,620	$1,365,515	$2,825,505

Source: PMC internal data.

Pied.Supp.CON
0592

Pied.Supp.Con.0558

JOINT-B-PMC-001.0627

RECORD 002778

Fort Mill Medical Center
CON Financial Pro Forma Assumptions

Summary
In general, financial assumptions were gathered from actual experience of Piedmont Medical Center in Rock Hill, SC and were adjusted for service mix. Base-line time period used in the pro forma was Fiscal Year 2009.

Volume
Inpatient volumes were derived through market research of the Fort Mill service area. Outpatient volumes were based on current outpatient to inpatient ratios experienced at Piedmont Medical Center. The growth rate for Years 1-3 was based on the population trends in the Fort Mill area (Source: SC State Budget and Control Board, Office of Research and Statistics) and market share shifts. A conservative growth rate of 2.8% was assumed in Years 4-5 based on demographic information located in Part B of application.

Revenue
Gross and Net Revenues were based on case mix adjusted averages from Piedmont Medical Center's actual experience. O.B. and General Acute services were weighted accordingly. Gross Revenues were inflated by 4% per year based on current trends for medical care services.

An assumption for charity care that represents three percent of gross revenue. The following table details indigent and charity care dollars for Years 1-5 (2015-2019).

Fort Mill Medical Center
Indigent/Charity Care as a Percent of Gross Patient Revenue

	Year 1 2015	Year 2 2016	Year 3 2017	Year 4 2018	Year 5 2019
Gross Patient Revenue	$150,820,587	$189,990,327	$233,740,045	$253,437,486	$274,746,923
Charity/Indigent	$4,524,618	$5,699,710	$7,012,201	$7,603,125	$8,242,408
% Of Gross Revenue	3.0%	3.0%	3.0%	3.0%	3.0%

Overall case mix was assumed at 1.0 compared to Piedmont Medical Center's overall case mix of 1.34.

Salaries
Salaries were based on Piedmont Medical Center's actual experience volume and case mix adjusted. In years 1 through 5 paid FTEs per adjusted average daily census (AADC) was assumed at approximately 4.0. Inflation was assumed at 3% per year.

Supplies
Supplies were based on Piedmont Medical Center's actual experience volume adjusted. Five percent of supplies was assumed to be fixed and ninety-five percent variable. Inflation was assumed at 2% per year.

Bad Debt
Bad debt was assumed at 9.5% of net patient revenues based on current experience at Piedmont Medical Center adjusted for a reduction in-patient out migration.

Other Controllable Expenses
All other controllable expenses (OCE) were based on Piedmont Medical Center's actual experience volume adjusted. Various Fixed/Variable assumptions were used based on expense category. Inflation was assumed at 2% per year.

Non Controllable Expenses
Non-controllable expenses (NCE) were based on Piedmont Medical Center's actual experience volume adjusted. Real and personal property taxes were assumed at approximately three million dollars. Of the remaining NCE, sixty percent was assumed to be fixed and forty percent variable. Inflation was assumed at 2% per year.

Taxes
An effective tax rate of 38.25% was assumed.

Cost of Capital
A cost of capital expense was imputed for the project based on an interest rate of 8% payable over 15 years.

Piedmont Medical Center
Income Statement
(with Fort Mill Medical Center)

	Forecast					
	2015	2016	2017	2018	2019	2020
STATISTICS						
Acute Admissions	12,875	13,038	13,059	13,320	13,586	13,858
Psych Admissions	927	946	965	985	1,005	1,025
Total Admissions	13,803	13,984	14,024	14,305	14,591	14,883
Inpatient Patient Days	60,769	61,569	61,745	62,981	64,240	65,526
ALOS	4.4	4.4	4.4	4.4	4.4	4.4
Adjusted Admissions	22,436	22,727	22,781	23,237	23,701	24,175
Adjusted Patient Days	98,778	100,059	100,297	102,304	104,348	106,437
E/R I/P Admits	8,167	8,270	8,283	8,449	8,618	8,790
Hospital O/P Visits	122,984	124,542	124,741	127,236	129,778	132,373
GROSS REVENUE						
Inpatient Revenue	$446,546,045	$470,521,634	$490,741,325	$520,587,490	$552,233,880	$585,820,428
Outpatient Revenue	$279,299,072	$294,150,813	$306,405,656	$325,035,580	$344,790,517	$365,752,233
Gross Patient Revenue	$725,845,117	$764,672,447	$797,146,981	$845,623,070	$897,024,397	$951,572,661
Deductions from Revenue						
Indigent Care	$23,952,889	$25,234,191	$26,305,850	$27,905,561	$29,601,805	$31,401,898
Other	$434,310,958	$464,862,722	$492,035,235	$529,633,818	$569,766,531	$612,614,916
Total Deductions from Revenue	$458,263,847	$490,096,913	$518,341,085	$557,539,379	$599,368,336	$644,016,814
Net Patient Revenue	$267,581,270	$274,575,534	$278,805,896	$288,083,691	$297,656,061	$307,555,847
Other Revenue	$2,387,131	$2,411,002	$2,435,112	$2,459,463	$2,484,058	$2,508,899
Net Operating Revenue	$269,968,401	$276,986,536	$281,241,008	$290,543,154	$300,140,119	$310,064,746
OPERATING EXPENSES						
Salaries Wages and Benefits	$89,310,974	$92,278,585	$94,348,040	$98,160,718	$102,125,354	$106,252,237
Supplies	$44,145,371	$45,612,227	$46,635,134	$48,519,696	$50,479,369	$52,519,239
Provision for Bad Debt	$27,795,967	$28,522,521	$28,961,965	$29,925,729	$30,920,093	$31,948,469
Other Controllable Expenses	$46,155,425	$46,999,642	$47,733,004	$48,691,372	$49,668,721	$50,665,944
Non Controllable Expenses / Corp Overhead	$25,146,710	$25,700,294	$26,225,540	$26,830,372	$27,449,040	$28,082,093
Total Operating Expenses	$232,554,447	$239,113,269	$243,903,683	$252,127,887	$260,642,577	$269,467,982
Operating Income	$37,413,954	$37,873,267	$37,337,325	$38,415,267	$39,497,542	$40,596,764
EBITDA	$37,413,954	$37,873,267	$37,337,325	$38,415,267	$39,497,542	$40,596,764
Operating Margin	13.9%	13.7%	13.3%	13.2%	13.2%	13.1%
Depreciation & Amortization	$11,729,802	$11,847,100	$11,965,571	$12,085,227	$12,206,079	$12,328,140
EBIT	$25,684,152	$26,026,167	$25,371,754	$26,330,040	$27,291,463	$28,268,624
Interest Expense	$15,978,601	$15,818,815	$15,660,627	$15,504,020	$15,348,980	$15,195,490
PRE TAX INCOME	$9,705,551	$10,207,352	$9,711,127	$10,826,020	$11,942,483	$13,073,134
Income Tax	$3,712,373	$3,904,312	$3,714,506	$4,140,953	$4,568,000	$5,000,474
NET INCOME	$5,993,178	$6,303,040	$5,996,621	$6,685,067	$7,374,483	$8,072,660

generally accepted accounting principles. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the Company's financial position, results of operations, and cash flows. Accordingly, these financial statements are not designed for those who are not informed about such matters.

RECORD 002781
Pied.Supp.Con.0561
Pied.Supp.CON 0595
JOINT-B-PMC-001.0630

Piedmont Medical Center (With Fort Mill Medical Center)
Financial Forecast Assumptions

Summary
In general, financial assumptions were gathered from 2009 actual and 2010 expected experience of Piedmont Medical Center in Rock Hill, SC.

Volume
Volumes were assumed to grow from historical levels at a rate of approximately 2.0 percent per year. Volumes were adjusted in 2015 to account for those patients from Fort Mill ZIP Codes who are currently being seen at Piedmont Medical Center and now will be seen at Fort Mill Medical Center.

Revenue
Gross and Net Revenues were based on same case mix as 2009 and 2010 expected. Gross Revenues were volume adjusted and inflated by 4-5 percent per year based on recent Hospital and Related Services CPI. Net Revenues were volume adjusted and inflated by 1.3 percent per year.

While the expected impact of the Patient Protection and Affordable Care Act is to decrease the pool of uninsured and potential Indigent/Charity Care patients in the future, the figures in these projections, as a percentage of gross revenue, were held constant throughout the projection period, based on PMC's 2009 actual experience.

Salaries
Salaries were based on Piedmont Medical Center's 2010 expected experience volume adjusted. Inflation was assumed at 3.0 percent per year.

Supplies
Supplies were based on Piedmont Medical Center's 2010 expected experience volume adjusted. Inflation was assumed at 2.0 percent per year.

Bad Debt
Bad debt was based on same percent of Net Patient Revenue as Piedmont Medical Center's 2010 expected experience.

Other Controllable Expenses
All other controllable expenses (OCE) were based on Piedmont Medical Center's actual experience volume adjusted. OCE was assumed 75 percent variable and 25 percent fixed. Inflation was assumed at 1.5 percent per year.

Non Controllable Expenses
Non-controllable expenses (NCE) were based on Piedmont Medical Center's actual experience volume adjusted. Inflation was assumed at 2.0 percent per year.

Taxes
An effective tax rate of 38.25 percent was assumed.

Combined FMMC and PMC income statement

Statistics	Year 1 2015	Year 2 2016	Year 3 2017	Year 4 2018	Year 5 2019
Beds	332	332	332	332	332
Occupancy	63%	66%	68%	70%	72%
Admissions	18,115	19,102	19,970	20,422	20,884
Adjusted Admissions	29,991	31,793	33,428	34,296	35,187
Inpatient Days	76,013	79,783	83,003	84,851	86,740
Adjusted Patient Days	125,851	132,785	138,938	142,494	146,145
ADC	208.3	218.0	227.4	232.5	237.6
Adjusted ADC	344.8	362.8	380.7	390.4	400.4
ALOS	4.2	4.2	4.2	4.2	4.2
Gross Patient Revenues					
Inpatient Revenue	$529,501,101	$573,603,576	$615,863,130	$654,461,816	$695,472,983
Outpatient Revenue	$347,164,603	$381,059,198	$415,023,895	$444,598,740	$476,298,337
Total Gross Patient Revenue	$876,665,704	$954,662,774	$1,030,887,026	$1,099,060,556	$1,171,771,320
Deductions from Revenue					
Indigent/Charity	$28,477,507	$30,933,901	$33,318,051	$35,508,686	$37,844,213
Other	$507,885,511	$560,216,832	$612,319,123	$662,673,016	$716,766,560
Total Deductions	$536,363,018	$591,150,732	$645,637,175	$698,181,702	$754,610,773
Other Revenue	$2,605,783	$2,638,400	$2,671,606	$2,705,416	$2,739,849
Net Revenue	$342,908,469	$366,150,442	$387,921,457	$403,584,271	$419,900,396
Operating Expenses					
Salaries, Wages, and Benefits	$114,390,376	$123,310,231	$131,949,296	$138,089,641	$144,031,207
Supplies	$54,384,305	$58,041,648	$61,437,757	$64,214,839	$67,120,001
Provision for Bad Debt	$34,748,134	$37,078,213	$39,265,740	$40,911,978	$42,631,533
Other Controllable Expenses	$59,857,134	$62,219,393	$64,578,530	$66,252,078	$67,981,183
Total Controllable Expenses	$263,379,950	$280,649,486	$297,231,323	$309,468,536	$321,763,923
Non-Controllable Expenses	$33,146,251	$34,924,788	$35,739,924	$36,556,667	$37,392,552
Total Expenses	$296,526,201	$315,574,273	$332,971,247	$346,025,203	$359,156,475
EBITDA	$46,382,268	$50,576,169	$54,950,209	$57,559,068	$60,743,921
Depreciation and Amortization	$19,088,626	$19,305,924	$19,524,395	$19,944,051	$20,314,903
EBIT	$27,293,643	$31,270,245	$35,425,815	$37,615,017	$40,429,018
Interest Expense	$26,369,882	$25,801,329	$25,206,800	$24,577,638	$23,910,819
Pretax Income	$923,760	$5,468,916	$10,219,014	$13,037,380	$16,518,199
Income Taxes at 38.25%	$353,338	$2,091,860	$3,908,773	$4,986,798	$6,318,211
Net Income	$570,422	$3,377,056	$6,310,241	$8,050,582	$10,199,988

Source: PMC internal data, CON projections.

Piedmont Medical Center (without FMMC)
Income Statement
(With N.C. Provider in Fort Mill)

	Forecast					
	2015	2016	2017	2018	2019	2020
STATISTICS						
Acute Admissions	11,876	11,857	11,745	11,628	11,511	11,396
Psych Admissions	787	782	777	772	767	762
Total Admissions	12,763	12,639	12,524	12,400	12,278	12,158
Inpatient Patient Days	57,436	56,874	56,358	55,798	55,252	54,712
ALOS	4.5	4.5	4.5	4.5	4.5	4.5
Adjusted Admissions	20,563	20,361	20,173	19,972	19,775	19,580
Adjusted Patient Days	92,536	91,623	90,779	89,875	88,989	88,111
E/R I/P Admits	7,484	7,419	7,349	7,276	7,203	7,131
Hospital O/P Visits	114,997	113,847	112,775	111,647	110,531	109,426
GROSS REVENUE						
Inpatient Revenue	$407,700,690	$419,859,875	$432,692,642	$445,528,929	$458,816,068	$472,505,149
Outpatient Revenue	$249,149,586	$256,524,346	$264,273,230	$272,095,108	$280,150,314	$288,443,580
Gross Patient Revenue	$656,850,276	$676,384,221	$696,965,872	$717,624,037	$738,966,382	$760,948,729
Deductions from Revenue						
Indigent/Charity	$26,274,011	$27,055,369	$27,878,635	$28,704,961	$29,558,655	$30,437,949
Other	$376,749,410	$394,728,123	$413,558,074	$432,647,177	$452,364,972	$472,694,102
Total Deductions	$403,023,421	$421,783,492	$441,436,709	$461,352,138	$481,923,627	$503,132,051
Net Patient Revenue	$253,826,855	$254,600,729	$255,529,163	$256,271,899	$257,042,755	$257,816,678
Other Revenue	$2,257,082	$2,279,653	$2,302,450	$2,325,475	$2,348,730	$2,372,217
Net Operating Revenue	$256,083,937	$256,880,382	$257,831,613	$258,597,374	$259,391,485	$260,188,895
OPERATING EXPENSES						
Salaries Wages and Benefits	$83,882,207	$84,715,681	$85,614,015	$86,456,678	$87,316,464	$88,184,065
Supplies	$42,164,233	$42,583,187	$43,034,744	$43,458,317	$43,890,497	$44,326,605
Provision for Bad Debt	$23,144,685	$23,215,249	$23,299,906	$23,367,631	$23,437,920	$23,508,489
Other Controllable Expenses	$45,556,974	$46,126,272	$46,710,348	$47,292,971	$47,884,062	$48,482,441
Non Controllable Expenses / Corp Overhead	$25,722,019	$26,197,952	$26,685,545	$27,178,686	$27,681,569	$28,193,807
Total Operating Expenses	$220,470,118	$222,838,341	$225,344,558	$227,754,283	$230,210,512	$232,695,407
Operating Income	$35,613,819	$34,042,041	$32,487,055	$30,843,091	$29,180,973	$27,493,488
EBITDA	$35,613,819	$34,042,041	$32,487,055	$30,843,091	$29,180,973	$27,493,488
Operating Margin	13.9%	13.3%	12.6%	11.9%	11.2%	10.6%
Depreciation & Amortization	$11,729,802	$11,847,100	$11,965,571	$12,085,227	$12,206,079	$12,328,140
EBIT	$23,884,017	$22,194,941	$20,521,484	$18,757,864	$16,974,894	$15,165,348
Interest Expense	$15,978,601	$15,818,815	$15,660,627	$15,504,020	$15,348,980	$15,195,490
PRE TAX INCOME	$7,905,416	$6,376,126	$4,860,857	$3,253,844	$1,625,914	-$30,142
Income Tax	$3,023,822	$2,438,868	$1,859,278	$1,244,595	$621,912	-$11,529
NET INCOME	$4,881,595	$3,937,258	$3,001,579	$2,009,249	$1,004,002	-$18,613

generally accepted accounting principles. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the Company's financial position, results of operations, and cash flows. Accordingly, these financial statements are not designed for those who are not informed about such matters.

RECORD 002784
Pied.Supp.Con.0564
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0598
JOINT-B-PMC-001.0633

Piedmont Medical Center (Without Fort Mill Medical Center)
Financial Forecast Assumptions

Summary
In general, financial assumptions were gathered from 2009 actual and 2010 budgeted experience of Piedmont Medical Center in Rock Hill, SC.

Volume
Volumes were assumed to decline approximately 1.0 to 2.0 percent per year, to reflect continued decline in marketshare at PMC due to a North Carolina provider operating a hospital in the Fort Mill area

Revenue
Gross and Net Revenues were based on same mix as 2010 expected experience. Gross Revenues were volume adjusted and inflated by 4 percent per year based on recent Hospital and Related Services CPI. Net Revenues were volume adjusted and inflated by 1.3 percent per year.

While the expected impact of the Patient Protection and Affordable Care Act is to decrease the pool of uninsured and potential Indigent/Charity Care patients in the future, the figures in these projections, as a percentage of gross revenue, were held constant throughout the projection period, based on PMC's 2009 actual experience and increased slightly from historical levels to illustrate the expected disproportionate impact on payor mix/redirected patients.

Salaries
Salaries were based on Piedmont Medical Center's 2010 expected experience volume adjusted. Inflation was assumed at 2.0 percent per year.

Supplies
Supplies were based on Piedmont Medical Center's 2010 expected experience volume adjusted. Inflation was assumed at 2.0 percent per year.

Bad Debt
Bad debt was based on same percent of Net Patient Revenue as Piedmont Medical Center's 2010 expected experience.

Other Controllable Expenses
All other controllable expenses (OCE) were based on Piedmont Medical Center's experience volume adjusted. OCE was assumed 75 percent variable and 25 percent fixed. Inflation was assumed at 1.5 percent per year.

Non Controllable Expenses
All other controllable expenses (NCE) were based on Piedmont Medical Center's actual experience volume adjusted. OCE was assumed 85 percent variable and 15 percent fixed. Inflation was assumed at 2.0 percent per year.

Taxes
An effective tax rate of 38.25 percent was assumed.

D H E C
PROMOTE PROTECT PROSPER
C. Earl Hunter, Commissioner
Promoting and protecting the health of the public and the environment.

April 22, 2011

Mr. Charles Miller, President and CEO
Piedmont Medical Center
222 South Herlong Avenue
Rock Hill, SC 29732

Re: Amisub of South Carolina, Inc. d/b/a Fort Mill Medical Center
As Per December 9, 2009 Order from Judge Matthews, Administrative Law Court
Fort Mill, South Carolina

Dear Mr. Miller:

This is to acknowledge acceptance of information on March 24, 2011 for the above referenced project. As a result of this Department's review of the application, we find the following additional information is needed.

1. Within the letters of support received on March 25, 2011 was a form letter that stated "If either Carolinas Medical Center or Presbyterian builds a hospital in Fort Mill, Piedmont will face an estimated loss of more than $13 million annually." Please provide information that supports this statement as it does not appear to reconcile with the "Piedmont Medical Center (without FMMC) Income Statement (With N.C. Provider in Fort Mill)" provided in the response of March 24, 2011.

2. The budget for "Piedmont Medical Center (without FMMC) Income Statement (With N.C. Provider in Fort Mill)" provided in the response of March 24, 2011, indicated a negative net income of $18,613 for 2020 as compared with a positive income of $4,881,595 in 2015. This equates to approximately a five percent change of the items captured in the "Statistics" column (admissions, patient days, outpatient visits, etc.) However, using data from "Figure 2 Piedmont Medical Center Historical Utilization" in the October 4, 2010 submission and the "Piedmont Medical Center 2011 Budget" in the March 24, 2011 submission, since 2003, Piedmont Medical Center has experienced approximately a 13% decline in occupancy and 20% decline in average daily census, but has projected a net income of $12.8 million for 2011. Please further address any negative impact upon Piedmont Medical Center if a NC provider is approved for a hospital in Fort Mill.

Please keep the Department informed of any potential change in ownership issues relative to Tenet Healthcare Corporation or the licenssee.

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Please provide all the requested information to this Office within thirty (30) days of the date of this letter. Pursuant to Section 302.2 of Regulation No. 61-15, Certification of Need for Health Facilities and Services, this application will be considered withdrawn if additional information has not been received by May 22, 2011.

Should you require further information, please contact me at (803) 545-4200.

Sincerely,

Beverly Brandt

Beverly A. Brandt, Chief
Bureau of Health Facilities and Services Development

cc: Stuart M. Andrews, Jr., Esquire
Ashley Biggers
M. Elizabeth Crum, Esquire
Barbara Freedy
David Levitt
Donald B. Meyer, Esquire
Douglas M. Muller, Esquire
F. Del Murphy, Jr.

Pied Supp CON
0601

From: "Stuart Andrews" <stuart.andrews@nelsonmullins.com>
To: "Doug Muller" <dougmuller@mvalaw.com>, "Crum, Liz" <LCrum@MCNAIR.NET>, "...
CC: "Beverly Brandt" <brandtba@dhec.sc.gov>, "Dan Westbrook" <dan.westbrook@...
Date: 5/23/2011 6:57 PM
Subject: Fort Mill - Response Letter to DHEC
Attachments: Response Letter.pdf

Doug, Liz, and Arial, I'm attaching a copy of our response letter to the most recent set of questions from the Department which was hand-delivered to Beverly this afternoon.

Stuart

Stuart M. Andrews, Jr.

Partner
stuart.andrews@nelsonmullins.com

Nelson Mullins Riley & Scarborough LLP

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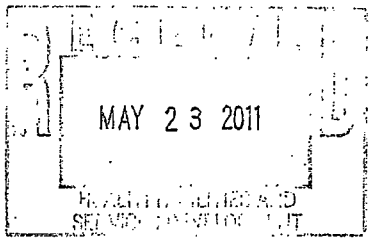
To ensure compliance with the requirements imposed by the

Pied.Supp.CON
0602

LEVITT

healthcare

affiliates



May 18, 2011

Ms. Beverly Brandt
Chief
Bureau of Health Facilities and Services Development
South Carolina Department of Health and Environmental Control
2600 Bull Street
Columbia, SC 29201-1708

RE: Amisub of South Carolina, Inc. d/b/a Fort Mill Medical Center
As Per December 9, 2009 Order from Judge Matthews, Administrative Law Court
Fort Mill, South Carolina

Dear Ms. Brandt:

The following is in response to your letter dated April 22, 2011, requesting additional information on the above referenced project.

1. Within the letters of support received on March 25, 2011 was a form letter that stated "If either Carolinas Medical Center or Presbyterian builds a hospital in Fort Mill, Piedmont will face an estimated loss of more than $13 million annually." Please provide information that supports this statement as it does not appear to reconcile with the "Piedmont Medical Center (without FMMC) Income Statement (With N.C. Provider in Fort Mill)" provided in the response of March 24, 2011.

Response: The $13 million annual impact to Piedmont Medical Center is based on the contribution margin analysis provided in the CON application (Pied.Supp.CON.041). That analysis projects the impact that the estimated reduced cases would have on Piedmont's financial performance compared to potential performance without a North Carolina provider in Fort Mill. The volume of patients redirected from Piedmont to the new facility would be substantial. The analysis compares where Piedmont would be in the future without a North Carolina provider versus. with a North Carolina provider and was based on 2009 marketshare and PMC financial experience. The following provides that "contribution margin analysis".

Assuming that either North Carolina provider is approved to build a new hospital in the Fort Mill area, the likely impact to volume at Piedmont would be significant. Patients would be redirected from Piedmont to the new facility at a significant level. The expected impact of a North Carolina provider's facility would be to reduce Piedmont's marketshare to a level from the current 53.4 percent to 37.8 percent (35.9 percent in the PSA and 41.1 percent in the SSA), with resulting lost cases exceeding 3,500. This represents nearly 27 percent of the total admissions at Piedmont in 2009. **Attachment W** (Pied.Supp.CON.333) of the CON application contains the detailed calculations.

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0603

1778 Emory Ridge Drive, Atlanta, GA 30329
(p) 404.315.9011 (f) 404.315.1071

9 River Place, Beaufort, SC 29906
(p) 843.379.9372 (f) 843.379.9373

cell 404.964.2658
david.levitt@comcast.net

Figure 1
Piedmont Medical Center Lost Cases
Projected 2017 Volume With and Without a NC Provider in Fort Mill

	PSA	SSA	Total
2009 Market Share	54.8%	50.3%	53.4%
2017 Cases (at 2009 market share)	8,666	3,380	12,046
2017 Marketshare with NC provider in Fort Mill	35.9%	42.1%	37.8%
2017 Cases with NC provider in Fort Mill	5,702	2,838	8,540
Net Impact	**(2,963)**	**(542)**	**(3,505)**

The 2009 occupancy rate at Piedmont was 57 percent. If 2009 marketshare were to remain constant, utilization would be expected to total approximately 66 percent by 2017. The projected reduction outlined above would result in an occupancy in 2017 of 47 percent, or nearly 30 percent less than projected levels without a North Carolina provider or 18 percent less than 2009 levels.

Figure 2
Piedmont Medical Center Historical and Projected Utilization

	ADC	Occupancy
2009 Actual	153.0	57.1%
2017 Projected at 2009 mkt share (a)	176.5	65.9%
2017 Projected with NC provider in Fort Mill (a)	125.1	46.7%

(a) Assumes 2009 inmigration rate and ALOS of 4.4

Based on 2009 information, patients with a case mix index of less than 2.0 provided a contribution of approximately $4,000 per case to Piedmont Medical Center. The following figure summarizes that calculation.

Figure 3
Piedmont 2009 Contribution Margin
Patients with a CMI < 2.0

	PSA	SSA
Net Patient Revenue	$49,956,034	$20,884,187
Total Variable Costs	$23,937,789	$9,786,654
Contribution Margin	$26,018,245	$11,097,532
Patients	6,645	2,744
Contribution Margin per Patient	$3,915	$4,044

Source: PMC internal data.

Based on the projected impact of a loss of over 3,500 cases, the financial impact is estimated to total approximately $13,800,000. This represents over 5.3 percent of 2009 net patient revenue and nearly 27 percent of admissions at Piedmont in 2009, a magnitude of lost cases and revenue rises that will adversely impact Piedmont Medical Center.

Piedmont Medical Center has been forced to operate as efficiently as practical due the reduced inpatient utilization and lower acute marketshare that has occurred over the last 8 years, as the proposed Fort Mill Medical Center CON application has been held up through the appeal process. Inpatient units have been closed, positions have been eliminated, and other operating efficiencies have been implemented to reduce both fixed and variable expenses as inpatient volume has decreased in order to maintain financial performance.

One of the factors that led to the submission of the Fort Mill Medical Center CON application was the potential negative impact that outmigration and reduced utilization would have on PMC operations. PMC predicted that if the Fort Mill Medical Center proposal was not implemented, the existing operations in Rock Hill would be significantly impacted by the Charlotte providers.

The projected Piedmont Medical Center's income statement with a North Carolina provider operating a hospital in Fort Mill (Pied.Supp.CON.545) was based on the historical experience and relationships between fixed and variable expenses. Volume assumptions were projected to decline approximately 1 percent annually throughout the projections period. Gross and Net Revenues were based on historical case mix. Gross Revenues were volume adjusted and inflated by 4-5 percent per year based on recent Hospital and Related Services CPI. Net Revenues were volume adjusted and inflated by 1.3 percent per year. Salaries were based on Piedmont Medical Center's historical experience, volume adjusted. Inflation was assumed at 3.0 percent per year. Supplies were based on Piedmont Medical Center's historical experience volume adjusted. Inflation was assumed at 2.0 percent per year. Bad debt was based on same percent of Gross Revenue as Piedmont Medical Center's historical experience. All other controllable expenses (OCE) were based on Piedmont Medical Center's actual experience volume adjusted. OCE was assumed 75 percent variable and 25 percent fixed. Inflation was assumed at 1.5 percent per year. Non-controllable expenses (NCE) were based on Piedmont Medical Center's actual experience volume adjusted. Inflation was assumed at 2.0 percent per year. An effective tax rate of 38.25 percent was assumed. The resulting income statement was provided as Pied.Supp.CON.545.

As presented in the February 2011 submission, continued reduced volumes will result in no alternative but to reduce services. As Piedmont experiences the loss of patients, it will have no choice but to reduce costs to offset the loss in revenue due to the decline in utilization of hospital services. The cost reduction would take the form initially of scaling back or eliminating jobs and services. Over time, it would limit Piedmont's ability to continue to invest in new technology, upgrade its facilities, and establish new services. These constraints in turn would impede Piedmont's ability to recruit physicians to York County, which would diminish its competitiveness. The disadvantage to which Piedmont would be put not only would drive even more York County patients to the new Fort Mill-area hospital, but would increase outmigration for tertiary and other specialty services to the Charlotte-area hospitals not available at the new Fort Mill area hospital. Outmigration for such high-end services would particularly weaken Piedmont's open heart surgery and neurosurgery programs.

The establishment of a new hospital in northeastern York County by a third party would substantially and permanently change Piedmont's payor mix. It would drain off commercially insured managed care patients who are heavily represented in the demographics of the Fort Mill, Tega Cay, and northern Rock Hill communities. This northeastern quadrant (ZIP Codes 29708

Figure 4
Financial Impact to Piedmont Medical Center

	PSA	SSA	Total
Reduced Cases	(2,963)	(542)	(3,505)
2009 PMC Contribution Margin	$ 3,915	$ 4,044	$ 7,960
Net Impact	**$ (11,602,401)**	**$ (2,192,551)**	**$ (13,794,952)**

The contribution margin was defined as the variable revenue less the variable expenses for each lost patients. This analysis illustrates the impact on the ability of PMC to cover fixed costs in the organization, with lower volumes.

Piedmont projects that it will lose over 3,500 cases and some $13.8 million in net patient revenue by the third year of operation of a Fort Mill facility owned by either Carolinas or Presbyterian. The reduction in patient volume represents a decline of 29 percent in Piedmont's market share in its primary and secondary service areas, which would be a reduction of 27 percent in 2009 admissions.

The March 24 submission was a different analysis that projected the entire Income Statement for Piedmont Medical Center, not just the incremental impact from the defined service area for patients with a CMI < 2.0. The March 24 submission represents all services at PMC on a fully allocated basis. Since the analyses are based on different assumptions and present different financial information, they are not directly comparable. One is a contribution analysis that compares where PMC would be with and without a North Carolina provider operating a hospital in Fort Mill, while the other projects PMC's expected financial performance with a North Carolina Provider operating a hospital in Fort Mill.

2. The budget for "Piedmont Medical Center (without FMMC) Income Statement (With N.C. Provider in Fort Mill)" provided in the response of March 24, 2011, indicated a negative net income of $18,613 for 2020 as compared with a positive income of $4,881 ,595 in 2015. This equates to approximately a five percent change of the items captured in the "Statistics" column (admissions, patient days, outpatient visits, etc.) However, using data from "Figure 2 Piedmont Medical Center Historical Utilization" in the October 4, 2010 submission and the "Piedmont Medical Center 2011 Budget" in the March 24, 2011 submission, since 2003, Piedmont Medical Center has experienced approximately a 13% decline in occupancy and 20% decline in average daily census, but has projected a net income of $12.8 million for 2011. Please further address any negative impact upon Piedmont Medical Center if a NC provider is approved for a hospital in Fort Mill.

Response: The financial impact experienced at PMC over the last 8 years has been mitigated by numerous operating changes and other factors in an attempt to maintain margins in the face of declining utilization. The projected pro forma for PMC with a North Carolina provider operating a Fort Mill hospital does reflect reduced variable expenses estimated with reduced volume. The relationship between reduced volume and net income would not be linear.

and 29715), in particular, comprises not only the wealthiest area in York County, but among the most affluent in the state.

The loss of managed care patients will necessarily increase Piedmont's percentage of Medicaid and Medicare patients who utilize its services. Because the reimbursement from neither government-sponsored program generally covers the full cost of a hospital's services, Piedmont's ability to continue to meet its obligations under the contract with York County to provide a broad range of services to all residents of the county would be jeopardized.

When a hospital is faced with an actual or potential patient volume loss, the first question management must ask itself is whether it can develop and implement a strategy to avoid or recover the lost market share. That was precisely what Piedmont did over a decade ago, when in 1999 it began plans to build a hospital in Fort Mill to serve the growing I-77 corridor and stem the outmigration of York County residents into Charlotte. If that strategy were thwarted by the approval of another provider, Piedmont would be forced to identify how it could reduce costs to offset the decline in patient revenue without further eroding its market share. Its options would be limited. Piedmont's contract with York County ("County Contract") requires the hospital to provide and maintain certain core services and facilities, none of which could be reduced or eliminated even if utilization declined. These contractual obligations, set forth in the Sixth Addendum to the County Contract, include:

- 24-hour county-wide ambulance services with mandatory response times and equipment standards that operate annually at over Five (5) million dollar loss;
- urgent care services in western York County at an $863,00 loss;
- minimal levels of capital reinvestments that Piedmont has generally exceeded; and
- minimal levels of indigent care and discounts for medical services to inmates in York County custody that Piedmont has generally exceeded.

In addition, Piedmont is required under the County Contract to maintain certain tertiary and other specialty services that include the following:

- Open heart surgery
- Neurosurgery
- A minimum of two cardiac cath labs
- Minimal number of intensive care beds

The quality of these services is volume-sensitive. As Piedmont's census is driven down, it cannot – even if it wanted to – consider the closure of these advanced services. The consequence would be that Piedmont's open heart volume,[1] for example, could drop far below generally recognized and accepted standards that would jeopardize the quality of services it would provide to York County patients. Even with the declining number of open heart cases, which should be

[1] Notwithstanding the fact that the new Fort Mill facility would not offer open-heart or other advanced services, the operation of the new hospital would increase the owner's market share for all services in general and would increase outmigration for tertiary services in particular.

reasonably anticipated with the pending establishment of CMC-Pineville's open heart program, Piedmont would also be required to maintain a second cardiac cath lab even if utilization did not justify it.

After removing from consideration for potential cuts in services that are required under the County Contract, Piedmont has identified the following services that it would likely reduce or eliminate to begin the process of offsetting losses of patient volume and associated revenues:

1. Neonatal services for high-risk newborns would have to be terminated and Piedmont's Level II Nursery designation relinquished due to its loss of a substantial number of deliveries to the new non-affiliated Fort Mill facility.
2. Closing of Piedmont's infusion center.
3. Closing of Piedmont's wound care center and hyperbaric chamber.
4. With the reduction in outpatient and inpatient surgeries, Piedmont would close the number of operating rooms necessary to reflect the decline in demand and lay off a corresponding number of OR and nursing staff.
5. With the reduction in demand for services in the Emergency Department, Piedmont would reduce the number of bays it staffs and would lay off personnel as well.
6. With the reduction in patient admissions, projected by 2017 to be 27 percent below 2009 admissions, Piedmont would reduce the number of staffed beds, close wings as necessary, and terminate clinical and administrative staff to correspond to the loss in patient volume and revenues.

The adverse consequences of the approval of Carolinas or Presbyterian would extend not only to Piedmont, but to residents throughout York County. As a result of a process that would weaken Piedmont's tertiary services, reduce the utilization of its core services, compromise its ability to continue to invest and grow, and diminish its ability to compete for the recruitment of physicians and patients alike, the people of York County would be the losers. Their valuable asset, protected vigorously by the County Contract, would be at risk of becoming a second-class facility, and an increasing number of York County residents would become dependent on North Carolina-based hospitals for their care.

If you have any additional questions, please do not hesitate to contact me at 843-379-9372. I look forward to working with you as this project continues.

Sincerely,

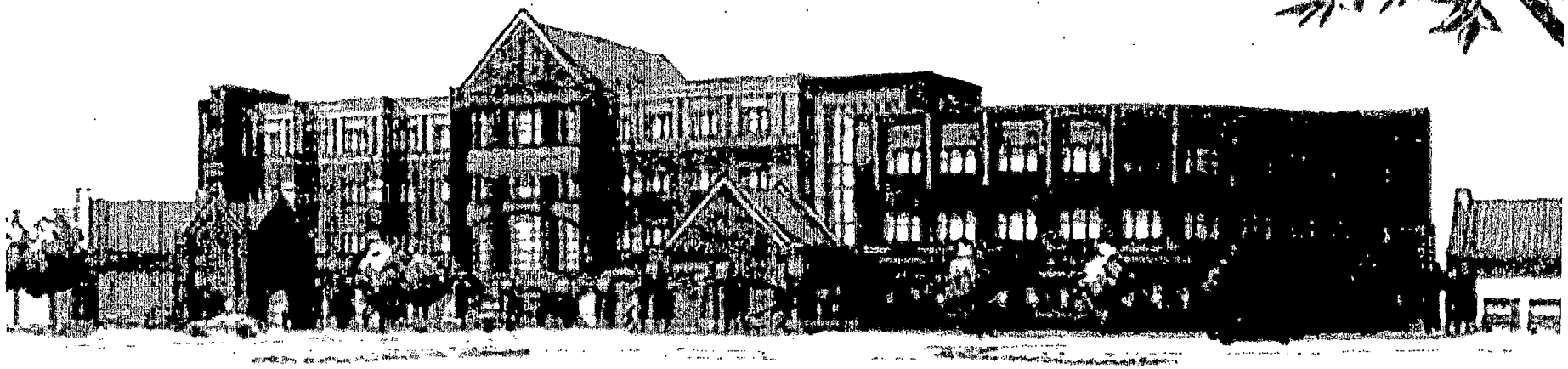
David S. Levitt
Managing Principal

cc: Charles Miller, PMC

Pied.Supp.CON
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Fort Mill Medical Center

June 29, 2011



PIEDMONT MEDICAL CENTER

FORT MILL MEDICAL CENTER

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0653

RECORD 002795

JOINT-B-PMC-001.0690

Independent Physician Support

- Over 75% Support of Independent Physician Letters

York County Physicians, 2005-2010			
	Independent	Employed	Total*
Piedmont	45	22	67
CHS	1	55	56
Presbyterian	13	20	33

* Totals include only physicians who practice in South Carolina.

Pied.Supp.CON
0654

RECORD 002796
JOINT-B-PMC-001.0691

Independent Physician Support

- Over 75% Support of Independent Physician Letters

York County Physicians, 2005-2010			
	Independent	Employed	Total*
Piedmont	45	22	67
CHS	1	55	56
Presbyterian	13	20	33

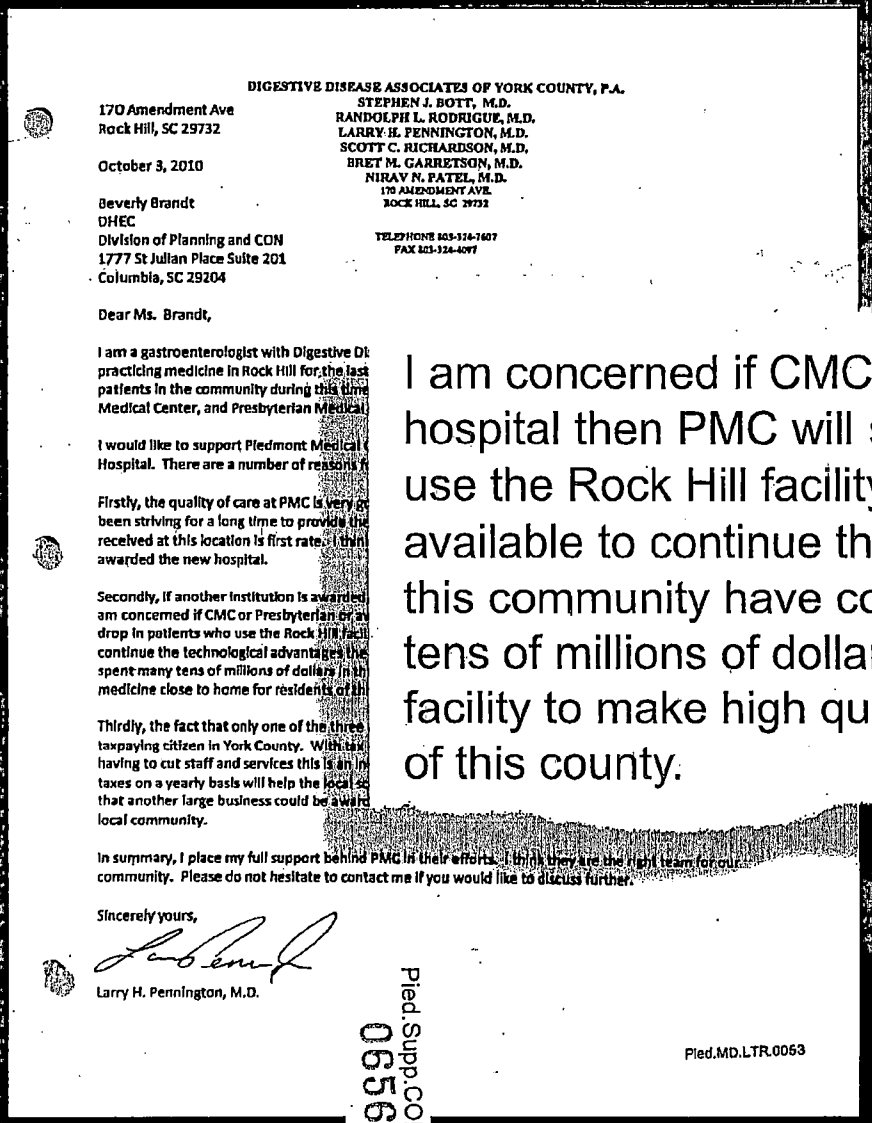
* Totals include only physicians who practice in South Carolina.

Pied.Supp.CON
0655

RECORD 002797
JOINT-B-PMC-001.0692

Larry H. Pennington, MD

Gastroenterologist



DIGESTIVE DISEASE ASSOCIATES OF YORK COUNTY, P.A.
STEPHEN J. BOTT, M.D.
RANDOLPH L. RODRIGUE, M.D.
LARRY H. PENNINGTON, M.D.
SCOTT C. RICHARDSON, M.D.
BRET M. GARRETSON, M.D.
NIRAV N. PATEL, M.D.
170 AMENDMENT AVE.
ROCK HILL, SC 29732

TELEPHONE 803-326-7607
FAX 803-324-4097

170 Amendment Ave
Rock Hill, SC 29732

October 3, 2010

Beverly Brandt
DHEC
Division of Planning and CON
1777 St Julian Place Suite 201
Columbia, SC 29204

Dear Ms. Brandt,

I am a gastroenterologist with Digestive Di
practicing medicine in Rock Hill for the last
patients in the community during this time
Medical Center, and Presbyterian Medical

I would like to support Piedmont Medical
Hospital. There are a number of reasons f

Firstly, the quality of care at PMC is very g
been striving for a long time to provide the
received at this location is first rate. I thin
awarded the new hospital.

Secondly, if another institution is awarded
am concerned if CMC or Presbyterian or a
drop in patients who use the Rock Hill facil
continue the technological advantages the
spent many tens of millions of dollars in th
medicine close to home for residents of th

Thirdly, the fact that only one of the three
taxpaying citizen in York County. With tax
having to cut staff and services this is an in
taxes on a yearly basis will help the local sc
that another large business could be award
local community.

In summary, I place my full support behind PMC in their efforts. I think they are the right team for our
community. Please do not hesitate to contact me if you would like to discuss further.

Sincerely yours,

Larry H. Pennington, M.D.

Pied.Supp.CON 0656

Pied.MD.LTR.0053

I am concerned if CMC or Presbyterian or [sic] awarded the new hospital then PMC will suffer. There will be a drop in patients who use the Rock Hill facility and thus a subsequent drop in the funds available to continue the technological advantages the people in this community have come to enjoy. Piedmont has spent many tens of millions of dollars in the last several years upgrading the facility to make high quality medicine close to home for residents of this county.

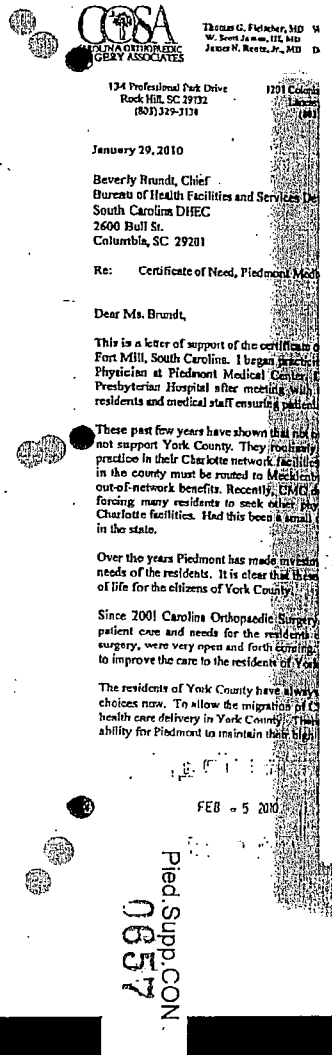
Pied.MD.Ltr.00053

RECORD 002798

JOINT-B-PMC-001.0693

Thomas Fleisher, MD

Orthopaedic Surgery



CAROLINA ORTHOPEDIC SURGERY ASSOCIATES

134 Professional Park Drive
Rock Hill, SC 29732
(803) 329-3120

January 29, 2010

Beverly Brandt, Chief
Bureau of Health Facilities and Services
South Carolina DHEC
2600 Bull St.
Columbia, SC 29201

Re: Certificate of Need, Piedmont Medi

Dear Ms. Brandt,

This is a letter of support of the certificate
Fort Mill, South Carolina. I began
Physician at Piedmont Medical Center
Presbyterian Hospital after meeting with
residents and medical staff ensuring patients

These past few years have shown that not
not support York County. They routinely
practice in their Charlotte network facilities
in the county must be routed to Mecklenb
out-of-network benefits. Recently, CMC
forcing many residents to seek other
Charlotte facilities. Had this been a small
in the state.

Over the years Piedmont has made investm
needs of the residents. It is clear that th
of life for the citizens of York County.

Since 2001 Carolina Orthopaedic Surgery
patient care and needs for the residents
surgery, were very open and forth coming
to improve the care to the residents of Yor

The residents of York County have always
choices now. To allow the migration of C
health care delivery in York County. Th
ability for Piedmont to maintain their high

FEB - 5 2010

Pied.Supp.CON.
0657

Pied.MD.LTR.0021

During the first CON process I specifically submitted a letter of support for Presbyterian Hospital after meeting with their CEO. At the meeting he presented their plan to support York County's residents and medical staff ensuring patients would not be directed out of York County.

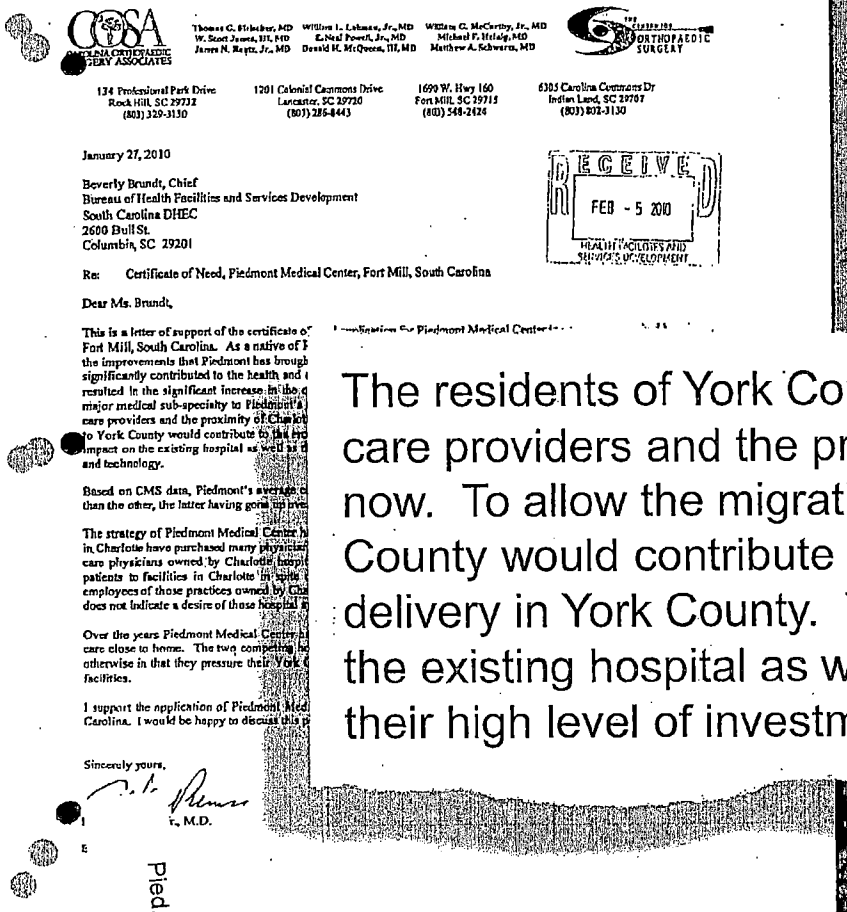
These past few years have shown that not only Presbyterian but also Carolinas Medical, by their actions, have proven they do not support York County. They routinely encourage their York County practitioners to refer patients to physicians who practice in their Charlotte network facilities. Their employees as well as the physicians and their families who work and live in the county must be routed to Mecklenburg County for surgery and most diagnostic testing or face high deductibles and out-of-network benefits.

RECORD 002799

JOINT-B-PMC-001.0694

E. Neal Powell, Jr., MD

Orthopaedic Surgery



COSA — Carolina Orthopaedic Surgery Associates

Thomas G. Stinchfield, MD · William L. Lehman, Jr., MD · William G. McCarthy, Jr., MD
W. Scott Jones, III, MD · E. Neal Powell, Jr., MD · Michael F. Hulsig, MD
James N. Hayes, Jr., MD · Donald H. McQueen, III, MD · Matthew A. Schwartz, MD

ORTHOPAEDIC SURGERY

134 Professional Park Drive, Rock Hill, SC 29732, (803) 329-3130
1201 Colonial Commons Drive, Lancaster, SC 29720, (803) 286-8443
1699 W. Hwy 160, Fort Mill, SC 29715, (803) 548-2424
6305 Carolina Commons Dr, Indian Land, SC 29707, (803) 802-3130

January 27, 2010

RECEIVED
FEB - 5 2010
HEALTH FACILITIES AND SERVICES DEVELOPMENT

Beverly Brandt, Chief
Bureau of Health Facilities and Services Development
South Carolina DHEC
2600 Bull St.
Columbia, SC 29201

Re: Certificate of Need, Piedmont Medical Center, Fort Mill, South Carolina

Dear Ms. Brandt,

This is a letter of support of the certificate of [illegible] for Piedmont Medical Center in Fort Mill, South Carolina. As a native of [illegible] the improvements that Piedmont has brough[t] significantly contributed to the health and [illegible] resulted in the significant increase in the [illegible] major medical sub-specialty to Piedmont's [illegible] care providers and the proximity of Charlotte to York County would contribute to the [illegible] impact on the existing hospital as well as [illegible] and technology.

Based on CMS data, Piedmont's average [illegible] than the other, the latter having gone through [illegible]

The strategy of Piedmont Medical Center [illegible] in Charlotte have purchased many physician [illegible] care physicians owned by Charlotte hospi[tals] patients to facilities in Charlotte in [illegible] employees of those practices owned by Ch[arlotte] does not indicate a desire of those hospital [illegible]

Over the years Piedmont Medical Center [illegible] care close to home. The two competing [illegible] otherwise in that they pressure their York [County] facilities.

I support the application of Piedmont Med[ical] Carolina. I would be happy to discuss this [illegible]

Sincerely yours,

[signature] M.D.

Pied.Supp.CON 0658

Pied.MD.LTR.0033

The residents of York County have always had a choice of health care providers and the proximity of Charlotte allows them choices now. To allow the migration of Charlotte based hospitals to York County would contribute to the erosion of overall health care delivery in York County. There would be an adverse impact on the existing hospital as well as the ability for Piedmont to maintain their high level of investments in the facility and technology.

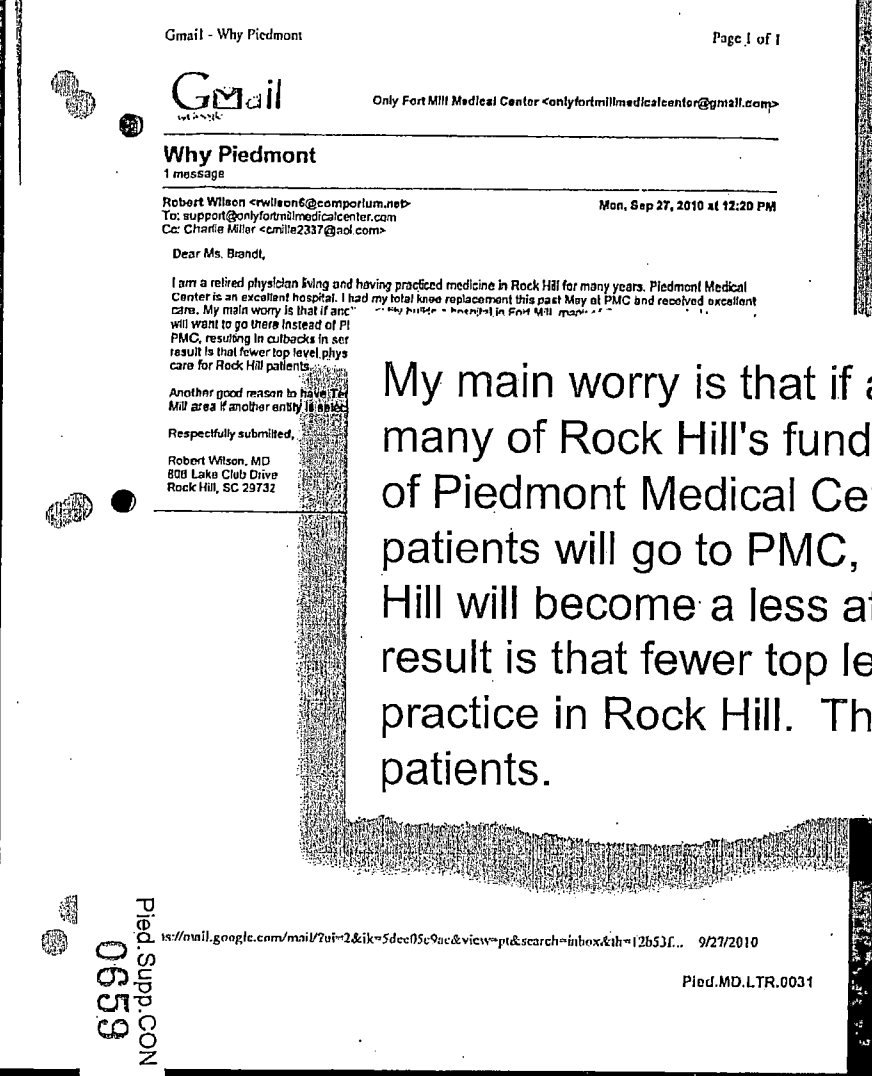
Pied.MD.Ltr.00033

RECORD 002800

JOINT-B-PMC-001.0695

Robert Wilson, MD

Otolaryngologist



Gmail - Why Piedmont Page 1 of 1

Gmail Only Fort Mill Medical Center <onlyfortmillmedicalcenter@gmail.com>

Why Piedmont
1 message

Robert Wilson <rwilson6@comporium.net> Mon, Sep 27, 2010 at 12:20 PM
To: support@onlyfortmillmedicalcenter.com
Cc: Charlie Miller <cmille2337@aol.com>

Dear Ms. Brandt,

I am a retired physician living and having practiced medicine in Rock Hill for many years. Piedmont Medical Center is an excellent hospital. I had my total knee replacement this past May at PMC and received excellent care. My main worry is that if anc... by builder - hospital in Fort Mill ...
will want to go there instead of Pl
PMC, resulting in cutbacks in ser
result is that fewer top level phys
care for Rock Hill patients.

Another good reason to have Te
Mill area if another entity is suc

Respectfully submitted,

Robert Wilson, MD
808 Lake Club Drive
Rock Hill, SC 29732

ps://mail.google.com/mail/?ui=2&ik=5dec05c9ac&view=pt&search=inbox&th=12b53f... 9/27/2010

Pied.MD.LTR.0031

Pied.Supp.CON 0559

My main worry is that if another entity builds a hospital in Fort Mill, many of Rock Hill's funded patients will want to go there instead of Piedmont Medical Center. That will mean fewer attractive patients will go to PMC, resulting in cutbacks in services. Rock Hill will become a less attractive place to practice medicine. End result is that fewer top level physicians will want to come to and practice in Rock Hill. This will mean less good care for Rock Hill patients.

Pied.MD.Ltr.00031

RECORD 002801

JOINT-B-PMC-001.0696

Adverse Impact

- FMMC will serve PMC's existing and historical patient base and the increasing patient population projected for the area.
- FMMC will reduce outmigration and recapture patients.
- Either NC provider will cause further erosion of PMC's marketshare and utilization.

Pied.Supp.CON
0660

RECORD 002802
JOINT-B-PMC-001.0697

Adverse Impact

Piedmont Medical Center Lost Admissions
Projected 2017 Volume With and Without a NC Provider in Fort Mill

	PSA	SSA	Total
2009 Market Share	54.8%	50.3%	53.4%
2017 Admissions (at 2009 market share)	8,666	3,380	12,046
2017 Market Share with NC provider in Fort Mill	35.9%	42.1%	37.8%
2017 Admissions with NC provider in Fort Mill	5,702	2,838	8,540
Net Impact	**(2,963)**	**(542)**	**(3,505)**

- Projected 2017 utilization at PMC from the service area based on 2009 marketshare totals over 12,000 admissions.
- PMC market share is estimated to be less than 40% with a NC provider in Fort Mill
  - Historical PMC marketshare ranged from 65-70 percent of York County.

Lost admissions are estimated at over 3,500.

RECORD 002803
JOINT-B-PMC-001.0698
Pied.Supp.CON
0661

Adverse Impact

Piedmont Medical Center Historical and Projected Utilization

	ADC	Occupancy
2009 Actual	153.0	57.1%
2017 Projected at 2009 mkt share (a)	176.5	65.9%
2017 Projected with NC provider in Fort Mill (a)	125.1	46.7%

(a) Assumes 2009 inmigration rate and ALOS of 4.4

Pied.Supp.CON
0662

RECORD 002804
JOINT-B-PMC-001.0699

Adverse Impact

Piedmont 2009 Contribution Margin
Patients with a CMI < 2.0

	PSA	SSA
Net Patient Revenue	$49,956,034	$20,884,187
Total Variable Costs	$23,937,789	$9,786,654
Contribution Margin	$26,018,245	$11,097,532
Patients	6,645	2,744
Contribution Margin per Patient	$3,915	$4,044

Source: PMC internal data.

Pied.Supp.CON
0663

RECORD 002805
JOINT-B-PMC-001.0700

Adverse Impact

Financial Impact to Piedmont Medical Center

	PSA	SSA	Total
Reduced Admissions	(2,963)	(542)	(3,505)
2009 PMC Contribution Margin	$ 3,915	$ 4,044	
Net Impact	**$ (11,602,401)**	**$ (2,192,551)**	**$ (13,794,952)**

Approval of either CMC or PHY will fundamentally change the nature and operations of an existing hospital

Pied.Supp.CON
0664

RECORD 002806
JOINT-B-PMC-001.0701

Adverse Impact

- Historical Outmigration
- Why We Proposed Fort Mill Hospital
- Subsequent Increases in Outmigration
  - Pressure on employed physicians

Pied.Supp-CON 0665

RECORD 002807

JOINT-B-PMC-001.0702

Adverse Impact

- How We Managed Patient Losses
  - 1st Option: Cut Incremental Costs
  - 2nd Option: Reduced Staff, Services
  - 3rd Option: Terminated Programs

Pied.Supp-CON 0666

RECORD 002808

JOINT-B-PMC-001.0703

Adverse Impact

- The Practical Effect of Losing 3,500 Admissions
- We will no longer have the resources to support the level of staffing, services, and programs that we have today.
- Distinctive programs that will be at risk for closure:
  - Stroke Program
  - In-House Neonatologists
  - Infusion Center
  - Wound Care Center and Hyperbaric Chamber
- Insufficient resources for programs of the future

RECORD 002809
Pied.Supp-CON
0667
JOINT-B-PMC-001.0704

Ongoing Contractual Duties

- 24/7, County-Wide EMS Services
- Urgent Care Services in Western York County
- Major Capital Investments
- Support for Educational Organizations

Pied.Supp-CON 0668

RECORD 002810

JOINT-B-PMC-001.0705

Ongoing Contractual Duties: Transparency

- Financial Reports Must Be Submitted to County Council, Including:
  - Financial Statements
  - Indigent Care Levels
  - Charge Comparisons

Pled Supp-CON
0669

RECORD 002811
JOINT-B-PMC-001.0706

Charges and the Contract

- The Contract's broad mandate requires Piedmont/FMMC to maintain charges at "**reasonable, competitive levels**."

- Since the 8th Addendum took effect in 2004, PMC's charges have never ranked higher than 6th in the specified peer group of 11 hospitals. PMC's charges are currently rank 9th out of the 11.

- Neither CHS nor Presbyterian will have any restriction on charges.

Pied.Supp-CON 0670

RECORD 002812

JOINT-B-PMC-001.0707

Charlotte Observer

June 12, 2011

Printed from the Charlotte Observer - www.CharlotteObserver.com

Posted: Sunday, Jun. 12, 2011

County presses hospital system

By Ames Alexander
PUBLISHED IN: LOCAL NEWS

Top Mecklenburg County officials are trying to determine whether Carolinas HealthCare System is overcharging taxpayers for running the county's psychiatric hospital on Billingsley Road.

They're also asking why the county's costs for that hospital have risen rapidly at a time when some services are being cut.

CHS officials deny any overcharging and say they have honored the terms of their contract.

But county officials contend they have yet to receive the information required to evaluate the need for a new psychiatric hospital that CHS wants to build in Huntersville - or even to explain what taxpayers are getting for the roughly $19 million spent annually at the existing hospital, known as CMC-Randolph.

In a June 3 letter to Carolinas HealthCare CEO Michael Tarwater, County Manager Harry Jones contended the hospital system has breached its contract by failing to provide requested information about CMC-Randolph's patients and finances. He said the county would halt its payments to the hospital chain until that information comes.

"If we are asked what we are buying, we want to be," Manager Michelle Lancaster. "Right now, I can't ans

Carolinas HealthCare, the multi-billion-dollar pub
county, says it has provided complete information to
performance.

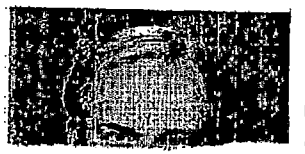
ong the county's questions:

Why have the county's costs for running CMC-Randolph grown rapidly as the county reduces some
vices there?

ler the contract, the county covers financial losses at the 66-bed hospital. Since 2005, the county's

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In a June 3 letter to Carolinas HealthCare CEO Michael Tarwater, County Manager Harry Jones contended the hospital system has breached its contract by failing to provide requested information about CMC-Randolph's patients and finances.

RECORD 002813

JOINT-B-PMC-001.0708

Pltd.Supp-CON 0671

Charlotte Observer

June 12, 2011

Printed from the Charlotte Observer - www.CharlotteObserver.com

Posted Sunday, Jun. 12, 2011

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By Ames Alexander
PUBLISHED IN: LOCAL NEWS

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getting for
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In a time
Michael
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said the
hospital

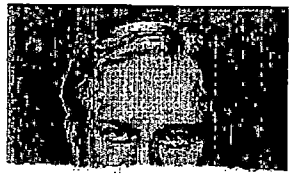
"If we ar
Manager

Carolina
county
formance

long the county's questions.

Related Stories

Related Images



CHS doesn't intend to provide the media detailed responses to many of the questions Jones has raised, hospital spokeswoman Gail Rosenberg said.

"It doesn't feel ... that there's a lot to be gained by that," she said.

Why have the county's costs for running CMC-Randolph grown rapidly as the county reduces some
vices there?

ler the contract, the county covers financial losses at the 66-bed hospital. Since 2005, the county's

Pled.Supp-Ex.0172

RECORD 002814

JOINT-B-PMC-001.0709

RECORD 002815

JOINT-B-PMC-001.0710

Sanger Heart & Vascular Institute

Paul G. Colavita, MD, FACC
President

Dear Mr I

For many years, Sanger Heart & Vascular Institute has been providing care for thousands of cardiology patients in York County. We take great pride in providing the region's most advanced care for patients with heart conditions and appreciate the confidence you and your family place in us

We will continue to serve our patients in York County at our same office locations for outpatient services and physician visits. However, effective June 30, 2011, we will no longer provide inpatient care at Piedmont Medical Center in Rock Hill.

Sanger patients who require hospitalization will be offered the option of inpatient care at Carolinas Medical Center and CMC-Pineville. By providing your care at a CMC facility, we offer continuity of care, connecting with your primary care physician, electronic medical records and the comprehensive care of our medical specialists. We believe this provides a higher level of care for our patients who require hospitalization.

This letter is intended to provide you with an update about the changes in our inpatient care services in Rock Hill. You do not have to do anything. Please feel free to contact our Rock Hill office at (803) 327-5456 if we can assist in answering any questions.

For more than 60 years, Sanger Heart & Vascular Institute has offered total cardiac care, including preventive, diagnostic and full-range treatment of cardiovascular disease for pediatric and adult patients, a level of care that is unmatched in the region. We look forward to caring for you and your family and continuing to work with your primary care physician to provide the very best cardiac care in York County.

Sincerely,

Paul G Colavita, MD
President
Sanger Heart & Vascular Institute

Pied Supp-CON 0673

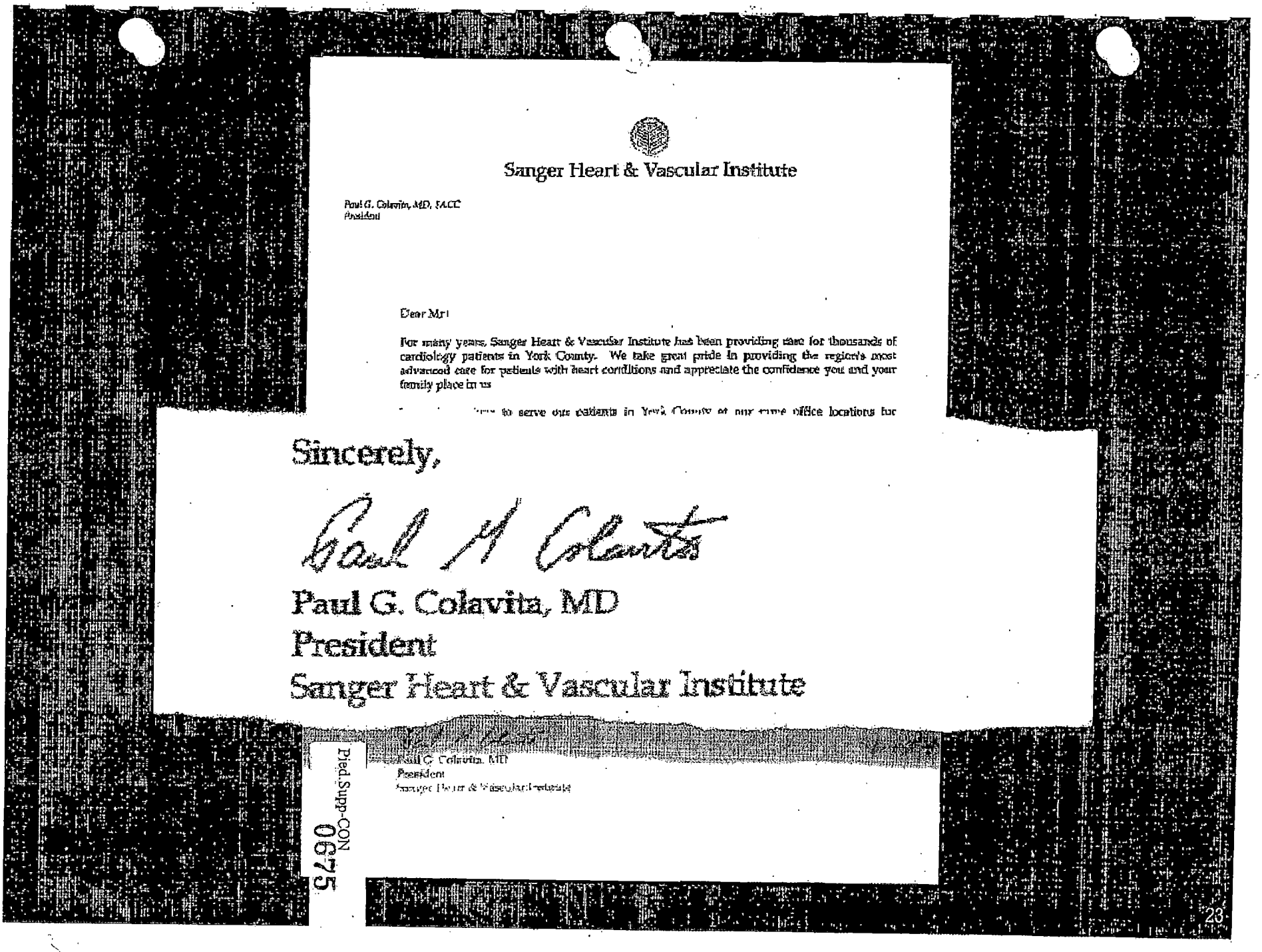
Sanger Letter

- Corporate decision requiring physicians to resign their privileges
- Announcement timed just before Project Review
- Disregard for patients and the community
- No adverse effect on PMC's cardiology program

Pied.Supp-CON 0674

RECORD 002816

JOINT-B-PMC-001.0711



Sanger Heart & Vascular Institute

Paul G. Colavita, MD, FACC
President

Dear Mr.

For many years, Sanger Heart & Vascular Institute has been providing care for thousands of cardiology patients in York County. We take great pride in providing the region's most advanced care for patients with heart conditions and appreciate the confidence you and your family place in us.

We look forward to serve our patients in York County at our same office locations for

Sincerely,

Paul G. Colavita, MD
President
Sanger Heart & Vascular Institute

Paul G. Colavita, MD
President
Sanger Heart & Vascular Institute

Pied.Supp-CON 0675

RECORD 002817

JOINT-B-PMC-001.0712

Accountability to the Community

- History of going beyond contractual obligations
- Commitment to transparency
- Strong corporate citizenship

We are York County's medical center.

Pied.Supp-CON
0676

RECORD 002818
JOINT-B-PMC-001.0713

Financial Feasibility/Charges

Projected Net Income

	Year 1	Year 2	Year 3
FMMC	($5,422,756)	($2,925,984)	$313,620
PHY	($1,101,582)	$1,998,254	$4,985,226
CMC-FM	$663,000	$1,671,000	$2,776,000
Trident Berkeley	($4,576,851)	($2,855,147)	$69,552
Roper Berkeley	($11,765,772)	($3,313,318)	$285,160

- FMMC performance and ramp-up is consistent with two most recent hospital approvals
- CMC-FM projects no first year loss and minimal ramp up
- PHY Year 3 net income totals nearly $5,000,000

RECORD 002819
JOINT-B-PMC-001.0714
Pied-Supp-CON 0677

Financial Feasibility/Charges

Projected Inpatient Charges per Patient

	Year 1	Year 2	Year 3
FMMC	$19,238	$20,141	$21,043
PHY	$18,750	$19,345	$19,954
CMC-FM	$18,642	$19,201	$19,777
FMMC Adjusted (a)	*$18,155*	*$18,824*	*$19,478*

Source: CON applications

(a) assumes a 3% charge inflation for all parties

- Charges for all three providers are comparable (within 3% variance Yr 1)
- FMMC assumed 4% charge inflation vs. 3% for other providers
- Adjusting inflation assumption for FMMC results in charges lower than the other two providers

RECORD 002820
Pied.Supp-CON 0678
JOINT-B-PMC-001.0715

Financial Feasibility/Charges

Average Medicare Inpatient Charges

		2005			2010			Avg Annual	09-10
		Avg. Charge	CMI	CMI Adjusted	Avg. Charge	CMI	CMI Adjusted	Change	Change
1	Palmetto-Baptist	$29,766	1.4176	$20,997	$56,771	1.577	$35,999	11.4%	13.4%
2	Springs	$29,008	1.2100	$23,974	$43,625	1.2717	$34,305	7.4%	8.6%
3	Palmetto-Richland	$37,801	1.7451	$21,661	$64,973	1.8766	$34,623	9.8%	13.2%
4	Mary Black	$36,891	1.4733	$25,040	$46,561	1.4858	$31,337	4.6%	10.2%
5	Spartanburg	$34,174	1.5948	$21,428	$37,633	1.6933	$22,225	0.7%	-17.2%
6	Providence	$31,766	1.8805	$16,892	$39,887	1.9342	$20,622	4.1%	5.1%
7	CMC	$30,282	1.7951	$16,869	$44,200	2.0372	$21,696	5.2%	12.3%
8	Presbyterian	$23,747	1.5655	$15,169	$35,543	1.6816	$21,136	6.9%	11.1%
9	Piedmont	$27,754	1.5050	$18,441	$31,604	1.6199	$19,510	1.1%	3.2%
10	CMC-Mercy/Pineville	$25,420	1.4725	$17,263	$32,358	1.6877	$19,173	2.1%	6.5%
11	Gaston	$18,546	1.4138	$13,118	$22,196	1.5236	$14,568	2.1%	4.1%

Source: MEDPAR data from Data Advantage Corp.

- 2010 PMC charges are lowest for all S.C providers and 3rd lowest of the entire comparison peer group
- From 2005 to 2010 PMC charges increased 1.1% annually
  - CMC charges increased 2.1% to 5.2% percent annually
  - Presbyterian charges increased 6.9% percent annually

RECORD 002821
JOINT-B-PMC-001.0716
Pied.Supp-COM 0679

Indigent Care

Indigent Care as a Percent of Gross Patient Revenue

	Original CON			Updated CON		
	Indigent Care	Compact	Combined	Indigent Care	Compact	Combined
FMMC	3.0%	1.00%	4.0%	3.0%	2.0%	5.0%
PHY	3.0%	-	3.0%	6.5%	-	6.5%
CMC	3.5%	-	3.5%	6.3%	-	6.3%

Source: CON applications

FMMC projections are based on PMC's actual experience in the market

Pltd.Supp-CON 0680

RECORD 002822

JOINT-B-PMC-001.0717

Indigent Care

Presbyterian and Carolinas indigent care thresholds and definitions are misleading and they have not demonstrated need now or in the future.

- PHY and CMC-FM would be paid for those "indigents" that have insurance
- Presbyterian: 300% of FPL for family of four is $67,050
  - 2009 **Median** household income of York County = $50,644
  - More than half the households in York County qualify for this program
- Health Reform (PPACA) will provide access to insurance to the uninsured - estimated 75% nationally

RECORD 002823
Pied.Supp-CON 0681
JOINT-B-PMC-001.0718

Efficiency/Community Need

FY 2016 Hospital Bed Need
Piedmont Medical Center

Age Category	2009 Patient Days	Projected ADC	Bed Need (a)	Existing Beds	Need/ (Excess)
<18	1,363	4			
18-64	29,411	90			
65+	25,064	88			
Total	55,838	181	259	268	-9
Total York Residents Treated in NC.	34,459	105	149		149
Total for all residents		286	408	268	140

Source: 2010-2011 State Health Plan. Thompson data.

(a) Based on 70% occupancy

Note: Excludes psychiatric utilization.

RECORD 002824

JOINT-B-PMC-001.0719

Pied.Supp-CON 0682

Efficiency/Community Need

Projected Utilization

	Year 1			Year 2			Year 3		
	FMMC	CMC-FM	PHY	FMMC	CMC-FM	PHY	FMMC	CMC-FM	PHY
ADC	41.8	40.9	35.3	49.9	42.0	41.3	58.2	43.2	47.7
Beds	100	64	64	100	64	64	100	64	64
Occupancy	41.8%	63.9%	55.2%	49.9%	65.6%	64.5%	58.2%	67.5%	74.5%

Source: Pied. Supp.CON 0036, S-CHS-0451, PHY2010_37

- Projected utilization at CMC and PHY approach/exceed threshold for additional beds.
  - PHY would show a need for 74 beds (10 more than requested) by their third year of operations without giving consideration to population growth.

Projected ADC vary by less than one patient to 15 patients throughout the projection period.

RECORD 002825
Pied.Supp-CON 0088
JOINT-B-PMC-001.0720

Project Cost

Comparable Hospital Total Project Costs

	Total Costs	Per Bed	Per S.F.
St. Francis-millennium (10/08)	$151,054,596	$2,904,896	$655
Trident Berkeley (8/08)	$115,000,000	$2,300,000	$792
Roper Berkeley (8/08)	$112,978,119	$2,259,562	$814
Novant Haymarket (Spring 2010)	$93,103,164	$1,551,719	$640
FMMC	**$146,522,042**	**$1,465,220**	**$660**
Parkridge (10/06)	$99,509,451	$1,309,335	$535
Georgetown Memorial (7/08)	$154,647,000	$1,247,153	$562
CMC-FM	**$77,532,435**	**$1,211,444**	**$554**
PHY	**$76,248,012**	**$1,191,375**	**$501**

RECORD 002826
Pied.Supp-CON 1684
JOINT-B-PMC-001.0721

CHS Response to Additional Information Request

December 3, 2010

Figure 4

Comparison of Amisub Investment in Piedmont Medical Center to Carolinas' Benchmarks

Hospital	County	County Population (2009)	Years Owned	Total Capital Expenditure	Capital Expenditure Per Year
Piedmont Medical Ctr.	York	233,764	15	$200,000,000	$13,333,333
CMC - Lincoln	Lincoln	76,841	3	$103,958,000	$34,652,667
CMC - NorthEast	Cabarrus	180,215	4	$112,438,000	$28,109,500
CMC - Union	Union	201,210	14	$170,615,000	$12,186,786
CMC Average	3 Counties	152,755	7	$129,003,667	$18,429,095
CMC Avg. Pop. Adj.	3 Counties	233,764	7	$197,416,434	$28,202,348

Sources: Piedmont Medical Center - annual reports submitted to York County; Carolinas - internal records

RECORD 002827

Pied.Supp-CON 0685

JOINT-B-PMC-001.0722

Figure 4

Comparison of Amisub Investment in Piedmont Medical Center to Carolinas' Benchmarks

Hospital	County	County Population (2009)	Years Owned	Total Capital Expenditure	Capital Expenditure Per Year
Piedmont Medical Ctr.	York	233,764	15	$200,000,000	$13,333,333
CMC - Lincoln	Lincoln	76,841	3	$103,958,000	$34,652,667
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CMC Avg. Pop. Adj.	3 Counties	233,764	7	$197,416,434	$28.202,348

Sources: Piedmont Medical Center - annual reports submitted to York County; Carolinas - internal records

RECORD 002828
Pied.Supp-CON 0686
JOINT-B-PMC-001.0723

CHS Response to Additional Information Request

December 3, 2010

Figure 4

Comparison of Amisub Investment in Piedmont Medical Center to Carolinas' Benchmarks

Hospital	County	County Population (2009)	Years Owned	Total Capital Expenditure	Capital Expenditure Per Year
Piedmont Medical Ctr.	York	233,764	15	$200,000,000	$13,333,333
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ources: Piedmont Medical Center - annual reports submitted to York County; Carolinas - internal records

RECORD 002829

JOINT-B-PMC-001.0724

Pied.Supp-CON 0687

Community Benefit

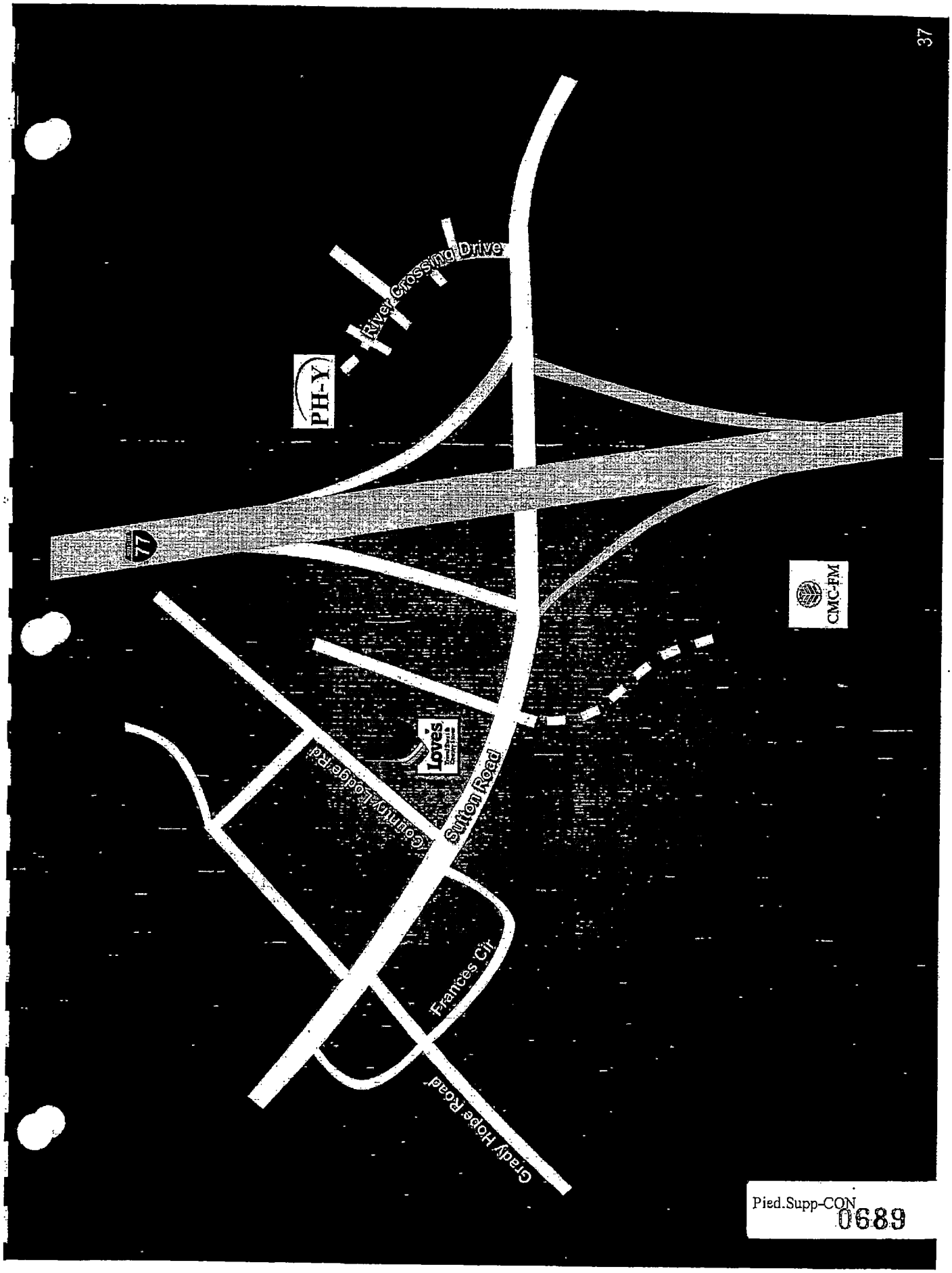
- Nancy Kane, D.B.A., Associate Dean and Professor with the Harvard School of Public Health and Congressional advisor, has developed an analysis for quantifying community benefit.

2007 - 2009 Net Community Benefit
Percentage of Total Operating Revenue

	2007	2008	2009
CMC	-3.57%	4.10%	-4.03%
CMC Mercy/Pineville	-8.77%	-4.90%	-8.28%
Presbyterian Hospital	4.15%	5.95%	3.54%
Presbyterian Matthews	-4.32%	-3.00%	-3.01%
Piedmont	10.48%	10.79%	9.27%

- Dr. Kane's conclusions show that PMC's net community benefit as a percentage of Total Operating Revenue Exceeds CMC and Presbyterian's Charlotte hospitals

RECORD 002830
Pied.Supp-CON 0688
JOINT-B-PMC-001.0725



Pied.Supp-CON 0689

SCDOT Letter

February 9, 2011

SCDOT
South Carolina
Department of Transportation

Exhibit D-1

Cherokee County
Chester County
Chesterfield County
Fairfield County
Lancaster County
Union County
York County

February 9, 2011

SCDOT
South Carolina
Department of Transportation

Exhibit D-1

Cherokee County
Chester County
Chesterfield County
Fairfield County
Lancaster County
Union County
York County

February 9, 2011

Mr. D. Theron Pickens, P.E. LEED AP Principal
LandDesign/Charlotte
Post Office Box 36959
Charlotte, North Carolina 28236

RE: Kanawha Site
York County

BK 11971 PG 0277

Pied.Supp-CON 0690

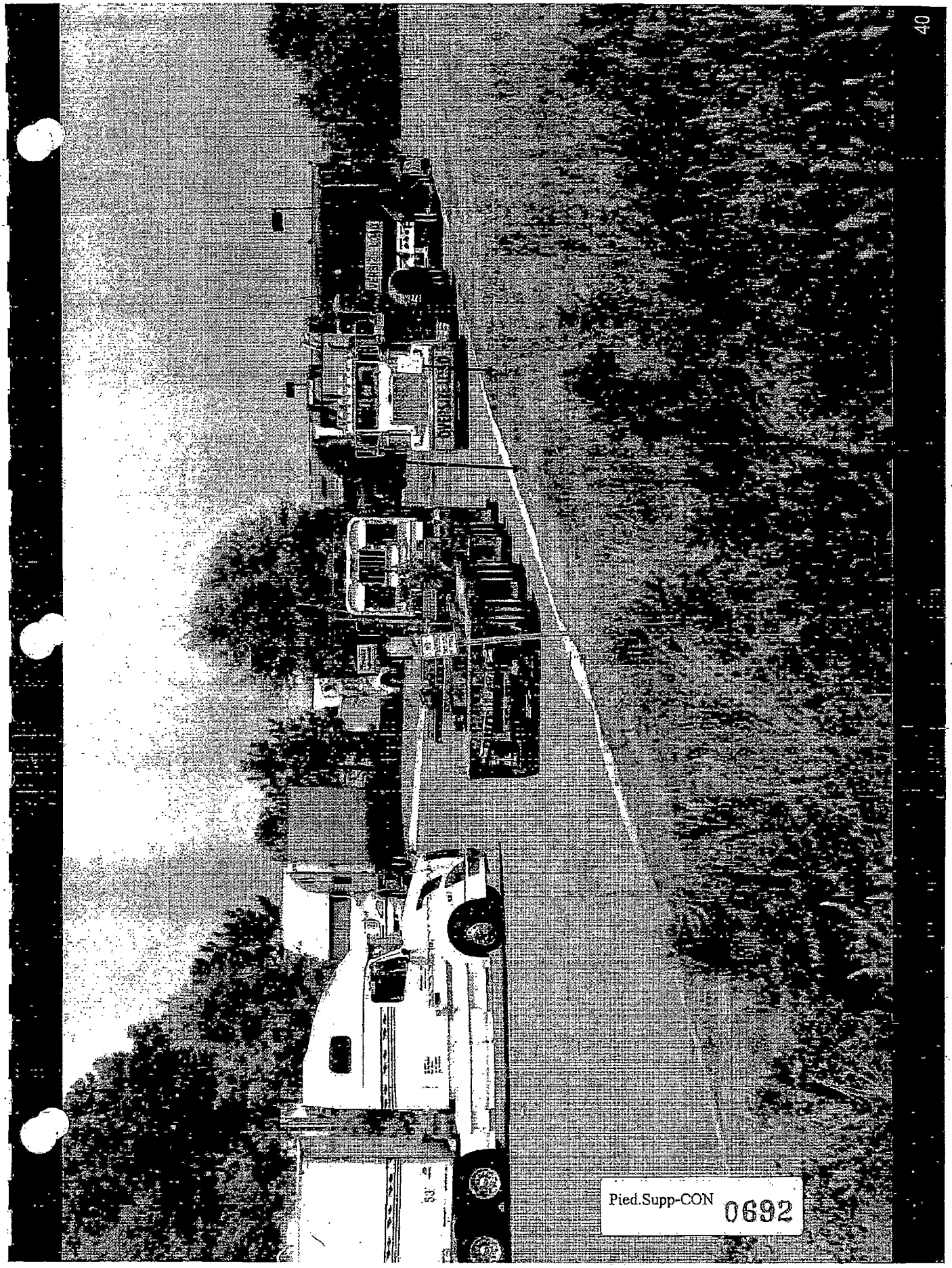
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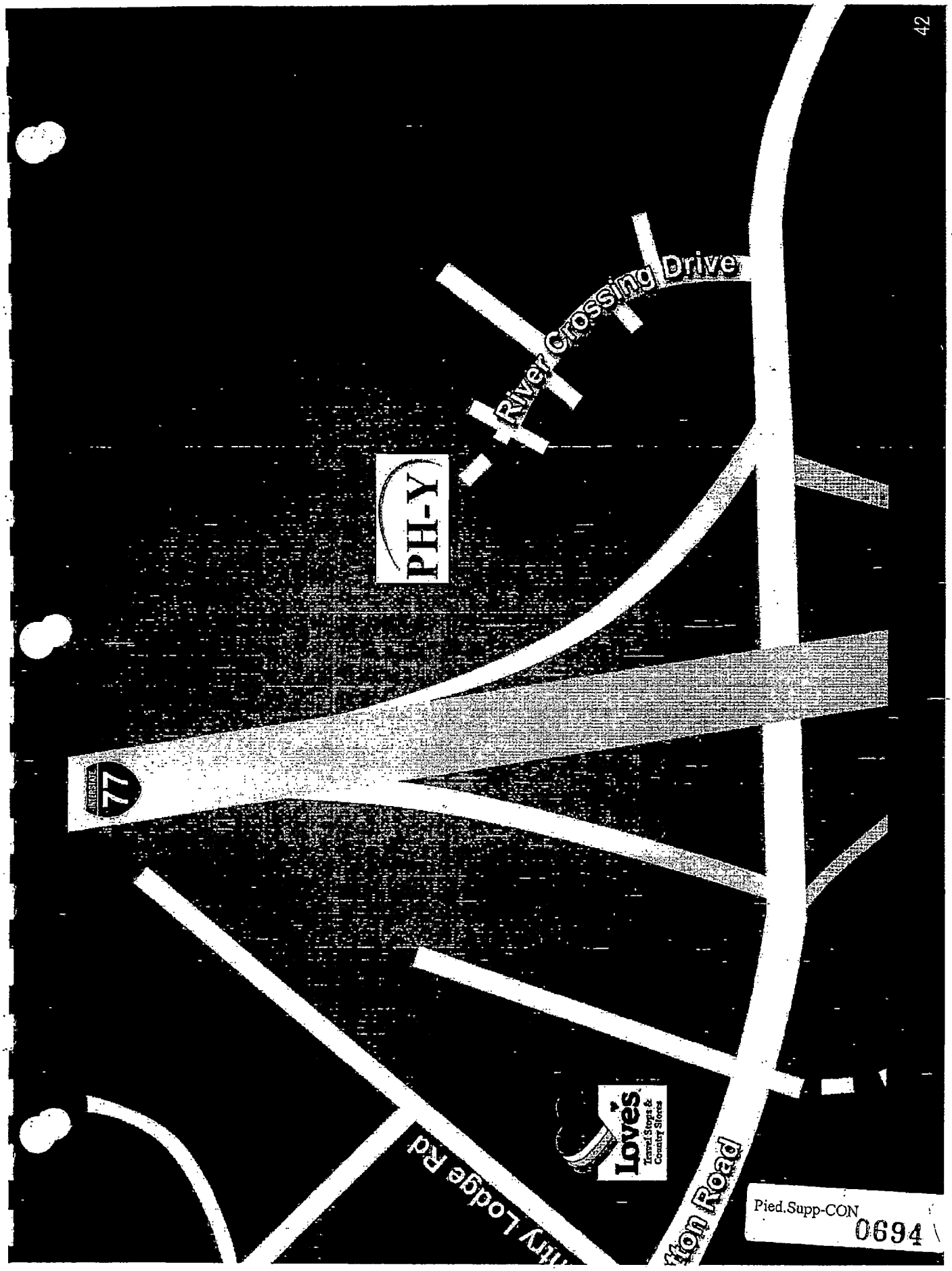
See Attached Video

Pied.Supp-CON
0691

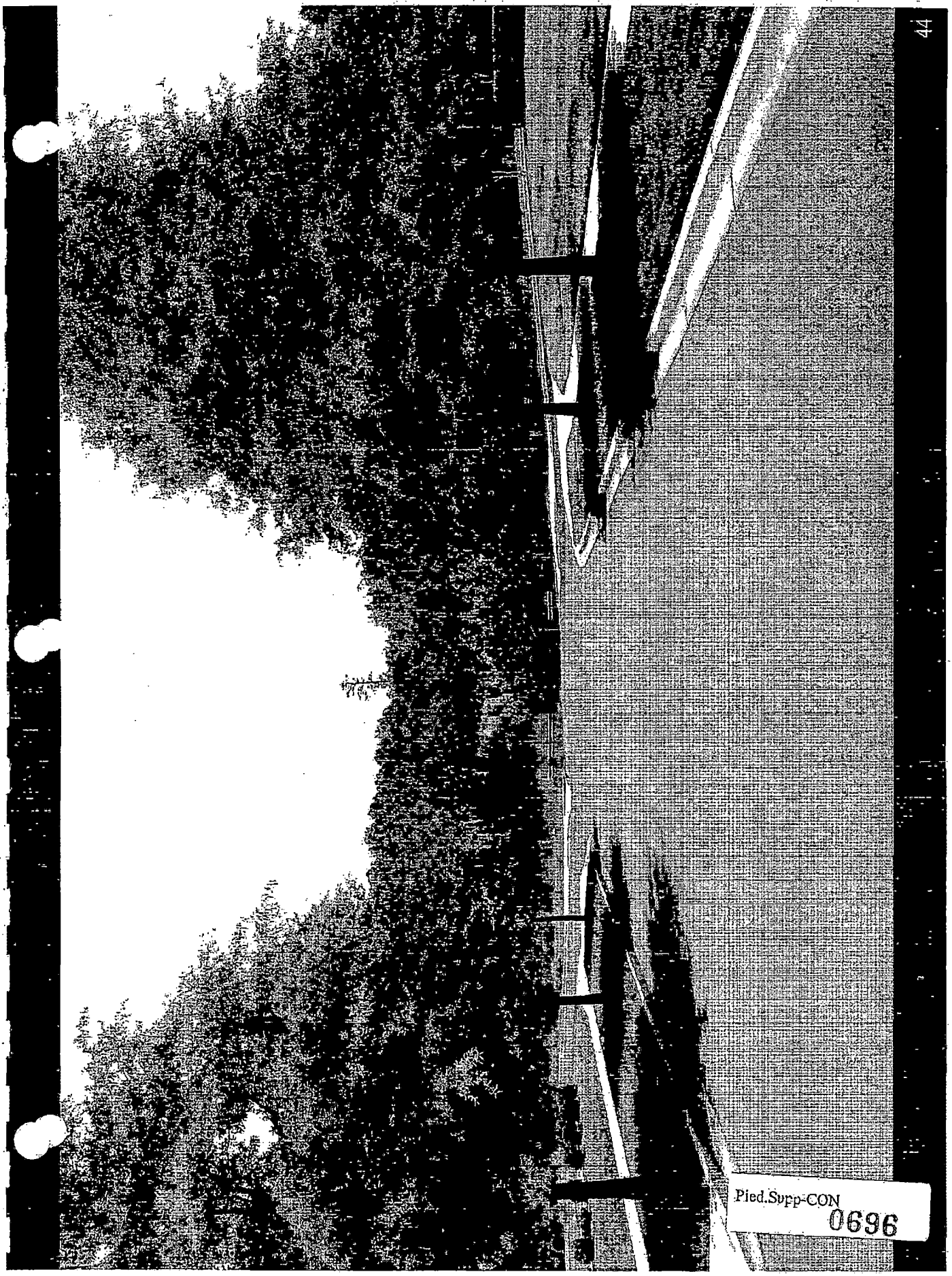
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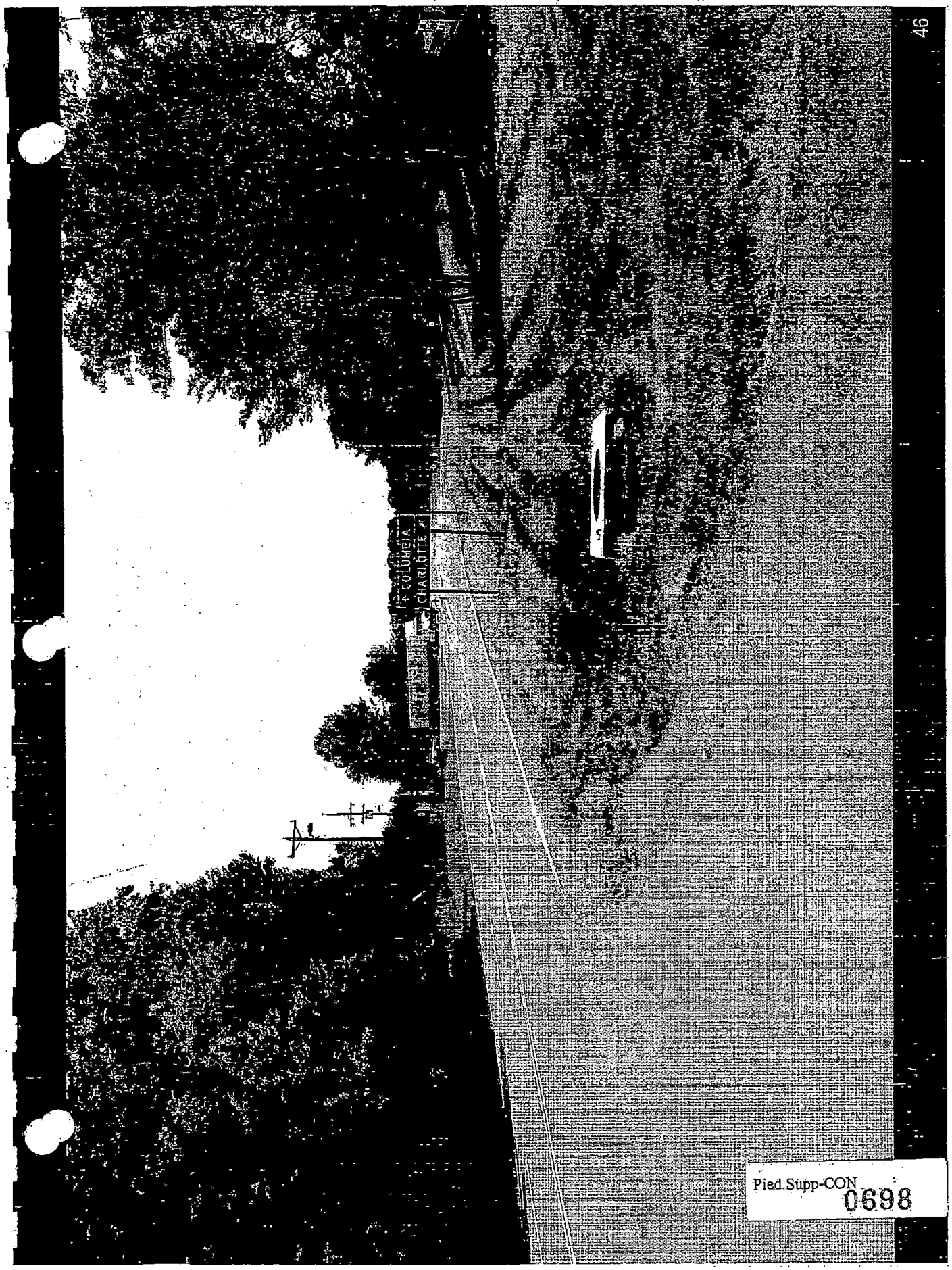
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Google
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Travel Stops & Country Stores
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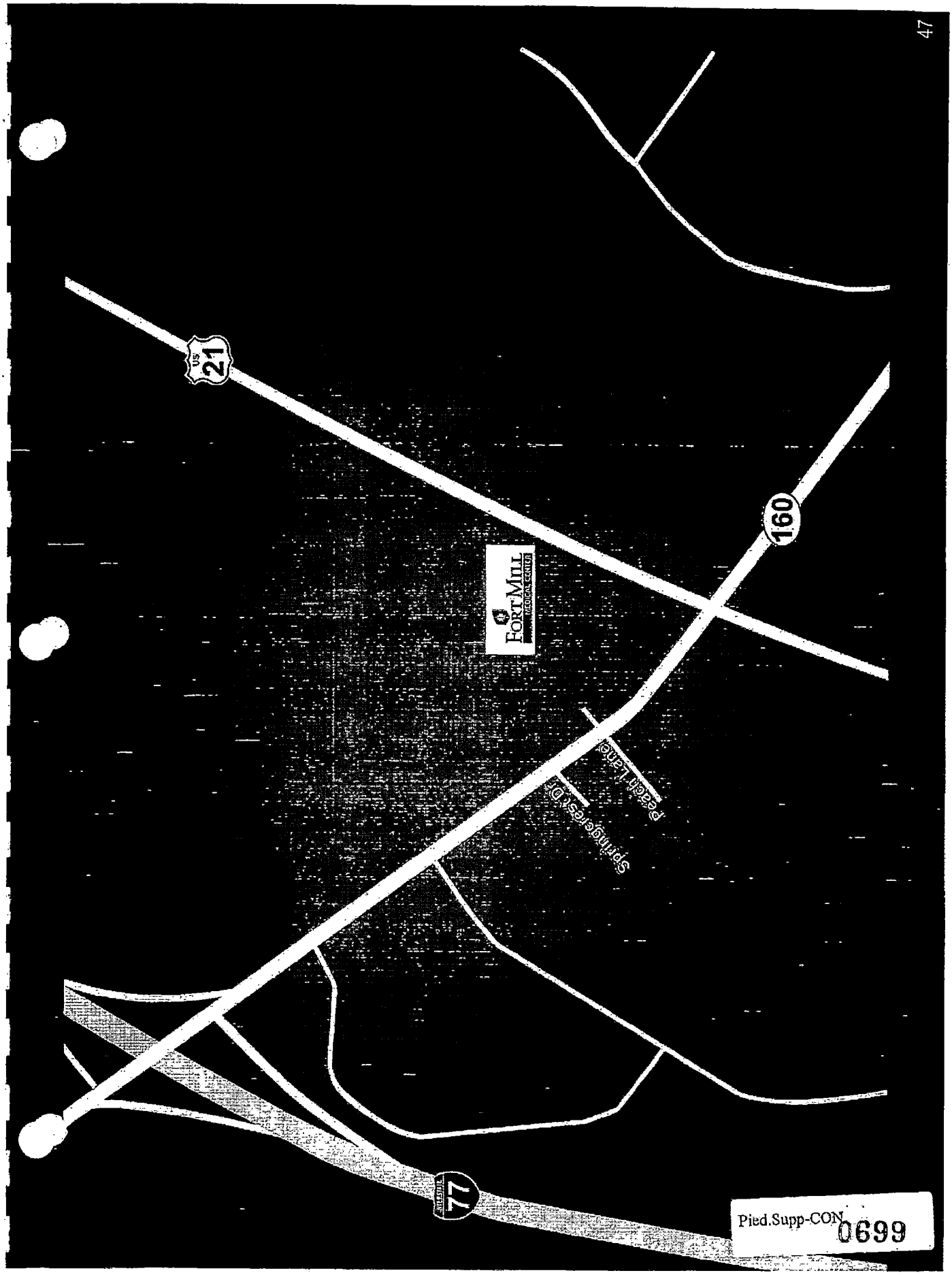

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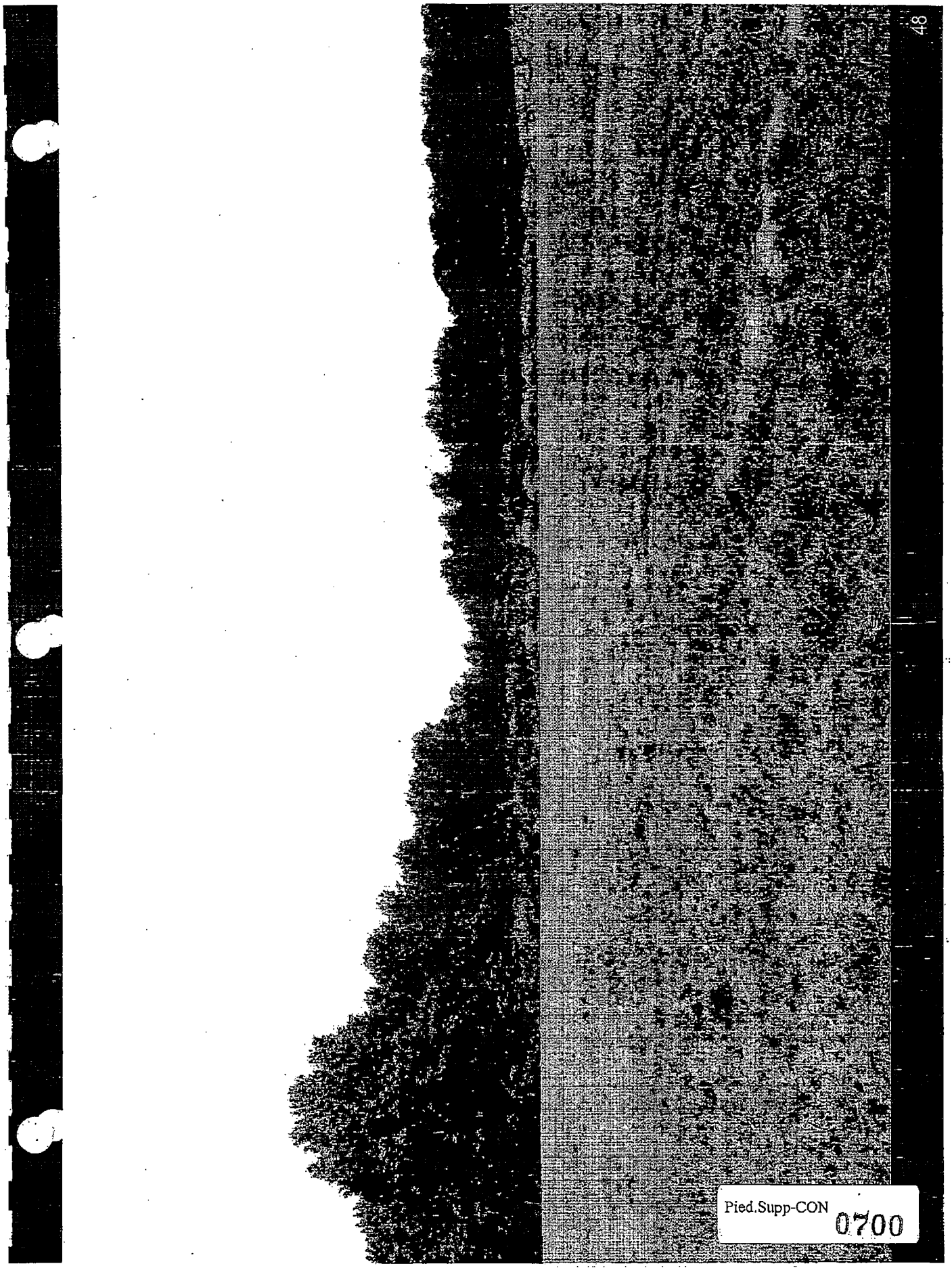

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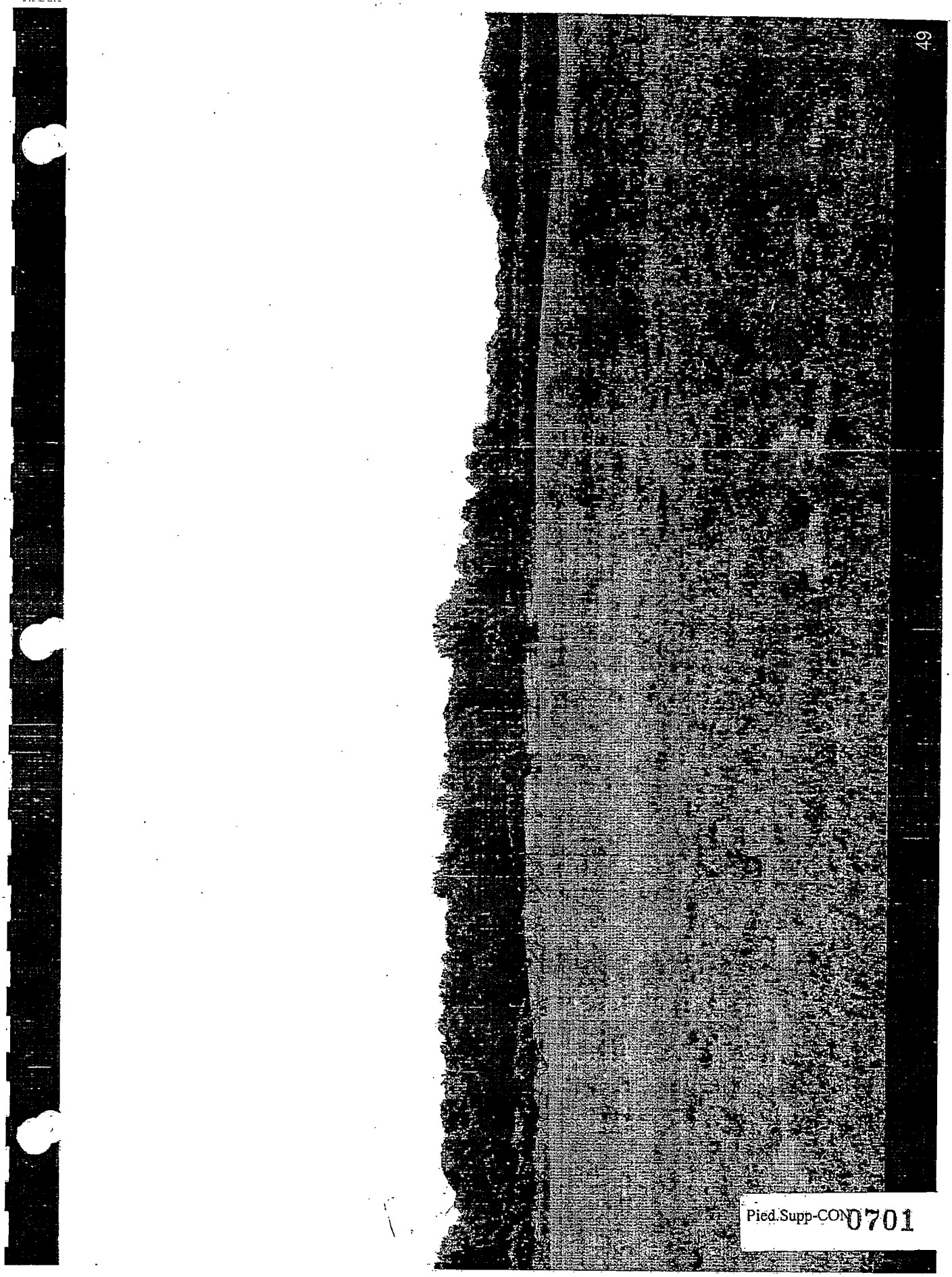


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FORT MILL
Springleaf Dr
Peach Land
Pied.Supp-CON
0699



Pied.Supp-CON 0700


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Pied.Supp-CON 0701

Pled.Supp-CON 0702

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Pled.Supp-CON 0703

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Pled.Supp-CON 704

RECORD 002847

JOINT-B-PMC-001.0742

Pled.Supp-COS 706

54

Awards & Distinctions

- 2010 SC Distinguished Hospital of the Year (DHEC/AHA)
  - For significant quality contributions for patients with cardiovascular disease & stroke
- Joint Commission Accreditation for Stroke
- Joint Commission Accreditation for Heart Failure
- Blue Distinction Center for Spine Surgery and Cardiac Care
- Gold Performance Award for Heart Failure (AHA)
- Silver Performance Award for Coronary Artery Disease (AHA)
- Designated as a United Premium Specialty Center

Pied.Supp-CON 0707

RECORD 002849

JOINT-B-PMC-001.0744

Our Physicians

- 283 Specialists
  - York County: among highest concentration of specialists per capita in SC*
- 90 Primary Care Physicians
- Trained at top medical schools
  - Harvard, Duke, Cleveland Clinic, UVA, Emory

*...for Disease Control & Prevention, 2006

Pied Supp-CON 0708

RECORD 002850

JOINT-B-PMC-001.0745

Quality Comparison

Overall Core Measure Scores*

	Piedmont	CMC	Presbyterian
Heart Attack Care	99%	98%	100%
Heart Failure Care	97%	96%	99%
Pneumonia Care	96%	94%	99%
Surgical Care Improvement Project	94%	97%	99%

Joint Commission Quality Check, January-December 2009

RECORD 002851
Pied.Supp-CON 0703
JOINT-B-PMC-001.0746

CMC-FM's View of Mortality Data

We Are Most Qualified

qualifications

- As you consider your options, we encourage you to focus on the most important (data-driven) clinical outcome measures

National Hospital Mortality Rankings
Performance Levels as of May 2010

	Better Than	No Different	Worse Than
Heart Attack	95	2,744	45 PMC
Heart Failure	199	3,801	140 PMC
Pneumonia	222	3,988	221 PMC

Carolinas HealthCare System
Uncompromising Excellence. Commitment to Care.

RECORD 002852
JOINT-B-PMC-001.0747
Pied.Supp-CON 0710

Piedmont Medical Center Mortality Rates

HEALTHGRADES

SCHA South Carolina Hospital Association

Heart Attack

In Hosp.	As Expected	Better than Expected
1 Mo. After Hosp.	As Expected	N/A
6 Mos. After Hosp.	As Expected	N/A

Heart Failure

In Hosp.	As Expected	As Expected
6 Mos. After Hosp.	As Expected	N/A

Pneumonia

In Hosp.	As Expected	Better than Expected
1 Mo. After Hosp.	As Expected	N/A
6 Mos. After Hosp.	As Expected	N/A

RECORD 002853

JOINT-B-PMC-001.0748

Pied.Supp-CON 0711

Differing Statistical Assumptions and Models Produce Different Results

- Medicare reports deaths from ANY CAUSE within 30 DAYS of Admission.
- HealthGrades reports in-hospital and post-discharge deaths separately.
- SCHA reports only in-hospital deaths.
- HealthGrades excludes patients where death is expected. MEDICARE DOES NOT.

Plaintiff-CO 0712

RECORD 002854

JOINT-B-PMC-001.0749

Quality Comparison

HealthGrades
Hospital Survival/Complications*

	Worse than Expected	Expected	Better than Expected
Piedmont Medical Center	4 Categories	22 Categories	0 Categories
Carolinas Medical Center	11 Categories	13 Categories	2 Categories
Presbyterian Hospital	4 Categories	21 Categories	1 Category

*althGrades: 2007-2009 data (www.healthgrades.com)

RECORD 002855
Pied.Supp-CON 0713
JOINT-B-PMC-001.0750

Quality Comparison

HealthGrades
Hospital Survival/Complications*

Worse than

Piedmon

Carolina

Presbyte

thGrades: 200

	Worse than Expected
Piedmont Medical Center	4 Categories
Carolinas Medical Center	11 Categories
Presbyterian Hospital	4 Categories

Pied.Supp-CON 0214

RECORD 002856

JOINT-B-PMC-001.0751

Quality Comparison

HealthGrades® Rates Hospitals on Cardiac Care by Mortality Rates

Category	Piedmont Medical Center	CMC-Main	Presbyterian
Heart Attack Survival in Hospital	★★★	★	★★★
Coronary Angioplasty/ Stents Survival in Hospital	★	★	★★★
Heart Valve Replacement Survival in Hospital	★★★	★★★	★

lthGrades: 2007-2009 data (www.healthgrades.com)

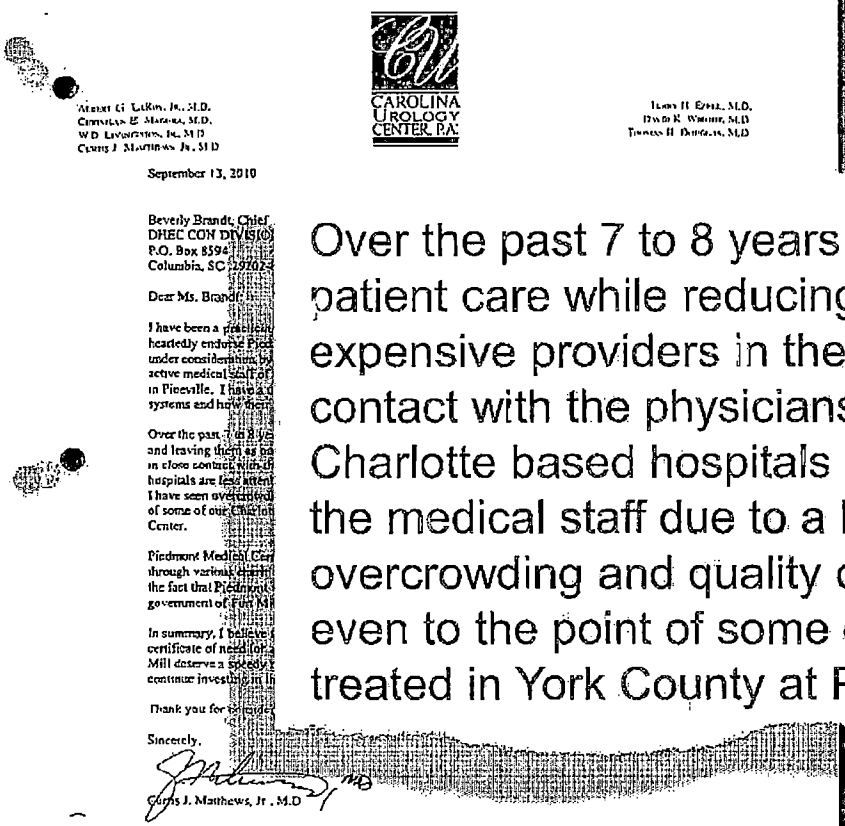
Pied.Supp-CON 0715

RECORD 002857

JOINT-B-PMC-001.0752

Curtis J. Matthews, Jr., MD

Urologist



CAROLINA UROLOGY CENTER, P.A.

September 13, 2010

Beverly Brandt, Chief
DHEC CON DIVISION
P.O. Box 8594
Columbia, SC 29202

Dear Ms. Brandt:

I have been a practicing urologist in Rock Hill for 8 years. I have headedly endorse Piedmont Medical Center's application that is currently under consideration by the DHEC CON Division. I have had the opportunity to be active medical staff of Piedmont Medical Center in Rock Hill and Carolina Pavilion in Pineville. I have a unique perspective on the relative merits of the two systems and how they function.

Over the past 7 to 8 years I have seen a commitment to quality patient care while reducing cost and leaving them as one of the least expensive providers in the area. Their administrative staff is in close contact with the physicians in facilitating quality care. In contrast, the Charlotte based hospitals are less attentive and effective in assisting the medical staff due to a larger bureaucracy. I have seen overcrowding and quality concerns at the Charlotte based hospitals even to the point of some of our Charlotte patients choosing to be treated in York County at Piedmont Medical Center.

Piedmont Medical Center has been a valuable asset to the community through various charitable endeavors. I am also aware of the fact that Piedmont Medical Center is a non-profit hospital and not a government or for profit hospital.

In summary, I believe that Piedmont Medical Center should receive a certificate of need for a new hospital in Rock Hill. Piedmont Medical Center Mill deserve a speedy approval of their application. I look forward to continue investing in the Rock Hill community.

Thank you for your consideration.

Sincerely,

Curtis J. Matthews, Jr., M.D.

1780 Medical Park Drive • Rock Hill, South Carolina • 29732 • 803-327-1116 • Fax 803-327-6872
500 Kingsley Park Drive • Suite 150 • Fort Mill, South Carolina • 29715 • 803-578-7600 • Fax 704-543-7894
1977 W. Meeting St • Lancaster, South Carolina • 29720 • 803-285-1337

Pied.MD.LTR.0025

Pied.Supp-COM 0716

Pied.MD.Ltr.00025

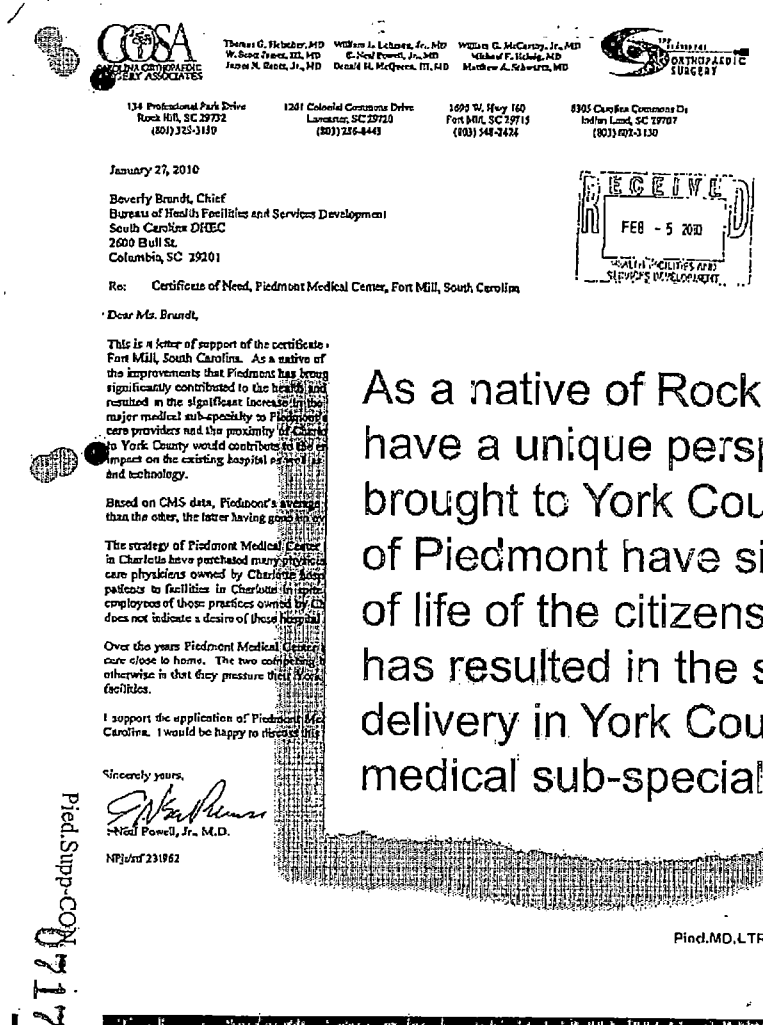
64

RECORD 002858

JOINT-B-PMC-001.0753

E. Neal Powell, Jr., MD

Orthopaedic Surgery



CCSA Carolina Orthopaedic Specialty Associates

Thomas G. Fleischer, MD · William L. Lehnen, Jr., MD · William G. McCarthy, Jr., MD
W. Scott Rees, III, MD · E. Neal Powell, Jr., MD · Michael F. Hidalgo, MD
James N. Rees, Jr., MD · Donald H. McGeorge, III, MD · Matthew A. Schwartz, MD

The Piedmont Orthopaedic Surgery

134 Professional Park Drive, Rock Hill, SC 29732, (803) 325-3150
1201 Colonial Commons Drive, Lancaster, SC 29720, (803) 286-8443
1695 W. Hwy 160, Fort Mill, SC 29715, (803) 548-2424
8305 Carolina Commons Dr, Indian Land, SC 29707, (803) 802-3150

January 27, 2010

RECEIVED
FEB - 5 2010
HEALTH FACILITIES AND SERVICES DEVELOPMENT

Beverly Brandt, Chief
Bureau of Health Facilities and Services Development
South Carolina DHEC
2600 Bull St.
Columbia, SC 29201

Re: Certificate of Need, Piedmont Medical Center, Fort Mill, South Carolina

Dear Ms. Brandt,

This is a letter of support of the certificate
Fort Mill, South Carolina. As a native of
the improvements that Piedmont has brou
significantly contributed to the health and
resulted in the significant increase in the
major medical sub-specialty to Piedmont's
care providers and the proximity of Charlo
to York County would contribute to the e
impact on the existing hospital patient ac
and technology.

Based on CMS data, Piedmont's average
than the other, the latter having gone to ov

The strategy of Piedmont Medical Center
in Charlotte have purchased many physicia
care physicians owned by Charlotte Hosp
patients to facilities in Charlotte in spite
employees of those practices owned by C
does not indicate a desire of those hospital

Over the years Piedmont Medical Center
care close to home. The two companies
otherwise in that they pressure their
facilities.

I support the application of Piedmont Me
Carolina. I would be happy to discuss this

Sincerely yours,

E. Neal Powell, Jr., M.D.

NPj/mf 231962

Pied.MD.LTR.0033

As a native of Rock Hill and a practicing Physician at Piedmont, I have a unique perspective of the improvements that Piedmont has brought to York County. It is clear that the upgrades and investment of Piedmont have significantly contributed to the health and quality of life of the citizens of York County. The investment by Piedmont has resulted in the significant increase in the quality of health care delivery in York County and the addition of nearly every major medical sub-specialty to Piedmont's medical staff.

Pied.Supp-CON 217

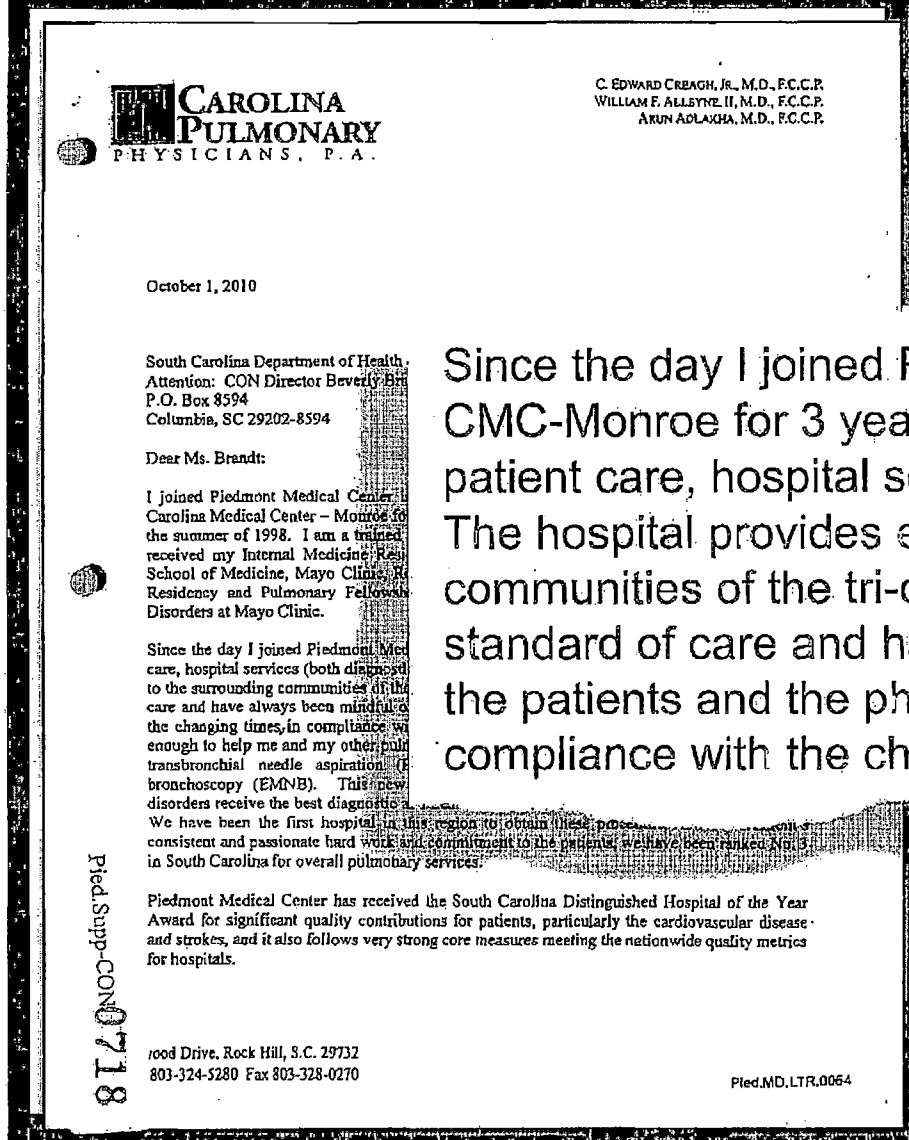
Pied.MD.Ltr.00033

RECORD 002859

JOINT-B-PMC-001.0754

Arun Adlakha, MD

Pulmonologist



CAROLINA PULMONARY PHYSICIANS, P.A.

C. EDWARD CREAGH, JR., M.D., F.C.C.P.
WILLIAM F. ALLSYNE, II, M.D., F.C.C.P.
ARUN ADLAKHA, M.D., F.C.C.P.

October 1, 2010

South Carolina Department of Health
Attention: CON Director Beverly Br
P.O. Box 8594
Columbia, SC 29202-8594

Dear Ms. Brandt:

I joined Piedmont Medical Center
Carolina Medical Center – Monroe fo
the summer of 1998. I am a trained
received my Internal Medicine Res
School of Medicine, Mayo Clinic, R
Residency and Pulmonary Fellowsh
Disorders at Mayo Clinic.

Since the day I joined Piedmont Me
care, hospital services (both diagnost
to the surrounding communities of th
care and have always been mindful o
the changing times, in compliance w
enough to help me and my other pati
transbronchial needle aspiration (E
bronchoscopy (EMNB). This new
disorders receive the best diagnostic
We have been the first hospital in this region to obtain these proce
consistent and passionate hard work and commitment to the patients, we have been ranked No. 1
in South Carolina for overall pulmonary services.

Piedmont Medical Center has received the South Carolina Distinguished Hospital of the Year Award for significant quality contributions for patients, particularly the cardiovascular disease and strokes, and it also follows very strong core measures meeting the nationwide quality metrics for hospitals.

Pied.Supp-CON-0718

wood Drive, Rock Hill, S.C. 29732
803-324-5280 Fax 803-328-0270

Pied.MD.LTR.0064

Since the day I joined Piedmont Medical Center [after working at CMC-Monroe for 3 years], I have been highly impressed by their patient care, hospital services (both diagnostic and therapeutic). The hospital provides excellent service to the surrounding communities of the tri-county. They have maintained a very high standard of care and have always been mindful of the needs of the patients and the physicians according to the changing times in compliance with the changing disease understandings.

RECORD 002860

JOINT-B-PMC-001.0755

John C. Hoitink, MD

Internal Medicine

02/02/2010 14:07 9803667235 CAROLINA MED CONSULT PAGE 01/01

Carolina Medical Consultants

311 Glenwood Drive • Rock Hill, SC 29732
803-366-7175 • Fax 803-366-0529

Tracy N. Timony, M.D.
Rhea Hsu, M.D.
Matthew David Jenkins, M.D.
John C. Hoitink, M.D.
Debra J. Gazzuola, M.D.
Randolph V. Villamor, M.D.

January 29, 2010

Beverly Brandt, Chief
Bureau of Health Facilities and Services Development
South Carolina DHEC
2600 Bull Street
Columbia, SC 29201

Dear Ms. Brandt,

I was asked to write a letter regarding the pro
Medical Center in Fort Mill, SC.
I am a physician on active staff at Piedmont M
current board member of the governing body.
In my 12 years here working with the nurses a
examples of people going the extra mile to pr
at Piedmont Medical Center. The hard work,
delivered at this hospital are to be commende
try and make this the best hospital that it can
From the patient perspective, my family has
care at Piedmont Medical Center. I have hu
Medical Center and my wife has delivered bo
They both spent time in the special care unit a
had outpatient surgery at Piedmont Medical C
experiences from a patient perspective. I have
everyone that I have encountered caring for m
into account as you make a fair and speedy de
best provides for the future health care needs
populations.

Sincerely,

John C. Hoitink MD

Dr. John C. Hoitink

JCH:kw

Pied.MD.LTR.0064

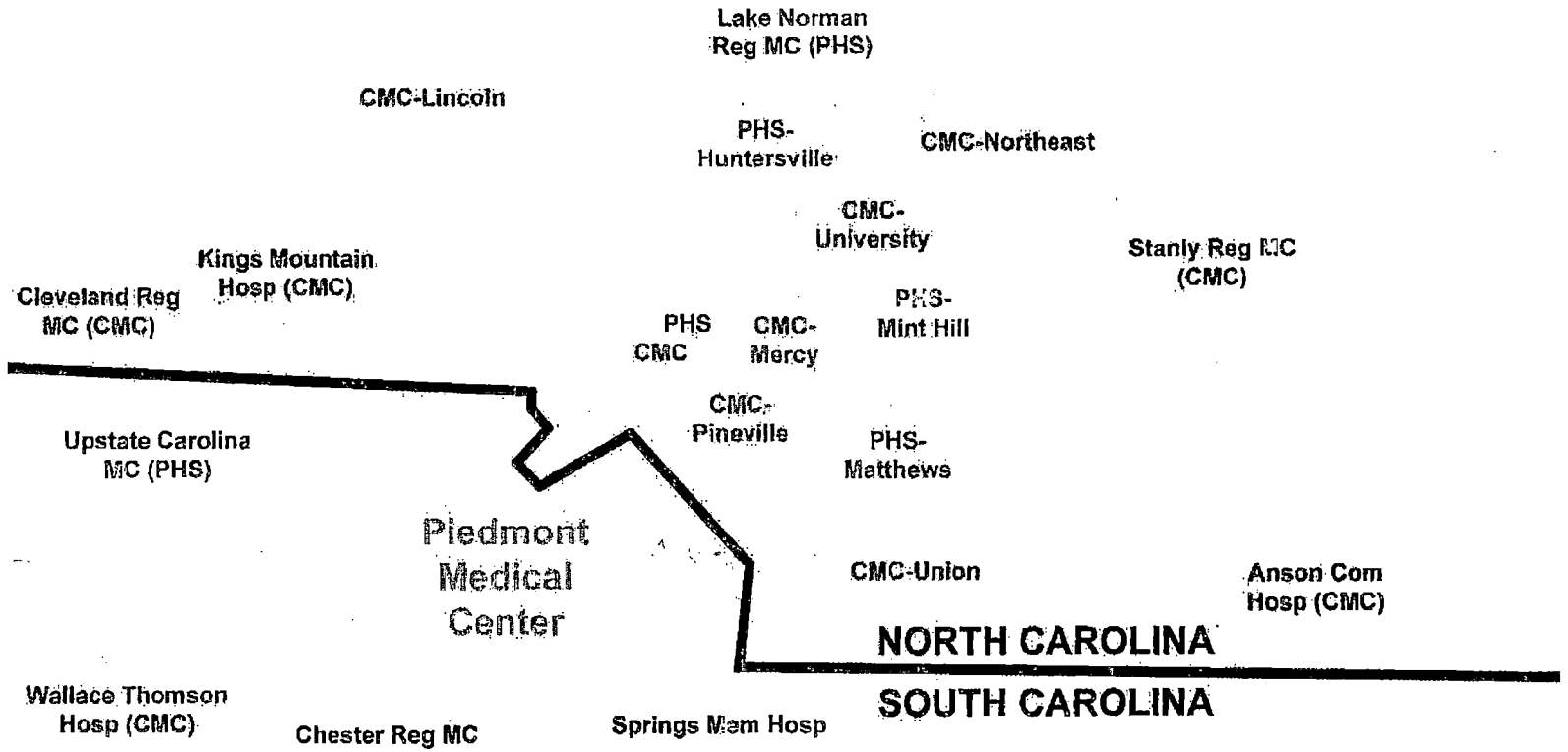
In my 12 years here working with the nurses and physicians I have seen countless examples of people going the extra mile to provide the best care they can for the patients at Piedmont Medical Center. The hard work, outstanding compassion and excellent care delivered at this hospital are to be commended. I have personally worked with the staff to try and make this the best hospital that it can be.

RECORD 002861

Pied.Supp-CON 0719

JOINT-B-PMC-001.0756

Acute Care Hospitals in the C rlotte and Surrounding Areas



Carolinas Health System
Presbyterian Healthcare System
Piedmont Medical Center
Other Hospitals

Pied.Supp-CON 0720

RECORD 002862

JOINT-B-PMC-001.0757

Amisub of South Carolina d/b/a Fort Mill Medical Center

Additional Information
Submitted July 11, 2011

(6)

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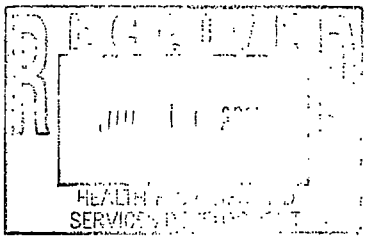
COMPARATIVE REVIEW OF THE COMPETING CERTIFICATE OF NEED PROPOSALS TO BUILD A HOSPITAL IN FORT MILL

SUBMITTED BY:
PIEDMONT MEDICAL CENTER

JULY 11, 2011

LEVITT

healthcare
affiliates



July 11, 2011

Beverly Brandt
Bureau of Health Facilities and Services Development
Division of Planning and Certificate of Need
South Carolina Department of Health and Environmental Control
2600 Bull Street
Columbia, SC 29201-1708

Re: Amisub of South Carolina, Inc. d/b/a Fort Mill Medical Center
As Per December 9, 2009 Order from Judge Matthews, Administrative Law Court
Fort Mill, South Carolina

Dear Ms. Brandt,

Attached is a report that provides additional clarification and information in support of the proposed Fort Mill Medical Center CON application, and responds to issues raised by the competing applicants. This information is being submitted in order to further delineate Piedmont Medical Center's demonstrated need for the above referenced project. The information contained within this letter serves to reiterate and supplement the material previously provided.

Thank you in advance for your consideration of this information. If you have any additional questions, please do not hesitate to contact me at 404.315.9011.

Sincerely,

David S. Levitt
Managing Partner

cc: Charles Miller, President/CEO



1778 Emory Ridge Drive, Atlanta, GA 30329
(p) 404.315.9011 (f) 404.315.1071

cell 404.964.2658
david.levitt@comcast.net

9 River Place, Beaufort, SC 29906
(p) 843.379.9372 (f) 843.379.9373

COMPARATIVE REVIEW OF THE COMPETING CON PROPOSALS TO BUILD A HOSPITAL IN FORT MILL

Submitted By

Piedmont Medical Center

July 11, 2011

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COMPARATIVE REVIEW OF THE COMPETING CON PROPOSALS TO BUILD A HOSPITAL IN FORT MILL

BACKGROUND: YORK COUNTY OUTMIGRATION

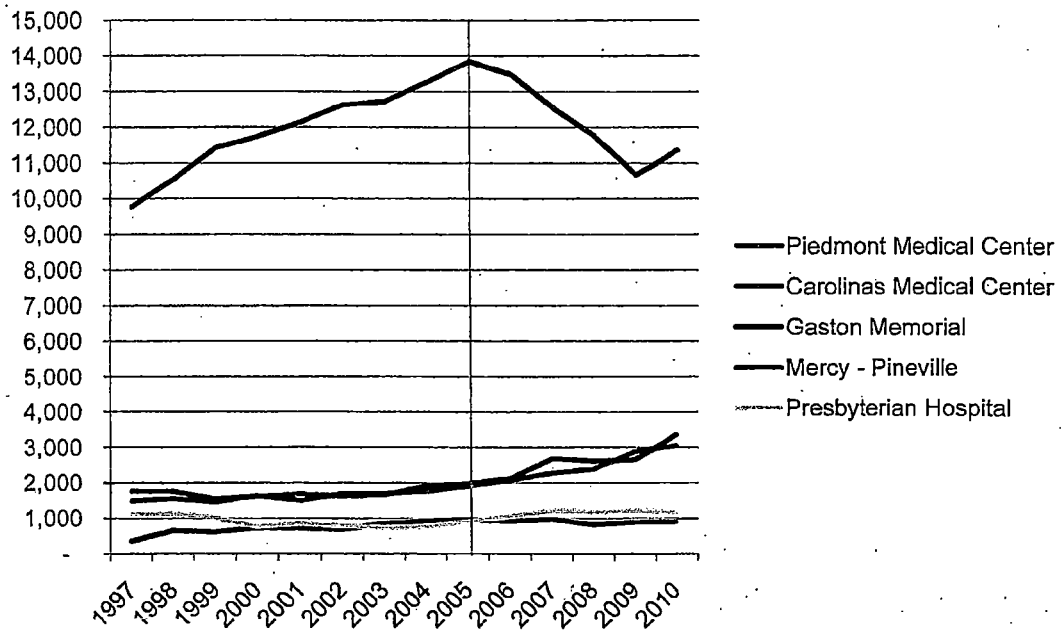
In November 2004, Piedmont Medical Center filed an application to build a hospital in Fort Mill. The filing was the culmination of a plan Piedmont began to develop in 1998 with the support of community leaders and physicians to provide medical services to residents of the Fort Mill-Tega Cay communities in northeastern York County and to stem the historical pattern of outmigration to Charlotte-area facilities.

The period between 1998 and 2004 was marked by consistent growth in Piedmont's York County utilization, increasing from 10,531 discharges in 1998 to 13,259 in 2004, an average increase of over three percent annually for a total increase of 26 percent.

In 2005, CHS and Presbyterian filed competing applications. One of the first things they did was to acquire physician practices in York County. It was not long afterwards that well-established referral patterns began to change. Patients of physicians employed by CHS and Presbyterian who had been treated at Piedmont began to be directed to Charlotte-area providers. The graph in Figure 1 shows the unmistakable change.

Figure 1

York County Inpatient Discharges Before and After the Filing of the Fort Mill CON Applications



Source: NC and SC state discharge Databases
*Includes 29704, 29708, 29710, 29715, 29717,29726,29730, 29732, 29742, 29743, 29745 and 29707
*1997-2003 does not include 29707 zip code
Excludes normal newborns and psych

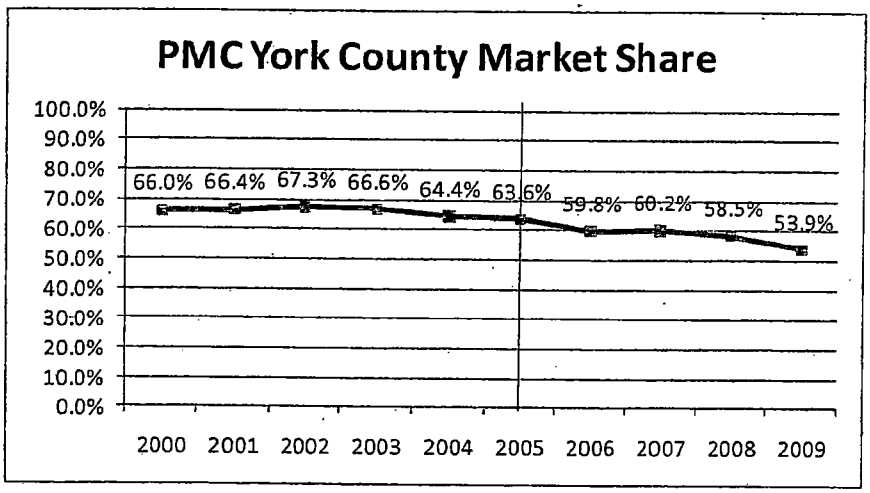
The effect on Piedmont's discharges since 2005 is no mere coincidence. It is the direct product of a calculated strategy of CHS and Presbyterian to attempt to affect the outcome of this CON process by buying marketshare through the acquisition of York County physician practices.

A. Piedmont's Declining Marketshare After 2005

Piedmont's marketshare for York County patients declined from 2005 to 2009, after the competitive CON applications were submitted. The figure below presents information that was

provided in the Presbyterian project review presentation, correcting the scale in the axis to accurately reflect the actual experience over time.

Figure 2



Source: PHY project review presentation

During the period from 2005 to 2010, only two facilities, CMC and CMC-Mercy (which includes data for CMC-Pineville) experienced an increase of more than 100 patients from York County. If residents of York County were truly dissatisfied with Piedmont, utilization at all accessible hospitals would show an increase over the period.

The following table gives the Department the clearest information it has been provided to date concerning changes in volume of inpatient discharges to York County residents from 2005 to 2010.

Figure 3

York County Inpatient Discharges

	2005	2010	Variance
Piedmont Medical Center	13,137	10,937	(2,200)
Carolinas Medical Center	1,888	2,790	902
Mercy Hospital (incls. Pineville)	1,973	2,910	937
Presbyterian Hospital	911	992	81
Presb Orthopaedic Hosp	229	206	(23)
Other North Carolina Hospitals	1,515	1,515	0
Other South Carolina Hospital	691	849	158
TOTAL	**20,344**	**20,199**	(145)

Source: Market Expert, NC and SC State Databases combined

This table shows that Piedmont's York County inpatient discharges dropped by 2,200 discharges from 2005 to 2010. During this same period, York County discharges from CMC, Mercy, and Pineville increased by 1,839 discharges and from Presbyterian and Presbyterian Orthopaedic a combined 58 discharges.

B. Changes in Referral Patterns

Until the filing of their CON applications, CHS and Presbyterian exerted little direct influence on the choice of medical provider made by York County residents. Prior to September 2005, Presbyterian owned none of the practices in York County it currently operates. Within a year of filing its application, it had purchased eight. *See* PHS Response to Amisub 2RFP 000523. CHS, which owned four York County practices before filing its CON application, bought two additional physician groups within weeks of filing its application. *See* CHS 01383.

The primary reason for these purchases was to shift marketshare from Piedmont in an attempt to affect the outcome of the CON process. To achieve that objective, the referral patterns of physicians employed by CHS and Presbyterian had to change. For years, these

physicians had been productive members of the Piedmont medical staff. They admitted their patients to Piedmont, referred patients to other members of the staff, and were active members of medical staff committees. Some even served as the chiefs of staff and on the hospital board.

The unequivocal denials by CHS and Presbyterian representatives at project review of this practice are disingenuous. While virtually every employed physician contract recognizes the principle that referrals should be subject to physician and patient choice, there are countless means by which corporate practice managers can lawfully convey expectations that employed physicians and their staffs should keep referrals within the corporate family of providers.

This is how it typically happens: physician practice managers for each system collect data to monitor referral patterns of employed physicians and the physician-office staffs. They track patient referrals to make sure they are being made to affiliated providers – surgeons and physician specialists, labs, imaging centers, and hospitals, etc., owned by or affiliated with the healthcare system.

When soliciting support in 2005 from independent specialists to whom the employed primary care physicians had made referrals over the years, Presbyterian officials gave assurances that this standard means of keeping referrals within the company would not be applied. Instead, specialists, several of whom are identified below, were assured that the employed primary care physicians would continue to make referrals to them and, in turn, they would be able to continue to treat patients in York County and admit them to Piedmont. As a result of these communications, a number of independent York County physicians wrote letters of support for Presbyterian.

Five years later, many of these same specialists who supported Presbyterian changed their positions and have submitted letters in 2010 in support of Piedmont. The following is a

statement from the late Thomas G. Fleischer, M.D., an independent orthopaedic surgeon who had been on the Piedmont medical staff since 1983, describes what occurred:

> **During the first CON process, I specifically submitted a letter of support for Presbyterian Hospital after meeting with their CEO, at the meeting he presented their plan to support York County's residents and medical staff ensuring patients would not be directed out of York County.**
>
> **The past few years have shown that not only Presbyterian but also Carolinas Medical, by their actions, have proven they do not support York County practitioners to refer patients to physicians who practice in their network facilities. Their employees as well as the physicians and their families who work and live in the county must be routed to Mecklenburg County for surgery and most diagnostic testing or face high deductibles and out-of-network benefits.**

Pied.MD.LTR.0021.[1]

The concerns expressed by the physicians who changed their support to Piedmont are consistent with observations of other York County physicians who also witnessed first-hand since 2005 the referral practices of CHS and Presbyterian-employed physician networks. Orthopaedic surgeon Neal Powell, M.D., reports of the pressure on employed primary care doctors:

> **Our own patients who also are treated by those primary care physicians owned by Charlotte hospitals have indicated to us the pressure placed on those physicians to refer their patients to facilities in Charlotte in spite of those hospital systems indicating their support for York County.**

Pied.MD.LTR.0033.

[1] The other physicians who submitted letters of support in 2005 for Presbyterian or CHS and switched their support to Piedmont in 2010 because of concerns, among other things, about adverse impact and patient steerage to Charlotte-area providers include the following: York County Medical Society president Sushil R. Singhi (Pied.MD.LTR.0028-29); former York County Medical Society president R. Norman Taylor, III, M.D. (Pied.MD.LTR.0044); Jay K. Shah, M.D. (Pied.MD.LTR.0068); Joe C. Robinson, M.D. (Pied.MD.LTR.0065-66); and Harry E. Hicklin, III, M.D. (Pied.MD.LTR.0075-76). John C. Hoitink, M.D. changed his support to Piedmont on other grounds without addressing adverse impact.

Similarly, Robert E. Thomas, M.D., a pathologist on Piedmont's Medical staff observes the change in referral patterns over the past five years:

> **Since the competing companies began the campaign for this hospital five years ago, they have both bought primary care and specialty practices in York County, which has resulted in change of referral patterns to their out-of-state hospitals and laboratories.**

Pied.MD.LTR.0019-20.

In the enclosed CD, York County Medical Society president Sushil R. Singhi, M.D. and Robert E. Thomas, M.D. provide personal statements that describe the changes in referral patterns that have occurred since the filing of the 2005 CON applications and the disruptive effect they have had on the continuity of care for York County patients. Exh. A; *also see* Exh. B for a transcript of the statements and Exh. B-1 for related correspondence.

C. Piedmont Plans to Recapture Lost Marketshare

Some residents of York County will always look to Charlotte for goods and services. That is the nature of living and working within close proximity of a major urban area. Piedmont does not expect to change that fact completely by being awarded the CON. It can, however, reduce the extent of the outmigration. Through the location of a hospital and medical services in the Fort Mill-Tega Cay area, Piedmont and FMMC together can achieve a combined York County marketshare at a level consistent with what Piedmont experienced from 1998 to 2005.

In order to restore its marketshare, Piedmont recognizes that it will take more than adding a hospital alone in Fort Mill. It will need to continue to invest in the development of a physician network in York County to compete with those established by CHS and Presbyterian. Since 2005, it has done just that, recruiting 24 new physicians to York County, 15 of which

were recruited to practice in Rock Hill, 7 in Fort Mill-Tega Cay, and 2 in York. Of this group, 19 are currently in practice or are under contract to begin practice later this year. Piedmont intends to maintain for the foreseeable future the pace of recruitment it has established since 2005, recruiting at least 4 physicians per year, many of which will practice in the Fort Mill-Tega Cay area.

Piedmont's physician practices in York County are listed below:

- Piedmont Family Practice at Tega Cay (Fort Mill)
- Piedmont Internal Medicine (Fort Mill)
- Piedmont UCC at Baxter Village (Fort Mill)
- Piedmont UCC at Rock Hill
- Piedmont Family Practice at Rock Hill
- Piedmont Behavioral Medicine (Rock Hill)
- Catawba Cardiothoracic Surgery (Rock Hill)
- Piedmont Internal Medicine and Family Practice (York)

By locating the hospital in Fort Mill and continuing to expand its network of physician services, FMMC would improve accessibility for residents of northern York County while enabling Piedmont to continue to perform as an advanced medical center that can meet the future healthcare needs of the residents of all of York County.

COMPARATIVE REVIEW

The CON Act requires DHEC to award a competitive CON to the applicant that most fully complies with the requirements, goals, and purposes of the CON Act, the applicable State Health Plan, and the regulatory criteria. S.C. Code Ann. § 44-7-210(C).

I. The Regulatory Criteria

A. Adverse Impact (§ 802.23)

1. Concerns of Independent Physicians

Of the 59 letters of support for the three applicants submitted by physicians practicing in York County who are not employed by an applicant or applicant affiliate, 45 physicians support Piedmont. *See* PMC Project Review Slide 3. This large discrepancy in the views of independent York County physicians should give the Department pause.

Three out of every four independent physicians who have expressed an interest in the outcome of this process favor Piedmont. While they support Piedmont because of its quality and its commitment to York County, many of these physicians express concern about the adverse effect on the healthcare system in York County that approval of either CHS or Presbyterian would cause. These doctors understand that the effect of approving either North Carolina applicant would be to substantially diminish Piedmont, weakening its capacity to:

- Meet the future medical needs of the residents of York County.
- Invest in state-of-the-art technology to continue to recruit first-class physicians.
- Maintain outreach programs for medically underserved communities.
- Compete effectively with the two large, aggressive healthcare systems in Charlotte whose employed physicians are increasingly referring patients to their employers' North Carolina facilities.

The following excerpt from a sample of these letters expresses the concerns about adverse impact conveyed by two-thirds of the independent physicians supporting Piedmont:

E. Neal Powell, Jr., MD, orthopaedic surgeon – Pied.MD.LTR.0033

- **As a native of Rock Hill and a practicing Physician at Piedmont, I have a unique perspective of the improvements that Piedmont has brought to York County. It is clear that the upgrades and investment of Piedmont have significantly contributed to the health and quality of life of the citizens of York County. The investment in Piedmont has resulted in the significant increase in the quality of healthcare delivery in York County and the addition of nearly every major medical sub-specialty to Piedmont's medical staff. The residents of York County have always had a choice of healthcare providers and the proximity of Charlotte allows them choices now. To allow the migration of Charlotte based hospitals to York County would contribute to the erosion of overall healthcare delivery in York County. There would be an adverse impact on the existing hospital as well as the ability for Piedmont to maintain their high level of investments in the facility and technology.**

See PMC Slides 4-7 for examples of other physician statements concerning the threat of adverse impact. *Also see* http://www.charlotteobserver.com/2011/07/10/2442901/the-battle-to-build.html, Bill Brandon, who is the Metrolina Medical Foundation Distinguished Professor of Public Policy at UNC Charlotte and serves on the faculty of the University's MHA program, was quoted in a July 10, 2011 *Charlotte Observer* article on this CON review, recognizing that the award of a Fort Mill hospital to either Presbyterian or CHS "gets the patients there that can then be referred to Presbyterian or CMC."

2. Projected Effects of Loss of Patient Volume and Revenue

Piedmont projects that it will lose over 3,500 cases and some $13.8 million in net revenue by the third year of operation of a Fort Mill facility owned by either CHS or Presbyterian. *See* PMC Slides 9 and 12. The reduction in patient volume represents a decline of 29 percent in Piedmont's marketshare in its primary and secondary service areas, which would be a reduction of 27 percent in projected utilization.

a. The Long-Term Effects of the Adverse Impact on Piedmont

As Piedmont experiences the loss of patients, it will have no choice but to reduce costs to offset the loss in revenue due to the decline in utilization of hospital services. The cost reduction would take the form initially of the reduction or elimination of jobs and services. Over time, it would limit Piedmont's ability to continue to invest in new technology, upgrade its facilities, and establish new services. These constraints in turn would impede Piedmont's ability to recruit physicians to or retain physicians in York County, which would diminish competition in York County, not strengthen it. York County physicians know exactly what to expect:

Bruce A. Leonard, MD, radiologist – Pied.MD.LTR.0058

- **There are presently three hospital systems that compete in this market. Awarding this new hospital to either North Carolina entity will remove the third competitor. Piedmont Medical Center will not be able to survive in the long term without the Fort Mill facility, leaving only CHS and Novant.**

Robert E. Thomas, MD, pathologist – Pied.MD.LTR.0078

- **Awarding the CON to CMC or Presbyterian will only weaken PMC and actually erode the current competitive environment. As you know, CMC already owns eleven facilities in the Charlotte area, and Presbyterian owns four. Awarding one of them the CON will be detrimental to competition, it will not promote it.**

The long-term disadvantage to which Piedmont would be put not only would drive even more York County patients to the new Fort Mill-area hospital, but would increase outmigration for tertiary and other specialty services to the Charlotte-area hospitals who historically would have been treated at Piedmont. Outmigration for such high-end services would reduce the volume of Piedmont's open heart surgery program and particularly weaken its effectiveness.

b. **Reduction and Elimination of Services**

After removing from consideration for potential cuts services that are required under the County Contract, Piedmont would have little choice but to search for ways to further reduce costs to offset losses in revenue. With the reductions in incremental costs it has already made since 2005, substantial losses in patient volume and revenue would jeopardize the following programs:

1. Stroke Program
2. In-house Neonatologists
3. Infusion Center
4. Wound Care Center and Hyperbaric Chamber

PMC Slide 15.

With the reduction in demand for services in the Operating and Emergency Departments, Piedmont would have to reduce the number of operating rooms and ED bays it staffs and would lay off a corresponding number of personnel as well.

The adverse consequences of the approval of either CHS or Presbyterian would extend not only to Piedmont, but to residents throughout York County. As a result of Piedmont's weakened tertiary services, reduced utilization of core services, compromised ability to invest and grow, and diminished capacity to compete for the recruitment of physicians and patients alike, the people of York County would be negatively impacted. Their valuable resource, protected by the County Contract, would be at risk of reverting back to the community hospital it was prior to the significant strides Piedmont has made since the mid-1990s after establishing advanced services for open heart surgery, cardiac catheterization, and neurosurgery. If this were to occur, as independent York County physicians widely predict,

York County residents would become dependent on North Carolina-based hospitals for their advanced healthcare needs.

c. FMMC Will Not Adversely Affect Piedmont

FMMC will not adversely impact Piedmont because both hospitals collectively will be serving the residents of York County. Even though Piedmont may see a decrease in patients as a result of FMMC, Piedmont has also transferred beds to FMMC for the specific purpose of serving patients who have historically been cared for at Piedmont. FMMC will allow Piedmont to recapture some of those patients who are leaving the state for care and shift some of the patients currently receiving care at Piedmont to FMMC. Those patients who are shifted from Piedmont will help fill the 36 beds from Piedmont. The result is simply a redistribution of beds within the County to better serve service-area residents. The projected utilization at Piedmont in 2015, 2016, and 2017, including the tertiary level services, is summarized in the table below.

***Revised* Figure 25**
Piedmont Medical Center
Projected Utilization

	Year 1 2015	Year 2 2016	Year 3 2017
Total Discharges	12,875	13,038	13,059
LOS	4.3	4.3	4.3
Total Patient Days	55,519	56,141	56,089
ADC	152.1	153.8	153.7
Beds	232	232	232
Occupancy	**65.6%**	**66.3%**	**66.2%**

Source: Claritas, SC State Budget and Control Board, Office of Research and S

The utilization at Piedmont is based upon actual historical utilization and assumes that patients will seek services at Piedmont from outside of the proposed FMMC service area, consistent with historical experience.

CHS contends that Piedmont's projected adverse impact is overstated and that many other Tenet-owned facilities are located in areas that have multiple competitors and are not adversely impacted. Piedmont's analysis projects the impact that the reduced cases would have on Piedmont's financial performance compared to potential performance without a North Carolina provider in Fort Mill. The volume of patients redirected from Piedmont to the new facility would be substantial. The analysis compares where Piedmont would be in the future without a North Carolina provider versus its projected performance with a North Carolina provider. It was based on 2009 marketshare and Piedmont financial experience.

Piedmont currently operates in a highly competitive market. There are currently 12 hospitals within a 30-mile radius and 20 hospitals within a 50-mile radius of Piedmont. The contention of CHS and Presbyterian that Piedmont does not currently have competition is false. In fact, one of CHS's own facilities, CMC-Pineville, is less than 30 minutes driving time. The fact that other facilities operate in markets with more than one provider is irrelevant and unrelated to any projected adverse impact of a new provider in close proximity to Piedmont.

B. Distribution (§ 802.22)

Criterion 22 requires DHEC to "carefully" consider "the effect of the proposed project" upon "existing distribution." Approval of either CHS or Presbyterian would result in an annual cost to Piedmont's net revenue of over $13 million, which would have a material adverse effect on Piedmont's distribution of services throughout York County, as discussed above.

C. Accessibility (§ 802.3)

1. Accessibility and Adverse Impact

Regulation 61-15 § 802.3, ("Accessibility") contains eight subparts (a-h). In its 2005 review, DHEC listed only the first seven subparts (a-g) of § 802.3 as priority criteria, omitting – perhaps inadvertently – § 802.3(h), which provides: "Potential negative impact of the proposed project upon the ability and/or resources of existing providers to serve medically underserved groups ***must*** be considered." (Emphasis added). Given the State Health Plan requirement that adverse impact and accessibility must be "equally weighted," *see* Exh. H, as well as the language of § 802.3(h) ("must be considered"), DHEC should include this subpart as a priority criterion. If either CHS or Presbyterian are approved, Piedmont will suffer an annual loss of some 3,500 inpatients and over $13 million in net revenue, undoubtedly affecting Piedmont's ability and resources to serve medically underserved groups.

2. Accessibility and the York County Contract

Since 1980, when Piedmont's predecessor purchased the former York General Hospital, Piedmont has been party to a unique contract with York County. The Contract requires Piedmont to provide the County with a variety of services and financial contributions and binds both d/b/a's of Amisub – Piedmont Medical Center and Fort Mill Medical Center. Pied.Supp.CON.0385. The Contract does not expire until July 1, 2045. Pied.Supp.CON.0370.

The Contract has imposed many obligations that Piedmont has already fulfilled, including developing an open heart surgery program, constructing a women's tower, establishing a new ER, and providing various scholarships and charitable contributions. These

services evidence Piedmont's longstanding commitment to the entire York County population, as recognized previously by DHEC.

The Contract also imposes a number of ***ongoing*** obligations on Piedmont that relate both to the "public needs" purpose of the CON Act and the Accessibility criteria, particularly § 802.3(f), (g), and (h), all of which address concerns of low-income and medically underserved populations.

The Contract requires Amisub to provide:

a) Twenty-four hour, county-wide ambulance services, with mandated response times and equipment requirements. Pied.Supp.CON.0347-351. (Piedmont provided these services at a loss in 2010 of $4.7 million.)

b) Urgent care services in western York County. 6th Add. § 1, Pied.Supp.CON.0357-358; 0386-389. (Piedmont provided these services at a loss in 2010 of over $800,000.)

c) Major capital investments. Pied.Supp.CON.0359-360; 389-390.

d) Support for educational programs. Pied.Supp.CON.0364-366; 0381-382.

In addition, the Contract requires Piedmont, as it will require FMMC, to submit detailed quarterly and annual reports to York County Council, providing financial statements, indigent care levels, EMS calls and response times, and charge comparisons. Pied.Supp.CON.0366-369; 0379-380. As CHS's health planning expert conceded at trial, such reports are a good way to hold Piedmont accountable for its obligations under the Contract. Exh. C at 1801:19-23. By contrast, CHS – a public hospital – has refused to disclose patient and financial information about one of its facilities, prompting the Mecklenburg County Manager to allege a breach of contract. PMC Slides 19-20; Exh. D.

As a d/b/a of Amisub, Fort Mill Medical Center would be legally bound by these and all other obligations of the Contract, to the same extent as Piedmont. By contrast, neither

Presbyterian nor CHS is legally bound to provide any services or report any information to the County.

3. Accessibility and Indigent Care

In what appears to be a contest to show the Department who would serve the greater number of poor people in York County, Presbyterian and CHS each projected huge increases in indigent care from their 2005 applications. Presbyterian more than doubled its projection from 3.0 percent to 6.5 percent, while CHS's estimate climbed from 3.5 to 6.3 percent. Neither applicant, however, has demonstrated need to justify their projections.

All applicants accept patients without regard to the patient's ability to pay for services. Presbyterian's "charity" threshold of 300 percent of the Federal Poverty Level ("FPL"), however, overstates the true level of charity care purported. The median household income in York County was estimated to be over $50,000 in 2009. PHY's threshold of over $67,000 for a family of four illustrates this policy is not intended for low-income individuals unable to pay for care. By having such a high threshold, adjustments and write-offs that would normally be considered bad debt, contractual adjustments, or administrative write-offs are classified as "charity care," overstating the actual levels of true charity care.

Figure 4

Proposed Payor Mix in CON applications

	PHY	CMC-FM	FMMC
Medicare	28.1%	30.7%	42.0%
Medicaid	23.9%	15.3%	14.0%
Commerical/Managed Care	44.3%	50.5%	34.0%
Self Pay/Charity/Other	3.8%	3.5%	10.0%
TOTAL	100.0%	100.0%	100.0%

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The PHY projected payor mix includes 3.8 percent of discharges as "self pay" patients while CMC-FM projects 3.5 percent of patients as "other." This compares to FMMC's projected payor mix of 10.0 percent "self pay/charity/other." This level of expected payor mix does not comport to either CMC-FM or PHY's claim that they represent a more financially accessible alternative. FMMC's projected payor mix, which is based on PMC's actual experience, represents the most accessible proposed project.

The recession that has occurred since the original applications were filed greatly increased York County's unemployment rate. Presumably, the number of uninsured York County residents has also increased. Even if the York County unemployment rate does not return over the next four years, there are several reasons why the projections proposed by CHS and Presbyterian are unrealistic.

- The principal reason is that in 2014, under the Patient Protection and Affordable Care Act, healthcare coverage will be extended to an estimated 30-32 million Americans who will be required to carry insurance.
- Even if there were a large number of uninsured patients in York County after 2014, most would not be able to benefit from the ostensibly generous charity care policies presented by Presbyterian and CHS.[2] The reason is that, with the exception of the small number of patients admitted into a hospital through an emergency department, many patients would be admitted by CHS- or Presbyterian-employed physicians. Phone calls to Presbyterian and CHS York County physician offices during the past thirty days reveal a uniform practice by both systems' physician offices of refusing to accept new uninsured patients unless they pay in advance for services. Some practices also require advance payment of expensive well-visit charges. In addition, many Presbyterian and CHS practices are not accepting new Medicaid or Medicare patients. The following summarizes the practices of some of the York County employed physician offices.

[2] Presbyterian Project Review Slide 35 states that under Piedmont's charity care policy charges are not totally written off for any patient. That is incorrect. Piedmont's policy and practice is to write-off charges for all inpatient services for South Carolina residents below 100 percent FPL. A sliding scale co-pay is asked of patients between 100 and 200 percent FPL for all outpatient services, but is not required as a condition for services to be provided.

Presbyterian

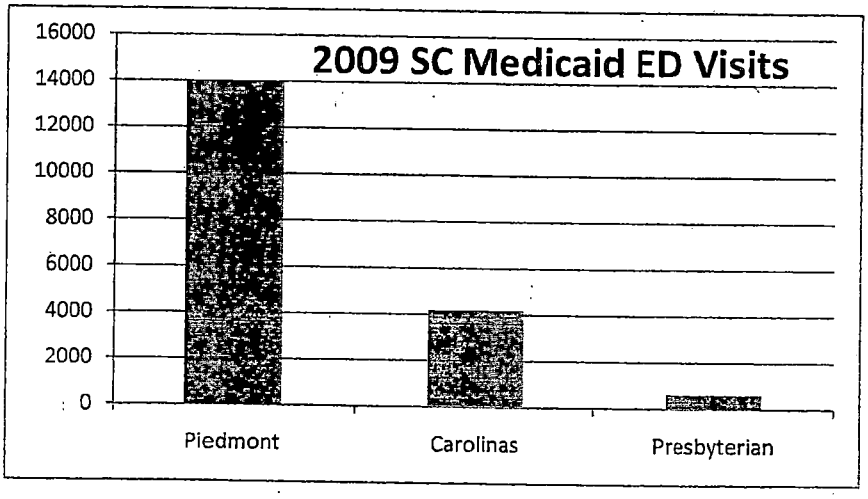
- Fort Mill Family Practice. No Medicaid patients. If an existing patient becomes Medicaid eligible, the practice will not file for Medicaid coverage.
- Rock Hill Family Practice. No new Medicaid or Medicare patients. No uninsured patients without advance payment of 60 percent of a new-patient visit charge that starts at $208.
- Family Medicine of York and Clover. No new Medicaid or Medicare patients.

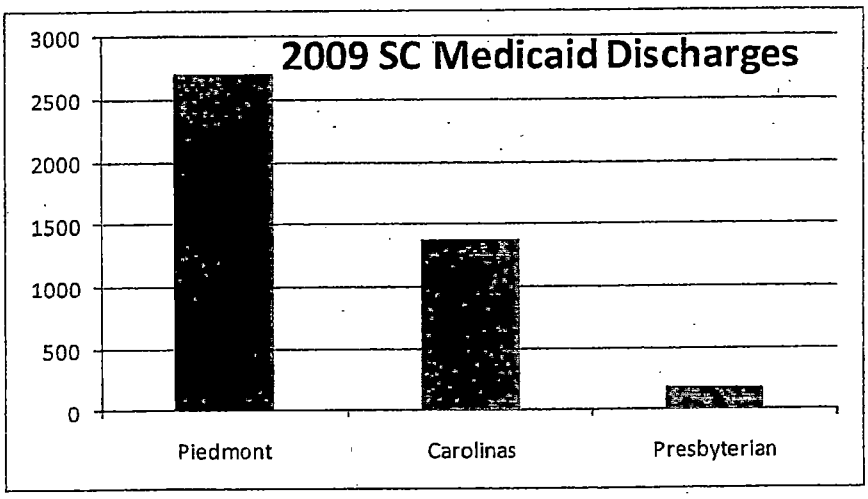
CHS

- Shiland Family Physicians, Fort Mill and Rock Hill offices. No new uninsured patients. No new Medicaid or Medicare patients.
- Medical Associates of Fort Mill and Rock Hill. No uninsured patients without advance payment of 70 percent of a new-patient visit charge of $290-$800.
- Palmetto Pediatrics. No new uninsured patients. No new Medicaid.
- Rock Hill Pediatrics. No uninsured patients unless they pay in advance 70 percent of a standard well-visit fee of approximately $300.

In contrast to the burdensome obstacles both Presbyterian and CHS place in front of poor and uninsured York County residents, these offices accept new commercially insured patients without reservation. Given these practices, it should come as no surprise that Piedmont is the provider of choice for low-income York County residents, particularly Medicaid beneficiaries, as the figures below demonstrate.

Figure 5





With the advent of the Affordable Care Act's expansion of healthcare coverage beginning in 2014 to uninsured Americans, there is no basis for projecting any material difference in the extent of indigent care that would, in fact, be provided by any of the applicants. The purpose of providing the detailed report concerning the discriminatory patient-acceptance practices of Presbyterian and CHS physician offices is to show where their true interests lie. They are not in meeting the healthcare needs of all York County residents. For Presbyterian, it is in capturing marketshare of one of South Carolina's most affluent regions – northeast York County. For CHS, it is about holding on to that treasure trove.

D. Community Need Documentation (§ 802.2)

Under each of the three proposals, 64 additional beds would be added to the existing bed count in York County. As DHEC found in its previous analysis, all three applicants have adequately demonstrated the need for 64 additional beds in the County.

By relocating 36 acute care beds from Piedmont, the proposed 100-bed Fort Mill Medical Center will be better able to meet the needs of the rapidly growing population base in northern York County. In information submitted to DHEC, the other applicants have

contended that the resulting distribution of beds in the County is insufficient to meet the needs of the residents and will "drastically skew the distribution of beds in York County." In order to illustrate this, CHS compared the 2010 bed-to-population ratio of "Northern York County" to that of "Greater Rock Hill and Western York" combined. A more representative comparison would be the projected third year of operation (2017) of "Greater Rock Hill" and "Northern York" bed-to-population ratio relative to the County-wide ratio.

Figure 6

Northern York County	2010	2017
Population	39,442	65,287
Beds	100	100
Beds per 1,000 Pop.	2.54	1.53
Greater Rock Hill	2010	2017
Population	104,515	145,430
Beds	232	232
Beds per 1,000 Pop.	2.22	1.60
York County	2010	2017
Population	203,436	290,702
Beds	332	332
Beds per 1,000 Pop.	1.63	1.14

Source: Claritas, Inc. S-CHS-0047-0048.

As illustrated, the ratios in 2017 are nearly equal, demonstrating that the proposed distribution of beds is consistent with expected population patterns.

FMMC is proposing a 100-bed facility versus a 64-bed facility proposed by either competing applicant. Bed need calculated in the current State Health Plan shows a surplus of nine beds. This is due to the fact that the calculation does not include York County residents that were treated in North Carolina. The true bed need for all York County residents is actually 140.

Figure 7

FY 2016 Hospital Bed Need
Piedmont Medical Center

Age Category	Population 2009	Population 2016	2009 Patient Days	Projected ADC	Bed Need (a)	Existing Beds	Need/ (Excess)
<18	45,710	46,810	1,363	4			
18-64	123,240	137,260	29,411	90			
65+	20,400	26,020	25,064	88			
Total	189,350	210,090	55,838	181	259	268	-9
Total York Residents Treated in NC.			34,459	105	150		150
Total for all residents				286	408	268	140

Source: 2010-2011 State Health Plan. Thompson data.
(a) Based on 70% occupancy
Note: Excludes psychiatric utilization.

This calculation clearly demonstrates additional beds are needed in York County, particularly the northern York County area, where outmigration to North Carolina is higher. The 64 additional beds represent approximately 45 percent of the total bed need, recognizing that a portion of patients will continue to leave the County for services.

E. Projected Revenues (§ 802.6(a))/Financial Feasibility (§ 802.15)

1. Charges

Criterion 6(a) provides that "proposed charges should be comparable to those charges established by other facilities for similar services within the same service area or state." The first test under this regulation is whether the proposed charges are comparable to charges of other hospitals in the service area for similar services. Piedmont is the only hospital in the service area, and the proposed charges of the applicants are comparable to Piedmont's charges, adjusted for acuity, as demonstrated in Figure 8.

Figure 8

Applicants' Projected Charges Per Patient Compared to Piedmont's Medicare Charges Adjusted by Case Mix Index

	2009	Year 1
Piedmont	18,830[3]	-
FMMC	-	19,238
CMC-FM	-	18,642
PHY	-	18,751

Charges proposed for all three applicants are within a 3 percent variance for Year 1. Moreover, FMMC's charges were based on an assumption of a 4 percent annual inflation factor from Piedmont's 2009 charges. In contrast, the other applicants used a 3 percent annual inflation assumption. Adjusting the inflation assumption for FMMC to apply the same inflation factor used by the other applicants results in FMMC having the lowest proposed charges, as demonstrated below.

Figure 9

Projected Inpatient Charges per Patient

	Year 1	Year 2	Year 3
FMMC	$19,238	$20,141	$21,043
PHY	$18,750	$19,345	$19,954
CMC-FM	$18,642	$19,201	$19,777
FMMC Adjusted (a)	*$18,155*	*$18,824*	*$19,478*

Source: CON applications
(a) assumes a 3% charge inflation for all parties

As pointed out in Piedmont's project review presentation, the 3 percent assumption adopted by CHS and Presbyterian is approximately one-half of the average annual change in charges at CMC and Presbyterian from 2005 to 2010. Piedmont's assumption of a 4 percent

[3] Piedmont's 2009 average Medicare charge was $30,972, which equates to a case mix index charge of $18,830 when adjusted by a case mix index of 1.6448. Source: MedPar data files for FY 2009.

annual adjustment, in contrast, is conservative when compared to its annual overage increase in charges during that same period of 1.1 percent. *See* PMC Slide 27.

Even if the analysis, however, were to include a comparison of an applicant's historical charges to other providers of similar services in North and South Carolina, the data shows that Piedmont's 2010 charges, adjusted for acuity are the third lowest in the 11-hospital comparison group established under the York County Contract.

Figure 10

2010 Average Medicare Inpatient Charges

	2010 Avg. Charge	CMI	CMI Adjusted
Palmetto-Baptist	$56,771	1.577	$35,999
Springs	$43,625	1.2717	$34,305
Palmetto-Richland	$64,973	1.8766	$34,623
Mary Black	$46,561	1.4858	$31,337
Spartanburg	$37,633	1.6933	$22,225
Providence	$39,887	1.9342	$20,622
CMC	$44,200	2.0372	$21,696
Presbyterian	$35,543	1.6816	$21,136
Piedmont	$31,604	1.6199	$19,510
CMC-Mercy/Pineville	$32,358	1.6877	$19,173
Gaston	$22,196	1.5236	$14,568

Source: 2010 MEDPAR data from Data Advantage Corp.

2. Charges and the York County Contract

Piedmont is the only applicant legally bound to maintain its charges at "reasonable, competitive levels." 6th Add. § 3.1(e) (Pied.Supp.CON.0345); 8th Add. § 1(e) (Pied.Supp.CON.0377-78). In addition, the Sixth Addendum requires Piedmont and Fort Mill Medical Center to immediately reduce its charges should they ever become the highest in the peer group of area hospitals identified in the Contract. 6th Add. § 3.1(e)

(Pied.Supp.CON.0346.). Failure to do so subjects Piedmont to penalties of $100,000 per month. Pied.Supp.CON.0380.

Since the Eighth Addendum was signed in June 2004, Piedmont's average charge per case has never ranked higher than sixth among the eleven peer group hospitals. It currently ranks ninth. PMC Slide 18.

F. **Projected Expenses/Cost Containment/Efficiency (§§ 802.7, 16, 17)**

Piedmont's initial projected total project cost was $146,522,042. This projection is consistent with comparable CON applications recently approved in South Carolina, while CMC-FM and PHY's projected costs are significantly lower than other recently approved CONs. PMC Slide 32.

Presbyterian's projected costs merit particular scrutiny, given its assertion that PHY will use the same prototypical design as Novant's 60-bed Haymarket Community Hospital in Virginia. PHY 2010_000014. Haymarket's projected costs, however, are much higher than PHY's, as demonstrated in PMC Slide 32 and Figure 11 below.

Figure 11

Cost Comparison PHY and Haymarket

	Total Cost	Per Bed	Per SF
PHY	$76,248,012	$1,191,375	$501
Haymarket	$93,103,164	$1,551,719	$640

Of even greater concern is PHY's misleading presentation of construction and equipment costs. PHY's Project Review Slide 35 purports to demonstrate that it has the lowest construction and equipment costs of the three applicants. However, Presbyterian ***fails to include IT costs*** in its projected equipment costs, whereas Piedmont and CHS do include IT

costs in their projected equipment costs. Moreover, Presbyterian ***fails to include site development, road development, and contingency costs*** in its construction costs, whereas Piedmont and CHS do include those costs in their construction costs. As a result, Presbyterian's Slide 35 is inaccurate.

To make a fair, apples-to-apples comparison of the three applicants' project costs, Piedmont has made the following adjustments, detailed in its December 3, 2010 submission to DHEC at Pied.Supp.CON.0434-435 and in Figure 12 below:

1) **IT Costs**. Included IT costs in the equipment costs for all three applicants.

2) **Construction Costs**. Included site development, road development, and contingency costs in the construction costs for all three applicants.

3) **Equipment Costs**. Unlike the other applicants, FMMC's medical equipment cost in the CON application reflects retail pricing. It has been adjusted to include the standard average discount of 22 percent Piedmont receives through its group purchasing organization.

4) **Interest**. Excluded capitalized interest costs for all three applicants.

5) **Inflation**. Based all capital costs on 2010 prices.

These adjustments result in the following apples-to-apples comparison of capital costs:

Figure 12

Adjusted Capital Cost Comparison

	FMMC	CMC-FM	PHY
Land Cost	4,668,605[1]	2,397,000[2]	1,309,000[3]
Construction	68,160,435[4]	43,447,925[5]	48,071,639[6]
Equipment	40,966,040[7]	28,315,963[8]	23,162,359[9]
A&E	4,849,059[10]	3,345,495[11]	3,155,014[12]
Misc/Other	1,164,816[13]	0[11]	550,000[14]
Total Cost	119,808,954	77,506,383	76,248,012

1. Pied.Supp.CON.0443. This amount includes site cost only.
2. S-CHS-0664. This amount includes site cost only.
3. PHY 2010_000013. This amount includes site cost only.

4. Pied.Supp.CON.0441. This amount includes all site and road development costs and a 5% contingency.
5. S-CHS-0664. This amount includes an unspecified amount of site development costs and a contingency of $2,083,170. S-CHS-0497.
6. PHY 2010_000013. This amount includes site improvements ($2,901,474), road improvements ($1,910,109) and a contingency ($3,000,000).
7. Pied.Supp.CON.0443. This amount includes all IT costs.
8. S-CHS-0671. This amount includes medical equipment ($16,796,148), information systems ($9,559,835), interiors ($1,680,330), and exterior signage ($279,650).
9. PHY 2010_000013. This amount includes FF&E ($20,162,359) and IT ($3,300,000).
10. Pied.Supp.CON.0443.
11. S-CHS-0664.
12. PHY 2010_000013.
13. Pied.Supp.CON.0443 (includes tests, inspections, and permitting).
14. PHY 2010_000013 (owners specialty consultation fees).

See Pied.Supp.CON.0423-24, 434-36, 441, 443.

The apples-to-apples costs in Figure 12 allow DHEC to make a fair comparison of the applicants' costs and cost efficiency, as demonstrated in Figure 13 below:

Figure 13

Cost Efficiency Comparison

	FMMC	CMC-FM	PHY
Total Cost per Bed	1,198,090	1,211,037	1,191,375
Total Cost per SF	540	554	501
Construction & Equipment Cost per Bed	1,091,265	1,121,311	1,113,031
Construction & Equipment Cost per SF	492	513	468

Figure 13 shows that no material difference exists in the applicants' projected 2010 costs. Good reason exists, however, for concern over the projected equipment, IT, and land costs of Presbyterian and CHS, as discussed below.

1. Equipment Costs

The major medical equipment costs projected by the applicants are summarized below:

Figure 14

Major Medical Equipment Costs

	FMMC	CMC-FM	PHY
MRI	$2,097,152 3.0T	$1,600,000 1.5T	$975,000 1.5T
CT	$1,677,673 64-slice	$1,345,000 64-slice	$535,000 16-slice

Cost containment must be balanced with quality. The low-cost equipment PHY proposes to use raises serious quality concerns.

2. IT Costs

The IT costs projected by the applicants are summarized below:

Figure 15

IT Costs

	FMMC	CMC-FM	PHY
IT Costs	$15,444,468[1]	$9,559,835[2]	$3,300,000[3]
Per Bed	$154,445	$149,372	$51,563
Per SF	$70	$68	$22

1. Pied.Supp.CON.0088. This projection is based on 2014 prices.
2. S-CHS-0671.
3. PHY 2010_000013.

PHY's projected IT costs are unreasonably low and insufficient for a modern hospital.

3. Land Costs

Piedmont's land cost is significantly higher than CHS's or Presbyterian's, reflecting the greater value of the Piedmont site. Both Sutton Road sites are likely to require significant

costs to improve the sites, the road, and the bridge over I-77 that are not fully reflected in CHS and Presbyterian's total project costs.

G. Net Income/Financial Feasibility (§§ 802.9, 15)

All three applicants "show an improvement in . . . net revenue position over time, especially the first three years . . ." and therefore comply with the Net Income criterion (§ 802.9) and Financial Feasibility (802.15) criterion. CHS's prediction that it will achieve net income of $663,000 its first year of operation, however, is unrealistic. While Piedmont agrees that the growing population in northern York County should assure high utilization and positive net income trends for whichever applicant is approved, it is rare for any hospital to have a positive bottom line the year it opens. For instance, in its 2005 application CHS projected a first-year bottom line *loss* of $1.7 million, a far more reasonable figure than its current projection.

Figure 16

Applicants' Projected Net Income

	Year 1	Year 2	Year 3
PHY	($1,101,582)	$1,998,254	$4,985,226
CMC-FM	$663,000	$1,671,000	$2,776,000
FMMC	($5,422,756)	($2,925,984)	$313,620
Trident Berkeley	($4,576,851)	($2,855,147)	$69,552
Roper Berkeley	($11,765,772)	($3,313,318)	$285,160

As shown in Figure 16, FMMC's projected performance is far more consistent with the two most recent hospital CON applications the Department has approved than either CHS or Presbyterian. One of these new facilities, Roper Berkeley, will, in fact, be partly owned and managed by CHS.

H. Record of the Applicant (§ 802.13)

Section 802.13(c) provides that "the applicant's record or his representative's record of cooperation and compliance with State and Federal regulatory programs will be considered." In September 2011, Tenet's corporate integrity agreement with the United States will expire.[4] In 2011, Presbyterian Orthopaedic Hospital paid $637,873 to settle Medicare fraud allegations brought by the United States. In 2008 and 2010 CMC/Behavioral Health received several serious deficiencies from North Carolina regulatory agencies arising out of taser incidents, as well as the discharge of a seriously mentally ill patient who subsequently killed his family and himself. In addition, Bon-Secours-St. Francis Hospital, a CHS facility, was fined $37,508 for a CON cost overrun. S-CHS-0613.

I. Acceptability (§ 802.4)

Criterion 4 (Acceptability) requires an applicant to demonstrate support for its project and requires DHEC to consider documented opposition.

DHEC has never interpreted this criterion as a contest to see who could submit the most letters. Such an interpretation would lead DHEC staff to being routinely swamped with thousands, if not tens of thousands, of letters generated by PR firms, which is exactly what has happened during both review processes in this case. In an internal memo, Presbyterian actually stated that its express goal was ***"to secure the CON in York County by implementing a coordinated public relations campaign."*** (emphasis added). Exh. E. Quality – not quantity – is more important in evaluating support letters.

[4] At present, 345 providers in the United States are parties to corporate integrity agreements, including Saint Joseph's Hospital of Atlanta, St. Elizabeth's Hospital in Washington, University Hospitals in Cleveland, and Marion Regional Healthcare System in South Carolina. McLeod Regional Medical Center in Florence was subject to such an agreement from 2002 to 2007, as was MUSC from 2000 to 2005.

Each applicant has met this criterion, providing several thousand personal letters of support in addition to thousands more form letters and cards voicing their support for a particular applicant. In addition to the more than 5,400 letters of support Piedmont has filed with the Department, we have attached a CD providing personal statements of support from five Piedmont patients. Exh. F; *also see* Exh. G for a transcript of these statements.

Letters of opposition to the approval of Piedmont's application were alluded to during project review by CHS and Presbyterian. If they are similar to letters filed during the first review cycle, they are largely the product of a well-orchestrated negative PR campaign underwritten by Presbyterian and CHS. The attacks on Piedmont are not consistent with the facts. They are, however, consistent with the attacks levied against Piedmont by the other applicants. As discussed in this paper, however, Piedmont's charges and quality are equal to or better than that of the other applicants. Moreover, the theme of choice pressed by Presbyterian and echoed in many of the letters of opposition, to the extent it is relevant, is fundamentally a planning consideration relegated to DHEC.

Of particular importance to this criterion are letters of support from York County physicians who are not employed by or under contract with one of the applicants. As Figure 17 below demonstrates, over 75 percent of these physicians support Piedmont. Only thirteen favor Presbyterian, while CHS has the support of no more than one independent physician practicing in York County who has expressed his opinion to the Department.

Figure 17

Letters of Support
York County Physicians 2005-2010

	Independent	Employed	Total[5]
Piedmont	45	22	67
CHS	1	55	56
Presbyterian	13	20[1]	33

These figures are telling. The independent York County practitioners applaud Piedmont for the strides it has made transforming the facility from a struggling community hospital to a well-regarded tertiary medical center. They recognize its commitment to continuous quality improvement and its openness to members of the medical staff. They are grateful for its investment in the recruitment of physicians needed for the community and in technological advances and capital improvements, particularly in its cardiology and women's health programs.

Nearly two-thirds of the 45 physicians asking the Department to approve Piedmont's application recognize the adverse impact on Piedmont and the residents of York County if either other applicant is approved. They understand all too well that the current healthcare system in York County will be disrupted severely if CHS or Presbyterian is awarded the CON. They understand just as well that if Piedmont is permitted to build and operate FMMC that the disruption to medical services in York County that has occurred since the filing of the 2005 applications would be resolved. If there is any uncertainty in the Department's view as to whether the potential for substantial adverse impact is real, the views of the York County independent physicians should be given careful consideration.

[5] This amount includes only letters from physicians licensed in South Carolina. The totals for Presbyterian and CHS do not include 7 physicians who supported another applicant in 2005 but subsequently have submitted letters of support for Piedmont.

Pied.Supp-CON 0758

JOINT-B-PMC-001.0795

RECORD 002900

II. The 2004-05 South Carolina Health Plan

Under Judge Matthews' ruling, all three applicants comply with and can be approved under the 2004-05 State Health Plan. However, it is important to note that the Plan provides that "the benefits of improved accessibility will be ***equally weighted*** with the adverse effects of duplication in evaluating Certificate of Need applications for [acute care hospital] beds." 2004-05 Plan at II-9 (emphasis added).

In its 2005 review, DHEC ranked the Distribution/Accessibility criteria (§ 802.23) as more important than the Adverse Impact criterion (§ 802.23). At the September 2009 trial, however, DHEC staff conceded that giving Distribution/Accessibility greater weight than Adverse Impact had been a mistake, since the State Health Plan requires that those criteria be "equally weighted." Exh. H at 477:14-17 (Fechtel testimony); at 1092:13-23 (Grice testimony).

The construction of a hospital in the Fort Mill area by any of the three applicants would improve accessibility for residents of northeastern York County. On the other hand, there is only one applicant who will be adversely affected by approval of one of the other two applications – Piedmont. Because the State Health Plan requires adverse impact to be weighted equally with improved accessibility, the applicant that best complies with the Plan is the one that improves accessibility with the least adverse impact. Based on the analysis provided above in discussion of the project review criteria, that applicant is Piedmont.

III. The CON Act

The four purposes of the CON Act are "to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health

facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State." S.C. Code Ann. § 44-7-120.

For this review, the unnecessary duplication of services is not at issue, since the 2004-05 State Health Plan identifies a need for an additional 64 hospital beds. Cost containment is addressed in the context of regulatory criteria § 802.16. The other two purposes of the CON Act – public need and quality – relate generally to various regulatory criteria, but do not fit precisely into any particular criterion. For that reason, Piedmont addresses these two statutory purposes now.

A. The Public Needs Purpose of the CON Act

1. Community Benefit

In order to determine which of the competing projects "will best serve the public needs" of York County, DHEC must examine the community benefits each applicant would provide. Community benefits can take many forms, but for DHEC to compare the community benefits of these three projects they must be both quantified and specific to York County.

One such benefit Fort Mill Medical Center will provide is the annual payment of $4.1 million in local taxes, of which $2.5 million will go directly to Fort Mill schools. This is particularly relevant to the issue of public need, given that in 2009-10 Fort Mill schools lost over $2 million and laid off 47 teachers.

In light of these facts, DHEC has asked both CHS and Presbyterian to address their "planned contributions to the York County economy to offset not paying taxes." We believe that because of the CON Act's public need purpose it is not only appropriate but necessary that CHS and Presbyterian offer projections of community benefits specific to their York County proposals. Those projections should be quantified so that DHEC can compare them to the $4.1

million in annual local taxes that Fort Mill Medical Center will pay, in addition to the other community benefits it would provide, which are discussed on pp. 15-16 of this paper and in PMC Slides 16-24.

The responses by CHS and Presbyterian, however, were neither specific to their York County proposals nor quantifiable.

a. CHS's Planned Contributions to York County

CHS's response to DHEC's question is found at S-CHS-0467-470. Rather than providing DHEC with any specific and quantifiable plans to contribute to the York County economy, CHS offers only a general assertion that nonprofits are inherently better for society than for-profits,[6] followed by a series of attacks on Piedmont. After that, it takes credit for the individual charitable contributions that CHS employees have made in North Carolina.

CHS also contends it invests more capital in its hospitals than Piedmont. CHS bases its claim on investments in two newly acquired hospitals, CMC-North East and CMC-Lincoln over 3-4 year periods of time. CHS's selection of these two facilities from among its 32 hospitals is again misleading. Bank-rolling the major CMC-Northeast expansion was a commitment CMC made when it acquired an interest in the facility in 2007. *See Charlotte Business Journal*, September 22, 2008. Similarly, the construction of a replacement hospital for Lincoln Medical Center was planned as part of its acquisition by CHS in 2006. *See* www.cmc-lincoln.org/body.cfm, June 16, 2010.

A more apt comparison is between Piedmont and CMC-Union. Piedmont opened in 1983; Union in 1985. Tenet assumed control of Piedmont in 1995, when it merged with American Medical International; CHS leased Union the same year. During the 14-year period

[6] Ironically, CHS also argues that the taxable status of a CON applicant is irrelevant. CHS Project Review Slide 45.

reflected in CHS's materials, CHS averaged an annual capital investment in CMC-Union of $12.2 million. During almost the same period, Piedmont made an average annual investment of $13.3 million, over $1 million more per year than CHS did at Union. PMC Slides 33-35. Moreover, CHS's re-investment comparisons fail to acknowledge the $146 million investment Piedmont has proposed since 2004 to make in York County through the construction of FMMC.

CHS further attempts to minimize Piedmont's commitment to York County by contrasting the local taxes it paid and the capital improvements it made from 2002 to 2010 with the facility's net cash flow returned to Tenet. CHS Slide 36. Through this slide, CHS implies that Piedmont's profits are provided to the parent corporation to be distributed to shareholders. That is not true, however. Tenet pays no dividends to its shareholders. The net income from each Tenet facility is returned to the company to re-invest in expansion and renovation projects for other Tenet hospitals, such as the construction of the Tenet East Cooper Medical Center replacement facility and the FMMC project. This process is what enables large healthcare systems to continue to re-invest in their facilities, just as CHS and Novant do.

b. Presbyterian's Planned Contributions to York County

Presbyterian's response to DHEC's directive to identify its planned contributions to York County is found at PHY 2010-001782-1785. Most of the response involves a report discussing the charity care practices of North Carolina hospitals.[7] Presbyterian also references certain community services and benefits, described at PHY 2010-000096-102. Presbyterian's commitment to providing these services in York County, however, is not only tentative, but

[7] The conclusions of this report are remarkably inconsistent with the conclusions of a North Carolina administrative judge in a May 17, 2011 order, who found: [A Novant representative's] "testimony regarding the Novant charity care policy was not reasonable or credible and was unsupported by any facts or evidence." CHS Slide 27.

conditioned on first obtaining the CON. If Presbyterian truly wanted to demonstrate a commitment to York County, it would provide such services without regard to the outcome of this process.

Even if it were to obtain the CON, Presbyterian characterizes its community cruiser as a "potential placement;" Presbyterian "would look into" hospice services; and PHY has "potential" to become affiliated with a Presbyterian foundation. PHY 2010-000096-98. None of these represents a firm, specific, or quantifiable commitment to the York County.

While Presbyterian appears to commit deployment of a critical care transport (CCT) ambulance to the PHY campus, even that is conditioned on completion of a "financial feasibility study." PHY2010_001755. In other words, Presbyterian will do it if it is profitable. Even if Presbyterian did deploy a CCT ambulance, it would not provide emergency services, but would simply transport patients to another Presbyterian facility. By contrast, Piedmont provides 24/7 EMS services throughout York County to a patient's hospital of choice, with contractually mandated response times, equipment requirements, and public reporting obligations, all of which it undertook in 2010 at a loss of $4.7 million.

Finally, Presbyterian provides material on what Novant characterizes as the community benefits it provides throughout North Carolina, including such things as marketing activities and individual employee charitable contributions. However, Presbyterian projects no specific, quantifiable community benefits for York County.

c. A Comparison of Quantified Community Benefits

As support for its position that nonprofit hospitals are better for society than for-profits, CHS offers an article written 16 years ago by a consulting firm which, according to its website, serves exclusively nonprofit hospitals. S-CHS-0468, 598-600. In response, Piedmont

refers DHEC to Exh. I, a more up-to-date and objective group of articles discussing the intense scrutiny nonprofits have received in recent years for failing to justify their tax-exempt status.

Piedmont's position is not that for-profit hospitals better serve public needs than nonprofits or vice versa. Such generalizations from either point of view are not applicable to specific communities and institutions. To determine which of the competing projects best serves the public needs of York County, DHEC must compare the history of providing specific and quantifiable community benefits for each applicant, particularly with respect to their experience in community, non-urban, non-academic hospital settings similar to the opportunity presented by the Fort Mill Medical Center.

To that end, Piedmont offers Exh. J, an analysis by Nancy Kane, DBA. Dr. Kane, whose CV is attached as Exh. K, is an Associate Dean and Professor with the Harvard School of Public Health. From 2005-2011, Dr. Kane served as a commissioner of the Medicare Payment Advisory Commission (MedPAC), an independent agency established by law to advise Congress on issues affecting the Medicare program.

For the purposes of her community benefit analysis, Dr. Kane defines community benefit (CB) as the sum of the annual cost of two clear, quantifiable components: free care (charity care) at cost and Medicaid shortfall (the difference between Medicaid payments and Medicaid cost).[8]

[8] These elements are commonly accepted as undisputed community benefits by the organizations that have studied the issue during the past decade, including the Catholic Healthcare Association, the Finance Committee of the U.S. Senate, and the IRS. Dr. Kane's analysis does not include consideration of bad debt (which DHEC also excludes from charity care); discounts to non-indigent, uninsured patients (such as Tenet's Compact with the Uninsured); charitable giving (by the hospital or its employees); marketing events (which often benefit the hospital by increasing referrals to health services for which patients or their insurers are charged); or medical research and teaching (difficult to quantify, often not publicly reported, often reimbursed, and not applicable to community hospitals such as CMC-FM or PHY).

In order to calculate Net Benefit, Dr. Kane adds to CB the value of taxes paid (TP) or subtracts from CB the value of tax exemptions (TE). To summarize:

- Charity care at cost + Medicaid shortfall at cost = CB
- CB + TP - TE = Net Benefit

Finally, Dr. Kane calculates Net Benefit as a percentage of Total Operating Revenue to compare hospitals, as illustrated in Figure 18.

Figure 18

2009 Community Benefit Comparison

	Piedmont (2009)	**Pres. Hosp. (2009)**	**Pres. Matt. (2009)**	**CMC (2009)**	**CMC-Mercy/Pine (2009)**
Total Operating Revenue (TOR)	$235,279,000	$570,038,000	$156,447,000	$1,279,471,000	$339,949,000
Community Benefit at Cost (CB)	$9,234,000	$48,722,000	$11,175,000	$61,386,000	$14,669,000
Estimated Value of Tax Exemption (TE)	N/A	$28,395,000	$15,887,000	$112,987,000	$42,826,000
Total Amount of Taxes Paid (TP)	$12,577,000	N/A	N/A	N/A	N/A
CB as % of TOR	3.92%	8.55%	7.14%	4.80%	4.32%
TE as % of TOR	N/A	4.98%	10.15%	8.83%	12.60%
TP as % of TOR	5.35%	N/A	N/A	N/A	N/A
Net Benefit as % of TOR (NB)	**9.27%**	**3.57%**	**-3.01%**	**-4.03%**	**-8.28%**

Source: Exh. J.

Dr. Kane's 2009 findings for these hospitals are consistent with her findings going back to 2004. *See* Exh. J. Her analysis shows that the community benefits Presbyterian and CHS provide are substantially less than Piedmont's. The study also reveals that the benefits Presbyterian and CHS do provide are generated by their urban, tertiary hospitals (Presbyterian

Hospital and CMC), not their smaller, community hospitals (Matthews and Mercy/Pineville) – the hospitals PHY and CMC-FM are modeled on.

In summary, Dr. Kane's findings show that neither CHS nor Presbyterian can demonstrate a history of providing net community benefits relative to total patient activity that is equivalent to that historically provided by Piedmont.

2. Public Needs and the Proposed Hospital Sites

The CHS and Presbyterian sites are located on either side of I-77 at the Sutton Road exit. This stretch of Sutton Road is narrow and in poor condition. Serious questions exist concerning ambulance and patient access as well as traffic congestion with both Sutton Road sites. *See* PMC Slides 37-54 and the accompanying video from project review.

a. CHS Site

On May 19, 2011 CHS submitted to DHEC a February 9, 2011 letter from the South Carolina Department of Transportation ("DOT letter"), apparently to demonstrate that traffic issues with the CHS site can potentially be resolved. However, in a subsequent meeting with Piedmont representatives, the DOT officials who wrote the letter clarified that they based their findings and conclusions on a 2007 traffic impact study ***that did not take into account any traffic volume projections from a hospital located on site***. As a result, the DOT letter's conclusions about traffic are unreliable for the purpose for which CHS presents them.[9]

The proposed main entrance to the CHS-FM site is an overgrown frontage road directly across from Sutton Ridge Lane, which serves as the sole entrance to Love's Truck Stop. PMC Slides 37, 41. Truck traffic in and out of Love's is already heavy. PMC Video and Slides 40,

[9] The focus of the DOT letter is the larger Kanawha site that encompasses the proposed CMC-FM site. Even without considering the traffic impact of a hospital on site, DOT did not give the project its blessing, noting that "we are unsure if the design will be possible given the design tapers called for."

41. The last bullet point of the DOT letter states that traffic signals will eventually be placed at each of the Sutton Road exit ramps for I-77. The west exit ramp is only about 300 feet from the entrances to the CMC-FM site and Love's. A traffic signal at this exit will likely result in further congestion, with 18-wheelers stacked up behind a red light all the way from the exit ramp to the Love's entrance. Ambulances and other automobiles needing to reach the hospital quickly would be delayed.

Should CHS decide to build an alternate road entrance - which it has not proposed doing – DOT standards would require that it be located at least 750 feet from the exit ramp. Exh. L (SCDOT Access and Roadside Management Standards p. 30). To comply with this standard, CHS would have to either build a new road directly across from County Lodge Road or use Frances Circle.[10] PMC Slide 37. Either option would cause major problems and expense, as County Lodge Road and Frances Circle do not align and private residences border both streets. *See* 7th bullet point of DOT letter; PMC Slides 37, 41.

On August 9, 2009 Gralla Equestrian Architects (GH2) issued a Site Evaluation Report for York County for a proposed facility for staging horse shows and other events. *See* Exh. M. Five sites were considered, including the "museum site" to the west of I-77 between Sutton Road and the Catawba River, which contains the proposed CHS site. GH2 rejected the museum site, however, due to its "extremely difficult topography and access." GH2 Report p. 2. If access to this property is inadequate for purposes of a horse show, it is surely inadequate for a hospital.

[10] The DOT letter refers to Frances Circle as the "main drive" to the larger Kanawha site.

b. **PHY Site**

The PHY site is located at the dead end of River Crossing Drive. PMC Slides 42, 44. River Crossing Drive is the only access to the proposed hospital site. The entrance to River Crossing Drive is approximately 300 feet from the I-77 exit ramp. Traffic lights at the exit ramps, as proposed by DOT, will back up trucks headed to and from Love's, as well as ambulances and other traffic headed to and from PHY. River Crossing Drive is the current site of an office park, with several driveways branching off the drive to both right and left. PMC Slides 42-46. The drive itself is only 30 feet wide from curb to curb, with no median. Presbyterian could not widen the drive without authorization from the current owner, which it has not presented, nor without costs that it has not identified. Ambulances and other automobiles headed to PHY would have to compete with office park traffic.

c. **FMMC Site**

Unlike the proposed sites for CMC-FM and PHY, the FMMC site has multiple access points; is located reasonably close, but not too close, to the interstate; is fronted by a four-lane road in good condition with a median; and is nowhere near a truck stop. PMC Slides 47-54.

3. **Public Needs and Choice**

Choice is not, of course, among the CON regulatory criteria, but Presbyterian asserts that choice relates to the public need purpose of the CON Act. In fact, the CON Act is based on the principle that unrestricted choice is not in the public interest – that, for example, open heart surgery centers should not be available on every city block. The concept of choice runs counter to the principle of adverse impact, which is, of course, a CON criterion. This case provides a perfect example. Even if approving PHY were to provide greater choice, it would adversely impact the existing provider and, consequently, the York County community.

Moreover, although it appears Presbyterian has retained a first rate PR firm, the number of York County residents actually choosing to use Presbyterian services is small. Between 2005 and 2010, the total number of York County patients who were discharged from Presbyterian hospitals increased by only 58. *See* Figure 3 at p. 3. Moreover, Presbyterian Hospital is located less than a mile from CMC, which during the same period discharged an additional 902 York County patients.

Finally, any discussion of choice is academic because hospital choice already exists for York County citizens. As PMC Slide 68 demonstrates, 21 acute care hospitals operate in the Charlotte Metropolitan Statistical Area, including York and surrounding counties, of which 18 are owned or managed by CHS or Presbyterian. Approving another facility by either of these two systems would not promote choice in York County, but dilute it.

4. Conclusion as to the Public Needs Purpose of the CON Act

Neither CHS nor Presbyterian has provided specific and quantifiable evidence of planned contributions to the York County economy that will offset the $4.1 million in annual local taxes and other community benefits that Fort Mill Medical Center is projected to provide. The Piedmont site is far superior to those of the other applicants, whose sites pose serious issues of access and traffic congestion.

B. The Quality Purpose of the CON Act

The second purpose of the CON Act that this paper will address is quality – "to ensure that high quality services are provided."

1. Piedmont Recognitions for Quality

In 2010 alone, Piedmont received the following awards and distinctions:

- 2010 South Carolina Distinguished Hospital of the Year (DHEC/AHA) for significant quality contributions for patients with cardiovascular disease and stroke.
- Advanced Stroke Center Accreditation (Joint Commission).
- Blue Distinction Center for Spine Surgery and Cardiac Care (Blue Cross Blue Shield of South Carolina) for clinical quality and outstanding patient outcomes.
- Gold Performance Award for Heart Failure (AHA).
- Silver Performance Award for Coronary Artery Disease (AHA).
- United Premium Specialty Center designee for cardiac surgery, cardiac care, and rhythm management.

2. Objective Measures of Quality

As demonstrated in Figure 19, the overall core measure scores, adjusted for patient acuity, for Piedmont and the flagship hospitals of CHS and Presbyterian are very similar.

Figure 19

Overall Core Measure Scores

	Piedmont	CMC	Presbyterian
Heart Attack Care	99%	98%	100%
Heart Failure Care	97%	96%	99%
Pneumonia Care	96%	94%	99%
Surgical Care Improvement Project	94%	97%	90%

Source: Joint Commission Quality Check, Jan-Dec. 2009. *See* PMC Slide 57.

In an attempt to demonstrate Piedmont provides an inferior quality of care, CHS has presented a slide that compares the number of Joint Commission certifications Piedmont has

been awarded to the number received by Carolinas and Novant. CHS Slide 41. The slide is actually measuring the number of Joint Commission certifications for all 32 CHS hospitals and 13 Novant hospitals against Piedmont, a single facility. Having freely made reference to Tenet in many other contexts throughout its presentation, CHS apparently made no effort to determine, or at least report to DHEC, that 49 hospitals within the Tenet system had received 32 Joint Commission certifications as of January 2011. Two of those certifications have been awarded to Piedmont, not one as CHS represented.

A more direct facility-to-facility quality performance comparison can be found in HealthGrades' hospital survival/complications scores. According to these scores, Piedmont and Presbyterian Hospital are virtually identical, while CMC lags behind both, with eleven "worse than expected" scores. PMC Slides 61-63. All scores are adjusted for patient acuity, meaning that the medical conditions of patients at various hospitals do not affect the grades.

Figure 20

HealthGrades
Hospital Survival /Complications

	Worse than Expected	As Expected	Better than Expected
Piedmont	4 categories	22 categories	0 categories
CMC	11 categories	13 categories	2 categories
Presbyterian Hospital	4 categories	21 categories	1 category

Source: HealthGrades 2007-2009 data (www.healthgrades.com). *See* PMC Slide 61.

Specifically, CMC, CHS's flagship hospital, ranked "worse than expected" in nearly three times as many categories as Piedmont and Presbyterian, which included the following:

1. Appendectomy complications
2. Carotid surgery complications
3. Gallbladder surgery complications

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4. Coronary angioplasty/stents survival
5. Heart attack survival
6. Peripheral vascular complications
7. Pneumonia survival
8. Pulmonary embolus survival
9. Respiratory failure survival
10. Sepsis survival
11. Stroke survival

HealthGrades: 2006-2009 Data for Inpatient Medicare Patients (www.healthgrades.com).

3. Conclusion as to the Quality Purpose of the CON Act

While questions can be raised about CHS's performance under the HealthGrades report and Presbyterian's use of less than top-grade major medical equipment, the fact is that all these applicants would provide high-quality clinical services to the community.

CONCLUSION

While the applicants comply equally well with some of the regulatory criteria, Piedmont best satisfies the following:

1) **Adverse Impact** – As recognized by the overwhelming majority of independent physicians, approval of either of the other applicants would substantially reduce Piedmont's utilization, producing a minimum of $13 million annual loss of net revenue and weakening its ability to serve the rest of York County.

2) **Distribution** – The adverse impact on Piedmont from approval of either of the other applicants would force Piedmont to reduce staff, clinical services, and community services.

3) **Accessibility** – The York County Contract provides legal guarantees of accessibility that the other applicants cannot match.

4) **Projected Revenues** – While all three applicants have comparable charges, only FMMC has contractual restrictions on its prices.

5) **Efficiency** – It is more efficient to build a 100-bed hospital than build a 64-bed hospital and add beds in a few years, which all applicants acknowledge would be needed. Piedmont's costs per bed and per square foot are comparable to the North Carolina applicants, even though Piedmont has a far superior site and more sophisticated equipment.

6) **Cost Containment** – The projected costs of the applicants are comparable, but serious questions exist about the land and equipment costs of Presbyterian and CHS.

Of the four purposes of the CON Act, one (unnecessary duplication) is not at issue and another (cost containment) is directly covered by a regulatory criterion (§ 802.16). Piedmont's application best furthers the remaining two purposes of the Act:

1) **Public Need** – Neither CHS nor Presbyterian can identify specific, quantifiable public benefits that offset the $4.1 million in taxes FMMC will pay and the other benefits FMMC will provide. Moreover, the location of the CHS and Presbyterian sites raises serious concerns about access and traffic congestion.

2) **Quality** – While all three applicants would provide quality services, CHS's relatively low HealthGrades scores are troubling. In addition, Piedmont's more sophisticated medical equipment has greater capabilities than that proposed by the other applicants.

Piedmont's application best complies with the regulatory criteria, the State Health Plan, and the CON Act and should be approved.

INDEX TO EXHIBITS

Exh. A - CD, York County Medical Society president Sushil R. Singhi, M.D. and Robert E. Thomas, M.D.

Exh. B - Transcript of statements of Drs. Singhi and Thomas

Exh. B-1 -Correspondence from Drs. Singhi and Thomas

Exh. C - Trial testimony of CHS expert Dawn Carter

Exh. D - *Charlotte Observer* article

Exh. E - Internal Presbyterian memo

Exh. F - CD providing personal statements of support from five Piedmont patients

Exh. G - Transcript of these patient statements

Exh. H - Trial testimony of Mary Fechtel and Joel Grice

Exh. I - Articles on Scouting of Non-Profit Hospitals

Exh. J - Kane Analysis

Exh. K - Kane CV

Exh. L - SCDOT Access and Roadside Management Standards p. 30

Exh. M - Gralla Equestrian Architects Site Evaluation Report

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Physician Testimonials
Piedmont Medical Center
July 2011

Robert E. Thomas, M.D.

I'm Dr. Rob Thomas, and I live in York County. I've been very proud to see that the physicians in practice here at Piedmont provide excellent quality care. We are an independent pathology practice. We provide pathology services to Piedmont Medical Center as well as two other hospitals in neighboring counties. As a pathologist, we do have a unique position in the sense that we are behind the scenes, and we do interact with different specialists in different ways. The administrative team and other ancillary services, nurses, etc., are continually trying to improve the quality. And I would say that the biggest forces in conjunction with the quality of the medical staff at the hospital put the hospital in a position to provide quality that is second to none.

If you go back to the 1980s, I guess late 1970s, 1980s, 1990s, the referral patterns were always fairly consistent. The referral patterns continued into the 2000s, and this provided for a good communication between specialists and primary care physicians. It provided for a good continuity of care, and we have seen over the past five to six years as these primary care physicians and their practices have been bought that those referral patterns have changed dramatically in both that the patients are not being referred to this facility and the specimens are not being referred to this facility, presumably because of the pressure from the corporate office at one of the North Carolina-based facilities.

So what I think happens when the referral patterns are changed - the continuity of care to some extent in most cases suffers. The communication also I think has a negative impact or is negatively impacted by this change in referral pattern.

The question for DHEC is when they have to make this decision, which is a very big and important decision for them to have to make, is are we going to, as we change these referral patterns, are we going to cripple the existing facility in York County – that being Piedmont – or are we going to allow another North Carolina-based facility to build a Fort Mill Hospital which is in effect going to export jobs, export taxes, and export patients to North Carolina.

Sushil R. Singhi, M.D., President, York County Medical Society

I am Dr. Sushil Singhi. I live in York County. Piedmont Medical Center is one of the best institutions I have seen where we are big enough to serve our patients and smart enough to know our patients.

I have been with Carolina Cardiology Associates for about 18 years, but my group has been here for 28 years and still maintaining independent status. My cardiology training was done in Pittsburgh. I was at the University of Pittsburgh Medical Center. Following my fellowship I decided to be on the staff, on the academic staff, at the University of Pittsburgh Medical Center.

Piedmont Medical Center has been very supportive to the staff, to the cardiologists as well, to bring all of the latest technologies to our patients. In the upstate South Carolina, Piedmont Medical Center has been named as one of the best hospitals for providing cardiac services.

I am the president of York County Medical Society which organizes periodic meetings with physicians on staff from different hospitals. We have been hearing from different physicians that things are changing in York County. Reason being that lot of member physicians are the employee of health organizations from the Charlotte area. So their personal interest is in front of the patient, which I am a little bit baffled and confused about. That the patient and their family members are being steered away to get their basic care and some specialized care to out-of-state hospitals and in the long run, we lose out on the continuity of patient care. And who will suffer the most – at least my impression is that the patient and their family members.

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CAROLINA CARDIOLOGY ASSOCIATES

Diagnostic and Interventional Cardiology

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July 7, 2011

To: Dr. Richard Patterson
Chief Medical Officer
Piedmont Medical Center
Rock Hill, SC 29732

RE: Letter of Introduction

Dear Dr. Patterson,

This letter of introduction is to state that I Dr. Sushil K. Singhi, resident of Rock Hill, South Carolina, am currently a senior interventional cardiologist at Carolina Cardiology Associates with an 18 year tenure. My cardiology fellowship was at St. Francis Medical Center/University of Pittsburgh, in Pittsburgh, PA. I have to my credit the privilege of having been Chief of Medicine at Piedmont Medical Center, Director of ICU and CCU at Piedmont Medical Center, President of Indian Physicians Association in Charlotte, NC, and I am currently the president of the York County Medical Society. My extensive service in community as well as various professional committees have afforded me a good deal of knowledge which I would like to share in part with you. In particular the necessity and benefits of maintaining a state of the art hospital, such as Piedmont Medical Center, in the York County area for this community as well as the surrounding counties.

This practice was founded in 1982 by Dr. Jay K. Shah. Dr. Shah is the dedicated senior partner and founder of the practice who actively participates along with the other physicians of the practice in providing interventional cardiac care to our patients. His fellowship was at Mount Sinai Hospital in Chicago, Illinois. Our practice is independently operated by a growing group of board certified interventional cardiologists who are admirably trained, enthusiastic and committed. We have a thriving practice with a vast array of professional physicians who are dedicated to providing professional, courteous, comprehensive and much needed cardiac care not only to the residents of York County but to the surrounding counties as well. Suffice it to say that it is imperative to our mission that we support Piedmont Medical Center as a leader in providing the latest technology and services to our residents and community and families. Having said that allow me please a moment to stress with clarity the unyielding importance of having the continued means to meet the needs of our patients locally without the threat of losing them to a North Carolina based hospital or out of state hospital affiliated group(s) of physicians. Here at Carolina Cardiology we pride ourselves on our autonomy and convenient accessibility to our patients. Our practice is large enough to treat the patients professionally and small enough to know them personally. That is precisely what we do – with much success.

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Fort Mill, SC 29715

It is a well known fact in the community that the physicians of Carolina Cardiology are committed to treating York County residents in York County as this provides economic stability for this state and for the physicians who choose to practice in this area. I personally trained at The University of Pittsburgh and can compare the treatment I offer my patients here in York County to that of Pittsburgh – the outcome is essentially the same. The patient needs are basically the same – they desire and deserve comprehensive state of the art care in an easily accessible facility in a familiar location. Currently, all of our physicians are within fifteen minutes or less to Piedmont Medical Center. This is a security our patients have come to trust and a potential vulnerability in that many of our patients are elderly and could be lost to follow if they have to seek care out of state to North Carolina. A large percentage of our clients are elderly. They have an established trust with the practice and we value that relationship.

There are several medical practices in York County that are owned by Charlotte, NC hospitals. Their patients are directed to go to Charlotte for their medical need. This has impacted negatively to our hospital. It has also hampered the continuity of patient care. It has been very inconvenient for patients and their families.

Piedmont Medical Center has been instrumental in providing resources and compassionate care to the patients in York county and in upper state South Carolina for that matter. I have found PMC to be comparable to the many other facilities where I have had the pleasure of practicing. I believe many other physicians in the area would concur with my conviction on that matter.

In conclusion, this letter is to familiarize you with my convictions and concerns regarding the future of Piedmont Medical Center and the importance of PMC to Carolina Cardiology Associates. I invite your comments. I am open and welcome further communication with you regarding this very important issue.

Thank you again for your time. I look forward to hearing from you.

Sincerely,

Sushil K. Singhi

Sushil K. Singhi, M.D., F.A.C.C., F.A.C.P., F.A.H.A.
SKS:sdc



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1460 Museum Rd
Rock Hill, SC 29732

July 7, 2011

South Carolina Department of Health and Environmental Control
Attn: CON Director Beverly Brandt
PO Box 8594
Columbia, SC 29202-8594

Dear Ms. Brandt,

I am writing to endorse the application filed by Piedmont Medical Center/Tenet Healthcare for a hospital in Fort Mill, South Carolina. I have written to you before with the same opinion that I now express. I thought it imperative; however, that some additional points relating to quality of healthcare services at Piedmont Medical Center be restated.

As the CMS data for the first half of 2009 clearly shows, there is no statistical difference between the three applicants when it comes to measurable outcomes in heart attack care, heart failure care, pneumonia care, and surgical care improvement project (See CMS Hospital Care website). I believe all three applicants deliver quality healthcare. I will address the quality of medical services I have witnessed at Piedmont.

I am a member of York Pathology Associates, a four member independent pathology practice, which provides pathology services to Piedmont Medical Center and two other hospitals in neighboring counties. The level of quality delivered at Piedmont is the result of the many individuals who contribute to the care at this hospital. This includes the quality of physicians who practice at Piedmont, the nurses and other healthcare professionals demonstrating a caring attitude, and the administrative team's guidance to ensure that the highest quality of medicine becomes the expectation of patients at this facility.

As a physician, I have the privilege to participate in multiple Quality Assurance activities which continually improve the quality of care at Piedmont. As a member of the Pharmacy and Therapeutics Committee, I meet every two months with a dozen other staff members and physicians to discuss which medicines should be used at the hospital, how

to better guide physicians as to the best blood utilization practices, and how the laboratory can help in this process. As a member of the Radiation Safety Committee, I interact in their quarterly meeting to ensure the safety of the employees and patients and to prevent overexposure to radiation. I meet monthly with our Medical Executive Committee to discuss policy changes or other administrative issues which impact the physicians and patients at this hospital. Members of my group participate on the Infection Control Committee, which has been largely responsible for significant reduction in rates of MRSA and other hospital acquired infections (including a zero rate of Ventilatory Acquired Pneumonia since April 2009). We have recently introduced a PCR molecular test (Gene Expert) in the laboratory which reduces the test turnaround time for MRSA results, which in turn saves on the cost of gowns/gloves, and also helps reduce MRSA in the hospital. One of my partners sits on the Credentials Committee, which ensures that all physicians are fully compliant with their board certification and other numerous requirements for practice at this hospital. In the past, I have participated in our Trauma committee, which meets to discuss and review cases of trauma which have been treated at Piedmont Medical Center. Lastly, our entire medical staff meets once a quarter to discuss hospital wide issues and policy changes which impact physicians and patients. In fact, on Monday, July 11th, our medical staff will be meeting to discuss and hopefully approve a blood utilization policy which will ensure that the right patient is getting the right blood product and at the right time. In fact, our hospital was one of only several hospitals nationwide which participated in a voluntary Joint Commission Patient Blood Management Performance Measures initiative. The result of this initiative has lead the Joint Commission to develop seven optional Core Measures. Our blood utilization policy will prepare PMC for adoption of these measures, likely in advance of other area hospitals. This will ultimately lead to the practice of evidence based medicine, the best patient care, decreased cost, decreased length of stay, and improved outcomes. On a side note, the CEO of the Charlotte area independent blood center CBCC (of which Piedmont is a member) has proposed that Piedmont (not the Charlotte facility) participate in trial of software to help optimize the blood resources in the area by reducing expiring products. Piedmont has an active Peer Review Committee, which reviews physician cases referred from a variety of sources to ensure adherence to the highest quality statndards.

On a personal note, my mother was admitted to Piedmont Medical Center several months ago with a diagnosis of sepsis. I am proud to report that she received excellent care, and I am proud to say I am on staff at this hospital. My wife delivered all three of our children at Piedmont, each time receiving excellent care. One of our children was born six weeks early and had an extended stay in the NICU. He and my wife received excellent care and never felt the need to be transferred to a larger facility. My daughter was admitted to Piedmont at the age of three and received excellent care. My brother has been admitted to Piedmont, and his wife delivered a child at Piedmont. The point of this is, I would not use this facility or allow my family to do so, if I did not believe in the excellent quality of this hospital.

I believe it is important to address the misnomer that outmigration from York County to Charlotte based healthcare facilities is a reflection of quality at Piedmont Medical Center.

I believe the outmigration is a reflection of three things: geography, patient-physician relationships, and ownership.

The northern portion of York County sits geographically close to the Charlotte based applicants, especially CMC-Pineville. Many residents of Fort Mill are geographically closer to CMC-Pineville than they are to Piedmont Medical Center. It would make sense; therefore, that many of these individuals, without a current Fort Mill hospital, would visit Mecklenburg County for their healthcare needs.

The patient-physician relationship also plays a large role in this equation. The reality is that many of the Fort Mill residents have migrated down from Charlotte to enjoy our lower taxes and better schools. Often, they have established patient-physician relationships in Charlotte which influence their choice of healthcare provider. Having been born in Charlotte myself, my parents moved to Fort Mill, when I was six. We continued to visit physicians and facilities in Charlotte, because of the relationships already developed.

I believe the biggest force in this outmigration; however, has been the ownership change in physician practices. As practices have been bought by the Charlotte based applicants, the physician referral pattern has changed dramatically. This has occurred with several family medicine practices, internal medicine, pediatrics, ob/gyn groups, and now cardiology. When these practices were independent, they trusted Piedmont enough to send their patients here for care. My physician practice surveys our clients to evaluate how we are doing as pathologists, and these results have always been excellent. As many practices have been bought by the Charlotte hospital systems, these referring physicians can no longer send their patient's specimens to our group. At one time, we were trusted with their care, but now we are excluded from participating. Additionally, these physician groups owned by the Charlotte applicants have, for the most part, resigned their active staff privileges from Piedmont Medical Center. The patients who live here in Rock Hill and have well established doctor patient relationships no longer have the option of being treated here by their physician.

Since the original decision of DHEC to award the Fort Mill hospital to Tenet, the Charlotte applicants appear to have intensified their purchasing of medical groups in the Rock Hill/Fort Mill area; thus leaving the citizens of York County with fewer choices.

In summary, there are many great things occurring at Piedmont Medical Center. Services have been expanded, and quality is continually improving. Piedmont has and will continue to be a member of this community, and accountable to this county and this state. Awarding the CON to one of the North Carolina based hospitals will potentially cripple or decimate the existing hospital in York County. It is a myth that competition does not currently exist in our county, as evidenced by the other applications' own data regarding outmigration. A CMC or Presbyterian owned hospital in Fort Mill will monopolize and reduce competition, and eventually raise healthcare costs, both by potentially driving PMC out of business and by facilitating acquisition of more physician practices.

Piedmont Medical Center provides quality healthcare locally, benefitting the local tax base and providing local jobs. The Rock Hill facility provides convenient quality services, as will the Fort Mill hospital. Awarding the CON to CMC or Presbyterian will only weaken PMC and actually erode the current competitive environment. As you know, CMC already owns eleven facilities in the Charlotte area, and Presbyterian owns four. Awarding one of them the CON will be detrimental to competition; it will not promote it.

Thank you for your time. It is my hope and prayer that you will make the right decision; a decision that will no doubt be a difficult one. Let's keep our patients, jobs, and tax dollars in the state of South Carolina, rather than exporting them!

Sincerely,

Robt E Thomas

Robert E Thomas, Jr. MD

CAROLINA CARDIOLOGY ASSOCIATES

Diagnostic and Interventional Cardiology

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July 7, 2011

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Fort Mill, SC 29715

It is a well known fact in the community that the physicians of Carolina Cardiology are committed to treating York County residents in York County as this provides economic stability for this state and for the physicians who choose to practice in this area. I personally trained at The University of Pittsburgh and can compare the treatment I offer my patients here in York County to that of Pittsburgh – the outcome is essentially the same. The patient needs are basically the same – they desire and deserve comprehensive state of the art care in an easily accessible facility in a familiar location. Currently, all of our physicians are within fifteen minutes or less to Piedmont Medical Center. This is a security our patients have come to trust and a potential vulnerability in that many of our patients are elderly and could be lost to follow if they have to seek care out of state to North Carolina. A large percentage of our clients are elderly. They have an established trust with the practice and we value that relationship.

There are several medical practices in York County that are owned by Charlotte, NC hospitals. Their patients are directed to go to Charlotte for their medical need. This has impacted negatively to our hospital. It has also hampered the continuity of patient care. It has been very inconvenient for patients and their families.

Piedmont Medical Center has been instrumental in providing resources and compassionate care to the patients in York county and in upper state South Carolina for that matter. I have found PMC to be comparable to the many other facilities where I have had the pleasure of practicing. I believe many other physicians in the area would concur with my conviction on that matter.

In conclusion, this letter is to familiarize you with my convictions and concerns regarding the future of Piedmont Medical Center and the importance of PMC to Carolina Cardiology Associates. I invite your comments. I am open and welcome further communication with you regarding this very important issue.

Thank you again for your time. I look forward to hearing from you.

Sincerely,

Sushil K. Singhi

Sushil K. Singhi, M.D., F.A.C.C., F.A.C.P., F.A.H.A.
SKS:sdc

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Transcript of the Testimony of
CMHA, ET AL V. SCDHEC, ET AL

Date: September 9, 2009

CREEL COURT REPORTING, INC.
Condensed Transcript and Word Index

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the Sixth Addendum requires to the hospital, those -- from the county's perspective, you would agree those are good ideas, aren't they?

A: I mean, good ideas for whom or for --

Q: For the county in order to see what the hospital is doing and to keep tabs on the hospital and to keep tabs on their prices and their expenses and the other things that are contained in those reports?

A: As I testified to this morning, if the -- if the county is trying to hold Piedmont accountable for what the county is demanding, and otherwise, the county wants Piedmont out, then certainly a way to then hold Piedmont accountable is through a reporting process.

Q: I didn't understand part of your answer, but let me rephrase it and you tell me if I've got this correctly and correct my language if I didn't. The quarterly and annual reports are a good way for a county to hold Piedmont accountable for its obligations under the contract; wouldn't you agree?

A: Yes.

Q: And the Carolinas, or for that matter Presbyterian, don't have those obligations, do

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County presses hospital system

By Ames Alexander
PUBLISHED IN: LOCAL NEWS

Top Mecklenburg County officials are trying to determine whether Carolinas HealthCare System is overcharging taxpayers for running the county's psychiatric hospital on Billingsley Road.

They're also asking why the county's costs for that hospital have risen rapidly at a time when some services are being cut.

CHS officials deny any overcharging and say they have honored the terms of their contract.

But county officials contend they have yet to receive the information required to evaluate the need for a new psychiatric hospital that CHS wants to build in Huntersville - or even to explain what taxpayers are getting for the roughly $19 million spent annually at the existing hospital, known as CMC-Randolph.

In a June 3 letter to Carolinas HealthCare CEO Michael Tarwater, County Manager Harry Jones contended the hospital system has breached its contract by failing to provide requested information about CMC-Randolph's patients and finances. He said the county would halt its payments to the hospital chain until that information comes.

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"If we are asked what we are buying, we want to be able to answer the question," said county General Manager Michelle Lancaster. "Right now, I can't answer the question."

Carolinas HealthCare, the multi-billion-dollar public hospital system that runs CMC-Randolph for the county, says it has provided complete information to help the county evaluate the hospital's finances and performance.

Among the county's questions:

-- Why have the county's costs for running CMC-Randolph grown rapidly as the county reduces some services there?

Under the contract, the county covers financial losses at the 66-bed hospital. Since 2005, the county's

annual funding has more than doubled, rising from about $8.5 million to $19.2 million, Jones noted. But during that period, the county has cut some services, such as intensive outpatient care for children.

It's clear, though, that CMC-Randolph has grown much busier. The emergency department saw more than 1,800 visitors in March - its highest number in at least 31/2 years.

CHS doesn't intend to provide the media detailed responses to many of the questions Jones has raised, hospital spokeswoman Gail Rosenberg said.

"It doesn't feel ... that there's a lot to be gained by that," she said.

-- Are Mecklenburg residents subsidizing treatment costs for CMC-Randolph patients who live in other counties?

In 2009, 23 percent of inpatients treated at CMC-Randolph came from other counties, a CHS consultant found.

Rosenberg said Mecklenburg taxpayers are not subsidizing their treatment. In fact, she said, those patients may help reduce the county's subsidy. Under the contract, she said, CHS absorbs any losses associated with treating out-of-county residents. But any financial gains are credited to the county, she said.

-- Why is the county being charged millions for things that aren't directly related to patient care?

Those indirect expenses - which include the salaries of 99 employees - are costing Mecklenburg $7 million a year, county officials say.

"This number would appear excessive without further explanation," Jones wrote.

Among the larger indirect costs billed to the county in the second half of 2010: $914,000 for "information services" and $672,000 for liability and malpractice insurance.

Hospital officials declined to discuss those charges.

-- How could the planned 44-bed hospital in Huntersville operate with far fewer employees than CMC-Randolph? Plans call for 102 employees at the new hospital; CMC-Randolph, which has 50 percent more beds, employs 525.

Rosenberg said that's largely because the new hospital won't offer some of the services provided at CMC-Randolph, such as a 24-hour emergency department and a pediatric treatment program.

A changing relationship

CHS officials have said the new hospital would meet the growing local need for psychiatric care. An Observer investigation last year showed that soaring demand has made it harder for dangerously ill patients to get hospital beds.

But some county leaders expressed skepticism, saying they're worried a new hospital in Huntersville would draw paying patients away from CMC-Randolph and increase the need for taxpayer subsidies.

Now, N.C. lawmakers are considering a bill that would let CHS build the hospital over the objections of county officials.

In his letter, Jones told Tarwater he was "stunned" that the hospital system pushed that legislation without telling the county. The bill won final approval in the Senate and is awaiting action in the House. It's unclear whether lawmakers will pass the bill before their expected adjournment this week.

The recent developments represent rare public friction between the county and its largest health care contractor.

Lancaster, the county general manager, said some of the questions have been prompted by a consultant with expertise in mental health finances. The county initially asked that consultant, Jennifer Huber, to work on other projects and has kept her on to review the contract with CHS.

The county has also increased scrutiny of mental health contractors following a scandal last year involving one provider. Mecklenburg Open Door's former executive director pleaded guilty to charges that he unlawfully took up to $120,000 from the now-defunct nonprofit.

Shrinking county's role

CHS has received about $60million from the county each year for running CMC-Randolph, caring for the indigent and providing public health services.

County officials are now re-evaluating their entire relationship with the hospital system. Some have said they believe CHS no longer needs so much taxpayer money. The hospital system had net income of $428million last year.

County commissioners last week approved a budget that ends the $16 million subsidy to local hospitals for care of indigent patients and cuts $500,000 from what the county pays CHS to run the health department. Jones also has proposed phasing out county money for CMC-Randolph.

CHS contends the county seems to be trying to damage the organization's reputation.

But Lancaster said that's not the county's goal.

"It's not accusations. It's not gotcha. It's really an effort to understand what it is the taxpayers are buying," she said. "I don't think that's too much to ask."

Staff Writer Jim Morrill contributed.

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Presbyterian Heatlhcare – York County CON
Positioning Campaign: "Promises Made, Promises Kept"

DRAFT 1/24/06

Light 31 + Days and her comments to date

GOAL:
Secure the CON in York County by implementing a coordinated public relations campaign over the next 90 days that will maximize stakeholder support in time for the DHEC project review in late March.

KEY MESSAGES:
- Presbyterian Healthcare is committed to serving this community (through investments in and affiliations with local physician practices).
- Our remarkable people deliver remarkable medicine.
- Having a choice is good for the community, and we want to be the provider of choice.
- We are the only applicant experienced in developing community hospitals of this type.

TARGET AUDIENCES:
- Legislative delegation and other elected officials
- York County Medical Society members
- Patients
- Residents

STRATEGIES/TACTICS

1) **Mobilize medical professionals as advocates.**
   - Make direct appeal to "independent" physicians to write letters to DHEC, news media and legislative delegation promoting choice.
   - Recruit physicians as speakers at public forum.
   - Place paid advertising for new clinics to support hospital campaign.
   - Conduct mini-campaigns for new practices, including briefings and outreach direction for staff; advertising; exterior signage; letters to patients; signage on counters, in waiting areas and in exam rooms; lapel stickers; pamphlet for each practice with docs photos and key messages; signage on public hearing, how to write DHEC, etc.; yellow pages (how much of this is already planned?).
   - At Presbyterian Lab Services, install new exterior signage; updated counter signs, pamphlets on serving York County, how to write DHEC, etc.
   - Install sign in Western York County at site of planned 24/7 clinic.
   - Install sign at new hospital site in Fort Mill.

EXHIBIT
AMISUB
276

2) **Energize citizen/patient supporters**

Pied.Supp.CON
0792

PHS Response to AMISUB 2RI

JOINT-B-PMC-001.0834

RECORD 002939

- Send direct mail "thank you" letter to those who have written on Presbyterian's behalf along with an update on the process and encouragement to attend the forum and write additional letters to DHEC and delegation.
- Send mass mailing to northern York County, Presbyterian patients and employees in York county, patients of newly acquired practices.
- Consider sending DVD to same audiences, portraying Carl, Paula, Huntersville mayor and physicians, Matthews or Huntersville businessmen, etc.
- Continue issues advertising in local newspapers; consider augmenting with radio.