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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.

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1 was what was provided in December of 2010.
2 Q: And of the three CON applicants, CHS was the
3 only one who waited until December of 2010 to
4 present its updated charity care projection, is
5 that correct?
6 A: I wouldn't characterize it that way. Again, we
7 did not know at the time that the information
8 was submitted in October what the other two
9 applicants were going to do, whether they were
10 going to submit anything or not, or whether
11 they were going to similarly say here's what's
12 in our '05 application and we think it should
13 have been approved. And so we didn't know what
14 they were going to do. And it was -- it wasn't
15 a waiting; it was, you know, at DHEC's request
16 for updated information that CHS responded.
17 Q: So whatever the reason, though, it wasn't until
18 December that you submitted that 6.3 projection,
19 isn't that correct?
20 A: The timing of that is correct, yes.
21 Q: At the time of your deposition at least, you
22 didn't know why CHS had changed that projection
23 from three point something to 6.3, isn't that
24 correct?
25 A: I did not know -- at the time of my deposition

1 I had not read Mr. Stewart's deposition and did
2 not know or certainly didn't recall if there
3 was a particular reason behind that change.
4 Q: And Mr. Stewart testified in this trial, and
5 you were here for his testimony, that that 6.3
6 was based on a waited average from 2009 charity
7 care data from Pineville and University; do you
8 recall that?
9 A: I do recall it was weighted average data from
10 University and Pineville. I can't recall the
11 specific year, but 2009 is likely.
12 Q: All right.
13 **MR. WESTBROOK:** Let's look at CHS Demonstrative
14 2.11, Dan, if you could put that on the screen
15 for us, please.
16 Q: You recall seeing this demonstrative during Mr.
17 Stewart's testimony?
18 A: Yes.
19 Q: Now, and he walked through this in some level
20 of detail; do you recall that?
21 A: Yes.
22 Q: So we won't try to retrace all his steps. But
23 are you familiar with the DHEC definition of
24 charity care?
25 A: Yes.

1 Q: And that DHEC definition does not include bad
2 debt, isn't that correct?
3 A: That's correct.
4 Q: And in this particular case, as Mr. Stewart
5 testified there was some -- the charity care
6 that went into that 6.3 percent projection is
7 that number towards the bottom in the charity
8 care line item of 19,486,000, is that right?
9 A: I believe that's correct.
10 Q: And as Mr. Stewart explained, that number, that
11 19486 number was -- that amount was created
12 from various portions of various amounts in the
13 line items in the top half, is that right?
14 A: It -- I'm hesitating on your use of your word
15 "created."
16 Q: Well, created is probably not the -- I
17 struggled to think of a verb. What's a better
18 verb than that? Constituted?
19 A: Well, I mean, the bottom line is the two bottom
20 line figures match up, and so the subtotals --
21 so in essence, I mean, the two bottom line
22 numbers add up and they're -- because of the
23 differences in the reporting software and what
24 occurs before charity care is reported in GAAP
25 related financial statements -- well, let me

1 back up. What happens in between the report of
2 the PeopleSoft report and what happens as those
3 actual results feed into the GAAP reports is
4 what creates the differences in the numbers.
5 Q: And that $19 million number includes amounts
6 that were characterized on the top part of this
7 demonstrative as both bad debt and self-pay,
8 isn't that correct? Didn't Mr. Stewart testify
9 to that?
10 A: He did. But I understand his testimony to be
11 it is not as though they were bad debt and CHS
12 decided we're going to make them charity care
13 instead of -- because of our definition of
14 charity care, we're going to make them charity
15 care when they really are by some other
16 definition bad debt. What my understanding of
17 his testimony is, and again, I think I told you
18 in my deposition this has been my experience
19 with my own father's bills, is that it is not
20 always determined at the point of admission
21 whether or not a patient is a charity care
22 patient. And so, and it could be some period
23 of time afterwards. And so it's, you know,
24 while these numbers in this PeopleSoft report
25 get put into these buckets, it isn't until they

1 get translated through the practices that are
2 then approved by the audit firm, as Mr. Stewart
3 testified, as to what really is charity care
4 and what really is bad debt. And that's the
5 reason, in my opinion, and is, you know, is
6 supported by Mr. Stewart, you need to look at
7 charity care once that process has been gone
8 through to determine what is really charity
9 care.
10 Q: So you need to look at it after it's been
11 reclassified as a charity care is what you're
12 saying, is that right?
13 A: And what I want to be clear about, again, this
14 isn't -- Mr. Stewart said that this charity
15 care that he based the projections on for the
16 Fort Mill Hospital met the definition that's in
17 the South Carolina regulations, and it is not
18 as though -- it's not as though this is bad
19 debt that everybody else would call bad debt
20 and CHS calls, you know, decides they're going
21 to reclassify it as indigent -- as charity
22 care.
23 Q: Well, at some point in time, CHS called it bad
24 debt, isn't that right?
25 A: For a report, which is an internal report that

1 is not utilized for any purpose to determine
2 what is actually bad debt and charity care.
3 Q: So internally they called it bad debt and
4 externally they called it charity care; is that
5 what you are saying?
6 A: No, that's not what I'm saying. As I told you
7 in my deposition, I have seen similar reports
8 for other clients similar to the PeopleSoft
9 reports, and I have never used that report for
10 any client of mine to evaluate revenue
11 deductions because they never match up what the
12 ultimate categorization is based on when you
13 both let time lapse so that you determine what
14 patients are actually charity care patients and
15 -- AND maybe the best way to explain it is
16 this. You might have a patient who comes in
17 who's admitted that you have no idea whether or
18 not they're charity care, and so they -- until
19 you know that they're charity care, they're bad
20 debt, and then three months after they're
21 discharged, you may, once you've gotten
22 paperwork for that patient, oh, they meet the
23 charity care definition. And so they really
24 are a charity care patient, they were a charity
25 care patient from the day they were admitted,

1 you just didn't know that. So it's not a
2 matter of deciding this -- I'm going to take
3 this bad debt and I want to call it charity
4 care. It's a matter of not knowing until some
5 subsequent time frame that the charity care
6 patient actually really was a charity care
7 patient and not a bad debt patient.
8 Q: And Mr. Stewart testified I believe consistent
9 with what you just said that these
10 reclassifications from bad debt to charity care
11 occurred sometimes before, sometimes --
12 sometimes before admissions or at admissions,
13 sometimes during patient care, and sometimes
14 after discharge. So they occur at different
15 times, right?
16 A: I recall his testimony that, yes, it --
17 Q: Now ---
18 A: At different times, it is at different times in
19 the process that you're able to determine
20 whether or not a patient is really a charity
21 care patient.
22 Q: You mentioned doing this for other clients.
23 You've done this for other clients in South
24 Carolina, other South Carolina clients?
25 A: I very well ...

1 Q: If you recall?
2 A: Well, I seem to recall that we got similar
3 performance reports from -- that I've seen
4 similar performance report from Beaufort, but I
5 can't bring up a specific example.
6 Q: And during this period of time, this was before
7 Mecklenburg County terminated the contract with
8 CHS, right? When this -- these charity care
9 projections were made, when Mr. Stewart made his
10 decision or his projection of the 6.3 percent,
11 that was prior to 2012 termination of the
12 contract, wasn't it?
13 A: I don't know the timing of the contract issues
14 between Mecklenburg County and CHS.
15 Q: Well, do you know at the time that he made the
16 projection, 6.3 projection, wasn't it true at
17 that time that CHS was being reimbursed, I
18 believe Mr. Murphy said 16 and a half million
19 dollars a year for charity care by Mecklenburg
20 County?
21 A: Again, I don't recall the timing. I know at
22 some point in time there has been and I --
23 there has been some reimbursement from
24 Mecklenburg County for some certain, and I don't
25 know which ones, but for some very specific

1 patients seen at CHS.
2 Q: Let's go to Demonstrative 4.9, please. This
3 is, Ms. Carter, your Demonstrative 4.90. This
4 is your efficiency chart that you testified
5 about day before yesterday. I have a few
6 questions.
7 **MR. WESTBROOK:** At the top of the page, let's just
8 focus, Dan, at the top. We can just kind of
9 take this in small bites.
10 Q: The first part involves capital costs. Let's
11 just look at the capital costs for a minute.
12 And two categories, two line items, cost per
13 square foot and costs per bed, is that right?
14 And I believe that you said, and there may even
15 be a footnote, I'm not sure, to this effect
16 that you considered numbers that were within
17 five percent of each other to be close enough
18 that you wouldn't count it one way or the
19 other, is that correct?
20 A: That's correct.
21 Q: Is that the best way to say it?
22 A: Yes.
23 Q: Was that clear? And costs of square foot would
24 be an example of that, that they're close
25 enough that I guess that would be what, de

1 minimus or immaterial or something of that
2 nature?
3 A: Again, I looked at it and given the differences
4 in the other -- in the other items, I just said
5 if it's five percent or less, I'm not going to
6 allocate it.
7 Q: Now, for the cost per bed you've got Fort Mill
8 Medical Center as 1,271,378, and then that
9 figure 1.2 million for CMC-Fort Mill. Get out
10 your calculator, if you don't mind, and what's
11 the difference? What's the percentage
12 difference in those two numbers?
13 A: It's five percent.
14 Q: Okay. If you subtract, tell me -- let's make
15 sure I understand the process here. You would
16 subtract one number from -- the smaller number
17 from the larger number, is that the way you
18 would do it, and then divide by the larger
19 number; is that the process?
20 A: No, I divide by the smaller number.
21 Q: Divide by the smaller number. All right. And
22 that comes out to five percent?
23 A: Yes.
24 Q: All right. Now, if you divide by the larger
25 number, what does it come out to?

1 A: It comes out to slightly less 4.7, but that's
2 not the way I would do the math for that
3 formula.
4 Q: Okay. Now, that's based on a total project
5 cost for FMMC of roughly $127 million, right?
6 Do you recall, or is that -- I think it
7 probably said it somewhere on your chart.
8 A: I think it's in the footnotes to the chart, but
9 yes, it would be roughly 127 million.
10 Q: All right. And you're aware, of course, that
11 Piedmont contends its costs are 119 million?
12 A: Yes, I'm aware of that and I think I footnoted
13 what I added to that cost.
14 Q: Right, and you disagree with that. That
15 involves the capital interest issue whether that
16 interest should be capitalized, right?
17 A: That's correct.
18 Q: All right. And Mr. Levitt has testified about
19 why he feels that that number should -- that
20 capitalized interest should not be included.
21 You've testified a different opinion than him on
22 that. If it were to be 119 million, let me
23 just ask you to do the -- and I realize that
24 you disagree with this, but let me just ask you
25 to do this exercise for me. If it were, the

1 cost were 119,808,943, if that were the case,
2 what would the cost per bed be for FMMC?
3 A: It would be approximately 1.19 million.
4 Q: So it would be slightly less that CHS's cost
5 per bed, right?
6 A: Yes, it would be. That calculation would be
7 less than CHS's cost per bed.
8 Q: And the calculation that you did for the
9 difference between the two costs that are up
10 there on your chart, it rounded out to five
11 percent, but was it exactly five percent?
12 A: I believe my calculation was 4.9 something.
13 Q: 4.9? So just under five percent, is that
14 right?
15 A: I calculate it to be 4.95, which I would round
16 a 4.95 number up to five.
17 Q: All right. Thank you. Now, the next area of
18 your chart involves space program.
19 A: And just to clarify, I mean, that's actually
20 what I did in this spreadsheet. I don't have
21 the column on here, but I had the -- I had the
22 spreadsheet actually do that calculation, and so
23 the ones where it came back to five percent or
24 greater are the ones that got highlighted, and
25 the ones that came back with a number less than

1 that did not.
2 Q: All right. Space program, the line item, let's
3 pull it out so I can read it, please, Dan, non-
4 patient care percentage of total patient care,
5 so we are talking about patient care space and
6 non-patient care spaces, is that right?
7 A: That's correct.
8 Q: Now, there's not a standard definition of what
9 space in a hospital constitutes patient care
10 space as opposed to non-patient care space, is
11 there?
12 A: No, what I did, and as I recall, fortunately
13 the applicants had very similar space programs,
14 and so what I did is counted any space where
15 you might find a patient, obviously, the nursing
16 units, the imaging department, I think even lab
17 where patients might not necessarily go, but you
18 need that space for patient care, I counted
19 that as patient care versus non-patient care,
20 which would be even though it might involve
21 support functions to patients like dietary and
22 housekeeping, materials management, things like
23 that, it's not directly involved in patient
24 care.
25 Q: What about hallways, for example?

1 A: I believe that -- I did it one of two ways, and
2 I just can't recall. I either compared this on
3 a net square footage basis, and so that was
4 before any applicant showed their square footage
5 for hallways, or if they grossed it up, so to
6 speak, by department then that would have been
7 -- that would have been factored in.
8 Q: I'm sorry. So a hallway would be counted as
9 patient care or non-patient care? I just
10 missed it.
11 A: Again, what I can't recall is I can't recall
12 whether the -- in other words, if the space
13 program had the net square footage of a nursing
14 unit, for example, and then they applied a
15 factor directly to that unit to gross it up,
16 which would gross it up for hallways as well as
17 the outside walls, then that would have been --
18 then I would have allocated that -- that
19 portion that was attributed to that nursing unit
20 to that nursing unit. Sometimes that -- it
21 happens in space programs that way, or other
22 times they'll do all the net departments, and
23 then at the very bottom they'll gross it up for
24 hallways and wall thickness and that sort of
25 thing, and I just can't -- and so I either, to

1 the best of my recollection, I was either
2 comparing net to net between the applicants, or
3 if they were grossed up at the department
4 level, then I would have been comparing the
5 hallways as they got, so to speak, as they got
6 allocated unit to unit.
7 Q: Now, a waiting room, you would count that as
8 non-patient care then?
9 A: Again, it depends -- it depends on where -- I
10 did it at a unit by unit level. So in other
11 words, if in the space program there was a
12 waiting room for the imaging department, I
13 included that in the patient care area. If
14 there was a waiting room at the business
15 office, that would have been included in the
16 non-patient care area.
17 Q: All right. And what about a lobby?
18 A: I believe the lobby was -- those areas were
19 included in non-patient care areas.
20 Q: How about kitchen?
21 A: Again, to the best of my recollection, and as I
22 said a moment ago, I'm not -- these patients,
23 these spaces are needed to support patient care,
24 but they don't directly involve direct patient
25 medical care. I believe the kitchen was

1 included in non-patient care areas.
2 Q: And a chapel? If the hospital had a chapel,
3 would the chapel be ---
4 A: Likewise, that would be non-patient care.
5 Q: Non-patient care. So under this way of
6 evaluating things, a hospital with a larger
7 kitchen would be considered less efficient than
8 a hospital with a smaller kitchen, right; is
9 this how it works out?
10 A: Well, ultimately the purpose of this analysis is
11 to say throughout your entire building that
12 you're building, and it may differ slightly
13 department by department, but throughout the
14 entire building that you're building, are you
15 able, based on any number of factors, which in
16 CHS's case may be because there are functions
17 that are happening in Charlotte that don't have
18 to be replicated in Fort Mill, are you able to
19 allocate more of the space that you're building
20 for areas that involve patient care versus non-
21 patient care.
22 Q: But if you're comparing two hospitals based on
23 this set of criteria that you're using here and
24 you're comparing them under your method for
25 efficiency, the hospital that had a chapel, a

1 larger kitchen, larger waiting rooms, larger
2 lobby, would be considered less efficient than
3 the hospital with smaller ones or none of
4 those, is that right?
5 A: Again, I would say that I didn't look at it --
6 I didn't look at it at that level. I looked at
7 it overall, are you proposing a facility where
8 most of your space is being dedicated to
9 patient care, or are you -- are you building a
10 facility where there is more that is less
11 involved in patient -- more space that is less
12 involved in patient care.
13 Q: And I believe you testified earlier that if a
14 hospital wants to expand, unless they have some
15 rooms or areas that they can -- that it's okay
16 to convert to bed space, or unless they have
17 some shell space, they're going to have to do
18 new construction, isn't that right? Didn't you
19 talk about that a few minutes ago before lunch?
20 A: Yes, I recall that.
21 Q: And I think you also said that, as far as you
22 know at least, the CHS plan doesn't have any
23 shell space, is that right?
24 A: That's correct, yes.
25 Q: So, again, if you're comparing two hospitals,

1 one with shell space and one without shell
2 space, the one with shell space would be
3 considered more inefficient under the way you're
4 evaluating this, isn't that right?
5 A: Again, it all depends on how that would have
6 been listed in the space program.
7 Q: Let's go to the staffing part of the efficiency
8 chart. And stroll down to where it says
9 staffing there at the bottom. Now, the first
10 line item is clinical FTEs per adjusted occupied
11 bed, and we've got -- you gave us a green mark
12 on that one, which is good. That's a change in
13 your opinion, isn't it?
14 A: Not that I recall.
15 Q: Didn't you, prior to this argue that CHS had
16 higher clinical FTEs than per occupied, adjusted
17 occupied beds?
18 A: I did not, no, not to my recollection.
19 Q: Really? Well, good. That's a different
20 conclusion though than Ms. Platt came to, isn't
21 that correct, than she testified? You heard
22 her testify that clinical FTEs were -- went in
23 the favor of CHS?
24 A: She may have. I don't recall that
25 specifically, but ...

1 Q: And there's also -- I'm sorry, somewhere before
2 I forget, it's not under staffing. I think I
3 just skipped over it, there's a line item about
4 depreciation.
5 **MR. WESTBROOK:** Can you find that, Dan?
6 Q: And the depreciation, just that single line item
7 there, you rated the people equal, or the two
8 applicants equal on that, and I think there's a
9 footnote that basically says they used different
10 methods to calculate depreciation, do you recall
11 that, or do you want to go to the footnote and
12 read it?
13 A: Yes, and I didn't, that's one I did not rank
14 them one way or the other, but what that
15 footnote says is that they used different
16 depreciation methods, which I do believe Ms.
17 Platt had testified to, in my opinion, making
18 the comparison of the results not useful.
19 Q: All right. Let's go back to the staffing then,
20 please. At the bottom there, staffing. So the
21 staffing, as I understand it, so the clinical
22 FTEs per adjusted occupied bed basically you
23 give the mark to us, the good mark to us; on
24 the non-clinical FTEs per adjusted occupied bed
25 you give the good mark to CHS. The total FTEs

1 per adjusted occupied bed goes to CHS at 3.1
2 compared to our 4.2, is that right?
3 A: Yes.
4 Q: Now, those non-clinical FTEs, there are, in
5 fact, non-clinical personnel that provides
6 services to CHS that are offsite and that are
7 counted in intercompany expense, is that right?
8 A: My understanding is that there are centralized
9 personnel, which is the reason that CHS is able
10 to operate its individual hospitals at these
11 levels, and in my opinion, more efficient levels
12 because there are offsite personnel who perform
13 functions that are spread across multiple
14 hospitals versus being, you know, located at a
15 single hospital.
16 Q: All right. Let's look at Joint Exhibit 1A,
17 page 543. This is, as you see, the projected
18 income statements for CMC-Fort Mill, three years
19 of proposed budgets, or projected budgets, Ms.
20 Carter. And you see there's a line item there
21 about three-quarters of the way down that says
22 intercompany expense, and those are, that's
23 $9,344,000 year one and so forth, correct?
24 A: That's correct.
25 Q: And is it your understanding that that's where

1 the expenses for these centralized employees or
2 personnel would be accounted for?
3 A: Yes.
4 Q: And that goes from, starts from year one 9.3
5 million up to 11.2 million in year three, is
6 that right?
7 A: That's correct.
8 Q: Now, again, my understanding is that these
9 centralized folks that are providing services to
10 a number of different CHS facilities, they're
11 centralized somewhere by -- and by centralized,
12 you mean they wouldn't be onsite there in Fort
13 Mill, right?
14 A: My understanding is they wouldn't be onsite at
15 Fort Mill, and they wouldn't be, it's not --
16 and there's not a person sitting there that
17 says this is the Fort Mill person.
18 Q: Right. There would be people in Charlotte or
19 somewhere that would provide a number of
20 services, non-clinical services to a number of
21 different CHS hospitals or facilities, isn't
22 that right?
23 A: Yes.
24 Q: And I think, it seems like to me in your
25 direct, you referred to that and talked about

1 as much as a dozen or so hospitals they might,
2 did you say that? Did I hear you say 12, or
3 did I dream that?
4 A: I think what I was talking about is that
5 relative to the efficiencies overall that CHS
6 offers as a system, it is -- you know, it's
7 their large size as a total system, but in
8 addition, it is what they can offer in terms of
9 local supplies and materials management and
10 inventory of supplies and things like that, that
11 given their -- I guess, their geographic
12 relationship to each other in the broader
13 Charlotte market, and that would involve
14 probably a dozen or so hospitals, I think is
15 what I said.
16 Q: A dozen or more hospitals? I'm sorry, a dozen
17 more hospitals?
18 A: Yes.
19 Q: Let's go to Bates page 546 on this Joint 1A.
20 And this is the staffing projections that CHS
21 submitted, right? The staffing plan?
22 A: Yes.
23 Q: And the totals are at the bottom, 313.9 going
24 up to 348 by year three, those are the total
25 FTEs upon which that 3.1, is it 3.1 or 3.2

1 whatever that number is FTEs per adjusted
2 occupied bed, those are the numbers on which
3 those FTEs per adjusted occupied bed are based,
4 isn't that correct?
5 A: Yes.
6 Q: All right. And the offsite centralized
7 employees that we've been talking about aren't
8 reflected in those numbers, or even portions of
9 them are not reflected in those numbers, isn't
10 that correct?
11 A: That's correct.
12 Q: All right. So if you have a guy in Charlotte
13 or wherever that's providing accounting services
14 or maintenance services or whatever kind of --
15 laundry services or whatever those centralized
16 services may be to a dozen or more hospitals, a
17 percentage of his time, of that particular
18 individual's time, while the cost of that time
19 are counted in the intercompany expense line, it
20 doesn't -- it's not reflected on the FTE total,
21 is it?
22 A: That's correct, and that's why, because of their
23 ability to have, you know, in this example,
24 that person served multiple hospitals and some
25 of those -- some of those services that are

1 provided centrally are not only provided to the
2 hospitals in the immediate Charlotte region but
3 are provided to some of the managed hospitals
4 that are even broader than that. And so the
5 very reason that CHS hospitals like CMC-Fort
6 Mill can operate more efficiently is because
7 those personnel are centralized and they can
8 perform those functions for many different
9 hospitals instead of being dedicated and located
10 at one hospital and serving only that hospital.
11 Q: But that failure to account for whatever
12 percentage of that individual's time -- I'll use
13 my hypothetical guy providing accounting
14 services, Joe the accountant -- that failure to
15 account for his time on the FTE total is
16 inconsistent with what DHEC intends, isn't that
17 correct?
18 A: I don't believe so.
19 Q: Have you read Ms. Brandt's deposition?
20 A: Some time ago, I did.
21 **MR. WESTBROOK:** Let's take a look at Ms. Brandt's
22 deposition and let's put that on the screen
23 Dan, page 354.
24 Q: Now, Ms. Brandt gave more than one -- she was
25 deposed on two or three different days, so this

1 is from the May 17th, 2012, deposition, and as
2 you can see there, Beverly Brandt, Thursday, May
3 17, 2012. I want to go to page 354 of that
4 deposition, and this is going to spill over to
5 the next page. But on page 354, let's start at
6 the top of the page at line 4, and once again,
7 using our same old technique, I'll read the
8 questions if you'll read the answers, Ms.
9 Carter. And of course the answers are not your
10 answers, they're Ms. Brandt's answers, I guess
11 that's obvious. Line 4, Question: "Now, when
12 you determine how many FTEs serve a facility,
13 when you're making that calculation, you're
14 relying on what the applicant provides you in
15 terms of information, correct?" Answer?
16 A: "Yes."
17 Q: Question: "And would you expect the applicant to
18 include offsite FTEs as well as onsite FTEs, or
19 would that be limited to just onsite FTEs?"
20 Answer?
21 A: "You might have to expand on offsite, but I
22 expect for them to identify the FTEs associated
23 with the project."
24 Q: Question: "Well, a hospital obviously has a
25 geographic site. In this case, all of these

1 are going to be in Fort Mill. Now, if there
2 are employees of any of these three applicants
3 who are providing services to that particular
4 facility, but the employee is located in some
5 city other than Fort Mill, Rock Hill or
6 Charlotte or Atlanta or whatever, if that
7 employee is providing services to the Fort Mill
8 facility, would you expect that employee to be
9 included among the FTEs that they have
10 provided?" Answer?
11 A: "Well, I don't believe that was part of this
12 application, and as far as somebody living in
13 Atlanta, I can't quite grasp why they would be
14 living in Atlanta, but I can tell you if it was
15 associated with the project, then they needed to
16 be captured in the application."
17 Q: And here in this case, though, Ms. Carter, you
18 have employees associated, offsite employees
19 associated with this project, but they're not
20 captured in the FTE totals in this application,
21 are they?
22 A: I don't agree with that. The way I read Ms.
23 Brandt's testimony, and the way I understand
24 what went into the staffing projections of the
25 CHS application is she's saying if it is an

1 employee of the facility and if for whatever
2 reason they're located offsite, and if it's an
3 employee for the project, then that employee
4 needs to be counted in the FTEs. That's very
5 different from saying that, you know, we have
6 an accounting staff in Charlotte that can
7 accommodate additional work for a CMC-Fort Mill
8 hospital, and therefore, that service is
9 provided by various people in Charlotte, and
10 they are not employees, they are not
11 specifically hired because they're needed to
12 serve as the CMC-Fort Mill hospital.
13 Q: Okay. Ms. Carter, you testified about the
14 opposition and support letter the day before
15 yesterday, right?
16 A: Yes.
17 Q: And the opposition letters, DHEC counted found
18 34 opposition letters to Piedmont or Fort Mill
19 Medical Center and over 5,000 support letters to
20 Piedmont; are you aware of that?
21 A: I believe those were the ballpark numbers in
22 the DHEC letter, yes.
23 Q: And the 34 letters of opposition, including the
24 four that you put on the screen day before
25 yesterday, I mean you don't know personally who

1 wrote these letters? You don't know these
2 individuals, do you?
3 A: Well, first of all, I don't believe the four I
4 read were the ones that were counted in the
5 DHEC opposition. As I believe Mr. Murphy
6 testified, there were, and I can't recall his
7 exact characterization, but there were many,
8 many, many of the CHS support letters that
9 included opposition to Piedmont, and those were
10 the letters I read into the record. Those four
11 letters, I do not personally know those four
12 people.
13 Q: Do you know anybody who wrote an opposition
14 letter?
15 A: I don't know one -- if I know them, I don't
16 know that I know them.
17 Q: I understand. So, and you would know, for
18 example, for those four or any of the others,
19 you wouldn't know whether -- who that employee
20 was?
21 A: I did verify -- I did verify two things for the
22 four that I read into the record. I verified
23 that they live at the addresses that they
24 indicated, and I asked CHS to verify whether or
25 not they were or had been employees, and they

1 told me no, they were not employees and had
2 never been employees of CHS.
3 Q: Do you have any knowledge of whether they were
4 ever employed by Piedmont?
5 A: I do not know that.
6 Q: Do you know anything about their history other
7 than they weren't employed by CHS?
8 A: No. I've told you the extent of what I know
9 about those four individuals.
10 Q: Now, CHS had over 5,000 support letters counted
11 by DHEC too, is that right?
12 A: That was how DHEC counted it, yes.
13 Q: And in terms of who wrote those letters, let's
14 take a look at CHS 3988.
15 **MR. WESTBROOK:** And look at the top of the page.
16 Dan, if you could highlight those two lines in
17 italics. There you go.
18 Q: It says, To be used by registration personnel
19 in our physician practices in York County and
20 the emergency departments of CMC-Pineville and
21 CMC Steele Creek, right?
22 A: That's what that says.
23 Q: All right. And you were here for Dr. Robert
24 Alexander's testimony, were you not?
25 A: Yes, I was.

1 Q: And he was one of the physicians, one of the
2 pediatricians that testified on behalf of CHS,
3 correct?
4 A: Yes.
5 Q: And did you hear Dr. Alexander testify that he
6 wasn't aware of any registration personnel or
7 any personnel in his office seeking support
8 letters from patients; do you recall him saying
9 that?
10 A: I recall something along those lines.
11 Q: Do you recall him saying that if he -- if that
12 were to be done, he would consider it
13 unethical?
14 A: I can't remember if he used that word in the
15 trial itself, but I think he said he was not --
16 he would not have allowed that in his office.
17 Q: All right. Do you consider that -- let's
18 assume for the moment -- I mean, the record
19 will speak for itself as to what words he used
20 and whether he said that, but if he did say it
21 was unethical, or if he did feel it was
22 unethical, what would be your feelings about
23 that? Would you consider it to be unethical to
24 solicit support letters in a physician office
25 from patients?

1 A: No.
2 Q: Let's go to 3989, please, CHS 3989, and I think
3 this has been looked at before, but there are a
4 couple of line items here I wanted to ask for.
5 This is a focus area, public support plan, I
6 think is what it says, March and April 2011,
7 you see that?
8 A: Yes.
9 Q: All right. And A1, line A1 says, we are
10 talking about physician practices here, it says
11 in parenthesis Cole, do you know who Cole is?
12 A: No.
13 Q: All right. A1 says, provide new script to
14 registration staff message, please help us if
15 not already done so. And have you seen this
16 document before?
17 A: No.
18 Q: Well, you saw it the other day when it was in
19 trial, right?
20 A: Honestly, from where I was sitting, it was a
21 little hard to read the small screen from a
22 couple rows back, but ...
23 Q: I understand. All right. So, and then line 3
24 talks about physicians sending letters to
25 patients requesting a support letter and the

first bullet under there is, draft a letter for approval, right? So does that indicate to you that somebody at CHS was going to draft a model letter or a form letter?

A: I don't know anything beyond what it says right there.

Q: All right. And look at number 6, read number 6, please.

A: "Pursue CMC-Pineville volunteers to station at highest volume physician practices to help with support effort."

Q: At the highest volume physician practices. Again, you don't consider -- you wouldn't consider that to be unethical?

A: No. As I testified the other day, almost every CON application that we assist clients with filing there's a support campaign. I think a physician educating their patients about a particular CON review and asking them whether, you know, that if they would like to support an applicant, here's how you go about doing that, I don't think that is a problem.

MR. WESTBROOK: Dan, if you would move down to B.

Q: B says, employees parenthesis Murphy 1. Determine which employees have not completed

1 letter of support. I don't think I have any
2 questions about that for you. Ms. Carter,
3 let's go to CHS Exhibit 21. I think this was
4 put on the board yesterday. As you said,
5 public support campaigns aren't uncommon, and I
6 think -- and there was testimony or has been
7 testimony, I think from you but it might have
8 been somebody else, that all three applicants in
9 this case had a public support campaign going,
10 is that right?
11 A: Yes, I do believe that's correct.
12 Q: And this Exhibit 21, I think, did you testify
13 about this Tuesday?
14 A: Yes, I did.
15 Q: I thought so, yeah. This is a memo related to
16 Piedmont's public support campaign, is that
17 right?
18 A: Yes.
19 Q: And you went through some of it on your direct
20 testimony. This by the way, just for the
21 record, is page 577, Exhibit 21. Is there
22 anything in this memo, just take a minute to
23 look over it and maybe you can do this from
24 your memory, is there anything in this memo
25 about trying to get support letters from

1 patients in physician offices?
2 A: I think, no, there's nothing in this document
3 which was sent to employees, which is a little
4 bit different from the document we were looking
5 at for CHS, which was not something that
6 appeared to be sent to employees. But there's
7 -- this as I read this Piedmont document is a
8 document that went to employees to say basically
9 here's how you as employees can help us in our
10 support campaign.
11 Q: Have you seen any evidence anywhere of anything
12 related to the Piedmont campaign where support
13 letters were solicited from patients in
14 physician offices?
15 A: I don't -- there's nothing I've seen that I can
16 recall. I don't know whether something like
17 that exists or not.
18 Q: Have you seen anything, any evidence that
19 physicians were asked to call their patients for
20 support letters?
21 A: Again, I don't recall seeing anything like that
22 in the materials that I reviewed. I don't know
23 whether it exists in some other materials or
24 not.
25 Q: All right. Bear with me for just a moment,

1 okay.
2 **MR. WESTBROOK:** Your Honor, if I could beg your
3 indulgence for a second.
4 **THE COURT:** Certainly.
5 **MR. WESTBROOK:** Or a few seconds.
6 Q: Ms. Carter, in your review of the support
7 letters that Piedmont received, did you -- as
8 part of that review when you read those
9 letters, did you see that within some of the
10 support letters, particularly within some of the
11 physicians support letters for Piedmont, there
12 were negative comments about CHS made?
13 A: Yes, I recall that.
14 Q: And those weren't counted as opposition letters
15 by DHEC, were they?
16 A: I don't believe they were.
17 Q: Well, DHEC, according to DHEC's count, CHS had
18 no opposition letters, isn't that correct?
19 A: I can't recall exactly what they counted, but I
20 don't believe they did.
21 **MR. WESTBROOK:** Let's look at, Dan if I could ask
22 you to pull up, this is from support letters
23 produced to DHEC, Piedmont MD letter 21, Bates
24 page 21, please. Excuse me, I'm throwing
25 something at Mr. Bupp here. Your Honor, we

1 obviously have a little glitch going on right
2 now.
3 **THE COURT:** Yes.
4 **MR. WESTBROOK:** I am almost done. I would say I'm
5 probably 15-20 minutes of being through with my
6 cross- examination, would a five minute break be
7 okay?
8 **THE COURT:** Yes, let's take a five-minute break.
9 **(Break from 2:25 p.m. until 2:41 p.m.)**
10 **THE COURT:** Was that enough time, Mr. Westbrook?
11 **MR. WESTBROOK:** It was. Thank you. I appreciate
12 it, Your Honor. I'm sorry we ---
13 **THE COURT:** No problem at all.
14 **MR. WESTBROOK:** --- weren't ready for that.
15 Q: Ms. Carter, let me ask ---
16 **MR. WESTBROOK:** Well, first of all, let me ask Dan
17 if he can put on the screen, let's start with
18 Piedmont support letter, Bates page 27, please.
19 Q: Ms. Carter, you see at the top this is kind of
20 a letterhead from Carolina Urology Center PA?
21 A: Yes, I see that.
22 Q: And it looks like it's a letter from -- written
23 by a physician named Christian E. Magura down
24 at the bottom.
25 A: Yes.

1 Q: All right. And I just want you to take a look
2 at that third paragraph. It's a fairly short
3 paragraph, the one that ends "in contrast."
4 **MR. WESTBROOK:** Dan, if you could highlight that.
5 Thank you.
6 Q: It says, "In contrast, the Charlotte-based
7 hospitals are not very attentive to the medical
8 staff or the patients of York County. They
9 simply try to draw patients into Mecklenburg
10 County, which is of no value to South
11 Carolinians. We need to have a choice for
12 these patients who wish to remain in York
13 County for delivery of all their healthcare."
14 Now I'm sure you don't agree with that
15 sentiment. I wouldn't expect you to. But
16 again, this is a support letter for Piedmont
17 that expresses some negative things about the
18 Charlotte-based hospitals, which I would assume
19 here would be CHS and Presbyterian, is that
20 correct?
21 A: Yes.
22 Q: And DHEC did not consider that or did count
23 that as an opposition letter; they counted it
24 as a support letter, correct?
25 A: That's correct.

1 Q: And let's go to -- bear with me a second.
2 **MR. WESTBROOK:** Dan, would you put our next letter
3 up on the screen, please.
4 Q: This is Bates page, Petitioner Exhibit 66,
5 number 25, and this is another letter from the
6 letterhead of Carolina Urology Center. This one
7 is from Dr. who, let's look at the bottom,
8 Curtis Mathews, Jr., MD.
9 **MR. WESTBROOK:** And let's take a look at, Dan, if
10 you could just call out those first two
11 paragraphs.
12 Q: It starts off, the letter starts off saying,
13 I've been a practicing physician in York County
14 for over 19 years and would like to
15 wholeheartedly endorse the Piedmont Medical
16 Center proposal, etcetera. And then he goes on
17 to the second sentence, do you see that where
18 he says he has worked on the staff before of
19 CMC-Pineville?
20 A: I see that.
21 Q: And then again in the second paragraph, if you
22 would read that second paragraph for us, please.
23 A: "Over the past seven to eight years, I have
24 seen a commitment to quality patient care while
25 reducing costs and leaving them as one of the

1 least expensive providers in the area. Their
2 administrative staff is in close contact with
3 the physicians and facilitating quality care.
4 In contrast, the Charlotte-based hospitals are
5 less attentive and effective in assisting the
6 medical staff due to a larger bureaucracy. I
7 have seen overcrowding and quality concerns at
8 the Charlotte-based hospitals, even to the point
9 of some of our Charlotte patients choosing to
10 be treated in York County at Piedmont Medical
11 Center."
12 Q: All right. And again, I don't expect you to
13 agree with that opinion, but once again, that's
14 a support letter for Piedmont that contains
15 criticism of CHS and was not counted as an
16 opposition letter by DHEC, isn't that correct?
17 A: Yes, that's my understanding.
18 Q: Let's just do one more and we'll leave this.
19 **MR. WESTBROOK:** Let's go to 21, please, Dan.
20 Q: And the heading up here, the letterhead says
21 Carolina Orthopedic Surgery, is that -- you see
22 that?
23 A: Yes.
24 Q: And if you go to the bottom of the second page,
25 it looks like it is from Dr. Thomas Fleischer,

1 MD. And Dan, if you'd move back to the first
2 page please in the bottom paragraph it says,
3 "The residents of York County have always had a
4 choice of healthcare providers in the proximity
5 of Charlotte allows them choices now to allow
6 the migration of Charlotte-based hospital to
7 York County would contribute to the erosion of
8 overall healthcare delivery in York County.
9 There would be an adverse impact on the
10 existing hospital, the employees, as well as the
11 ability for Piedmont to maintain their high
12 level investments in the facility and
13 technology." And you, of course, disagree with
14 those statements, don't you?
15 A: Well, I would agree with part of the first
16 sentence that says that the proximity of
17 Charlotte allows patients' choices. I mean
18 they're exercising that choice, as we have
19 discussed throughout this case, in terms of the
20 number of patients that choose to go to
21 Charlotte. I don't agree with the second two
22 sentences.
23 Q: All right. And again, criticism of CHS in a
24 Piedmont support letter that it was not counted
25 as an opposition letter by DHEC, right?

1 A: Yes.
2 Q: All right. And if you'll turn over to the next
3 page there is just a sentence over on the next
4 page I would like to read and then we'll move
5 on. It says, "The strategy of Piedmont Medical
6 Center has been to keep York County patients in
7 York County. The competing hospitals in
8 Charlotte have purchased many physician groups
9 in York County. Our own patients who are also
10 treated by those primary care physicians owned
11 by Charlotte hospitals have indicated to us on
12 numerous occasions the pressure they feel is
13 being placed on them to be referred to
14 physicians in other facilities in Charlotte.
15 This to me does not indicate a desire of those
16 hospital systems to support the patients in York
17 County." I would assume you would disagree
18 with those statements, would you not?
19 A: I would -- as we've talked about, certainly
20 both CHS and Presbyterian have acquired or
21 employed physician practices in York County, so
22 I would agree with that which is factual, but I
23 wouldn't agree with the sentiment expressed
24 there.
25 Q: But again, a support letter for Piedmont,

1 criticism of CHS not counted as an opposition
2 letter, right?
3 A: Yes.
4 Q: Now, you're aware that in 2012 the "Charlotte
5 Observer" and the "Raleigh News and Observer"
6 ran a series of articles criticizing CHS and
7 some other non-profit systems in North Carolina
8 for excess profits and high executive salaries
9 and lawsuits against their patients, aren't you?
10 A: I am aware of some articles. Frankly, there
11 have just been a lot of different series of
12 articles around healthcare in both the News and
13 Observer and the Charlotte Observer, and there
14 have been some articles, I can't recall the
15 exact time frame, but there have been articles
16 that I recall specifically about executive
17 compensation. And I'm sorry, what else did you
18 mention?
19 Q: High profits or big profits or excess profits
20 and also about lawsuits against poor patients
21 who didn't pay their bills.
22 A: I seem to recall the latter two, I think.
23 Q: And you're aware that the NAACP and other non-
24 profit groups have protested a number of those
25 CHS policies about lawsuits against patients?

1 A: I'm not aware of that.
2 Q: You're aware that Senator Charles Grassley, US
3 Senator Charles Grassley of the Senate Finance
4 Committee is investigating CHS for potential
5 misuse of the Federal 340(B) drug program?
6 A: I don't know anything specifically about that.
7 I'm trying to recall. I know you asked that
8 question of another witness and I'm trying to
9 recall if I have actually read anything about
10 that or if I'm just recalling what you said,
11 and I can't recall specifically.
12 Q: I think I asked you if you had read Bo Sellers'
13 deposition and I believe you were unsure whether
14 you had or not, is that right?
15 A: That's correct.
16 Q: Well, if you are unsure, let me put a portion
17 of it on the screen and see if it jogs your
18 memory.
19 **MR. WESTBROOK:** Dan, if you could put, let's go to
20 Sellers deposition page 18 please, and well
21 before we go to page 18, let's just look at the
22 cover page and kind of establish when this was
23 and what this is.
24 Q: This is -- it says, Macland Rhett Sellers but
25 he's known as Bo Sellers, isn't he?

1 A: Yes.
2 Q: This is October 25, 2012?
3 A: Yes.
4 Q: Let's go to page 18, please.
5 A: On page 18, let's look at line 14 and let me
6 read that question, if you'll read his answer
7 and tell me if this is something you are
8 familiar with. Question: "So it looks like
9 then that you've got at least a sort of planned
10 future expansion or potential future expansion
11 of nine or ten beds on the second floor and
12 nine or ten -- and nine or ten on the third
13 floor." Answer?
14 A: "Yes, sir. That's what the plans represent."
15 Q: Question: "Okay." Answer?
16 A: "Is that capacity."
17 Q: All right. So it's nine or ten beds and nine
18 or ten on the third floor, that would be a
19 total of 18 to 20 beds, is that correct?
20 A: That's how that would add up.
21 Q: Do you recall -- and to be fair, we can go to
22 this part of the deposition if you'd like to.
23 I think he also testified, and I'm asking you
24 if you are aware of this, that there were some
25 potential capacity for horizontal expansion that

1 could include additional OB or ICU beds; are
2 you familiar with that?
3 A: I don't recall that specifically.
4 Q: Okay. Just a moment, please.
5 **MR. WESTBROOK:** No further questions, Your Honor.
6 **THE COURT:** Thank you, Mr. Westbrook.
7 **MS. ROBERTSON:** One minute, Your Honor.
8 **THE COURT:** Does the Department have any questions?
9 **MS. BIGGERS:** No, Your Honor.
10 **THE COURT:** Thank you.
11 **MS. ROBERTSON:** Your Honor, I think I have just a
12 few follow ups for Ms. Carter.
13 **THE COURT:** All right.
14 **MS. CARTER - RE-DIRECT EXAMINATION BY MS. ROBERTSON:**
15 Q: Ms. Carter, Mr. Westbrook had a demonstrative
16 that he showed you, 289, Piedmont's 289, and
17 you looked at Piedmont's expenses I think from
18 2009 until 2020, and I think it was a
19 demonstrative that they had made of exhibits; do
20 you recall looking at that?
21 A: Yes.
22 Q: And it was just looking at the expense portion,
23 I believe?
24 A: That's correct.
25 Q: Okay. What I'd like to do now is look at some

1 **DAVID LEVITT,** being duly sworn, testifies as follows:
2 **MR. LEVITT - REBUTTAL DIRECT EXAMINATION BY MR.**
3 **ANDREWS:**
4 Q: All right. Mr. Levitt, good morning. Mr.
5 Levitt, let's begin with the issues related to
6 the need for 100 beds. Do you recall Ms.
7 Platt's testimony related to CHS Demonstrative
8 3.7 concerning her bed population need
9 methodology?
10 A: Yes.
11 **MR. ANDREWS:** All right. Dan, if you'll bring that
12 up on the screen, please.
13 Q: And -- all right. Mr. Levitt, do you recall
14 this exhibit?
15 A: I do.
16 Q: And what did you understand was Ms. Platt's
17 point in drawing this to the Court's attention?
18 A: I think she was criticizing Mr. Sullivan's
19 exhibit that showed population of 96,000 in 2020
20 for the northern York area. She pulled some
21 Claritas population that showed a bit lower at
22 84,000.
23 Q: Okay. And what did you do after observing Ms.
24 Platt's testimony that's reflected here on
25 Demonstrative 3.7?

1 A: Well, during lunch break we pulled the current
2 Claritas population projections and they had
3 been updated since we had pulled them, very
4 recently been updated, and they were slightly
5 lower. So we pulled the population for all of
6 the zip codes, but Ms. Platt only provided the
7 one data point, the 84,144, so we pulled all
8 populations for all zip codes.
9 Q: And have you incorporated that data into a
10 demonstrative?
11 A: I did.
12 **MR. ANDREWS:** Dan, let's pull up Piedmont
13 Demonstrative 294, please.
14 Q: And what do you have here, Mr. Levitt?
15 A: This shows the three scenarios. The one on the
16 left is the original scenario by Ms. Platt
17 showing the population in northern York 47,000.
18 We corrected that and updated it in the center
19 sort of section showing the 96,752. And then
20 to the right is the updated population using
21 the most current Claritas population for all the
22 areas, so it shows the 84,151, which is
23 slightly different than hers, but very
24 consistent.
25 Q: All right. Just so we'll make sure what each

1 of these four boxes represents, the one on the
2 far left was the one that Ms. Platt originally
3 prepared and presented to the Department?
4 A: Yeah, there were three boxes, but yeah ---
5 Q: Okay.
6 A: --- the one on the left is the original one in
7 Ms. Platt's submission to DHEC.
8 Q: And the center one, is that what was reflected
9 in Piedmont Demonstrative 149?
10 A: Correct. That was using updated population
11 projections and accounting for all the zip
12 codes. Ms. Platt had left off one of the zip
13 codes in her original analysis, so this includes
14 all three zip codes in northern York, and at
15 the time, the most current Claritas population
16 available.
17 Q: Okay. And then let's go into some detail if
18 you would in the last table.
19 A: So updating it for the most current population
20 projections shows the distribution in the
21 various three years that we show, 2010, 2015,
22 and 2020, showing the population of northern
23 York 67,000 approximately in 2010, increasing to
24 75,000 by 2015, with 84,000 by 2020. With 100
25 beds in that region, using Ms. Platt's bed-to-

1 population analysis shows by 2020 1.19 beds per
2 1,000 population.
3 Q: And how does that bed distribution relate to
4 the rest of your accounting?
5 A: Well, going down to the other areas that she
6 had identified, she sort of segregated it into
7 three -- well, into two areas, northern York
8 and then Rock Hill and western York. Looking
9 at the Rock Hill and western York populations
10 for the same time period by 2020 shows the same
11 bed-to-population distribution, 1.19 beds per
12 1,000 population using the 232 beds that would
13 be remaining at Piedmont Medical Center.
14 Q: Okay. Now, have you also applied the -- Ms.
15 Platt's bed need methodology to her 60 -- to
16 the 64-bed application for Carolinas?
17 A: Yes.
18 **MR. ANDREWS:** All right. Dan, let's look at the
19 next page in this demonstrative. And let's
20 call out the ---
21 Q: What do we have here on this page?
22 A: This is the same analysis just using 64 beds in
23 northern York instead of 84 -- or 100 beds.
24 And what it shows is, you know, the first one
25 is, again, what Ms. Platt submitted in the

1 original application. The middle one shows the
2 updated population projections based off the
3 Claritas information we had pulled prior to the
4 trial. And then the one to the right updates
5 that based on Ms. Platt identifying there had
6 been some updates, so we pulled the most recent
7 population projections and that shows this. So
8 everything really here is the same. The
9 populations are the same as what we just
10 showed, just the number of beds in the
11 different regions are different. So the top
12 section, northern York, with 64 beds in the CMC
13 proposal shows a bed-to-population ratio by 2020
14 of .76 per 1,000. In Rock Hill and western
15 York with 268 beds remaining at Fort Mill,
16 which is the -- or at Rock Hill, which is the
17 current bed population of -- bed complement of
18 Piedmont Medical Center shows 1.37, and what it
19 shows is not enough beds in northern York and
20 more than enough beds -- a maldistribution in
21 the inverse to Ms. Platt's assumption that ---
22 **MR. ANDREWS:** Let me interrupt you there, Mr.
23 Levitt, if I could and let's go back, Dan, to
24 the first table on this page.
25 Q: And look at the -- Ms. Platt's table as it was

1 presented to the Department. What does that
2 show there in terms of distribution of beds?
3 A: When Ms. Platt submitted this to the Department
4 she was arguing that having 64 beds in northern
5 York represented an equitable distribution of
6 beds, 64 beds in northern York, 268 beds in
7 Rock Hill and western York, and a total of 332
8 beds in York County. The distribution between
9 those three areas was comparable. So the 1.34
10 compared to the 1.25 compared to the 1.27, she
11 presented that as an equitable distribution of
12 beds.
13 Q: Okay. And then compare what her presentation
14 was to DHEC under the Department's review with
15 what you just determined based on the updated
16 Claritas data.
17 A: That it is not an equitable distribution.
18 Remember, with 100 beds in northern York it was
19 equal. All three regions had the same number
20 of bed-to-population. Using the current
21 population it shows 64 beds is not enough.
22 There's a much lower bed-to-population ratio in
23 northern York with 64 beds.
24 Q: Okay. Now let's -- to what degree did
25 Carolinas present this information during the

1 staff review?
2 A: That was a point that they raised on a number
3 of different occasions and a number of different
4 places, project review and their summaries and
5 in their correspondence with DHEC.
6 **MR. ANDREWS:** Okay. Let's take a look at some
7 examples where they've done that. Dan, if
8 you'd pull up Joint Exhibit 1A, page 1164,
9 please.
10 Q: All right. Now, what is this document, Mr.
11 Levitt?
12 A: This is the executive summary of their, I
13 believe it's their last submission to DHEC,
14 where they're summarizing their positions and --
15 -
16 Q: They being?
17 A: CHS's positions and the information presented at
18 project review.
19 Q: Okay. And where is the bed need methodology,
20 bed-to-population need methodology presented
21 here?
22 A: Well, on this page at the bottom, I believe.
23 Q: And that relates to what?
24 A: The community need documentation.
25 Q: Okay. Let's take a look at that. And what is

1 this summary related to community need
2 documentation pertain to?
3 A: This is where they identify the bed-to-
4 population ratio and moving the 64 beds, or I'm
5 sorry, moving the 36 beds to supplement the 64
6 beds in northern York, which was Piedmont's
7 proposal. This is where they identify that as
8 a maldistribution of beds within the county.
9 **MR. ANDREWS:** Okay. Dan, let's pull out that third
10 bullet point if you would. All right, Dan.
11 Q: Read this into the record if you would just so
12 it's -- Carolinas' position to the Department is
13 clear, Mr. Levitt.
14 A: "Amisub proposes to develop a 100-bed hospital
15 in Fort Mill through development of 64 new beds
16 and relocation/replacement of 36 existing beds
17 at Piedmont Medical Center. Amisub has not
18 proven the need for the relocation/replacement
19 of 36 beds. These beds are available at
20 Piedmont to serve Rock Hill population, which is
21 projected to remain the largest population base
22 in York County. Relocation/replacement of 36
23 beds in northern York County results in a
24 tremendous maldistribution of beds within the
25 county and reduces the accessibility to greater

1 Rock Hill and western York County. As such,
2 Amisub has not documented the need for an
3 incremental capital expenditure of roughly 50
4 million more than the other applicants."
5 Q: All right. Based on your review of the data,
6 what's your position concerning the statement
7 that's been made to DHEC?
8 A: That it's incorrect. That, you know, based on
9 the population projections that 100 beds is an
10 equitable distribution of beds within York
11 County and the 64 results in a maldistribution,
12 not enough beds in northern York.
13 **MR. ANDREWS:** Okay. Let's take a look at the next
14 section, Dan, on the second page, 1165, of this
15 executive summary.
16 Q: What does this next section relate to?
17 A: The distribution accessibility criteria.
18 Q: Okay. And what are Carolinas' comments with
19 regard to Piedmont, or as it's referred to here
20 Amisub in the third bullet point?
21 A: "Amisub does not project the geographic
22 distribution of services that aligns with the
23 population distribution and demands of York
24 County residents. Further, Amisub has not
25 documented the need for duplication of

1 modernization of the 36 beds it proposes to
2 relocate/replace. Amisub's proposal will create
3 a disparity in bed-to-population ratios for Rock
4 Hill and western York County's geographic
5 segments."
6 Q: Okay. Now, is this the only place in which
7 Carolinas referred to their bed-to-population
8 ratio and their bed need methodology to the
9 Department?
10 A: No, they -- that was sort of an underlying, or
11 not really underlying, main thing of their
12 opposition to the relocation of beds.
13 Q: Okay. Now let's -- are you aware of the extent
14 to which Ms. Brandt relied on the -- this
15 presentation concerning the population-to-bed
16 methodology in her decision?
17 A: Yeah, throughout her decision she references the
18 maldistribution and the impact of moving the
19 beds and she seemed to adopt that analysis. In
20 the absence of seeing any analysis of her own
21 and hearing her own testimony that she didn't
22 do those calculations, she appeared to have
23 adopted the CHS's analysis.
24 **MR. ANDREWS:** Okay. Let's take a look at a few
25 examples where she does that. Dan, let's begin

1 on page 5 of 10, which is Joint Exhibit 1B,
2 page 1026. And if you'll scroll down to the
3 bottom of the page and call out the last
4 paragraph, please.
5 Q: All right. Mr. Levitt, what are Ms. Brandt's
6 findings here concerning the maldistribution
7 theory?
8 A: She wrote in her analysis, "There are currently
9 beds available at Piedmont that serve the Rock
10 Hill population, which is projected to remain
11 the largest population base in York County.
12 Relocation/replacement of 36 beds in northern
13 York County does not appear to equitably
14 distribute beds within the county and reduces
15 accessibility to greater Rock Hill and western
16 York." So that's sort of reiterating what was
17 conveyed in the CHS information.
18 **MR. ANDREWS:** Okay. All right. Dan, let's turn to
19 the next page, 1027, of the same exhibit. And
20 scroll down if you would to the paragraph right
21 under rank two.
22 Q: And what is contained here, Mr. Levitt, in Ms.
23 Brandt's analysis?
24 A: She states, "Piedmont has not adequately
25 justified the duplication of services by the

1 transfer of 36 existing beds to a project with
2 a total cost of either $119,808,964 or
3 $146,522,042, which includes financing cost
4 during construction.
5 Q: Now, based on your review of Ms. Brandt's
6 decision, how does that finding relate to her
7 determination concerning any duplication that
8 the transfer of the 36 beds may represent?
9 A: I think she was couching it in the terms of the
10 distribution of beds within the county and based
11 on the populations that were presented by CHS,
12 which we I think just demonstrated those
13 populations don't -- the analysis doesn't hold
14 true with the new population projections.
15 **MR. ANDREWS:** Okay. Now let's look at one final
16 example on the next page, Dan, at 1028, under
17 the second full paragraph if you'd call that
18 out.
19 Q: And what does this finding contain?
20 A: Ms. Brandt identified, "The Department is
21 concerned with the cost effectiveness of
22 Piedmont's proposal and the balance of the
23 distribution to the target population." Again,
24 she's talking about the distribution based on
25 the population analysis and demonstrated having

1 100 beds in northern York by 2020 results in an
2 actually equal distribution of beds among the
3 areas.
4 Q: Okay. Now Mr. Levitt, based on your review of
5 Carolinas' submissions concerning the
6 maldistribution theory and Ms. Brandt's response
7 to it, what do you believe is the significance
8 of the presentation of this data by Carolinas?
9 A: Well, I think it was incorrect that having that
10 analysis showing the maldistribution can go --
11 there's some underlying flaws in the logic of
12 presenting that, but even assuming that they --
13 accepting that logic, the population doesn't
14 support it. The population that Ms. Platt
15 identified as the most current population shows
16 that 100 beds in northern York results in a
17 better distribution of beds than the 64 beds.
18 Q: Okay. Have you prepared a demonstrative showing
19 the population growths in northern York County
20 compared to the rest of the county?
21 A: Yes.
22 **MR. ANDREWS:** All right. Dan, if you'd pull up
23 Demonstrative 316, please.
24 Q: And what do we have here, Mr. Levitt?
25 A: Well, this shows that based on -- on the new

1 population data that northern York is projected
2 to grow, those three zip codes in northern
3 York, at more than double the rate of the
4 county, greater Rock Hill and western York. So
5 that's the high growth area, that's the high
6 population growth area with a growth rate of
7 25.2 percent from 2010 to 2020 compared to 10.9
8 percent for greater Rock Hill and then compared
9 to 10.0 percent for western York. So you can
10 see that that northern York area is growing at
11 a faster rate, that the 100 beds by 2020
12 results in an equitable distribution. And if
13 we were to continue it out into the future
14 beyond 2020, the population of northern York is
15 going to continue to grow at a faster rate.
16 And at some point northern York's population is
17 going to be greater than the Rock Hill
18 population.
19 Q: Okay. Let's move on to a different element of
20 Ms. Carter's analysis.
21 **MR. ANDREWS:** Dan, pull up CHS Demonstrative 4.90,
22 please.
23 Q: Okay. Mr. Levitt, let me focus your attention
24 particularly on the space program in Ms.
25 Carter's demonstrative. Does this analysis

1 concerning the percent of clinical or patient
2 care space and non-patient care space relate to
3 your opinion concerning future bed need in Fort
4 Mill any way?
5 A: It does.
6 Q: How?
7 A: Well, I guess the first comment is when Mr.
8 Westbrook was asking Ms. Carter about what was
9 included and what wasn't included, she wasn't
10 able to identify, but I think what her attempt
11 here was to show was that the non-clinical
12 space for the CMC-Fort Mill was smaller and
13 that makes it better. And I think the
14 inconsistency with that assumption is that if
15 it's -- to be located in a fast growing area,
16 which we've just identified that northern York
17 is a fast growing population area, the ability
18 to expand needs to be available. And by having
19 small or low amount or proportionally small
20 percentage of non-patient care areas, it limits
21 the ability of that facility to grow. So for
22 them to meet the needs in the future to expand
23 is limited by having Piedmont's larger
24 percentage of non-patient care area represents
25 a plan for the future to have the

1 infrastructure available to expand the hospital,
2 to add beds to the hospital and have sufficient
3 support space to support that area.
4 **MR. ANDREWS:** All right. Dan, let's pull up
5 Piedmont Exhibit 2, please, page 577.
6 Q: Mr. Levitt, are you aware of the extent to
7 which Piedmont has incorporated in its proposed
8 hospital the ability to grow?
9 A: Yes, we presented at project -- well, throughout
10 the planning process we had always assumed that
11 the Fort Mill Medical Center would grow, that
12 it would add beds at some point in the future,
13 so we designed it -- well, I say we, the
14 architects designed it to be able to grow, to
15 add beds. And we presented that at project
16 review, that the final design we presented has
17 the ability to expand to 250 beds. So 150
18 additional beds could be added to Fort Mill
19 Medical Center based on the infrastructure and
20 the design and the way it was sited and a lot
21 of other factors that the architect takes into
22 consideration when designing a building.
23 Q: What effect does that capability of expanding in
24 the future have on the projected construction
25 costs?

1 A: Well, it would make the initial costs higher,
2 but then it would make subsequent costs lower.
3 As Mr. Sullivan, I believe, testified it's
4 cheaper to build it now. It's cheaper to build
5 the infrastructure now than try to go back, if
6 you want to add acute care beds go back and add
7 areas to the cafeteria and dietary and ancillary
8 areas like x-ray and other areas. If it's not
9 big enough to support more beds you'd have to
10 expand those areas in addition to expanding the
11 inpatient bed areas. So Fort Mill Medical
12 Center was designed to be able to expand
13 without having to address those other expansion
14 areas.
15 Q: Okay.
16 A: So Ms. Carter's analysis showing that the
17 percentages doesn't give effect of that and it
18 needs to be considered.
19 Q: Have you given consideration to Carolinas'
20 ability to grow its proposed facility?
21 A: Yes.
22 **MR. ANDREWS:** Dan, let's pull up Mr. Sellars'
23 deposition transcript, page 18.
24 Q: And what is this that's showing on the board,
25 Mr. Levitt?

1 A: Well, this was a section of the -- of the
2 transcript from their individual that was
3 identified as the, I believe he's the
4 architectural witness for CHS.
5 Q: Okay. The testimony in the record is that Mr.
6 Sellars is an in-house architect for Carolinas
7 ---
8 A: Right.
9 Q: --- is that your understanding?
10 A: That's my understanding.
11 Q: Okay. And read the "Q" and "A" that's
12 presented in this excerpt deposition if you
13 will.
14 A: I believe it was Mr. Westbrook asked Mr.
15 Sellars, "So it looks like then that you've got
16 at least a sort of planned future expansion or
17 potential expansion of nine or ten beds on the
18 second floor and nine or ten beds on the third
19 floor?" The answer is, "Yes, sir. That's what
20 the plans represent."
21 Q: Okay. And what's your opinion concerning the
22 implications of this for the future growth at
23 the proposed CMC-Fort Mill site?
24 A: Well, it appears that based on his analysis and
25 then looking at, you know, my experience with

1 hospital projects looking at the schematics and
2 the space program and layout and things like
3 that that they can only add 18 to 20 beds to
4 that building, and that's what he identified as
5 the potential expansion. So they could go from
6 at most from 64 to 84 beds. And so, of course,
7 adding 18 to 20 beds would not likely require
8 an expansion of their non -- as Ms. Carter
9 called it, non-clinical space. Of course, that
10 would also change the relationships and ratios
11 and things like that. And so Ms. Carter's
12 analysis I think is lacking a lot of other
13 areas -- she didn't consider a lot of other
14 impact areas.
15 Q: All right. What effect would this limited
16 potential for physical growth have on the
17 construction costs that are proposed for CMC-
18 Fort Mill?
19 A: Well, they wouldn't be able to expand so
20 they've sort of identified the maximum growth of
21 that hospital in the future.
22 Q: And what are the implications, generally,
23 looking at then what you have for both Piedmont
24 and Carolinas' future plans for growth?
25 A: That Piedmont has or Fort Mill Medical Center

1 has the ability to expand to meet the
2 population growth. We've identified that as
3 growing at more than two and a half times the
4 rate of Rock Hill, the population growing at
5 more than two and a half times the rate of Rock
6 Hill and western York, that there's a need for
7 additional resources in that market and there
8 will be a need for additional resources in the
9 market in the future. And the CMC-Fort Mill
10 facility is limited about their -- in regards
11 to their ability to grow, and the Fort Mill
12 Medical Center has the ability to grow
13 substantially.
14 Q: Okay. Let's move on to a different
15 demonstrative that Ms. Carter presented, CHS
16 Demonstrative 4.31. Let's pull this up, Mr.
17 Levitt. And the title here is "FMMC's Own
18 Projections Fail to Demonstrate Need for 100
19 Beds." Do you feel that Ms. Carter's
20 demonstrative, Mr. Levitt, demonstrates that
21 Piedmont has failed to show the need for 100
22 beds?
23 A: No.
24 Q: Have you performed a similar bed distribution
25 analysis for CMC-Fort Mill?

1 A: Yes.
2 **MR. ANDREWS:** Okay. Dan, let's take a look at that
3 at Demonstrative 317, please.
4 Q: And what do we have here, Mr. Levitt?
5 A: Well, Ms. Carter assumed that looking at just
6 the northern York and a portion of Rock Hill
7 was the way to calculate the bed need, and she
8 showed that that resulted in 52 beds for Fort
9 Mill Medical Center looking at that limited
10 population. But in the application we had to
11 identify the entire county as a service area
12 just as they did. So looking at their
13 analysis, their need projections, it shows a
14 very similar analysis that -- because it's all
15 population driven. So they say we don't need
16 100 beds, well, using that same argument they
17 don't need 64 beds. Their northern York
18 average daily census in 2017 is 19. Rock Hill
19 their average daily census is 15, so nearly as
20 many people from Rock Hill will be treated at
21 their CMC medical center as from northern York,
22 but the zip code's right around the hospital.
23 And then they project another average daily
24 census of five from western York and the
25 remaining portions of York County.

1 Q: And did you then apply the calculations that
2 Ms. Carter did to show the actual needs under
3 the plan?
4 A: Yes. Yeah. So assuming though the need at
5 using a 65 percent occupancy standard of the
6 northern York results in a need for 29 beds.
7 So that average daily census of 19 in northern
8 York would result in a need of 29 beds. If you
9 assumed a portion of Rock Hill just as they
10 did, half of one of the zip codes would result
11 in the census of 23 beds from northern York and
12 a portion of Rock Hill, that would result in a
13 need of 35 beds.
14 Q: That would be zip code 29730?
15 A: The southern one?
16 Q: The southern one.
17 A: Yes.
18 Q: Okay.
19 A: So that results in a bed need of 35 beds. So
20 they said we didn't need 100 beds, using their
21 same analysis they don't need 64 beds, they
22 only need 35 beds. But the fallacy is that
23 both hospitals will serve all of York County
24 and beyond. There'll be in-migration from other
25 areas, so Ms. Carter, I think, the analysis is

1 flawed in that she just looked at northern York
2 and a portion of Rock Hill.
3 Q: Okay. And have you compared the distribution
4 and the similarity of it between CMC-Fort Mill's
5 projections and FMMC's projections?
6 A: Yes.
7 **MR. ANDREWS:** All right. Dan, let's take a look at
8 Demonstrative 318.
9 Q: All right. And what's reflect here, Mr.
10 Levitt?
11 A: That the bed need is consistent. That the Fort
12 Mill Medical Center and the CMC-Fort Mill bed
13 need is based off of, you know, the population
14 by region. We did it by zip code, they did it
15 by region, those three regions, but it's
16 consistent, 29 percent of the beds are from
17 Fort Mill Medical Center associated with
18 northern York; 30 percent of the beds for CMC-
19 Fort Mill are associated with northern York,
20 very comparable. Rock Hill, 23 percent for
21 both. And then western York, they're a little
22 more reliant on western York, 81 percent versus
23 three percent. So the bed need distribution is
24 consistent between our application and their
25 application, and based on what we've shown

1 before, there's a need for more than 64 beds in
2 the area, not less than 100 beds as they
3 identified.
4 Q: Okay. Now let's move on to review of Ms. Platt
5 and Ms. Carter's testimony concerning the lack
6 of need for 100 beds. In that regard, did you
7 review their projections to determine whether
8 they were current?
9 A: Yes.
10 Q: Did you update them?
11 A: I did.
12 **MR. ANDREWS:** All right. Dan, let's pull up
13 Demonstrative 311, please.
14 Q: All right. And what do we have here, Mr.
15 Levitt?
16 A: All right. This -- their application, their
17 most recent application -- the first application
18 assumed that they would redistribute patients,
19 they would take some patients from Piedmont and
20 some patients out-migrating to North Carolina,
21 the 2005 application identified that. In their
22 2010 application they changed their assumptions
23 and said well, we're just going to redirect CMC
24 patients. They assumed 80 percent -- or 75
25 percent of northern York would be redirected; 75

1 percent of their historical market share would
2 be redirected; 80 percent of their historical
3 market share from Rock Hill would be redirected,
4 and 50 percent of western York would be
5 redirected. That was based off their 2009
6 experience. Well, I looked at the 2011
7 experience. So what -- I looked at their 2011
8 market share for each of those regions and
9 applied that to the projected utilization in the
10 future and resulted in a much higher
11 utilization. So their assumption that if they
12 only took their own patients and they redirected
13 them their 64 beds wouldn't be enough.
14 Q: Why is that?
15 A: Because they have more patients now. 2011
16 they've gotten more patients. Using their same
17 assumptions, holding their assumptions constant
18 they would redirect, by 2020 they'd have an
19 average daily census of 61.5 patients and 64
20 beds, which is 96.1 percent occupancy. Even
21 going back to their year three projections,
22 2017, they would have an average daily census
23 of 56.4 on 64 beds or 88.1 percent occupancy.
24 So had they submitted the application in two
25 thousand, I guess, twelve, whenever they would

1 have had 2011 information, if they'd submitted
2 shortly after that this is what their own
3 methodology would show, a need just for their
4 patients of more than 64 beds. This doesn't
5 give effect to any redistribution of market
6 share, increase in market share, or taking
7 patients from anyone else. This is just their
8 patients.
9 Q: Did you change their methodology in any respect
10 in performing this calculation?
11 A: No. No, these are their numbers, their
12 methodology, and it shows that they need more
13 than 64 beds.
14 Q: All right. Now, Ms. Platt and Ms. Carter also
15 testified that it was reasonable for Carolinas
16 -- sorry, do you have something to say?
17 A: We also turned this occupancy into bed need.
18 Q: Okay. What does that look like?
19 A: So assuming a 64, or 65 percent occupancy -- or
20 I'm sorry, 65 percent bed need standard,
21 occupancy standard for bed need, it shows that
22 by 2020, again, based on their own projection,
23 their own methodology, they need 95 beds so.
24 Q: How have you calculated that?
25 A: Again, that takes the average daily census for

1 instance in 2020 of 61.5, dividing that by 65
2 percent shows a need for 95 beds. You know,
3 and that's consistent with what Ms. Carter was
4 demonstrating as far as how you calculate bed
5 need. But that would be the bed need. So they
6 would need 31 more beds by 2020 than the 64
7 they've identified.
8 Q: And what would they need by their third year of
9 operation?
10 A: They would need 87 total beds. So they would
11 need 23 more beds than they've actually applied
12 for. And again, this is just assuming their
13 redistributed patients, no increase in other
14 patients.
15 Q: Based on their original set of market share
16 shift?
17 A: Based on their 2010 assumptions, yes.
18 Q: All right. Now have you given consideration to
19 the effect of -- that would occur on the CMC-
20 Fort Mill utilization if there were any market
21 share taken from Piedmont?
22 A: Yes. From Piedmont or anyone, yes.
23 **MR. ANDREWS:** All right. Let's take a look at that
24 demonstrative, Dan, at 311.2.
25 A: So again, they assumed that they would only

1 take their patients, no other patients would go
2 to the CMC facility. We've heard a lot of
3 testimony, I know I testified about it and I
4 believe Mr. Sullivan did as well, as well as
5 some of the physicians about how patients can
6 be admitted to a hospital. So there's really a
7 limited ability to control only taking their
8 patients at their facility. So other patients
9 would be treated at that facility. Market
10 share will change so it won't stay static. But
11 assuming a five percentage point increase in
12 market share from what they assumed, so assume
13 that they can redistribute 75 percent, 80
14 percent, and 50 percent of their patients, and
15 then in addition to that, they get five
16 percentage point increase in market share by
17 having a new facility in the market.
18 Q: What's the effect of adding that five percent
19 market share gain?
20 A: By 2017 they'd be 108 percent occupied and by
21 2020 they'd be 118 percent occupied. They'd
22 have an average daily census of 75 by 2020 and
23 70, 69.2 by 2017. So again, the 64 beds aren't
24 enough for them to serve that area based on
25 their own assumptions and then increasing it by

1 only five percentage points.
2 Q: Have you identified the bed need that would be
3 required for that degree of utilization?
4 A: Yes. Doing the same calculation which we did
5 on the last slide shows that by 2020 they
6 actually would need 116 beds to serve that
7 population and by 2017 they'd need 107 beds.
8 So more than their 64 beds that they
9 identified. Their ability to expand, we talked
10 about that, they identified 18 to 20 additional
11 beds. So they won't have enough beds at their
12 facility to serve -- with 84 beds, certainly
13 not with 64, but even with 84 beds they
14 wouldn't have enough beds to serve this
15 population.
16 Q: All right. Now given the bed population need
17 analysis that you conducted and this update of
18 CMC's projected utilization, Mr. Levitt, what's
19 your opinion concerning the need for beds in
20 the Fort Mill area?
21 A: Well, I think this demonstrates that there's a
22 need for more than 64 beds. The 100 beds
23 initially proposed by Fort Mill Medical Center
24 with the ability to grow 250 beds represents a
25 much superior alternative and better -- better

1 solution for the future for the residents in
2 that area.
3 Q: Okay. All right. Let's move on to a different
4 subject. You'll recall that Ms. Carter
5 testified, Mr. Levitt, concerning your
6 involvement in a satellite hospital project
7 undertaken by Spartanburg Regional Health Care
8 System. I'll refer to it as Village at Pelham.
9 Were you involved in that case?
10 A: Yes, I was.
11 Q: And what was your role?
12 A: I was the consultant that helped them develop
13 that CON application and worked on the planning,
14 actually, did a lot of work on the planning for
15 the whole campus.
16 Q: Okay. Tell the court about that project, if
17 you would.
18 A: Well, Spartanburg Regional had identified a
19 growing population area in what they called
20 western Spartanburg County, and they had
21 identified an opportunity to purchase some land.
22 They purchased the land and developed a plan on
23 how to develop that campus. That campus was
24 going to include, or it does include a variety
25 of different levels of care, of outpatient

1 services; they initially started with an
2 ambulatory surgery center; they've added
3 radiation therapy, and the hospital. So it was
4 sort of a satellite campus to serve the
5 residents of Spartanburg County.
6 Q: Okay. And is the hospital operational now?
7 A: It is. They changed the name a little bit,
8 it's Village Hospital. In the application it
9 was -- they didn't have a real hospital name,
10 that was part of the plan back then. It was
11 more of a non-hospital focused campus. They
12 had partnered with Michelin and BMW to have
13 more of a European-type health care delivery
14 system than what was traditionally done in the
15 area. But yes, the hospital's open, the
16 ambulatory surgery facility is open, and others
17 -- I think they've -- well, their building
18 hasn't opened yet, but the linear accelerator.
19 Q: Okay. What was the projected occupancy that
20 was reflected in the application?
21 A: It was very high, it was in the 70 percent
22 range by the third year of operation. And the
23 project assumed that beds at Regional,
24 Spartanburg Regional, would be relocated, 48
25 beds, I think, from Spartanburg Regional that

1 were not operational moved to Village to create
2 the hospital. So it was redistributing their
3 bed resources to what they thought at the time
4 could be a growing population area. The other
5 element of that was literally across the border,
6 the Village Hospital is located on the -- I
7 mean, it couldn't be more literal on the border
8 of Spartanburg and Greenville County. The road
9 is on -- they had to sort of move the border,
10 because the border ran through part of the
11 hospital and part of the property, so they
12 aligned it better. So now the border is the
13 road it's on, and at the same time Greenville
14 Hospital System was developing a new hospital a
15 mile or two away across the border. And so the
16 theory was that this would prevent, much like
17 the Waccamaw Georgetown analogy, it would
18 prevent out-migration, people from Spartanburg
19 leaving to go to the new hospital in Greenville
20 and helping Spartanburg Regional maintain the
21 market share of their home county.
22 Q: Did it work?
23 A: The last element worked. The new hospital at
24 the time was Allen Bennett, they changed that
25 name to Greer, was not able to increase their

1 market share of Spartanburg County, nor was
2 Greenville Hospital System able to increase
3 their market share of Spartanburg County. So
4 to the extent that they prevented out-migration,
5 to the extent that they were able to re-locate
6 patients from -- that would have otherwise gone
7 to Spartanburg Regional, that didn't work as
8 well as they had thought. I think we assumed
9 30 percent relocation, that those residents in
10 that area that had traditionally gone to
11 Spartanburg Regional would go to the new
12 hospital, we said 30 percent, that didn't
13 happen. Some of it was relocated, and I think
14 the lesson was the ability to relocate en mass
15 as CHS has proposed is very difficult and
16 wasn't -- we weren't able to achieve that at
17 Spartanburg Regional.
18 Q: Okay. All right. Let's move on to indigent
19 care. You were present, were you not, for Mr.
20 Stewart's testimony concerning the
21 classification of indigent care by Pineville?
22 A: I was.
23 **MR. ANDREWS:** All right. Dan, let's pull up CHS
24 Demonstrative 2.11.
25 Q: All right. Mr. Levitt, from the perspective of

1 classification of indigent care what are your
2 observations concerning this Carolinas'
3 demonstrative?
4 A: Well, they appear, based on Mr. Stewart's
5 testimony, they reclassify patients from these
6 other categories into charity care at some point
7 in time. I'm not sure when it's done, but they
8 do that for reporting purposes. And for
9 whatever reason it was -- it seemed odd to me
10 that Mr. Stewart was resisting Mr. Westbrook's
11 classification or terminology as
12 reclassification, because that's precisely what
13 it is. They're reclassifying the -- there's
14 nothing wrong with that, they're reclassifying
15 the numbers from one category to another. And
16 that's what they've done here. So what it
17 showed was that the CMC-Pineville PeopleSoft
18 software, their internal accounting software
19 identified 511, approximately, $511,000 worth of
20 charity care. Then they went on to reclassify
21 that from $510,000 into $19 million by assuming
22 some of the charity care adjustment -- or I'm
23 sorry, some of the bad debt adjustments and
24 self-pay discounts were reclassified into
25 charity care to go from $500,000 to 19 and a

1 half actually, 19 and a half million dollars.
2 Q: Okay. All right. Let's take a look at the
3 Pineville performance report that, I believe,
4 Mr. Stewart testified about as well, which is
5 S-CHS-1205. Are you familiar with this
6 document, Mr. Levitt?
7 A: Yes.
8 Q: And what is it?
9 A: This is the source document to the upper
10 portion of the last exhibit, which has a lot of
11 different names, but yeah, the last exhibit.
12 And what it shows is, again, it's a source
13 document, this is the PeopleSoft report, the
14 departmental performance report for the year
15 ending 12/31/2009, calendar year 2009, for CMC-
16 Pineville.
17 Q: And does the document have a date that -- when
18 it was prepared?
19 A: It does.
20 **MR. ANDREWS:** And Dan, if you could highlight that,
21 please.
22 Q: And what is that?
23 A: August 29, 2010.
24 **MR. MULLER:** Your Honor, I object to this testimony.
25 This witness has no idea when this report was

1 created. That may be a date that's simply when
2 it was printed. So to allow him to
3 characterize something that's --
4 **MR. ANDREWS:** I'll rephrase the question.
5 **MR. MULLER:** --- as being prepared on that date is
6 completely speculative. He has no basis for
7 that.
8 **THE COURT:** Okay. All right. Thank you.
9 **MR. ANDREWS:** Excuse me for interrupting. I'll
10 rephrase the question.
11 **THE COURT:** If you could, sir.
12 **MR. ANDREWS:** Yes, sir.
13 **THE COURT:** Thank you.
14 Q: Mr. Levitt, are you familiar generally with
15 reports of this nature?
16 A: Yes.
17 Q: All right. Based on your familiarity and
18 experience with reports of this nature, when
19 does it appear to you that the report was
20 prepared?
21 **MR. MULLER:** I'm going to make the same objection,
22 Your Honor.
23 **THE COURT:** All right. Mr. Andrews, do you have any
24 response to this objection?
25 **MR. ANDREWS:** No. I think his experience and he's

1 qualifying it with his opinion and if it can be
2 disproven then it can be disproven.
3 **MR. MULLER:** Your Honor, this is a witness who
4 testified incorrectly about this report
5 previously. He did not understand how this
6 report was integrated or what it reflected in
7 terms of charity care. He had virtually no
8 idea what this report reflected based on the
9 testimony of a witness with knowledge of it.
10 So he is now being asked after making those
11 mistakes to tell the Court when this report was
12 generated.
13 **MR. ANDREWS:** Your Honor, I completely disagree with
14 Mr. Muller's characterization of Mr. Levitt's
15 prior testimony concerning this document. The
16 Court can draw any inferences of who's correct
17 and who's not. But that's what we would offer
18 based on this document.
19 **THE COURT:** All right. Mr. Muller, I'm going to
20 overrule your objection and allow you to inquire
21 into the basis for Mr. Levitt's opinion of his
22 understanding of the date of this report as
23 fully as you wish to do so, sir. I'm going to
24 go ahead and allow him to testify about his
25 understanding of that based on his experience.

1 Q: All right. Mr. Levitt, based on your
2 experience, your review of reports such as this
3 internal performance report, when does it appear
4 to you the document was prepared?
5 A: Well, there's a August 29, 2010, date on it
6 2:12 p.m. And since it's a calendar year 2009
7 report, it has actual year-to-date and budgeted
8 information in it, well, it had to been -- you
9 know, it had to be prepared after December 31,
10 2009, otherwise, you couldn't have actual
11 information year-to-date in it. And August 29,
12 2010, is after December 31, 2009, and it's
13 after it by nine months. So based on the date
14 printed at the top and the date of the report,
15 it was provided or it was developed or
16 generated August 29, 2010.
17 **MR. ANDREWS:** All right. Dan, let's pull if you
18 would from this document the line that it ties
19 to the $510,000 in charity care reflected on
20 CHS Demonstrative 2.11.
21 Q: And what do you have here, Mr. Levitt?
22 A: This shows the line item provision for charity
23 care identified of about $511,000 was the actual
24 experience. They'd only budgeted $356,000. And
25 you can see it, so their actual experience was

1 higher than what they had budgeted, but still
2 substantially less than the 19 and a half
3 million dollars that they identified as charity
4 care in the reclassified information.
5 Q: Okay. Now let me move you to demonstrative --
6 to Exhibit 8A -- Exhibit 8A, the definition of
7 indigent care under the state Health Plan.
8 **MR. ANDREWS:** Dan, let's begin on page 15. Okay.
9 Q: Well, what we have here is the definition that
10 Mr. Stewart testified about you were here for,
11 Mr. Levitt, that the projected and historical
12 charity care was consistent with the
13 Department's definition; do you remember that?
14 A: Yes.
15 Q: And do you remember what he referred to in
16 offering that statement?
17 A: Yes. The last marked block of highlighted area
18 he identified that definition, "Indigent care
19 does not include bad debt, contractual
20 adjustments" -- well, actually it says debt, and
21 he identified that as a typo. It should say
22 "bad debt, contractual adjustments, or care that
23 is reimbursed by governmental program (Medicare,
24 Medicaid, county indigent care programs),
25 church, or philanthropic organizations." He

1 used that definition to say that they're
2 reclassifying and -- of their indigent care is
3 consistent with the definition.
4 Q: Is that a complete definition of indigent care
5 under the State Health Plan?
6 A: No, he forgot the first part.
7 Q: What's the first part?
8 A: The first part is that where it identifies that
9 "Medical care (measured in dollars) provided to
10 an individual who has been determined to be
11 unable to pay for this care prior to admission
12 in non-emergency situations and as soon as
13 possible but before the discharge of emergency
14 situations for which only one billing has
15 occurred and no other efforts have been
16 undertaken to collect such debt." So it's not
17 just those other categories, bad debt,
18 contractual adjustments, etcetera, but it's also
19 when the patient is identified as charity care.
20 This definition prevents organizations from
21 retroactively shifting patients from other
22 categories into indigent or charity category.
23 **MR. ANDREWS:** Okay. Now Dan, let's go back to
24 demonstrative -- Carolinas Demonstrative 2.11,
25 if you would.

1 Q: Okay. Now applying the State Health Plan
2 definition of indigent care to the
3 classification schedule, what would be your
4 opinion about the charity care that Pineville
5 historically provided that would be a basis for
6 a projection that's consistent with DHEC policy?
7 A: Right. What I had said on my direct, that the
8 $510,846, that's their charity care amount,
9 that's their indigent care amount.
10 Q: Why would you limit it to that?
11 A: Because that's the amount that they've
12 identified as -- as provision for charity care
13 consistent with the DHEC definition. It's not,
14 you know, the definition says it doesn't include
15 bad debt. Mr. Stewart said they reclassified
16 bad debt into that. It doesn't include
17 patients who have down -- later Mr. Stewart
18 identified that some patients are identified at
19 time of admission, some are during their stay,
20 and some of them are later, after their stay.
21 The definition says you've got to do it before
22 they're discharged. So it doesn't include those
23 patients either. So that's -- that's the South
24 Carolina definition of charity care. Again, for
25 other purposes, reclassifying it into charity

1 care could be perfectly acceptable, but not for
2 definitions -- not consistent with the
3 definition in the South Carolina State Health
4 Plan.
5 Q: What inferences can you make from this
6 Demonstrative 2.11 about the timing of the
7 classification of charity care?
8 A: Well, that it's done later. That the 511,000
9 is done consistent with the definition, and then
10 they reclassified those amounts down the road.
11 Q: Why do you believe that to be true?
12 A: I believe that's what Mr. Carter, or I mean,
13 Mr. Stewart said that that's how they do it.
14 Q: Okay. Now based on these observations, what's
15 your opinion concerning the reasonableness of
16 Carolinas' projection of doing 6.3 percent in
17 charity care?
18 A: Well, I think it's overstated that -- that
19 they, you know, we -- I talked about in my
20 direct that they're proposing a hospital in the
21 wealthiest portion of one of the wealthiest
22 counties in South Carolina and to assume a 6.3
23 percent charity care is unreasonable,
24 particularly based on their experience at the
25 other facilities, I think their definition is

1 inconsistent with the DHEC definition, and,
2 again, back on what I talked about on my
3 direct, the three and a half percent, their
4 initial application included three and a half
5 percent charity care, and I believe it was like
6 eight percent other was apparent. And then
7 they come back with a much lower other, I think
8 three percent other and 6.2 or three percent
9 charity care. I identified that inconsistency
10 and Mr. Stewart said, well, that's because of
11 outpatient. Well, they had outpatient in 2005
12 also. So if they had eight percent other
13 category in 2005 they should have had, what,
14 three times their projection, so it would be 18
15 percent indigent care is what they should have
16 projected if those relationships are consistent
17 and what Mr. Stewart said was correct. And
18 that's not what they had.
19 Q: Okay. Let's move on. All right. This time
20 I'm going to take you to Ms. Carter's testimony
21 concerning Carolinas' incentives to shift
22 patients to CMC-Fort Mill. Do you recall Ms.
23 Carter's testimony that Carolinas would have a
24 need to decompress utilization at CMC-Main?
25 A: Yes.

1 Q: And have you prepared an exhibit that analyzes
2 that question?
3 A: Yes.
4 **MR. ANDREWS:** All right. Dan, let's pull up our
5 Demonstrative 307, please.
6 Q: And what is this, Mr. Levitt?
7 A: Well, Ms. Carter said that there were incentives
8 for CHS to shift patients to CMC-Fort Mill and
9 the -- one of the first or actually the first
10 incentive she identified was decompressing the
11 Charlotte facilities, especially CMC-Main. CMC-
12 Main is the highest utilized CHS facility. And
13 what I looked at was what sort of relief that
14 CMC-Main would get from the 64 beds in York
15 County that CMC-Fort Mill would represent.
16 Based on their projections in the CON
17 application, their admissions by region from
18 sort of the re-directed patients from CMC-Main
19 to CMC-Fort Mill in the third year of operation
20 was a little less than 1,400 admissions,
21 assuming their would stay for four days results
22 in about a 55,000 -- or I'm sorry, 5,556
23 patient days or an average daily census of 15.
24 So they're going to be moving 15 patients, if
25 you're, you know, if their assumption is

1 correct, moving 15 patients out of CMC-Main to
2 the Fort -- the CMC-Fort Mill Hospital.
3 Q: And is your testimony they're moving 15 patients
4 to support the $77 million facility?
5 A: That would be a piece of it. Yeah, the 15
6 patients from Main would be treated at the Fort
7 Mill Medical Center.
8 Q: Okay.
9 A: You know, in 2011 -- I'm sorry, 15 patients,
10 that's average daily census, not just 15
11 patients. Average daily census of 15. In
12 2011, CMC-Main had an average daily census of
13 702. So that 15 patient shift represents a 2.2
14 percent relief to Main. So they would be
15 spending the 70 million or $80 million that
16 they identified for CMC-Fort Mill to move 2.2
17 percent of the patients. So I'm not sure that
18 that's a tremendous incentive or that CMC-Main
19 would experience a tremendous amount of relief
20 from the 64 beds in Fort Mill. You know, if --
21 if Fort Mill were bigger it could have a bigger
22 impact, but they're saying that 64 is the
23 number and 2.2 is -- moving 15 patients out of
24 a 700 average daily census of 700, they're not
25 going to notice that.

1 Q: All right. From a health care planning
2 perspective, are there other solutions available
3 to Carolinas that you have analyzed?
4 A: Yes.
5 **MR. ANDREWS:** And Dan, let's pull up Demonstrative
6 304.
7 Q: And what does this consist of, Mr. Levitt?
8 A: This shows the Charlotte facilities, the CHS
9 Charlotte facilities and their occupancies in
10 2009 and 2011.
11 Q: Does it include Main?
12 A: It does not include Main. So these facilities,
13 these six facilities serve as an option for CMC
14 to relieve their capacity constraints. You
15 know, Mercy in 2009 was 46 percent occupied,
16 Pineville was 74 percent occupied, combined in
17 2011 there's 65 percent occupancy. So there's
18 an ability to move patients from Main to those
19 two facilities.
20 Q: Why are they separate in '09 and combined in
21 '11?
22 A: Well, internally they identified them -- in 2009
23 we had internal information that split it out.
24 2011 we had -- they don't -- they don't report
25 it separately, we couldn't get it separately so

1 we had to use publically available information,
2 and it's all reported consolidated. So 2011 is
3 consolidated. But University, again, University
4 as far as proximity is very close to Main.
5 It's less than half full and going down. You
6 know, in 2009 it was 47 percent, 2011 it was 43
7 percent. If they were truly having a capacity
8 constraint issue at Main, send them a mile or
9 two down the road to University. Union, same
10 thing. If -- and CMC-Main does draw from a
11 very broad geographic area, so if some of those
12 patients from Union were being treated at Main
13 there's beds available at Union. Cleveland and
14 Kings Mountain I believe are in the same
15 county. There are tremendously available number
16 of beds -- there's a tremendous number of beds
17 available at those two facilities. So the
18 individuals from those portions or those regions
19 of Charlotte could be redistributed to those
20 facilities. And what it shows is in total over
21 450 available beds. And Ms. Carter applied an
22 occupancy standard to that -- it doesn't matter
23 what occupancy standard you apply, they're empty
24 beds. You could put a patient in an empty bed.
25 And there are a lot of other options that -- we

1 just identified six options for them to transfer
2 or redistribute patients or redistribute the
3 historical market share from those areas to CMC
4 -- from CMC-Main to those areas, just as they
5 proposed CMC-Fort Mill to do. They're not
6 doing that in North Carolina, so there was no
7 cost associated with sending the patients to
8 those facilities. There's a $75 million cost
9 associated with building 64 beds to help with
10 2.2 percent of Main's patients.
11 Q: Good. Okay. Let's move on to another subject.
12 Ms. Carter's testimony related to the adverse
13 impact on Piedmont of the operation of CMC-Fort
14 Mill. Let me ask you first to begin by ---
15 **MR. ANDREWS:** Dan, if you'll pull up CHS
16 Demonstrative 4.12.
17 Q: Mr. Levitt, you'll remember Ms. Carter's
18 testimony about what she characterized as the
19 inconsistencies and your assumptions related to
20 your need methodology and your adverse impact
21 methodology. How do you respond to that?
22 A: That they aren't inconsistent. That they're
23 very consistent. That the premise that Ms.
24 Carter fails to understand or accept is that
25 whoever gets approved, CMC-Fort Mill or Fort

1 Mill Medical Center, is going to increase the
2 system market share of the respective systems,
3 of their own systems. If Fort Mill's approved,
4 Fort Mill Piedmont market share's going to go
5 up. If CMC-Fort Mill's approved, the CHS
6 market share is going to go up. It's not going
7 to be a static environment where only those
8 patients stamped with CHS are going to CMC-Fort
9 Mill and only those stamped with Piedmont are
10 going to go to Fort Mill Medical Center. It's
11 going to change the market, it's going to
12 change the dynamics, and the market share's
13 going to increase by the nature of a new
14 facility being in the market. And our
15 assumptions are consistent with that, and of
16 course, they would be -- or she says one
17 assumption assumes if we're approved we transfer
18 these patients, but if they're approved they're
19 going to transfer those patients. Precisely,
20 that's the point is that if we're approved,
21 we're going to capture North Carolina patients
22 and some of the Piedmont patients are going to
23 go to the new facility. If they're approved,
24 they're going to capture some of the PMC
25 patients and some of their North Carolina

1 facility patients are going to go to the new
2 facility. It's logical and consistent.
3 Q: Okay. Let's move to the assumptions related to
4 your need methodology and begin there as you're
5 providing explanations of this.
6 **MR. ANDREWS:** Dan, let's pull up Demonstrative 321,
7 please.
8 Q: And what are you comparing here, Mr. Levitt?
9 A: What this shows is the 2017 projected market
10 share. The center column is the Fort Mill
11 Medical Center. If we're approved we'd have
12 about a 50 percent market share of northern
13 York, 44, 55, and 52 percent of the three zip
14 codes. And PMC would have about a 20 percent,
15 14, and 20 percent market share. So some of
16 the patients from that area will go to
17 Piedmont. Majority of those patients would go
18 to Fort Mill Medical Center, and some of those
19 patients would go to North -- continue to go to
20 North Carolina. And you can see, it's balanced
21 and it's consistent. Obviously, being located
22 close to North Carolina, closer to North
23 Carolina than Piedmont, more people would go to
24 North Carolina. So that's why the North
25 Carolina is slightly higher than the Piedmont

1 and the Fort Mill is the highest because that's
2 where it's located. That's its home base.
3 Q: All right. Now, how did your assumptions
4 concerning your need methodology for --
5 particularly related to the need for Fort Mill
6 Medical Center relate to your adverse impact
7 assumptions related to CMC-Fort Mill?
8 A: Again, they were consistent.
9 **MR. ANDREWS:** Dan, let's take a look at Demonstrative
10 319, please.
11 A: So we assumed, again, that the first column is
12 the same, Fort Mill Medical Center, the --
13 about the 50 percent market share, 44 to -- 44
14 to 55 percent market share for Fort Mill
15 Medical Center. We assumed in the adverse
16 impact if they're approved they'll have a
17 comparable market share, 40 to 50 percent market
18 share. So either facility, if approved, would
19 have comparable market share. The difference is
20 where those patients come from. If we're
21 approved, they're going to come from -- majority
22 are going to come from those that had
23 previously left to go to North Carolina and
24 some that have gone to Piedmont. If they're
25 approved, it's going to be the inverse of that,

1 mostly people that went to Piedmont, some people
2 that went to North Carolina.
3 Q: Okay. Now, have you also studied Ms. Carter
4 and Ms. Platt's adverse impact analyses related
5 to their financial effects?
6 A: Yes.
7 Q: Okay. Let's begin by looking at the models
8 themselves that have been developed by the
9 various experts. What's shown here in
10 Demonstrative 306?
11 A: The top section shows the -- are my adverse
12 impact assumptions, the different scenarios.
13 The first two, 103 and 104, are really
14 comparable and they show about a 12 to 12 and a
15 half million dollar adverse impact, about three
16 -- a little over 3,000 patients. Again, what
17 this assumes is that the majority of the impact
18 is to Piedmont, about two-thirds of the impact
19 is to Piedmont, a third of the impact is to the
20 North Carolina providers. And the difference is
21 an occupancy assumption at CMC-Fort Mill. The
22 next two are based off 105 -- exhibit Piedmont
23 Exhibit 105 and 107, and they represent a
24 proportional distribution of patients. Instead
25 of assuming 67 percent or two-thirds of the

1 patients come from Piedmont, this is based off
2 the historical proportional market share. And
3 it comes out a little over 50 percent. I think
4 it was about 51 percent for Piedmont in 2011.
5 And what it shows is, again, the difference is
6 the occupancy standard at CMC-Fort Mill, but it
7 shows about 2,000 to 2,200 patients or about
8 eight to $8.8 million negative impact.
9 Q: Okay. Now, how do these assumptions and this -
10 - your models compare with those testified about
11 by Ms. Platt and Ms. Carter?
12 A: In the bottom section we show their analyses,
13 and what it shows is that in CHS Exhibit 33 Ms.
14 Platt assumed, and based on the 2009 adverse
15 impact model that I had, a proportional
16 distribution, instead of the 67 percent, the
17 proportional distribution of about 1,600
18 patients and the financial impact of that was
19 about six and a half million dollars. And that
20 ---
21 Q: Now, how does that analysis that you just
22 described compare with the other two?
23 A: The other ---
24 Q: The other two, the other from Ms. Platt and
25 then Ms. Carter.

1 A: Yes. It was the most consistent with my
2 assumptions that she also did what we call look
3 back. She compared the 2009 experience at
4 Piedmont to where Piedmont would be in 2017
5 with CMC-Fort Mill, and she said that because
6 of population growth and market growth we'd only
7 have 62 less patients than we had in 2009 and
8 that would only be a $250,000 negative impact.
9 Q: And what did Ms. Carter do?
10 A: Ms. Carter did a similar analysis. She did
11 more of a hybrid. She looked at where we were
12 in 2011 and where we'd be in 2017 projected and
13 applied a proportional distribution of the
14 growth. So she still looked at where we were
15 in the past, you know, that's why we called it
16 the look back, where we were in the past
17 compared to where we'd be in the future with
18 them, and it showed about 676 patient impact or
19 a $2.7 million negative impact.
20 Q: Okay. Now specifically, have you examined Ms.
21 Carter's testimony related to the adjustment of
22 the financial impact on Piedmont?
23 A: Yes.
24 **MR. ANDREWS:** Let's pull up her demonstratives,
25 please Dan, at CHS Demonstrative 4.74 and 75.

1 All right.
2 Q: Just review if you would, Mr. Levitt, before
3 providing your opinions about this what Ms.
4 Carter's done.
5 A: So the line in red comes from my Exhibit 107.
6 That showed the eight million dollar negative
7 impact in contribution margin. She took the
8 2011 and 2012 pre-tax income at Piedmont Medical
9 Center and subtracted that out, applied an
10 income tax percentage to get the adjusted net
11 income, and then she calculated the margin and
12 said even with the eight million dollar negative
13 impact we'd still have 2.7 or 5.4 percent
14 margin, and that's fine.
15 Q: Did she do -- apply your assumptions on the
16 next page as well?
17 A: Yes. She did the same analysis using Piedmont
18 Exhibit 104, the $12.1 million negative impact.
19 And again, she assumed that an adjusted margin
20 of 2.1 and 4.6 was fine, that that's not
21 adverse.
22 Q: All right. Now, with regard to the reduction
23 that's shown in red, on the previous slide the
24 eight million and on this one the 12 million,
25 what is the basis for those calculations?

1 A: That is based off the pool of patients, the
2 pool of inpatients with the case mix, less than
3 2.0. So this is what we sort of call the
4 community hospital patient pool, inpatients
5 only.
6 Q: All right. And did your adverse impact
7 analysis quantify financially the effect of the
8 loss of outpatient business?
9 A: No, as I testified on direct, the order of
10 magnitude was so large just looking at the
11 current dollar value for inpatients, we stopped
12 the analysis. It was clearly adverse. Twelve
13 million -- eight to $12 million negative impact
14 to Piedmont was adverse, so, no, it did not
15 include outpatient.
16 Q: All right. Now, following Ms. Carter's
17 testimony, have you calculated the value of the
18 loss of the outpatient services?
19 A: Yes.
20 **MR. ANDREWS:** All right. Dan, let's look at
21 Demonstrative 315.
22 Q: And what do we have here, Mr. Levitt?
23 A: Again, using the same assumptions on those
24 adverse impact scenarios that we have
25 identified, excluding those that use that look

1 back approach, those understate the impact, from
2 six and a half to 12 and a half million dollar
3 inpatient impact, the associated outpatient
4 impact is five and a half to ten and a half
5 million dollars for a total negative impact on
6 the low side using the CHS calculation of 12.1
7 million to a high of $23 million negative
8 impact. And that's the negative impact giving
9 consideration to in and outpatient services
10 only.
11 Q: How did you calculate the value of the loss of
12 outpatient services?
13 A: The outpatient is assumed the same relationship
14 to outpatient revenue that we assumed in the
15 Fort Mill pro forma. The relationship, the
16 outpatient/inpatient was substantially lower
17 than the CMC relationship. Had we assumed the
18 CMC relationship, the outpatient impact would be
19 tremendously greater. Again, we took a
20 conservative approach and just used the
21 relationships that we used and chose a, again,
22 a substantial negative impact on the -- $23
23 million on the high side. And even using their
24 assumption, it's still $12 million.
25 Q: All right. Now, have you applied these

1 financial impacts reflected by both the
2 inpatient and the outpatient to the pre-tax net
3 income for Piedmont?
4 A: Yes.
5 **MR. ANDREWS:** Dan, let's take a look at that,
6 Demonstrative 322.
7 Q: All right. Give an overview of what's
8 reflected in this demonstrative, please, Mr.
9 Levitt.
10 A: Well, Ms. Carter seemed to say that what's the
11 impact on the net income what I think is -- or
12 I'm sorry, on the margin. She calculated the
13 margin and said if they were positive margins
14 fine. What I think's important is to look at
15 the pre-tax income. So from 2009, 2011, and
16 2012, which is what she had used, that was the
17 Piedmont pre-tax income reported to the county
18 in the county reports. In 2009, it was a
19 little lower than $28 million, in 2011 it was
20 $24.7 million, and 2012, it was $36 million,
21 $36.1 million. That was the pre-tax income.
22 Again, the adverse impact that we assumed that
23 $22.3 million, the $12 million inpatient, the
24 $10 million outpatient, again, 23, $22.3 million
25 total adverse impact represents -- in 2009

1 represented 80 percent of the pre-tax income,
2 represented 90 percent of the pre-tax in 2011,
3 and represented 62 percent of the pre-tax income
4 in 2012.
5 Q: All right. Now, if you make the lower
6 assumption of eight instead of a $12 million
7 inpatient loss, what's the effect of that?
8 A: So again, the pre-tax income is constant
9 throughout all three models, but you know, 27,
10 24, $36 million, assuming the lower impact of
11 about $15 million, the pre-tax income, that
12 represents about 53.2 percent of the pre-tax
13 income in 2009, 60.2 percent of the pre-tax
14 income in 2011, and 41.3 percent of the pre-tax
15 income in 2012.
16 Q: Now, if you assume and apply the analysis that
17 Ms. Platt undertook, what's the effect?
18 A: So again, Ms. Platt identified the six and a
19 half million dollars on the inpatient side,
20 another five and a half would be associated
21 with outpatient. The pre-tax income is
22 consistent so the $12.1 million negative impact
23 on her analysis represents 43.4 percent of the
24 pre-tax income in 2009, 49.1 percent of the
25 pre-tax income in 2011, and 33.7 percent of the

1 pre-tax income in 2012. So you can see, even
2 on the low side, it represents a substantial
3 portion of the pre-tax income historically at
4 Piedmont and it represents -- you know, all
5 three of these scenarios show tremendous
6 negative impact to Piedmont's pre-tax income.
7 Q: Now that you've given financial effect to the
8 potential both outpatient and inpatient losses,
9 does this demonstrative reflect all the
10 potential financial losses that Piedmont would
11 suffer as a result of the adverse impact?
12 A: No.
13 Q: What else ---
14 A: Again ---
15 Q: --- should be included?
16 A: Again, you know, when I did the initial
17 analysis I stopped at inpatient because it was
18 so large. Now we've added in outpatient. I
19 haven't given effect to the patients with a
20 case mix greater than two. I haven't inflated
21 these numbers. I haven't -- there are other
22 analyses that could be done that would continue
23 to make the number higher, but I don't think we
24 need to do that. These are -- these are
25 tremendously large numbers and they represent an

1 adverse impact to Piedmont.
2 Q: Okay. All right. Let me ask you one final
3 series of questions, Mr. Levitt, related to the
4 testimony that Ms. Carter and Ms. Platt provided
5 concerning whether or not the operation of CMC-
6 Fort Mill would have an adverse effect on the
7 existing distribution of health services under
8 -- particularly under Section 22 of the project
9 review criteria, do you remember that
10 distribution?
11 A: Yes.
12 Q: And what's your opinion concerning whether or
13 not such an adverse effect would take place?
14 A: Absolutely that the health care delivery system
15 would fundamentally change in York County if
16 CMC-Fort Mill's approved, that the physicians --
17 we heard three physicians from Piedmont testify
18 that if CMC-Fort Mill's approved, they would
19 seek privileges and treat patients at that
20 facility. Those patients would have
21 historically been treated at Piedmont. So the
22 shift would have occurred, or the shift will
23 occur if they're approved.
24 Q: All right. Have you analyzed anything that
25 relates to the development of that opinion?

1 A: Yes. We looked at the independent physicians
2 on staff at Piedmont. Independent are not
3 employed and non-hospital based physicians.
4 **MR. ANDREWS:** All right. Let's pull that up. We've
5 got an exhibit of that, Exhibit 28, Dan.
6 Q: And what did you do with that exhibit, Mr.
7 Levitt?
8 A: We identified in that exhibit, this is a list
9 of physicians and where they have privileges
10 that are not employed by any hospital entity
11 and they're not hospital-based physicians. And
12 we identified those physicians that are
13 affiliated with CHS.
14 Q: And why did you do that?
15 A: Those are the physicians that, obviously, would
16 have the highest likelihood of initially
17 realigning services from -- away from Piedmont
18 to the CMC system or CHS system. And we
19 identified about half of the independent
20 physicians. We currently have or currently as
21 in now have a relationship with CHS ---
22 Q: How did you identify them?
23 A: We went to the CHS website on their Find a
24 Physician section, and these are the physicians
25 that are listed.

1 Q: And you're saying "these," you're referring to
2 the exhibit that's on the screen. And what are
3 the blue highlights?
4 A: The blue highlights are those physicians that
5 are identified on the CHS website when an
6 individual seeks to find a physician. So they
7 have a relationship with CHS, there's a full
8 relationship, and they have privileges at the
9 CHS facilities. So to the extent that a new
10 hospital's built in Fort Mill that's operated by
11 CHS, these physicians who are not employed by
12 CHS, not employed by Piedmont, would shift their
13 business from Piedmont to CHS facilities, either
14 CMC-Fort Mill or Pineville or Main or all of
15 the above.
16 **MR. ANDREWS:** Thank you. I don't have any further
17 questions.
18 **MR. MULLER:** Your Honor?
19 **THE COURT:** Mr. Muller.
20 **MR. MULLER:** There's been a great deal of new
21 demonstrative exhibits that I've never seen
22 before, and so I wonder if this would be a good
23 time to break to allow us to receive copies of
24 those from Piedmont's counsel and then we could
25 be more efficient on our cross?

1 what -- how they've calculated the operating
2 cash flow. And the scales are very misleading,
3 you know. So I don't even have a comment on
4 this exhibit.
5 Q: But suffice it to say if your market share is
6 not as projected you think you're still going
7 to be profitable?
8 A: Depending on the order of magnitude.
9 Q: What order of magnitude would that be?
10 A: I don't know. I did a sensitivity that showed
11 that if we weren't at 54 percent but we're in
12 the 40 percent range that we're still
13 profitable, not changing any other assumptions.
14 Obviously if utilization is lower they would
15 change assumptions, operating assumptions, and
16 respond as best they could.
17 **MR. MULLER:** Thank you. I have no further
18 questions, Your Honor.
19 **THE COURT:** Thank you, Mr. Muller. Mr. Andrews.
20 **MS. BIGGERS:** No questions.
21 **THE COURT:** The Department. Thank you.
22 **MR. ANDREWS:** Thank you, Your Honor.
23 **MR. LEVITT - REBUTTAL RE-DIRECT EXAMINATION BY MR.**
24 **ANDREWS:**
25 **MR. ANDREWS:** Would you mind pulling up the

1 demonstrative showing the Tenet southern
2 regional facilities. I'm sorry I missed the
3 demonstrative on that? I'm sorry? What number
4 was that?
5 **MR. MULLER:** I believe it was Demonstrative 8, page
6 64.
7 **MR. ANDREWS:** And if you'd turn, please, to the page
8 where the questions were posed concerning the
9 inpatient and outpatient utilization at the
10 various southern regional hospitals. Thank you.
11 And if you wouldn't mind zooming in on the
12 southern region. There you go. Thanks. Could
13 you do it a little more so we could actually
14 read those values under the inpatient and
15 outpatient if that's possible.
16 Q: Mr. Levitt, as she's doing that, Mr. Muller
17 asked you as I understood it about the
18 relationships between Atlanta Medical Center and
19 Piedmont and the ratios of ---
20 **MR. ANDREWS:** Thank you. That's great.
21 Q: --- inpatient admissions to outpatient visits.
22 Is that what you understood the question to be?
23 A: Yes.
24 Q: And the ratio is different, is it not?
25 A: Yes.

1 Q: Almost two to one different. If you would,
2 take out your calculator and perform a few
3 computations for us. Just running down that
4 list, first of all, what's the ratio of
5 inpatient admissions to outpatient visits at
6 Piedmont so we can establish a baseline?
7 A: 10.8 percent.
8 Q: Okay. And then do Atlanta which you had
9 testified about.
10 A: 17.4 percent.
11 Q: And what are the reasons that the relationships
12 between inpatient and outpatient services may be
13 different from facility to facility?
14 A: Well, the most basic would be about services
15 offered. If there are outpatient services
16 offered at that facility that another facility
17 doesn't have, radiation therapy, some sort of
18 outpatient imaging, an outpatient imaging
19 center, if they don't have a lot of outpatient
20 services if there are a lot of market
21 competitors like freestanding the imaging
22 centers, lab testing, things like that then the
23 hospital has lower volume and others would have
24 a higher volume.
25 Q: Okay. How about run the -- let's close the gap

1 between Atlanta Medical Center and Piedmont by
2 performing the same calculations for the
3 intervening hospitals. Look at North Fulton and
4 identify what that relationship is, please.
5 A: 10.5 percent.
6 Q: So about the same as Piedmont's?
7 A: Yes.
8 Q: All right. Look at South Fulton.
9 A: 7.1 percent.
10 Q: All right. And so it would be -- it would have
11 a greater inpatient or greater outpatient to
12 inpatient services, is that right?
13 A: Yeah.
14 Q: Okay. And do the next one then at Spalding.
15 A: 7.1.
16 Q: So about the same as South Fulton?
17 A: Yes.
18 Q: All right. Now what inferences can you draw
19 just on the calculations you performed
20 concerning the relationships of the various
21 Tenet hospitals to their inpatient outpatient
22 activity?
23 A: Well, there's a variety -- it's not related to
24 bed size, which was what Mr. Muller was asking.
25 And it's related more to the market it's

1 located.
2 Q: Okay. All right. Now, Mr. Muller also asked
3 you a series of questions about bed-to-
4 population ratio analysis. In the -- all of
5 the attention that was given to that load by
6 Carolinas, did Carolinas ever discuss the use
7 rate in the context of its presentation to bed-
8 to-population ratio methodology?
9 A: No, I don't recall them discussing their use
10 rate analysis anywhere. That was never brought
11 up until Ms. Platt showed those exhibits during
12 the trial.
13 Q: Okay. Does the use rate tell a consultant how
14 many beds are needed?
15 A: No, not at all. As I said to Mr. Muller that
16 that's one of the variables that you use to
17 project it.
18 Q: All right. Now finally, with regard to the
19 examination of Demonstrative 9.6, the HHS
20 report, we have it actually.
21 **MR. ANDREWS:** Dan, let's bring it up as
22 Demonstrative 268. And go to 268.4, please,
23 let's take a look at Village. And you'll --
24 and you've gone through your testimony
25 concerning that. And Dan, if you'll zoom in if

1 you would on the last two columns. Pull those
2 out for us.
3 Q: And next to Village, what hospital is reported
4 there, Mr. Levitt?
5 A: Roper Mount Pleasant.
6 Q: All right. And what information is -- are you
7 familiar with Roper Mount Pleasant project?
8 A: Yes.
9 Q: And describe it if you would for the Court.
10 A: That was a relocation of 84 beds from the Roper
11 main hospital in downtown Charleston on the
12 peninsula out to Mount Pleasant by Roper, which
13 we talked about CHS has an ownership interest
14 in.
15 Q: And who manages Roper?
16 A: CHS.
17 Q: All right. And was that a transfer of existing
18 beds or was that a new need that was ---
19 A: It was transferred as existing beds.
20 Q: Okay. And what is the -- and how many years of
21 experience based on this report were reported
22 for Roper Mount Pleasant?
23 A: Just one.
24 Q: And what was that performance?
25 A: They lost almost $12 million.

1 Q: All right. And what was their occupancy after
2 the first year?
3 A: Twelve percent.
4 Q: Do you remember what their occupancy was
5 projected to be?
6 A: For?
7 Q: In year one.
8 A: I think it was in the 30's, 30 percent. So
9 they didn't achieve their projections either.
10 Q: All right. Now, the ---
11 **MR. ANDREWS:** Let me ask you, Dan, if you bring up
12 page two of this demonstrative and call out the
13 column that's the third from the end.
14 Q: Do you recognize this facility, Mr. Levitt?
15 A: Yes, that's the Roper facility in West Ashley.
16 Q: And where is it ranked in the state in terms of
17 its aggregate financial performance?
18 A: It's ranked ninth.
19 **MR. ANDREWS:** And let's turn to the next page, 268.1
20 and look at Roper.
21 Q: Now, is Roper -- are Roper and Saint Francis
22 for profit or non-profit hospitals?
23 A: They're not for profit.
24 Q: Okay. And where is it ranked?
25 **MR. ANDREWS:** Pull out, Dan, the next to the last

1 column is Roper, the first page in the
2 demonstrative.
3 Q: What was Roper's performance reflected in this
4 report?
5 A: It's the second most profitable hospital.
6 Q: Okay. And now Roper Mount Pleasant, did you
7 notice when you were there -- we'll go back to
8 it if you didn't -- where it ranked in
9 performance in the state?
10 A: I didn't notice.
11 **MR. ANDREWS:** Dan, if you'd go back to 268.4 and
12 bring out that last column, please.
13 Q: And what was the performance for Roper Mount
14 Pleasant?
15 A: Fifty-fourth.
16 **MR. ANDREWS:** All right. Thank you. No further
17 questions, Your Honor.
18 **MR. MULLER:** I have just one question on redirect.
19 **THE COURT:** All right, Mr. Muller.
20 **MR. MULLER:** I think it's one question. It may be
21 more.
22 **MR. LEVITT - REBUTTAL RECROSS EXAMINATION BY MR.**
23 **MULLER:**
24 **MR. MULLER:** If I could ask Mr. Bupp to put up the
25 Piedmont Demonstrative 150.

1 Levitt, Your Honor.
2 **THE COURT:** All right. Then if we're finished with
3 Mr. Levitt, sir, you may be excused. Thank
4 you.
5 **MR. LEVITT:** Thank you.
6 **THE COURT:** Are we ready for our next witness?
7 Would it be all right to take a break.
8 **MR. MULLER:** That would be fine.
9 **THE COURT:** All right. Let's take ten minutes.
10 **(Break from 2:27 p.m. until 2:56 p.m.)**
11 **THE COURT:** All right. We're back on the record.
12 Mr. Westbrook.
13 **MR. WESTBROOK:** Thank you, Your Honor. We call --
14 Piedmont calls Bill Masterton.
15 **THE COURT:** Okay. Mr. Masterton.
16 **BILL MASTERTON,** being duly sworn, testifies as
17 follows:
18 **MR. MASTERTON - REBUTTAL DIRECT EXAMINATION BY MR.**
19 **WESTBROOK:**
20 Q: All right. Mr. Masterton, you've been here
21 about every day of trial, haven't you?
22 A: I have all but one day. This is an important
23 case for Piedmont.
24 **MR. WESTBROOK:** Let me ask Dan to put up on the
25 screen CHS Demonstrative 4.69.

1 Q: And ask you if you recognize this. Do you
2 recall Ms. Carter testifying about this
3 demonstrative?
4 A: I do.
5 Q: And could you read the heading for us, please?
6 A: "PMC's or Piedmont Medical Center's projected
7 impact not adverse."
8 Q: Now Ms. Carter had some concerns about
9 particularly with -- in particular with the
10 expense portion of this chart, is that right?
11 A: Yes, I recall the -- what led to the conclusion
12 was that inability to manage expenses by them
13 growing 25 percent with the same volume around
14 12,000 admissions is why the impact should not
15 be adverse.
16 Q: All right. You're talking about Piedmont's
17 inability or her concern that Piedmont didn't
18 have the ability to manage those expenses?
19 A: Yes.
20 Q: When you said their, okay, I was just
21 clarifying that. Refresh our memories, please,
22 about Ms. Carter's chart. What was she
23 comparing in this chart?
24 A: It was comparing actual 2009 Piedmont Medical
25 Center data from the York County report to

1 projected 2020 Piedmont Medical Center
2 experience with a North Carolina Fort Mill
3 provider, in this case it would be CMC, from
4 Mr. Levitt's projections that he prepared.
5 Q: All right. And there's -- in the margin there
6 towards my right, down towards the bottom,
7 there's that fuzzy sort of number, what does
8 that represent?
9 A: That number represents bad debt expense and it's
10 roughly $23.5 million.
11 Q: And now where did Ms. Carter include that bad
12 debt amount in her chart?
13 A: Well, the number on the right, the fuzzy
14 number, the $23.5 million, is included in the
15 line that says other expenses in the column
16 that says "Projected Piedmont Medical Center
17 experience with North Carolina Fort Mill
18 provider."
19 Q: All right. It's within that 144 number; is
20 that what you're saying?
21 A: Yes, it's included in the 144 million.
22 Q: All right. Now what about the margin number on
23 the -- to my left, that 24,914,730 number, what
24 does that represent?
25 A: That number was intended to represent the 2009

1 Piedmont Medical Center actual bad debt from the
2 York County report.
3 Q: All right. Now where was that included in Ms.
4 Carter's chart?
5 A: On this chart it was included as a deduction
6 from revenue rather than an expense. So it's
7 included in the third line titled "net revenue"
8 in the 2009 column, 235,278,000.
9 Q: All right. Now is that $24.9 million number
10 accurate?
11 A: No, I believe it's 26 million.
12 Q: And where did Ms. Carter get the 24.9 number?
13 A: I don't know.
14 Q: All right. Let's go back over to the -- you
15 pointed out earlier that figure down towards the
16 bottom under the expense that said "other
17 expenses," there was a figure 144 million --
18 and I can't even read it from here -- 511,000
19 so forth. What's the problem with that number?
20 A: Well ---
21 **MR. GASKINS:** I'm going to object, Your Honor. He's
22 testifying about a -- I guess numbers that Mr.
23 Levitt prepared and no foundation's been
24 established that he knows anything about how
25 those figures were calculated. If he lays

1 proper foundation I think it's fine, but at
2 this point, I don't think he's done that.
3 **MR. WESTBROOK:** Your Honor, he's testifying about
4 numbers that Ms. Carter used in her
5 demonstrative that I think we got her to
6 testify on cross were incorrect. And I want --
7 and Mr. Masterton is being called to rebut this
8 demonstrative. So to understand what he's
9 rebutting we've got to first show what's wrong
10 with it. And this is -- this is not Mr.
11 Levitt's number, this is not Mr. Levitt's chart.
12 Part of the source for this is Mr. Levitt's
13 numbers, part is something else, but it's Ms.
14 Carter's chart.
15 **MR. GASKINS:** Well, in either case, I think he needs
16 to establish some foundation about how he's
17 knowledgeable about the numbers that are used,
18 how they were calculated, what they include, and
19 I don't think that's been done. And so I don't
20 think -- I don't think he has any personal
21 knowledge about this.
22 **MR. WESTBROOK:** He testified he listened to Ms.
23 Carter's testimony. She described it. And he
24 just said that the 144 million included the $23
25 million of bad debt, and I'm going to ask him

1 why that's wrong.
2 **THE COURT:** Mr. Gaskins, I do recall the witness
3 just testifying that he'd been in the hearing
4 all day and he's heard -- hearing, except for
5 one day, and that he's heard all the testimony,
6 and therefore, I do think -- and certainly if
7 you could -- subject to -- you can certainly
8 cross-examine him about his understanding of
9 those numbers, but I do think -- I do think
10 that he has established that he's at least
11 heard what Ms. Carter said and what her basis
12 for it, and I believe he's about to offer his
13 analysis of that, so.
14 **MR. GASKINS:** Okay.
15 **THE COURT:** Objection overruled, sir.
16 Q: Mr. Masterton, you testified a minute ago, I
17 believe, that the sort of fuzzy number, the
18 margin number, the $23 million number was
19 included based on your understanding of Ms.
20 Carter's testimony in that $144 million number,
21 is that right?
22 A: Yes.
23 Q: And what's the problem with that from your
24 point of view?
25 A: Well, the problem is it's treated as a

1 deduction from revenue in the 2009 experience,
2 so it's in the net revenue number, and then
3 it's treated as an expense item in the 2020
4 projection.
5 Q: All right.
6 A: And so in other words, that's what led to the
7 incorrect conclusion that, you know, inability
8 to manage expenses is what's leading to adverse
9 impact.
10 Q: And as a result of that $144 million number,
11 what's the percentage difference between 2009
12 and 2020 in other expenses, according to Ms.
13 Carter's chart?
14 A: Well, if you reduce the 144 million by the 23
15 million and move it up to net revenue and ---
16 Q: Now what is it on her chart, Mr. Masterton?
17 A: 48.8 percent.
18 Q: All right. And look at the total line on
19 expenses there. What's the percentage
20 difference in expenses from 2009 to 2020 on her
21 chart?
22 A: 25.5 percent.
23 Q: All right. Now, have you prepared a
24 demonstrative that corrects the errors in Ms.
25 Carter's chart?

1 A: Yes.
2 **MR. WESTBROOK:** All right. Let's take a look at
3 that. And Dan, that would be Demonstrative
4 320, I believe, if you'll pull that up, please.
5 Q: All right. Now, Mr. Masterton, it looks like
6 you've got similar columns there. Can you
7 explain that first column that says "Actual 2009
8 PMC experience"?
9 A: Right. We copied this information right off
10 her demonstrative and put it in the -- so all
11 these numbers are the same except that bad debt
12 is the updated number from the York County
13 report. And bad debt is the number, the
14 $26,292,000, the I guess fourth line down on
15 the chart.
16 Q: All right. And it looks like you're comparing
17 it as she did with projections?
18 A: Yes, and that also came from her demonstrative,
19 same column. And all the numbers there are the
20 same with the exception of other expenses and
21 total. In other words, once you make the
22 adjustment to put bad debt in the same place in
23 both years.
24 Q: All right. And you've alluded to this, but it
25 looks like another change that you've made from

1 Ms. Carter's chart is you moved bad debt up
2 above the expense line, is that right?
3 A: Right. To keep it consistent from year to year
4 I treat it as a deduction from revenue, because
5 it's not and expense that you would pay anyway.
6 Q: All right. And I think you've testified that
7 you didn't use Ms. Carter's $24 million number
8 in 2009, is that right?
9 A: Right. We updated it to the York County
10 report.
11 Q: All right. And you've also moved income down
12 to the bottom, why is that?
13 A: Only for presentation, to make it read like a
14 more traditional financial statement. So you
15 have revenues minus expenses equals income,
16 that's what's left over. So that is -- it was
17 cosmetic to make it flow.
18 Q: All right. And there's a column over on the
19 far right, to my right, labeled CAGR. Can you
20 explain what that is, please?
21 A: That stands -- it's an acronym that stands for
22 compound annual growth rate. And we added that
23 in so that it would -- this time period is 11
24 years, 2009 to 2020. So we added in the
25 compound annual growth rate so that the expense,

1 the changes in the expense or those differences
2 would make sense. I like to use the example of
3 an employee. If an employee in 2009 was
4 earning $25,000 and then at 2020 was earning
5 $35,000 that's a 40 percent increase. But if
6 you went and talked to that -- over 11 years.
7 but if you went and talked to that employee
8 they wouldn't think they were getting a 40
9 percent increase, it's really a CAGR or annual
10 growth rate of 3.1 percent each year. So
11 that's what we were trying to show with that
12 column.
13 Q: All right. Thank you. Now let's move down to
14 the bottom part of that chart, or maybe it's
15 the middle part of that chart where it says
16 "Expense Detail" please. The first line there
17 under that is "Salaries and Benefits," and if
18 you move over to the CAGR column it looks like
19 .5 percent. Can you comment on that, please,
20 sir?
21 A: Yes. So over 11 years, the salary, wages, and
22 benefits are expected to grow annually at half
23 a percent or five and a half percent total over
24 those 11 years. And I think that's an
25 optimistic projection and demonstrates actually

1 ability to manage expense for this reason.
2 Employees at our hospital are accustomed to a
3 two to three percent merit increase each year
4 in their wage. And also that's commensurate
5 with what other hospitals in the area offer.
6 We know that if we don't keep our wages
7 competitive that we'll lose employees and
8 they'll go to these other hospitals. So for us
9 to only have a five and a half percent increase
10 over 11 years or half a percent per year when
11 we know we'll lose employees that will be able
12 to treat these 12,000 patients if we don't
13 offer them competitive wages, we know that we're
14 actually getting more efficient and have fewer
15 employees paid for in the projected 2020
16 salaries of 88,184,000.
17 Q: All right. The next line, Mr. Masterton, it
18 says "Other Expenses," and if you'll look at
19 the percentage difference between 2009 and 2020
20 it says 24.6 percent. Do you recall from Ms.
21 Carter's chart what that percentage difference
22 was for that line?
23 A: Yes, it was 48.8 percent when it included bad
24 debts. And when you move bad debts out of
25 there and make it comparable it's only a 24.6

1 percent change over 11 years. But again, I
2 think you need to look at that in context of
3 what is that doing every year, and that's two
4 percent. I think it'd be unreasonable to ask
5 all the vendors and everybody to take an 11
6 year freeze on the payments that we make to
7 them for the services we purchase from them for
8 supplies.
9 Q: How does that link to Consumer Price Index?
10 A: The health care -- the medical care Consumer
11 Price Index, the most recent one I looked at
12 was about 3.7 percent, and that's what it also
13 kind of trends. If you look at a ten year
14 block of time and just kind of do the math it's
15 around 3.7. So it's not growing as fast as the
16 medical care CPI.
17 Q: All right. The total line for the expenses
18 there, if you'll go down to that for a moment,
19 total line, what does it -- what's the
20 percentage difference in the CAGR there?
21 A: So total expenses are growing at 1.2 percent
22 per year under these projected assumptions,
23 which in my mind demonstrates an ability to
24 manage costs very well, particularly when your
25 labor is going to be growing somewhere between

1 two and three percent and the medical care CPI
2 is growing over three percent.
3 Q: All right. Good. And let's go down to the
4 last two lines. Those are income lines,
5 correct?
6 A: Yes.
7 Q: And what do these show?
8 A: Well, this shows pre-tax income of almost $28
9 million in 2009, and it shows that in 2020 with
10 modest expense increases that we actually go to
11 a unprofitable situation. We're actually losing
12 money treating the same 12,000 patients.
13 Q: And what's the after-tax and pre-tax loss there
14 on the chart?
15 A: In 2020 projected after-tax loss is $18,000.
16 Q: Now that $18,000 is that -- is it your
17 understanding that's the projection simply for
18 that one year for 2020?
19 A: That is the projection for the year 2020, but
20 it's not that that's the only time that will
21 occur. In other words, you'll continue to lose
22 in perpetuity.
23 Q: That same amount?
24 A: Yes. Well, it will increase, because that
25 would be pressure -- the same inflationary

1 pressures that were on your hospital cost
2 structure from '09 to '20 aren't going to go
3 away, they're going to continue. And so this
4 situation will actually exacerbate.
5 Q: Now, now during this 11 year period from 2009
6 to 2020 while the projected loss, income loss,
7 is over 100 percent, what is the population
8 projected to do in York County, do you know?
9 A: Yeah, well, just even from this morning, yes,
10 the north -- northern York County's growing at
11 25 percent, Rock Hill almost 11 percent, I
12 think it was 10.9, and western York ten
13 percent. So this shows that there's no
14 accretion of the population growth to Piedmont
15 Medical Center.
16 Q: All right. Now going back to Ms. Carter's
17 chart, her heading, I believe, you caught --
18 read that into the record was "PMC's Projected
19 Impact Not Adverse." What's your response to
20 that, Mr. Masterton, as Piedmont's CEO?
21 A: Well, I think it's adverse, very adverse, as
22 one that would even -- and one that would be --
23 have to manage to these expense controls, I
24 think -- I think it demonstrates that it's
25 adverse.

1 Q: All right. Do you recall Ms. Carter also
2 testifying about Piedmont's annual after-tax
3 income from 2005 to 2012?
4 A: I do.
5 Q: And do you recall her opining that that after-
6 tax income during that eight year period gave
7 no evidence of adverse impact?
8 A: I do.
9 Q: All right. And do you have a demonstrative
10 that puts Piedmont's annual net income in some
11 context?
12 A: Yes.
13 **MR. WESTBROOK:** Let's look, Dan, at Demonstrative
14 305, please.
15 Q: 305, Mr. Masterton, you see there that middle
16 column, that after-tax income, is that the
17 after-tax income that Ms. Carter was looking at
18 in her demonstratives?
19 A: Yes.
20 Q: And it comes to a total there that's given.
21 What's that next column? What have you added
22 there?
23 A: I thought to give some context to what after-
24 tax income is used for we put our capital
25 expenditures for the same years in a column to

1 the right of that. And you can see there that
2 it totals $98,133,000 an investment back in our
3 hospital.
4 Q: All right. Now what kind of things -- when you
5 say capital expenditures, what kind of things
6 are you spending money on?
7 A: These are things like MRIs, CT scanners,
8 telemetry monitors, ambulances. I mentioned in
9 my direct testimony the first day that we're
10 doing a $20 million expansion of our emergency
11 room, and ultimately that will show up on this
12 chart as we make that investment.
13 Q: Now, if the net income for Piedmont decreases
14 in a year or multiple years, what kind of
15 effect does that have on capital expenditures?
16 A: It will decrease it.
17 Q: All right. Mr. Masterton, on direct you
18 testified about a plan that involved building
19 Fort Mill Medical Center and how that would
20 enable you to halt and recapture out-migration.
21 Do you remember that testimony?
22 A: I do.
23 Q: And you heard CHS witnesses testify that that
24 kind of recapture just couldn't be done, right?
25 A: I did.

1 Q: What's your response to that?
2 A: Well, I did, as you suggested, hear a lot of
3 theories and projections on what would happen in
4 Fort Mill for Piedmont, would it be able to
5 regain market share in that. I think there was
6 some belief that it wouldn't. And I guess in
7 my own experience I have -- I have direct
8 experience with a hospital that I consider that
9 would be in a similar situation where we were
10 able to actually increase market share through
11 the emergency room and through a new hospital.
12 And the hospital was -- I was the CEO at right
13 before, it was Coastal Carolina Hospital. It
14 was located right off the interstate, the same
15 as Fort Mill Medical Center was. It was
16 located in a border town. It bordered the
17 state of Georgia and was very close in
18 proximity to Savannah where there were competing
19 systems, Saint Jo Candler and Memorial Health
20 System of Savannah. And there was also
21 additional competition in the area from Beaufort
22 Memorial Hospital. And there's a population
23 center, a community, they're called the Okatie
24 area where that was the mostly densely part of
25 the service area. And by focusing on the

1 emergency room and giving patients a good
2 alternative, we were able during my tenure there
3 as CEO to increase the market share over 50
4 percent from 19 percent or so to over 28
5 percent. And I learned a couple lessons from
6 that. One, that for patients, proximity to the
7 emergency room matters. There's been a lot of
8 testimony here about that that's how patients --
9 one way patients access the hospital through,
10 their physician and their physician network, but
11 the other way is also the emergency room. And
12 I learned that lesson firsthand at Coastal.
13 And then what I learned over time and I
14 remember being frustrated by this at first, is
15 that by offering a good service in the
16 emergency room and attracting patients to your
17 hospital through that, I remember they would
18 come -- patients would come to us from that
19 community at two in the morning, but then for
20 their elective procedure they would go during
21 the weekday, you know, at 10:00 in the morning
22 to their own physician. But over time by
23 coming to our ER and getting good service, they
24 actually adopted our hospital and a lot of
25 those relationships started to change. So it

1 created a virtuous cycle we were building market
2 share and it started with our emergency room.
3 **MR. WESTBROOK:** Thank you, Mr. Masterton. No
4 further questions.
5 **THE COURT:** Mr. Gaskins, sir.
6 **MR. GASKINS:** Could we take a short break to review
7 the demonstratives that they ---
8 **THE COURT:** Any objection to that?
9 **MR. GASKINS:** I'm not going to take long. Maybe
10 five minutes.
11 **THE COURT:** Five minutes. Five minutes.
12 **(Break from 3:16 p.m. until 3:28 p.m.)**
13 **THE COURT:** We're back on the record. Mr. Gaskins,
14 is that a sufficient amount of time for you,
15 sir?
16 **MR. GASKINS:** I have, Your Honor.
17 **THE COURT:** Okay.
18 **MR. GASKINS:** Are you ready?
19 **THE COURT:** Yes.
20 **MR. MASTERTON - REBUTTAL CROSS EXAMINATION BY MR.**
21 **GASKINS:**
22 **MR. GASKINS:** Mr. Bupp, do you mind pulling up
23 Piedmont Demonstrative 320?
24 Q: Mr. Masterton, this is the demonstrative that
25 you were testifying about a few minutes ago.

1 Will Piedmont, is it your testimony that
2 Piedmont will be as competitive if it has to
3 reduce programs and services?
4 **MR. GASKINS:** Objection, Your Honor. He's leading
5 the witness.
6 **MR. WESTBROOK:** Well, it is sort of a leading
7 question, isn't it? Let me see if I can
8 rephrase that.
9 **THE COURT:** If you could, sir.
10 **MR. WESTBROOK:** I'll do my best.
11 **THE COURT:** Thank you.
12 Q: What will be the effect on competitiveness if
13 you have to cut programs and services as you
14 discussed in your direct?
15 A: Well, I think I've reviewed it in my direct,
16 but they'll obviously be limited. All the ones
17 that aren't required by the county contract
18 we'll have to either reduce or eliminate them.
19 **MR. WESTBROOK:** No further questions.
20 **THE COURT:** Thank you, Mr. Westbrook. Any further,
21 Mr. Gaskins?
22 **MR. GASKINS:** Very briefly.
23 **MR. MASTERTON - REBUTTAL RECROSS EXAMINATION BY MR.**
24 **GASKINS:**
25 Q: Mr. Masterton, you don't know if you'll have to

1 cut services or not, do you?
2 A: I think anything is on the table, so I guess I
3 don't know what services I would cut at this
4 point, if that's what you are asking me.
5 Q: And you would only have to cut those services
6 if they became unprofitable or you lost enough
7 volume, right?
8 A: Well, even some unprofitable services would need
9 to be maintained because of the county contract,
10 so that might require you to look at other ones
11 that you wouldn't necessarily consider if you
12 didn't have the constraint of the contract.
13 Q: And that's all based on the projections of this
14 adverse impact, right?
15 A: Yes.
16 Q: And if that adverse impact doesn't happen, you
17 don't have to cut any services, do you?
18 A: If the adverse impact, if we're not adversely
19 impacted I think that's probably right.
20 **THE COURT:** Does the Department have any questions?
21 **MS. BIGGERS:** No, Your Honor.
22 **MR. WESTBROOK:** Nothing further, Your Honor.
23 **THE COURT:** All right. Mr. Masterton, thank you very
24 much. You can return to your seat.
25 **MR. MASTERTON:** Thank you.

1 **THE COURT:** We're going to have Mr. Sullivan come
2 back on rebuttal, is that right?
3 **MR. WESTBROOK:** That's right, Your Honor.
4 **DANIEL SULLIVAN,** being duly sworn, testifies as
5 follows:
6 **MR. SULLIVAN - REBUTTAL DIRECT EXAMINATION BY MR.**
7 **WESTBROOK:**
8 Q: Mr. Sullivan, good afternoon.
9 A: Good afternoon.
10 Q: All right. Mr. Sullivan, you've heard testimony
11 from CHS consultants during the trial about
12 different ways of looking at adverse impact,
13 haven't you?
14 A: I have.
15 Q: And do you have a demonstrative addressing those
16 two basic ways of looking at adverse impact
17 that were discussed?
18 A: I do.
19 **MR. WESTBROOK:** Dan, let's go to Demonstrative 323.1
20 please. This of course is Piedmont's
21 demonstrative.
22 Q: And Mr. Sullivan, the heading there says "Ms.
23 Carter's testimony on adverse impact is flawed."
24 Can you explain why?
25 A: Sure. Ms. Carter, I think, presented a couple

1 of different approaches to adverse impact. I
2 mean, her initial approach, I think which is
3 consistent with what we heard from other CHS
4 witnesses, is that there would be no adverse
5 impact because patients who would go to CMC-Fort
6 Mill would come from other CHS facilities and
7 not impact Piedmont in any way. I don't
8 believe that Ms. Carter has demonstrated any
9 basis for that. I mean, that was her opinion,
10 but I don't think she introduced any facts or
11 any other materials that would support that
12 notion, and I won't go back over my testimony
13 on direct in that regard. But then she
14 presented another approach to impact, which I
15 think was referred to as the look back method,
16 and that is looking at where Piedmont is today
17 or most recent historical year and then where
18 they'll be in the future with a Fort Mill
19 facility operated by CHS, and then determining
20 impact on whether or not there will be any
21 lower in terms of utilization in the future
22 than they would be in 2011 or 2012. And so,
23 just theoretically, I have a problem with using
24 the look back method as a way of assessing
25 adverse impact.

1 Q: Why is that?
2 A: Well, when you're looking at health planning and
3 you're looking at future events, you want to
4 give consideration to not only where things are
5 today, but where things would be in the future
6 absent the approval of a project, and then
7 looking at where you would be after the
8 approval of a project. And that would give you
9 sort of a full array of potential options that
10 would occur, and from the standpoint of a state
11 agency making a decision or a judge trying to
12 evaluate this, to be able to make that
13 determination is the incremental effect of
14 approving this project so significant that I
15 would reach a different conclusion or is it so
16 insignificant that, you know, the decision that
17 the Department made was correct. By not doing
18 that, I think you tend to understate what the
19 impact would be. And let me give you an
20 example. Let's say you had a hospital that is
21 operating at 20 percent occupancy, and you did
22 an analysis and said this project is going to
23 come in and they're going to be approved, and
24 they're going to take all the growth in the
25 market, and so five years from now, this

1 hospital is still going to be operating at 20
2 percent occupancy. There's no adverse impact on
3 that hospital under the look back approach
4 because that -- the volume stayed the same.
5 But obviously, from a health planning
6 perspective, is that the optimal outcome. If
7 that hospital, for example, could have gone from
8 20 percent to 40 percent utilization absent the
9 approval of that project, would that give a
10 better health planning result than allowing a
11 new provider to come in and maintain utilization
12 at a lower level. So I think that, you know I,
13 this is not a topic that is new to health
14 planning. I mean this issue has come up in
15 many, many hearings that I have been involved
16 in about whether you consider incremental impact
17 or you consider just sort of a status quo. I
18 mean, are you going to reduce the status quo?
19 Q: And let me interrupt you just a second, when
20 you say incremental impact, what do you consider
21 incremental impact? There was testimony, there
22 was a discussion of an approach to adverse
23 impact called with or without, I think a couple
24 of experts referred to it that way. Is that
25 what you're talking about?

1 A: Yeah.
2 Q: Or how did that you relate to the incremental
3 approach you're talking about?
4 A: Yeah, I mean, my terminology is incremental, and
5 that is looking in the future, where you would
6 be with all the projected growth in the market
7 and then where you would be with the approval
8 of a project. And so I mean generally that is
9 the approach that I take in looking at adverse
10 impact.
11 Q: Good. Let's see, have you covered your bullet
12 points up there, Mr. Sullivan?
13 A: I think I have.
14 Q: All right. Now, on direct you also testified,
15 or you testified rather on direct that, in your
16 opinion, CHS didn't have an incentive to shift
17 as many patients from its North Carolina
18 facilities to CMC-Fort Mill as it was
19 projecting. Do you recall that?
20 A: I do.
21 Q: And in her testimony, Ms. Carter offered a
22 number of various incentives that CHS had. Do
23 you recall that?
24 A: I do.
25 Q: Now, Mr. Levitt I think talked about one of

1 those, and we don't want to -- I think we can,
2 don't need to go over what he said. Let's see,
3 this is talking about the decompression of
4 Charlotte facilities. Is there anything in
5 addition that you would like to rebut Ms.
6 Carter's opinion about that Mr. Levitt did not
7 cover here with respect to this issue?
8 A: Yeah, there's one other issue, and that is, I
9 think Mr. Carter -- Mr. Carter, I mean Mr.
10 Levitt spoke about the impact on CMC of
11 transferring, of CMC-Main downtown on
12 transferring patients through a shift. I want
13 to focus a little bit more on Mercy and
14 Pineville. And there's -- Mercy and Pineville,
15 as already been testified to, report together
16 for purposes of licensure in the state of North
17 Carolina, but one of the things that Ms. Carter
18 didn't take into account in her exhibits, she
19 was showing what the historical utilization of
20 Pineville was, she didn't take into account that
21 there were 86 additional beds that were being
22 transferred. Well, they had been transferred.
23 I think the construction is either completed or
24 about to be completed and they're going to open
25 up 86 new beds. So that's a 75 percent

1 increase in the capacity of the Pineville
2 facility. And so there's plenty of capacity at
3 Pineville and, in fact, one of the stated
4 purposes of transferring those 86 beds from,
5 essentially from Mercy but I think a small
6 number came from University as well, was to
7 decompress the CMC-Main facility. And just to
8 give an indication of the level of available
9 capacity within the Mercy Pineville system, I
10 want to refer to a page from the 2013 North
11 Carolina State Medical Facilities Plan.
12 Q: And that is, I believe, Piedmont's Exhibit 13,
13 and this is Demonstrative 323.3, is that right?
14 A: That's correct. The North Carolina bed need
15 methodology is similar to North -- to South
16 Carolina's in the fact that they look at the
17 historical number of patient days that were
18 provided at a facility and projected forward
19 based on population growth. In this case,
20 they're projecting utilization for Mercy and
21 Pineville forward to 2015. Without going into
22 all the graphic details here, what this exhibit
23 shows is that there's projected to be in 2015
24 excess of 97 beds at Mercy and Pineville. And
25 that's taking into account population growth

1 between now and then. And so CMC-Main will
2 have an outlet for those patients. They will
3 be the patients that can be shifted down to
4 Pineville, which is the stated purpose of doing
5 that. And so this notion that somehow there's
6 a lack of capacity in Mecklenburg County to
7 accommodate these patients, I just think isn't
8 demonstrated. I mean in fact the opposite. It
9 appears that there's plenty of capacity to
10 handle additional growth in the future.
11 Q: All right. Let's go to Demonstrative 323.4,
12 please. And again, you have the same heading,
13 but what's your point here, Mr. Sullivan?
14 A: Well, another -- another incentive that Ms.
15 Carter presented in terms of why CMC facilities
16 would shift patients to Fort Mill was that way
17 they could reserve Charlotte beds for more acute
18 care -- more acutely ill patients who needed
19 those expensive resources. As I said before,
20 there is already available capacity to shift
21 these patients in the county. I think what
22 this does is that it sort of underscores a
23 point that I made in my direct testimony, and
24 that is that CHS has every intention of trying
25 to move specialized patients out of York County

1 into Mecklenburg County, so they want to free
2 up space, particularly at CMC-Main, to be able
3 to accommodate those most specialized patients,
4 and that would be a different level, a
5 secondary level of impact that I talked about
6 before, not only the loss directly to CMC-Fort
7 Mill but then the loss of these specialty
8 patients from Piedmont to the CMC hospitals in
9 Mecklenburg.
10 Q: All right. Now, Mr. Sullivan, you heard Ms.
11 Carter also testify about Piedmont's bed
12 capacity in relation to the transfer, proposed
13 transfer of 36 beds?
14 A: Yes.
15 Q: And let's look at demonstrative, I believe Dan
16 already has it on the screen, 323.7. What are
17 your opinions about Ms. Carter's testimony?
18 A: As the heading says, I believe she presented a
19 skewed picture of Piedmont's available bed
20 capacity. And let me just start off by a
21 fairly simple premise, and that is, if you can
22 measure available beds by looking at your
23 licensed bed capacity and subtracting your
24 average daily census, that's a common measure of
25 available bed capacity. And Ms. Carter had an

1 exhibit, if you want to show that exhibit, I
2 think ---
3 Q: Is that CHS Demonstrative 4.45?
4 A: Yes, it is.
5 Q: Okay.
6 A: And what she showed is that the left-hand side
7 of this I think is taken from an exhibit that I
8 did, and it showed that there were 106
9 available beds based on 288 beds, and I think
10 Ms. Carter said, well, we need to take out the
11 psychiatric beds. If you do that, you'd have
12 268 psychiatric beds and 166 ---
13 Q: Excuse me, 268 what?
14 A: Licensed acute care beds.
15 Q: Okay.
16 A: And 166 acute average daily census. So you
17 would have 102 available beds under that
18 formulation. So either 102 or 106, somewhere
19 around 100 empty beds. And as I had testified
20 originally, that would mean, even with
21 relocating 36 beds to the Fort Mill facility by
22 Piedmont, there would still be 70 available beds
23 in Rock Hill. Ms. Carter tried to I think
24 obfuscate that by saying, well, there's a 70
25 percent occupancy standard in the State Health

1 Plan, so we have to reserve 30 percent of the
2 beds for whatever purpose, you know, and so
3 therefore, there would only be 31 available
4 beds, even though that 30 percent that she is
5 saying is put in reserve are not being used.
6 And so, you know, it's really not meaningful in
7 terms of looking at the availability of beds to
8 apply an occupancy standard for this particular
9 purpose. We're not doing bed need planning
10 here. We're just talking about whether there
11 would be a sufficient number of beds left over.
12 The other factor that Ms. Carter did not
13 consider in her analysis is the fact that a
14 portion of Piedmont's existing volume is going
15 to be shifted to Fort Mill, and so that would
16 reduce the average daily census whether you're
17 looking at total beds or you are looking at
18 just acute care beds, and therefore, the
19 available bed capacity would be even greater
20 than it would be simply by looking at the
21 historical utilization of Piedmont alone. So I
22 think that, you know, I think her attempt
23 failed to show that there was actually going to
24 be a capacity crunch at Piedmont if 36 beds
25 were shifted.

1 Q: Now, Ms. Carter also claimed that you gave
2 testimony on a North Carolina case that was
3 inconsistent with your testimony in this case.
4 Do you recall that?
5 A: I do.
6 Q: And can you discuss your feelings about that?
7 A: Sure. I mean first of all, let me just say
8 that I think the testimony was taken completely
9 out of context, and maybe to provide just a
10 brief amount of context. The case in Wake
11 County, North Carolina that's where Raleigh,
12 North Carolina, is located, it's a county with
13 a population of about a million people. There
14 are three large hospital systems that operate in
15 Wake County, that being Wake Med, UNC hospitals
16 and Duke University Health System. And the
17 county has had intense competition. There are
18 hospitals. There are outpatient service
19 centers. There's freestanding emergency
20 departments. There's urgent care centers.
21 There's diagnostic centers permeating the
22 county, including the area where this hospital
23 was proposed to be based, which was the Holly
24 Springs area. And so any similarities to York
25 County are very, very limited in terms of

1 trying to draw analogies between these two
2 circumstances. She specifically took some
3 testimony where I was talking about that I
4 didn't think the service area population
5 proposed, and I think there were two applicants
6 and I think I was talking about Novant at that
7 time, that the service area couldn't support 50
8 beds, and she was saying I was somehow being
9 inconsistent because the service area population
10 that Novant had identified was 133,000, and she
11 said that there were only 86,000 people in
12 northern York County, and I was saying that
13 could support 100 beds, so that was an apparent
14 inconsistency. Well, point of fact, I said
15 that the service area in Wake County was not
16 properly drawn, that they made it much too
17 expansive, that the actual population that would
18 be served by this hospital was much smaller
19 than that. In addition to that, there were
20 many other factors, but one of which was that
21 Novant had no historical presence in the market.
22 They had a few physicians in their network who
23 had admitted relatively few patients to
24 hospitals in Wake County historically. So they
25 had no basis, and so what I was saying is that

1 they couldn't support 50 beds, I was talking
2 about Novant not being able to support 50 beds.
3 And so, you know, I mean I've done a lot of new
4 hospital applications. If you have a population
5 of 133,000, I think it could support 50 beds.
6 Also, I think the 86,000 number that she used
7 for northern York County is too small. I won't
8 go into all the testimony that was given
9 earlier today, but the hospital proposed by Fort
10 Mill Medical Center and by CMC-Fort Mill, both
11 planned to serve the entire area of the county.
12 So to narrowly look at just 86,000, and I
13 wasn't looking at that in my testimony about
14 why there was a need for 100 beds.
15 Q: All right. And that's, we've been looking at
16 Demonstrative 323.8 and let's go to 323.9. Was
17 there something else about Ms. Carter's
18 testimony or characterization of your Wake
19 County testimony that you wanted to address?
20 A: Just a couple other brief points. When she
21 said that I testified that the declining
22 utilization trends were not supportive of
23 recruiting additional beds in Wake County, and
24 that's true, I did say that. There had been a
25 fairly material drop in the number of inpatient

1 days between 2010 and 2011 in Wake County. In
2 fact, and then if you looked at the two state
3 medical facility plans side by side for those
4 two years and used that data, the projected
5 number of patient days for the county dropped
6 by about 30,000, and that's roughly equivalent
7 to 100 beds. So the need for beds in the
8 county dropped by about 100, and so what I was
9 talking about is I didn't think there was any
10 basis for proving additional beds in the county
11 given the drop in utilization. And you know, I
12 don't think anybody that I've heard in this
13 hearing who's saying there is not a need for 64
14 beds that both applicants are applying for here,
15 so I think it's a different circumstance. And
16 then my comments about the inability of the
17 applicants of Wake County to shift market
18 shares, she said I said that they weren't going
19 to be able to do that somehow was insignificant
20 -- was inconsistent with what I said here about
21 Piedmont's ability to shift market share. As
22 I've said before, Novant had no presence, unlike
23 Piedmont, which has had a long-standing presence
24 throughout York County, and Rex Hospital who was
25 Ms. Carter's client had taken the position three

1 years before that there was no need for a 50-
2 bed hospital in this area where they were now
3 proposing to put a 50-bed hospital, and this
4 particular client had got a CON approved for an
5 ambulatory surgery center on the basis that they
6 were going to shift volume to the ambulatory
7 surgery center, and that didn't occur in the
8 same market. And so I was just saying there
9 was no evidence in the record these particular
10 applicants would be able to do that.
11 Q: Thank you. All right. Now, Mr. Sullivan,
12 you've reviewed exhibits and her testimony from
13 CHS witnesses about CHS's charity care
14 projections, have you not?
15 A: I have.
16 Q: All right. Let's go to Demonstrative 323.10,
17 please. Now, you've got several bullet points
18 here. I do believe that Mr. Levitt addressed
19 the first two bullet points, so I'm going to
20 ask you to just skip over to the third bullet
21 point here.
22 A: Okay.
23 Q: Why don't you tell us what your point is there,
24 please.
25 A: Well, you know, I believe Ms. Carter, Ms. Platt

1 and Mr. Stewart all addressed this issue of
2 charity care in one form or another, and they
3 were all claiming that the 6.3 percent was
4 reasonable and consistent with the experience at
5 Pineville and was consistent with what you could
6 expect in this particular market. Mr. Stewart
7 I think went further to say well, you can't
8 rely on the Medicare cost report for charity
9 care because somehow it's not presented
10 according to GAAP. I guess I have a couple of
11 things to say about that. I mean, first of
12 all, I've never heard anyone say that the
13 information in the Medicare Cost Report was
14 inaccurate. The Medicare Cost Report is
15 prepared after the end of the year, after
16 whatever reclassifications of accounts that are
17 going to take place have already been done, so
18 it's, you know, if indeed that PeopleSoft report
19 that we saw earlier today that had $511,000 in
20 charity care for Pineville somehow was not the
21 final number, the information in the Medicare
22 Cost Report should be the final number. And I
23 had an exhibit in my direct case that showed
24 that Mercy and Pineville in 2011 had a charity
25 care percentage of 2.6 percent, and I think Mr.

1 Stewart corrected that. It should be 2.5
2 percent. And that's much more reflective of
3 the three percent that I looked at in my direct
4 testimony from the inpatient services in those
5 northern York County zip codes. So I just
6 don't think that CMC has demonstrated the 6.3
7 percent. The objective data that we have, the
8 only objective data, the only public source of
9 data we have on charity care is the Medicare
10 Cost Report, and it would say that Mercy and
11 Pineville had a 2.5 percent experience.
12 Q: All right. The next bullet point -- before we
13 go there, do you want to go first to the CHS
14 demonstrative?
15 A: Yeah. Let's do that.
16 Q: Let's go to CHS Demonstrative 2.15, please.
17 A: Sure.
18 Q: And you recall Mr. -- I believe it was Mr.
19 Stewart testifying about this?
20 A: Yes, it was.
21 Q: And this is -- tell us what this is.
22 A: I think he was taking my slides where I said
23 that the charity care projections were
24 unrealistic and pointing out reasons why they
25 weren't unrealistic, and one was that I was

1 discussing inpatient payer mix and that a
2 significant percentage of every hospital's
3 revenue is outpatient revenue, which I don't
4 disagree with. And he says the charity care
5 line ties to CHS's demonstrated results. Well,
6 let me just comment on the whole
7 inpatient/outpatient issue. In my experience,
8 inpatient and outpatient payer mix is not the
9 same. There's no reason to think it's going to
10 be vastly different. Let's assume that the
11 inpatient experience in the service area was
12 around three percent. In order for it to be
13 6.3 percent, that would mean that the outpatient
14 experience would have to be 10 or 11 percent.
15 You'd have to get to that number. I don't
16 believe there's any evidence that that's the
17 case. As we've heard, this is a relatively
18 affluent area in northern York County. And
19 again, the objective data that we have is that
20 the inpatient and outpatient experience of Mercy
21 Pineville in the Medicare Cost Report is 2.5
22 percent. That's not just inpatient. That's
23 inpatient and outpatient revenues added
24 together. So, again, I think that this point
25 is simply just off base that -- I won't go over

1 what Mr. Levitt talked about earlier today, but
2 I think that CHS has come up with a different
3 definition of charity care that's not the same
4 as used traditionally in South Carolina CON
5 applications. And using the traditional
6 definition I think would show that the number
7 projected by Piedmont of three percent would be
8 much more realistic.
9 Q: Let's go to 323, our Demonstrative 323.10,
10 please. I know the first two bullet points I
11 think we said that Mr. Levitt covered those and
12 we won't go over those. You covered the last
13 two bullet points?
14 A: I have.
15 Q: All right. Now, you also heard testimony from
16 Ms. Platt criticizing Piedmont's financing
17 proposal as too indefinite. Do you recall
18 that?
19 A: I do.
20 Q: And what's your response to that?
21 A: Well, without repeating my direct testimony
22 where I said I've used that same type of an
23 approach many times in CON applications, I
24 recall that Ms. Platt had worked on a CON
25 application for Hilton Head Medical Center in

1 2011, and so I obtained the financing letter
2 from that particular application.
3 Q: And that's Demonstrative 324?
4 A: I believe that's right.
5 Q: Let's see if that comes up. All right. And
6 what is this?
7 A: This is a letter dated June 20, 2011. It's
8 relative to a CON application for relocation of
9 outpatient services acquisition and replacement
10 equipment for Hilton Head Medical Center.
11 Q: All right. What's the relevant language?
12 A: It says ---
13 **MR. MULLER:** Your Honor, I need to impose an
14 objection here. I understand that this is
15 being brought into this demonstrative. He's
16 reading into the record. He references Ms.
17 Platt and somebody being involved in this
18 application and she has nothing to do with this
19 letter as far as we can tell. There has not
20 been any foundation in the report. He is
21 simply reading a demonstrative documented into
22 the record as if Ms. Platt has been involved in
23 this. She obviously has not, unless that's her
24 signature, and I don't believe that it is.
25 **MR. WESTBROOK:** I'll be happy to lay some

1 foundation, Your Honor.
2 **THE COURT:** All right. If you could do that, Mr.
3 Westbrook. Thank you.
4 Q: All right. Mr. Sullivan, this Hilton Head
5 application of 2011 for certificate of need for
6 relocation of various outpatient services,
7 what's your understanding of Ms. Platt's
8 involvement in this?
9 A: That she wrote the application and assembled the
10 application that was submitted to DHEC.
11 Q: And what did DHEC do with the application?
12 A: They approved it.
13 Q: All right. And as part of that application, we
14 all know CON applications contain many parts.
15 Is one of the required parts a financing
16 letter?
17 A: Absolutely.
18 Q: All right. Have you looked to verify that this
19 is the financing letter that was submitted as
20 part of the application that Ms. Platt prepared
21 and submitted?
22 **MR. MULLER:** Your Honor, that goes to my whole point,
23 which is that she may have prepared the
24 application and the projections. This is a
25 separate component of the application where the

1 applicant Tenet Healthcare has to certify how
2 they're going to fund it. Ms. Platt has
3 nothing to do with that, so having Mr.
4 Westbrook ask a question totally unrelated to
5 Ms. Platt's role is misleading. That was the
6 basis of my objection. He has laid no
7 foundation that Ms. Platt knew anything about
8 this letter or that she participated in it or
9 anything else. He simply is trying to go from
10 point A to point B without making any
11 connection to Ms. Platt. And the fact of the
12 matter is I would seriously doubt that she
13 would have written this letter.
14 **MR. WESTBROOK:** We're not saying she wrote the
15 letter. I think that what I could do if I
16 really need to go to this detail to lay the
17 foundation. Mr. Sullivan has already testified
18 that he worked with Ms. Platt for 18 years or
19 something like that, and she was his employee.
20 He's been involved in a lot of CON
21 applications, and I think what he testified is
22 consistent with what I think Mr. Levitt's
23 already testified and I think what Mr. Murphy's
24 testified is when you're responsible for a CON
25 applications, you're responsible for the whole

1 thing, for putting the thing together and
2 submitting it to DHEC, and that would include
3 responding to everything that's required by DHEC
4 to be in the application, including the
5 financing letter. Whether she signed the
6 letter, I mean she's not, obviously she is not
7 an employee of Tenet, just like Mr. Levitt's
8 not an employee of Tenet. He didn't sign the
9 financing letter here, but that financing letter
10 was the subject of a lot of debate here and it
11 was the subject, it was one of the grounds that
12 Ms. Brandt said she relied on in disproving
13 Piedmont's application.
14 **THE COURT:** Yes, Mr. Westbrook, I do recall all that
15 testimony and certainly understand that the
16 financing letter was relevant to the decision
17 the Department made in this matter. At this
18 point though, what I understand Mr. Muller's
19 objection is that, and I understand your point
20 that the -- that in these situations that the
21 person in Ms. Brandt -- pardon me, in Ms.
22 Platt's capacity, it's customary for a person to
23 have a great deal of control over preparation,
24 reviews to provision that the application was
25 submitted to the Department in those situations.

1 Mr. Muller's objection here though is this is
2 not a letter written by Ms. Platt, and there's
3 no evidence that Ms. Platt other than the fact
4 that generally, I guess what you're trying to
5 say, is that generally individuals in her
6 capacity would have some supervisory or have a
7 great deal of supervision over what goes into
8 the Department, that she prepared or signed off
9 or even knew of this letter going in.
10 **MR. WESTBROOK:** Well, that's right, Your Honor. I
11 would say that, and if necessary I think we
12 could -- we could even show this if it's really
13 necessary, but that an application is not
14 submitted piece meal to the Department. It is
15 submitted by in one hard copy volume to the
16 Department and includes a number of things, nad
17 I think Mr. Sullivan could testify and I think
18 it would be beyond dispute that the point
19 person for getting that application in is
20 responsible for looking, overseeing everything
21 in that application, whether she, he or she
22 wrote that specific letter or signed that
23 specific letter. It's just like support
24 letters. I think it is kin also to, akin to an
25 industry practice. That's what CON consultants

1 do.
2 **THE COURT:** Yes, sir. And that seems to be where I
3 understood the direction you seemed to
4 proceeding with with your witness is that this
5 is, that the language used in this case as in
6 the application prepared by Piedmont for the CON
7 pertaining to the financing is something that's
8 customarily used and ---
9 **MR. WESTBROOK:** Well, yes. I'm sorry to interrupt
10 you, Your Honor. That was actually not quite
11 the point that I was about to make, although
12 that was a point that was made earlier. The
13 point that I was saying about customary use,
14 it's customary for the CON preparer of the
15 application to compile everything and to be
16 familiar with everything. I think Mr. Sullivan
17 could certainly testify to this.
18 **MR. MULLER:** To the extent that his testimony is
19 limited to that, that is how it's normally
20 done, that's one thing. But where he was going
21 with this witness was to say that Ms. Platt
22 did that. And that is entirely speculative for
23 this witness ---
24 **MR. WESTBROOK:** I never said that.
25 **MR. MULLER:** --- to say whether Ms. Platt did it or

1 not. That was the basis of it.
2 **THE COURT:** Yes, Mr. Muller, and I understand that
3 that's where your objection was, but that's not
4 where you're going, Mr. Westbrook?
5 **MR. WESTBROOK:** I never was going to say that Ms.
6 Platt wrote this letter or signed this letter.
7 I didn't ask that. That's not my
8 understanding. I don't think that's Mr.
9 Sullivan's understanding. I think she was -- I
10 think what will come out is that she was
11 responsible for submitting this letter, that the
12 letter contains very similar language to the
13 financing letter in this case that she testified
14 was inappropriate, and yet it was submitted by
15 her as a package application to DHEC in this
16 other case. So that's where it goes.
17 **MR. MULLER:** I'm not so sure there has been any
18 foundation laid that she submitted this package.
19 I assume that the applicant submitted it, and
20 if he -- if Mr. Westbrook wants to show us
21 where she submitted this package, I may have
22 to, you know, that's another aspect of it that
23 is very troublesome because we're getting into
24 these questions that are becoming more and more
25 speculative in terms of what she did and what

1 she didn't do. As Mr. Westbrook said, he had
2 an opportunity to cross-examine about this while
3 she was on the stand, and he didn't. So I
4 think we're venturing far beyond where we need
5 to be at this point in rebuttal testimony.
6 **MR. WESTBROOK:** The evidence, the only evidence that
7 she was involved in this that's been submitted
8 is Mr. Sullivan's testimony, that it's his
9 understanding. Now, I can ask him what the
10 basis of his understanding is.
11 **THE COURT:** Is the point that you're trying to
12 convey to the Court here is that in a -- that
13 while on the one hand Ms. Platt criticized the
14 financing letter as being nonspecific and having
15 difficulties in this particular matter, at least
16 in this particular situation where she was
17 involved as the -- in a highly rather senior
18 level to preparing and submitting this
19 application or at least reviewing and being A
20 part of the preparation of this application,
21 that this type of language was used in that
22 very same way.
23 **MR. WESTBROOK:** That's the only point.
24 **THE COURT:** Mr. Muller.
25 **MR. MULLER:** Your Honor, if -- I don't believe the

1 witness has any personal knowledge of any of
2 this. As I said, if he wants to ask him
3 questions about whether if she were the
4 reviewer, she would have possibly reviewed this
5 letter, you know, that would seem to be within
6 the scope of what He need to know. I haven't
7 heard any information where he has said he has
8 personal knowledge that she reviewed this
9 letter. And so that, I don't mean to beat a
10 dead horse, I'm just trying to avoid at this
11 stage testimony that appears to be entirely
12 speculative unless the witness can testify that
13 he has personal knowledge of it, and this
14 witness I don't believe can.
15 **THE COURT:** All right. Mr. Muller, what I -- here's
16 what I'm going to consider with regard to this.
17 That to the extent that Ms. Platt had
18 involvement in this, you can develop that with
19 your witness and his understanding of Ms.
20 Platt's involvement with this application. To
21 the extent that Ms. Platt had an involvement
22 with this particular application, that this
23 application that was submitted contained similar
24 language to that or states a similar language
25 to that as that in this application, and then

1 Mr. Muller, I'll allow you to further inquire
2 to the extent of his knowledge of what Ms.
3 Platt's actual involvement with this was. And
4 again, this is not going to evidence. We are
5 not offering this letter as evidence or
6 anything.
7 **MR. WESTBROOK:** No.
8 **MR. MULLER:** Okay. Thank you Your Honor.
9 **THE COURT:** Yes, sir. Thank you.
10 Q: Mr. Sullivan, you testified a moment ago that
11 it was your understanding that Ms. Platt had
12 significant involvement in this CON matter, that
13 -- this 2011 CON matter?
14 A: Right.
15 Q: And what's the basis of your understanding?
16 A: A conversation I had with Ms. Platt.
17 Q: All right. What's the significance of this
18 letter in relationship to the financing letter
19 that Piedmont submitted in the Fort Mill case?
20 A: They say substantially the same things in terms
21 of that there would be -- there was cash for
22 debt financing available and a determination
23 that would be made, you know, later in terms of
24 how that would be financed. And, you know, the
25 point is I think that this is the type of

1 letter that is commonly submitted to DHEC and
2 which DHEC often accepts, and in this particular
3 case, approved this project based on the
4 financing letter.
5 Q: All right. And based on your years of
6 experience as a CON consultant and working with
7 other CON consultants, including Ms. Platt, what
8 level of involvement does the person have who
9 prepares the CON application? How would you
10 characterize that level of involvement with the
11 entire CON package and component parts?
12 A: Well, you know, I did work with Ms. Platt for
13 18 years, and I think we have a similar
14 approach to doing CON applications. And
15 basically, you're responsible for reviewing all
16 the attachments to the application, in addition
17 to the body of the application, trying to make
18 sure that everything meets the requirements that
19 DHEC has set forth in the application form.
20 So, you know, one of the roles and one of the
21 reasons people hire us to prepare CON
22 applications is so that we can, you know,
23 identify potential problems as well. I mean,
24 oftentimes I've gotten a financing letter and I
25 said, well, the amounts that you've got in here

1 are incorrect, or this doesn't specifically
2 address the project or that sort of thing. I
3 have no idea whether that happened in this case
4 or not, but you know, typically, you would look
5 at all the attachments and try to make sure
6 that they were accurate and consistent with DHEC
7 requirements.
8 **MR. WESTBROOK:** Thank you. No further questions,
9 Your Honor.
10 **THE COURT:** Thank you. Mr. Muller, sir?
11 **MR. MULLER:** Your Honor, what I was going to ask the
12 court is that based on our conversation on
13 Thursday, I didn't expect that we would move
14 this quickly. Obviously, I'm very happy that
15 we have moved this quickly, but I do not -- I
16 really was not prepared to take Mr. Sullivan on
17 cross today. Based on Mr. Andrews' comments, I
18 assumed it would be Tuesday or Wednesday. The
19 preparation issue is that he raises Wake County
20 testimony, which is two volumes of deposition
21 testimony. I'd also like the chance to go back
22 and re-review his deposition which I he took,
23 but could we defer cross-examination until
24 tomorrow morning? It might help it be a little
25 more efficient as well.

1 section 3? In other words, 3(b) and 3(c),
2 3(d)?
3 **THE COURT:** I mean, how -- and how did that, how
4 does that relate to his testimony that he just
5 gave on direct?
6 **MR. MULLER:** Well, his testimony on direct was that
7 our numbers were inflated.
8 **THE COURT:** And I believe he disagreed with your
9 characterization, but that his explanation was
10 that the numbers used by CHS regarding charity
11 care were not those that are customarily seen
12 by DHEC, South Carolina DHEC in reviewing these.
13 And the characterization whether it's inflated
14 or whether it's different numbers however, that
15 there's a difference in CHS's numbers than the
16 numbers that have been seen in other situations.
17 **MR. MULLER:** And despite that, he found that we
18 equally met those criteria.
19 **THE COURT:** I will allow you to ask that question.
20 Q: Despite what you testified to yesterday, did CHS
21 equally meet the criteria related to charity
22 care?
23 A: Yes. I mean, I -- I don't think -- what I was
24 saying is I don't think that there should have
25 been any differentiation between CHS and

1 Piedmont, or I'm sorry, FMMC on that particular
2 criterion and that -- I would expect that CHS
3 would be an accessible facility. But I don't
4 believe that they would provide twice as much
5 charity care as FMMC would do.
6 Q: You said that there was no objective data to
7 support that, but certainly there was data from
8 Piedmont's trial exhibits that would support
9 that, correct?
10 A: In Piedmont's trial exhibits?
11 Q: Yes.
12 A: That would support what? I'm sorry.
13 Q: That would support a six percent level of
14 charity care finding?
15 A: In Piedmont's Exhibits?
16 Q: Yes.
17 A: I'm not sure what exhibit you're referring to.
18 Q: Well, it's an exhibit that you referred to
19 frequently, I thought. It's Piedmont Exhibit
20 87. This is the 2007 Pineville CON
21 application. If we turn to page 145 of that
22 application. Can you see that on the screen,
23 or do you need it enlarged?
24 A: I'm familiar with the page.
25 Q: In this CON application, did CHS not project

Figure 3.

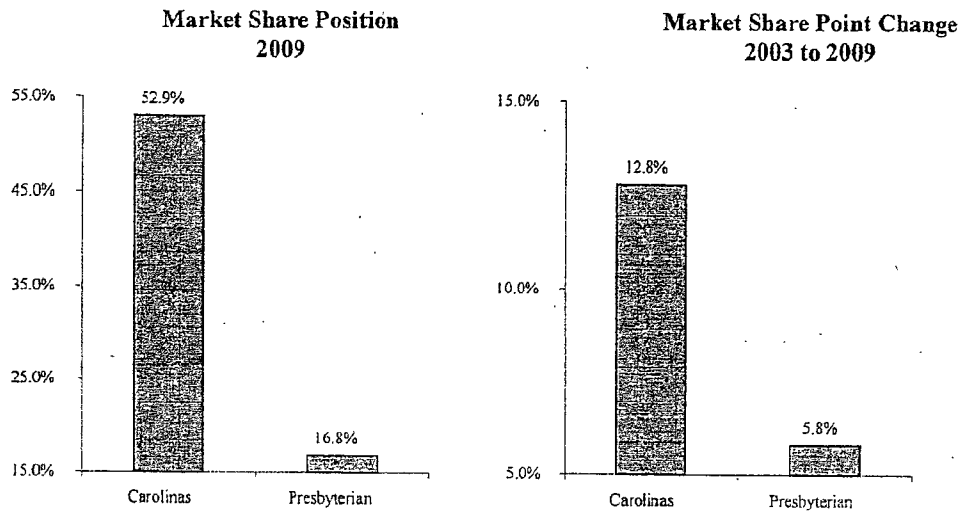
Piedmont Medical Center
Market Share of Northern York County
Community Hospital Services Only

Source: Thomson Healthcare.

Importantly, Carolinas is also preferred in Northern York County over the other applicant, Presbyterian, as reflected in Figure 4 below. Note that the rate at which Northern York County residents are choosing Carolinas over Presbyterian is over three times greater (52.8% / 16.8% = 3.1 times). In addition, between 2003 and 2009 Carolinas gained more than two times the market share that was gained by Presbyterian over the same time period (12.8% / 5.8% = 2.2 times).

Figure 4.

Carolinas and Presbyterian Comparisons
Northern York County



Source: Thomson Healthcare.

It is clear from these data that the citizens of Northern York County consider Carolinas their provider of choice rather than Amisub and Presbyterian, and that logically Carolinas should be selected to build a hospital that is closer and more accessible to its patients in Northern York County. It is equally clear that the citizens of York County have been "voting with their feet," and that they do not want Amisub to build another hospital in their community. The choice among residents is clear – Carolinas is "the People's Choice."

DHEC's Prior Conclusions Regarding Amisub Are Unfounded

In its decision letter dated May 30, 2006, DHEC reached the following conclusions when it selected Amisub:

- That because of its contract with York County, Amisub will maintain reasonable charges at Piedmont Medical Center and its new hospital in Northern York County;
- That the construction of a 100-bed hospital is much more effective than a 64-bed hospital and is preferred over a 64-bed hospital;

100-Beds Versus 64-Beds

DHEC noted in its prior decision letter that a 100-bed hospital will result in economies of scale and operating efficiencies that cannot be achieved in smaller facilities, such as the 64-bed hospital as proposed by Carolinas and Presbyterian. Three (3) important points need to be considered regarding this conclusion.

First, the difference in 100 beds and 64 beds (or 36 beds) is largely immaterial when considering there are so many other facets of hospital operations, e.g. the emergency department, the operating room suite, the imaging department, etc. In addition, the majority of patients served in today's hospitals are cared for as an outpatient and they are never admitted to an inpatient bed. This will be the case at any hospital developed in Fort Mill, no matter the size.

Second, DHEC has a long history of recognizing the appropriateness of, and approving, hospitals with less than 100 beds. Figure 7 below contains a listing of the new hospitals in South Carolina approved by DHEC over the last 15 years.

Figure 7.

History of New Hospital Development
In South Carolina

New Hospital	County	Beds	CON Issued
Providence Hospital Northeast	Richland	46	2/14/97
Coastal Carolina Medical Center	Jasper	31	5/28/02
AnMed Women's and Children's Hospital	Anderson	72	1/13/03
Patewood Memorial Hospital	Greenville	72	8/25/03
Spartanburg Regional - Pelham	Spartanburg	48	9/9/05
Roper St. Francis Mt. Pleasant	Charleston	85	5/31/06
Seacoast Medical Center	Horry	50	9/28/07
St. Francis Millennium Hospital	Greenville	52	6/12/09
Palmetto Health Parkridge	Richland	76	6/8/10
Roper Hospital Berkeley	Berkeley	50	Under Appeal
Trident Medical Center - Berkeley	Berkeley	50	Under Appeal
Average		57	

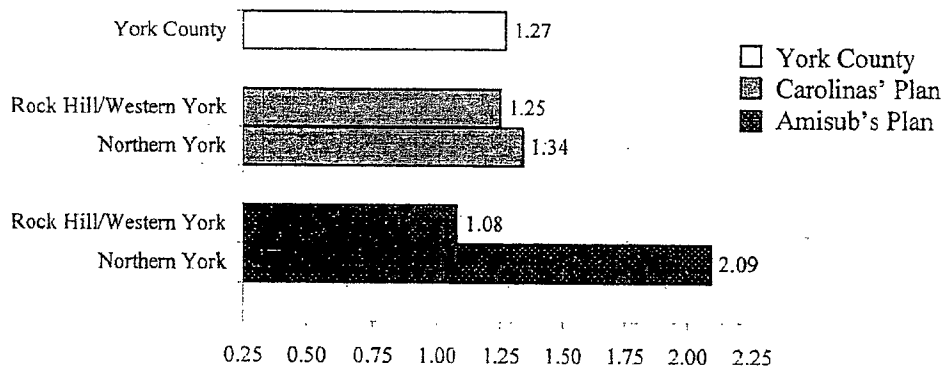
Source: SC Department of Health and Environmental Control.

Third, and most importantly, Amisub should not be allowed to relocate 36 beds from its campus in Rock Hill to its proposed location in Northern York County. This relocation

of beds does not represent prudent health planning for two reasons. As shown in Figure 8, placing 100 beds in Northern York County will negatively impact the hospital bed-to-population ratios that are currently in place in York County. If a picture can tell a story, Figure 8 certainly does – by relocating beds, Amisub is proposing too many beds in Northern York County, while depriving the rest of York County of accessible beds.

Figure 8.

Hospital Beds per 1,000 Population – 2015
Carolinas versus Amisub

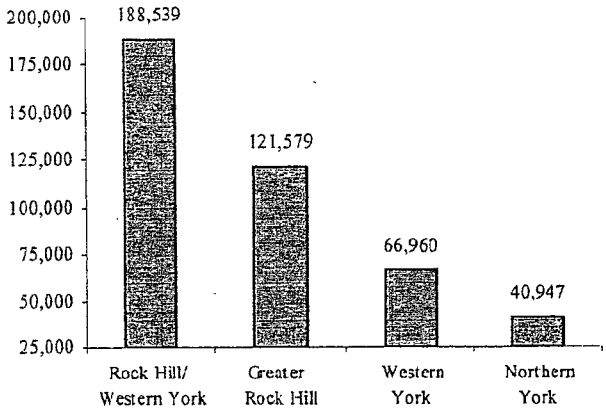


Source: Claritas, Inc.

As reflected in Figure 8 above, under Amisub's 100-bed plan, Northern York County will have 2.09 beds per 1,000 population compared to Rock Hill/Western York's bed-to-population ratio of only 1.08. Under this plan, people residing in Western York County will be most penalized by Amisub's relocation of 36 beds as these residents will have to drive past Piedmont Medical Center to get to the hospital in Fort Mill. The weakness of a 100-bed plan may be better understood when the three York County population centers are viewed by total population (see Figure 9 below). Even though Northern York County is fast growing, Greater Rock Hill and Western York County have 4.6 times the population (188,539 / 40,947 = 4.6 times).

Figure 9.

York County Population
By Population Center – 2010



Source: Claritas, Inc.

The decision to build a 100-bed hospital should be further questioned in light of the current economic times and the cost differential between a 64-bed hospital and a 100-bed hospital. Based on the original project cost estimates in the DHEC record, Carolinas' total project capital costs were $73,421,664 versus Amisub's costs of $124,493,883, a differential of over $51.1 million. If you compare Amisub's past project costs of $124,493,883 to Carolinas' revised project costs, the cost difference is still substantial at $45.4 million. DHEC should seriously consider this major cost differential, especially in connection with the maldistribution of the York County bed-to-population ratios brought about by Amisub's 100-bed plan. Amisub's plan is simply not congruent with current demographic trends or economic conditions. Moreover, Amisub has not demonstrated any plausible reason why it should be entitled to relocate beds away from the majority of York County patient population, at a cost well in excess of $45.4 million, simply because it wants to differentiate itself from the other applicants.

Amisub's Commitment to York County

While it is true that Amisub has provided hospital services in York County for over two decades, five important points need to be considered with respect to Amisub's commitment to York County. First, Amisub's owner, Tenet Healthcare Corporation, has received approximately $192.3 million in compensation for operating Piedmont Medical

Presbyterian's project could achieve such market share projections without significantly adversely impacting other providers.

Amisub – Amisub failed to adequately document the need for a 100-bed hospital in Northern York County. Amisub's project entails moving 36 beds from the existing Piedmont Medical Center ("Piedmont") in Rock Hill to the Northern York County, Fort Mill location. This relocation is not justified for two major reasons:

1. The population in Northern York County does not justify 100 beds. The relocation of beds away from Rock Hill will result in a maldistribution of beds in the County.
2. Amisub does not provide adequate justification of its projected market share to support the need for 100 beds or the utilization projections for the project.

Each of these issues will be discussed in detail below.

Maldistribution of Beds

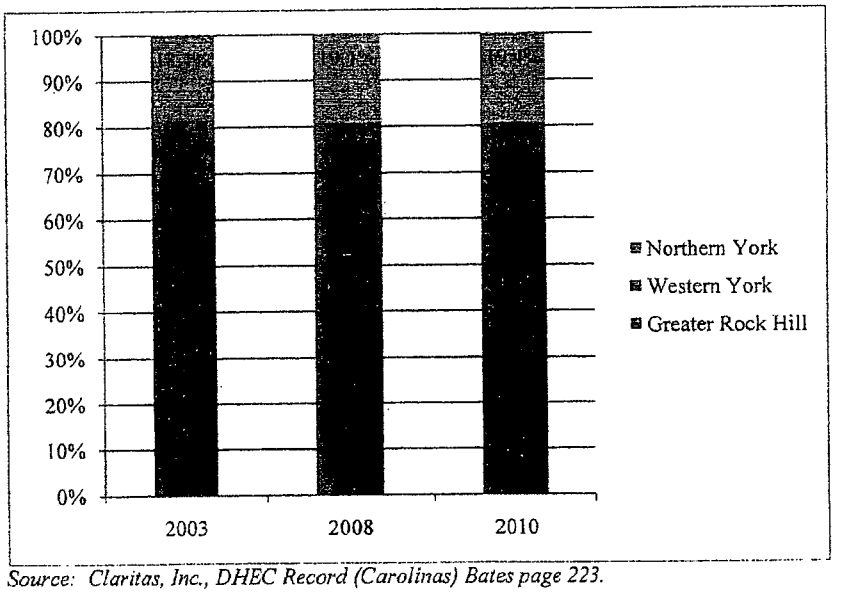
- While the population is growing rapidly in Fort Mill, the largest base of population remains in greater Rock Hill. The population in Western York County in fact is projected to continue to exceed the Northern York County population including Fort Mill. Amisub is proposing to move beds away from this more concentrated population.

- Carolinas' application presents a map of York County divided into three natural geographic regions as originally described in Carolinas' application, which serves as the basis for analysis of distribution of beds. [See DHEC Record (Carolinas) Bates pages 22-23, 28-29.]

- Exhibit 2 shows the percent of population in each geographic region of York County over time based on data from Claritas, Inc.[1] Despite rapid population growth in Northern York County, Greater Rock Hill is projected to continue to represent over 50 percent of the total population of York County. Western York County will continue to represent almost 30 percent of the total county population. Amisub proposes to move 36 existing beds away from these communities.

[1] Note all Claritas population data used in this submission are found in the DHEC Record (Carolinas) as noted by Bates page numbers.

Exhibit 2
Comparison of York County Population Distribution



Source: Claritas, Inc., DHEC Record (Carolinas) Bates page 223.

- All of York County is experiencing rapid population growth as shown in Exhibit 3. The greatest net population growth is projected to occur in Rock Hill. The net increase in population in Northern York County is only 57 percent of the net increase in population of Rock Hill, between 2003 and 2010. While Northern York County is experiencing the most rapid rate of growth on a percentage basis, the largest number of new residents will be in Greater Rock Hill. For this reason, there is no logical rationale to move 36 existing beds away from Rock Hill to Northern York County as proposed by Amisub.

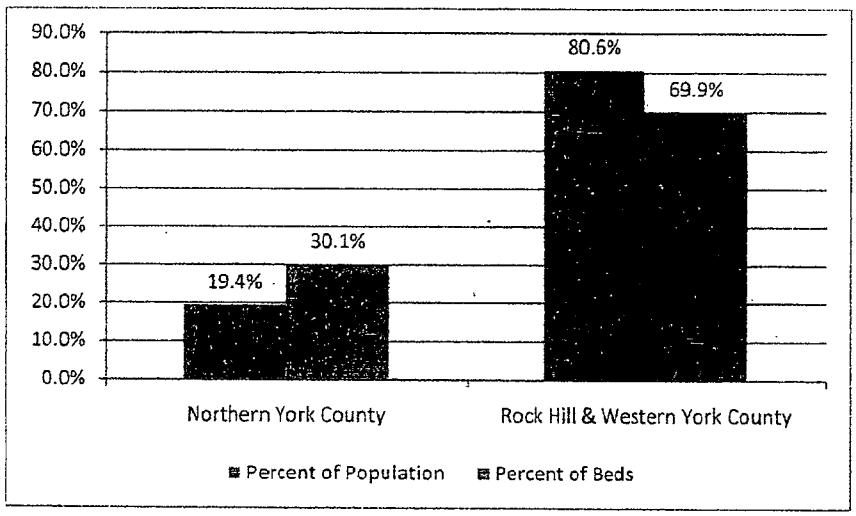
Exhibit 3
Summary of Population Growth Trends in York County

	2003-2008		2008-2010	
	Net Growth	CAGR	Net Growth	CAGR
Greater Rock Hill	7,646	1.6%	3,263	1.6%
Western York	4,351	1.6%	1,842	1.6%
Northern York	4,367	2.5%	1,913	2.5%
Total York County	16,364	1.8%	7,017	1.8%

Source: Claritas, Inc., DHEC Record (Carolinas) Bates page223

- It is clear that the relocation of 36 beds to Northern York County will mis-align the beds in the county with the distribution of population as shown in Exhibit 4 below.

Exhibit 4
Comparison of Population and Bed Distribution
In 2010 with 100 Beds in Fort Mill



- An analysis of bed-to-population ratios shows that the relocation of these 36 beds will drastically skew the distribution of beds in York County. With 100 beds in Northern York County as proposed by Amisub and only 232 beds remaining in Rock Hill closer to the Greater Rock Hill and Western York County populations, the bed-to-population ratio for the various portions of the County becomes significantly unbalanced. As shown in Exhibit 5 below, the bed-to-population ratio for Northern York County is more than double the ratio for the remaining parts of the County and far above the County average bed-to-population ratio.

Exhibit 5

Bed-to-Population Ratio with 100-Beds in Fort Mill

	2003	2008	2010
Northern York County			
Population	33,162	37,529	39,442
Beds	100	100	100
Beds per 1,000 Pop.	3.02	2.66	2.54
Greater Rock Hill			
Population	93,606	101,252	104,515
Western York County			
Population	53,287	57,638	59,480
Rock Hill & Western York			
Population	146,893	158,890	163,995
Beds	232	232	232
Beds per 1,000 Pop.	1.58	1.46	1.41
Total York County			
Population	180,055	196,419	203,436
Beds	332	332	332
Beds per 1,000 Pop.	1.84	1.69	1.63

Source: Claritas, Inc., DHEC Record (Carolinas) Bates page 223.

- With 64-beds in Northern York County, as proposed by Carolinas, the bed-to-population ratio for each geographic segment of York County is balanced with the total average for the County. Exhibit 6 below summarizes the bed-to-population ratios assuming that 64 beds are developed in Northern York County.

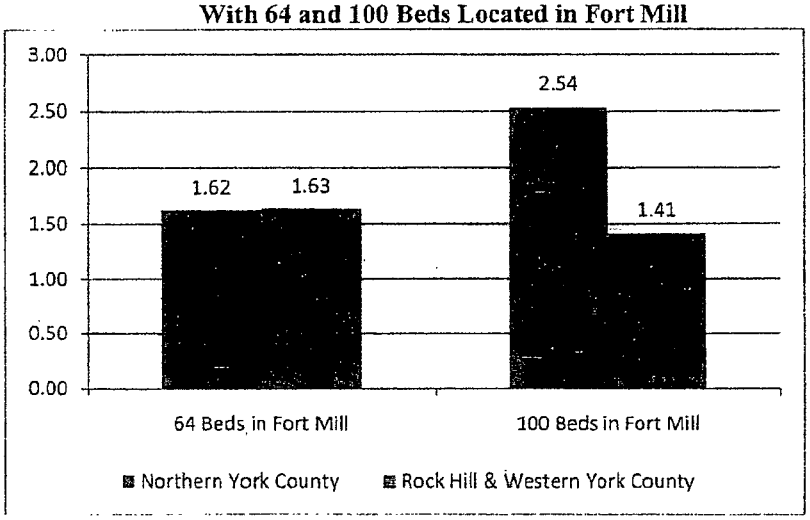
Exhibit 6
Bed-to-Population Ratio with 64-Beds in Fort Mill

	2003	2008	2010
Northern York County			
Population	33,162	37,529	39,442
Beds	64	64	64
Beds per 1,000 Pop.	1.93	1.71	1.62
Greater Rock Hill			
Population	93,606	101,252	104,515
Western York County			
Population	53,287	57,638	59,480
Rock Hill & Western York			
Population	146,893	158,890	163,995
Beds	268	268	268
Beds per 1,000 Pop.	1.82	1.69	1.63
Total York County			
Population	180,055	196,419	203,436
Beds	332	332	332
Beds per 1,000 Pop.	1.84	1.69	1.63

Source: Claritas, Inc., DHEC Record (Carolinas) Bates page 223.

- The resultant bed-to-population ratios based on the number of beds located in Fort Mill is graphically presented in Exhibit 7. It is clear that 64 beds in Fort Mill is the right number of beds to ensure access and equitable distribution of hospital services.

Exhibit 7
Comparison of Bed-to-Population Ratios for 2010
With 64 and 100 Beds Located in Fort Mill



- Citizens of Western York County expressed their desire to ensure equal access for their portion of the County. [See DHEC Record (Carolinas) Bates page 403.] Moving 36 beds further east to Fort Mill will reduce access for Western York County, which will continue to have a larger overall population than Fort Mill through the projection period.

Exhibit 9
2003 York County Inpatient Market Shares

	PMC	CHS	Novant	Other SC	Other NC	Total
Northern York County	41.2%	40.1%	10.7%	3.9%	4.2%	100%
Greater Rock Hill	76.9%	12.9%	3.1%	5.0%	2.2%	100%
Western York County	63.6%	12.4%	4.8%	4.1%	15.1%	100%
Sources: Amisub CON application. North Carolina Inpatient Discharge Database (Solucient, Inc.)						
DHEC Record (Carolinas) Bates page 27.						

Carolinas is affiliated with numerous physician practices in the Northern York County area. These relationships and the support of these physicians also support the projected market share and utilization of Carolinas proposed project. Carolinas documented four existing physician practice locations in York County. [DHEC Record (Carolinas) Bates page 252.] Carolinas has been affiliated with six local York County physician practices starting with the first one in 1993. [DHEC Record (Carolinas) Bates page 672.]

Thus, Carolinas' projected utilization is sufficient to fully justify the implementation of the proposed project. Current/historical utilization data also support the utilization of the proposed service.

Presbyterian – Presbyterian provides detailed projections to document its utilization of the proposed hospital. These projections are based on Census Tract level population data and use rates from SC Office of Research and Statistics ("ORS"). Presbyterian projects total service area demand and proposed market share capture by ZIP code for its service area. Presbyterian's service area is comprised of the Census Tracts that roughly comprise a 7-mile radius around its proposed site approximating the Fort Mill or Northern York County area with one Census Tract in Lancaster County. Presbyterian projects to capture market share by Census Tract ranging from 20 to 50 percent. [See DHEC Record (Presbyterian) Bates pages 861, 1429, 1939-1941, 1944, 1946, 1948, and 1950.]

While Presbyterian provides a detailed projection of utilization, the historical market share of the Presbyterian Hospital System (Novant) does not support projected market shares of 20 to 50 percent for the proposed new hospital. As shown above in Exhibit 9, Novant as a system has historically captured only about 10 percent market share in Northern York County. In order for Presbyterian to meet its market share projections, it will have to capture significant market share from other existing providers currently serving its proposed service area.

Amisub – As described above, Amisub relies upon unreasonable market shares to project its utilization. In order for Amisub to meet its projected market share figures, significant numbers of patients would need to travel past the existing Piedmont Medical Center

facility to receive care in Northern York County. While it may be reasonable for a patient to travel past Piedmont Medical Center to make a choice for another hospital system, such as Carolinas, it would not be reasonable for 22 percent of Rock Hill residents and almost 20 percent of residents of the other more distant parts of York County, to travel past Piedmont Medical Center to what will essentially be a satellite for Piedmont Medical Center. [Please see DHEC Record (Carolinas) Bates pages 715-718.]

Further, Amisub does not project to meet the target occupancy rate of 65 percent for a 100-bed hospital by the third year of operation. In the third year of operation, Amisub is projected to be occupied at 60 percent. Thus, Amisub's own projections do not justify a 100-bed hospital.

Carolinas best meets this criterion. Presbyterian and Amisub do not meet this criterion.

3. Distribution (Accessibility):

DHEC's Review – DHEC did not discuss Criterion 3 in its decision regarding the York County Hospitals. [See DHEC Record (Carolinas) Bates 990-999.] In the CON Summary Sheet prepared by DHEC for each respective applicant, DHEC first focuses on Accessibility in terms of the physical location of each facility. Each applicant is found to guarantee access to the high growth areas of York County. [Please see DHEC Record (Carolinas) Bates pages 1029, DHEC Record (Presbyterian) Bates pages 2248, and DHEC Record (Amisub) Bates page 893.]

DHEC recognizes the high level of out-migration of York County to North Carolina as follows:

> *"The York County population that is out-migrating to Charlotte facilities for tertiary service that are doing so out of choice and/or physician direction. Since none of the four (4) competing applicants have opted to offer these types of services at their proposed facility, a segment of out-migration will continue, and cannot be curbed by any of the four applicants. Only a portion of the out-migration will be affected by a community hospital in a more convenient location." [DHEC Record (Carolinas) Bates page 1029.]*

DHEC's basic premise in this statement is counter-intuitive and lacks factual support. First, DHEC does not quantify what portion of the outmigration is for tertiary services so to the extent this portion of the outmigration cannot be curbed the magnitude is unknown. Further, Carolinas specifically quantified the patient volume that was out-migrating to its existing facilities including other community hospitals such as CMC-Pineville and CMC-Mercy. The outmigration of these patients as well as non-tertiary patients served at CMC can be curbed by developing a Carolinas' facility in Northern York County. [See DHEC Record (Carolinas) Bates page 27.]

vary significantly. DHEC does recognize that Amisub participates in Tenet's corporate Compact with the Uninsured, which offers discounted prices to patients who are uninsured that are comparable to the hospital uninsured rates. However, DHEC fails to consider the fact that this agreement is less meaningful when Amisub's gross charges and net revenue are correctly found to be significantly higher than Carolinas and Presbyterian.

DHEC in its March 27, 2006 correspondence specifically identified the relative importance of each Review Criterion including the relevant sub-parts. [See DHEC Record (Carolinas) Bates page 697.] However, DHEC did not evaluate several of the sub-parts it identified such as "duplication and modernization of services." A detailed review under the specific language of each sub-criterion shows that Amisub's project clearly does not meet several sub-criteria and thus should be found to not meet the Distribution (Accessibility) Criterion. As described below, Presbyterian meets and Carolinas best meets the Distribution (Accessibility) Criterion.

a. Duplication and modernization of services must be justified. Unnecessary duplication of services and unnecessary modernization of services will not be approved.

Carolinas – Not applicable. Carolinas does not project to modernize or duplicate any existing services. The 2004-2005 State Health Plan recognizes a need for 64 acute care beds. Carolinas proposes to meet this need and as such will not duplicate any existing services.

Presbyterian – Not applicable. Presbyterian does not project to duplicate any existing services. The 2004-2005 State Health Plan recognizes a need for 64 acute care beds. Presbyterian proposes to meet this need and as such will not duplicate any existing services.

Amisub – Proposed to relocate and replace 36 existing beds from the existing Piedmont Medical Center to the proposed Amisub hospital in Fort Mill. Amisub has not provided any documentation that the existing beds at Piedmont require replacement or modernization. The relocation and replacement of these beds at Amisub represents an unnecessary duplication of services and adds unnecessary capital cost to the proposed project. Amisub's project is over $50 million greater than Carolinas' project. [See DHEC Record (Carolinas) Bate page 709-711.]

Amisub claims that greater economies of scale can be achieve with a 100-bed hospital; however, no actual quantitative documentation was provided. No offsetting loss in operating efficiencies at Piedmont was considered and the incremental capital required to replace these beds is not warranted. From a capital cost perspective, Amisub's project is almost $100,000 more per bed that Carolinas. [See DHEC Record (Carolinas) Bates page 709-711, 720.] Therefore, the larger bed size of the Amisub does not create any efficiency from a building and design perspective. As discussed in greater detail under

the financial criteria, Carolinas projects lower gross and net revenue as well as more efficient staffing and lower supply and operating costs. Thus, Amisub's assertion that a 100-bed hospital is more efficient is not illustrated by the facts.

DHEC Review – This criterion was clearly included among the most important criterion because it specifically relates to Amisub's project. The criterion is not applicable to Carolinas and Presbyterian. As this criterion fall under those ranked second in importance and is included solely for Amisub, its seems that it would be imperative from DHEC's perspective for the Amisub project to fully comply with and demonstrate this criterion. A detailed comparative review of Amisub's project costs and operating costs demonstrates that the replacement/relocation to modernize such facilities represents an unnecessary duplication of services and has not been justified. While DHEC included this specific sub-criterion in its March 27, 2006 letter identifying the relative importance of Review Criterion, DHEC did not specifically provide any evaluation of this sub-criterion in either its Decision or the CON Summary Sheet for the Amisub. [See DHEC Record (Amisub) Bates page 893-894.]

Amisub does not meet this criterion. This criterion is not applicable to Carolinas and Presbyterian.

b. The proposed service should be located so that it may serve medically underserved areas (or an underserved population segment) and should not unnecessarily duplicate existing services or facilities in the proposed service area.

Carolinas – The proposed project, a new 64-bed hospital, is located in the most rapidly growing part of York County, the Northeastern portion bordering North Carolina. Data in Carolinas' original CON submission show that Carolinas already has a very high market share of this area (over to 40 percent). [See DHEC Record (Carolinas) Bates page 27.] By locating 64 beds in this part of York County, Carolinas will be able to better serve these patients who are traveling into North Carolina for their inpatient healthcare needs. Carolinas will also meet the identified bed need and the demand resulting from population growth in this area.

While not directly related to this criterion, questions were raised during the review of the Carolinas' CON application regarding the physical accessibility of Carolinas' proposed site. Carolinas provided a detailed response to questions related to road access and the physical accessibility of the proposed site. [See DHEC Record (Carolinas) Bates pages 980-986.]

Presbyterian – The proposed project is located in the rapidly growing Northern portion of York County. Presbyterian proposes to meet the bed need in York County identified in 2004-2005 State Health Plan. Presbyterian purports to be able to meet the growth in

demand for service and purports to be able to serve some patients who are traveling to North Carolina for care. Presbyterian has the lowest existing system market share of York County and Northern York County. As such, Presbyterian will not be able to meet its projected market share without impacting existing providers. Thus, Presbyterian's project while located in an underserved area will duplicate existing services to the proposed service area. Please see Exhibit 9 above.

Amisub – By proposing to develop 64 new beds and relocate 36 existing beds to develop a new 100-bed hospital in Northern York County, Amisub will create the unintended consequence of an underserved area in Rock Hill and Western York County. As shown previously in Exhibit 5-7, the relocation of 36 beds away from the largest population base in Greater Rock Hill will create a disparity in bed-to-population ratios for Rock Hill and Western York County geographic segments. Amisub's project also represents an unnecessary duplication of existing services by replacing 36 existing beds. There is no documentation that the existing beds are insufficient in any way. The capital cost of replacing and relocating these beds has not been justified. Amisub's project cost is more than $50 million higher than Carolinas.

Carolinas best meets this criterion. Presbyterian meets this criterion. Amisub does not meet this criterion.

c. The location of the proposed service should allow for the delivery of necessary support services in an acceptable period of time and at a reasonable cost.

All three projects include the necessary support services and are supported by the services of other acute care hospitals or hospital systems in the area.

All three applicants meet this criterion.

d. The proposed facility should not restrict admissions. If any restrictions are applied, their nature should be clearly explained.

All three applicants provide admission policies. None of the information provided indicates that any of the applicants restrict admissions. However, as discussed below, all three applicants are not equal with respect to their level of financial accessibility.

All three applicants meet this criterion.

Criterion 3 Summary – Amisub does not meet several sub-parts of this criterion and thus does not meet Criterion 3. CHS best meets Criterion 3 and Presbyterian meets Criterion 3.

22. Distribution:

> *The existing distribution of the health service(s) should be identified and the effect of the proposed project upon that distribution should be carefully considered to functionally balance the distribution to the target population.*
>
> As described above, both Carolinas and Presbyterian meet the need for beds in York County identified in the 2004-2005 State Health Plan. Both do so by proposing a new 64-bed hospital to serve the growing Northern York County community, which often travel to North Carolina for their hospital services. Placing 64 beds in Northern York County aligns the distribution of beds in the County with the population in each major geographic segment of the area. By contrast, Amisub proposes to develop 64 new beds and replace/relocate 36 existing beds from Rock Hill to Northern York County. This replacement/relocation is clearly not cost effective and it shifts the distribution of beds in the area so that it is no longer in line with the population of the County. The largest population base in York County is and will continue to be Rock Hill. It does not make sense in terms of distribution to take beds out of Rock Hill, which is growing, and replace them in an area with a lower number of residents.
>
> Carolinas and Presbyterian meet this criterion. Amisub does not.

<u>Criteria Ranked 3rd in Importance:</u>

6. Projected Revenues:

DHEC's Review – In its decision, DHEC did not identify or evaluate projected revenue or charges. [See DHEC Record (Carolinas) Bates pages 996-999.] In the CON Summary Sheets for each respective application, DHEC addressed charges and revenue briefly. [See DHEC Record (Carolinas) Bates page 1030, DHEC Record (Amisub) Bates page 895, DHEC Record (Presbyterian) Bates page 2249.] All three applicants were found to have reasonable projections of revenue. DHEC recognized that Carolinas had the lowest projected charges. DHEC did not recognize that Amisub's charges, both gross and net, are significantly higher than Carolinas and Presbyterian. [See DHEC Record (Carolinas) Bates page 1030, DHEC Record (Amisub) Bates page 895. DHEC Record (Presbyterian) Bates page 2249.]

> *a. The proposed charges should be comparable to those charges established by other facilities for similar services within the service area or state. The applicant should document how the proposed charges were calculated.*

level of market share of obstetrics services is not justified. As described previously, Presbyterian projects an increase in market capture of over 20 percentage points for acute care services and almost 30 percentage points for obstetrics services. (See Exhibit 1.) These market shares may be achievable for a new hospital, although Presbyterian did not demonstrate that it had achieved such success. Further, Presbyterian's high level of projected market share cannot be achieved without taking significant market share from existing providers resulting in significant adverse impact.

Amisub – As described previously, Amisub failed to adequately document the need for a 100-bed hospital in Northern York County. Amisub's project entails moving 36 beds from existing Piedmont in Rock Hill to the Northern York County, Fort Mill location. This relocation is not justified for because the population in Northern York County does not justify 100 beds. In addition, the relocation of beds away from Rock Hill will result in an overwhelming mal-distribution of beds in the County. Amisub does not provide adequate justification of its projected market share to support the need for 100 beds or the utilization projections for the project.

Carolinas meets this criterion. Amisub and Presbyterian do not meet this criterion.

7. Projected Expenses:

Projections of construction costs, start-up costs, operating costs, debt service, depreciation, manpower costs, etc. should be consistent with those experienced by similar facilities offering a similar level and scope of services (with proper consideration given to such factors as inflation, cost of capital, etc.).

DHEC's Review – In its decision, DHEC's only mention of projected cost and expenses was in relation to purported economies of scale and operating efficiencies of the proposed 100-bed facility proposed by Amisub. It was DHEC's conclusion that the larger 100-bed facility will be more cost effective. [See DHEC Record (Carolinas) Bates page 997.] As will be discussed below, by every conceivable comparative measure, the Amisub project is the most costly and least cost effective. The project does not achieve economies of scale as suggested by DHEC and thus, the underlying basis for DHEC's finding in favor of Amisub's project on this point is incorrect.

In the CON Summary Sheets for each respective applicant, DHEC found that the average cost (expense) per patient day for all applicants was comparable. DHEC evaluated project cost per square foot among the four applicants as well as with five other projects under review. [See DHEC Record (Carolinas) Bates page 1030, DHEC Record (Amisub) Bates page 895. DHEC Record (Presbyterian) Bates page 2249.] As will be discussed in detail below, the applicants' average costs per patient day are not comparable. Amisub's costs are significantly higher. Further, cost per square foot is just one measure

DHEC found that all three applicants would achieve economies of scale by operating as part of a larger healthcare organization. While this is true in theory, DHEC did not perform any quantitative analysis or side-by-side comparison to determine how these efficiencies actually related to the costs of the services provided by each applicant.

DHEC described, in the Amisub CON Summary Sheet, that construction of a 100-bed facility would be more efficient and would result in economies of scales and operating efficiencies. DHEC stated that the cost of additional beds is incremental and overall more efficient operationally. Again, DHEC did not perform any quantitative analysis or side-by-side comparison to determine if these statements were factually accurate.

Carolinas – During the review, questions were raised regarding the efficiency of design of the proposed Carolinas facility. Carolinas responded and addressed all questions raised. [See DHEC Record (Carolinas) Bates pages 987-992.] When a side-by-side comparison of project costs is performed such as presented in Exhibit 12, it is clear that Carolinas represents the most efficient project design in terms of cost per bed and square footage per bed.

In terms of operating efficiency, Carolinas also projects the most efficient staffing ratios as presented previously in Exhibit 13. Carolinas' efficiencies in both design and operation are further reflected in the fact that it projects the lowest average charges, net revenue and lowest non-salary operating expenses. Carolinas will also share services with Carolinas' other hospitals in the Charlotte/Mecklenburg MSA allowing the proposed York County hospital to maximize economies of scale. Carolinas is the fourth largest employer in North and South Carolina. Carolinas is the largest healthcare system in the Southeast and the third largest public, multi-hospital system in the nation. [See DHEC Record (Carolinas) Bates page 193.]

Presbyterian – Based on a quantitative analysis of both project costs and operating costs and revenue, Presbyterian's project consistently ranked second to Carolinas on all measures of efficiency. Please see Exhibits 12, 13, and 15.

Amisub – Amisub repeatedly makes the statement that their 100-bed hospital will achieve greater economies of scale and operating efficiencies. [See DHEC Record (Amisub) Bates pages 539 and 608.] Amisub does not provide any type of quantitative analysis or comparison to support this statement.

The second finding that DHEC makes in its decision, states that Amisub's project "will result in economies of scale and operating efficiencies that cannot be achieved in smaller hospitals." [See DHEC Record (Carolinas) Bates page 997.] DHEC apparently made this finding based on Amisub's statements without performing a quantitative analysis or

side-by-side finding. When comparatively reviewed, Amisub's project is least efficient by every measure as summarized in Exhibit 15 below:

Exhibit 15
Summary of Measures of Efficiency

Measure:	CHS	FMMC	Presbyterian
Total Project Cost	Lowest	[illegible]	Second Lowest
Square Footage per Bed	Lowest	[illegible]	Second Lowest
Cost per Bed	Lowest	[illegible]	Second Lowest
Total FTEs	Lowest	[illegible]	Second Lowest
FTEs per Adjusted Occupied Bed	Lowest	[illegible]	Second Lowest
Gross Inpatient Revenue per Discharge	Lowest	[illegible]	Second Lowest
Net Revenue per Adjusted Discharge	Second Lowest	[illegible]	Lowest
Supplies and Other Operating Expenses per Adjusted Discharge	Second Lowest	[illegible]	Lowest
Capital Costs per Adjusted Discharge	Lowest	[illegible]	Second Lowest

Thus, DHEC's finding that Amisub's project will result in operating efficiencies is unfounded and a major basis for the approval of Amisub is flawed.

The Efficiency Criterion also requires that the project should avoid duplication of services. As discussed above, the replacement/relocation of 36 beds from Piedmont Medical Center is a duplication of existing services without any justification as to the need to replace or modernize. The relocation of these beds is not warranted based on the fact that the majority of York County residents will continue to reside in Rock Hill and that these 36 beds are not needed in Northern York County based on bed-to-population ratios.

Carolinas best meets this criterion. Presbyterian meets this criterion. Amisub does not meet this criterion.

Criteria Ranked 4th in Importance

13. Record of the Applicant (Owner and/or Administrator):

DHEC's Review – In its decision, DHEC identified the applicant's commitment to the community as the third factor for approval of Amisub. DHEC recognized that Amisub through Piedmont has served York County for two decades. [See DHEC Record (Carolinas) Bates page 997.] DHEC failed to recognize that both Carolinas and Presbyterian are longstanding hospital providers to the Charlotte-Mecklenburg MSA,

Carolinas HealthCare System
Application for Carolinas Medical Center-Fort Mill
Executive Summary

On December 9, 2009, Honorable Carolyn C. Matthews granted a Motion for Summary Judgment filed by the petitioners The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System ("Carolinas") and Presbyterian Healthcare System d/b/a Presbyterian Hospital-York ("Presbyterian") in the Fort Mill matter. The Order remanded the applications filed by Carolinas, Presbyterian and Amisub of South Carolina, Inc. d/b/a Piedmont Healthcare System d/b/a Fort Mill Medical Center ("Amisub") to the Department of Health and Environmental Control ("DHEC") to determine "which of the applications, if any, most fully complies with the requirements, goals, and purposes of this article and the State Health Plan, Project Review Criteria, and the regulations adopted by the department."

The following analysis reviews each project in light of all additional and updated information submitted on remand in the context of each Project Review Criteria identified by DHEC in its original review to determine the project that most fully complies.

1. Compliance with the State Health Plan – 1

As ordered by Judge Matthews all applicants are in equal compliance with the State Health Plan.

2. Community Need Documentation – 2a, 2b, 2c, 2d, 2e

Carolinas best meets this criterion. Presbyterian and Amisub do not meet this criterion based on the following factors:

- Carolinas proposes to develop a 64-bed hospital in a high growth area of York County. Carolinas provided reasonable utilization projections documenting all assumptions. Carolinas projections are based on a high level of current market share and are supported by the tremendous level of community support for the project. Carolinas projections meet the need of the target population. Carolinas is the only applicant that projects no increase in market share as a result of this project. Carolinas proposes to serve only its existing base of patients in the proposed CMC-Fort Mill.
- Presbyterian proposes to develop a 64-bed hospital in a high growth area of York County. Presbyterian provided utilization projections and documented all assumptions. Presbyterian's projections meet the need of the target population; however, in order for Presbyterian to meet its projections it has to capture unrealistically high level of market share that is currently held by other providers. If it is assumed that Presbyterian can capture this level of market share, it will significantly impact existing providers.
- Amisub proposes to develop a 100-bed hospital in Fort Mill through development of 64 new beds and relocation/replacement of 36 existing beds at Piedmont Medical Center ("Piedmont"). Amisub has not proven the need for the relocation/replacement of 36 beds. These beds are available at Piedmont to serve the Rock Hill population, which is projected to remain the largest population base in York County. Relocation/replacement of 36 beds in Northern York County results in a tremendous maldistribution of beds within the County and reduces accessibility to Greater Rock

Hill and Western York County. As such, Amisub has not documented the need for an incremental capital expenditure of roughly $50 million more than the other applicants. Amisub's project does not meet the needs of the York County population.

Distribution (Accessibility) – 3a, 3b, 3c, 3d, 3e, 3f, 3g
Distribution – 22

Carolinas best meets these criteria. Presbyterian meets these criteria. Amisub does not meet these criteria based on the following factors:

- Carolinas' project meets the needs of the community by aligning the number and location of beds with the population of the area. Carolinas' project is most financially accessible based on projected charity care, Medicaid provision, and track record of serving underserved patients who currently travel into North Carolina for care.
- Presbyterian meets the community need in terms of geographic distribution of services. Presbyterian is demonstrated to be financially accessible but historically has not been as financially accessible as Carolinas based on the applicant's track record. Presbyterian's project, while located in an underserved area, is not the best applicant to meet the need and cannot do so without adversely impacting existing providers.
- Amisub does not project a geographic distribution of services that aligns with the population distribution and demands of York County residents. Further, Amisub has not documented the need for duplication or modernization of the 36 beds it proposes to relocate/replace. Amisub's proposal will create a disparity in bed to population ratios for Rock Hill and Western York County geographic segments. Finally, Amisub is the least accessible in terms of charity care, Medicaid provision as well as projected and historical charges.

3. **Projected Revenue/Expenses – 6a, 6b, 7**
Net Income/Financial Feasibility – 9, 15
Cost Containment – 16a, 16b, 16c
Efficiency – 17

Carolinas best meets these criteria. Presbyterian and Amisub do not meet all of these criteria based on the following factors:

- Carolinas' projected revenue, expenses, and net income are based on reasonable and well documented assumptions. Carolinas projects the lowest total expenses and most efficient health manpower resources. Carolinas' project reflects efficiency in both project design and construction cost with the lowest square footage per bed and second lowest cost per bed. Carolinas' operating expense structure is cost effective based on operating assumptions and the use of cash funding for the project.
- Presbyterian's projected revenue assumptions are reasonable but they are based on unrealistic market share assumptions. Presbyterian projects the lowest project cost and cost per square footage. While Presbyterians' expenses supplies and other operating expenses are the lowest of all three applicants, square footage per bed and

FTEs per adjusted occupied bed are the highest of all applicants. Presbyterian is not the most efficient applicant.

- Amisub's project is projected to be financially feasible; however, this projection is based on higher project costs as well as significantly higher expenses compared to the other applications. Amisub's project cost is approximately $50 million more than the next highest project and these costs have not been justified. Amisub claims that construction of a 100-bed facility will be most cost effective, efficient and achieve economies of scale. By all quantifiable measures (including project cost, cost per bed, cost per square foot, net revenue per adjusted discharge, and expense per adjusted discharge) Amisub's project is the most costly and least cost effective project.

4. **Record of the Applicant – 13a, 13b, 13d**
Acceptability – 4a, 4b, 4c
Adverse Impact on Other Facilities – 23a, 23b

Carolinas meets these criteria. Presbyterian and Amisub do not meet these criteria based on the following factors:

- Carolinas has an outstanding track record of providing high quality, financially accessible services to the greater Charlotte/Mecklenburg metropolitan area including York County as well as serving South Carolinians through the Roper/St. Francis system. Carolinas has the financial, management, physician, and human resources to successfully implement the proposed project. Carolinas has a high level of market share of Northern York County. Carolinas received an overwhelming level of support for its proposed project, which supports its projected utilization and demand. Carolinas already served a significant percentage of York County residents, particularly those residing in Northern York County. Carolinas has almost as much market share of York County as a whole as Piedmont. As a result, Carolinas can meet its projected utilization without adversely impacting existing providers.
- Presbyterian has a track record as a North Carolina provider and has developed other new hospitals. Presbyterian serves some residents of York County and is reasonably financially accessible. Presbyterian brings financial, management, physician, and manpower resources to the community. Presbyterian does not currently capture a significant market share of York County. In order to meet its projected utilization, Presbyterian would have to capture a significant level of market share and utilization from existing provider, which would significantly impact existing providers.
- Amisub has a track record as a high charge provider and, as a result, operates under a contract with York County which places penalties on Amisub if charges are too high. The contract only stipulates that Piedmont not have the highest charges in a wide area. The contract in no way prevents Piedmont from having charges well above the median for the area. [See DHEC Record (Amisub) Bates pages 48]. Over the last several years, Piedmont has lost a significant level of market share to other providers. Between 2004 and 2009, Piedmont's market share in FMMC's PSA dropped from 71.8 percent to 53.7 percent. [See DHEC Record (Amisub) Bates pages 31] This drastic drop in market share is evidence of a patient preference for other providers,

including Carolinas. Amisub received a high level of opposition to the proposed project indicating that York County residents want a choice when it comes to their local hospital provider. Additionally, Amisub's own proposed FMMC project will have a greater impact on Piedmont, through cannibalization of its own market share, than Carolinas' project.

In conclusion, Carolinas' project meets all important criteria and best meets many of the criteria. While Presbyterian's project meets some of the criteria, it does not best meet any of the criteria. Presbyterian's project will also adversely impact existing providers. Amisub's proposed hospital fails to meet numerous criteria and thus cannot be approved. Amisub's project does not meet the needs of the population and is the most costly and least effective project.

Presbyterian Hospital York are unreasonable as they are higher than all of the Presbyterian hospitals, for which they are based.

In Figure 43, Updated Submission (Presbyterian) Bates page 1101, the 2008 medical/surgical and obstetric market shares for hospitals within the Presbyterian Hospital service area (note: not the Presbyterian Hospital York service area) were presented. Of the nine hospitals presented, the only hospital that had a medical/surgical market share of at least 20 percent was Piedmont Healthcare System. The Piedmont Healthcare System and Mercy Hospital (note: Presbyterian presents CMC-Mercy and CMC-Pineville together as Mercy) were the only hospitals with an obstetric market share of at least 20 percent, which is the obstetric market share projected for Presbyterian Hospital York. In reviewing 2009 market share, Carolinas Medical Center and CMC-Pineville consistently had the second and third highest limited med-surg market shares in the Presbyterian Hospital service area ZIP Codes. In regards to obstetrics, CMC-Pineville had over 20 percent market share in four of the six ZIP Codes. Clearly, Presbyterian's market share projections are unrealistic based on current market share.

As will be discussed in detail later in this document, Presbyterian projects the highest number of adjusted discharges of all three applicants but currently has the lowest market position in its proposed service area. Its utilization projections are unrealistic at best and it is unlikely to meet them.

Furthermore, Presbyterian contends that there is a need for competition in York County and that it will bring competition and choice to York County residents. However, Presbyterian has not proposed to provide any new services or technology in Presbyterian Hospital York that Carolinas does not already offer service area residents. More importantly, competition is not part of the South Carolina project review criteria. Therefore, competition has no relevance in the awarding of the Certificate of Need for this project.

The project review criteria do, however, mention adverse impact. As stated in detail to Criterion 23, Presbyterian Hospital York will have a material adverse impact on existing providers. It will reduce medical/surgical and obstetric market shares by over 20 percent. As such, Presbyterian is not the best applicant and should not be awarded the CON.

Presbyterian has failed to develop reasonable utilization projections, and as such, again fails to demonstrate need.

[See Update Submission (Presbyterian) Bates pages 34 to 39 and 80 to 91.]

Amisub – Amisub failed to adequately document the need for a 100 bed hospital in northern York County. Amisub's project entails moving 36 beds from the existing

Piedmont Medical Center ("Piedmont") in Rock Hill to the Northern York County, Fort Mill location. This relocation is not justified for two major reasons:

1. The population in Northern York County does not justify 100 beds. The relocation of beds away from Rock Hill will result in a maldistribution of beds in the County.
2. Amisub does not provide adequate justification of its projected market share to support the need for 100 beds or the utilization projections that were provided for the project.

Each of these issues will be discussed in detail below.

Maldistribution of Beds

Amisub's proposed project will cause a malditribution of beds in York County. While the population is growing rapidly in Fort Mill, the largest base of population remains in greater Rock Hill. The population in Western York County in fact is projected to continue to exceed the Northern York County population, including Fort Mill. Amisub is proposing to move 36 beds away from this more concentrated population and the distribution of beds will no longer coincide with the population distribution in York County. As originally shown in Carolinas application, the map below divides York County into three natural geographic regions, which serve as the basis for analyzing the distribution of beds. [See Update Submission (Carolinas) Bates pages 15 and 45.]

York County Natural Georgraphic Regions

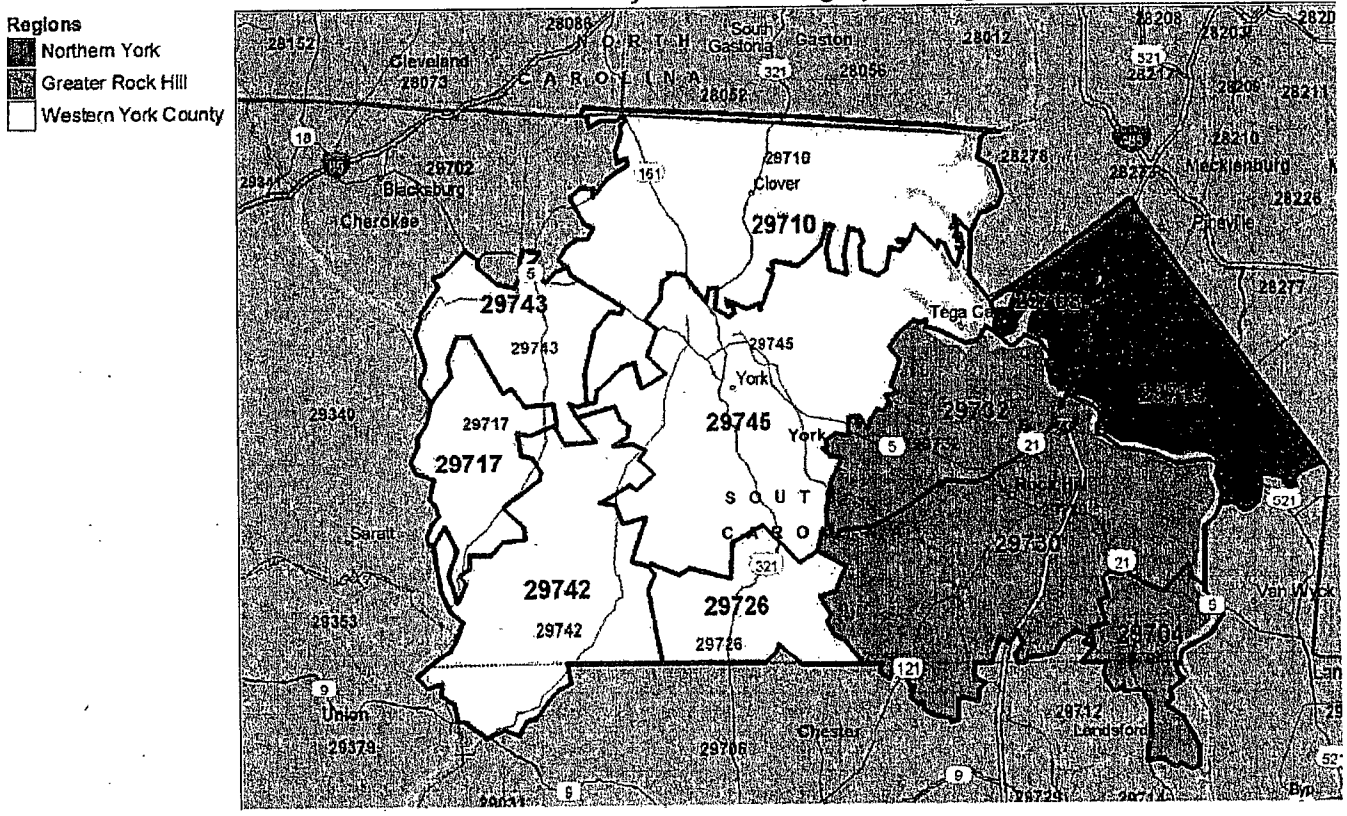
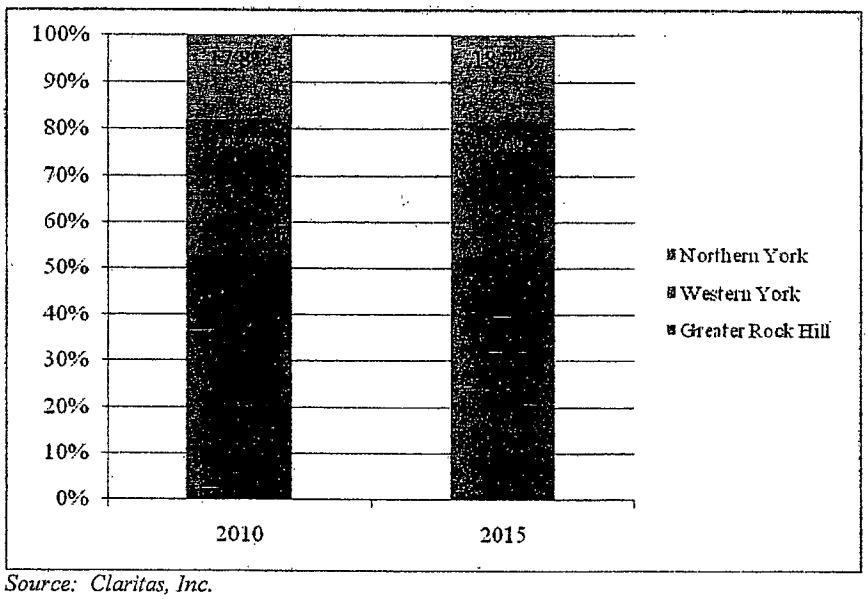


Exhibit 1 shows the percent of population in each geographic region of York County over time based on data from Claritas, Inc. As discussed above, despite rapid population growth in Northern York County, Greater Rock Hill is projected to continue to represent over 50 percent of the total population of York County in 2015. Additionally, Western York County will continue to represent almost 30 percent of the total county population. Amisub proposes to move 36 existing beds away from these communities and limiting access to beds for a huge majority of York County's population.

Exhibit 1
Comparison of York County Population Distribution
For 2010 and 2015



Source: Claritas, Inc.

Between 2010 and 2015, all of York County is projected to experience rapid population growth, as shown in Exhibit 2. However, the greatest net population growth is projected to occur in Rock Hill. The population of York County as a whole is projected to increase by 32,470, with 16,592 in the Greater Rock Hill area. Further, the net increase in population in Northern York County is projected to be just 41 percent of the net increase in population of Rock Hill. While Northern York County is experiencing the most rapid rate of growth on a percentage basis, by far the largest number of new residents will be in Greater Rock Hill. For this reason alone, there is no logical rationale to move 36 existing beds away from Rock Hill to Northern York County as proposed by Amisub.

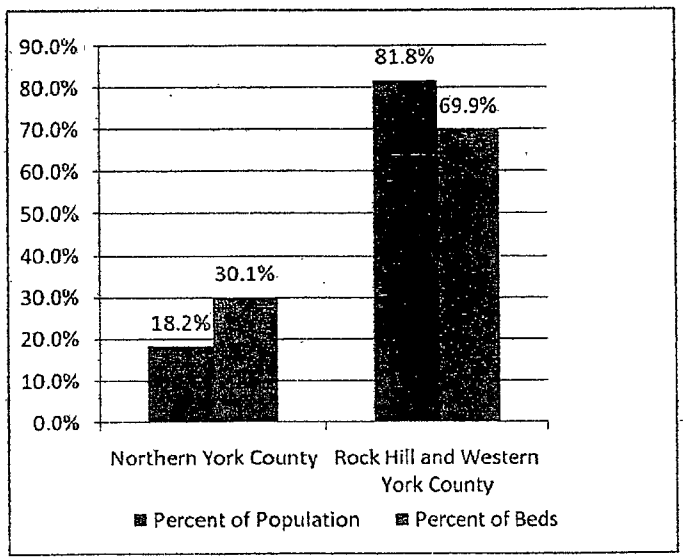
Exhibit 2
Summary of Population Growth Trends in York County

	2010-2015	
	Net Growth	CAGR
Greater Rock Hill	16,592	2.6%
Western York	9,063	2.6%
Northern York	6,815	3.1%
Total York County	32,470	2.7%

Source: Claritas, Inc.

As shown in Exhibit 3 below, it is clear that the relocation of 36 beds to Northern York County will misalign the beds in the county with the distribution of population. Even with population growth, 100 beds in Northern York County will far exceed the percentage of population in Northern York County. The area will be over-served with 30 percent of the beds in the county and only 18.2 percent of the population. Also, the relocation of 36 beds would reduce access for a large majority of York County's population.

Exhibit 3
Comparison of Population and Bed Distribution
In 2015 with 100 Beds in Fort Mill



Source: Claritas, Inc.

Further, an analysis of bed-to-population ratios shows that the relocation of these 36 beds will drastically skew the distribution of beds in York County, as illustrated in Exhibit 4 below. With 100 beds in Northern York County as proposed by Amisub and only 232 beds remaining in Rock Hill, closer to the Greater Rock Hill and Western York County populations, the bed-to-population ratio for the various portions of the County becomes severely unbalanced. Exhibit 4 below shows that the bed-to-population ratio for Northern York County following Amisub's proposed project will be almost double the ratio for the remaining parts of the county and far above the county average bed-to-population ratio. The beds per 1,000 population for Northern York County will be 2.09 in 2015, compared to just 1.08 for Greater Rock Hill and Western York and 1.27 for York County as a whole.

Exhibit 4

Bed to Population Ratio with 100-Beds in Fort Mill

	2010	2015
Northern York County		
Population	40,947	47,762
Beds	100	100
Beds per 1,000 Pop.	2.44	2.09
Greater Rock Hill		
Population	121,579	138,171
Western York County		
Population	66,960	76,023
Rock Hill & Western York		
Population	188,539	214,194
Beds	232	232
Beds per 1,000 Pop.	1.23	1.08
Total York County		
Population	229,486	261,956
Beds	332	332
Beds per 1,000 Pop.	1.45	1.27

Source: Claritas, Inc.

With 64-beds in Northern York County, as proposed by Carolinas, the bed-to-population ratio for each geographic segment of York County is balanced with the total average for the county. Exhibit 5 below summarizes the bed-to-population ratios assuming that 64 beds are developed in Northern York County.

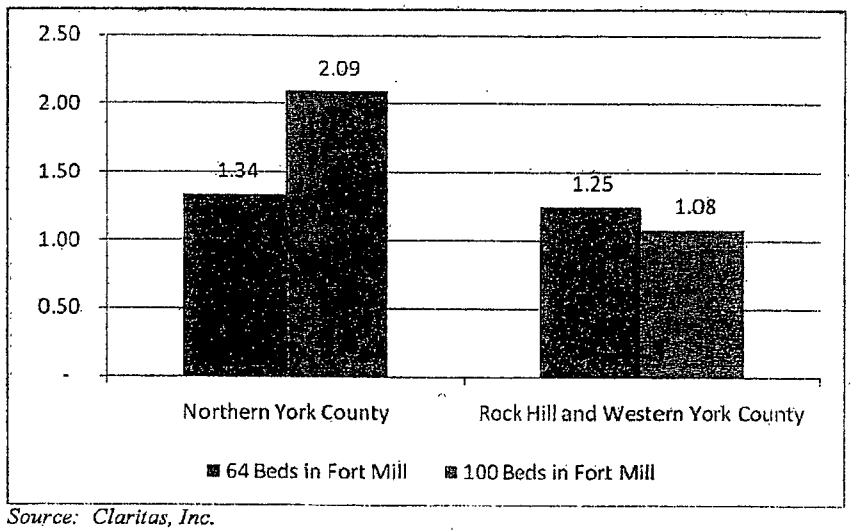
Exhibit 5
Bed to Population Ratio with 64-Beds in Fort Mill

	2010	2015
Northern York County		
Population	40,947	47,762
Beds	64	64
Beds per 1,000 Pop.	1.56	1.34
Greater Rock Hill		
Population	121,579	138,171
Western York County		
Population	66,960	76,023
Rock Hill & Western York		
Population	188,539	214,194
Beds	268	268
Beds per 1,000 Pop.	1.42	1.25
Total York County		
Population	229,486	261,956
Beds	332	332
Beds per 1,000 Pop.	1.45	1.27

Source: Claritas, Inc.

The resulting bed-to-population ratios based on the number of beds located in Fort Mill is graphically presented in Exhibit 6. It is clear that 64 beds in Fort Mill is the right number of beds to ensure access and equitable distribution of hospital services. With the approval of a 64 bed hospital, the bed-to-population ratios for Northern York County and Rock Hill and Western York will be closer in line. The closer the bed-to-population ratios are to each other assures equal access to beds for all York County residents. Further, citizens of Western York County expressed their desire to ensure equal access for their portion of the County. [See Update Submission (Carolinas) Bates page 48] Moving 36 beds further east to Fort Mill will reduce access for Western York County, which will continue to have a larger overall population that Fort Mill through the projection period.

Exhibit 6
Comparison of Bed-to-Population Ratios for 2015
With 64 and 100 Beds Located in Fort Mill



Source: Claritas, Inc.

Amisub suggests that a 100 bed facility will be much more efficient in terms of cost to develop and operate. [See DHEC Record (Amisub) Bates pages 11 & 43] However, there is no DHEC precedent that would support that a new hospital must be a minimum of 100 beds to be efficient. In fact, all new hospitals approved in South Carolina over the past 15 years have been for facilities smaller than 100 beds. Exhibit 7 identifies each new hospital approved and number of beds for which they were approved. The average beds size for all hospitals in this set is 57. The largest of all facilities approved was 85. None of the hospitals were 100 beds.

Exhibit 7
History of New Hospital Development in South Carolina

New Hospital	County	Beds	CON Issued
Providence Hospital Northeast	Richland	46	2/14/97
Coastal Carolinas Medical Center	Jasper	31	5/28/02
AnMed Women's and Children's Hospital	Anderson	72	1/13/03
Patewood Memorial Hospital	Greenville	72	8/25/03
Spartanburg Regional – Pelham	Spartanburg	48	9/9/05
Roper St. Francis Mt. Pleasant	Charleston	85	5/31/06
Seacoast Medical Center	Horry	50	9/28/07
St. Francis Millennium Hospital	Greenville	52	6/12/09
Palmetto Health Parkridge	Richland	76	6/8/10
Roper Hospital Berkeley	Berkeley	50	Under Appeal
Trident Medical Center – Berkeley	Berkeley	50	Under Appeal
Average		57	

Source: Updated Submission (Carolinas) page13. SC DHEC.

Amisub has done nothing since its initial CON application to address the mal-distribution of beds in York County that would result from its proposed project.

Market Share Projections

Amisub has not adequately documented that either its market share assumptions or the resulting utilization projections are realistic. Amisub assumes overly aggressive market share capture; utilization projections that fail to meet the target occupancy standards, identified in the acute care bed methodology in the South Carolina Health Plan, for a 100 bed hospital; and a service area population that does not adequately support a 100 bed hospital. The proposed Amisub project was only expected to operate at 58.2 percent occupancy in the third year of operation, well below the target occupancy rate of 65 percent identified in the acute care bed need methodology contained in the South Carolina Health Plan. [See DHEC Record (Amisub) Bates pages 542.]

Amisub unrealistically projects that together, the new hospital and Piedmont will capture 77.6 percent market share in its PSA in 2017. [See DHEC Record (Amisub) Bates pages 31.] These market share projections are grossly inconsistent with all other hospitals in the Charlotte MSA. Carolinas presented comparable market share data to show that other similarly situated community hospitals in the Charlotte MSA do not capture the level of market share projected by Amisub. [See Update Submission (Carolinas) Bates page 53.] Additionally, Amisub's market share projections fail to take into account a growing patient and physician preference for providers other than Piedmont. Piedmont's market share in the PSA dropped from 71.8 percent to 53.7 percent between 2004 and 2009. [See DHEC Record (Amisub) Bates pages 429] Piedmont's significant drop in market share corresponds with the growth in Carolinas market share, from 43.4 percent to 52.9 percent between 2004 and 2009. [See Update Submission (Carolinas) Bates page 0477.] Amisub claims that the large drop in Piedmont's market share is due to change in referral patterns resulting from the purchase of physician practices by Carolinas but provides no explanation or analysis to substantiate this claim. [See DHEC Record (Amisub) Bates pages 426] Further, the purchase of physician practices could not account for all of Piedmont's lost market share.

Amisub claims that patients go to NC providers out of convenience. [See DHEC Record (Amisub) Bates pages 44] However, the distance from Piedmont to Fort Mill is roughly the same as from the closest Carolinas affiliated facility in Pineville, NC. Additionally, it is more than twice as far from Fort Mill to Carolinas Medical Center than to Piedmont, and yet CMC has significant market share in the PSA. Therefore, Amisub's argument regarding convenience holds no weight and does not explain Piedmont's loss of market share. Please see Exhibit 8 for straight line distances from Fort Mill to the facilities in question. The loss in market share illustrates that a growing number of patients in the

d. In the case of a reduction, relocation, or elimination of a facility or service, the applicant should address the need that the population presently has for the service, the extent to which that need will be met by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination, or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, the elderly, handicapped persons, and other underserved groups, to obtain needed health care.

Carolinas – Not applicable. Carolinas does not propose the reduction, relocation, or elimination of a facility or service.

Presbyterian – Not applicable. Presbyterian does not propose the reduction, relocation, or elimination of a facility or service.

Amisub – Amisub proposed a reduction in the number of beds available to the residents of Rock Hill and a relocation of these beds to northern York County, Fort Mill. This reduction in Rock Hill is not justified and will leave the greater Rock Hill area underserved. The greatest base of population and concentration of population will remain in the Rock Hill area. As documented above, the proposed beds remaining in the Rock Hill area are not aligned with the demands of the population and thus will affect underserved groups from obtaining needed healthcare. As discussed above, the beds per 1,000 population for Northern York County will be 2.09 in 2015, compared to just 1.08 for Greater Rock Hill and Western York and 1.27 for York County as a whole. As a result of Amisub's project, the more populous sections of York County will have less access to beds. Amisub has done nothing to address this mal-distribution of beds since its original filing. Amisub does not meet this criterion.

Amisub does not meet this criterion. This criterion is not applicable to Carolinas and Presbyterian.

Amisub – Amisub fails to prove that it will be utilized sufficiently to justify the added cost of a 100 bed hospital. Amisub's project is significantly more expensive than the other two proposals. The added cost is due to Amisub's misguided attempt to transfer 36 beds from Piedmont to the new hospital. As discussed above, the transfer will cause a mal-distribution of beds where the distribution of beds does not coincide with the distribution of the York County population. Amisub's proposal will cause excess capacity in Fort Mill while reducing the number of beds where they are more needed, Rock Hill. In addition to causing this mal-distribution of the bed supply in York County, Amisub will not be well utilized. As shown in Exhibit 11, Amisub projects an ADC of just 58.2, which is the lowest percentage of utilization among the three applicants. Amisub's proposed project is an inefficient use of health care resources and will not be adequately utilized to justify the high cost of the project.

Amisub utilized a multistep process for its utilization projections for its acute care beds. First, it calculated a 2009 medical/surgery and ICU use rate per 1,000 residents on a ZIP code basis for its service area using population and discharge data. This use rate was applied to population projections for the years of 2015, 2016 and 2017, its first three years of operation to get total discharges for the area. Amisub assumes it will capture a large percentage of the patients leaving its PSA to receive care in NC. Amisub then projected market share for itself and Piedmont for its first three years of operation. The true basis and methodology for their market share projections are unclear. Amisub then applies its projected market share to the projected total discharges in the area. Amisub assumes in-migration from outside the service area of 10 percent. It then assumes an average length of stay of 3.8 days to arrive at its total patient days and average daily census. [See DHEC Record (Amisub) Bates pages 29-33] Amisub projects that just 18 percent of its admissions will be redirected from Piedmont, which equates to just 5 percent of the market share in its PSA. [See DHEC Record (Amisub) Bates pages 430]

Amisub lowered its utilization projections for its updated pro forma in its December 3rd submission. The admissions listed on the pro forma on Bates page 0542 do not match the projection listed on Bates page 0432 of the same submission. Amisub provided no explanation for the change it its projections and fails to explain why there are two varying utilization projections within the same submission. Additionally, Amisub fails to analyze the impact these new projections will have on its market share in the service area and its project overall.

Exhibit 11 provides a summary of Amisub's updated utilization projections for Ft. Mill Medical Center and a comparison to the original CON submission. Amisub projects the lowest level of utilization/occupancy of their proposed hospital. It is questionable whether a projection of 58.2 percent occupancy justifies the need for 100 beds in Ft. Mill. Amisub's projected utilization for all unadjusted measures has decreased from its original application. Amisub's percent occupancy dropped by 2.44 percent despite significant population growth in the service area. At a lower level of utilization, the proposed 100 bed hospital is clearly not needed and is needed less today than it was 5 years ago with the original CON application.

Exhibit 11
Fort Mill Medical Center Summary of Projected Utilization
And Comparison to Original CON

	Updated Projections Year 3	Change from Original CON Projections
Discharges	5,946	-0.54%
Days	21,258	-2.48%
ALOS	3.6	0.00%
ADC	58	-2.44%
Percent Occupancy	58.24%	-2.44%
Adj. Discharges	11,108	9.34%
Adj. Days	39,712	7.16%

Source: Updated Submission (Amisub) pages 542.

Carolinas best meets this criterion. Presbyterian and Amisub do not meet this criterion.

3. Distribution (Accessibility):

a. Duplication and modernization of services must be justified. Unnecessary duplication of services and unnecessary modernization of services will not be approved.

Carolinas – Not applicable. Carolinas does not project to modernize or duplicate any existing services. The 2004-2005 South Carolina Health Plan recognizes a need for 64 acute care beds. Carolinas proposes to meet this need and as such will not duplicate any existing services.

Presbyterian – Not applicable. Presbyterian does not project to duplicate any existing services. The South Carolina Health Plan recognizes a need for 64 acute care beds. Presbyterian proposes to meet this need and as such will not duplicate any existing services.

Amisub – Proposes to relocate and replace 36 existing beds from the existing Piedmont Medical Center to the proposed FMMC. Amisub has not provided any documentation that the existing beds at Piedmont require replacement or modernization. The relocation and replacement of these beds at Amisub represents an unnecessary duplication of services and adds unnecessary capital cost to the proposed project. Amisub's project is roughly $50 million greater than both Carolinas' and Presbyterian's projects. [See DHEC Record (Amisub) Bates pages 423-424, 441, 443]

Amisub claims that greater economies of scale can be achieved with a 100 bed hospital; however, no actual quantitative documentation was provided. No offsetting loss in operating efficiencies at Piedmont was considered and the incremental capital required to replace these beds is not warranted. Amisub fails to provide justification that the larger bed size of the proposed hospital creates any efficiency from a building and design

Presbyterian – Presbyterian's proposed hospital continues to be located in the Northern portion of York County. Presbyterian proposes to meet the bed need in York County identified in the 2004-2005 South Carolina Health Plan. Presbyterian projects to meet the growth in demand for service and to serve some patients who are traveling to North Carolina for care. Presbyterian has the lowest existing system market share of York County and Northern York County. As such, Presbyterian will not be able to meet its projected market share without impacting existing providers. Even its own impact analysis, Bates pages 1101 to 1117, supports this fact. Piedmont Medical Center is projected to lose 13 percent of its acute care discharges by FFY 2017. The hospitals identified by Presbyterian as "Mercy Hospitals," which is really CMC-Mercy and CMC-Pineville, will lose 5.1 percent. Springs Memorial Hospital will lose 5 percent. Several additional hospitals are also projected to lose acute care discharges to Presbyterian Hospital York.

Thus, Presbyterian's project, while located in an underserved area, is not the best applicant to meet the need and cannot do so without adversely impacting existing providers.

Amisub – By proposing to develop 64 new beds and relocate 36 existing beds to develop a new 100 bed hospital in Northern York County, Amisub will create the unintended consequence of an underserved area in Rock Hill and Western York County. As shown previously in Exhibit 5, the relocation of 36 beds away from the largest population base in Greater Rock Hill will create a disparity in bed to population ratios for Rock Hill and Western York County geographic segments. Amisub's project also represents an unnecessary duplication of existing services by replacing 36 existing beds. There is no documentation that the existing beds are insufficient in any way. The capital cost of replacing and relocating these beds has not been justified. Amisub's project cost is almost $50 million higher than Carolinas. Amisub has not justified these costs. Please see Exhibit 15. [See DHEC Record (Amisub) Bates pages 443] Amisub's proposal for a 100 bed hospital has not changed since its original application.

Carolinas best meets this criterion. Presbyterian meets this criterion. Amisub does not meet this criterion.

c. The location of the proposed service should allow for the delivery of necessary support services in an acceptable period of time and at a reasonable cost.

All three projects include the necessary support services and are supported by the services of other acute care hospitals or hospital systems in the area.

All three applicants meet this criterion.

[See Updated Submission (Presbyterian) Bates pages 37 and 39.]
Amisub – As described in detail on pages 6 to 15, Amisub failed to adequately document the need for a 100-bed hospital in Northern York County. Amisub's project entails moving 36 beds from existing Piedmont in Rock Hill to the Northern York County, Fort Mill location. This relocation is not justified because the population in Northern York County does not justify 100 beds. In addition, the relocation of beds away from Rock Hill will result in an overwhelming mal-distribution of beds in the County. Amisub does not provide adequate justification of its projected market share to support the need for 100 beds or the utilization projections for the project. As shown above in Exhibit 11, Amisub's beds will only be utilized at 58.2 percent of capacity, the lowest of the three applicants. Like its original application, Amisub does not project either the existing Piedmont Hospital or the proposed FMMC to meet the target occupancy rate set forth in the South Carolina Health Plan bed need methodology of 65. In the third year of operation, Amisub is projected to be occupied at 58.2 percent. Thus, Amisub's own projections do not justify a 100-bed hospital.

Carolinas meets this criterion. Presbyterian and Amisub do not meet this criterion.

7. Projected Expenses:

Projections of construction costs, start-up costs, operating costs, debt service, depreciation, manpower costs, etc. should be consistent with those experienced by similar facilities offering a similar level and scope of services (with proper consideration given to such factors as inflation, cost of capital, etc.).

Carolinas – Carolina's project costs and design is very consistent between its original CON submission and the updated submission. Inflation in cost has been considered but the original efficient hospital design remains.

In calculating the total cost per bed and a total cost per square foot, Carolinas and Presbyterian have the lowest of both with less than a 2 percent variation in the cost of Carolinas and Presbyterian's projects. This information is demonstrated below in Exhibit 15. Carolina's has maintained the lowest square footage per bed in both the original and updated submissions. Carolinas has developed a very cost effective and efficient model for developing new hospitals, which will be utilized in the design and construction or the proposed CMC-Fort Mill.

17. Efficiency:

The proposed project should improve efficiency by avoiding duplication of services, promoting shared services, and fostering economies of scale or size.

Carolinas – Carolinas projects the most efficient staffing ratios as presented in Exhibit 25. Carolinas' efficiencies in operation are further reflected in the fact that it projects the lowest gross inpatient revenue per discharge and capital costs per adjusted discharge. Carolinas is the most efficient of all three applicants as it avoids duplication of services and promotes shared services within the healthcare system, which is reflected in its staffing efficiencies. Further, Carolinas proposes the most efficient design with the lowest square footage per beds.

Presbyterian – Overall, based on a quantitative analysis of project costs and operating costs and revenue, Presbyterian's project ranks second to Carolinas regarding measures of efficiency, which was also true in Presbyterian's original 2005 application. In terms of cost efficiency, Presbyterian ranks first among the applicants. Presbyterian projects the lowest net revenue and lowest non-salary operating expenses. Of the two design measures of efficiency, Presbyterian has the lowest cost per bed but the highest square footage per bed. Carolinas has the second lowest and lowest, respectively.

The South Carolina Health Plan recognizes a need for 64 acute care beds. Presbyterian proposes to meet this need and as such will not duplicate any existing services.

Amisub – Amisub repeatedly makes the statement that their 100-bed hospital will achieve greater economies of scale and operating efficiencies. [See DHEC Record (Amisub) Bates pages 11 & 43] However, as in its original application, Amisub does not provide any type of quantitative analysis or comparison to support this statement. Amisub's alleged operational efficiencies do not lead to lower charges. As shown in exhibit 22 above, Amisub will have the highest Inpatient Net revenue per Adjusted Discharge. Amisub's Inpatient Net revenue per Adjusted Discharge in Year 3 will be 48.0 percent higher than Carolinas and 46.9 percent higher than Presbyterian.

Amisub does not provide adequate justification of the cost of building 36 additional beds in Fort Mill and abandoning 36 beds in Rock Hill. While Amisub claims that the proposed hospital will operate efficiently with 100 beds, there is no documentation of the abandoned capital cost related to operating these 36 beds in Rock Hill or the impact on operating costs for the Piedmont Rock Hill facility. The only mention of these beds is that 17 are not set up and staffed. [See DHEC Record (Amisub) Bates pages 11 & 43.] A more cost effective approach would be to open these existing beds and serve the growing Rock Hill area from Piedmont. It is reasonable to expect that any gain in operating efficiencies in Fort Mill will be offset by loss of efficiency in Rock Hill.

Amisub's Total Expenses per Adjusted Discharge are significantly higher than those of CHS for Year 3 of operation. As shown in Exhibit 24, Amisub's Total Expenses per Adjusted Discharge are 25.9 percent higher than those of CHS. The great variance in expenses proves the falsehood of Amisub's claims that a 100 bed hospital will lead to

operational efficiencies. Not only will the 100 bed hospital cause a mal-distribution of beds in York County, it will not lead to higher operating costs as well.

Exhibit 24
Total Expenses per Adjusted Discharge

	CHS	Amisub
Total Expenses (in 000's)	77,759	106,174
Adjusted Discharges	10,249	11,111
Expense per Adjusted Discharge (in 000's)	7.59	9.56
Variance		25.9%

Source: Updated submission (Amisub) Bates page 542, updated submission (Carolinas) Bates pages 677-682.

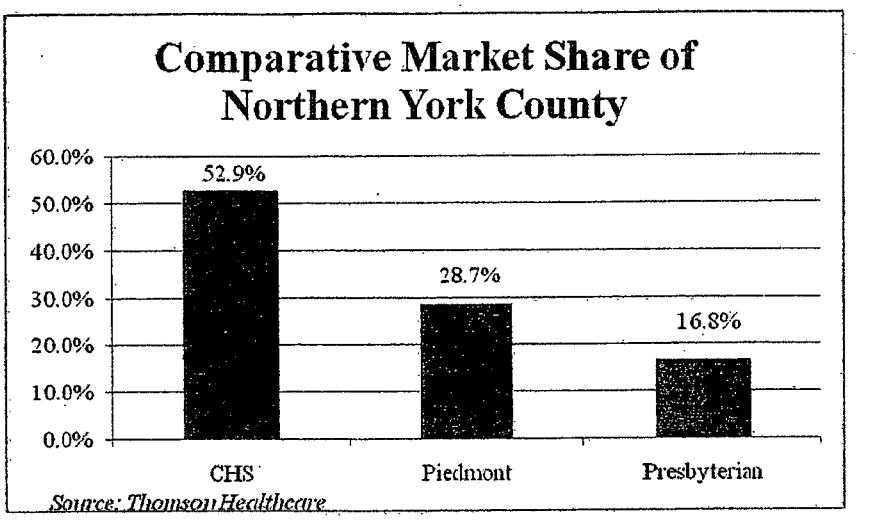
Exhibit 25
Summary of Measures of Efficiency

Measure:	CHS	Amisub	Presbyterian
Total Project Cost	Second Lowest	Highest	Lowest
Square Footage per Bed	Lowest	Second Lowest	Highest
Cost per Bed	Second Lowest	Highest	Lowest
FTEs	Lowest	Highest	Second Lowest
FTEs per Adjusted Occupied Bed	Second Lowest	Lowest	Highest
Net Revenue per Adjusted Discharge	Lowest	Highest	Second Lowest
Supplies and Other Operating Expenses per Adjusted Discharge	Second Lowest	Highest	Lowest
Capital Costs per Adjusted Discharge	Second Lowest	Highest	Lowest

Note: Capital related costs adjusted for consistent depreciation method across projects and handling of imputed interest.

The Efficiency Criterion also requires that the project should avoid duplication of services. As discussed above, the replacement/relocation of 36 beds from Piedmont Medical Center is a duplication of existing services without any justification as to the need to replace or modernize. The relocation of these beds is not warranted based on the fact that the majority of York County residents will continue to reside in Rock Hill and that these 36 beds are not needed in Northern York County based on bed-to-population ratios.

Carolinas best meets this criterion. Presbyterian meets this criterion. Amisub does not meet this criterion.



Anyone can develop a marketing campaign and influence people to write a letter of support. The best measure of support of the directed affected persons is how they vote with their "feet" and with their "healthcare dollars." Patients are overwhelmingly voting for Carolinas as the provider of choice. Please also see Updated Submission (Carolinas) Bates pages 355-357.

Presbyterian – Presbyterian provides a letter and CV of the physician who agreed to be the Chief of Staff of the proposed Presbyterian Hospital York on Bates page 846 through 848. On Bates pages 74 and 75, Presbyterian discusses the letters of support received from physicians who have expressed an interest in utilizing the proposed hospital and also provides a table summarizing the total of 131 physician signatures; however, it should be noted that a sizable number of these physicians are based in Charlotte and not York County. In Presbyterian's original 2005 application, it provided just six letters of support from physicians and two of those physicians were affiliated with Novant or Presbyterian.

Amisub – Amisub received a large number of letters of support. However, the quality of these letters is quite low. Many are just a few words written on a form that was provided by Amisub. A large number of the "letters" reiterate the same points, such as job creation and taxes being paid. Further, many of the letters are extremely general, simply stating that there is a need for a hospital in the Fort Mill area, and could be applied to any of the applicants. Additionally, some of the letters state that they support Piedmont and do not even reference Amisub. The letters of support do very little to strengthen Amisub's case for approval.

However, the level of outmigration to North Carolina providers for services is more indicative of affected persons' desire for a choice than any number of letters. Market share data provided by Carolinas indicates that 52.9 percent of patients in Northern York County (Fort Mill and Tega Cay ZIP codes) are leaving York County for care in North Carolina.

D H E C
PROMOTE PROTECT PROSPER
C. Earl Hunter, Commissioner
Promoting and protecting the health of the public and the environment.

CERTIFIED MAIL 91 7199 9991 7030 0505 8648

September 9, 2011

Mr. F. Del Murphy, Jr.
Vice President-Planning
Carolinas HealthCare System
P.O. Box 32861
Charlotte, NC 28232-2861

Re: Carolinas Medical Center – Fort Mill
As Per December 9, 2009 Order from Judge Matthews, Administrative Law Court
Fort Mill, South Carolina

Dear Mr. Murphy:

It is the decision of this Department that a Certificate of Need be issued to Carolinas Medical Center – Fort Mill for the construction of a sixty-four (64) bed general acute care hospital to be located in York County, South Carolina.

This decision is made in accordance with the December 9, 2009 Order ("the Order") from the Administrative Law Court ("ALC") issued by the Honorable Carolyn C. Matthews, which remanded Docket No. 06-ALJ-07-0713-CC to the Department for further action consistent with the Order's instructions. The Order instructed, among other things, that the Department:

- "determine 'which of the applicants, if any, <u>most fully complies with the requirements, goals, and purposes of this article and the State Health Plan, Project Review Criteria, and the regulations adopted by the department'</u> as required by S.C. Code Ann. § 44-7-210(C)" (emphasis in original);

- "be made based upon the fact that each of the parties is in equal compliance with 24A S.C. Code Reg. 61-15 § 802.1"; and

- "be accompanied by written findings as to each applicant's compliance with the relevant Project Review Criteria and which party best meets each project review criterion and the basis thereof."

The Department has determined that the application presented by Carolinas Medical Center – Fort Mill most fully complies with the requirements, goals, and purposes of Certificate of Need Program, the South Carolina Health Plan, Project Review Criteria, and Regulation 61-15, "Certification of Need for Health Facilities and Services."

This decision is based upon the written findings contained in the attached Project Review Criteria Analysis and upon the following conclusions:

01218

1. Carolinas Medical Center – Fort Mill ("the applicant") best meets the following Project Review Criteria: Community Need Documentation - 2e; Distribution - 22; Projected Revenues - 6b; Net Income - 9; Financial Feasibility - 15; Cost Containment – 16a; Record of the Applicant - 13b; and Adverse Affects on Other Facilities – 23a;

2. The applicant has adequately demonstrated that its current significant level of market share and utilization will be sufficient to justify the implementation of the project;

3. The applicant's proposed project appears to be financially feasible based upon the information provided; and

4. The applicant's proposed project will increase accessibility and availability of services by shifting current market share to a facility in South Carolina, resulting in less adverse impact to existing facilities.

If you have any questions, please feel free to contact us at (803) 545-4200.

Sincerely,

Beverly Brandt

Beverly A. Brandt, MPH, Chief
Bureau of Health Facilities and Services Development

Enclosures: Project Review Criteria Analysis
Notice of Appeal Procedure

cc: Ashley Biggers, Esquire, Chief Counsel for DHEC Health Regulation
Doug Muller, Esquire, Moore & Van Allen
Ariail B. Kirk, Esquire, McNair Law Firm, P.A.
Barbara L. Freedy, Director, Certificate of Need, Novant
Stuart M. Andrews, Jr., Esquire, Nelson Mullins
Charles Miller, President and CEO, Piedmont Medical Center
David Levitt, Levitt Healthcare Affiliates

Notice of Appeal Procedure
Pursuant to S.C. Code Section 44-1-60

1. This decision of the S.C. Department of Health and Environmental Control (Department) becomes the final agency decision 15 calendar days after notice of the decision has been mailed or otherwise sent to the applicant, permittee, licensee and affected persons who have requested in writing to be notified, unless a written request for final review accompanied by a filing fee in the amount of $100 is filed with the Department by the applicant, permittee, licensee, or affected person.

2. An applicant, permittee, licensee, or affected person who wishes to appeal this decision must file a timely written request for final review with the Clerk of the Board at the following address or by facsimile at 803-898-3393. A filing fee in the amount of $100 made payable to SC DHEC must also be received by the Clerk within the time allowed for filing a request for final review. However, if a request for final review is filed by facsimile, the filing fee may be mailed to the Clerk of the Board if the envelope is postmarked within the time allowed for filing a request for final review.

   Clerk of the Board
   SC DHEC
   2600 Bull Street
   Columbia, SC 29201

3. In order to be timely, a request for final review must be received by the Clerk of the Board within 15 calendar days after notice of the decision has been mailed or otherwise sent to persons entitled to receive notice. If the 15th day occurs on a weekend or State holiday, the request is due to be received by the Clerk of the Board on the next working day. The request for final review must be received by the Clerk of the Board by 5:00 p.m. on the date it is due. A request for final review will be returned to the requestor if the filing fee is not received on time as described above.

4. The request for final review should include the following:
   a. the grounds on which the Department's decision is challenged and the specific changes sought in the decision
   b. a statement of any significant issues or factors the Board should consider in deciding whether to conduct a final review conference
   c. a copy of the Department's decision for which review is requested

5. If a timely request for final review is filed with the Clerk of the Board, the Clerk will provide additional information regarding procedures. If the Board declines in writing to schedule a final review conference, the Department's decision becomes the final agency decision and an applicant, permittee, licensee, or affected person may request a contested case hearing before the Administrative Law Court within 30 calendar days after notice is mailed that the Board declined to hold a final review conference.

The above information is provided as a courtesy; parties are responsible for complying with all applicable legal requirements.

January 7, 2011

Project Review Criteria Analysis for the "Fort Mill Hospital" Decision

Note: This document, in addition to the Project Review Summary for each applicant, will serve as the "Summary of Staff Findings." Since the Project Review Meeting of June 29, 2011, Presbyterian Hospital - York has revised some information, such as projected acute care occupancy, outpatient cases, Emergency Department (ED) cases and excess of revenues over expenses. This information was dated August 9, 2011 and has been included in this analysis as applicable.

Administrative Law Court Remand. On December 9, 2009, an Order from Judge Carolyn C. Matthews of the Administrative Law Court remanded the "Fort Mill Hospital" case back to the South Carolina Department of Health and Environmental Control ("Department") so that the Certificate of Need ("CON") applications for the Fort Mill Medical Center ("FMMC"/ Piedmont Medical Center "Piedmont"/ Tenet/Amisub), Presbyterian Hospital – York ("Presbyterian"/ "PH-Y"/ Novant) and Carolinas Medical Center – Fort Mill ("Carolinas") may all be reviewed equally under the South Carolina Health Plan ("Plan") as competing applicants, and for the Department to determine which applicant most fully complies with the purposes of the Certificate of Need Act and the Project Review Criteria as set forth in the statute and regulations. The Order stated that "because the CON Act defines the parameters of the Department's authority and contemplates that applicants can freely apply and be approvable to compete for a new hospital to meet the public need and other purposes of the CON Act and the CON Regs (R.61-15 "Certification of Need for Health Facilities and Services"), I find the Department committed an error of law and exceeded its statutory authority in interpreting and applying the Plan." In summary, Judge Matthews concluded that any of the competing applicants could have been approved for a Certificate of Need to build an acute care hospital in Fort Mill.

Compliance with State (South Carolina) Health Plan. The December 9, 2009 Order from Judge Carolyn C. Matthews states that "the Department's decisions must be made based upon the fact that each of the parties is in equal compliance with 24A S.C. Code Reg. 61-15 § 802.1," which states "Need: The proposal shall not be approved unless it is in compliance with the State Health Plan." It is noted that the Project Review Criterion ranked as first, as referenced in the March 27, 2006 letter from Mary Fechtel with the Department's Division of Planning and Certificate of Need, was Compliance with State Health Plan – 1.

Project Review Criteria. Judge Matthews's Order provided the following instructions to the Department: "to determine 'which of the applicants, if any, <u>most fully complies with the requirements, goals, and purposes of this article and the State Health Plan, Project Review Criteria, and the regulations adopted by the department'</u> as required by S.C. Code Ann. § 44-7-210(C)" (emphasis hers); and "the Department's decisions must be accompanied by <u>written findings as to each applicant's compliance with the relevant Project Review Criteria</u> and <u>which party best meets each project review criterion and the basis thereof</u>" (emphasis ours).

Note that the purpose of "this article," Article 3. State Certification of Need and Health Facility Licensure Act, and the CON program as a whole is "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."

Background Information

Population Growth. Substantial population growth has occurred in York County. According to U.S. Census 2000 and Census 2010 data, York County's population grew by 61,459 people during that period for an increase of 37.3 percent, which is second in S.C. only to Dorchester County. By comparison, the rate of growth for S.C. was 15.3%. The Fort Mill area (Northern York County) is also projected to grow more rapidly than the Rock Hill area and Western York County. The projected growth for the entire population between 2010 and 2015 is predicted to be 16.1% for Northern York County as compared with 14.2% for York County as a whole and 5.9% for South Carolina. The projected growth is particularly dramatic for the age 65 and over population. Between 2010 and 2015, the growth for this age group is predicted to be 45% for Northern York County as compared with 36.9% for York County and 20.7% for South Carolina.

While the most rapid population growth is in Northern York County, the population of Greater Rock Hill is projected to continue to increase as well. While the projected percent increase for Northern York County was greater than that for Greater Rock Hill, the total projected population increase for Greater Rock Hill was 87,266 residents as compared with 25,845 for Northern York County from 2010 to 2017.

Significant Outmigration for Services. In 2009, over 40% of all hospital discharges for York County residents were from hospitals outside of York County. Of the 8339 residents who left South Carolina for services, 8054 (97 percent) went to one of the 14 Charlotte/Gaston area hospitals. An analysis of the DRG information shows that the vast majority of these patients were general acute care patients.

Written Findings

Each Project Review Criterion as described in R. 61-15 "Section 802. Criteria for Project Review Project Review Criteria" has been ranked in accordance with the March 27, 2006 letter from Mary Fechtel, with the Department's Division of Planning and Certificate of Need, which stated: "These criteria are ranked according to their relative importance with the most important being listed first. All other relevant criteria will be given equal importance."

The Department has determined that the application for Carolinas best meets the following Project Review Criteria and therefore should be awarded the Certificate of Need: Community Need Documentation - 2e (Current or projected utilization justified); Distribution - 22 (Identify existing distribution and effect upon balance to target population); 6b (Projected Utilization/Projected Expenses); Net Income - 9 (improvement over time); Financial Feasibility - 15 (Immediate and long-term); Cost Containment – 16a (Feasible sources of funding); Record of the Applicant - 13b (Ability to obtain financing); and Adverse Effects on Other Facilities – 23a (Impact on existing facilities vs. increased accessibility).

Rank 2 - Project Review Criterion: Community Need Documentation – 2a (Target population), 2b (Population projections), 2c (Service to meet need), 2d (Reduction, elimination or relocation of services), 2e (Current or projected utilization justified) 01222

All applicants equally met **2a**, **2b,** and **2c.** All applicants clearly identified their target population as the residents of York County. All applicants used population projections that were reasonable

and consistent with those of the S.C. Budget and Control Board Office of Research and Statistics (SCORS). The sources for ZIP-Code specific data were Claritas, Inc. and Thomson Reuters. All applicants proposed to offer services consistent with those of a community hospital and not a comprehensive range of services as would a tertiary hospital.

Piedmont Medical Center provided current utilization data and projected utilization data for both PMC and FMMC. The other two applicants provided projected utilization data. All three applicants provided utilization data for Medical/Surgical and Obstetrics service lines.

Item **2d** only applied to Piedmont, and states "In the case of a reduction, relocation, or elimination of a facility or service, the applicant should address the need that the population presently has for the service, the extent to which that need will be met by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination, or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, the elderly, handicapped persons, and other underserved groups, to obtain needed health care." The Department was concerned with this criterion being adequately demonstrated. The FMMC project involves a proposed relocation via the transfer of 36 existing beds from Piedmont Medical Center and the addition of 64 beds. Areas identified in the proposed Primary and Secondary Service areas are presently served by Piedmont Medical Center, specifically the ZIP Codes 29730 and 29732 that are considered to be Rock Hill, in which Piedmont Medical Center currently has 69.3% market share and 64.6% market share of the total discharges for these areas. The historical utilization for Piedmont Medical Center has declined from 75.1% in 2003 to 57.1% in 2009. Yet, the projected Inpatient Medical/Surgical and ICU Market Share is projected to a combined (Fort Mill Medical Center and Piedmont Medical Center) Market Share of 65.7% in 2015, 70.4% in 2016 and 72.2% in 2017, with the Market Share for FMMC being 19.4%, 22.8% and 26.1% respectively. The Department is concerned that the high level of projected market share is not reasonable. In 2009, the proposed five-ZIP Code primary service area generated 10,125 medical/surgical and ICU inpatient discharges, excluding normal newborns, cardiac catheterization, open heart surgery and psychiatry. Of these, 4310 sought care at North Carolina facilities. The Department is concerned with the redirection of existing patients from Piedmont to FMMC when the 2010 Patient Days of Care at Piedmont was 56,723 days (155.4 beds) with 249 acute care beds set up and staffed out of 268 licensed acute care beds.

Carolinas best met item **2e**, which states "Current and/or projected utilization should be sufficient to justify the expansion or implementation of the proposed service." Carolinas' projections are based on a high level of current market share, and Carolinas proposes to serve only its existing base of patients at CMC-Fort Mill. Carolinas captured 56.8% of the market share for Northern York County in 2010, as compared with 44.3% in 2005. The total inpatient discharges from Carolinas' Charlotte hospitals by York County citizens are up 69% since 2005 (3,749 discharge vs. 6,354 discharges in 2010). The need for the project is based on the level of service area residents that are currently choosing Carolinas for their care. Carolinas projects that 75% of its 2009 market share for Northern York County, 80% of its 2009 market share for Rock Hill and 50% of its 2009 market share for Western York County will shift to the proposed CMC-Fort Mill. These projections appear reasonable.

01223

Presbyterian's projections meet the need of the target population, but in order to meet its projections, it has to capture a high level of market share that is held by other providers, even in light of updated projections which reduced the total number of discharges by approximately 9% as

compared with the October 2010 submission. The information, dated August 9, 2011, was submitted by Presbyterian in response to statements by other applicants indicating a projected "unrealistic market share capture." However, Presbyterian did not provide detailed outpatient and ancillary projections with the information dated August 9, 2011. Presbyterian currently captures 18% market share in the Service Area, but in October 2010 projected that market share by census tract for medical/surgical services would range from 20-25% for Years 1-3 and from 20-50% for obstetric services for Years 1-3. Based upon review of historical and current data, the Department feels that even with recently updated information, market share projections could be difficult to achieve. For example, in the October 2010 submission, Presbyterian projects to provide 62.5% more MRIs in 2015 than Carolinas and 294% more than Fort Mill Medical Center. This projected number of scans is significantly higher than the number performed in 2010 by several existing S.C. hospitals (for example, Conway Medical Center, Aiken Regional Medical Center, Mary Black Memorial) with more licensed beds than the proposed applicant. Presbyterian projects 54% more surgeries than Carolinas for 2015 in a comparably sized hospital. Updated projections for medical/surgical and obstetric discharges show a decrease in discharges, but the market share did not change from the previous information. If Presbyterian fails to meet updated projections, this would have a substantial negative financial impact upon the project.

The Presbyterian Hospital-York service area is defined as a 7-mile radius around the proposed site at the quadrant north of the intersection of I-77 and Sutton Road in Fort Mill, South Carolina. The service area radius expands out and takes into account the next nearest hospitals in various directions, and major transportation routes. PH-Y did not use a set of ZIP codes to define the service area, but used the smaller census tract level. The proposed PH-Y service area consists of 23 census tracts. These census tracts are all located within SC, encompassing parts of Rock Hill and part of the panhandle section of Western Lancaster County. They assumed patients residing in the census tracts in the service area will account for approximately 80 percent of PH-Y's patients. The other 20 percent of patients may come from other parts of York County and surrounding counties.

In its August 9, 2011 revision, PH-Y analyzed CY 2009 discharge volumes for two South Carolina hospitals and seven North Carolina hospitals where York County residents currently receive hospital care. Discharge data for these hospitals were used to calculate current and projected service levels and market shares. The projected occupancy rates for the 64 bed hospital for total acute care discharges (combined medical/surgical and normal newborn discharges) were 50.1% for FY2015, 58.5% for FY2016 and 67.6% for FY 2017, which translates into an average daily census of 32.1, 37.5 and 43.3, respectively. The market share for medical/surgical services remained the same in the August 9, 2011 document with 27.6% in Year 1 (2015), 31.1% in Year 2 (2016) and 34.6 % in Year 3 (2017). The market share for obstetric services likewise remained the same, with 30.2% in Year 1 (2015), 34.0% in Year 2 (2016) and 37.8 % in Year 3 (2017). These projections seem difficult to achieve even with significant inpatient outmigration.

01224

The projections for Carolinas Medical Center- Fort Mill are based on a high level of current market share, and it is the only applicant that projects no increase in market share as a result of the proposed project. Carolinas proposes to serve only its existing base of patients. It projects to shift a portion of its existing market share of the service area to CMC-FM. The need for the project is based on level of service area patients currently choosing Carolinas for their care. It already serves a significant percentage of York County residents, particularly those residing in Northern York County. Carolinas has almost as much market share for the entire York County

as Piedmont. The primary service area identified consists of six ZIP codes, three for Northern York County (Fort Mill and Tega Cay) and three ZIP codes for the Rock Hill area (two for Rock Hill and Catawba), which will comprise 78.8% of their projected patients in Year 3, and a secondary service area of six (6) ZIP Codes in Western York County, which will comprise 12.1% of their projected patients.

Market share data from Thomson Reuters and SC ORS are used to demonstrate current market share of the service area and assumed a shift of existing Carolinas market share to new hospital. CMC-FM projects utilization on a ZIP code basis. The existing market share has continued to grow since the original filing. The applicant proposes to shift 75% of its 2009 market share held by Carolinas' Mecklenburg facilities for Northern York County, shift 80% of its 2009 market share held by Carolinas' Mecklenburg facilities for Rock Hill, and shift 50% of its 2009 market share held by Carolinas' Mecklenburg facilities for Western York County. The projections were submitted for obstetrical market share. It is assumed inpatient discharges at CMC-Fort Mill will be derived from York County patients currently seeking care at Carolinas' hospitals in North Carolina. CMC-Fort Mill is projected to reach 63.9% occupancy in Year 1 (2015), 65.7% occupancy in Year 2 (2016), and 67.5% occupancy in Year 3 (2017), with the following projected occupancies for obstetrical beds in Years 1-3, respectively: 79.5%, 81.0%, and 82.0%.

Fort Mill Medical Center identified five (5) ZIP Codes in the Primary Service Area, three (3) identified by the ZIP Name "Fort Mill" with a total projected population in 2015 of 61,502 residents, and two (2) ZIP Code Areas identified by "Rock Hill" with a total projected population in 2015 of 133,934 residents. The Secondary Service area was identified by seven (7) other ZIP Codes for a total projected population in 2015 of 80,260 residents, for a combined Primary and Secondary Service Area population total of 275,696 residents. Some of FMMC's residents are predicted to be from Rock Hill, but it does not seem reasonable to assume that a patient choosing to use Piedmont's services will drive past the main hospital to receive care at FMMC.

The Primary Service area for the proposed Fort Mill Medical Center includes two Rock Hill area ZIP codes, identified by 29732, which includes Piedmont Medical Center, and 29730, some of which is located south of Piedmont Medical Center. The remaining three Primary Service Area ZIP codes are in the Fort Mill area. Piedmont projects to capture medical and surgical discharges from the 29732 Rock Hill ZIP codes as follows: 18.9% in Year 1 (2015), 18.9% in Year 2 (2016), and 19.2% in Year 3 (2017); for both Rock Hill ZIP codes combined (29730 and 29732): 43.3%, 43.2%, and 43.8%, respectively. The remaining projected discharges are from the Fort Mill area. Piedmont provided no rationale for projecting so many discharges at Fort Mill from areas immediately in the vicinity of Piedmont Medical Center.

Piedmont projects to capture 32.3% of the medical and surgical discharges from the 29732 Rock Hill ZIP codes in each of the first three years of operation; for both Rock Hill ZIP codes combined (29730 and 29732): 68.4%, 68.0%, and 68.2%, respectively. The applicant provided no rationale for projecting so many discharges at FMMC from areas immediately in the vicinity of Piedmont Medical Center. The remaining projected discharges are from the Fort Mill area. 01225

There are currently beds available at Piedmont to serve the Rock Hill population, which is projected to remain the largest population base in York County. Relocation/replacement of 36 beds in Northern York County does not appear to equitably distribute beds within the County and reduces accessibility to Greater Rock Hill and Western York County. Piedmont has not

documented the need for a capital expenditure of over $40 million more than the other applicants.

Information provided by Piedmont indicates a substantial reduction in utilization, from an average daily census of 201.2 for 75.1% occupancy in 2003 to an average daily census of 153 in 2009 with 57.1% occupancy. They are licensed for 268 acute care beds (excluding 20 psychiatric beds) and the most recent Joint Annual Report (JAR) indicated they have 249 acute care beds set up and staffed (excluding 20 psychiatric beds). The utilization slightly improved to an average daily census of 155.4 in 2010, for an occupancy of 58%. Based on this information, there are currently 94 unused beds at Piedmont on an average daily basis.

The JAR also showed a dramatic reduction in outpatient endoscopies, from 5813 in 2009, to 2316 in 2010, a decrease of 60.2%. All inpatient operations decreased from 4271 in 2008 to 3844 in 2010, a decrease of 10.0%; total operations (inpatient and outpatient) decreased from 8,434 in 2008 to 7,537 in 2010, a decrease of 10.6%. There has also been a decline in tertiary services at Piedmont. Total heart catheterizations (diagnostic and therapeutic) have decreased from 2459 in 2008 to 2090 in 2010, a decrease of 15%. Open heart surgeries have declined from 164 in 2008 to 127 in 2010, a decrease of 22.6%.

Rank 2 – Project Review Criterion: 3. Distribution (Accessibility) – 3a (Duplication and modernization), 3b (located to serve medically underserved areas), 3c (Location allows for timely delivery of necessary support services at a reasonable cost), 3d (No restriction on admissions), 3e (Documentation of means by which persons will access the services), 3f (Extent of access to medically underserved populations), 3g (Provisions for access to the appropriate service, regardless of ability to pay)

Item **3a** only applied to Piedmont, which states "Duplication and modernization of services must be justified. Unnecessary duplication of services and unnecessary modernization of services will not be approved." Piedmont has not adequately justified the duplication of services by the transfer of 36 existing beds in a project with a total project cost of either $119,808,964, or $146,522,042 which includes financing cost during construction.

All applicants met items **3b**, **3c**, **3d** and **3e**. Items **3f** and **3g** are equally met by Presbyterian and Carolinas. Presbyterian has the most generous charity care policy. Novant's charity care policy provides that any uninsured family of four (4) with an annual household income less than 300 percent of the Federal Poverty level ($67,050 for 2011) without an asset test access to medical care at Presbyterian hospitals and employed physician practices for free. PH-Y estimates it will provide charity (indigent) care in the amount of 6.5 % of projected gross charges. In its October 2010 submission, this equated to $11,543,636 in Year 1 (2015), $13,893,633 in Year 2 and $16,525,574 in Year 3. However, revised figures were not submitted even though a reduction in inpatient discharges and outpatient cases was indicated by their August 9, 2011 letter. By comparison, Carolinas proposed 6.3% of gross charges for totals of $10,514,000, $11,598,000 and $12,770,000, for Years 1-3, respectively. Piedmont proposed significantly less charity care, 3.0% of gross charges, which equates to $4,525,618, $5,699,710 and $7,012,201 for Years 1-3, respectively, for a 100 bed hospital vs. the other applicants' 64 bed proposals.

The Department also examined Medicaid Inpatient Discharges. Carolinas served the largest number of Medicaid patients traveling from S.C to N.C. for care in all years between 2005 and

2009. Carolinas indicated there were 1,387 SC Medicaid inpatient discharges from Charlotte hospitals in 2010 vs. 183 Medicaid inpatient discharges for Presbyterian. In addition, Carolinas indicated they had 4,190 SC Medicaid ED discharges from Charlotte hospitals in 2010 vs. 83 Medicaid ED discharges for Presbyterian. According to the 2010 JAR, Piedmont had 2,744 Medicaid discharges.

Rank 2 - Project Review Criterion: 22 - Distribution (Identify existing distribution and effect upon balance to target population)

Even though patient choices exist for all three applicants within a reasonable travel distances and times within approximately thirty (30) minutes, Carolinas best met this criterion because it is the only applicant that proposes to successfully shift its current market share. The Department is concerned with the cost-effectiveness of Piedmont's proposal and the balance of the distribution to the target population. Presbyterian's application would require a substantial change to the existing market shares of both Piedmont and Carolinas to be successful.

In a response dated December 3, 2010 regarding plans to recapture market share, Piedmont states that "without a hospital location in the northern portion of the county, Piedmont will continue to lose patients to providers in the north." The Department feels this could result in the recapture of some patients who currently travel out of state for care, but not to the extent proposed by Piedmont. It is not clear that the number of beds proposed to be constructed are fully justified given the target population includes patients who would have to drive past Piedmont to reach FMMC.

Rank 3 - Project Review Criteria: Projected Revenues, 6a (Proposed/comparable charges), 6b (Projected Utilization/Projected Expenses), 7 (Consistent with similar facilities)

Rank 3 - Project Review Criteria: Net Income, 9 (improvement over time) /Financial Feasibility, 15 (Immediate and long-term)

All projects show an improvement in net income over the first three years. All applicants provided projections of immediate and long-term financial feasibility and comparable projected inpatient charges per patient (**6a, 7**). However, Carolinas best meets these Criteria **6b, 9** and **15** with its more conservative financial projections based on current market share. Their projected revenue, expenses and net income are based on reasonable and current market share assumptions. Both Carolinas and Presbyterian have comparable Total Project Costs and FTEs per adjusted occupied bed. On August 9, 2011, Presbyterian revised their projected revenue, but did not submit the pro forma in its entirety. However, the excess of revenue over expenses have been reduced from $1,998,254 to $585,036 for Year 2 and from $4,985,226 to $2,544,000 for Year 3. The Department remains concerned that Presbyterian's high level of projected market share cannot be achieved without taking market share from existing providers resulting in adverse impact. Piedmont least meets this criteria since it is the only application in which a profit is not shown until Year 3. Piedmont also has the highest cost per bed of all of the applicants, particularly if the Total Project Cost of $146,522,042 is used.

Rank 3 – Project Review Criteria: Cost Containment – 16a (Feasible sources of funding), 16b (Lease alternatives), 16c (Impact upon costs to provide services and charges)

The Department has received numerous projections for expenses per adjusted discharge, making it difficult to assess impact per adjusted discharge. However, it appears that Piedmont has the highest cost and revenue per adjusted discharge. Carolinas best meets **Criteria 16a** as it proposed the most definitive method of financing, which is to finance the capital cost for the project from accumulated cash reserves. Presbyterian proposes to fund the capital costs out of Accumulated Reserves of Novant Health, Inc. but reserves the right to seek tax exempt bond finding for all or part of the project. Presbyterian projects approximately $3 million per year in interest expense for Years 1-3. Piedmont proposed the least definitive method of financing. Note that in its response dated December 3, 2010, FMMC removed the capitalized interest costs of $ 8,962,851 for financing cost during construction, but interest expense remained a line item of the Financial Projections for the Years 1-5 provided. The interest expenses ranged from $10,391,282 in Year 1 to $8,561,839 in Year 5. The applicant stated that 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." The FMMC application states that "since the other applicants did not include capitalized interest expense" they would "provide project costs that exclude this line item."

All applicants propose to build and not lease their hospital buildings. All applicants addressed impact upon costs to provide services and charges.

Rank 3 - Project Review Criterion: Efficiency – 17 (Avoid duplication, foster economies of scale)

Carolinas and Presbyterian both meet Criterion **17**, Efficiency. They both are similar with regards to Total Project Cost, cost per bed, and FTEs per adjusted occupied bed. Since Carolinas already has a significant market share, its project would shift its existing market share into a South Carolina facility. Presbyterian focused on the use of the "prototypical hospital design" to reduce construction costs and ongoing costs to operate and maintain the facility. Presbyterian also had the lowest equipment costs due to "enhanced purchasing power for imaging equipment."

Piedmont least meets Criterion 17. Piedmont claims the construction of 100-bed facility will be most cost effective, efficient and achieve economies of scale. However, their project is the most costly and they provide no information to support the "economies of scale" statement. Piedmont also had the greatest land and equipment costs. A unique feature of PMC, and subsequently FMMC, is a contract which Tenet maintains with York County. It sets forth certain pricing restrictions relative to a "peer group" of similar hospitals, which include hospitals in South Carolina and North Carolina.

Rank 4- Project Review Criteria: Record of the Applicant – 13a (Successful operations and management experience), 13b (Ability to obtain financing), 13d (Record of compliance)

All applicants have adequately demonstrated successful operations and management experience (**13a**) and have addressed capital financing (**13b**). All applicants adequately addressed compliance with state regulatory programs (**13d**).

Regarding Criterion **13b**, Ability to obtain financing, see 16a, feasible sources of funding. Note that Carolinas best met Criterion 16a and therefore best meets Criterion **13b**.

Rank 4- Project Review Criteria: Acceptability – 4a (Support of affected persons), 4b (Consideration of opposition), 4c (Possible transfer agreements)

All applicants meet the criterion for acceptability. All applicants submitted substantial letters of support, primarily from the community. The current reported totals are 10,004 letters for Presbyterian, 5753 for Carolinas and more than 5400 for Piedmont. The Department directly received thirty-four (34) letters of opposition to Piedmont from the community. This was significant in that most were lengthy and detailed. In contrast, one letter opposing both Carolinas and Presbyterian was received directly by the Department. However, Piedmont also provided forty-five (45) letters of support from independent physicians. All applicants submitted significant letters of support on postcards and duplicated form letters. Support was also submitted via e-mail.

Rank 4- Project Review Criteria: Adverse Effects on Other Facilities – 23a (Impact on existing facilities vs. increased accessibility), 23b (Impact upon existing staffing and staffing costs)

Carolinas best meets this Project Review Criterion **23a** as it currently has a high level of market share in Northern York County and already serves a significant percentage of York County residents. Carolinas has almost as much market share of York County as a whole as Piedmont. As a result, Carolinas can meet its projected utilization without adversely impacting existing providers and with the least impact upon Piedmont Medical Center. All applicants meet Criterion **23b**.

In order to meet its projected utilization, Presbyterian would have to capture a significant level of market share and utilization from PMC, which would result in an adverse impact. Presbyterian proposed to capture 2174 inpatient discharges from Piedmont, resulting in a 14.2% reduction. This volume reduction will have a material impact upon Piedmont. The Department also had difficulty with reconciling Presbyterian's utilization methodology.

Piedmont projects around 18% of its admissions will be redirected from Piedmont to FMMC with the remainder of its patients coming from N.C. providers. The Department is concerned about Piedmont's ability to capture/recapture market share. Additionally, the projections proposed for FMMC will not negatively impact any of the other applicants, but Piedmont Medical Center itself could be negatively impacted by the approval of FMMC due to shifting of patients and current market share.

Piedmont projects that it will lose over 3500 cases and some $13.8 million in net revenue by the third year of operation if a Fort Mill facility owned by either Carolinas or Presbyterian is built. The Department notes that Piedmont's 2011 budget projects a pre-tax income of $19,122,474, which is approximately $12 million after taxes. Even with a N.C. provider in Fort Mill, Piedmont

projected Net Operating Revenue of $256,083,937 for the year 2015 and $260,188,895 for the year 2020. However, during this period, the Net Income for Piedmont was projected to decrease from $4,881,595 to a negative value of $18,613 if there is a N.C. provider in Fort Mill.

Piedmont claims that it will experience the loss of patients and will have no choice but to reduce costs in the form of a reduction or elimination of jobs and services to offset the loss in revenue due to the decline in utilization of hospital services. Over time, Piedmont indicates its ability to continue to invest in new technology, upgrade its facilities and establish new services will be limited and this would impede Piedmont's ability to recruit or retain physicians.

Piedmont states there would be increased outmigration for tertiary and other specialty services to the Charlotte-area hospitals which would reduce the volume of Piedmont's open heart surgery program. Piedmont states the substantial losses in patient volume and revenue would jeopardize the following programs: stroke program; in-house neonatologists; infusion center; wound care center and hyperbaric chamber. Piedmont states it 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. Piedmont Medical Center's historical utilization has decreased from 75.1% in 2003 to 57.1% in 2009. The Department is unaware of a loss of services due to this decrease. The Department does note, however, that Piedmont serves a valuable community role as a Level III Trauma Center. From 2005 to the present, the SC Trauma Registry indicated Piedmont as serving 1948 trauma patients. Of these patients, 1108 or 56.9% were from Rock Hill ZIP codes.

PIEDMONT
MEDICAL CENTER

RECEIVED
OCT - 4 2010
HEALTH FACILITIES AND
SERVICES DEVELOPMENT

State
Original

Updated Certificate of Need Application for Construction of a 100-Bed Hospital

October 2010

PIEDMONT
MEDICAL CENTER

October 1, 2010

Ms. Beverly Brandt
Director, Bureau of Health Facilities and Services Development
Division of Planning and Certification of Need
Department of Health and Environmental Control
1777 St. Julian Place, Suite 201
Columbia, SC 29204

RE: Updated Application for 100-Bed Hospital in Fort Mill

Dear Ms. Brandt:

Enclosed is Piedmont's Medical Center's CON Updated Application for construction of a 100-bed hospital in Fort Mill, South Carolina.

Piedmont Medical Center has a long history of service to the York County community. Approval of either of the competing applicants for the Fort Mill hospital would result in a substantial adverse impact on Piedmont, jeopardizing our ability to invest in new equipment and Technology, to recruit and retain physicians, continue providing the same level of services to York County, as well as continue to maintain the significant level of competition in the market that exist today.

Piedmont's 100-bed proposal is more efficient than the 64-bed proposals of the other applicants and our unique contract with York County makes us the only applicant contractually bound to provide community outreach services to York County. The York County contract also requires that Piedmont maintain reasonable prices and submit detailed quarterly and annual financial reports for oversight by the York County Council. No other applicant is held accountable in these ways.

Along with our Updated Application we are submitting six notebooks containing numerous letters of support from local physicians and the general public.

Thank you for your careful consideration of this material.

Sincerely,

Charles F. Miller
President & CEO

222 South Herlong Avenue • Rock Hill, SC 29732 • tel: (803) 329-1234 • fax: (803) 329-0979 • www.piedmontmedicalcenter.com

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

Proposal Prepared By:

Name: Charles F. Miller

Title: President and Chief Executive Officer

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

Address: 222 South Herlong Avenue

City: Rock Hill **State:** South Carolina

Zip Code: 29732 **Telephone Number:** (803) 329-6839

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

Signature:

Date: 9/30/2010

Forward to:
Bureau of Health Facilities and Services Development
S.C. Department of Health and Environmental Control
2600 Bull Street, Columbia, SC 29201

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B. Published Notification of Project

C. Architect's Verification of Costs (Revised)
Equipment Quotes

D. Space Program (Revised)

E. Project Timeline (Revised)

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K. Financial Projections and Assumptions (Revised)

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

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

PART A - QUESTIONNAIRE (Page 1)

1. **Name of Facility:** Amisub of South Carolina, Inc. d/b/a Fort Mill Medical Center

2. **Address, City, County, State, ZIP Code:** Intersection of SC Highway 160 and Highway 21 Bypass, located on the Kingsley property in Fort Mill, York County

3. **Type of Facility (Circle)**

   [A. Hospital] B. Nursing Home C. Psychiatric Facility D. Rehabilitation Facility

   E. Substance Abuse Facility F. Ambulatory Surgery Center G. Other (Specify)

4. **Purpose of Review (Circle)**

   [A. New Facility] B. Change of Licensure C. Addition to Existing Facility

   D. Renovation of Existing Facility E. Change of Services F. Other (Specify)

5. **Management**

   A. Name of Administrator: Charles F. Miller

   B. Address, City, State, ZIP Code: 222 South Herlong Ave, Rock Hill, SC 29732

   C. Telephone: (803) 329-6835

   D. Name of Licensee: Amisub of South Carolina, Inc.

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

   A. Individual B. Partnership [C. Corporation] D. Proprietary

   E. Non-Profit F. Government (Specify) _____ G. Other (Specify) _____

Pied.Supp.CON.0004

PART A - QUESTIONNAIRE (Page 2a)

7. **Is the Proposed Site of the Property?**

A. Owned B. Leased C. Length of Site Lease _____

D. Option E. Length of Option _____

F. Name and Address of Owner(s) of Real Property: AmiSub of South Carolina, Inc. 222 South Herlong Avenue, Rock Hill, SC 29732. A copy of the land closing document is provided in **Attachment A**.

Total Bed Capacity for Which Application is Made: Fort Mill Medical Center will be comprised of 100 Beds that will come from the 64 Piedmont Medical Center projected beds in the 2004-2005 South Carolina Health Plan, and the transfer of 36 acute care beds from Piedmont Medical Center.

		Fort Mill Medical Center		
Type of Beds		**Existing Beds**	**# Gained or Lost**	**Bed Total**
A. Medical/Surgical			82	82
B. Obstetrics			8	8
C. Pediatrics				
D. Substance Abuse				
E. Psychiatric				
F. Rehabilitation				
G. Nursing Care				
H. RTC's				
I. ICU/CCU			10	10
J. Other				
K. Total		**0**	**100**	**100**

Pied.Supp.CON.0005

PART A - QUESTIONNAIRE (Page 2b)

Total Bed Capacity for Which Application is Made: Fort Mill Medical Center will be comprised of 100 Beds that will come from the 64 Piedmont Medical Center projected beds in the 2004 - 2005 South Carolina Health Plan, and the transfer of 36 acute care beds from Piedmont Medical Center.

		Piedmont Medical Center		
Type of Beds		**Existing Beds**	**# Gained or Lost**	**Bed Total**
A. Medical/Surgical		205	(36)	169
B. Obstetrics		19		19
C. Pediatrics		12		12
D. Substance Abuse				
E. Psychiatric		20		20
F. Rehabilitation				
G. Nursing Care				
H. RTC's				
I. ICU/CCU		32		32
J. Other				
K. Total		**288**	**(36)**	**252**

Pied.Supp.CON.0006

PART A - QUESTIONNAIRE (Page 2c)

Total Bed Capacity for Which Application is Made: Fort Mill Medical Center will be comprised of 100 Beds that will come from the 64 Piedmont Medical Center projected beds in the 2004 - 2005 South Carolina Health Plan, and the transfer of 36 acute care beds from Piedmont Medical Center.

		Combined (Piedmont Medical Center & Fort Mill Medical Center)		
Type of Beds		**Existing Beds**	**# Gained or Lost**	**Bed Total**
A. Medical/Surgical		205	46	269
B. Obstetrics		19	8	27
C. Pediatrics		12		12
D. Substance Abuse				
E. Psychiatric		20		20
F. Rehabilitation				
G. Nursing Care				
H. RTC's				
I. ICU/CCU		32	10	42
J. Other				
K. Total		**288**	**64**	**352**

Pied.Supp.CON.0007

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:** $75,631,867
C. Architect's Fee: $5,260,735	**D. Equipment Costs:** $50,833,168 **1) Fixed Equipment** **2) Movable Equipment**
E. Financing Cost During Construction: $8,962,851	
F. Other Costs: (includes tests, inspections, and permitting): Other Costs - $1,164,816	**G. Total Project Cost:** $146,522,042 Increase from original submission is attributable to inflation and changes in technology/equipment costs.
H. Construction and Equipment Cost: **1) Per Square Foot:** $570 **2) Per Bed:** $1,264,650	

Pied.Supp.CON.0008

PART B: ADDITIONAL INFORMATION

(1) Document that the applicant has published notification of this project in a local newspaper as required by Section 201 of these Regulations.

Response: The original published notification of the intent of Amisub of South Carolina, Inc., to file this CON is provided as **Attachment B**.

Pied.Supp.CON.0009

(2) **Describe the project setting forth the proposed change in services or facilities in as much detail as possible. State whether the project will change the existing licensed or survey bed capacity, will encompass the development of a new service, or result in the discontinuance of an existing service. If a new facility is proposed, list all services to be provided.**

Response: Piedmont Medical Center (Piedmont) proposes to build a 100-bed affiliated hospital in Fort Mill, York County, South Carolina. The facility will be known as Fort Mill Medical Center (FMMC).

Piedmont Medical Center is a 288-bed acute care facility (including 20 psychiatric beds) located in Rock Hill, York County. Founded in 1983, Piedmont is the sole acute care provider in York County and offers a full range of services including acute care, emergency and critical care, women's services and education and community support programs. Piedmont also offers pain care, neonatology, and neurosurgical services as well as a sleep disorder center and a wound care center. Additionally, Piedmont offers a full range of cardiac services including diagnostic and therapeutic catheterization, open heart surgery, and cardiac rehabilitation.

The 2004-2005 South Carolina Health Plan shows that Piedmont Medical Center has a need for 64 additional acute care beds based on the current utilization at Piedmont and expected population growth in York County.

Figure 1
FY 2010 Hospital Bed Need
Piedmont Medical Center

Age Category	Population 2003	Population 2010	2003 Patient Days	Projected ADC	Bed Need (a)	Existing Beds	Need/ (Excess)
<18	44,300	45,910	2,937	8.34			
18-64	110,120	125,480	36,863	115.08			
65+	17,670	20,910	33,632	109.04			
Total	172,090	192,300	73,432	232.46	332	268	64

Source: 2004-2005 State Health Plan.
(a) Based on 70% occupancy

When the original CON application was submitted, Piedmont was experiencing a steady increase in utilization, with 2004 data showing the facility to be utilized at 74 percent of licensed capacity. From 2001 to 2004, the average daily census increased by nearly 44 patients or 27 percent. This illustrated the need for additional capacity to serve the medical needs of the patients in the York County area.

Since the original CON application, the outmigration from the northern portion of York County has continued to increase due to the lack of an acute care facility in that area. More residents are leaving the state to receive care in North Carolina. While Piedmont is 10 miles south, the orientation of the residents of that area is directly primarily either local or to the north. Approval of the proposed Fort Mill Medical Center will allow residents a local alternative to leaving the state, as well as provide an opportunity for Amisub of South Carolina to recapture marketshare to levels consistent with historical percentages.

Piedmont's marketshare of Medical/Surgical and ICU residents York County decreased from approximately 67 percent in 2004 to 52 percent in 2009. However, the decrease is predominately from the Northern portion of the county. For the five ZIP Code primary service area, the marketshare decreased from 72 percent to 54 percent for the same time period. However, for the remainder of ZIP Codes in York County, the number only decreased from 54 percent to 47 percent.

The calculated bed need contained in the State Health Plan does not include the utilization of South Carolina residents who were treated in North Carolina hospitals. As patients in the northern York County area increasingly leave the state, utilization at Piedmont continues to decline. Factoring in the outmigration utilization would result in a higher demand for acute care beds in York County.

Figure 2
Piedmont Medical Center
Historical Utilization

	2001	2002	2003	2004	2005	2006	2007	2008	2009
Beds	268	268	268	268	268	268	268	268	268
Inpatient Days	59,019	64,813	73,432	72,697	71,951	70,762	63,495	61,429	55,838
ADC	161.7	177.6	201.2	199.2	197.1	193.9	174.0	168.3	153.0
Percent Occupancy	60.3%	66.3%	75.1%	74.3%	73.6%	72.3%	64.9%	62.8%	57.1%

Source: 2001-2004 State Health Plan; 2004-2009 JARS.

Rather than adding the 64-bed need in the 2005-2005 Health Plan to the existing site in Rock Hill, Piedmont proposes the construction of an affiliated hospital in the high growth area of Fort Mill, York County, approximately 10 miles from Piedmont.

Fort Mill Medical Center will be developed by Amisub of South Carolina, Inc., which is Piedmont Medical Center. The proposed facility will encompass approximately 221,895 gross square feet of space on a 40-acre site, and will offer the following services:

- 82 medical/surgical beds
- 10 intensive care beds
- 8 obstetrics beds
- One fixed-base MRI scanner
- 24-hour emergency department

Additionally, Fort Mill Medical Center will offer numerous other imaging modalities and ancillary services in support of this mix of services.

The original CON application also proposed a diagnostic cardiac catheterization lab. Since then, however, utilization in the defined service area has declined below the threshold for need as outlined in the State Health Plan, therefore a new cardiac catheterization provider cannot be approved at this time. As a result, the current revised application has excluded this service. Piedmont will monitor the utilization levels and continue to develop a strategy to provide diagnostic cardiac catheterization at the Fort Mill Medical Center, at the appropriate time. Additional detail is provided in response to Question 11.

In addition to the need for 64 additional beds at Piedmont, Piedmont will also transfer 36 acute care beds to Fort Mill Medical Center resulting in a more efficient 100-bed hospital. Piedmont is licensed for 288 acute care beds, including 20 psychiatric beds. The 2009 Joint Annual Report shows Piedmont had 249 non-psychiatric beds operational. Of the 36 licensed beds that are being transferred from Piedmont Medical Center, 17 are licensed beds that are not currently set up and staffed (these 17 beds are currently not set up and staffed because they are semi-private rooms operated as private rooms); 19 beds will come from the fourth floor of the hospital, which is currently an orthopedic unit. That unit will be relocated to an empty unit on the Women's Tower, which is currently closed.

The 2004-2005 South Carolina Health Plan shows a net bed need of 64 beds at Piedmont. As an alternative to the expansion of Piedmont's existing facility, it was decided that based on patient service patterns and population growth, York County residents would best be served by an affiliated hospital to be located in the Fort Mill area. 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.

(3) Provide the total cost of the project, indicating design fees, land cost, interest cost, construction cost, equipment cost, and any other cost involved in the project. Provide an estimate of the construction cost from a licensed architect or engineer; in the case of equipment, an estimate from a vendor is acceptable.

Response: The revised total cost associated with this project is $146,522,042. A letter from the architect verifies the construction costs, and is provided as **Attachment C**.

The following table summarizes the total project costs:

Original Figure 3
Project Cost Summary

	Amount
Land	$11,227,435
Construction	$55,687,051
A/E Fees	$4,434,642
Furn, Fix, Equip	$45,537,069
Financing Costs	$6,883,553
Other Costs	$724,133
Total	*$124,493,883*

***Revised* Figure 3**
Project Cost Summary

	Amount
Land	$4,668,605
Construction	$75,631,867
A/E Fees	$5,260,735
Furn, Fix, Equip	$50,833,168
Financing Costs	$8,962,851
Other Costs	$1,164,816
Total	*$146,522,042*

The total project costs have changed as a result of inflation and changes in technology and equipment. In addition, the original CON application included the costs associated with all 40 acres of the site. Consistent with the approach of the other two applicants, the land costs included in the revised project total includes only the 16.75 acres directly associated with the proposed hospital.

Included in **Attachment C** is a list of equipment costing more than $600,000 involved in this project and the corresponding vendor quotes. Also included in **Attachment C** are letters verifying the total equipment cost of $50,833,168.

The equipment associated with the proposed project is based on the Space Program, which is provided as **Attachment D** and takes into consideration all services to be provided at the proposed Fort Mill Medical Center facility.

(4) State the specific location of the facility or service and/or equipment, including, where applicable, specific areas of an existing facility to be affected by the project. Provide room numbers of all patient rooms affected. Sufficient detail should be provided to allow the Department to visually inspect the site. The number of private and semi-private patient rooms shall be identified.

Response: The 100-bed Fort Mill Medical Center will be located at the intersection of SC Highway 160 and Highway 21 Bypass, located on the Kingsley property in Fort Mill. The building will encompass approximately 221,895 gross square feet on five floors, including the basement level. The following lists the services to be offered and the locations of departments on each floor of the facility:

Figure 5
Service and Location Summary

Basement Level:	
Central Sterile	Laboratory
Dietary	Linen/Environmental Services
Education	Materials Management
Employee Lounge/Lockers	Medical Staff Services
Engineering	Mechanical
Information Systems	Pharmacy
First Floor:	
Admitting/Registration	Emergency Department
Cardiology	Gift Shop
Chapel	Imaging
Community Relations	Surgery
	Volunteer/Auxiliary
Second Floor:	
Administration	8 OB Beds
Case Management	4 LDRs
Human Resources	1 C-Section Suite
Medical Records	Nursery
10 Medical/Surgical Beds	Nursing Administration
Third Floor:	
36 Medical/Surgical Beds	10 ICU Beds
Fourth Floor:	
36 Medical/Surgical Beds	

The detailed space program summary for the proposed project is provided as **Attachment D**.

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(5) **Provide details regarding any proposed construction and/or renovations. Discuss alternatives to new construction and why these alternatives were rejected. For a multi-floor project, construction and/or renovation must be described, by floor, to include any additions and/or deletions made to each floor. Provide evidence that the applicant has adequately planned for any temporary move or relocation of any department, facility, or services, which may be necessary during the construction period. Document that plans exist to assure adequate protection (from fire, noise, dust, etc.) and continuation of all services during the proposed construction period.**

Response: The proposed 100-bed Fort Mill Medical Center will be located in the rapidly growing Fort Mill area of York County. The response to Part B question 4 details the locations of the departments in the new facility by floor. The space program summary for the proposed facility is provided as **Attachment D**. Since these beds will be contained in a new structure, no departments will be temporarily relocated during the construction period.

Of the 36 licensed beds that are being transferred from Piedmont Medical Center, 17 are licensed beds that are not currently set up and staffed because they are semi-private rooms operated as private rooms; 19 beds will come from the fourth floor of the hospital, which is currently an orthopedic unit. That unit will be relocated to an empty unit on the Women's Tower, which is currently closed.

Piedmont Medical Center first investigated the potential of expanding the current facility. After much discussion and market research regarding patient service patterns in York County, it was decided that a second facility location in York County would better serve the residents of South Carolina by increasing access to services in the immediate area, and decreasing the need to travel out of state for care. The proposed new facility will be in a geographic location that will enable it to better serve this patient population, and accommodate new growth in the fastest growing portion of York County.

(6) **If a replacement facility or ancillary service is being constructed, describe plans for disposition of the existing facility or ancillary service area upon completion of the project.**

Response: Not applicable.

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(7) **Provide a timetable for development and completion of the project to include, at a minimum, the date of site acquisition, date of architectural contract, architectural design schedule, date of closing for financing, date of valid construction contract, date that all necessary permits (grading, building, sewer, etc.) will be obtained, and date of start of construction. The timetable shall be presented in one month increments commencing with the month following receipt of the Certificate of Need and ending with the execution of a contract or purchase order for equipment only projects.**

Response: Upon approval of this CON application, construction of Fort Mill Medical Center will commence in July 2013, and will be completed in May 2015. It is anticipated that the new hospital will be licensed by July 2015 and will begin operation that same month. A project timeline is provided as **Attachment E.**

(8) **Provide the following ownership information:**

(a) **Proposed name of facility;**

Response: Fort Mill Medical Center.

(b) **Name and address of licensee or prospective licensee. (Note: The licensee is defined as the legal entity who, or whose governing body, has the ultimate responsibility and authority for the conduct of the facility or service; the owner of the business. The licensee must be the entity to whom the Certificate of Need is issued.)**

Response: Amisub of South Carolina, Inc.
222 South Herlong Avenue
Rock Hill, SC 29732
(York County)

(c) **Complete title of the licensee's governing body.**

Response: Amisub of South Carolina, Inc., Board of Directors

(d) **Name, title and mailing address of presiding officer of the governing body.**

Response: Harold "Skip" P. Tuttle
Chairman of the Board
Amisub of South Carolina, Inc.
222 South Herlong Avenue
Rock Hill, SC 29732

(e) **Name and mailing address of all persons and/or legal entities having any ownership interest or owner's equity of the licensee to include a schedule of percent and type ownership claim of each.**

Response: Amisub of South Carolina, Inc., is a wholly owned subsidiary of Tenet Medical Systems, Inc. The ultimate parent corporation of Amisub of South Carolina, Inc., is Tenet Healthcare Corporation. The mailing address of Tenet Healthcare Corporation is:

P.O. Box 809088
Dallas, TX 75380-9088

(f) **Name and mailing address of all persons and/or legal entities claiming liabilities of the licensee or of the facility or service for which this Certificate of Need is requested to include a schedule of percent and type of claim of each.**

Response: Amisub of South Carolina, Inc., is a wholly owned subsidiary of Tenet Medical Systems, Inc. The ultimate parent corporation of Amisub of South Carolina, Inc., is Tenet Healthcare Corporation. The mailing address of Tenet Healthcare Corporation is:

P.O. Box 809088
Dallas, TX 75380-9088

(g) **Provide a listing which identifies all officers of the licensee.**

Response: The Officers of Amisub of South Carolina, Inc., are:

President: Charles F. Miller

Vice President: Jay Pennisson

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(h) **Is the land and/or building on/in which the proposed facility or service is to be conducted owned by the applicant. ☒ YES ☐ NO If no, provide information on the land and building similar to that required in (b) through (g) above.**

Response: The site for the proposed Fort Mill Medical Center was purchased by Amisub of South Carolina, Inc., on October 6, 2006. A copy of the Land Closing Document is provided in **Attachment A**.

(i) **Has the licensee engaged an entity other than an employee of the licensee to manage or operate the facility or service? ☐ YES ☒ NO If yes, provide information similar to that required in (b) through (g) above.**

Response: Not applicable. The facility will be owned and operated by the applicant/licensee, Amisub of South Carolina, Inc.

(j) **Is there any agreement, contract, option, understanding, intent or other arrangement that will effect a change in any of the information requested and/or provided in (b) through (g) above. ☐ YES ☒ NO If yes, provide information similar to that required in (b) through (g) above.**

Response: Not applicable. There is no agreement, contract, option, understanding, intent or other arrangement that will effect a change in any of the information requested in parts (b) through (g) above.

(k) **Provide a complete listing of all existing licensed health care facilities and/or services and Certificates of Need in which the proposed licensee currently has an ownership interest, to include names and addresses of each facility or service. In the cases of Certificates of Need for undeveloped facilities and services, provide the name, address, and telephone number of a contact person representing the authority which issued the Certificate of Need.**

Response: Amisub of South Carolina, Inc., currently operates Piedmont Medical Center and will own and operate the Fort Mill Medical Center. Piedmont Medical Center is an equity owner with HEALTHSOUTH Corporation of Piedmont HEALTHSOUTH Rehabilitation, LLC, 1795 Frank Gaston Boulevard, Rock Hill, S.C. Piedmont Medical Center is also an equity owner with Carolinas Physician Network, Inc. (an affiliate of Carolinas Healthcare System) of Piedmont/Carolinas Radiation Therapy, LLC, which provides radiation therapy services as Rock Hill Radiation Therapy Center at 228 South Herlong Avenue, Rock Hill, S.C.

(l) **Should the licensee be a subsidiary corporation, provide a diagram of the licensee's relationship to the parent corporation and list the name and address of the parent corporation as well as the corporation which has ultimate control. In addition, please provide the name and mailing address of all persons and/or legal entities having ownership interest of 5 percent or more or any person with any agreement, contract, option, arrangement, or intent to acquire ownership interest of 5 percent or more, of all corporations in the corporate organizational structure which have ultimate control of the licensee.**

Response: An organizational chart illustrating the relationship between Amisub of South Carolina, Inc., Tenet South Carolina, Inc., and Tenet Healthcare Corporation is provided as **Attachment F**.

(9) Provide documentation that the applicant has sought cooperative agreements such as transfer agreements with other facilities, as applicable.

Response: Amisub of South Carolina, Inc., through Piedmont Medical Center, has transfer agreements with a variety of providers including Richland Memorial Hospital. Since Fort Mill Medical Center will be an affiliated hospital of Piedmont Medical Center, it will seek the same cooperative agreements currently in place between Piedmont and other health care facilities. Additionally, FMMC and Piedmont will have transfer provisions between the two facilities.

(10) Indicate the means by which a person will have access to the facility's services (i.e. physician referral, self admission, etc.) Identify the specific facilities or agencies the applicant expects to receive referrals from (i.e. hospitals, home health agencies, etc.) Describe any limitations placed on admissions.

Response: Patients will have access to Fort Mill Medical Center services by self-referral and by internal and external physician referral. Referrals will originate from private physician practices, public clinics, and other hospitals. There will be no limitations placed on admissions. All patients in need of emergent care will be accepted at the Fort Mill Medical Center regardless of age, sex, race, religion, national origin, or ability to pay.

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

Response:

Background

Piedmont Medical Center (Piedmont) is a 288-bed acute care facility (including 20 psychiatric beds) located in York County, Rock Hill, South Carolina. Founded in 1983, Piedmont is the sole acute care provider in York County and offers a full range of services including acute care, emergency and critical care, women's services, and education and community support programs. Piedmont also offers pain care, neonatology, and neurosurgical services as well as a sleep disorder center and a wound care center. Additionally, Piedmont offers a full range of cardiac services including diagnostic and therapeutic catheterization, open heart surgery, and cardiac rehabilitation.

The 2004-2005 South Carolina Health Plan shows that Piedmont Medical Center has a need for 64 additional acute care beds based on the current utilization at Piedmont and expected population growth in York County.

Figure 7
Piedmont Medical Center
FY 2010 Hospital Bed Need

Age Category	Population 2003	Population 2010	2003 Patient Days	Projected ADC	Bed Need (a)	Existing Beds	Need/ (Excess)
<18	44,300	45,910	2,937	8.34			
18-64	110,120	125,480	36,863	115.08			
65+	17,670	20,910	33,632	109.04			
Total	172,090	192,300	73,432	232.46	332	268	64

Source: 2004 State Health Plan.
(a) Based on 70% occupancy

Rather than adding these to the existing site in Rock Hill, Piedmont proposes the construction of an affiliated hospital in the high growth area of Fort Mill, York County, approximately 10 miles from Piedmont to better serve the residents of northern York County who are currently traveling to Rock Hill and out of state for acute care services.

In order to best serve the residents of Fort Mill, Piedmont proposes to add the 64 beds at Fort Mill Medical Center, and transfer an additional 36 beds from Piedmont to build a larger, more efficient hospital that will accommodate the future growth of the community and reduce the outmigration of residents to other states.

Revised **Figure 8**
Existing and Proposed Licensed Beds at Piedmont Medical Center and Fort Mill Medical Center

	Existing	Proposed	Variance
Piedmont Medical Center			
General Acute Care Beds Staffed	249	232	(17)
General Acute Care Beds Not Staffed	19	0	(19)
Total General Acute Care Beds	268	232	(36)
Psychiatric Beds	20	20	0
Piedmont Medical Center Subtotal	*288*	*252*	(36)
Fort Mill Medical Center			
Projected Need 2004 - 2005 State Health Plan	0	64	64
Transfer of beds from PMC	0	36	36
Fort Mill Medical Center Subtotal	*0*	*100*	100
Total Licensed Beds	**288**	**352**	

Source: 2009 Joint Annual Report.

A new 100-bed facility in Fort Mill will better serve the community and create additional access to the quality services historically provided to the residents of the area by Piedmont. Fort Mill is an area experiencing substantial population growth as the result of abundant residential and commercial development, which is projected to continue into the future. The long range plan is to build additional bed capacity and medical office buildings, as needed, in order to provide a comprehensive medical services campus in support of the explosive population growth projected for the area. By relocating the beds to the Fort Mill area, it will allow residents in the fast growing area access to services closer to home and their community.

The proposed facility will be located at the intersection of SC Highways 160 and 21 in Fort Mill, and will be named Fort Mill Medical Center. Fort Mill Medical Center will be built on approximately 40 acres in a development within Kingsley Village, which includes both residential and commercial development. The hospital will encompass approximately 16.75 acres, leaving approximately 23 for future development for other health care services.

The services offered at Fort Mill Medical Center will be in addition to, and complementary to, the services offered at Piedmont. Piedmont will continue to offer its existing complement of comprehensive services while the Fort Mill Medical Center will operate as a community-based affiliated hospital offering a more basic set of services.

The services to be offered at the Fort Mill Medical Center are the following:

24-Hour Emergency Department
Imaging Services, including Fixed-Base MRI and CT
Intensive Care Unit
Surgical Services
Women's Services, including 8 obstetrics beds
Medical/Surgical Beds

The original CON application also proposed a diagnostic cardiac catheterization lab. Since the filing of the original CON application, utilization in the defined service area has declined below the threshold for need as outlined in the State Health Plan, therefore a new cardiac catheterization provider cannot be approved at this time. As a result, the current revised application has excluded this service. Piedmont will monitor the utilization levels and continue to develop a strategy to provide diagnostic cardiac catheterization at the Fort Mill Medical Center, at the appropriate time.

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Fort Mill Medical Center Service Area Definition

The original CON application defined the Fort Mill Medical Center as primarily serving the residents of four ZIP Codes within northeast York County: 29708, 29715, 29730, and 29732. The secondary service area is comprised of the other ZIP Codes that make up York County. Since that time, a portion of ZIP Code 29715 was divided to create a new ZIP Code, 29707. Since this area was previously included within 29715, the ZIP Code has been added to the new primary service area definition. A map of the original Fort Mill Medical Center's proposed service area and the revised service area is included on the following pages.

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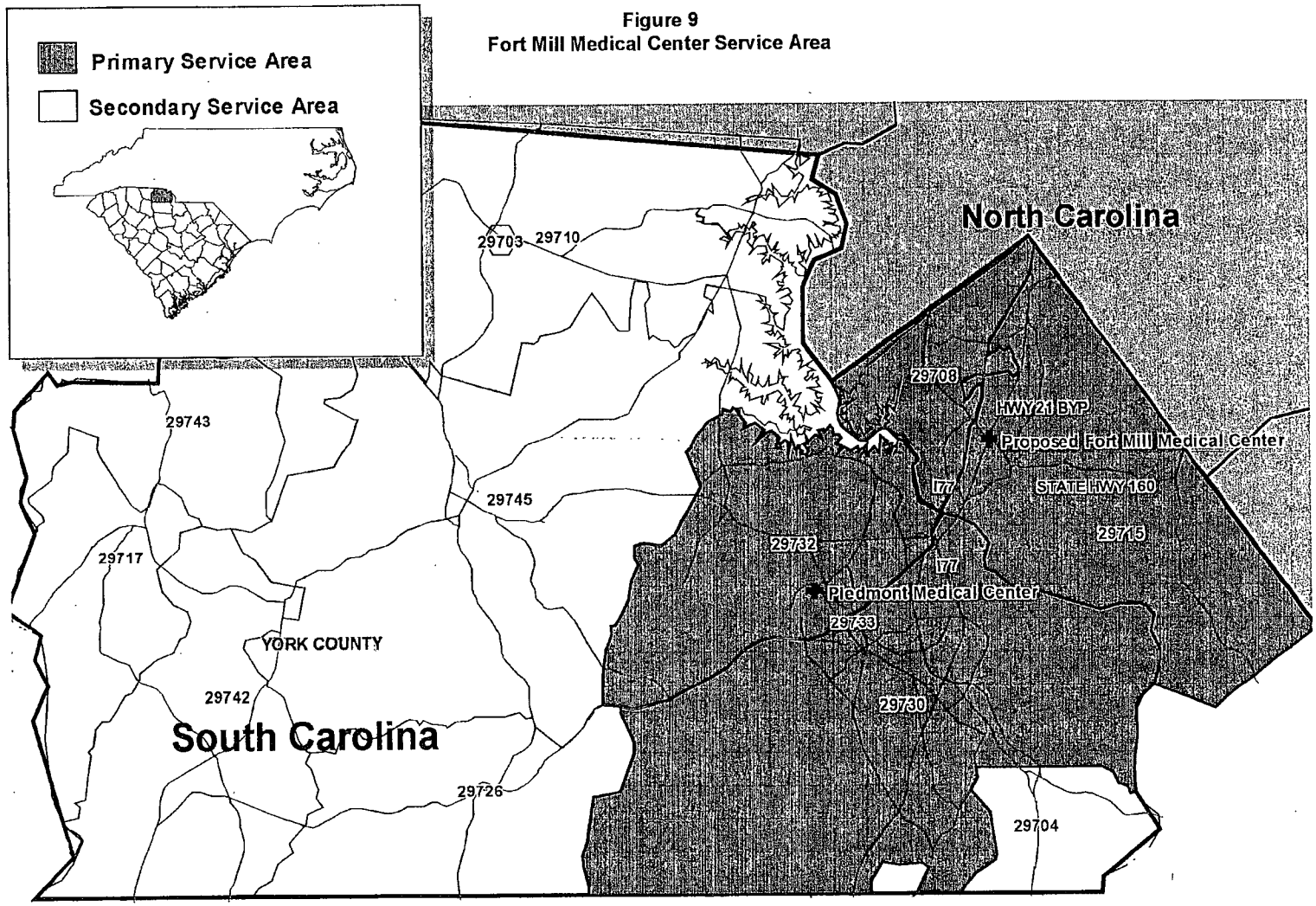
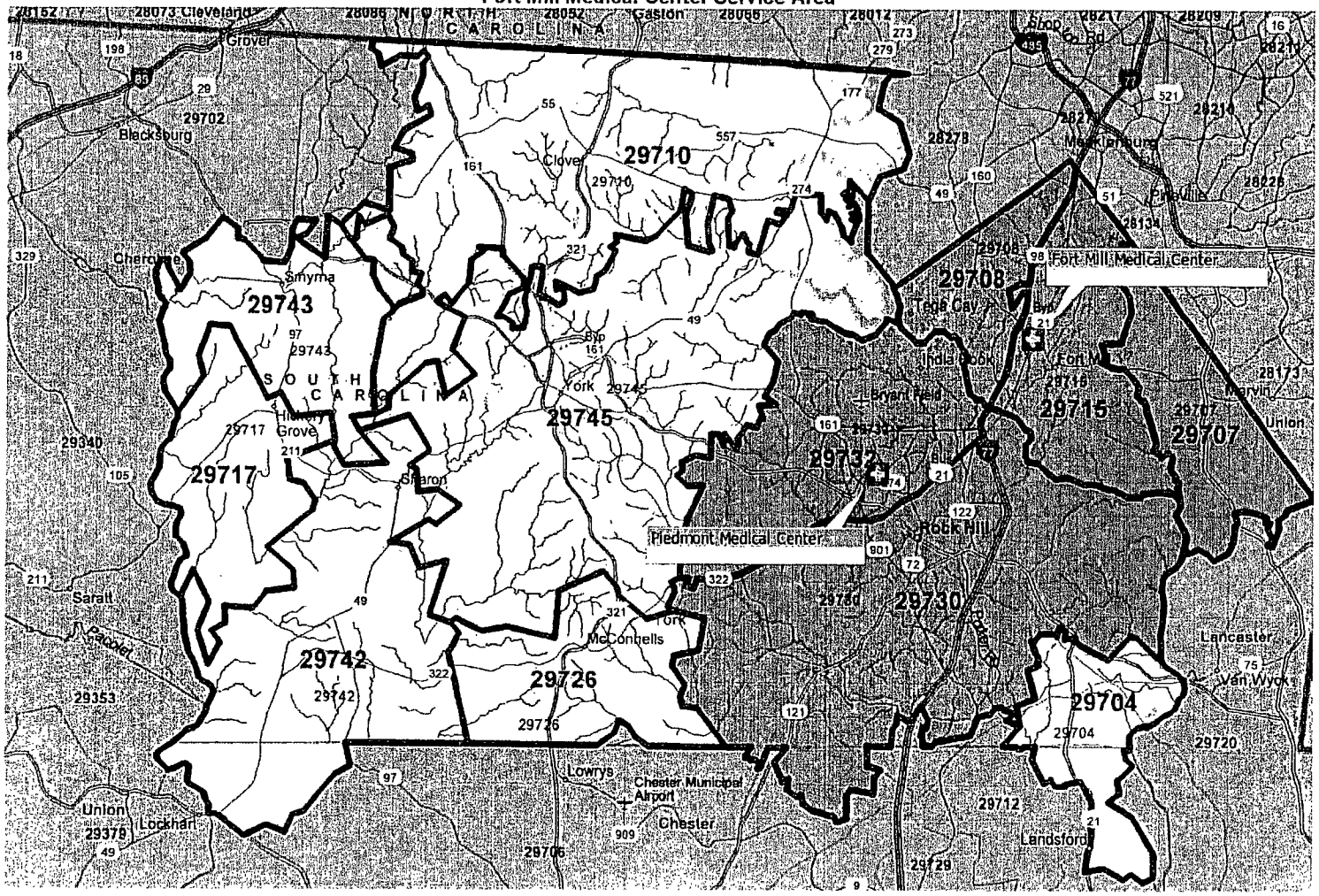
Figure 9
Fort Mill Medical Center Service Area



RECORD 002210
Pied.Supp.CON.0024
JOINT-B-PMC-001.0026

***Revised* Figure 9**
Fort Mill Medical Center Service Area



RECORD 002211
Pled.Supp.CON.0025
JOINT-B-PMC-001.0027

***Revised* Figure 10**
Primary and Secondary Service Area
Fort Mill Medical Center

	ZIP Code	ZIP Name
Primary Service Area	*29707*	*Fort Mill*
	29708	Fort Mill
	29715	Fort Mill
	29730	Rock Hill
	29732	Rock Hill
Secondary Service Area	29704	Catawba
	29710	Clover
	29717	Hickory Grove
	29726	Mc Connells
	29742	Sharon
	29743	Smyrna
	29745	York

These ZIP Codes in the primary service area represent the growing area of northern York County, and will create increased access to services for those residents currently leaving the area for services.

Fort Mill Medical Center Demographic Profile

As shown in revised Figure 11, the population in the five ZIP Codes comprising Fort Mill Medical Center's primary service area is projected to grow 14.5 percent between 2010 and 2015. This projected growth represents approximately 24,700 residents over the five-year time period. The growth projected for Fort Mill Medical Center's primary service area is greater than that projected for York County, and the State of South Carolina as a whole. The four ZIP Codes in the primary service that are located in York County are projected to represent 70 percent of the population in York County by 2015.

***Revised* Figure 11**
Fort Mill Medical Center
Service Area Population Projections

ZIP Code	2010	2015	Percent Change
29707	12,028	13,740	14.2%
29708	18,713	21,812	16.6%
29715	22,234	25,950	16.7%
29730	59,547	67,076	12.6%
29732	58,214	66,858	14.8%
PSA	**170,736**	**195,436**	**14.5%**
SSA	**70,778**	**80,260**	**13.4%**
York County	**229,473**	**262,113**	**14.2%**
South Carolina	**4,581,525**	**4,853,506**	**5.9%**

Source: Claritas, Inc., Aug 2010.

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.

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Additionally, the number of primary service area residents over the age of 65 is projected to grow approximately 38 percent between 2010 and 2015, as compared to approximately 20.7 percent statewide. Additionally, the 65+ population in York County is projected to grow by nearly 37 percent, or 9,744 residents, by 2015. This growing elderly population will require increasing access to healthcare services in the future. Revised Figure 12 details the projected growth in the 65+ population in the proposed primary service area.

***Revised* Figure 12**
Fort Mill Medical Center
Primary Service Area Population Age 65 and Over

ZIP Code	65+ 2010	65+ 2015	Percent Change
29707	1,464	2,103	43.6%
29708	1,996	3,010	50.8%
29715	2,649	3,740	41.2%
29730	6,233	8,367	34.2%
29732	7,063	9,517	34.7%
PSA	**19,405**	**26,737**	**37.8%**
SSA	**8,470**	**11,500**	**35.8%**
York County	**26,387**	**36,131**	**36.9%**
South Carolina	**634,633**	**766,067**	**20.7%**

Source: Claritas, Inc., Aug 2010.

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.

As stated in question B.11, population statistics used in all analyses must be consistent with those generated by the State Demographer of the State Budget and Control Board. The source for these population projections is Claritas, Inc., as ZIP Code-level projections are not available from the South Carolina State Demographer. A comparison of the area county-wide population projections from Claritas, Inc., and from the South Carolina State Demographer is included in **Attachment G**. The population projections calculated by Claritas, Inc., are consistent with those of the South Carolina State Demographer and are therefore reasonable population data to be used in the absence of ZIP Code-level projections from the South Carolina State Demographer.

Fort Mill Residential and Commercial Development

There is significant residential and commercial development, and subsequent population growth, projected for the Fort Mill area which is not accounted for in the Claritas, Inc., or South Carolina State Demographer population projections. Several articles from Fort Mill media sources citing the various residential and commercial developments in progress in the area are provided in **Attachment H**. Additionally, the following are examples of the residential development currently underway in and around Fort Mill. The time frame for completion of these projects ranges from 3 to 30 years. It is clear that the residential and commercial development in Fort Mill is an ongoing phenomenon that will require significant infrastructure improvements, such as access to healthcare, as the service area population density continues to grow. Kingsley Village, detailed following, is the site for the proposed Fort Mill Medical Center.

- **Baxter Village: 1,400** homes and townhomes (estimated build-out 2012), located in a village with a town center and shops, an elementary school, a public library, YMCA, the Piedmont Urgent Care Center, Piedmont Imaging Center, and numerous parks and trails. In addition, approximately 420,000 s.f. of commercial space with retail 97 percent leased and office 85 percent leased.

- **Tega Cay:** A recreational community based on a mini-cities concept, which is located on the shores of Lake Wylie. In addition to residential development, Tega Cay has its own police department, public works department and administrative staff, including a mayor.

- **Regent Park:** 2,300 homes to be built over the next three to five years.

- **Gold Hill Commons (near Knights Stadium):** 325-unit apartment complex, loft-style apartments, two large and eight smaller business office buildings attracting a significant number of employees, retail space, restaurants, a hotel, and movie theater to be built over the next ten years.

- **Springfield Village North and Kingsley Village:** Springfield Village North has 600 homes planned and approximately 320,000 s.f of commercial space. Kingsley Village has a combined 1,100 homes and 4 million square feet of commercial and industrial space. The total 1,750 acres will be developed over the next 30 years.

- **Sun City Carolina Lakes:** Del Webb plans to complete this 3,600 home retirement community over the next 10 years in the Lancaster County Panhandle. The community will eventually include a public golf course and shopping centers. Del Webb is also currently seeking approval to develop another 1,500-home retirement community across US 521 from Carolina Lakes.

- **St. Katharine:** 2,200 homes to be built in the Lancaster County panhandle, proximate to Fort Mill.

The York County 2025 Comprehensive Plan, published April 2004, recognizes the proliferation of housing and commercial developments in York County and calls for the simultaneous development of infrastructure systems such as water/sewer, community support facilities, and adequate access to healthcare for the growing population. The proposed Fort Mill Medical Center will create additional access to quality services for the growing Fort Mill area.

York County Out-Migration

In 2009, according to North Carolina inpatient data, 8,339 residents of the proposed Fort Mill Medical Center service area left the state to seek inpatient services in North Carolina. This out-migration pattern suggests the existing bed capacity and distribution in York County is not sufficient to serve all its residents. The proposed Fort Mill Medical Center will be easily accessible and convenient to the residents of northeast border York County, which is contiguous to North Carolina, and FMMC will be a local hospital from which the service area residents can seek services, rather than traveling out of state for care. The proposed facility will increase access to healthcare services and will aim to attract the majority of the patients who are out-migrating for care.

The volume of out-migration for residents of the northern portion of York County has increased since the original CON application. This supports the argument that the lack of a hospital in that area has led to increasing outmigration. Allowing Piedmont to develop the proposed project will give South Carolina residents the ability to seek treatment in their community.

Utilization Projections: Acute Care Beds

In 2009, the proposed five-ZIP Code primary service area generated 10,125 medical/surgical and ICU inpatient discharges, excluding normal newborns, obstetrics, cardiac catheterization, open heart surgery, and psychiatry. Of these, 4,310 sought care at North Carolina facilities, while 5,815 were treated by South Carolina facilities. Approximately 93 percent of the patients who sought care in South Carolina were treated by Piedmont Medical Center. The following table illustrates the distribution of inpatient discharges from the five-ZIP Code primary service area, highlighting the out-migration to North Carolina facilities, as well as Piedmont's current share of service area discharges from both North and South Carolina facilities.

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

	Discharges				PMC
ZIP Code	PMC	NC	Other	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: 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.

The 2009 medical/surgical and ICU discharges (excluding obstetrics, open heart surgery, cardiac catheterization, and psychiatry), and resulting use rates per 1,000 population for the five ZIP Codes comprising Fort Mill Medical Center's proposed primary service area are shown in Revised Figure 14. The use rate for the PSA ZIP Codes in aggregate was 60.9 discharges per 1,000 population in 2009.

***Revised* Figure 14**
Fort Mill Medical Center Service Area
Historical Inpatient Medical/Surgical and ICU Utilization

ZIP Code	2009 Discharges	2009 Population	2009 Use Rate/1,000
29707	627	11,712	53.5
29708	992	18,148	54.7
29715	1,608	21,557	74.6
29730	3,887	58,146	66.8
29732	3,011	56,624	53.2
PSA	**10,125**	**166,187**	**60.9**
SSA	**4,546**	**69,021**	**65.9**
York County	**14,076**	**223,450**	**63.0**
South Carolina	**363,060**	**4,528,986**	**80.2**

Source: Claritas, 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.
ZIP Code 29703 was combined with 29710, and 29731, 29733 and 29734 were combined with 29730.

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The ZIP Codes in the proposed primary service area have historically generated a lower use rate for inpatient medical/surgical and ICU services than York County, and the state as a whole. The 2009 inpatient medical/surgical and ICU use rate per 1,000 population for York County was 63.0, and the state use rate was 80.2. The low use rate for medical/surgical and ICU inpatient services per 1,000 population in the proposed service area is inconsistent with the fact that the service area population is aging at a rate faster than the South Carolina average. The development of Fort Mill Medical Center will increase access, resulting in a positive impact on the use rate of inpatient services for the primary service area ZIP Codes in the long run.

In order to project the total medical/surgical and ICU discharges from the service area in 2015, 2016, and 2017, the first three years of operation, the 2009 use rate for each ZIP Code was held constant and applied to the projected population in each ZIP Code in each respective year. As shown in Revised Figure 15, there are projected to be a total of 11,903, 12,228 and 12,563 inpatient medical/surgical and ICU discharges for residents of Fort Mill Medical Center's primary service area in the years 2015, 2016 and 2017.

***Revised* Figure 15**
Fort Mill Medical Center Service Area
Projected Medical/Surgical and ICU Discharges
First Three Years of Operation

ZIP	Cases		
Code	2015	2016	2017
29707	736	755	776
29708	1,192	1,229	1,268
29715	1,936	1,996	2,059
29730	4,484	4,592	4,703
29732	3,555	3,655	3,758
PSA	11,903	12,228	12,563
SSA	5,104	5,234	5,368
York County	18,132	18,619	19,120

Source: Claritas, 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.
ZIP Code 29703 was combined with 29710, and 29731, 29733 and 29734 were
were combined with 29730.
Excludes OB, OHS, Cardiac Cath, and Psych.

It is assumed that the proposed Fort Mill Medical Center will not only serve Piedmont's existing patients originating from the primary service area, but will also serve to redirect a large number of the primary service area residents currently out-migrating to North Carolina for services. The following table shows the projected market share for the Fort Mill Medical Center service area for Fort Mill Medical Center and Piedmont.

Revised Figure 16
Fort Mill Medical Center Service Area
Projected Inpatient Medical/Surgical and ICU Market Share

	2004	2009	2015 Market Share			2016 Market Share			2017 Market Share		
Area	PMC	PMC	FMC	PMC	Combined	FMC	PMC	Combined	FMC	PMC	Combined
PSA	71.8%	53.7%	25.7%	46.4%	72.0%	30.2%	45.1%	75.3%	34.6%	42.9%	77.6%
SSA	54.0%	47.3%	2.7%	46.4%	49.0%	3.1%	47.4%	50.5%	3.6%	47.3%	50.8%
York County (a)	**66.4%**	**53.8%**	**19.4%**	**46.4%**	**65.7%**	**22.8%**	**47.6%**	**70.4%**	**26.1%**	**46.0%**	**72.2%**

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.

As illustrated above, the majority of the shift in marketshare at Piedmont has occurred in the PSA. 2017 projections reflect a redirection of the outmigration and a recapture of patients, primarily in the PSA, by both PMC and FMMC.

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 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 area has made it an attractive location for physicians who continue to establish offices in Fort Mill, 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 town of Fort Mill.
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		

Finally, Piedmont has an existing presence with the Piedmont Urgent Care Center and Piedmont Imaging Center in the Baxter Village area of Fort Mill.

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The following table summarizes the projected discharges from the proposed service area at Fort Mill Medical Center in the first three years of operation.

***Revised* Figure 17**
Fort Mill Medical Center Service Area
Projected Medical Surgical and ICU Discharges

	Year 1 2015	Year 2 2016	Year 3 2017
29707	303	366	419
29708	579	702	816
29715	851	1,033	1,211
29730	745	898	1,071
29732	577	698	834
Primary Service Area	**3,056**	**3,697**	**4,351**
Secondary Service Area	140	169	199
Service Area Total	**3,196**	**3,866**	**4,549**

Source: Claritas, 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.
Excludes OB, OHS, cardiac Cath, and Psych.

It is expected that Fort Mill Medical Center will draw 90 percent of its cases from the primary and secondary service area and that the remaining 10 percent will come from areas outside the service area. In total for medical/surgical and ICU discharges, there will be a projected 3,551, 4,296 and 5,055 discharges at the Fort Mill Medical Center in each of the first three years of operation. Assuming a 3.8 overall length of stay, these projected medical/surgical and ICU discharges will result in 13,494, 16,324 and 19,208 patient days in 2015, 2016 and 2017. The following table summarizes these projections and illustrates the projected ADC and occupancy for the Fort Mill Medical Center during the first three years of operation.

***Revised* Figure 18**
Fort Mill Medical Center
Projected Medical Surgical and ICU
Discharges and Utilization Statistics

	Year 1 2015	Year 2 2016	Year 3 2017
Service Area Total	3,196	3,866	4,549
All Other (10%)	355	430	505
Total Discharges	**3,551**	**4,296**	**5,055**
LOS	3.8	3.8	3.8
Total Patient Days	13,494	16,324	19,208
ADC	37.0	44.7	52.6
Beds	92	92	92
Occupancy	**40.2%**	**48.6%**	**57.2%**

Source: Claritas, 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.
Excludes OB, OHS, Cardiac Cath, and Psych.

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As illustrated by Figure 18, the projected medical/surgical discharges in the proposed service area, coupled with the discharges expected to come from outside the service area, are sufficient to generate utilization that results in occupancy of approximately 57 percent in 2017, the third year of operation, at FMMC. This level of occupancy in Year 3 results in an occupancy rate that is approximately 90 percent of the threshold occupancy identified in the Health Plan for additional beds (57.2 is 90 percent of 65 percent).

Utilization Projections: Obstetrical Beds

Fort Mill Medical Center will be a community hospital serving the needs of residents in York County. As part of meeting the needs of the community, the new facility will provide Level 1 Community Perinatal Services. As described in the 2004-2005 South Carolina Health Plan, "these hospitals provide services for uncomplicated deliveries and normal neonates." In addition, the plan states that "this description does not constitute Certificate of Need review criteria." The proposed facility will have an obstetrical unit with 8 licensed obstetrical beds.

The total female 18-44 population in the primary service area is projected to grow 7.3 percent over the next five years, which is significantly higher than the projected growth rate of the state at 0.9 percent, as shown in Figure 19. The female population ages 18–44 in York County is projected to grow 72 percent between 2010 and 2015. This considerable and growing population base of females of childbearing age supports the need for additional obstetrical beds in York County.

***Revised* Figure 19**
Fort Mill Medical Center
Females Aged 18–44 Population Projections
Proposed Service Area

	Females 18-44		Percent
ZIP Code	2010	2015	Change
29707	2,013	2,158	7.2%
29708	3,233	3,552	9.9%
29715	3,773	4,092	8.5%
29730	13,258	14,027	5.8%
29732	10,810	11,682	8.1%
PSA	**31,074**	**33,353**	**7.3%**
SSA	**12,560**	**13,396**	**6.7%**
York County	**43,642**	**46,782**	**7.2%**
South Carolina	**819,187**	**826,381**	**0.9%**

Source: Claritas, Inc., August 2010.

In 2009, the proposed service area had 3,157 obstetrical discharges. Of these discharges, 1,051 service area residents sought care in North Carolina, while 1,947 were treated by South Carolina facilities. Approximately 96 percent of those residents who sought obstetrical care in South Carolina were treated by Piedmont Medical Center.

Revised Figure 20
Fort Mill Medical Center Service Area
Distribution of 2008 Obstetrical Discharges

ZIP Code	Obstetrical Discharges PMC	NC	Other	Total	PMC Market Share
29707	32	154	7	193	16.6%
29708	78	233	6	317	24.6%
29715	155	220	13	409	43.0%
29730	672	134	16	867	82.7%
29732	510	147	9	695	77.6%
PSA	**1,415**	**734**	**44**	**2,288**	**61.8%**
SSA	**532**	**317**	**20**	**869**	**61.2%**
Total	**1,947**	**1,051**	**64**	**3,157**	**61.7%**

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.
Similarly, ZIP Code 29703 was combined with 29710, and 29731, 29733 and 29734 were combined with 29730.
Includes MS-DRGs 765-770 and 774-782.

The obstetrical use rate in York County in 2009 was 75.1 discharges per 1,000 female population 18-44, which was consistent with the state rate of 77.9 obstetrical discharges per 1,000 female population 18-44.

Revised Figure 21
Fort Mill Medical Center Service Area
Historical Obstetrical Utilization

ZIP Code	2009 Discharges	2009 Population	2009 Use Rate/1,000
29707	193	1,985	97.2
29708	317	3,173	99.9
29715	417	3,712	112.3
29730	872	13,109	66.5
29732	759	10,644	71.3
PSA	**2,365**	**30,638**	**77.2**
SSA	**869**	**12,400**	**70.1**
York County	**3,232**	**43,040**	**75.1**
South Carolina	**63,728**	**817,756**	**77.9**

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.
Similarly, ZIP Code 29703 was combined with 29710, and 29731, 29733 and 29734 were combined with 29730.
Includes MS-DRGs 765-770 and 774-782.

In order to project obstetrics discharges for the proposed project, the 2009 obstetrical use rate for each ZIP Code was applied to the projected service area female population aged 18–44, which results in a total of 2,657 projected obstetrical discharges in the primary service area in 2017. Using a conservative approach, there was no change in the use rate across the projection period.

Revised Figure 22
Fort Mill Medical Center Service Area
Projected Obstetrical Cases

ZIP Code	2015	2016	2017
29707	210	213	216
29708	355	362	369
29715	460	467	475
29730	933	944	954
29732	833	846	859
PSA	2,581	2,619	2,657
SSA	938	951	963
York County	3,513	3,562	3,612

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. Similarly, ZIP Code 29703 was combined with 29710, and 29731, 29733 and 29734 were combined with 29730.
Includes MS-DRGs 765-770 and 774-782.

Fort Mill Medical Center is expected to have similar OB market share as that defined for the medical/surgical and ICU discharges, in the proposed service area. In addition, it is projected that Fort Mill Medical Center will receive an additional 10 percent of its obstetrics discharges from areas of South Carolina that are outside the service area. It is projected that by the third year of operation, Fort Mill Medical Center will reach 891 obstetrics discharges. The following table illustrates the projected obstetrical utilization at the proposed new facility.

Revised Figure 23
Fort Mill Medical Center
Projected Obstetrical Statistics

	Year 1 2015	Year 2 2016	Year 3 2017
Total Discharges	761	822	891
LOS	2.3	2.3	2.3
Total Patient Days	1,750	1,890	2,050
ADC	4.8	5.2	5.6
Beds	8	8	8
Occupancy	59.9%	64.7%	70.2%

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.
Similarly, ZIP Code 29703 was combined with 29710, and 29731 & 29733 were combined with 29730.
Includes MS-DRGs 765-770 and 774-782.

The development of a new obstetrics service will increase access to these services by enhancing the geographic distribution of beds within York County. The proposed location of the facility will help to decrease out-migration to other areas for obstetrics services for residents of the Fort Mill area.

Utilization Projections: Acute Care Bed Summary

Fort Mill Medical Center will have a total of 100 acute care beds. This will include 82 general medical/surgical beds, 10 ICU beds, and 8 obstetrical beds. Based on the need projections provided above, Fort Mill Medical Center will have 5,946 discharges in 2017 with 21,258 patient days, and an average length of stay of 3.6 days.

***Revised* Figure 24**
Fort Mill Medical Center
Total Projected Utilization

	Year 1 2015	Year 2 2016	Year 3 2017
Total Discharges	4,312	5,117	5,946
LOS	3.5	3.6	3.6
Total Patient Days	15,244	18,214	21,258
ADC	41.8	49.9	58.2
Beds	100	100	100
Occupancy	**41.8%**	**49.9%**	**58.2%**

Source: Claritas, SC State Budget and Control Board, Office of Research and Statistics, Polaris.

Piedmont Medical Center currently has 268 acute care beds. In order to better serve the needs of the growing population in the Fort Mill area, 36 acute care beds from Piedmont Medical Center will be transferred to Fort Mill Medical Center, resulting in 232 acute care beds at Piedmont. It is assumed that a portion of the general medical/surgical patients currently seeking care at Piedmont Medical Center will be redirected to the more conveniently located Fort Mill Medical Center. Even with the redirection of patients, Piedmont Medical Center is expected to operate at approximately 66 percent occupancy in 2017. Piedmont Medical Center will continue to provide the tertiary level services, like open heart surgery, angioplasty, and neonatal care that will not be provided at Fort Mill Medical Center to the majority of the residents in Piedmont's service area.

The utilization at Piedmont Medical Center is based upon actual historical utilization, and assumes that patients will seek services at Piedmont Medical Center from outside of the proposed Fort Mill Medical Center service area, consistent with historical experience. The projected utilization at Piedmont Medical Center 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 Statistics, Polaris.

The following table summarizes the combined utilization of Fort Mill Medical Center and Piedmont Medical Center in the first three years of operation. It is projected that the combined entities will have over 76,564 patient days in 2017, operating at 63.2 percent utilization.

Revised Figure 26
Fort Mill Medical Center and Piedmont Medical Center
Projected Combined Utilization

	Year 1 2015	Year 2 2016	Year 3 2017
Total Discharges	17,187	18,156	19,005
LOS	4.1	4.1	4.1
Total Patient Days	70,763	74,354	77,347
ADC	193.9	203.7	211.9
Beds	332	332	332
Occupancy	**58.4%**	**61.4%**	**63.8%**

Source: Claritas, SC State Budget and Control Board, Office of Research and Statistics, Polaris.

Based on the projected utilization at both facilities, the projected market share for each of the facilities is reasonable and consistent with Piedmont's historical performance. The projected market share for the two facilities is projected to increase in the proposed Fort Mill Medical Center service area as a result of more South Carolina residents seeking care at the more conveniently located Fort Mill Medical Center, rather than out migrating to North Carolina.

Revised Figure 27
Fort Mill Medical Center Service Area
Projected Market Share

	2015 Market Share			2016 Market Share			2017 Market Share		
Area	FMC	PMC	Combined	FMC	PMC	Combined	FMC	PMC	Combined
PSA	24.5%	44.9%	69.4%	28.4%	44.0%	72.4%	32.2%	42.5%	74.7%
SSA	2.7%	49.5%	52.1%	3.1%	49.5%	52.6%	3.5%	49.4%	53.0%
York County	**18.8%**	**48.2%**	**67.0%**	**21.8%**	**47.6%**	**69.4%**	**24.7%**	**46.5%**	**71.1%**

Source: Claritas, SC Office of Research and Statistics and Polans.

Utilization Projections: MRI

The proposed Fort Mill Medical Center will include one fixed-base MRI to be housed in the Imaging Department. According the standards for MRI outlined in the 2004-2005 South Carolina Health Plan, each hospital should have at least one MRI unit available for the diagnosis of patients. MRI standards are no longer in the current South Carolina State Health Plan.

In 2004, MRI providers in York County were operating at a combined utilization of 91.9 percent of capacity (defined as 2,500 scans annually). As shown in Figure 38, Piedmont's MRI units operated at 92 percent of capacity. Also, it is important to note that the Metrolina Neurodiagnostics Center MRI is located in a private physician office and is available only to patients of that practice. The residents of the proposed primary service area will benefit from an MRI scanner at FMMC, which will increase access and convenience. This additional MRI will not adversely affect the existing providers in York County due to the fact that it will serve existing Piedmont patients, and will reduce the burden on the two existing units at Piedmont.

Additionally, as MRI continues to evolve into a standard diagnostic tool for an expanded range of disorders, the proposed 3.0T magnet will enable Fort Mill Medical Center to offer advanced imaging procedures that are not readily available in the service area. The original CON application included a 1.5T MRI. Current equipment estimates indicate that a 3.0T MRI would only cost marginally

(approximately $320,000) more than a 1.5T MRI. Given the increased magnet strength, Piedmont is currently planning on acquiring the 3.0T MRI.

Utilization Projections: Diagnostic Cardiac Catheterization

The original proposed Fort Mill Medical Center CON application included one diagnostic cardiac catheterization lab. At that time,

The 2004-2005 South Carolina Health Plan defines the service area for a diagnostic catheterization laboratory as all facilities within 45 minutes' one-way automobile travel time. **Attachment I** includes a map depicting the 45-minute contour from the proposed Fort Mill Medical Center. As the map shows, Piedmont Medical Center and Springs Memorial Hospital (SMH) are the two hospitals located within a 45-minute drive of the proposed Fort Mill Medical Center site. Piedmont Medical Center provides both diagnostic and therapeutic catheterization services. SMH offers diagnostic catheterization services only. The following table details the historical utilization for these providers at the time of the original Con application.

Figure 29
Fort Mill Medical Center Service Area
Historical Cardiac Catheterization Utilization
Piedmont Medical Center and Springs Memorial Hospital

	2000	2001	2002	2003	2004
Total Diagnostic Caths	2,622	3,146	3,808	3,569	2,541
Total Therapeutic Caths	633	639	928	1,007	943
Total	**3,255**	**3,785**	**4,736**	**4,576**	**3,484**
Total Equivalents	**3,888**	**4,424**	**5,664**	**5,583**	**4,427**
Total Labs	3	3	3	3	4
Per Lab	1,296	1,475	1,888	1,861	1,107
Capacity	1,200	1,200	1,200	1,200	1,200
Occupancy	108.0%	122.9%	157.3%	155.1%	92.2%

Source: 2004-2005 State Health Plan, 2004 JARs.

One of DHEC's standards for the approval of a new cardiac catheterization service requires that the existing labs in the service area have performed at a combined use rate of 80 percent (960 equivalents) per lab for the most recent year.

***Revised* Figure 29**
Fort Mill Medical Center Service Area
Historical Cardiac Catheterization Utilization
Piedmont Medical Center and Springs Memorial Hospital

	2006	2007	2008	2009
Total Diagnostic Caths	2,055	1,840	2,139	1,989
Total Therapeutic Caths	828	798	864	759
Total	**2,883**	**2,638**	**3,003**	**2,748**
Total Equivalents	**3,711**	**3,436**	**3,867**	**3,507**
Total Labs	4	4	4	4
Per Lab	928	859	967	877
Capacity	1,200	1,200	1,200	1,200
Occupancy	77.3%	71.6%	80.6%	73.1%

Source: 2008 - 2009 SC State Health Plan and 2007-2009 JARs.

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As illustrated by *Revised* Figure 29, the four existing labs in FMMC's service area performed at a combined use rate of 73.1 percent of capacity in 2009. The existing providers do not meet the standard of having performed at a combined use rate of 80 percent (960 equivalents) per lab for the most recent year. For this reason, the revised application has deleted this service, since a new provider cannot be approved.

Adverse Impact

The proposed 100-bed Fort Mill Medical Center will primarily serve the residents of ZIP Codes 29707, 29708, 29715, 29730, and 29732. The facility will serve Piedmont's existing patient base and the increasing patient population projected for the area over the next decade. Furthermore, the Fort Mill Medical Center will serve to reduce the number of York County residents who are out-migrating to North Carolina for health care services. These patients are not currently utilizing South Carolina facilities, so the redirection of these patients to the Fort Mill Medical Center will not impact any existing South Carolina facilities. As previously discussed, a large percentage of the proposed service area residents who seek inpatient care are discharged from facilities in North Carolina. The proposed Fort Mill Medical Center aims to recapture the majority of these patients.

As shown in the previous bed need and service-specific projections, the patients projected to seek care at the Fort Mill Medical Center will more than support the proposed 100 beds in Fort Mill without adversely affecting any existing provider. Piedmont Medical Center is currently very well utilized and will redirect volume it currently captures from the proposed service area to Fort Mill Medical Center in order to achieve an optimal distribution of hospital services within the service area. Additionally, many residents of South Carolina traveled out of state for inpatient hospital services. Fort Mill Medical Center will focus on recapturing this volume. The 100 beds at the Fort Mill Medical Center will be at approximately 60 percent capacity by the third year of operation by capturing approximately 90 percent of the volume from service area ZIP Codes in addition to the 10 percent of discharges from other areas.

As the Fort Mill area continues to grow, there will be a sufficient medical infrastructure in place to support the proposed hospital. The physicians who currently practice in the Fort Mill area represent the following specialties:

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

Piedmont currently operates the Piedmont Urgent Care Center and Piedmont Imaging Center in the Baxter Village area of Fort Mill. The addition of an affiliated hospital in the Fort Mill area would not only enhance Piedmont's ability to serve patients in the Fort Mill area, but would strengthen its ability to serve York County as a whole.

It is not assumed that FMMC will 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. However, if either of the other applicants is awarded the CON, Piedmont will be adversely impacted. 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 Medical Center will help to fill the 36 beds from Piedmont and is simply a redistribution of beds within the county to better serve service area residents.

If a North Carolina provider is awarded the CON, then it is unreasonable to think that patients currently receiving care at Piedmont will not be redirected to the new facility. It is also unreasonable to assume that a North Carolina provider will only capture those patients going to North Carolina, and therefore have no adverse impact Piedmont. If one of the other applicants is awarded the CON, then it becomes a competitive situation, in which each facility will be seeking to find ways to direct Piedmont patients to their facility. The other applicants, in order to reach efficient occupancy levels, will seek to garner an increasing market share of the service area, to the detriment of the Piedmont Medical Center. It must be recognized that the awarding of the CON to one of the other facilities will negatively impact Piedmont. The negative impact would take the form of a substantial loss in patient volume and revenue that would require Piedmont to reduce personnel and services to residents of York County that it currently serves.

The following analysis quantifies the potential impact the approval of either of the North Carolina providers proposed hospital in Fort Mill would have on Piedmont Medical Center. The volume of patients redirected from Piedmont to the new facility would be substantial.

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** contains the detailed calculations.

Figure A
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 B
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.

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Figure C
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.

Figure D
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)**

A sensitivity analysis was also conducted to determine a possible range of impact if a higher or lower percentage market chare impact resulted from a North Carolina provider being approved for a new hospital in Fort Mill. The following summarizes the range.

Figure E
Sensitivity Analysis

Sensitivity 1

	PSA	SSA	Total
2009 Market Share	54.8%	50.3%	53.4%
2017 Projected Case	8,666	3,380	12,046
2017 Projected Case with NC Fort Mill Hospital	6,378	3,018	1,315
2017 Projected Maket Share at PMC with NC Fort Mill Hospital	40.1%	44.8%	41.5%
Reduced Cases	-2,288	-362	-2,650
PMC 2009 Contribution Margin	$3,915	$4,044	$3,933
Net Impact	**-$8,957,037**	**-$1,464,930**	**-$10,421,968**

Sensitivity 1 assumes 50% of cases redirected from PMC.

Sensitivity 2

	PSA	SSA	Total
2009 Market Share	54.8%	50.3%	53.4%
2017 Projected Case	8,666	3,380	1,315
2017 Projected Case with NC Fort Mill Hospital	5,054	2,806	7,860
2017 Projected Maket Share at PMC with NC Fort Mill Hospital	31.8%	41.7%	34.7%
Reduced Cases	-3,611	-574	-4,186
PMC 2009 Contribution Margin	$3,915	$4,044	$3,933
Net Impact	**-$14,140,289**	**-$2,323,356**	**-$16,463,644**

Sensitivity 2 assumes 80% of cases redirected from PMC.

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As illustrated, a larger impact of over 20 percentage points of market share at Piedmont totals $16.5 million dollars while a smaller impact of 14 percentage points of market share at Piedmont totals $10.4 million.

Summary

The need for an additional 100 beds, to be located at the Fort Mill Medical Center, is supported by the following:

1. The strong historical utilization of the existing beds at Piedmont;
2. High population growth in northeast York County;
3. Increasing residential and community development;
4. Existing maldistribution of hospital services within York County;
5. A high level of out-migration from the proposed service area to other North Carolina; and
6. Absence of adverse impact on existing providers due to redirection of Piedmont's existing volume.

Fort Mill is an area currently in the midst of significant growth and development. As it continues to expand and population density increases, infrastructure will be required to serve an area whose landscape has changed dramatically. The proposed location of Fort Mill Medical Center will place the facility in an area where there will be a great concentration of residents who will experience increased access to hospital services close to home, in addition to high quality care and an enhanced patient experience because of the size of the facility and its affiliation with Piedmont Medical Center. As such, the proposed location of the facility will result in a more desirable and effective distribution of hospital services within York County.

The need for an additional 100 beds in the area does not rely on the patient populations of other providers, as the projections for the proposed services were based on the capture of market growth that would have historically been served at Piedmont or by out-of-state facilities. There will be no impact on existing providers through the redirection of inpatient volume from South Carolina facilities, as Piedmont has historically captured over 93 percent of the inpatient discharges from South Carolina facilities that originated from the proposed service area.

The projections are conservative in that the potential impact of the Patient Protection and Affordable Care Act (PPACA) has not been factored in to the projections. The general consensus is that the impact of PPACA will be to increase utilization. As inpatient utilization increases, the need for additional beds will also increase.

(12) Discuss alternative facilities and/or services considered including the advantages and disadvantages of each alternative. Include a statement as to why this project alternative was adopted.

Response: During the development of this project, Piedmont considered four alternatives to the construction of the proposed facility.

Maintain the Status Quo

Piedmont considered doing nothing. However, the increasing outmigration in the northern portion of York County and the reduced marketshare at Piedmont warranted action to increase access for the community it serves in the northern part of South Carolina. In addition, if a North Carolina provider were to develop an acute care hospital in the northern portion of York County, the negative impact to Piedmont would be devastating. Maintaining the status quo would not address the continued outmigration to North Carolina.

Add 64 Beds to Piedmont Medical Center

Amisub of South Carolina, Inc., considered adding 64 beds to Piedmont rather than building the beds in Fort Mill, York County. This alternative was not pursued for several reasons. First, the development of 100 beds in Fort Mill provides greater geographic access to acute care services to Piedmont's existing patients. Adding 64 beds to Piedmont would not provide the same geographic access. Additionally, the population in the projected service area is projected to grow approximately 14 percent during the period between 2010 and 2015, and would greatly benefit from the addition of a 100-bed hospital. There are also factors which are expected to impact population growth in the area and are not reflected in the population projections published by Claritas, Inc., or the State Demographer. Significant development of residential and commercial properties in Fort Mill is currently underway and is expected to accelerate into the future. This increase in residential and business space will likely draw more residents into the proposed service area, specifically around the proposed site of the hospital. The placement of Fort Mill Medical Center in the Kingsley Village area will position it to meet the needs of a concentrated community population who would otherwise travel out of state for care.

Establish Fort Mill Medical Center

Amisub of South Carolina, Inc., initially looked at the establishment of a 64-bed hospital at Fort Mill. When the 64-bed hospital was proposed, it included shelled-in space on the fourth floor for expansion in the future. However, after considering the alternatives, the population growth in the area, and the historical practice patterns, it was determined that it would be more cost effective, and better for the community to transfer 36 beds from Piedmont Medical Center and build a 100-bed facility. By constructing a 100-bed facility, the cost of the additional beds is incremental, and overall more efficient and ultimately, less disruptive to patient care by avoiding a later expansion requiring a lengthy construction project. After carefully considering all of the alternatives, the Tenet Healthcare Corporation determined that building a 100-bed hospital would be the most efficient and cost effective alternative.

(13) Discuss any serious problems, such as costs, availability, or accessibility in obtaining care of the type proposed, experienced by patients in the absence of this project.

Response: In 2009, 8,339 service area residents sought inpatient care at North Carolina facilities. This out-migration pattern supports the argument that the bed capacity and distribution in York County is not sufficient to serve its residents. The vast majority of the patients seeking care outside the state are not seeking specialized services in distant metropolitan areas at Centers of Excellence such as Emory Healthcare, Johns Hopkins Hospital, or The Mayo Clinic. York County residents are traveling to North Carolina for routine care out of convenience. The proposed Fort Mill Medical Center will create additional, more convenient access to health care services and will attract the majority of these patients. The association with Piedmont will ensure high quality care at the proposed facility and will provide an alternative for York County residents to obtain care conveniently.

(14) **Where a project affects an increase or decrease in bed capacity, provide annual occupancy rates for the facility based on licensed beds, for the past three years by category (i.e. general acute, psychiatric, obstetric, nursing home, etc.)**

Response: The proposed project involves the addition of 100 beds. The following profiles Piedmont Medical Center's historical utilization.

***Updated* Figure 39**
Piedmont Medical Center
Historical Utilization

	2001	2002	2003	2004	2005	2006	2007	2008	2009
Beds	268	268	268	268	268	268	268	268	268
Inpatient Days	59,019	64,813	73,432	72,697	71,951	70,762	63,495	61,429	55,838
ADC	161.7	177.6	201.2	199.2	197.1	193.9	174.0	168.3	153.0
Percent Occupancy	60.3%	66.3%	75.1%	74.3%	73.6%	72.3%	64.9%	62.8%	57.1%

Source: 2001-2004 State Health Plan; 2004-2009 JARS.

Pied.Supp.CON.0045

(15) Identify the method of financing the cost of the project, including the start-up costs. Provide documentation that the applicant can obtain such financing. Alternative sources and/or methods of financing should be identified and the method chosen demonstrated to be the most feasible option.

Response: The proposed project, with a total cost of $146,522,042, will be funded by Tenet Healthcare Corporation, which is the ultimate parent company of Amisub of South Carolina, Inc. **Attachment J** is a letter from John Holland, Senior Vice President of Tenet's Southern States Region, that evidences the funds available and Tenet's commitment to finance the project.

During the first review period, the other applicants made exaggerated allegations about Tenet's financial stability. In fact, Tenet's financial record the past two years has been excellent, as documented in the attached articles. A brief chronology of Tenet's 2010 financial performance shows the following:

February 23: Modern Healthcare reports that Tenet's 2009 financial performance was the company's best in seven years.

May 4: Tenet's strong performance carries over into 2010, as Modern Healthcare reports the company's 1st Quarter operating earnings are its best in seven years.

May 24: J.P. Morgan announces that "Tenet will see a more favorable impact from healthcare reform then others in its sector."

July 1: Wells Fargo predicts high earnings for Tenet.

August 3: Modern Healthcare reports that Tenet's 2nd Quarter 2010 net income is $35 million, compared to $14 million for 2nd Quarter 2009.

September 10: Becker's Hospital Review reports that Tenet is the most cash-rich company in the U.S. healthcare facilities industry.

See **Attachment W** for copies of articles.

(16) **For an addition to an existing facility or service, provide a current annual budget and at least a three fiscal year projected budget for both the overall facility and the proposed project on forms provided by the department. The projections must be developed by an accountant. For a new facility or service, provide a projected annual budget for not less than three fiscal years following the completion of the proposed project on forms provided by the department. The projections must be developed by an accountant. These budgets must at a minimum include how proposed charges, proposed cost of service, utilization, depreciation, reimbursement rates and contractual adjustments were calculated. All assumptions used must be shown.**

Response: **Attachment K** contains the current annual budget and projected budget for both the Piedmont Medical Center location as well as the Fort Mill Medical Center site through the first five years after opening FMMC.

Pied.Supp.CON.0047

(17) Document that the proposed charges for the project are comparable to those established by other facilities for similar services within the health service area or state.

Response: The charges for services associated with the proposed project are comparable to those established by other facilities in the service area for similar services. The charges for services at the Fort Mill Medical Center will be based on, and will remain reasonable and consistent with, those currently in place at Piedmont.

The 2009 MedPar data for comparable providers illustrates that Piedmont's average charge per inpatient case was consistent with the charges of other area providers. There are no anticipated charge increases other than those necessary to offset inflation. Revised Figure 40 summarizes Piedmont's average charge per Medicare discharge Case Mix Adjusted for the 12-month period ended 9/30/2009, compared to other providers' charges for 2009. Detailed supporting information is included as **Attachment K.**

***Revised* Figure 40**
Average 2009 Charge Per Medicare Discharge
Piedmont Medical Center and Other Providers

	Average Charge	CMI	CMI Adjusted
Palmetto Health Baptist Columbia	$47,707	1.4596	$32,685
Palmetto Health Richland	$58,153	1.8898	$30,772
Presbyterian Orthopaedic Hospital	$49,248	2.2522	$21,867
Providence Hospital	$37,569	1.9148	$19,620
Carolinas Medical Center	$39,454	2.0206	$19,526
Presbyterian Hospital	$31,799	1.6596	$19,161
Piedmont Medical Center	**$30,972**	**1.6448**	**$18,830**
Carolinas Medical Center - Mercy	$29,818	1.6536	$18,032

Source: Medicare Provider Analysis and Review (MedPAR) data file FFY 2009.

In addition, Piedmont Medical Center has a contract with York County to provide services at rates that are not the highest among a select number of hospitals in the wider region. Fort Mill Medical Center will also be subject to the contract, ensuring that the costs at Fort Mill Medical Center are comparable to those at other facilities within the region. See **Attachment K** for an article in The Herald, a local newspaper in Rock Hill, discussing how Piedmont Medical Center has delivered on its pledge to lower rates; a copy of relevant sections of the York County Contract can be found in **Attachment W.** Between 2003 and 2004, Piedmont Medical Center lowered its rates by 13 percent.

(18) Document that the proposed project is economically feasible, both immediately and long-term. In the case of existing facilities, what impact will the proposed project have on patient charges and cost per unit of service?

Response: As evidenced by the financial projections included in **Attachment K**, the proposed project is feasible both immediately and in the long term. The proposed project will have no impact on patient charges and cost per unit of service and will remain consistent with Piedmont's historical experience.

(19) State how the project will foster cost containment and improve quality of care through the promotion of such services as ambulatory and home health care, preventive health care, promotion of shared services, economies of scale, and design and construction economies.

Response: The proposed Fort Mill Medical Center, as a community-based facility, will provide routine acute care services to complement the more extensive array of services currently provided by Piedmont. Through the development of a hospital in northeast York County, Piedmont is creating additional health service capacity and enhanced geographic distribution of hospital services, which will provide increased convenience to the residents of York County. The residents of the service area will have to travel less distance to the Fort Mill Medical Center to receive the high quality care which is offered at Piedmont. The quality and convenience of the proposed hospital will promote preventive care initiatives in the community.

The development of a 100-bed hospital also promotes design and construction economies. When the 64-bed hospital was proposed, it included shelled in space on the fourth floor for expansion in the future. However, after considering the alternatives, the population growth in the area, and the historical practice patterns, it was determined that it would be more cost effective, and better for the community to transfer 36 beds from Piedmont Medical Center and build a 100-bed facility. By constructing a 100-bed facility, the cost of the additional beds is incremental, and overall more efficient and less disruptive to patient care in the future to not have to undergo an expansion and lengthy construction project. By constructing the 100-bed hospital at this time, the cost per bed would be substantially reduced. Therefore, the development of 100-bed hospital promotes design and construction economies by reducing the cost per bed, and alleviating the need to incur additional construction costs in the future.

(20) **In the case of projects involving additional long-term care beds, discuss how the plans of other agencies, organizations, or programs responsible for providing and financing long-term care have been considered.**

Response: Not applicable. This proposal does not involve long-term care beds.

(21) Provide a three-year projected manpower budget in full-time equivalents (FTE's) detailing the existing and proposed nursing, other professional, and non-professional personnel required for the staffing of the new project. Include the name of the Nurse Supervisor or Director, if available.

Response: The following is the three-year projected manpower budget for the Fort Mill Medical Center. The nursing supervisor has not yet been identified.

***Revised* Figure 41**
Staffing Schedule

	Proposed FTEs				
	2015	2016	2017	2018	2019
Registered Nurse	116.10	137.60	162.10	167.90	174.80
Licensed Practical Nurse	2.60	3.30	3.90	4.00	4.10
Nursing Assistant	23.10	27.90	32.70	33.70	34.80
Pharmacist	6.00	6.10	7.20	7.50	7.70
Pharmacy Techs	6.00	6.60	7.80	8.10	8.50
Social Worker/Case Manager	4.50	5.90	7.00	7.30	7.60
Radiological Technician	19.10	22.90	27.10	28.10	29.20
Surgical Technician	7.00	9.00	11.00	11.00	11.00
Physical Therapist	4.10	5.00	6.00	6.20	6.40
Respiratory Therapist	9.00	11.00	13.00	13.50	14.00
Occupational Therapist	2.30	2.80	3.40	3.50	3.60
Speech - Language Pathologist	2.00	3.10	3.70	3.90	4.00
Medical Laboratory Technologist	14.30	16.20	18.90	19.60	20.30
Medical Staff Services	2.00	3.00	3.00	3.00	3.00
Quality/Risk Mgt/Infection Control	5.10	5.70	6.70	6.70	7.80
Central Sterile/Supply Distribution	5.49	6.79	8.03	8.34	8.66
Purchasing	1.00	2.00	2.00	2.00	2.00
Plant Maintenance	5.00	6.00	6.00	6.00	6.00
Bio Med	1.00	2.00	2.00	2.00	2.00
Human Resources	3.00	3.00	3.00	3.00	3.00
Nursing Education	2.00	2.00	2.00	2.00	2.00
Health Information Management	8.00	10.00	11.50	13.00	14.00
Business Office	4.00	5.20	5.70	5.80	6.00
Admissions	10.00	12.00	14.00	16.00	18.00
Accounting/PR	6.00	7.00	7.00	8.00	8.00
Administration	5.00	6.00	6.00	6.00	6.00
Other Staff	43.31	60.91	78.27	76.86	69.54
Total Projected FTEs	**317.0**	**389.0**	**459.0**	**473.0**	**482.0**

The only changes to the projected staffing result from minor changes in projected volume.

Pied.Supp.CON.0052

(22) **Provide the number of existing and proposed medical staff by specialty, to include physicians and dentists employed by, or with admission privileges to, the facility. Include the name of the Chief of the Medical Staff, if available.**

Response: As the proposed Fort Mill Medical Center will be an affiliated hospital of Piedmont, it is expected that there will be significant overlap of the medical staff. Included in **Attachment L** is Piedmont's medical staff roster.

Pied.Supp.CON.0053

(23) Indicate those physicians who have expressed a willingness to utilize the proposed services or to refer patients to the facility for the provision of services.

Response: Evidenced by the previous submissions, the medical staff is supportive of the Fort Mill Medical Center and will refer patients to the facility. Additional letters indicating physician and community leader support will be forwarded to DHEC under separate cover.

Forty-four support letters from physicians not previously included in the DHEC record will be forwarded to DHEC under separate cover.[1] The York County physicians who have documented their support of Piedmont's application have listed a wide variety of reasons for doing so, including:

1. The increasing outmigration resulting from patient referrals to Mecklenburg County by physicians employed by CHS and Presbyterian;

2. The concern that a CHS or Presbyterian hospital in Fort Mill would serve primarily as a "feeder" hospital to Mecklenburg County facilities;

3. The adverse impact on Piedmont and on the York County community that would result from approval of such a feeder hospital in Fort Mill;

4. The advantages of Piedmont's 100-bed project;

5. Piedmont's high level of quality; and

6. Piedmont's historical commitment to York County, as demonstrated by its major capital investments, equipment upgrades, and community services.

Dr. Vasant B. Patel, a Fort Mill cardiologist, notes that while he has no contractual relationship with Piedmont, CHS, or Presbyterian, he does have privileges with all three systems and is, therefore, "familiar with how the three systems operate with regards to the care of their patients and medical staff." Based on that first-hand experience, Dr. Patel "strongly" supports the Piedmont application. Dr. Patel provides several reasons for his recommendation, including his opinion that "Piedmont . . . strives to serve patients locally and does not have any vested interest to strategically channel patients to facilities outside of York County by creating a feeder system." Approval of such a feeder hospital would adversely impact Piedmont's "ability to maintain the high level of investments in facility and technology, maintain their current way of services and negatively impact employment of staff." (SUPP. LETTER NOTEBOOK I, Pied.md.ltr0027-28)

Similar concerns prompted Dr. Thomas G. Fleischer, an orthopedic surgeon, to switch his support from Presbyterian to Piedmont. Dr. Fleischer believes that both Presbyterian and CHS, "by their actions, have proven they do not support York County. They routinely encourage their York County practitioners to refer patients to (Mecklenburg County)." (SUPP. LETTER NOTEBOOK I, Pied.md.ltr0012-13)

Dr. Neal Powell, another surgeon, expresses similar concerns over CHS and Presbyterian having "purchased many physician groups in York County" and the "pressure placed on those physicians to refer their patients to facilities in Charlotte." (SUPP. LETTER NOTEBOOK I, Pied.md.ltr0026)

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[1]Piedmont's Notebooks I-IV, submitted with this updated application, contain 41 letters, cards, and e-mails from physicians written since the remand. Piedmont's Notebook VI, also submitted with the updated application, contains three physician letters written and submitted to DHEC during the initial review period, but which for unknown reasons were never entered into the DHEC record.

Dr. Curtis J. Matthews, Jr., a urologist, notes that he has served on the active medical staffs of both Piedmont and CMC-Pineville and gives his endorsement to Piedmont, based on its "long track record of supporting the citizens of York County through various charities and community organizations." Dr. Matthews praises Piedmont's "commitment to quality patient care" and the Piedmont administration's "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." (SUPP. LETTER NOTEBOOK I, Pied.md.ltr0018)

The York County Medical Society has submitted a letter stating that due to longstanding, inherent conflicts of interest in its membership, it cannot objectively evaluate the applicants and declines, therefore, to endorse any of them. See **Attachment M.**

(24) Discuss the availability of health manpower resources for the provision of the proposed services, including the contemplated program and plan for recruiting and training personnel.

Response: The Fort Mill Medical Center, being part of the Tenet Healthcare System, has access to national recruiting resources. FMMC will use more traditional methods for recruiting staff as well, including advertisement in newspapers and trade journals, attendance at local job fairs, and existing relationships with medical training programs. Additionally, Piedmont maintains relationships with numerous health professional training programs, which would be expected to generate qualified personnel. It is anticipated that there will be no problems in recruiting the necessary staff for Fort Mill Medical Center.

Additionally, Piedmont is in the process of recruiting a number of primary care physicians to the Fort Mill area as well as other areas of York County. Between 2011 and 2017, seven Family Practice and seven Internal Medicine physicians will be recruited to the Fort Mill area. For the total service area, a total of nine Family Practice, ten Internal Medicine, two General Surgeons, and one OB/GYN will be recruited. The success of this proposed recruitment plan is contingent on the approval of the Fort Mill Medical Center. By recruiting these physicians to complement the current medical community, the proposed projected utilization will be supported. In addition, these physicians will assist in retaining the patients who have historically out-migrated to North Carolina.

(25) Describe the previous experience of the applicant in the proposed health care field. If the applicant has no prior experience, specify the anticipated sources of technical assistance, either from specific individuals or organizations.

Response: Amisub of South Carolina, Inc., currently operates Piedmont Medical Center and will own and operate the Fort Mill Medical Center. Piedmont Medical Center is an equity owner with HEALTHSOUTH Corporation of Piedmont HEALTHSOUTH Rehabilitation, LLC, 1795 Frank Gaston Boulevard, Rock Hill, S.C. Piedmont Medical Center is also an equity owner with Carolinas Physician Network, Inc. (a Carolinas Healthcare System affiliate), of Piedmont/Carolinas Radiation Therapy, LLC, which provides radiation therapy services as Rock Hill Radiation Therapy Center at 228 South Herlong Avenue, Rock Hill, S.C.

Fort Mill Medical Center will have access to a broad range of technical expertise and executives with many years of experience in the development of new hospitals. Additionally, the facility will reap the benefits of tried and true techniques and procedures related to the provision of cost-effective, high quality care.

(26) Discuss the impact of the project on the clinical training programs of health professional schools, particularly the extent to which these schools will have access to the services for training.

Response: Piedmont Medical Center maintains a relationship with York Technical College, among others, and provides its facilities as clinical training sites for its RN, OR Technician, Radiology Technologist and Laboratory Technician education programs.

These institutions will have access to services at the Fort Mill Medical Center for training, as they currently do at Piedmont.

(27) **Provide any additional information that would assist the department in evaluating this project.**

At a minimum, all applicants must address the following issues:

a) **Accuracy of patient identification;**
b) **Effectiveness of communications among caregivers;**
c) **Safety of using high-alert medications;**
d) **Eliminating wrong-site, wrong-patient, wrong-procedure surgeries;**
e) **The safety of using infusion pumps;**
f) **The effectiveness of clinical alarm systems;**
g) **Any other areas concerning patient safety and/or quality of care issues the applicant wishes to address;**
h) **A discussion of deficiencies related to any of the foregoing including complaints cited by the SCDHEC Bureau of Health Facilities Regulation and/or Bureau of Certification within the past year. The applicant may provide additional information and discuss additional time spans if desired.**

Response: In order to ensure high quality and diminish the likelihood of adverse events, Amisub of South Carolina, Inc., will develop quality and patient safety policies and procedures consistent with those currently in place at Piedmont. Specifically, the facility will develop the following policies based on those developed by Piedmont:

- ✓ Patient Identification and Safety via Armband Use
- ✓ Communication and Verification of Critical Values
- ✓ Verification of Verbal or Telephone Orders
- ✓ Medication Administration and Recording
- ✓ Site/Side Identification Policy for Operative/Invasive Procedures
- ✓ Standard Concentrations of Intravenous Medications
- ✓ Infusion Control Devices Priority Ranking
- ✓ Clinical Alarms

Quality Policies

Consistent with the quality "Tenets" set forth by the parent corporation, Fort Mill Medical Center will work to provide high quality care that involves continuous review and evolution of practices in order to ensure that the risk of adverse events is as low as possible for patients of the facility. In order to ensure high quality and diminish the likelihood of adverse events, Fort Mill Medical Center will develop quality and patient safety policies and procedures consistent with those it uses at Piedmont Medical Center. Specifically, FMMC will use the following policies:

Patient Identification

Piedmont has in place a policy related to patient identification. It is the responsibility of all levels of staff to make sure that all patients are properly identified prior to the provision of any care, treatment or service. Additionally, special patient needs and issues must be noted on the identification arm band worn by the patient and signified by different colors, including:

1. Allergies (Cranberry)
2. Do Not Resuscitate Orders (Blue)
3. Elopement Precautions (Purple), for a patient with a cognitive impairment who cannot be allowed to leave the department without staff knowledge
4. Stop a Fall Precautions (Orange), so that at-risk patients do not sustain an injury due to a fall

Piedmont's policy includes the provision for a two-identifier system, which means that each armband has two identifiers that must be checked prior to any procedure, medication administration, or other service. The two identifiers are the patient's name or mother's maiden name (in the case of pediatric patients) and the patient's date of birth. Both of these identifiers appear on the armband, the chart, and any lab orders, or other documents completed for the patient.

Effective Communication and Verification of Orders
Fort Mill Medical Center will also adopt Piedmont policies related to communication and verification of orders. The Communication and Verification of Critical Values policy states:

> *Critical value test results are communicated to the physician or other licensed independent practitioner. Accuracy of this communication is verified as described in the following procedure.*

For the purposes of this policy, a critical value is defined as abnormal test results which could cause ill effects to the patient, as defined by the medical staff. The procedures outlined in the policy are set forth separately for each area of testing, including laboratory, imaging, surgical/procedural areas, and respiratory therapy/cardiopulmonary. Not only must these critical values be verbally communicated to the physician, but they must be documented in a specific part of the nursing record, and the verbal communication must be documented in writing as part of the record. This policy aims to ensure that no patient's test results are missed or misinterpreted, which could result in an adverse event.

Piedmont has developed standard abbreviations for patient records in order to ensure that the possibility of misinterpretation is diminished. Additionally, the organization has developed guidelines for the acceptance of verbal physician orders over the phone. As part of the procedure for the acceptance of verbal orders, all orders must be written down and then read back to the practitioner making the request. The practitioner must then verbally confirm that the order is correct, and the nurse must document that the order has been verbally confirmed. This policy aims to reduce the risk or medication and treatment errors within the facility.

Medication Administration and Recording
In order to decrease the risk of medication errors, Fort Mill Medical Center will adopt Piedmont's policies related to Medication Administration and the Medication Administration Record. As part of this policy, five rights of medication administration were developed as a guideline. They are:

1. Right Patient
2. Right Medication
3. Right Dose
4. Right Time/Date
5. Right Route/Method

By verifying these five rights each time medication is administered to a patient, clinical staff that is licensed to administer or dispense medications can eliminate the risk of medication errors, which are one of the leading medical errors that result in increased mortality in the health care setting. Additionally, medication administration must be documented clearly and in detail in the patient record in order to ensure that there is a reduced chance of under- or over-medication of patients.

Site/Side Identification
Wrong site surgery has been a visible topic in the media in recent years. In order to ensure that surgeries and treatments are performed on the appropriate site, there is a marking and confirmation requirement for all patients prior to any operative and invasive procedures. The part of the body that is scheduled for surgery or other invasive treatment must be marked, according to the order, and verified in the chart. The

marking must be in a permanent marker in any color other than black. Additionally, the procedure and site must be discussed with the patient prior to sedation for the procedure, if possible.

Standards for IV Medications and Infusion Devices
In order to provide a standardized, safe and effective procedure for the administration of possible high-risk medications to patients, Piedmont developed a policy that sets forth guidelines for the encouraged use of standard concentrations for commonly used intravenous medications. The policy specifically defines the standard base solution for IV medications and also addresses each potentially high-risk medication and sets forth a standard concentration for it. This eliminates the possibility for error with intravenous medications, unless a physician requests a deviation from these standards.

Clinical Alarms
Clinical alarms are extremely important in the provision of hospital services. As such, Fort Mill Medical Center will adopt a policy similar to that of Piedmont related to clinical alarms. Specifically, the policy states:

> *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.*

The policy related to clinical alarms addresses routine preventive maintenance and testing of medical devices, including ventilators, infusion pumps, anesthesia gas monitors, hemodynamic monitors, as well as safety and security alarms such as infant abduction alarms and patient bed alarms. The testing schedule for these clinical alarms is devised based on the inherent risk associated with the failure of the alarm. Testing of medical devices and safety monitors must be documented on a standard form, which is compiled by the engineering department in collaboration with the nursing staff.

As evidenced by the summary of policies and procedures presented above, Amisub of South Carolina, Inc., is dedicated to providing high quality care for patients of its proposed service area. The proposed facility will benefit from its relationship with the highly utilized and well established Piedmont Medical Center. Samples of Piedmont's policies related to quality and patient safety are provided as **Attachment N.**

In addition to the above information, the following provides additional insight regarding way the Fort Mill Medical Center represents the only logical alternative for approval.

Recognition of Piedmont Quality
Piedmont has been the recipient of state and national awards for the quality of care provided to its patients.

- In 2010, DHEC and the American Hospital Association named Piedmont Medical Center the ***South Carolina Distinguished Hospital of 2010*** for contributions in the care of patients with heart disease and stroke.
- In 2010, the American Heart Association has awarded Piedmont Medical Center the ***Gold Performance Award in Heart Failure, Silver Performance Award in Coronary Artery Disease***, and the ***Bronze Performance Award in Strokes***.
- In 2010, the Society of Chest Pain Centers gave official notice that Piedmont Medical Center is deserving of full accreditation as a ***Chest Pain Center with Percutaneous Coronary Intervention***. This recognition is based on an on-site inspection that affirmed and continued Piedmont's original certification as a Chest Pain Center in 2007.

- HealthGrades has awarded Piedmont Medical Center the ***2010 Pulmonary Care Excellence Award.***
- Prior to the October 4 filing deadline, officials representing Carolinas Healthcare Systems appearing before various York County groups presented highly selective and misleading data concerning the quality of Piedmont's services. Anticipating that Carolinas will present similar data to the Department, Piedmont will address the issue during this phase of the Department's review.

The May 2010 mortality rate reports published by the Centers for Medicare and Medicaid Services indicate that the mortality rates for Piedmont are worse than national rates in three categories – heart attacks, heart failure, and pneumonia. In attempting to disparage Piedmont, Carolinas fails to reveal numerous factors that would make confidence in the reports by the Department unreliable.

The CMS mortality rate reports are inconsistent with a broader body of data that reports Piedmont's services in the area of heart attacks, heart failure, and pneumonia to be equal to and, in some cases, substantially exceed national performance standards.

A. The South Carolina Hospital Association provides access to an online database for "Deaths due to illness" at http://www.myschospital.org that demonstrates Piedmont Medical Center performs "as expected," meaning within the national average, in heart attack, heart failure, and pneumonia.

B. HealthGrades also reports online at http://www.healthgrades.com that Piedmont performs "as expected" in heart attack, heart failure, and pneumonia.

C. The CMS mortality data is also strikingly inconsistent with multiple awards Piedmont received in 2010 from the following independent organizations:

   i. Heart Disease and Stroke: DHEC and the American Hospital Association named Piedmont as the only South Carolina Distinguished Hospital of the Year 2010 for contributions to patient care in heart disease and stroke.

   ii. Heart Failure: The American Heart Association awarded Piedmont a Gold Performance Award in heart failure in 2010. To give the Department some sense of performance standard comparison, Palmetto Health Richland received the Silver Plus Performance Award. For more information, see http://www.heart.org/idc/groups/heart.

   iii. Pneumonia: HealthGrades awarded Piedmont the 2010 Pulmonary Care Excellence Award.

If the CMS mortality rates are to be used to judge an applicant's qualifications, as Carolina has advocated, the reports raise more questions than they answer. The reports are not based on clinical information, but on billing and other administrative data. The reports are generated through statistical models, much as the databases are for myschospital.com and HealthGrades, from a broad range of information that take into consideration primary and secondary diagnoses, along with age, gender, and other factors, to develop predictors of death. This use of administrative data as a substitute for actual clinical data is an evolving science and vulnerable to the risks inherent in the use of surrogate data, as demonstrated by the inconsistencies identified with other reputable hospital quality reporting databases.

Another concern the Department should have about the data presented by Carolinas is the bias inherent in what it chooses to present. Although it is purportedly offering the information for comparative purposes, Carolinas fails to identify the "poor" grades its hospitals have received in recent years.

The following represents a sampling of Carolinas facilities that have been graded at a below average or poor grade from HealthGrades in 2010 for patients with diagnoses of heart attacks, heart failure, and pneumonia.

Heart Attack	Carolinas Medical Center
	CMC Mercy
Heart Failure	CMC University
	Cannon Memorial
	Wallace Thompson
Pneumonia	CMC Northeast
	Cannon Memorial
	Roper Hospital
	Wallace Thompson
	Wilkes Regional

In addition to the numerous poor grades assigned Carolinas hospitals by HealthGrades in heart attack, heart failure, and pneumonia, Carolinas facilities performed below the national average in numerous other areas. In the 25 separate 2010 HealthGrades Hospital Quality Ratings, Carolinas hospitals in the Charlotte area received a "poor" rating on 19 different occasions. Ten of the poor ratings were issued to Carolinas Medical Center alone. In contrast, Piedmont received poor ratings in seven areas as did Presbyterian. For more information, visit the HealthGrades website at http://www.healthgrades.com.

Comparative Review of Competing Applications

Remand Instructions

In her order remanding this matter to the Department, Judge Matthews held that DHEC's decision that only Piedmont's application could be approved under the 2004-2005 State Health Plan was erroneous. The court, however, made no finding on the merits of the competing applications. Instead, Judge Matthews ordered the Department to undertake a comparative review, instructing it to determine "which of the applicants, if any, most fully complies with the requirements, goals, and purposes of this article and the State Health Plan, Project Review Criteria, and the regulations adopted by the Department," as provided by S.C. Code Ann. § 44-7-210(C) and DHEC Regulation 61-15 § 307.2. (*Order* at paragraph 1, p. 27.) More specifically, Judge Matthews ruled that "the Department's decisions must be accompanied by written findings as to each applicant's compliance with the relevant Project Review Criteria and which party best meets each project review criterion and the basis thereof." (*Order* at paragraph 7, p. 28.)

Comparative Application of Project Review Criteria

Overview

The comparative application of Project Review Criteria cannot be finalized until after full consideration of each party's updated applications. There are several criteria, however, that will not be affected by review of the updated applications. While no question can be reasonably raised as to whether the three applicants could each build and operate a community hospital consistent with many of the applicable project review criteria, there are several significant criteria that heavily favor the approval of Piedmont's application. These criteria include the following: (a) adverse impact on Piedmont and a reduction in the distribution of services to residents in York County that would be caused by approval of another applicant (criteria 2, 22, and 23); (b) the efficiencies generated by the construction of the 100-bed Fort Mill Medical Center (criterion 17); and (c) the contractual requirements with York County that ensure Fort Mill's accessibility, transparency, and competitive rates (criteria 3 and 6).

Adverse Impact and Distribution

The 2004-2005 State Health Plan provides that "the benefits of improved accessibility will be ***equally weighted*** with the adverse affects (sic) of duplication in evaluating Certificate of Need applications for acute care hospitals' beds." 2004-2005 State Health Plan at II-9 (emphasis added). This adverse impact provision in the State Health Plan is similar to DHEC Regulation 61-15 § 802.23(a) that provides: "[t]he impact on the current and projected occupancy rates or use rates of existing facilities and services should

be weighed against the increased accessibility offered by the proposed services." The Adverse Impact project review criteria are also closely tied to the criteria for Distribution and Accessibility (802.3(a)-(h) and 802.22). These criteria require DHEC to "carefully" consider "the effect of the proposed project" upon "existing distribution." Because Adverse Impact and Distribution are inextricably related, the two criteria will be analyzed together.

The volume of patient loss caused by the approval of either Carolinas or Presbyterian's application would be substantial. It would result in losses of over 3,500 patients and approximately $13 million per year in Piedmont's net profitability. Piedmont's York County market share would drop some 18 percentage points, from 55.7 percent to 37.8 percent, although most patient loss would be concentrated in the northeast quadrant of the county, particularly in the Fort Mill and Tega Cay communities where the greatest population growth is projected. As a result of this decline in market share, the rate of admissions at Piedmont would drop by 27 percent from 2009 to 2017, and the current occupancy rates would fall from 57.1 percent to 46.7 percent. When the Department originally reviewed the applications, it agreed that a substantial impact would occur if ***either*** Carolinas or Presbyterian were approved, finding ***"their patient base would be siphoned from the existing utilization of PMC."*** **Attachment W**, DHEC Amisub Record at 898.

These dramatic reductions in patient volume and lost revenue would jeopardize Piedmont's ability to continue to serve residents throughout York County. The loss of over 3,500 patients would require a reduction in existing services and personnel. Moreover, Piedmont's investments in new technology, equipment, and services would be diminished, and its ability to recruit and retain physicians therefore constrained. Over time, faced with a competitive disadvantage in its scope of services and ability to recruit and retain, Piedmont physicians would struggle to continue to provide sophisticated, high quality services and to meet its obligations under its contract with York County.

Efficiencies of a 100-Bed Hospital
The greatest distinction among the three applicants when evaluating the Efficiency criterion (Regulation 61-15 § 802.17) is that Amisub proposes a 100-bed hospital, while the other applicants propose hospitals of only 64 beds. From an accounting perspective, it is more efficient to spread administrative costs over 100 beds, rather than over 64. Moreover, it is more cost effective and less disruptive to patient care to build a 100-bed hospital initially than to build a 64-bed hospital and add beds a few years later. Finally, approving Fort Mill Medical Center will allow Amisub to generate efficiencies by having an integrated health system in York County.

Accessibility and the York County Contract
In 1980 York County entered into a contract (the "Contract") with American Medical International ("AMI") and its subsidiary, Piedmont. Under the Contract, AMI and Piedmont agreed to lease York County General Hospital until a new hospital was built, which would be known as Piedmont Medical Center. When AMI was later purchased by Tenet Healthcare Corporation, Tenet assumed ownership of Piedmont and replaced AMI as party to the York County Contract. During the 30 years that the Contract has been in effect, the parties have agreed to amend the Contract nine times. The most significant of these addenda, for the purposes of this competitive review, are the Sixth (1995), the Eighth (2004), and the Ninth (2006).

The Contract is ***unique*** in South Carolina. In fact, no evidence has been presented to suggest that any similar contract exists anywhere in the United States. The Contract requires Amisub of South Carolina, Inc., to provide York County with a variety of services and financial contributions, at specified levels, and explicitly binds each d/b/a of Amisub, i.e., Piedmont Medical Center and Fort Mill Medical Center. (9th Add. p. 2.) The Contract does not expire until July 1, 2045. 6th Add. p. 51, § 4.4.

The various addenda to the Contract impose many obligations that Amisub has already fulfilled, including an open heart surgery program, a second cardiac cath lab, neurosurgical services facilities, intensive care and monitored bed capacity rooms, a new ER, various equipment purchases and upgrades, facility renovations, scholarships and financial support for educational and charitable organizations, and construction of a Women's Tower. (6th Add. pp. 4-5; 7th Add. § 4, 8th Add. § 2, pp. 6-7.) These services evidence Amisub's longstanding commitment to the entire York County population. Despite employing a number of physicians with offices in York County – ***physicians who have increasingly referred York County patients to Charlotte hospitals*** – neither Presbyterian nor Carolinas have demonstrated a commitment to the York County community commensurate with Piedmont's.

The Contract also imposes, however, a number of ***ongoing*** obligations on Amisub. The Contract's Sixth Addendum requires Amisub to provide:

1) Twenty-four hour, county-wide ambulance services, with mandated response times and equipment requirements. (6th Add. § 3.2, pp. 10-14.)

2) Required levels of care for indigent persons and county inmates. (*Id.* §§ 3.3, 3.4, pp. 14-20.)

3) Urgent care services in western York County. (*Id.* § 3.5, pp. 20-21; 9th Add. § 1, pp. 3-6.)

4) Major capital investments. (6th Add. § 3.7, pp. 22-23; 9th Add. § 2, pp. 6-7.)

5) Support for educational programs and charitable organizations. (6th Add. §§ 3.11, 3.12, pp. 27-29; *see also* 8th Add. ¶ 2, pp. 6-7.)

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. These contractual obligations relate to one of the purposes of the CON Act: to "guide the establishment of health facilities and services which will best serve public needs." They also relate specifically to Accessibility criterion § 802.3, since they serve to improve public access to hospital services.

In addition, the Contract requires Amisub (including both its d/b/a entities) 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. (6th Add. § 3.1, pp. 29-32; 8th Add. pp. 4-5.) As Carolinas' expert conceded at trial, such reports are a good way to hold Piedmont accountable for its obligations under the Contract. (*Trial Trans.* at 1801:19-23 (testimony of Dawn Carter)).

Neither Presbyterian nor Carolinas are legally bound – as Amisub is – to provide such services or report such information to the County.

Charges and the York County Contract

Criterion 802.6(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." As generally acknowledged by all parties at trial, however, charges have little relevance to most patients. The one group to whom charges do matter is uninsured persons who do ***not*** qualify for indigent care. This group can take comfort from Tenet's Compact with the Uninsured, which provides them with significant discounts, but also from the fact that ***Amisub is the only applicant with contractual restrictions on how much it can charge***. The Sixth Addendum to the York County Contract identifies a peer group of nine hospitals. Under the Sixth Addendum, if either Piedmont or FMMC discovers its average charge per case for all product lines is the highest in the peer group, Amisub must implement a plan reasonably expected to fix or reduce its charges. (6th Add. § 3.1(e), p. 9.)

In 2004, Piedmont self-reported to York County that its average charge per case was the highest in the peer group. Piedmont not only implemented a charge reduction, it recognized that certain of the pricing requirements of the Sixth Addendum needed tightening. As a result, it voluntarily agreed to negotiate an Eighth Addendum with York County, despite being under no obligation to do so. By willingly submitting to the more stringent requirements of the Eighth Addendum, Amisub demonstrated its commitment not only to the letter of the Contract, but also to its spirit.

The Eighth Addendum, entered into June 7, 2004, obligates Amisub to maintain reasonable pricing:

> *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 AMSISUB 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" . . .*
>
> (8th Add. p. 3.)[2]

The Eighth Addendum further provides that, should Amisub's average charge per case for all product lines be the highest in the peer group, Amisub and Tenet must, within 15 business days:

1) Reduce charges;
2) Maintain the reduced charges until a report is delivered to York County showing that Amisub's rates are no longer the highest in the peer group; and
3) Retain a consultant agreed upon by York County and work with the consultant to effectuate price reductions. (8th Add., pp. 3-4.)

In addition, the Eighth Addendum requires Amisub to submit ***quarterly*** financial reports to the County. (8th Add. p. 4.) Should Amisub and Tenet fail to substantially perform their contractual pricing obligations, they must, upon written demand by the County, submit an audited report showing rates have been reduced to the average of the peer group hospitals. Amisub's failure to do this results in liquidated damages of ***$100,000 per month***. (8th Add., p. 5.) Since the Eighth Addendum was signed in June 2004, Piedmont's average charge per case has never ranked higher than seventh among the nine peer group hospitals. It currently ranks eighth, meaning only one hospital in the group is less expensive than Piedmont.

Even if Presbyterian and Carolinas' projected charges are comparable to Amisub's, mere projections are not legally binding. Presbyterian and Carolinas criticize the York County Contract and the peer group of hospitals it identifies, but the Contract was negotiated and entered into by the York County Council – the elected representatives of the citizens of York County. The Council acted with the advice of the York County Attorney and it must be presumed that Council members had their constituents' best interests at heart when they negotiated the Contract. It is telling that neither Presbyterian nor Carolinas has offered to enter into a similar contract with York County.

Noted excerpts from the contract are included in **Attachment W**.

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[2] The "Hospital" referenced refers to both Piedmont Medical Center and Fort Mill Medical Center. *See* 9th Add. p. 2 ("Whereas . . . Amisub is the contractual party to the Prior Agreement, the Fort Mill campus would operate under the Prior Agreement").

PART C: PROGRAMMATIC DOCUMENTS

Provide adequate programmatic documents in support of the various elements of the proposed project. These documents will include as appropriate:

(1) **An Indigent Care Plan as required by the Board of Health and Environmental Control. It shall address at a minimum, the following:**

a. **The existing and proposed admission and treatment policies of the facility or agency with regard to race, sex, creed, national origin, and ability to pay.**

Response: Piedmont Medical Center admits and provides treatment to all patients regardless of race, sex, creed, and national origin. Piedmont also provides emergency care without consideration of ability to pay. Piedmont, as the only provider of acute hospital care in York County, has provided substantial levels of uncompensated and indigent care to the citizens of York and the surrounding counties. These policies will remain unchanged as a result of the approval of Fort Mill Medical Center and will also be implemented by the proposed facility.

b. **The proposed admission and treatment policies of the facility or agency with respect to admission and care of indigent patients including those patients unable to pay at the time of admission and those whose benefits expire while in the care of the facility or agency.**

Response: Fort Mill Medical Center will be committed, just as Piedmont has been, to admitting patients without regard to ability to pay. Patients will be financially counseled regarding their personal responsibility for the payment of their medical bills. The indigent determination is applied to patients unable to pay at the time of admission and to those whose benefits expire while in the care of the hospital.

Included in **Attachment O** is the charity care policy to be implemented at the proposed FMMC.

c. **In existing facilities or agencies, provide the amount, in dollars and percent of gross revenues, that the facility or agency provided in indigent care during the past three fiscal years. NOTE: Indigent care does not include bad debt; contractual adjustments; or care which is reimbursed by a governmental program (Medicare, Medicaid, county indigent program), church, or philanthropic organization.**

Response: The following table illustrates Piedmont's indigent care commitments over the past three years.

***Updated* Figure 42**
Piedmont Medical Center
Historical Indigent Care

Year	Indigent Care Dollars	Percent of Gross Revenue
2007	$17,813,323	3.3%
2008	$20,523,964	3.6%
2009	$19,373,602	3.3%

Source: PMC internal data.

The decline in the indigent/charity care dollar amount is the result of lower charges.

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d. Provide the proposed amount of indigent care the facility or agency projects to provide during the existing fiscal year and next fiscal year. This projection should be expressed in both dollars and a percent of gross revenues.

Response: Fort Mill Medical Center will provide uncompensated indigent care consistent with the historical levels at Piedmont. At the corporate level, Tenet Healthcare Corporation has implemented a system that offers discounted rates for indigent patients. In January 2003, Tenet became the first major hospital operator to offer discount pricing for uninsured patients. The program has been dubbed Tenet's Compact with Uninsured Patients. The initiative has been adopted by Piedmont. The five points of the program state:

1. *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.*
2. *Tenet hospitals will provide financial counseling to all uninsured patients. This will include help in understanding and applying for local, state and federal health care programs such as Medicaid.*
3. *If uninsured patients receive treatment at Tenet hospitals, they will be offered discounted pricing for the services provided at rates comparable to the hospital's current managed care rates.*
4. *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.*
5. *Tenet hospitals will not pursue legal action for non-payment of bills against any patient who is unemployed or without other significant income.*

Tenet's Compact with Uninsured Patients serves to put in writing what Piedmont and other Tenet facilities have been doing for years, by making it a system-wide initiative. See **Attachment P** for additional information regarding the Tenet Compact with Uninsured Patients. The following table illustrates Piedmont's indigent care commitments over the past three years.

***Revised* Figure 43**
Piedmont Medical Center
Projected Indigent Care

Year	Indigent Care Dollars	Percent of Gross Revenue
2010	$29,963,044	4.7%
2011	$27,062,059	4.4%

Source: PMC internal data.

The financial projections for the proposed facility are provided as **Attachment K.** Included in them are the projections for indigent and charity care for the new facility. Fort Mill Medical Center projects indigent and charity care in an amount equal to 3 percent of gross revenue in each of the first three years of operation. The following table details the indigent and charity care that is projected for the new facility.

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Revised Figure 44
Fort Mill Medical Center
Projected Indigent Care

	Year 1 2015	Year 2 2016	Year 3 2017	Year 4 2018	Year 5 2019
Gross Patient Revenue	$156,885,467	$201,766,932	$249,067,621	$270,056,729	$292,763,538
Charity/Indigent	$4,706,564	$6,053,008	$7,472,029	$8,101,702	$8,782,906
% Of Gross Revenue	3.0%	3.0%	3.0%	3.0%	3.0%

e. **A discussion of why the above figures are adequate or inadequate for the needs of the community; the need of indigent care within the proposed service area; and any solutions, remedial plans or proposals by the facility or agency to better address the indigent care problem in the service area. Include any initiatives or undertakings the facility or agency has begun to address the indigent care problem in the proposed service area.**

Response: The amounts in Figure 44 are adequate to meet the needs of the service area residents, based on Piedmont's experience as the county's sole acute care provider and its extensive knowledge of the service area population. The amount of charity care provided at the Fort Mill Medical Center is projected to be comparable to Piedmont's historical levels.

One of the major components of the Patient Protection and Affordable Care Act (PPACA) is to extend insurance coverage to those patients that had historically been classified as uninsured and/or indigent. As these individuals are expected to be covered under either Medicaid or commercial insurance, the level of indigent care is expected to decrease.

f. **Describe any Board or Advisory Board established to implement or control the indigent problem at the facility or agency. Include the Board's functions, responsibilities, and limitations.**

Response: As outlined in response to parts a-e above, Piedmont is committed to assuring access to necessary healthcare for indigent patients. Included as **Attachment O** is the charity care policy to be implemented at the proposed Fort Mill Medical Center.

(2) **A map of sufficiently large scale to be meaningful, indicating the location of the project site and its geographical area.**

Response: Please see **Attachment Q** for the site plan. The total site includes 40 acres, but only approximately 16.75 acres will be used for the development of the new hospital. The rest of the site will be used for the development of future health care services.

(3) **A plot plan of the project site showing existing buildings, roads, parking areas, walks, service and entrance courts, existing utilities (electricity, telephone, water, railroads, sewer, gas, etc.) and other natural land features necessary for adequate analysis of site conditions.**

Response: Please see **Attachment Q** for the site plan. The total site includes 40 acres, but only approximately 16.75 acres will be used for the development of the new hospital. The rest of the site will be used for the development of future health care services.

(4) **A legal description of the project site indicating its physical characteristics and existing easements.**

Response: The proposed Fort Mill Medical Center will be located at the intersection of Highway 21 Bypass and South Carolina State Highway 160 in Fort Mill, York County. Copies of the legal description of the site and the land purchase documents are provided as **Attachment A**. The total site includes 40 acres, but only approximately 16.75 acres will be used for the development of the new hospital. The rest of the site will be used for the development of future health care services.

(5) **A square foot program of space and/or equipment elements, and scale drawings describing the existing space and proposed alterations and additions.**

Response: Please see **Attachments Q** and **R** and for the site plan and schematics.

(6) **Evidence that the site will be properly zoned for the proposed project.**

Response: See **Attachment S** for a letter from David Hudspeth, Town Manager of Fort Mill, stating that the property was annexed into the town limits under the Highway Commercial (HC) zoning designation, and allows for the construction and operation of the hospital facility proposed by Tenet.

(7) **Documentation from appropriate sources that utilities supplied to the site are adequate for the project to include electricity, gas, water, and sewerage.**

Response: Included in **Attachment T** are letters which confirm that the electricity, water, and sewerage supplied to the site are adequate to support the proposed project.

(8) **Endorsement from the community that the project is desirable. This may include but is not limited to members of the medical community, citizen's groups, and other health and social service disciplines in the community.**

Response: Evidenced by the previous submissions, the community is supportive of the development of the Fort Mill Medical Center The Fort Mill and York County community strongly support Piedmont's application, as demonstrated by approximately 2,000 letters, cards, and e-mails compiled in notebooks submitted to the Department.[3]

Piedmont has described the physician support it has received in its response to question 23 of this updated Application. Other residents of York County who have documented support for Piedmont have listed a number of reasons for doing so, including:

1) Piedmont's historical commitment to the York County community;
2) The adverse impact that approval of another applicant would have upon Piedmont's ability to provide services;
3) The high quality of medical care at Piedmont;
4) The benefits of Piedmont's contract with York County; and
5) The increased tax base and economic growth that would result from approval of Piedmont's application.

[3] Since the remand to DHEC, approximately 1,770 letters, cards, and e-mails have been submitted to DHEC in support of Piedmont's application. These are contained in Notebooks I-V, submitted under separate cover. Prior to the remand, 204 support letters for Piedmont were submitted to DHEC, but for unknown reasons were not included in the DHEC Record. Piedmont has resubmitted these letters in Notebook VI. Also prior to the remand, 278 support letters for Piedmont were submitted to DHEC and placed in the DHEC record.

Former county council member Rick Lee cites several of these grounds in his letter, as well as another reason – competition:

> *We have watched over the years as Carolinas Medical Center and Presbyterian have gobbled up every community hospital around Charlotte by either buying them or running them out of business. They have bought dozens of medical practices and pulled properties off of the tax rolls . . . . [They] now are seeking to extend their monopoly into South Carolina. York County deserves to have long term competition for medical care.*

(SUPP. LETTER NOTEBOOK III, Bates Pied.comm.LTR.0896-897)

Manning Kimmel, owner of Rock Hill radio station WRHI, agrees with Mr. Lee, emphasizing "Piedmont's proven commitment to serving the healthcare needs of York County and . . . its unique contractual relationship with York County Council." (SUPP.LETTER NOTEBOOK I, Bates Pied.bus.LTR.004-5.) In Mr. Kimmel's opinion, approving the CHS or Presbyterian applications would result in "much less competition," as well as:

> *healthcare dollars being pulled out of South Carolina going to North Carolina to pay for North Carolina medical care and infrastructure. . . . Piedmont projects the negative impact to be in excess of $10,000,000 annually which undoubtedly will result in a reduction of jobs and services and certainly the significant level of reinvestment that we've seen the past 15 years. DHEC needs to pay SERIOUS attention to how this would negatively impact services at the existing Piedmont Medical Center.*

(SUPP.LETTER NOTEBOOK I, Bates Pied.bus.LTR.004-5. (emphasis in original))

Janet F. Martini, Executive Director of Keystone Substance Abuse Services, writes about Piedmont's "rich history in providing for the healthcare needs of the community," noting that Piedmont's "expansion into the Fort Mill area will further their commitment to York County." Ms. Martini discusses the 20-year relationship between her organization and Piedmont, the two entities that are "currently leading collaborative efforts in behavioral health for the three county regions of York, Chester, and Lancaster." (SUPP.LETTER NOTEBOOK I, Bates Pied.bus.LTR.0003)

These few excerpts are not intended to be comprehensive. They are, however, representative of the broad support Piedmont's application has received from the community.

(9) Documentation that the proposed project has been approved by the health facility's planning committee and governing body.

Response: Please see **Attachment V** for documented approval of the proposed project by the Governing Board.

(10) For the facilities or services not licensed by the Department of Health and Environmental Control, provide documentation of coordination and support from the appropriate licensing agency.

Response: Not applicable to this project.

PART D: ASSURANCES

The applicant must furnish written assurance of each of the following where applicable:

(1) Amisub of South Carolina, Inc. has or will have a fee simple title or such other estate or interest in the site including necessary easements and rights-of-way, sufficient to assure use and possession or the purpose of the construction and operation of the facility.

(2) That approval by the department of the final drawings and specifications, which will be prepared by an architect and/or engineer legally registered under the laws of the State of South Carolina, will be obtained.

(3) That Amisub of South Carolina, Inc. will submit to the Department for prior approval, changes that substantially alter the scope of work, function, utilities, major items of equipment, safety, or cost of the facility during construction.

(4) That Amisub of South Carolina, Inc. will cause the project to be completed in accordance with the Certificate of Need application.

(5) That Amisub of South Carolina, Inc. will cause the project to be completed in accordance with approved plans and specifications by maintaining competent and adequate architectural and engineering services throughout the construction administration phase of the project. That, at the completion of the project, the architect of record shall be required to issue a statement that to the best of his knowledge and belief, based upon available records, supplemental documents, and periodic observation of the work, the project was constructed according to those documents approved by the Department.

(6) That the proposed Fort Mill Medical Center facility will be operated and maintained in accordance with the standards prescribed by law and regulations for the maintenance and operation of such facilities.

(7) That Amisub of South Carolina, Inc. understands that the Certificate of Need shall become void at the end of the specified time period from the date of issuance unless otherwise extended under Chapter 6 of these regulations.

(8) That the Department or its authorized representatives may at any time during the course of construction and upon the completion of the project make an on-site inspection of the construction and equipment to check for compliance of the construction in accordance with the application for which the Certificate of Need was issued.

(9) That the controlling interest in any health care facility shall not be sold or leased or otherwise disposed of without a Certificate of Need or exemption by the Department being received by the appropriate individual.

(10) That Amisub of South Carolina, Inc. will notify the Department in writing that the contractual agreement has been completed. For a construction project, the letter shall indicate that a construction contract specifying the beginning and completion dates of the project, has been signed by both parties. For services projects, the letter should indicate that equipment purchase orders with estimated delivery dates have been properly negotiated.

(11) That Amisub of South Carolina, Inc. will notify the Department in writing of the date that a new or expanded service has been implemented, completed or terminated.

(12) That Amisub of South Carolina, Inc. will provide monthly progress reports and a final completion report which contain the information required by Section 607 of these regulations.

Signature

9/30/2010
Date

Pied.Supp.CON.0072

JOINT-B-PMC-001.0074

ATTACHMENT A

LEGAL DESCRIPTION OF SITE
LAND CLOSING DOCUMENT (REVISED)

Legal Description of Piedmont HealthCare System
Tract for Phase I – 100-Bed Hospital Site

THE POINT OF BEGINNING being a point along the northern right-of-way of SC 160 heading N56°04'30"E for 380.83' then following a curve bending to the right with a radius of 315.83' for a distance of 151.35' to a point and then heading N15°45'15"E for 99.40' then headed N33°42'02"W for 140.23' and then headed N29°00'00"E for 239.50' and then headed N55°51'34"E for 273.77' and then headed N75°18'58"E for 187.21' and then headed N 29°00'00"E for 240.98' and then headed S61°00'00"E for 342.73' then headed N29°00'00"E for 91.77' and then headed N78°50'43"E for 125.01' and then headed S61°00'00"E for 82.57' to a point along the western side of SC 21 right-of-way then headed S28°19'07"W for 217.34' then following a curve to the left with a radius of 10,625.28' for a distance of 47.06' to a point and then headed N61°00'00"W for 384.13' and then headed S29°00'00"W for 186.25' then headed S61°00'00"E for 388.65' to a point along the western right-of-way line of SC 21 then following a curve to the left with a radius of 10,625.28' for a distance of 850.96' to a point and then headed N67°41'53"W for 126.57' then following a curve to the right with a radius of 95.37' for 134.17' then headed N27°01'19"W for 158.69' and then following a curve to the left with a radius of 265.83' for 449.61' and then headed S56°04'30"W for 377.36' to a point along the northern right-of-way of SC 160 and then following a curve to the right with a radius of 9,803.20' for a distance of 50.12' to the POINT OF BEGINNING.

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Partner
Telephone: 803.253.8659
Direct Fax: 803.255.8017
simpsonfant@parkerpoe.com

1201 Main Street
Suite 1450
P.O. Box 1509
Columbia, SC 29202-1509
Telephone 803.255.8000
Fax 803.255.8017
www.parkerpoe.com

October 17, 2006

Tim Blakeley, Esquire
Tenet Healthcare Corporation
13737 Noel Road
Suite 100
Dallas, Texas 75240

Re: *Clear Springs-Baxter, LLC to AmiSub of South Carolina, Inc.*
Purchase of 41.098 Acres, York County, SC
Closing Date: October 6, 2006

Dear Tim:

Enclosed please find our firm's escrow check in the amount of $100,360.10 made payable to Tenet Healthcare Corporation. This amount represents a refund of the funds needed to close the above-referenced purchase, over and above the wire we received from Tenet on October 5, 2006 in the amount of $8,581,616.87. I have enclosed a copy of the Purchaser's and Seller's Closing Statement for your file. The $100,360.10 represents the difference between the wire we received and the $8,481,256.77 reflected on the Purchaser's Closing Statement as "Total Due From Purchaser." Please let me know if you have any questions regarding this check or the closing statement. I enjoyed working with you on this transaction and look forward to working with you again soon.

With personal regards, I am

Very truly yours,

Simpson Z. Fant

SZF/lcb
Enclosure

CHARLESTON, SC
CHARLOTTE, NC
RALEIGH, NC
SPARTANBURG, SC

COL 64188v1

PURCHASER'S CLOSING STATEMENT

PURCHASER:	AmiSub of South Carolina, Inc., a South Carolina corporation
SELLER:	Clear Springs – Baxter, LLC, a North Carolina limited liability company
PROPERTY:	Tract 1 – 40 acres; Tract 2 – 1.098 acres, York County, SC
CLOSING DATE:	October 6, 2006

PURCHASE PRICE

Tract 1 and Tract 2 ..... 11,148,907.00
Less Credit for Lots 441, 442, 496, 498 and 700 ..... (2,646,969.00)

TOTAL PURCHASE PRICE: 8,501,938.00

PLUS COSTS:

Title Insurance Premium 6,064.50
Deed Transfer Fee 9,793.90
S&ME 2,900.00
Attorney Fees/Costs (PPAB) 18,916.00
Recording Fees 16.00
Survey (Pharr) 250.00
2006 Prorata Taxes
Lot 441 ..... 3,160.06
Lot 442 ..... 8,216.16
Lot 497 ..... 9,480.18
Lot 498 ..... 8,216.16
Lot 700 ..... 12,640.24
*Tract 1 ..... 466.67

TOTAL COSTS: 80,119.87

SUBTOTAL 8,582,057.87

LESS CREDITS:

Refund of HOA Assessment for
Lots 441 442, 497, 498 and 700 ..... 801.10
Earnest Money Deposit 100,000.00

TOTAL CREDITS ..... (100,801.10)

TOTAL DUE FROM PURCHASER: 8,481,256.77

COL 63844v2

We have carefully reviewed this closing statement and to be best of our knowledge and belief, it is a true and accurate statement of all receipts and disbursements made on our account or by us in this transaction. We further certify that we have received a copy of this closing statement this 6th day of October, 2006.

AmiSub of South Carolina, Inc.

By: _____
Name: Charles Miller, its President

*Taxes to be paid at closing

COL 63844v1

2006 Tax Prorations (based on actual 2006 tax bills):

Tract 1

[$1,957.85 / 365] x 278 = $1,491.18 (seller's portion); $466.67 (buyer's portion) [to be paid at closing]

Tract 2

Taxes paid by Clear Springs-Kingsley, LLC -- $84.04 [to be paid at closing]

Lot 441:

[4,149.00 / 365] x 278 = 3,160.06 (buyer's portion)

Lot 442

[10,787.40 / 365] x 278 = 8,216.16 (buyer's portion)

Lot 497

[12,447.00 / 365] x 278 = 9,480.18 (buyer's portion)

Lot 498

[10,7887.40 / 365] x 278 = 8,216.16 (buyer's portion)

Lot 700

[16,596.00 / 365] x 278 = 12,640.24 (buyer's portion)

HOA Proration:

$680 X 5 lots = $3400
[3,400 / 365] x 86 days = $801.10

SELLER'S CLOSING STATEMENT

PURCHASER:	AmiSub of South Carolina, Inc., a South Carolina corporation
SELLER:	Clear Springs – Baxter, LLC, a North Carolina limited liability company
PROPERTY:	Tract 1 – 40 acres; Tract 2 – 1.098 acres, York County, SC
CLOSING DATE:	October 6, 2006

SALES PRICE:		
Tract 1 and Tract 2		11,148,907.00
Less Credit for Lots 441, 442, 496, 498 and 700		(2,646,969.00)
TOTAL SALES PRICE:		8,501,938.00
CHARGES:		
Recording Fees	63.00	
Deed Transfer Fee	41,251.30	
Refund of HOA assessments	801.10	
Earnest Money Held	100,000.00	
Survey	POC	
2006 Prorata Taxes		
*Tract 1	1,491.18	
*2006 Taxes – Tract 2	84.04	
TOTAL CHARGES		(143,690.62)
SUBTOTAL		8,358,247.38
CREDITS:		
2006 Prorata Taxes		
Lot 441	(3,160.06)	
Lot 442	(8,216.16)	
Lot 497	(9,480.18)	
Lot 498	(8,216.16)	
Lot 700	(12,640.24)	
TOTAL CREDITS		41,712.80
TOTAL DUE SELLER		8,399,960.18

We have carefully reviewed this closing statement and to be best of our knowledge and belief, it is a true and accurate statement of all receipts and disbursements made on our account or by us in this transaction. We further certify that we have received a copy of this closing statement this 6th day of October, 2006.

Clear Springs – Baxter, LLC, a North Carolina limited liability company

By: Clear Springs Development Company, a North Carolina limited liability company
Its: Manager

By: _____
Name: James E. Traynor
Its: President

*Taxes to be paid at closing

2006 Tax Prorations (based on actual 2006 tax bills):

Tract 1

[$1,957.85 / 365] x 278 = $1,491.18 (seller's portion); $466.67 (buyer's portion) [to be paid at closing]

Tract 2

Taxes paid by Clear Springs-Kingsley, LLC -- $84.04 [to be paid at closing]

Lot 441:

[4,149.00 / 365] x 278 = 3,160.06 (buyer's portion)

Lot 442

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Lot 700

[16,596.00 / 365] x 278 = 12,640.24 (buyer's portion)

HOA Proration:

$680 X 5 lots = $3400
[3,400 / 365] x 86 days = $801.10

ATTACHMENT B

PUBLISHED NOTIFICATION OF PROJECT

Wheelin & Dealin Special
4 lines, 28 days
$59

10 Day Special
5 lines, 10 days
$44

7 Day Special
5 lines, 7 days
$42

3 Day Special
5 lines, 3 days
$38

For Maximum Exposure, Run It Online and In The Herald, Lake Wylie Pilot, Fort Mill Times, Clover Herald, and Yorkville Enquirer

The Herald CLASSIFIEDS

Call To Place Your Ad:
803.329.4044
or
To Place Your Ad Online Right Now, Go To:
heraldonline.com

Deadlines

Run Day	Deadline by Phone	Deadline by Fax	Run Day	Deadline by Phone	Deadline by Fax
Monday	4pm Fri	2pm Fri	Thursday	4pm Wed	2pm Wed
Tuesday	4pm Mon	2pm Mon	Friday	2pm Thu	1pm Thu
Wednesday	4pm Tue	2pm Tue	Saturday	9:30am Fri	9:30am Fri
Saturday	9am Thu	9am Fri	Sunday	4pm Fri	1pm Fri

Hours: Monday-Friday 7:30am-5pm

•By Mail: The Herald, PO Box 11707, Rock Hill, SC 29731 •Fax: 803-329-4028 •In Person: 132 W. Main Street, Rock Hill, 29731

201 Legal

ROCK HILL

PUBLIC LAND SALE
Sealed bids will be received by the City of Rock Hill, South Carolina until 16:00 are local time, on October 17, 2005 for the sale of real property known as:

PARCEL #6001601009 MCCULLOUGH ST
PARCEL #6291101016 CHARLOTTE & SUMTER
PARCEL #6001202006 PHILADELPHIA RD
PARCEL #6001601008 MCCULLOUGH ST
PARCEL #6260901154 HWY 72
PARCEL #6270901094 E. WHITE ST.
PARCEL #6271301047 CEDAR ST.
PARCEL #6271301044 CEDAR ST.
PARCEL #6271301061 CEDAR ST.
PARCEL #5990100035 ROBINSON LOT 16 SEC 1

Applicable legal fees will be added to purchase offer. Please contact Linda Kimbrell, Purchasing Office @ 803-329-7077 for any questions.

Ad No. 08547423

201 Legal

ROCK HILL

201 Legal

NOTICE
In accordance with the South Carolina Department of Health and Environmental Control, Regulation 61-15 (Certificate of Need for Health Facilities and Services), Amisub of South Carolina, Inc., dba Piedmont Medical Center, 722 Herlong Avenue, Rock Hill, South Carolina, 29732, hereby notifies the public of its planned submission of a Certificate of Need application (CON) to develop a 100-bed hospital at the site located at the intersection of S.C. 160 and U.S. Highway 21 in Fort Mill. The facility will be approximately 330,000 square feet with an estimated total project cost of $125 million. Services will include medical/surgical, intensive care, obstetrical, diagnostic cardiac catheterization, MRI and 64 slice CT scanner as well as a full array of imaging, respiratory care, surgical services, lab, pharmacy, emergency and other related services. The CON application will be submitted within 20 days of this notice.

Ad No. 08547019

NOTICE TO CREDITORS
All persons having claims against the following estate are required to deliver or mail their claims to the indicated Personal Representatives (PR), appointed to administer these estates. AND to file their claims on form #371PC with the Probate Court for York County at PO Box 219, York, South Carolina, 29745, on or before the date that is eight months after the date of the first publication of this Notice. Creditors of such persons shall be forever barred as to their claims. All claims are required to be presented in written statements indicating the name and the address of the claimant, the basis of the claim, the amount claimed, the date when the claim will become due, the nature of any uncertainty as to the amount claimed and the date when due, and a description of any security as to the claim.

201 Legal

NOTICE
In accordance with the South Carolina Department of Health and Environmental Control, Regulation 61-15 (Certificate of Need for Health Facilities and Services), Amisub of South Carolina, Inc., dba Piedmont Medical Center, 722 Herlong Avenue, Rock Hill, South Carolina, hereby notifies the public of its planned submission of a Certificate of Need application (CON) to develop a 50-bed hospital at the site located at 1820 Frank Gaston Boulevard adjacent to Piedmont Medical Center in Rock Hill, SC. The facility will be approximately 75,000 square feet with an estimated total project cost of $73 million. Services will include 42 inpatient beds for adult and geriatric care and 8 beds for child and adolescent care. The inpatient services will include adult and child and adolescent psychiatric intensive care and stabilization and adult and geriatric psychiatric inpatient care. Additionally, the hospital will provide outpatient services with ancillary services being provided by Piedmont Medical Center through an Ancillary Services Agreement. The CON application will be submitted within 20 days of this notice.

Ad No. 08547020

NOTICE OF PUBLICATION
Notice is hereby given that PARCEL BEVERAGE, LLC, or

201 Legal

NOTICE TO CREDITORS
All persons having claims against the following estates are required to deliver or mail their claims to the indicated Personal Representatives (PR), appointed to administer these estates. AND to file their claims on form #371PC with the Probate Court for York County at PO Box 219, York, South Carolina, 29745, on or before the date that is eight months after the date of the first publication of this Notice. Creditors of such persons shall be forever barred as to their claims. All claims are required to be presented in written statements indicating the name and the address of the claimant, the basis of the claim, the amount claimed, the date when the claim will become due, the nature of any uncertainty as to the amount claimed and the date when due, and a description of any security as to the claim.
Estate: Jack Ervin Godfrey
Case Number: 2005ES4600801
Personal Representative: Helen C. Godfrey
Address: 251 N. Anderson Rd., Rock Hill, SC 29730
Date of Death: 08/29/2005

NOTICE TO CREDITORS
All persons having claims against the following estate are required to deliver or mail their claims to the indicated Personal Representatives (PR), appointed to administer these estates. AND to file their claims on form #371PC with the Probate Court for York County at PO Box 219, York, South Carolina, 29745, on

201 Legal

NOTICE TO CREDITORS
All persons having claims against the following estates are required to deliver or mail their claims to the indicated Personal Representatives (PR), appointed to administer these estates. AND to file their claims on form #371PC with the Probate Court for York County at PO Box 219, York, South Carolina, 29745, on or before the date that is eight months after the date of the first publication of this Notice. Creditors of such persons shall be forever barred as to their claims. All claims are required to be presented in written statements indicating the name and the address of the claimant, the basis of the claim, the amount claimed, the date when the claim will become due, the nature of any uncertainty as to the amount claimed and the date when due, and a description of any security as to the claim.
Estate: Barbara Alene S. Powell
Case Number: 2005ES4600824
Personal Representative: Edgar B. Powell
Address: 5865 Shale Village Road, Rock Hill, SC 29730
Date of Death: 08/23/2005

NOTICE TO CREDITORS
All persons having claims against the following estates are required to deliver or mail their claims to the indicated Personal Representatives (PR), appointed to administer these estates. AND to file their claims on form #371PC with the Probate Court for York County at PO Box 219, York, South Carolina, 29745, on

220 Tickets

Wanted 2-4 tickets for Greenbay game. 803-517-3458

221 Auctions

ESTATE AUCTION
of Mrs. Oris Stewart
712 Greenbriar Ave,
Rock Hill, SC
Saturday, 10/8 10:00AM
Vintage china cabinet, antique chairs, drop leaf table, pineapple bed, glassware, linens, 2 wingback chairs, rocker, dishes, kitchen items, collectible childrens' games & books. Murray 11hp riding mower w/ bagger, tools, chainsaw, weedeaters, way too much to list!
Terms: Cash only, checks w/ approval, 6% Sales Tax
Naomi W. Keller,
803-327-6831
Auctioneer SCAL #3227
keller@cellink.net

UPCOUNTRY AUCTION
Every Fri.-Dealers Draw
Every Sat.-One BIG Dealer
Sale 7:30 - Music 4:30
4127 Celanese Rd.
Faye Sanderson SCAL 154

241 Tax Services

NEW TODAY!
Learn To Earn
Become a qualified Tax preparer, day & evening classes available.
Many successful graduates work for us!
Call Jackson
Dorsett st.
803-380-4282
Rock Hill
803-222-1044
Clover
803-628-8318
York

Liberty Tax Service
Free Tax Course
Could lead to employment.
Call 803-366-1918 for details.

242 Legal Services

MATLOCK LAW FIRM
DUI, Uncs, Divorce $500
+cost RH Atty. 985-9989.

266 School Instruct

GOT MUSIC?
Voice or Piano lessons
Qualified instructor
(doctorate)
$30 hr lesson
$15 1/2 hr lesson
803-984-7144

TUTORING SERVICE
For all ages *Qualified tutors (advanced degrees) *English, History, Latin, Spanish, Language Arts, Social Studies, $30 hr, Ref's 803-984-8749.

301 Financial

READER ALERT!!
About 800 / 900 Numbers & International Long Distance Numbers
THE HERALD newspaper classified advertising department follows a policy of screening all 900 phone numbers to monitor our subscribers. Ads listing 900

RECORD 002271
Pled.Supp.CON.0083
JOINT-B-PMC-001.0087

201 Legal

NOTICE

In accordance with the South Carolina Department of Health and Environmental Control, Regulation 61-15 (Certificate of Need for Health Facilities and Services), Amisub of South Carolina, Inc., dba Piedmont Medical Center, 722 Herlong Avenue, Rock Hill, South Carolina, hereby notifies the public of its planned submission of a Certificate of Need application (CON) to develop a 50 bed hospital at the site located at 1868 Frank Gaston Boulevard adjacent to Piedmont Medical Center in Rock Hill, SC. The facility will be approximately 37,200 square feet with an estimated total project cost of $7.3 million. Services will include 42 inpatient beds for adult and geriatric care and 8 beds for child and adolescent care. The inpatient services will include adult and child and adolescent psychiatric intensive care and stabilization and adult and geriatric psychiatric inpatient care. Additionally, the hospital will provide outpatient services with ancillary services being provided by Piedmont Medical Center through an Ancillary Services Agreement. The CON application will be submitted within 20 days of this notice.

Ad No 08547020

NOTICE TO CREDITORS

All persons having claims against the following estates are required to deliver or mail their claims to the indicated Personal Representatives (PR), appointed to administer these estates, AND to file their claims on form #371PC with the Probate Court for York County at PO Box 219, York, South Carolina, 29745, on or before the date that is eight months after the date of the first publication of this Notice to

201 Legal

NOTICE

In accordance with the South Carolina Department of Health and Environmental Control, Regulation 61-15 (Certificate of Need for Health Facilities and Services), Amisub of South Carolina, Inc., dba Piedmont Medical Center, 722 Herlong Avenue, Rock Hill, South Carolina, 29732, hereby notifies the public of its planned submission of a Certificate of Need application (CON) to develop a 100-bed hospital at the site located at the intersection of S.C. 160 and U.S. Highway 21 in Fort Mill. The facility will be approximately 230,000 square feet with an estimated total project cost of $125 million. Services will include medical/surgical, intensive care, obstetrical, gynecologic cardiac catheterization, MRI and 64 slice CT scanner as well as a full array of imaging, respiratory care, surgical services, lab, pharmacy, emergency and other related services. The CON application will be submitted within 20 days of this notice.

Ad No. 08547019

211 Personals

Start Dating Tonight!
Carolinas' Dating Game
1-800-766-2623 ext. 9439

216 Lost and Found

FOUND small dog on Springdale Rd
White/tan 328-3609

free cat and kittens found on road
547-0709

226 Special Notices

Reach over 2.3 million readers by running your ad in over 80 SC newspapers for only $300.00. Ads also appear on the worldwide web at: scnewspapernetwork.com Call Jimmie Haynes at the SC Newspaper Network 1-888-727-7377

241 Tax Services

NEW TODAY!

Learn To Earn
Become a qualified Tax preparer, day & evening classes available. Many successful graduates work for us!
Call Jackson Hewitt at:
803-366-4202 Rock Hill
803-222-1044 Clover
803-628-0516 York

242 Legal Services

MATLOCK LAW FIRM

324 Dental

PT Receptionist needed. M-F, 8A-12; Medical exp req. Apply in person, 1157 Camden Ave, Rock Hill or fax resume, 803-327-4137.

330 Automotive

COTTMAN TRANSMISSION

One of America's fastest growing transmission franchise companies has Rebuilder, Swing, and R&R positions available for the new Rock Hill location. Applicants call 800-394-6116 Ext. 153 fax resume to: 215-956-0342

DO YOU LIKE CARS?

GOODYEAR

Management Opportunity
For a multi location tire & automotive service center in the Charlotte area. WE'RE GROWING! Looking for Career-Minded, Top Performers. Mgmt exp preferred, not req. Get on the Fast Track and manage a location within 1 yr. Send resumes to: tauman@clarktire.com, fax to 828-345-0124 or online at www.clarktire.com

Experienced Body Tech Top pay, paid holidays, BCBS insurance, 803-329-8989.

Lot Porter needed for East

341 Construction

Help wanted - CDL dump truck drivers, lo-boy driver, backhoe operators, paver operators, mill machine operators. Call 704-361-8400.

Lg. commercial drywall Co seeking top, quality drywall Foreman/Superintendant. Top benefits, top pay. All inquiries, call Jimmy, 704-201-3888. EOE

342 Truck Drivers

DRIVER TRAINEES NEEDED NOW! No experience required. Covenant Transport has immediate openings for entry-level semi drivers. Our avg. driver earns more than $38K first year. OTR and regional runs get you home weekly. Train for top pay - call today 1-888-263-7364.

Drivers:
Class B drivers needed. Competitive pay, 3 - 4 nights/wk. Apply at: 253 Bryant Blvd, RH, SC. No Phone Calls. Please!

NEED OWNER OPERATORS - to pull livestock from SC to western states & back to SC, NC, GA, PENN

ALSO EXCELLENT

351 Sales Work

"Your Hometown Newspapers"
Carolina Newspapers
The Yorkville Enquirer & The Clover Herald

Account Executive

Carolina Newspapers - The Yorkville Enquirer & The Clover Herald, located in York, SC has an immediate opening for an part-time (28-32 hrs/wk) Account Executive in the York areas. Qualified candidates will have excellent communication skills and the ability to develop new business, make sales presentations, and provide the highest quality of customer service. Knowledge of advertising principles, media, retail and classified business procedures and sales experience is highly important as well as the ability to work effectively under deadline situations. This position offers base wage plus commission as well as an excellent benefits package. Qualified candidates please send resume with salary history to: Publisher, Carolina Newspapers, P.O. Box 30, York, SC 29745 or fax to (803) 628-0300 EOE

Allstate Insurance Co. Sales position available. Must be willing to get licensed within one month. Please fax resume to 803-329-2935.

354 Education

!Instructors Needed!
Fortune Academy has immediate openings: Pre-license & CE in Real Estate, Insurance & Appraisal.
Fax Resumes to (843) 839-9696

357 Child Care

+ NANNY +
Exp.! Full time for loving care of 2 girls, 5 yrs & 19 mos. Housework, cooking, errands, etc. DL req'd. Refs checked. Live-In situation possible. Hrs & pay nego. Candice 242-1723

Nanny Needed
In home care for 1 child, yrs old. Part-time (28hrs/wk) Transp. & 2 refs req. Near Tega Cay 704-588-1744 bwelch@espossoc.com

361 Misc Employ

$ AVON $ Set your own hours / income! Health Benefits. Call 1-800-774-3735

$$$$
Sales Agents needed for class II Medical Equipment. up to $2,400/mo to start. No experience needed. Call 803-327-4143 Monday only

Attention!

361 Misc Employ

SOUTHERN FINANCE
Several openings avail. for: **Mgr Trainees/Asst Mgrs**
Career minded people with ambition. No experience necessary. Apply in person 875 Albright Rd, Suite 107.

TELEMARKETERS NEEDED
No Selling - Great Pay Plus Bonuses. 325-8447

Warehouse delivery, unload trucks, heavy lifting, 35-40 hrs, HS Dip., DL, prof. appear. Delivery experience. Apply in person, no calls! Tinsley Furniture, 951 Celriver Rd, Rock Hill

362 Maintenance

Night Shift Maintenance Mechanic needed for 12 hour rotating shift at Fort Mill, SC chemical plant. Great pay & benefits EOE. Drug-free work place. Fax or mail resume to 803-548-2683, 7300 Banks Street, Fort Mill, SC 29715 Attn: Brian McCarter

406 Business Oppty

Have A New Lifestyle?
FIRE YOUR BOSS!
Great income opportunity. Serious calls only. Call 800-294-8654 ext. 0515.

Profitable Specialty Sandwich Shop, Selling due to health. Turnkey

501 Pets

Chihuahua, Pekingese, Cocker, Chinese Crested, Dachshund, Toy Fox Terrier, & Poodle Pups
Pet Village Photo Days November 12 & 19
Call for an appointment
Pet Village 803-366-7368
Check our new website @ www.pet-village.com

FREE PETS POLICY
Your pet deserves a loving, caring home. An ad for a free pet may draw response from individuals who will sell your animal for research or breeding purposes. Please screen respondents carefully when giving an animal away

Free Kittens
Male or female, all sizes and colors, long hair or short
803-222-5127

Lab pups - AKC, choco., 8 wks, shots & wormed, parents on site. 803-325-2233

Lab PupsAKC , Black, Ready to go! Lake Wylie, Call 803-831-8373

Miniature Dotson
10 mos old w/ papers
803 313-9663

Put Your Ad In Print And Online. Reach Close to 100,000 Potential Buyers!

RECORD 002272

Pied.Supp.CON.0084

JOINT-B-PMC-001.0088

Wheelin & Dealin Special
4 lines, 28 days
$59

10 Day Special
5 lines, 10 days
$44

FOR MAXIMUM EXPOSURE, Run It Online and In The Herald, Lake Wylie Pilot, R

The Herald CLASSIFI

Deadlines

Run Day	Deadline by Phone	Deadline by Fax	Run Day	Deadline by Phone	Deadline by Fax
Monday	5pm Fri	2pm Fri	Thursday	4pm Wed	2pm Wed
Tuesday	4pm Mon	2pm Mon	Friday	2pm Thu	1pm Thu
Wednesday	4pm Tue	2pm Tue	Saturday	9:30am Fri	9:30am Fri
Sat (real est)	5pm Thu	9:30am Fri	Sunday	4pm Fri	3pm Fri

Hou
Monday
7:30am

•By Mail: The Herald, PO Box 11707, Rock Hill, SC 29731 •Fax: 803-329-402

NOTICE

In accordance with the South Carolina Department of Health and Environmental Control, Regulation 61-15 (Certificate of Need for Health Facilities and Services), Amisub of South Carolina, Inc., dba Piedmont Medical Center, 222 Herlong Avenue, Rock Hill, South Carolina, 29732, hereby notifies the public of its planned submission of a Certificate of Need application (CON) to develop a 100-bed hospital at the site located at the intersection of S.C. 160 and U.S. Highway 21 in Fort Mill. The facility will be approximately 230,000 square feet with an estimated total project cost of $125 million. Services will include medical/surgical, intensive care, obstetrical, diagnostic cardiac catheterization, MRI and 64 slice CT scanner as well as a full array of imaging, respiratory care, surgical services, lab, pharmacy, emergency and other related services. The CON application will be submitted within 20 days of this notice.

Ad No. 0854701B

NOTICE

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Ad No. 0854702B

211 Personals

Start Dating Tonight!
Carolinas' Dating Game

221 Auctions

UPCOUNTRY AUCTION
Every Fri.-Dealers Draw
Every Sat.-One BIG Dealer
Sale 7:30 - Music 6:30
4127 Celanese Rd.
Faye Sanderson SCAL 154

241 Tax Services

NEW TODAY!

Learn To Earn

Become a qualified Tax preparer, day & evening classes available. Many successful graduates work for us!

Call Jackson Hewitt at:
803-366-4202 Rock Hill
803-222-1044 Clover
803-628-0516 York

242 Legal Services

MATLOCK LAW FIRM
DUI, Unc., Divorce $500 +cost RH Atty. 985-3989

301 Employment Info

READER ALERT!!

About 800 / 900 Numbers & International Long Distance Numbers

THE HERALD newspaper classified advertising department follows a policy of screening 800 & 900 phone numbers to meet our guidelines. Ads listing 900

323 Health Care

NurseFinders
The Professional Choice
Hiring RN's/LPN's
Immediately
Daily Pay
Apply on line at
www.nursefinders.com
803-324-9700 EOE

324 Dental

PT Receptionist needed. M-F, 8A-12; Medical exp req. Apply in person. 1157 Camden Ave. Rock Hill or fax resume, 803-327-4137.

330 Automotive

COTTMAN TRANSMISSION
One of America's fastest growing transmission franchise companies has Rebuilder, Swing, and R&R positions available for the new Rock Hill location. Applicants call 800-394-6116 Ext. 153 fax resume to: 215-956-0342

DO YOU LIKE CARS?

GOODYEAR

Management Opportunity
For a multi location tire & automotive service center in the Charlotte area. WE'RE GROWING! Looking for Career-Minded, Top Performers. Mgmt exp preferred, not req. Get on the Fast Track and manage a location within 1 yr. Send resumes to: laurman@clarktire.com, fax to 828-345-0124 or online at www.clarktire.com

Experienced Body Tech Top pay, paid holidays, BCBS insurance. 803-329-8989.

Lot Porter needed for Fort Mill dealership. Great benefits. Apply in person JT's Lake Wylie Chrysler Jeep Dodge, 800 Gold Hill Rd., Fort Mill, SC. 803-396-1000

334 Landscape

Landscape/Lawn Maint Supvrs. Req: 2yr supvr. exp. Mail resume PO Box 506, Fort Mill SC 29716 or fax 803-547-2159 or email sales@flineonline.com334

341 Construction

Carpenter Needed for framing crew. Must have license & own transportation. 803-242-9910

Electrical helper wanted. Must be reliable. Local transportation required. Call 704-621-7314.

Help wanted - CDL dump truck drivers, lo-boy driver, backhoe operators, paver operators, mill machine operators. Call 704-361-8400

342 Truck Drivers

DRIVER TRAINEES NEEDED NOW! No experience required. Covenant Transport has immediate openings for entry-level semi drivers. Our avg. driver earns more than $36K first year. OTR and regional runs get you home weekly. Train for top pay - call today 1-888-263-7364.

Drivers:
Class B drivers needed. Competitive pay, 3 - 4 nights/wk. Apply at: 250 Bryant Blvd, RH, SC. No Phone Calls, Please!

NEED OWNER OPERATORS - to pull livestock from SC to western states & back to SC, NC, GA, PENN

ALSO EXCELLENT OPPORTUNITY FOR GOOD DRIVERS TO BECOME OWNER OPERATOR - have 379 Peterbuilts and W900 Kenworths with CAT power for LEASE PURCHASE.

CALL TODAY -

346 Rest/Club/Hotel

Red Bowl Asian Bistro needs exp Waitstaff. Apply in person, 845 Stockbridge Dr FM -803-887-5666

348 Customer Service

The Herald
ATTENTION
Sales & Service Professionals!

A Part Time Customer Service Representative is needed for York County's Largest Newspaper!

The Herald has an immediate opening in its classified advertising department for a part time customer service representative. Candidates should be people oriented, possess excellent customer service and telephone skills, and have the ability to produce professional results under deadline. PC skills a must! This position is offered with a base salary and a attractive commission program!

We have an excellent benefit package which includes health, dental, and 401k. If you meet these qualifications and would enjoy working in a professional environment, please send resume to ATTN: Customer Service Manager, The Herald, P.O. Box 11707, Rock Hill, SC 29731. EOE

Immediate opening for Assistant Manager & Floater for Finance Co. Seeking dependable energetic & eager to learn persons for one of our local offices. Exp helpful in the finance industry. Apply in person only. Colonial Credit 875 Albright Rd., Suite 117, Rock Hill.

351 Sales Work

Account Executive
The Herald's Classified Advertising Depart-

Pled.Supp.CON.0085

JOINT-B-PMC-001.0089

RECORD 002273

C

ATTACHMENT C

ARCHITECT'S VERIFICATION OF COSTS (REVISED)
EQUIPMENT QUOTES

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: 9/20/2010 11:38
Inflation Rate: 2.50%
Cap Interest Rate: 10.00%

	CER Category	Budget
1	Professional Fees	$5,260,734.89
2	Construction	$75,631,867.30
3	Equipment/Furniture	$50,833,168.08
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	$8,962,850.47
11	Land Purchase	$4,668,604.81
12	Other Substituted Funds	$0.00
	TOTAL PROJECT COST ESTIMATE INCLUDING CAPITALIZED INTEREST	**$146,522,041.55**

Project Manager's Comments:

This estimate includes utilizing a 3.0T MRI in the equipment estimate. Land cost calculated as follows: Amisub purchased 40 acres for $11,148,907.00 ($278,722.68 per acre). Amisub will use 16.75 acres for the hospital or 16.75 x $278,722.68 = $4,668,604.81

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**

Kim C. Pulliam, A.I.A.
Director, Central States
tel: 615-302-0174
fax: 615-302-0175
kim.pulliam@tenethealth.com

September 16, 2010

Beverly A. Brandt, Bureau Chief
Division of Planning and Certification of Need
Bureau of Health Facilities & Services Development
South Carolina Department of Health and Environmental Control
1777 St. Julian Place, Suite 201
Columbia, SC 29204

RE: Fort Mill Medical Center CON Application

Dear Ms. Brandt:

I provide the following as a breakdown of the total Furniture, Furnishing and Equipment (FF&E) components of the development budget for the Fort Mill Medical Center project.

In my capacity as Director, Central States/Construction & Design for Tenet Healthcare Corporation, I function as owner representative and project manager for capital improvement projects at twenty (20) hospitals in six states. I typically establish the FF&E budgets for these projects using our "completed projects" database, with assistance from independent equipment consultants. The following contains a breakdown of the estimate (budget) developed for the Fort Mill Medical Center project:

Medical Equipment	$ 31,119,011
Dietary Equipment	1,781,275
Medical Communications/IT	15,444,468
Furnishings	2,313,413
Exterior Signage	175,000
TOTAL FF&E	$ 50,833,168

By separate cover, we are providing quotes from GE Healthcare for all medical equipment costing more than $600,000. A summary of those quotes is as follows:

64-Slice CT	$1,677,672.80
MR-3T Discovery 750 HD	2,097,152.00
Innova 3100 Ipw Mac Lab	1,332,537.05

Sincerely,

Kim C. Pulliam, A.I.A.
Director, Central States
Construction and Design

Tenet Healthcare Corporation • Headquarters Office
1445 Ross Ave, Ste. 1400 • Dallas, TX 75202 • Tel 469.893.2000 • Fax 469.893.8600 • www.tenethealth.com

GE Healthcare

QUOTATION

Quotation Number: P1-C102111 V 1

Piedmont Medical Center Hospital
222 S Herlong Ave
Rock Hill SC 29732

Attn: Fred Schuls
Director of Cardiology
Cardiology
222 S Herlong Ave
Rock Hill SC 29732

Date: 08-11-2010

Quote Summary Heading

Qty	Description	Ext Sell Price
	Innova3100IQplus Xray System	
1	IC Innova3100IQplus	$1,157,781.05
	Mac-Lab XT	
1	MAC-LAB XT	$130,276.00
	CA1000 Workstation	
1	CA1000 Workstations	$44,480.00
	Quote Summary:	
	Total Contract List Price:	**$1,952,108.00**
	Total Extended Selling Price:	**$1,332,537.05**
	Total Quote Net Selling Price	**$1,332,537.05**

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GE Healthcare

QUOTATION

Quotation Number: P1-C102111 V 1

Piedmont Medical Center Hospital
222 S Herlong Ave
Rock Hill SC 29732

Attn: Fred Schuls
Director of Cardiology
Cardiology
222 S Herlong Ave
Rock Hill SC 29732

Date: 08-11-2010

This Agreement (as defined below) is by and between the Customer and the GE Healthcare business ("GE Healthcare"), each as identified herein. GE Healthcare agrees to provide and Customer agrees to pay for the Products listed in this GE Healthcare Quotation ("Quotation"). "Agreement" is defined as this Quotation and the terms and conditions set forth in either (i) the Governing Agreement identified below or (ii) if no Governing Agreement is identified, the following documents:

1) This Quotation that identifies the Product offerings purchased or licensed by Customer;

2) The following documents, as applicable, if attached to this Quotation: (i) GE Healthcare Warranty(ies); (ii) GE Healthcare Additional Terms and Conditions; (iii) GE Healthcare Product Terms and Conditions; and (iv) GE Healthcare General Terms and Conditions.

In the event of conflict among the foregoing items, the order of precedence is as listed above.

This Quotation is subject to withdrawal by GE Healthcare at any time before acceptance. Customer accepts by signing and returning this Quotation or by otherwise providing evidence of acceptance satisfactory to GE Healthcare. Upon acceptance, this Quotation and the related terms and conditions listed above (or the Governing Agreement, if any) shall constitute the complete and final agreement of the parties relating to the Products identified in this Quotation. The parties agree that they have not relied on any oral or written terms, conditions, representations or warranties outside those expressly stated or incorporated by reference in this Agreement in making their decisions to enter into this Agreement. No agreement or understanding, oral or written, in any way purporting to modify this Agreement, whether contained in Customer's purchase order or shipping release forms, or elsewhere, shall be binding unless hereafter agreed to in writing by authorized representatives of both parties. Each party objects to any terms inconsistent with this Agreement proposed by either party unless agreed to in writing and signed by authorized representatives of both parties, and neither the subsequent lack of objection to any such terms, nor the delivery of the Products, shall constitute an agreement by either party to any such terms.

By signing below, each party certifies that it has not made any handwritten modifications. Manual changes or mark-ups on this Agreement (except signatures in the signature blocks and an indication in the form of payment section below) will be void.

• Terms of Delivery:	FOB Destination
• Quotation Expiration Date:	10-29-2010
• Billing Terms:	40% Upon delivery - 50% Upon installation - 10% Upon acceptance
• Payment Terms:	NET 30
• Governing Agreement:	Broadlane

Each party has caused this Agreement to be signed by an authorized representative on the date set forth below.

Please submit Purchase Orders to: General Electric Company, GE Healthcare, 9900 Innovation Dr, RP2124, Wauwatosa, WI 53226.

Fax to (414) 721-4181.

GE HEALTHCARE _____ Date

Marc Brewer
Interventional Account Specialist
POB 1334, 314 W. Cooper Ave
Folly Beach, SC 29439
US
Phone: 803.467.1219
Fax: 888.490.1951
Dennis.M.Brewer@med.ge.com

CUSTOMER

_____ Date
Authorized Customer

_____
Print Name and Title

_____

INDICATE FORM OF PAYMENT:

(If there is potential to finance with a lease transaction, GE HFS or otherwise, select lease.)

____ Cash * ____ Lease ____ HFS Loan

If financing please provide name of finance company below*:

_____

*Selecting Cash or not identifying GE HFS as the finance company declines option for GE HFS financing.

1/25

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Quotation Number: P1-C102111 V 1

PO #

GE Healthcare Confidential & Proprietary

Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
		Innova3100IQplus Xray System	
1	S18731MP	Innova 3100IQ Plus Cardiovascular and Interventional Single Plane System with Omega V Table (Motorized)	$794,300.00
		The Innova 3100IQ cardiovascular and vascular x-ray system incorporates GE's exclusive Revolution solid-state digital detector to consistently provide excellent imaging performance through a full range of diagnostic, interventional and cardiovascular procedures.	
		The Innova 3100IQ is a fully integrated imaging system that meets a wide range of clinical needs for interventional and diagnostic imaging with excellent image quality, extensive real-time processing, innovative dose management, ease of positioning, improved workflow and image management for excellent clinical versatility without compromise.	
		The Innova 3100IQ (31 x 31 cm square and 43 cm diagonal) unites image quality, an optimal panel size and built-in protocols for imaging versatility.	
		The Innova Digital Flat Panel Detector	
		The key element in this image chain is GE's patented Revolution Digital detector, which captures dynamic and fluoroscopic images in digital form with very efficient use of X-ray dose. The specially designed Innova 3100IQ Digital System provides optimized and customizable image processing algorithms to take maximum advantage of the unique properties of these images.	
		Dose Reduction	
		The Innova 3100IQ is optimized for dose efficient operation in a wide range of imaging applications. GE's novel dose sensitive design has considered various aspects of dose optimization.	
		• Detector dose efficiency: The high DQE of the Revolution detector provides inherent dose efficiency improvements.	
		• Virtual Collimation: Enables you to position the collimator blades without irradiation.	
		• Dynamic exposure optimization - AutoEx: A neural network technology allows advanced exposure management algorithms to dynamically control x-ray technique and beam filtration. This optimizes the contrast-to noise ratio within the image automatically, in real time, without operator intervention.	
		• Temporal dose efficiency: The high temporal resolution of the Revolution	

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Qty	Catalog No.	Description	Ext Sell Price

detector and the real-time adaptive capability of the Innova 3100IQ architecture allow GE's unique fluoro algorithms to produce dose efficient noise reduction.

- Optimized frame rates: A choice of frame rates to enable dose reduction while capturing dynamic motion with required resolution is available.
- Integrated dose monitoring: This allows monitoring and display of air kerma, integrated air kerma over the exam and the total dose area product received by the patient during a procedure.
- Dose IQ customization: Several image quality and dose strategies are available and can be customized for the various clinical protocols in both Fluoro and Record acquisitions, making the Innova 3100IQ truly versatile without compromise over a wide range of clinical procedures.

Innova 3100 Positioner

The Innova 3100IQ combines GE's exclusive Innova LC Positioner with an ergonomically designed tableside user interface to provide easy access and control of critical features during an exam.

- The patented, three-axis isocentric Positioner design with floor mounted L-arm and offset C-arm provides maximum positioning flexibility and excellent patient access in all views.
- The rigid, floor-mounted construction provides minimum vibration and deflection during acquisitions.
- The three motor-driven axes make even the most complex angulations easy to achieve.
- Anatomical and mechanical movement for easy gantry positioning

Innova Digital Flat Panel Image Chain

- 30 cm Revolution Digital Flat Panel Imaging System
- Completely Digital Imaging Chain
- Amorphous Silicon Photodiode Array
- Cesium Iodine Scintillator
- 30 cm x 30 cm Active Area
- 30, 20, 16, and 12 cm Fields of View (measurements are length per side)

Innova 3100IQ X-ray Generation

The Innova 3100IQ utilizes a 100 kW high frequency, Jedi three-phase power unit that provides grid pulsed fluoroscopy capability.

Performix 160A X-ray Tube:

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price

- 1.0, 0.6 and 0.3 mm (Biased) Effective Focal Spots
- Grid Pulsed Fluoroscopy
- 3.7 MHU Anode Heat Storage Capacity
- 3200 Watt Continuous Casing Heat Dissipation Rate
  - 4500 Watt peak capability for a maximum of 10 minutes
- Continuous Water Cooling with External Chiller

Innova Angiographic Collimator

- Automated Spectral Filters
  - 0.1, 0.2 and 0.3 mm Thick
- Three Independent Motorized Contour Filter Plates including a Central Leg Filter
- Functions controlled from tableside.

Innova Digital Imaging Subsystems

A fully integrated imaging system that meets key vascular imaging demands with advanced real-time processing, storage, post processing and display capabilities. Based on the Windows XP operating system, the Innova Digital system is capable of true multitasking with background image networking that increases productivity and speeds patient throughput.

- High bandwidth, real-time processing and image presentation algorithms optimized for imaging using the Revolution Detector provide superior image enhancement.
- Innova Dynamic Range Management provides consistent visibility of vessels and devices over all backgrounds.
- Edge enhancement filters automatically adapt to field-of-view changes to maintain consistent image appearance.

Image Acquisition

- Fluoroscopy (un-subtracted, roadmap and subtracted) at 30 fps, 15 fps and 7.5 fps
- Optional Sub/no Sub simultaneous display at maximum 30 fps (requires an additional in-room B&W LCD monitor)
- Optional Angio Acquisition Package:
  - DSA (digital subtracted angiography) at 0.5 - 7.5 fps
  - Multi-segment DSA and flexible frame rate and duration and single shot capabilities

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
		• Dynamic Acquisition Package at 30 fps and 15 fps • Optional Innova Chase acquisition at 5 fps • Field-of-view adjustment from tableside with four magnification selections with 1024 x 1024 image display regardless of acquisition matrix • Integrated X-ray dose tracking and in-room display of air kerma and dose area product • Horizontal and vertical image flip capability for all acquisition modes • Automated electronic shutter matched to collimated portion of image for optimized image display and visualization comfort. Image Display • Innova 3100IQ includes 1 B&W 19" LCD monitor and 1 console color monitor for control room display of live and reference images. • Additional 19" LCD color monitors can be purchased and installed on the in-room LCD monitor suspension for AW, hemodynamic, and EP recording systems, ultrasound, IVUS. User Interface • Dedicated keypad for convenient control of commonly used review functions • Flat graphic display with easy "point-and click" mouse control for patient management and advanced processing and analysis features • Keyboard for patient data entry • Wireless remote for in-lab control of commonly used image playback and processing functions • Tableside TSSC with Contour Filter Controls, Collimation, 72 User Stored Gantry Positions, and Landscaped Roadmapping at Tableside • Virtual Collimation provided with display of Collimator position on Fluoro Last Image Hold • Dual Footswitch with Table Unlock and Footswitch Cover • InfraRed Remote Control for Tableside Review Image Management, Connectivity & Workflow • Acquisition of data at 14 bits • Cardiac images stored in 8 bits, maximum 450 images per sequence, storage capacity: 136000 cardiac images	

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price

- DSA images with 12 bits data stored in 16 bits, maximum 450 images per sequence, storage capacity: 68000 DSA images
- DICOM image output on 100Mbit Ethernet with Autosend and background transfer for fast transmission with minimal user interaction
- Capability to do full resolution 1024 x 1024 DICOM push to retain image quality at acquisition (configurable to 512 x 512 for cardiac acquisitions)
- Patient Worklist capability provides a single point of entry of patient data, increasing staff productivity and eliminating clerical errors. Patient information can easily be imported into the digital system from information systems that support DICOM Worklist Service Class Provider.
- MPPS: Modality Performed Procedure Step allows the Innova 3100IQ to share with the hospital information system the main exam parameters.

Omega V Long Table (Motorized) with Slicker Cover

The compact carbon fiber laminate structure tabletop provides maximum rigidity with lowest absorption and scatter while allowing increased system angulation capability. The compact base provides complete freedom of movement around the table and clearance for the positioner. Motorized vertical travel of tabletop facilitates magnification techniques and vertical positioning of the patients to isocenter. It also allows for positioning of the tabletop to a comfortable working height. Tabletop rotation of +/- 180 degrees along the vertical axis allows for easy loading and unloading of patient, excellent patient access at the beginning or at the end of patient anesthesia, and rapid patient access in emergencies. The tabletop is equipped with accessory rails to mount gantry controls, table-side system controls and optional I.V. poles.

Specifications:

Table: 61 cm x 52 cm (24 inches by 20.5 inches); Length: 333 cm (131 inches); Width. 46 cm (18 inches) in patient trunk area; Longitudinal travel: 170 cm (67 inches); Transverse travel: +/- 14 cm (+/- 5.5 inches); Vertical travel: 30 cm (12 inches); Vertical travel above floor: From 78 cm (30.7 inches) to 108 cm (42.7 inches); Vertical speed: 2.5 cm/s (1 inch/s)

The Omega V Table can support a maximum patient weight of 204 kg (450 lbs) for the tabletop, 40 kg (88 lbs) of accessories supported on each of two side rails, and 20 kg (44 lbs) of accessories on the (optional) table end rails.

Warranty:

Full One Year Warranty on System and Revolution Detector. Three Year

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
		Non-prorated Warranty on the X-Ray Tube as detailed in Warranty Documentation.	
		Broadband Built In	
		Includes hardware install support essential for systems to be ready for high speed internet connection. Enables customer to access GE Healthcare Digital Services designed to improve quality, enhance performance, increase productivity, reduce costs, reduce downtime, expand imaging capabilities, and increase privacy and security of data transmission.	
		Standard warranty coverage hours for this Innova system are 8 AM to 9 PM local time.	
1	S18061AC	Table Head Extender	$3,250.00
		• Extender to widen the table top head end for patient comfort	
1	S18061RE	Omega V Table Foot End Rail Extender	$3,250.00
1	S18751SA	In Room Browser	$3,250.00
		Enables a thumbnail display of acquired sequences and photos on the in room monitor for interactive table-side selection and review. With a press of a button, transfer the angulation information from a review image to positioner for auto-positioning of the gantry.	
1	S18751TS	Innova Central Touch Screen	$13,000.00
		The Touch Screen User Interface is a gateway to table-side integration of multiple work-flow enhancing features. The Touch Screen controls not only Innova functions, but also Maclab cardiolab functions (optional). In the future this centralized tableside platform is going to have ability to connect with, and control third-party devices as well.	
1	S18751FS	FluroStore	$9,750.00
		Lets you store and play fluoroscopic loops with a push of a button. Enables looping display and storage of the last 450 fluoroscopic images (60 seconds to 15 seconds depending on frame rate). The images are marked with a separate icon to identify them distinctly during the review.	
1	S18341TT	Table Panning Device with 5M Cable	$487.50
		Table mounted vertical grip for fast and easy table lock release and panning of the Omega Cardiac and Angio tables.	

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
1	S18061TB	SmartBox New SmartBox for Simplified and Intuitive Joystick Control of Positioner and Table • Anatomical and mechanical positioning • Independent or simultaneous movement of all three positioner axes • Remote SID Control • Manual or motor assisted 4-way table panning • Ergonomic design • Hermetically sealed	$3,250.00
1	S18061TE	Innova Smart Handle Single-handed, Simultaneous Control of Positioner and Table Movements From the SmartHandle Operator Control • Anatomical and Mechanical Positioning • Independent or Simultaneous Movement of All Three Positioner Axes • Remote SID Control • Manual or Motor Assisted 4-way Table Panning • Ergonomic Design • Hermetically Sealed	$3,250.00
1	S18461GA	Two 19 Inch Monochrome LCD Monitor Package All Components Required for Two Monitor In-lab Viewing of High Quality Flicker Free Images. The Kit Includes: • 2-19 Inch Premium LCD Monitors • 120Hz Scan Converter Kit	$19,500.00
1	S18751SH	Simultaneous Image Display with Monitor Includes: • Sub/No Sub Software • (1) 48 cm (19 inch) B&W LCD Monotor	$16,250.00
1	S18461GW	19 Inch In-room Color LCD Monitor • 19 Inch In-room Color LCD Monitor	$4,225.00

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
		• Dual Input Video Splitter • Required cabling for 2 color inputs • Required cabling from AW to In Room Monitor	
1	S18391LE	Six LCD Monitor Suspension with 36M Cable All Components Required for In-Room Support of Four LCD Monitors and two other monitors for Physiological Display and the repeater AW In-room Monitor • Six Monitor Boom Suspension • Articulating Arm Allows Rotation/Pivot for Optimal Clearance • Pre-Cabled for Four Monitors and the Digital System Remote Receiver • Pre-Cabled for ECG Display Monitor • Accomodates AW In-room Display Option	$19,500.00
1	S1876PE	Innova Main Disconnect Panel - UPS Ready This main disconnect panel provides emergency shut down, undervoltage protection, overcurrent protection, OSHA lockout tag provisions, and serves as a local disconnect for the GEHC Innova system. It reduces installation time and cost by providing a single-point power connection, eliminating the need to mount and wire a number of individual components, and its standardized design and testing assures high product quality and system reliability. It is UL and cUL listed for compliance with National Electric Code, and it can be either surface or semi-flush mounted. Customer is responsible for rigging and arranging for installation with a certified electrician.	$17,094.35
1	S1875PK	GE Digital Energy 20KVa UPS for Innova Systems	$16,250.00
1	S18751PT	Innova UPS Interface	$1,170.00
1	S18751LD	InnovaSense, Advanced Patient Positioning, Patient Contouring and Anti-Collision Package Patient contouring feature leverages advanced capactive sensor technology in real time to sense the distance of the patient from the detector. Ability to do so is critical in moving the detector rapidly near the patient, and also positioning it optimally close to the patient to reduce skin dose.	Incl.
1	S18721AF	Administration Package DICOM Patient Worklist Capability Provides Single Point of Entry of Patient Data, Increasing Staff Productivity and Eliminating Clerical Errors. Patient Information can Easily be Imported Into the Digital System From Information	$6,500.00

Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
		Systems That Support DICOM Worklist Service Provider. The Administrative Package is Required for Two-way Information Exchange with the Mac Lab Hemodynamic Recording Systems (Optional). Administration Package includes Multi-destination Push which enables images to be sent to multiple remote DICOM destinations sequentially (one after the other). Multi-destination helps to support a clinical scenario of handling post processing and archival activities in multiple destinations independently of each other (workstation, PACS). Multi-destination provides a seamless integration of the Innova into your workflow.	
1	S18741BE	InnovaBreeze Peripheral Vascular Imaging Option - Frontal Plane Only • InnovaBreeze Acquisition Software - Continuous panning while viewing subtracted contrast bolus • InnovaBreeze control handswitches with interface cables - Handles installed in control room • InnovaBreeze Advantage Paste Software on AW • Quickstrap Postioning Strap Kit	$26,000.00
1	S18711SB	Advanced Innova Software Package (for Omega Table Only). Enables Innova advanced application options. Includes Dynamic Field of View for Innova 3100IQ and Innova 4100IQ.	Incl.
1	S18751BP	Blended Roadmap Blended Roadmap is a vascular roadmapping application that superimposes a previously acquired vascular image over live fluoroscopy. Clinicians can select any DSA or bolus image as a reference roadmap image. By using it multiple times, it has the potential to minimize contrast media injections during roadmapping. Blended roadmap provides additional features to enhance roadmapping procedures: • Adjustment of the subtraction level • Adjustment of the vessels transparency • Automatic resizing of the roadmap image to adapt to the fluoroscopic field of view • Pixel shift of the vessel image to compensate for motion Blended Roadmap is available on systems with either Omega V or InnovaIQ tables. Blended Roadmap requires the Advanced Innova Software Package.	$13,000.00

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
1	M81521N8	AW VolumeShare 4 with Two Flat Panel Monitors and 4 GB of RAM - NO VOLUME VIEWER AW VolumeShare 4 is a multi modality image review, comparison and post processing workstation built with simplicity and power at its core. Powerful software is optimized to take advantage of state of the art 64 bit technology to ensure leading edge performance. AW VolumeShare 4 features include: Hardware: • HP XW8600 Workstation with Intel 5482 Quad Core Xeon 3.2 GHz CPU w/ 12MB Shared L2 Cache / 1600 MHz FSB • 4GB DDR-2 800 ECC DIMM • 146GB SAS 15,000rpm Hard Disk for OS and Apps. • 292GB: SAS 15,000rpm Hard Disks for Image Data • 2 x 19" NEC monitors Software: • Fast access to information you need through optional RIS integration & priors post-fetch • Efficient workflow through dynamic load, end review and Key Image Notes features • Optional productivity package to pre-process exams and allow up to 8 simultaneous sessions • Dedicated MR cardiac viewer for single and multiple Cine review • Support for external DICOM USB media and preference management tool to exchange preferences across users	$35,000.00
1	S18021CE	Cardiovascular Analysis Package for AW The Cardiovascular Analysis Package includes both the Stenosis Analysis Package and the Left Ventricular Analysis Package. The Stenosis Analysis Package is an application designed to estimate vessel dimensions and relevant parameters of the arterial Stenosis morphology in X-Ray angiography. The system is capable of automatic detection of vessel edges and display of stenosis severity. The Left Ventricular Analysis Package is an expert reporting tool designed to estimate wall motion dynamics of the left ventricle, and to perform Global Ejection Fraction analysis in X-Ray angiography. The system is capable providing Wall Motion and Global Ejection Fraction measurements. Wall	$28,000.00

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
		Motion is built on the centerline method.	
		GEF analysis is calculated using both Simpson's rule method and the Dodge-Sandler area-length method.	
1	S18751CB	Cardiovascular Analysis Package (on DL system)	$18,200.00
		The Cardiovascular Analysis Package includes both the Stenosis Analysis Package and the Left Ventricular Analysis Package.	
		The Stenosis Analysis Package is an application designed to estimate vessel dimensions and relevant parameters of the arterial Stenosis morphology in X-Ray angiography. The system is capable of automatic detection of vessel edges and display of stenosis severity.	
		The Left Ventricular Analysis Package is an expert reporting tool designed to estimate wall motion dynamics of the left ventricle, and to perform Global Ejection Fraction analysis in X-Ray angiography. The system is capable of providing Wall Motion and Global Ejection Fraction measurements (GEF). Wall Motion is built on the centerline method.	
		GEF analysis is calculated using both Simpson's rule method and the Dodge-Sandler area-length method.	
1	S18751BC	Dynamic Angiography Package at 30 fps and 15 fps	Incl.
1	S18751BN	Stent Technologies	$19,500.00
		Includes:	
		StentViz	
		StentViz is a stent visualization enhancement software application available on the DL, or the Innova Central Touch Screen. StentViz analyzes a recorded cardiac sequence and displays an image corrected for motion, artifact and noise.	
		Innova Onetouch Stenosis Analysis	
		The Innova Onetouch Stenosis Analysis is designed to bring the Stenosis Analysis capability to the tableside using the Innova Central Touch Screen. Program activation, distance measurements and other Stenosis Analysis parameters can be controlled directly on the Touch Screen with fingertip control.	
		Innova Onetouch Stenosis Analysis requires the purchase of either the Stenosis Analysis Software or the Cardiac Analysis Software, as well as the	

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
		Innova Touch Screen.	
1	E4502SS	X-Ray Warning and Room Lighting Control Panel The X-Ray in use Warning and Room Lighting Control Panel provides a low voltage interface between the X-Ray in use warning lights, interior room general lighting systems, and the X-Ray system. Convenient, pre-wired foot switch operation of the interior room lights, aids in easy precise imaging system positioning. The X-Ray in use portion of the panel provides low voltage, low energy control of the X-Ray in use Warning Lights. The room general lighting is controlled by a foot switch activated contactor. FEATURES/BENEFITS • Reduces installation time, procurement time and cost, by providing stock availability of this assembled control panel • Reduces shock hazard from the second source of energy running to the imaging control panel • Eliminates the sourcing inconveniences and delivery delays often associated with acquiring individual components • Reduces shock hazard from the second source of energy running to the imaging control panel • UL and cUL labeled to conform to domestic and Canadian Codes • Increases servicing safety by the use of low voltage interface circuit between the imaging system and the line voltage lighting systems SPECIFICATIONS • Dimensions (H x W x D): 12" x 12" x 6" • Weight: 26 lbs. • Mounting: Rear mounting holes located 9" horizontally and 9" vertically. Mounting hole diameter is 5/16" COMPATIBILITY • For use in CT, PET/CT and X-Ray applications NOTES: • Customer is responsible for rigging and arranging for installation with a certified electrician • ITEM IS NON-RETURNABLE AND NON-REFUNDABLE	$1,689.60
1	E7018JN	Medrad Provis Table Mount Injector w/Remote Keyboard, & Free-Standing	$26,800.00

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
		Pedestal FEATURES/BENEFITS • Programmed microprocessor helps protect against over-volume, over-flow, over-pressure • Exclusive mechanical stop automatically sets and locks to physically limit injection to selected volume and is unaffected by electrical interruption • Large, bright control panel for easy reading in any lighting situation • Common protocols are stored to save time • Multiple Turret configurations for different volume studies • Wide range of fast and slow loading speeds • Convenient free standing pedestal to allow injector to be removed from table and placed out of the way when not in use SPECIFICATIONS • Loda rate 5-10 ml/sec variable speed • Syringes, disposable: 60, 150, or 200 ml • 105-120 VAC single phase, 60 Hz	
1	E8015JB	Omega V Tempurpedic Table Pad (1 in. Thick), 131 in. L GE has partnered with Tempurmedic to produce a 1 in. thick pad that improves patient comfort for long procedures. This mattress is designed for use in acute, sub-acute, and long-term care settings. It is a superior therapeutic adjunct that has been clinically demonstrated effective in supporting comprehensive plans of care intended to prevent and treat pressure ulcers. Healthcare facilities that have convert ed to this mattress have reported: significant reduction in wound incidence rates, desirable wound healing rates, and better patient comfort. This rectangular mattress is recommended for use with the Omega V Angio table, has a neutral gray color and measures 131 in. L x 22 in. W x 1 in. T...H	$1,260.00
1	E6220J	VIS-A-VIS Vitalinq Intercom System for X-ray The VIS-A-VIS Vitalinq intercom system for X-ray is a two-way communication system that is designed to meet the specific needs that arise during diagnostic and interventional procedures. It enables physicians to have continuous two-way conversation with the control room operator during diagnostic and interventional procedures.	$9,600.00

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Qty	Catalog No.	Description	Ext Sell Price
		FEATURES/BENEFITS • Capable of picking up conversation in a normal tone of voice. Vitalinq allows control room operators to respond immediately to physicians' requests • Larger format and unique pyramidal construction of the microphones contribute to Vitalinq's high intelligibility, even within the acoustically active space of a full-functioning procedure room • Designed to minimize the loss of articulation by reducing the potential echo path it gathers and transmits speech in a highly efficient manner SPECIFICATIONS • Dimensions: 24" x 24" x 20" • Weight: 47 lbs. NOTES: • INSTALLATION IS THE RESPONSIBILITY OF THE CUSTOMER • Warranty Period 6 months - Exchange of non conforming products, which are returned to GE during warranty period. • Installation, parts, application training and onsite service is the buyer's responsibility	
2	E7058A	GE Anti-Fatigue Floor Mat FEATURES/BENEFITS • Ingenious device for those who spend a lot of time on their feet on concrete or tile surfaces • Cradles feet in cushiony comfort, minimizing stress and fatigue • Sealed to prevent moisture absorption and facilitate cleanup - ideal for medical environments SPECIFICATIONS • Dimensions (L x W x D): 60" x 36" x 0.5" • Weight: Approx 22 lbs. • Blue/White Marble Color COMPATIBILITY • Cath Labs, Angiography, R&F rooms • Mammography	$531.20

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
		• Ultrasound	
1	E3053KK	Mavig 360 Track-Mounted Shield & R-96 Lamp, 76 cm x.62 cm, 58 cm Column The Mavig Portegra2 standard overhead lead acrylic radiation protection systems provide protection for medical personnel while allowing visual contact from practitioner to patient, and with Mavig's patented systems, these shields provide the utmost in safety and convenience. This track-mounted system with 360 degree rotation of the spring-arm provides ease of use and positioning,and includes a center-mounted 76 x 62 cm, 0.5 mm lead equivalent acrylic shield with contour cutout and MUL protection, a 58 cm Portegra2 ceiling column with trolley, a cable spooler, and Uniflex R96 lamp, 115V, 40,000 lux and a 14-25 cm focusable light-field. UL and CE marked...H Warranty Period- 6 months-Exchange of non conforming products, which are returned to GE during warranty period Note: Installation, parts, application training and on-site service is the buyer's responsibility	$17,639.20
1	E3053LT	Mavig Cable Spooler for R-96 & Mach 3 Lamp This Mavig cable spooler is used when the R-96 or Mach 3 lamp is track-mounted. The spooler yields and retracts the electrical cable as the lamp travels along the track, eliminating all dangling and tangled power supplies. Warranty Code: H Warranty Period- 6 months- Exchange of non conforming products, which are returned to GE during warranty period Note. Installation,parts,application training and on-site service are the buyer's responsibility	$720.00
1	E3053J	Mavig Double-Pivot Lower Body Protector, System Includes: Pivotal, flexible shield, 0.5 mm Lead Equiv., 65 cm x 90 cm, Easy-on Upper Protective Shield, 25 cm x 65 cm, and One Set of Wall Storage Hangers. Mavig Part #: UT6902-US; Sold per Each ..H Warranty Period-6 months- Exchange of non conforming products, which are returned to GE during warranty period Note: Installation, parts, application training and on-site service is the buyer's responsibility	$4,199.20
1	W0100CV	6 Day Cardiovascular X-ray Onsite System Training Onsite Training for a new Cardiac, Digital Radiographic, Vascular, or Innova X-ray System. Includes: • One-4 day onsite visit to coincide with system start up • One-2 day onsite follow-up visit 6-8 weeks post system start up During the first visit, the applications specialist will work with the medical and	$12,000.00

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
		technical staff on system operation and patient procedures. The training produces the best results when a dedicated core group of 2-4 X-ray technologists complete the session with a modified patient schedule. By the end of this visit, the core group should be able to perform the routine patient procedures. The 2 day revisit is suggested after the staff has run the system for 6-8 weeks, however this is flexible based on the site needs. The training will focus on the intermediate and advanced functions of the system or special needs of the customer. The training produces the best results when the same dedicated core group of 2-4 technologists from the initial visit complete the session with a modified patient schedule.	
1	W4006CV	HQ Class for Innova 3100 and 4100 with AW Full Service, for Cardiovascular X-ray 3.5 day course held in the Milwaukee area. Includes travel and modest living expenses. This course provides the technologist with digital detector theory and performance. Focus on digital subtraction and image quality as well as basic AW workstation operation.	$4,840.00
1	W0600CV	Two Days Onsite Training Advantage Workstation Cardiovascular X-ray One 2 day onsite visit for Advantage Workstation training. Includes T&L expenses. Days provided consecutively.	$4,200.00
1	S18051NF	Mark V+ Provis Table/Rack Mount Interface	$325.00
1	S18101SP	Installation Template	Incl.
1	S18101SF	Anchor Kit - Above Grade and Through Bolts, 25 mm	Incl.
1	S18111SB	9 foot 6 inch Inboard Monitor Bridge	Incl.
1	S18111SH	Reinforcement Bridge	Incl.
1	S18121RD	In Board Rails, 228 inches long, to be used with LCD Monitor Suspensions	Incl.
1	S18751CC	MAC LAB Cable - 70 inches	Incl.
1	S18741EG	GROUP 1 CABLE-MAX LENGTH	Incl.
1	S18741EC	Group 2 Maximum Length Cable	Incl.

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
1	S18741EE	Group 3 Cable	Incl.
1	S18741EF	Group 4-5 Cable	Incl.
1	S18741CG	Bolus Cable Set - 100 ft./30m	Incl.
1	S18101SM	Vascular Base Plate Assembly	Incl.
1	S18741TP	Omega Table Baseplate	Incl.
1	S18741ET	Innova Omega 5 Table Elevator	Incl.
1	S18101SX	Rails and Cable Drapes	Incl.
1	S18121TB	X-ray Digital Detector Coolant Kit	Incl.
1	S18081KA	IVUS Ready Kit	Incl.
		Discounted Configuration Price	$1,157,781.05

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
1	P1008BB	**Mac-Lab XT** Invasive Recording XT Acquisition Controller. • Intel(R)2.0 GHz Quad-core or greater processor • 3 GB of RAM • 2 x 160 GB hard drives • 9.4 GB DVD-RAM/CD-RW drive • Optical Scroll Mouse • High-line video input Warranty: One year warranty on all hardware 90 day warranty on all cables	$16,000.00
1	P1003BA	Mac-Lab XT Hemodynamic Recording System Software Fully configured system includes: • Analog Input - up to 4 inputs of high level input channels • FFR - provides automated calculations of the FFR values • ST Segment software - allows real-time review of ST segment changes from user-chosen baseline during hemodynamic procedures • Holter - quickly review pages of electrogram data • Macros - automates procedural workflow with user-defined procedure setups • Audible Indicators - provides an audible ECG signal in the lab • Image Capture - provides comprehensive management of fluoroscopy images • CardioTree - provides the ability to quickly annotate a coronary diagram with lesions, grafts, and interventions • Innova Central Interface - allows clinicians to operate the CardioLab system from the Innova Central tableside touchpad control • GE Data Export: Allows HL7 files from the system to be sent to other GE devices • GE ADT Import: Enables admission data to be received from GE data management systems like Centricity DMS or Xi2 • GE X-Ray Interface: Enables admission data to be sent to, and Radiologic information to be received from, GE X-Ray systems • CVIS Integration: List Management with GE data management systems like Centricity DMS or Xi2 • InSite 2.0 remote monitoring system software to allow proactive monitoring and support (requires internet connection)	$72,000.00

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
		• Microsoft Windows XP operating system • Microsoft Office 2007 Professional (Does not support Digital image inputs)	
1	P1003C	Mac-Lab English Language Keyboard with dedicated function keys and manuals	$800.00
1	T451N5=A	TRAM 451N5 multi-parameter acquisition module Includes inputs for 12 lead ECG, (including 12SL ECG analysis program), Nellcor Oximax XL SpO2, Dinamap NIBP, 0-4 Invasive Blood Pressures Dual Temperature or Cardiac Output, Defib Sync	$7,800.00
1	P1008D	TRAM 451N AHA Cable Kit (TRAM and TRAM-RAC PURCHASED SEPARATELY) Includes: 12-lead ECG, Respiration Rate; Nelcor SpO2, Thermal Dilution Cardiac Output, SMART-PAC Connection, and Analog Output Connection, up to 4 Invasive BP, Non Invasive BPIncludes Cables & Mounting Kits (Table and Floor)	$1,216.00
1	TR4P=A	TRAM-RAC 4 W/PS USA/CAN Houses up to four (4) single parameter modules or Tram and two additional parameter modules. Analog outputs are conveniently located on the front. Internal Power Supply allows operation at distances greater than 20 feet from a Solar.	$2,400.00
1	P1008C	Integrated Electronics Box (110V IEB) Provides management of recording and distribution of video display signals. Includes Uninterruptible Power Supply (UPS) and Isolation Safety Transformer	$5,000.00
1	P1008CJ	Barcode scanner - allows automatic recording of supply usage	$400.00
1	P1008DK	20" LCD Flat Panel monitor with boom mount This cable is already included: 403689-010 CABLE ASSY,MON PWR, 100 FT	$1,520.00
1	P1008DL	Two 20" LCD Flat Panel monitors	$2,880.00
1	P1008DQ	Black and White Laser Printer (110V)	$800.00
1	P1008DS	Desk - 65inches	$960.00
1	2016376-006	Mac-Lab 1-Year Warranty	Incl.
1	W0009CD	Invasive Project Management Service expires 12 months from date of purchase. Project Management provides GEHC professional project	$2,500.00

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
		management services targeting the successful implementation of GEHC Invasive Cardiology Systems. Managers oversee the implementation process ranging from order review, equipment delivery coordination, installation, training, and final system acceptance.	
		As the GEHC single point of contact for our customers, the Cardiology Project Manager works with hospital's clinical and IT staff to communicate project timelines and administrate project execution. Providing system consultation, managers will track and direct resolution of implementation issues.	
1	W0010CD	The Mac-Lab Training Package consists of both classroom and on-site training. The package includes tuition for 4 students to attend three-day classes for either Mac-Lab or DMS at the GE Healthcare Institute in Waukesha, WI. Additionally, a GE Cardiology Applications Specialist will conduct on-site training for three consecutive days during the system go-live. Tuition includes local ground transportation, Hotel, and Meals (Breakfast and Lunch). Airfare not included. Training expires 12 months from date of go-live of equipment or purchase whichever is the latest.	$16,000.00
		Discounted Configuration Price	$130,276.00

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
		CA1000 Workstation	
1	P2024KP	Centricity PACS Dual Display Tech Workstation The Centricity PACS PC workstation hardware is a HP z600 with a single Intel quad core 2.66 GHz CPU, 3 GB RAM (3 x 1 GB), 2 x 160 GB hard drives, ATI FirePro V3700 video board, and 10/100/1000 Ethernet card. The PC comes with a DVD combo drive, which includes the CD burner. The PC includes a keyboard and mouse, and comes with the Microsoft Windows XP Pro Operating System. The display included is a pair of NEC LCD 2090 UXi 1280 x 1024 native resolution, 0.255 mm dot pitch flat panel display. This item does not include PACS software, floppy drive, or hi-res graphics board(s) that need to be ordered separately if required. A second CPU and additional 3 GB RAM may be added via P2024KL. Warranty on the workstation is a 3-year NBD parts and labor onsite. The warranty on the display is a NEC pass through warranty. Warranty starts upon shipment of hardware from GE	$5,019.00
1	S6599BY	Centricity Cardiology CA1000 is a primary diagnostic image review and analysis workstation, which includes support for seamless integration with GE's Cardiovascular Information System (CVIS). This catalog will include the following features in a seat-based configuration: CA1000 v2 Base SW - Seat Based Stenosis Analysis (SA) and Venticular Analysis (VA) Software Module • SA enables a user to graph and measure the extent of stenosis (or blockage) in a coronary vessel. • VA enables a user to define the diastolic and systolic outlines of the left ventricular wall of the heart. With this information, the application automatically calculates Ejection Fraction. Digital Subtraction Angiography (DSA) Software Module • DSA is the enhancement of images through the subtraction of a base image from a set of images. This option enables the display of subtracted images, as well as the ability to manually subtract non DSA images. CA1000 Echocardiography Analysis Software Module	$32,580.00

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Quotation Number: P1-C102111 V 1

Qty	Catalog No.	Description	Ext Sell Price
		• Ability to perform standard echocardiography measurements CA1000 Single Media Archive Software Module • Enables the CA1000 software to create DICOM compliant CDs, DVDs, or other removable media disks containing DICOM image and report data. CA1000 Interface to Centricity Cardiology CVIS • Allows the option of running Centricity CVIS client applications in conjunction with the CA1000 application to create a Cardiology PACS/CVIS workstation. Hardware not included.	
1	P0002WW	CVIS 2 Day Onsite Training This option is for two (2) days of an on site GE applications specialist for training and support at the customer's facility. GE travel and living costs are included. One (1) day of training equals 8 hours Monday- Friday 8:00 am to 5:00 pm. Requirements: Required with the purchase of select user-intensive CVIS software options Service performed only after customer has attended CVIS system administration course	$4,240.00
1	P0001SS	CVIT Project Management CVIT Project Management provides GEHC professional project management services targeting the successful implementation of GEHC Cardiovascular IT systems. Managers oversee the implementation process ranging from order review, equipment delivery coordination, installation, training, and final system acceptance. As the GEHC single point of contact for our customers, the Cardiology Project Manager works with hospital clinical and IT staff to communicate project timelines and administrate project execution. Providing workflow and system consultation, managers will track and direct resolution of implementation issues. Requirements: Required with all GEHC Cardiovascular IT system sales	$2,641.00
		Discounted Configuration Price	$44,480.00
		Quote Summary:	
		Total Contract List Price:	**$1,952,108.00**
		Total Extended Selling Price:	**$1,332,537.05**
		Total Quote Net Selling Price	**$1,332,537.05**

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Qty	Catalog No.	Description	Ext Sell Price
		(Quoted prices do not reflect state and local taxes if applicable. Total Net Selling Price Includes Trade In allowance, if applicable.)	

Service Option invoicing will be separate from the equipment.

For Third Party Products and Services Only. If GE Healthcare has agreed to provide any third party products and/or services (other than GE Healthcare accessories and supplies) to Customer as part of the Quotation, including but not limited to any Commitment Account/Non-Inventory items, (i) GE Healthcare is acquiring such products and/or services on Customer's behalf and not as a supplier of such products and/or services; (ii) GE Healthcare makes no warranties of any kind, express or implied, with respect to such products and/or services (warranties, if any, on such products and/or services will be provided by the manufacturer or service provider, as applicable); (iii) Customer is solely responsible for ensuring that the acquisition and use of such products and/or services is in compliance with applicable laws and regulations, including applicable FDA regulations; and (iv) Customer is solely responsible for any and all claims resulting from or related to the acquisition or use of such products and/or services.

For Mobile Systems Only. For products that are approved by GE Healthcare for use as transportable, relocatable and mobile systems, GE Healthcare will deliver the system to Customer's van manufacturer and furnish final assembly services to place the system in Customer's van. At the time of order, Customer must notify GE Healthcare of the van manufacturer to which the system is to be shipped. It is Customer's responsibility to make arrangements with the van manufacturer for delivery of the van and to comply with any additional planning requirements of the van manufacturer. For MR systems, GE Healthcare's product tests will be performed when assembly in the van is completed and MR system operation will be re-checked when the van is delivered to Customer.

For Healthcare IT Products Only:

a. Payment. Unless specified separately in the Quotation, fees for non-GE Healthcare software and hardware shall be due one hundred percent (100%) on delivery of the applicable software or hardware.

b. Audit Rights. Upon forty-five (45) days notice GE Healthcare may audit Customer's use of the software. Customer agrees to cooperate with GE Healthcare's audit and to provide reasonable assistance and access to information. If the audit uncovers underpaid or unpaid fees owe to GE Healthcare, Customer agrees to pay those fees and GE Healthcare's costs incurred in conducting the audit within thirty (30) days of written notification of the amounts owed. If Customer does not pay the amounts owed, GE Healthcare may terminate Customer's license to use the applicable software. Customer agrees to permit GE Healthcare to obtain certain reasonable information regarding the users and other use information regarding the software. All of such information shall be treated as confidential information, shall be used solely for the purposes of technical support and auditing the use of the software, and shall not be disclosed to any third party (other than third-party vendors of software licensed to Customer under this Agreement) without Customer's consent.

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GE Healthcare
General
Terms and Conditions

GE Healthcare

References herein to "Products" and "Services" mean the Products (including equipment and software) and Services identified on the applicable GE Healthcare Quotation ("Quotation").

1. General Terms

1.1. Confidentiality. Each party will treat the terms of this Agreement and the other party's written, proprietary business information as confidential if marked as confidential or proprietary. Customer will treat GE Healthcare (and GE Healthcare's third party vendors') software and technical information as confidential information whether or not marked as confidential and shall not use or disclose to any third parties any such confidential information except as specifically permitted in this Agreement or as required by law (with reasonable prior notice to GE Healthcare). The receiving party shall have no obligations with respect to any information which (i) is or becomes within the public domain through no act of the receiving party in breach of this Agreement (ii) was in the possession of the receiving party prior to its disclosure or transfer and the receiving party can so prove, (iii) is independently developed by the receiving party and the receiving party can so prove, or (iv) is received from another source without any restriction on use or disclosure.

1.2. Governing Law. The law of the state where the Product is installed or the Service is provided will govern this Agreement.

1.3. Force Majeure. Neither party is liable for delays or failures in performance (other than payment obligations) under this Agreement due to a cause beyond its reasonable control. In the event of such delay, the time for performance shall be extended as reasonably necessary to enable performance.

1.4. Assignment; Use of Subcontractors. Neither party may assign any of its rights or obligations under this Agreement without the prior written consent of the other party, which consent shall not be unreasonably withheld; provided, however, that either party may transfer and assign this Agreement without the other party's consent to any person or entity (except to a GE Healthcare competitor) that is an affiliate of such party or that acquires substantially all of the stock or assets of such party's applicable business if any such assignees agree, in writing, to be bound by the terms of this Agreement. Subject to such limitation, this Agreement shall be binding upon and inure to the benefit of the parties and their respective successors and permitted assigns. GE Healthcare may hire subcontractors to perform work under this Agreement, provided that GE Healthcare will at all times remain responsible for the performance of its obligations and duties under this Agreement.

1.5. Amendment; Waiver; Survival. This Agreement may be amended only in writing signed by both parties. Any failure to enforce any provision of this Agreement is not a waiver of that provision or of either party's right to later enforce each and every provision. The terms of this Agreement that by their nature are intended to survive its expiration (such as the confidentiality provisions included herein) will continue in full force and effect after its expiration.

1.6. Termination. If either party materially breaches this Agreement and the other party seeks to terminate this Agreement for such breach, such other party shall notify the breaching party in writing, setting out the breach, and the breaching party will have sixty (60) days following receipt of such notice to remedy the breach. If the breaching party fails to remedy the breach during that period, the other party may, subject to the terms of Section 1.4.5 of the GE Healthcare Product Terms and Conditions, terminate this Agreement by written notice to the breaching party. For the avoidance of doubt, this Agreement is not terminable for convenience and may only be terminated in accordance with this Agreement. If GE Healthcare determines in good faith at any time that there are legal or regulatory compliance and/or material credit issues with this Agreement, if any, GE Healthcare may terminate this Agreement (including warranty services hereunder) immediately upon written notice to Customer.

2. Compliance

2.1. Generally. This Agreement is subject to (i) GE Healthcare's on-going credit review and approval and (ii) GE Healthcare's on-going determination that Customer and this Agreement comply with all applicable laws and regulations, including those relating to workplace safety, FDA matters, Federal Healthcare Program Anti-kickback compliance, export/import control and money laundering prevention. CUSTOMER ACKNOWLEDGES THAT THE PRODUCTS ARE OR MAY BE SUBJECT TO REGULATION BY THE FDA AND OTHER FEDERAL OR STATE AGENCIES. CUSTOMER SHALL NOT USE OR PERMIT THE PRODUCTS TO BE USED IN ANY MANNER THAT DOES NOT COMPLY WITH APPLICABLE FDA OR OTHER REGULATIONS OR FOR ANY NON-MEDICAL, ENTERTAINMENT, OR AMUSEMENT PURPOSES. Further, Customer represents that it is purchasing the Products for its own use consistent with the terms of this Agreement and that it does not intend to re-sell the Products to any other party or to export the Products outside the country to which GE Healthcare delivers the Products.

2.2 Cost Reporting. Customer represents and warrants that it shall comply with (a) the applicable requirements of the Discount Statutory Exception, 42 U.S.C. 1320a-7b(b)(3)(A), and the Discount Safe Harbor, 42 C.F.R. § 1001.952(h), with respect to any discounts Customer may receive under this Agreement and (b) the Warranties Safe Harbor, 42 C.F.R. § 1001.952(g), with respect to any price reductions of an item (including a free item) which were obtained as part of a warranty under this Agreement. Customer agrees that, if Customer is required to report its costs on a cost report, then (i) the discount must be based on purchases of the same good bought within a fiscal year; (ii) Customer must claim the benefit in the fiscal year in which the discount is earned or in the following year; (iii) Customer must fully and accurately report the discount in the applicable cost report; and (iv) Customer must provide, upon request, certain information required to be provided to the Customer by GE Healthcare as a seller or offeror, as appropriate. If Customer is an individual or entity in whose name a claim or request for payment is submitted for the discounted items, the discount must be made at the time of the sale of the good; and the Customer must provide, upon request, certain information required to be provided to the Customer by GE Healthcare as a seller or offeror, as appropriate. GE

Healthcare agrees to comply with the applicable requirements for sellers or offerors under the Discount Safe Harbor, as appropriate.

2.3. Site Access Control and Network Security. Customer shall be solely responsible for establishing and maintaining security, virus protection, backup and disaster recovery plans for any data, images, software or equipment. GE Healthcare's Services do not include recovery of lost data or images. Customer shall comply with all applicable laws and regulations related to site access control.

2.4. Environmental Health and Safety. Customer shall provide and maintain a suitable, safe and hazard-free location and environment for the GE Healthcare Products and Services in material compliance with any written requirements provided by GE Healthcare, perform GE Healthcare recommended routine maintenance and operator adjustments, and ensure that any non-GE Healthcare provided Service is performed by, and GE Healthcare Products are used by, qualified personnel in accordance with applicable user documentation. GE Healthcare shall have no obligation to perform Services until Customer has complied with its obligations under this Section.

2.5. GE Healthcare-Supplied Parts. GE Healthcare can make no assurances that Product performance will not be affected by the use of non-GE Healthcare-supplied parts. In some instances, use of non-GE Healthcare-supplied parts may affect Product performance or functionality.

2.6. Training. Any Product training identified in the Quotation shall be in accordance with GE Healthcare's then-current training program offerings and terms. Unless otherwise stated in the catalog description, training must be completed within twelve (12) months after (i) the date of Product delivery for training purchased with Products and (ii) the start date for Services for training purchased with Services. If training is not completed within the applicable time period, GE Healthcare's obligation to provide the training will expire without refund.

2.7. Medical Diagnosis and Treatment. All clinical and medical treatment and diagnostic decisions are the responsibility of Customer and its professional healthcare providers.

3. Disputes; Liability; and Indemnity

3.1. Waiver of Jury Trial. EACH PARTY EXPRESSLY WAIVES ALL RIGHTS TO A JURY TRIAL IN CONNECTION WITH ANY DISPUTE ARISING UNDER THIS AGREEMENT.

3.2. Limitation of Liability. GE HEALTHCARE'S (AND ITS REPRESENTATIVES') LIABILITY UNDER THIS AGREEMENT, REGARDLESS OF THE FORM OF ACTION, SHALL NOT EXCEED: (A) FOR PRODUCTS OR SERVICES OTHER THAN SERVICES UNDER AN ANNUAL SERVICE CONTRACT, THE PRICE FOR THE PRODUCT OR SERVICE THAT IS THE BASIS FOR THE CLAIM; OR (B) FOR ANNUAL SERVICE CONTRACTS, THE ANNUAL CONTRACT PRICE FOR THE SERVICE THAT IS THE BASIS FOR THE CLAIM. NEITHER CUSTOMER NOR GE HEALTHCARE (NOR THEIR RESPECTIVE REPRESENTATIVES) SHALL BE LIABLE TO THE OTHER PARTY UNDER THIS AGREEMENT (OR OTHERWISE IN CONNECTION WITH THE PRODUCTS AND SERVICES) FOR ANY INDIRECT, SPECIAL, PUNITIVE, INCIDENTAL OR CONSEQUENTIAL DAMAGES, OR FOR LOSS OF PROFITS, REVENUE, TIME, OPPORTUNITY OR DATA, WHETHER IN AN ACTION IN CONTRACT, TORT, PRODUCT LIABILITY, STATUTE, EQUITY OR OTHERWISE. THE LIMITATION OF LIABILITY AND EXCLUSION OF DAMAGES SHALL APPLY EVEN IF THE LIMITED REMEDIES FAIL OF THEIR ESSENTIAL PURPOSE.

3.3. IP Indemnification. GE Healthcare will defend, indemnify and hold harmless Customer from any third party claims for infringement of intellectual property rights arising from Customer's use of GE Healthcare manufactured equipment and/or GE Healthcare proprietary software listed in the Quotation in accordance with their specifications and within the license scope granted in this Agreement. If any such claim materially interferes with Customer's use of such equipment and/or software, GE Healthcare shall, at its option: (i) substitute functionally equivalent non-infringing products; (ii) modify the infringing Product so that it no longer infringes but remains functionally equivalent; (iii) obtain for Customer at GE Healthcare's expense the right to continue to use the infringing Product; or (iv) if the foregoing are not commercially reasonable, refund to Customer the purchase price, as depreciated (based on five (5) year straight-line depreciation), for the infringing Product. Any such claims arising from Customer's use of such infringing Product after GE Healthcare has notified Customer to discontinue use of such infringing Product and offered one of the remedies set forth in clauses (i) through (iv) above are the sole responsibility of Customer. This Section represents Customer's sole and exclusive remedy (and GE Healthcare's sole and exclusive liability) regarding any infringement claim associated with such infringing Product. The above indemnification obligation is conditional upon Customer providing GE Healthcare prompt written notice of the infringement claim after receiving notice of such claim, allowing GE Healthcare to control the defense of such claim, and reasonably cooperating with GE Healthcare in such defense. Notwithstanding any other provision in this Agreement, GE Healthcare shall not have any obligation to Customer hereunder for infringement claims based on or resulting from: (a) use of such infringing Product in combination with any computer software, tools, hardware, equipment, materials, or services, not furnished or authorized in writing for use by GE Healthcare; (b) use of such infringing Product in a manner or environment or for any purpose for which GE Healthcare did not design or license it, or in violation of GE Healthcare's use instructions; or (c) any modification of such infringing Product by Customer or any third party. GE Healthcare shall not be responsible for any compromise or settlement or claim made by Customer without GE Healthcare's written consent. This indemnification obligation is expressly limited to the GE Healthcare manufactured equipment and/or GE Healthcare proprietary software listed in the Quotation.

4. Payment and Finance

4.1. Generally. The payment and billing terms for the Product(s) and/or Service(s) are stated in the Quotation.

4.2. Affiliate Billing. If Customer's order includes Products manufactured by more than one GE Healthcare affiliated company, each affiliated company may invoice Customer separately for the portion of the total price under the Quotation attributable to its Products, under the same payment terms specified in the Quotation. There shall be no additional fees or charges to Customer for such separate invoicing.

4.3. Late Payment. Failure to make timely payment is a material breach of this Agreement, for which (in addition to other available remedies) GE Healthcare may suspend performance under any or all GE Healthcare agreements until all past due amounts are brought current. If GE Healthcare so suspends, GE Healthcare will not be responsible for the completion of planned maintenance due to be performed during the suspension period and any product downtime will not be included in the calculation of any uptime commitment. Interest shall accrue on past-due amounts at a rate equal to the lesser of one-and-one-half percent (1.5%) per month or the maximum rate permitted by applicable law. Customer will reimburse GE Healthcare for reasonable costs (including attorneys' fees) relating to collection of past due amounts. Any credits that may be due to Customer under an agreement may be applied first to any outstanding balance. If Customer has a good faith dispute

regarding payment for a particular Product (or subsystem thereof) or Service, such dispute shall not entitle Customer to withhold payment for any other Product (or subsystem thereof) or Service provided by GE Healthcare. GE Healthcare may revoke credit extended to Customer because of Customer's failure to pay for any Products or Services when due, and in such event all subsequent shipments and Services shall be paid for on receipt.

4.4. Taxes. Prices do not include sales, use, gross receipts, excise, valued-added, services, or any similar transaction or consumption taxes ("Taxes"). Customer shall be responsible for the payment of any such Taxes to GE Healthcare unless it otherwise timely provides GE Healthcare with a valid exemption certificate or direct pay permit. In the event GE Healthcare is assessed Taxes, interest or penalty by any taxing authority, Customer shall reimburse GE Healthcare for any such Taxes, including any interest or penalty assessed thereon. Each party is responsible for any personal property or real estate taxes on property that the party owns or leases, for franchise and privilege taxes on its business, and for taxes based on its net income or gross receipts.

GE Healthcare
Product
Terms and Conditions

GE Healthcare

References herein to "Products" and "Services" mean the Products (including equipment and software) and Services identified on the applicable GE Healthcare Quotation ("Quotation"). References herein to "Healthcare IT Products" are (i) those software products identified in the Quotation as a "Centricity" product, any third party software licensed for use in connection with the Centricity software, all hardware used to operate the Centricity or the third party software, and services provided with respect to the implementation, installation or support and maintenance of the Centricity or the third party software, and/or (ii) any software, product or service that is included in a Quotation which Quotation is designated as an "Healthcare IT Quotation".

1. Commercial Logistics

1.1 Order Cancellation and Modification.

1.1.1. Cancellation and Payments Except for Healthcare IT Products, if Customer cancels an order without GE Healthcare's prior written consent, Customer will pay a cancellation charge of fifteen percent (15%) of the price of the Products ordered. GE Healthcare will retain as a credit any payments received up to the amount of the cancellation charge. If Customer cancels an order for Products for which GE Healthcare has provided site evaluation services, Customer will also pay GE Healthcare reasonable charges for such services performed prior to cancellation. If applicable for the order, Customer will pay all progress payments (other than the final payment) prior to final Product calibration, and GE Healthcare may, at its option, delay final calibration until required progress payments are received. If Customer fails to schedule a delivery date with GE Healthcare within six (6) months after order entry, GE Healthcare may cancel Customer's order upon written notice to Customer.

1.1.2. Order Modifications. No modifications may be made to an order without GE Healthcare's prior written consent. The Product configuration listed in the Quotation is based upon information furnished to GE Healthcare by Customer, and Customer is responsible to provide and pay for modifications, if any, to the configuration due to inaccuracies or incompleteness of the information furnished to GE Healthcare by Customer, changes in Customer's needs or requirements, or for other reasons attributable to Customer.

1.2. Site Preparation If applicable, Customer will be responsible, at its sole expense, for evaluating and preparing the site where the Products will be installed in accordance with GE Healthcare's site preparation requirements and applicable laws. Customer must provide GE Healthcare with prompt written notice if Customer is unable to prepare the site before the mutually agreed installation date. Upon receipt of such notice, GE Healthcare will reschedule the installation to a mutually agreed date. Customer shall be liable for any costs or expenses GE Healthcare or its representatives incur resulting from Customer's failure to provide GE Healthcare with timely notice of Customer's failure to properly prepare the site. GE Healthcare may, in its discretion, delay delivery or installation if GE Healthcare determines that the site has not been properly prepared or there are any other impediments to installation; provided that GE Healthcare gives Customer written notice of such delay stating the reasons therefor. If GE Healthcare provides site evaluation services, such services are intended only to assist Customer in fulfilling Customer's responsibility to ensure that the site complies with GE Healthcare's applicable site preparation requirements.

1.3. Transportation, Title and Risk of Loss; Delivery; Returns.

1.3.1. Transportation, Title and Risk of Loss. Unless otherwise indicated in the Quotation, shipping terms are FOB Destination. Title and risk of loss to equipment passes to Customer upon delivery to Customer's designated delivery location. Software is licensed to Customer; no title to or other ownership interest in such software passes to Customer.

1.3.2. Delivery. When feasible, GE Healthcare reserves the right to make delivery in installments. All such installments shall be separately invoiced and paid for when due, without regard to subsequent deliveries. At the time of such delivery, Customer will pay GE Healthcare for any amounts due upon delivery. Delivery dates are approximate. For GE Healthcare software or documentation, delivery means the first to occur of: (i) communication to Customer through electronic means, that allows Customer to take possession of the first copy or product master, or (ii) delivery to Customer's designated delivery location.

1.3.3. Product Returns. Customer shall not have any right to return Products for a refund after delivery except for products shipped in error that are different from the Products listed in the Quotation.

1.4. Installation and Certification. GE Healthcare will provide product assembly, installation and calibration, as required, at no additional charge, except for items excluded herein. GE Healthcare installation Services provided under the Quotation will be performed in accordance with applicable GE Healthcare installation guides and/or project plans. Customer will review the applicable GE Healthcare installation guides, and/or project plans, and perform Customer's obligations as set forth in those materials. Upon completion of assembly, installation and calibration, and prior to turnover of the Products to Customer for clinical use, as applicable, GE Healthcare will perform prescribed tests using its own performance specifications, instruments and procedures to verify that the Products meet GE Healthcare's applicable performance specifications.

1.4.1. Customer-Supplied Items.

- Customer will install necessary system cable and assemble any necessary equipment or hardware not provided by GE Healthcare, unless agreed otherwise in writing by the parties.
- For Products that will be operated on or in connection with Customer supplied hardware or software, Customer is responsible

for ensuring that such hardware and software conform to GE Healthcare's minimum hardware and software requirements as made available to Customer.

- Unless GE Healthcare has agreed in writing to maintain responsibility for an applicable service, Customer will be responsible for enabling the connectivity and interoperability between Customer-supplied hardware or software or other systems or devices and the Product, including, without limitation, procuring and installing any modifications, interfaces or upgrades consistent with GE Healthcare's written specifications.
- Unless otherwise agreed in writing by GE Healthcare, Customer is solely responsible for the performance of and payment for any applicable rigging and/or facility costs. GE Healthcare will not install accessory items unless otherwise agreed in writing by GE Healthcare.
- If applicable for the Product, electrical wiring and outlets, computer network infrastructure, conduit, cabinetry modification, wall mounts, ventilation and any other site preparation are not included in the purchase price and are the responsibility of Customer, unless otherwise agreed in writing by GE Healthcare.

1.4.2. Network. Unless Customer has elected to purchase network preparation and certification Services from GE Healthcare as set forth in the Quotation, Customer is solely responsible for ensuring that Customer's network is adequate for the proper operation and performance of the Products and otherwise meets GE Healthcare's written network configuration requirements.

1.4.3. License, Permits, and Approvals. Customer shall obtain and maintain all licenses, permits and other approvals necessary for installation, use, and disposal/recycling of the Products provided under this Agreement, including, but not limited to, any government licenses required to use radioactive sources for Products that require the use of such sources. GE Healthcare will ship such sources to Customer only after Customer provides GE Healthcare with satisfactory evidence that Customer has obtained all required licenses for such sources In addition, Customer will provide all radioactive sources for calibration and performance checks of Products that require the use of such sources. GE Healthcare will file any required Federal and State reports relating to its installation activities GE Healthcare will not install, test, certify or provide its own software license or warranty for Products that are not listed in its on-line catalog or price pages at the time of sale (such Products are normally identified by NL or NW series numbers), unless otherwise agreed in writing by GE Healthcare.

1.4.4. Non-GE Healthcare Labor. If local labor conditions make it impractical to, or GE Healthcare is directed not to, use GE Healthcare's employees or pre-qualified contractors for the installation, all work will be performed by Customer's laborers or outside labor at Customer's expense; provided that GE Healthcare will, at Customer's request, furnish guidance for installation. GE Healthcare is not responsible for the quality or adequacy of any work performed by any party other than GE Healthcare or its pre-qualified contractors.

1.4.5. Non-GE Healthcare Installation. For Products that GE Healthcare is obligated to install under the terms of this Agreement, if GE Healthcare delivers the Product but fails to perform its installation obligations, then in such event Customer shall nevertheless be obligated to pay GE Healthcare an amount equal to (a) the Product purchase price set forth in the Quotation, if the Product purchase price and the installation Services price are shown as separate line items in the Quotation, or (b) if the Product purchase price and installation Services price are not shown as separate line items in the Quotation, then the Product purchase price less the fair market value of the applicable installation Services, taking into account the type of Product and level of installation required ("Installation Service FMV"). An independent third party shall determine the Installation Service FMV. Notwithstanding any other provision of this Agreement to the contrary, either the discharge of Customer's obligation to pay for installation Services shown as a separate line item(s) in the Quotation or the deduction of the Installation Service FMV, as applicable, shall be Customer's sole and exclusive remedy (and GE Healthcare's sole and exclusive liability) in the event GE Healthcare fails to perform its installation obligations under this Agreement.

1.5. Acceptance. Unless expressly provided otherwise in this Agreement, Customer shall be deemed to have accepted a Product delivered by GE Healthcare under this Agreement on the earlier of: (i) if GE Healthcare installs the Product, five (5) days after GE Healthcare notifies Customer that it has completed assembly and the Product is operating substantially in accordance with GE Healthcare's published performance specifications, (ii) if GE Healthcare does not install the Product, five (5) days after delivery of the Product to Customer; or (iii) the date Customer first uses the Product for patient use.

1.6. Warranties. Product warranties (if applicable) are set forth in the GE Healthcare warranty forms delivered with the Quotation. GE Healthcare may use refurbished parts in new Products as long as it uses the same quality control procedures and warranties as for new Products. Any part for which GE Healthcare has supplied a replacement shall become GE Healthcare property.

1.7. Data Access. If applicable, Customer shall permit GE Healthcare to connect to the Products, or to otherwise access Product performance data through a Customer-furnished telephone line or Broadband connection. The data collected by GE Healthcare will be used, during and after the term of this Agreement, in accordance with all applicable laws and regulations and in a manner that will maintain confidentiality.

2. Software License

2.1. License Grant. GE Healthcare grants to Customer a non-exclusive, non-transferable license to use for Customer's internal business purposes the GE Healthcare software, third-party software and Documentation at the location (or, for mobile systems, in the specific vehicle) identified in the Quotation, subject to the license scope and other restrictions set forth in this Agreement. "Documentation" means the GE Healthcare user manuals, on-line help functions, technical specifications and user instructions regarding the operation, installation and use of the software as made available by GE Healthcare to Customer. Customer may only use third-party software provided by GE Healthcare together with the GE Healthcare software and will comply with all third-party software license terms included in any click or shrink wrap license or of which GE Healthcare otherwise makes Customer aware. To the extent permitted by applicable law, licensors of third-party software shall be third-party beneficiaries of this Agreement with respect to third-party software sublicensed under this Agreement. Customer may permit its employees, agents, independent contractors and healthcare providers with privileges at Customer's facilities to use the software and Documentation; provided, however, that Customer shall be responsible for any acts of such third parties that are inconsistent

with this Agreement. Notwithstanding the foregoing, independent contractors that supply products comparable to the software shall be provided access to the software only with GE Healthcare's prior written consent and subject to any conditions GE Healthcare deems appropriate to protect its confidential and proprietary information.

2.2. Additional License Terms. Without GE Healthcare's prior written consent, Customer may not: (i) copy, sublicense, distribute, rent, lease, loan, resell, modify or translate the software or create derivative works based thereon, except that to the extent applicable, the software may be configured as specifically permitted in the Documentation; (ii) directly or indirectly decompile, disassemble, reverse engineer or otherwise attempt to learn the source code, structure, algorithms or ideas underlying the software; (iii) provide service bureau, time share or subscription services based on the software; (iv) remove, obscure or modify any markings, labels or any notice of the proprietary rights, including copyright, patent and trademark notices of GE Healthcare or its licensors; (v) electronically transfer the software outside Customer's intranet or network dedicated for the software, unless otherwise authorized in writing by GE Healthcare; or (vi) publicly release the results of any testing or benchmarking of the software without the prior written consent of GE Healthcare. Customer may transfer authorized copies of the software, and Documentation to a party that purchases or otherwise acquires the equipment and accepts any applicable license terms, except for software and Documentation that are (a) not a part of the base system standard operating software or Documentation for the equipment and (b) generally provided by GE Healthcare to its customers for a separate fee or charge. Advanced service software is subject to a separate fee and eligibility criteria and licensed under a separate agreement with GE Healthcare

2.3. Backups. Customer may make a reasonable number of copies of the software in machine-readable form solely for backup, training, testing or archival purposes, so long as applicable license fees are paid Customer shall reproduce on any such copy the copyright notice and any other proprietary legends that were on the original copy. GE Healthcare and its licensors, as applicable, retain all ownership and intellectual property rights to the software and Documentation. If Customer acquires any rights to the software or Documentation, Customer hereby assigns all of those rights to GE Healthcare or its licensors, as applicable. No license rights are granted (whether by implied license or otherwise), to Customer, except as specifically provided in this Section.

2.4. Remedies. Customer agrees that a violation of GE Healthcare's license, confidentiality or intellectual property rights will cause irreparable harm to GE Healthcare for which the award of money damages alone are inadequate. In the event of any breach of this provision, GE Healthcare shall be entitled to seek injunctive relief in addition to immediately terminating the license granted herein and requiring that Customer cease use of the software and return all copies of stand-alone software in any media in addition to seeking any other legal or equitable remedies available to GE Healthcare. This paragraph shall survive the termination of this Agreement.

3. Payment and Finance

3.1. Security Interest; Upgrade Pricing. Customer grants GE Healthcare a purchase money security interest in all items of hardware or equipment listed in the Quotation until full payment is received, and Customer shall perform all acts and execute all documents as may be necessary to perfect GE Healthcare's security interest. Except for Healthcare IT Products, prices for upgrades and revisions assume that Customer returns the replaced component and transfers title to GE Healthcare at no charge to GE Healthcare. If, after Product delivery, Customer does not make any payments for the Products within forty-five (45) days after such payments are due, GE Healthcare may, upon ten (10) days prior written notice to Customer, either (a) enter upon Customer's site and remove the Products or (b) temporarily disable the Products so that they are not operational.

3.2. Leases. If Customer is acquiring use of Products through an equipment lease (a "Lease") with an equipment lessor (a "Lessor"), certain provisions of this Agreement (including, but not limited to, terms related to payment, title transfer, warranties, and software licenses) may be modified as agreed to in writing between GE Healthcare, the applicable Lessor, and/or Customer, as the case may be. Acceptance of the equipment as between GE Healthcare and Lessor will be defined by this Agreement; acceptance of the equipment as between Lessor and Customer will be defined by the lease agreement. Notwithstanding the foregoing, if the Lessor does not comply with the terms of this Agreement, Customer shall continue to be responsible for the payment obligations hereunder.

4. Product Specific Terms

4.1. MUSE CV Information Technology Professional Services (ITPS). MUSE CV Product ITPS shall be performed within six (6) months of the date Customer orders the Services. Without limiting the foregoing, Customer agrees that, if the Services have not been performed within one (1) year of the date Customer orders the Services for reasons other than GE Healthcare's failure to perform, GE Healthcare shall be relieved of its obligation to perform the Services and the Customer shall not be entitled to a refund for such unperformed Services. ITPS Services include clinical applications training, project management, HL7/HIS systems integration, database conversion, and network design and integration (ND&I).

4.2. Pre-Owned Products. Products identified as pre-owned/refurbished/remanufactured Products have been previously owned and used; they are not new. When delivered to Customer, such Products may have received mechanical, electrical, and/or cosmetic reconditioning, as necessary, and will meet their original specifications. Since pre-owned Products may be offered simultaneously to several customers, their sale to Customer is subject to their continued availability at the time Customer offers to purchase such Products. If the pre-owned Products are no longer available, (i) GE Healthcare will attempt to identify other pre-owned Products in its inventory that meet Customer's needs, and (ii) if substitute pre-owned Products are not acceptable to Customer, GE Healthcare will cancel the order and refund any deposit Customer has paid for such Products

4.3. CT and X-Ray Products. Certain Products that use x-ray or image intensifier tubes have been designed to recognize GE Healthcare-supplied tubes and report to the user the presence of a non-GE Healthcare-supplied tube. This will permit the user to make any adjustments to Product use that the user deems appropriate. Use of the Products with non-GE Healthcare-supplied tubes is always at the user's discretion; however, Customer acknowledges that advanced scanner functionality may be impaired or disabled by the use of non-GE Healthcare-supplied tubes. GE Healthcare assumes no liability for the use of non-GE-Healthcare-supplied tubes and disclaims any responsibility for any effect such tubes may have on Product performance.

GE Healthcare

GE Healthcare Additional Terms and Conditions: Healthcare IT

References herein to "Products" and "Services" mean the Products (including hardware and software) and Services purchased by Customer as identified on the applicable GE Healthcare Quotation ("Quotation"). References herein to "Healthcare IT Products" are (i) those software products identified in the Quotation as a "Centricity" product, any third party software licensed for use in connection with the Centricity software, all hardware used to operate the Centricity or the third party software, and services provided with respect to the implementation, installation or support and maintenance of the Centricity or the third party software, and/or (ii) any software, product or service that is included in a Quotation which Quotation is designated as an "Healthcare IT Quotation".

These Additional Terms and Conditions incorporate the GE Healthcare General Terms and Conditions as well as the GE Healthcare Product Terms and Conditions and will apply only to the license, purchase and use of Healthcare IT Products.

1. **Healthcare IT Product Specific Terms.** The following terms apply only to the purchase of Healthcare IT Products.

1.1. Statement of Work (SOW). Following the effective date of this Agreement, the parties may enter into a written statement of work ("SOW") signed by the parties that describe the professional services to be provided by pursuant to the quotation, which may include, among other things, an installation and implementation project work plan, identification of installation and implementation services, and other related professional services. GE Healthcare shall perform the professional services and provide any deliverables described in any such SOW and shall use commercially reasonable efforts to do so according to any delivery schedule in the SOW. GE Healthcare is responsible for the assignment of personnel to perform all services and may make any change in staffing it deems necessary provided that such change does not compromise the level of expertise required to complete the applicable SOW. Each SOW may include descriptions of the following: (i) professional services to be performed; (ii) deliverables; (iii) Customer's additional responsibilities; (iv) project work scope, (v) estimated performance schedule and applicable milestones; (vi) Customer's site and any site preparation requirements; (vii) network, hardware or other environmental or infrastructure requirements; (viii) preliminary implementation plans; or (ix) key assumptions. The terms and conditions of this Agreement shall prevail over those of the SOW. A SOW may only be modified in writing signed by authorized representatives of both parties and must be made pursuant to mutually agreed change control procedures. Changes to a SOW may require a change in fees reflecting the change in scope and/or change in schedule of delivery of the professional services or deliverables and/or change in Customer's responsibilities. From time to time during the term of this Agreement, the parties may enter into additional SOWs relating to services purchased by Customer under Change Orders to this Agreement. Each such additional SOW shall constitute a separate and independent work engagement and contractual obligation.

1.2. Project Managers. If required by the SOW, Customer and GE Healthcare shall each designate a project manager who will be responsible for day-to-day communications regarding the subject matter of the applicable SOW. The project managers will be responsible for monitoring the schedules and progress of services pursuant to the Agreement and/or SOW and will have the authority to act for the respective parties in all aspects of the engagement. The project managers for the parties will meet in person or via conference call as necessary. The responsibilities of the project managers include to: (i) serve as the single point of contact for all departments in their organization participating in this project; (ii) administer the change-of-control procedure; (iii) participate in project status meetings; (iv) obtain and provide information, data, decisions and approvals, within seven working days of the other party's request unless GE Healthcare and Customer mutually agree to an extended response time; (v) resolve deviations from project plans that may be caused by the parties' respective organizations; (vi) help resolve project issues and escalate issues within the parties' respective organizations, as necessary; (vii) monitor and report project status on a regular basis to the respective organizations as appropriate; and (viii) provide and coordinate technical and specialist resources as necessary

1.3. HITECH Certification. GE Healthcare will use diligent efforts to obtain certification under the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act") to the extent that certification standards are established for the applicable functionality included as part of GE Healthcare's EMR or Centricity Practice Solutions software licensed by Customer, including those product updates that GE Healthcare provides generally to Customer of such products as part of support and maintenance. If GE Healthcare fails to obtain certification for the applicable components within ninety (90) days after the beginning of the first Reporting Period in a Payment Year that Customer is actively seeking to demonstrate Meaningful Use, GE Healthcare will credit the standard support services fees for such software for each month during which the software is not certified (up to a maximum of 6 months) against future support fees. The foregoing is Customer's sole and exclusive remedy in the event GE Healthcare fails to obtain certification. For the avoidance of doubt, Customer's payment obligations under this Agreement are not conditioned on receipt of HITECH incentive payments, certification of the software or demonstration of meaningful use. GE Healthcare will keep Customer informed of GE Healthcare's certification status by posting such status at www.gehealthcare.com/hitech (or some other location that of which GE Healthcare may inform Customer). It is Customer's responsibility to ensure Customer meets all the requirements to qualify for the incentive payments, including "meaningful use", and to confirm that the GE Healthcare software Customer is using is certified according to HITECH criteria. GE Healthcare's obligations under this section apply only to the then-most current version of GE Healthcare's Centricity EMR or Centricity Practice Solution software products. GE Healthcare's obligations are contingent upon Customer then-receiving and paying for support services and complying with the requirements of the GE Healthcare service policy and, if GE Healthcare so requires, upon Customer installing software fixes, patches or updates or migrating to a new or different GE Healthcare software offering, and on Customer otherwise having installed all functionality not part of the GE Healthcare software that would have been required to show Meaningful Use. All capitalized terms shall the definitions set forth in this Agreement, the HITECH Act or any applicable implementing regulations.

1.4. Ownership Rights. GE Healthcare shall retain ownership of all deliverables (including any intellectual property embodied in the

deliverables or related to them) and any intellectual property developed under a SOW or during the course of performing the services whether or not the services are performed by GE Healthcare alone or jointly with Customer or others. In addition, GE Healthcare shall own all improvements, enhancements and derivative works of any GE Healthcare intellectual property. Customer hereby assigns, and will cause Customer's employees and independent contractors to assign, to GE Healthcare all of Customer's rights in and to such deliverables and intellectual property. GE Healthcare grants to Customer a nonexclusive, nontransferable, license, without the right to sublicense, to use the deliverables solely for Customer's internal business purposes and subject to the limitations described in this Agreement and the relevant SOW. Customer agrees to provide reasonable assistance to GE Healthcare in obtaining and enforcing GE Healthcare's rights to such deliverables and intellectual property. GE Healthcare will acquire no rights to any of Customer's confidential information that may be included in any deliverable unless expressly agreed to otherwise by Customer.

1.5. Software Product Testing and Acceptance. Commencing on the date that GE Healthcare gives notice of installation of the GE Healthcare software (or on the date as otherwise provided for in the applicable SOW) and implementation by GE Healthcare of appropriate option and parameter selections made by Customer, Customer will have thirty (30) days to test each unit or module of the GE Healthcare software. Customer shall be deemed to have accepted GE Healthcare proprietary software the earlier of (i) Customer's written acceptance, (ii) the expiration of the test period identified in the preceding sentence without GE Healthcare receiving written notice from Customer of the existence of any errors and a reasonable description of such error(s), or (iii) the date Customer first uses the software to process actual data in the operation of Customer's business (e.g. to register a patient, to produce a bill, to record a treatment or diagnosis or to process or view a medical image). As used in this section, an "error" is the failure of the software to perform substantially in accordance with the documentation. Acceptance tests will be conducted using test data, preferably from Customer's historical operations, in a non-productive environment and according to test protocol to be mutually agreed upon by the parties. Upon discovering an error, Customer shall promptly notify GE Healthcare in writing of the error, which notice shall include a reasonable description of the error. Upon GE Healthcare's timely receipt of Customer's written notice, GE Healthcare shall promptly correct such failures identified by Customer therein. An acceptance test for amendments or alterations provided by GE Healthcare as a result of testing may be conducted by Customer for a period of not more than five (5) days after delivery of such amendment or alteration, and the test period shall be extended for this purpose. Upon the occurrence of acceptance, all payments associated with acceptance, if any, shall be due and payable.

1.6 Software Support. GE Healthcare will provide to Customer the software support services as described in the applicable GE Healthcare service policy for the GE Healthcare software and the support period as specified in the applicable quotation for which Customer has paid the applicable fees. Software that is identified on the quotation and either (i) is delivered to Customer in a third-party developer/supplier's packaging and with its labeling or (ii) for which GE Healthcare expressly indicates (either in the quotation or in the product documentation) that the software is provided with the third-party developer/supplier's software support services in lieu of GE Healthcare software support services is not covered under this Agreement unless specifically stated otherwise in the applicable quotation. GE Healthcare support services will automatically renew for another annual term upon payment of the applicable renewal support fees, unless either party provides sixty (60) days prior written notice of non-renewal. GE Healthcare may increase its charges for support and maintenance fees for each successive annual software renewal support term. In connection with any annual renewal of support services, GE Healthcare may increase its annual charges for maintenance and support by no more than CPI plus two percent (2%). CPI shall mean the U.S. City Average (December to December percent) for ALL Urban Consumers (CPI-U). If GE Healthcare announces to its customers that it will no longer offer support ("end of product life") for a product or component, then upon at least twelve (12) months' prior written notice to Customer, GE Healthcare may, at its option, remove any such item from all GE Healthcare service agreements, with an appropriate adjustment of charges, without otherwise affecting such agreements.

1.7 Medical Diagnosis and Treatment. Customer acknowledges that: (a) the software does not make clinical, or other decisions and is not a substitute for competent, properly-trained and knowledgeable staff who bring professional judgment and analysis to the information presented by the software; (b) Customer is responsible for verifying the accuracy of all patient information and determining the data necessary for Customer and Customer's users to make medical and diagnostic decisions, as well as for complying with all laws, regulations and licensing requirements applicable to Customer's delivery of healthcare services; (c) Customer is responsible for establishing and maintaining reasonable quality control procedures to ensure the accuracy of input to the software; (d) Customer and Customer's staff will consider all relevant information including information presented to Customer and Customer's staff by the software and may give whatever weight Customer and Customer's staff deem appropriate to the information produced by the software in the performance of Customer's and Customer's staff's functions; (e) any and all financial and management information produced by the software must be tested for reasonableness and accuracy before any actions are taken or reliance placed on it; (f) Customer has reviewed and will communicate to users who use and access the software any software information, which may be provided to Customer by GE Healthcare from time to time; (g) although GE Healthcare and its third-party vendors have used reasonable care in obtaining information from sources believed to be reliable, Customer acknowledges that it is Customer's obligation to be informed about any changes or developments in clinical information or guidelines that may not be reflected in the software and that the absence of an alert or warning for a given course of treatment, drug or drug combination should not be construed to indicate that the treatment, drug or drug combination is safe, appropriate or effective in any given patient; (h) Customer is solely responsible for the proper, complete and accurate submission of claims, including without limitation the determination of proper billing, diagnosis and procedure codes and the maintenance of patient medical records containing appropriate documentation of the Services billed; (i) when selecting a narrative condition or coded diagnosis or procedure, Customer must make an independent and informed judgment based upon the patient's condition and symptoms and/or a physician's submitted diagnosis, to select a code appropriate for that patient (GE Healthcare does not make any representation or warranty regarding the appropriateness of any of the narrative or codes displayed for any or all patients); (j) since it is possible that a payor's local medical review policies may be in effect prior to their receipt or update by GE Healthcare or its licensors, Customer, as a provider under Federal health care programs, assumes responsibility for the accuracy of all claims submitted for Services performed for Medicare beneficiaries. Customer shall use the Products only for clinical diagnostic purposes in the diagnosis or treatment of a disease or condition, and not for any entertainment or amusement purposes. GE Healthcare will not deliver, install, service or provide training on use of the Products if GE Healthcare discovers the Products have been or are intended to be used for non-clinical purposes

in violation of the preceding sentence.

1.8 Return of Software. Upon termination of this Agreement for any reason, Customer shall immediately return to GE Healthcare any and all software for which license grant immediately terminates.

2. **Healthcare IT Warranty.** The following warranties apply only to Healthcare IT products and are in lieu of any other standard GE Healthcare warranties.

2.1. Express Warranties. GE Healthcare makes the following express warranties to Customer:

2.1.1. GE Healthcare warrants that its services will be performed by trained individuals in a professional, workman-like manner.

2.1.2. Except as indicated otherwise below, GE Healthcare warrants that (i) GE Healthcare has the right to license or sublicense the software to Customer for the purposes and subject to the terms and conditions set forth herein, (ii) for 90 days following the warranty commencement date, the software will perform substantially in accordance with the applicable documentation, (iii) it has not inserted any disabling code (as defined herein) into the software, and (iv) it will use reasonable commercial efforts consistent with industry standards to scan for and remove any software viruses before installation of the software. As used herein, (a) "disabling code" means computer code that is designed to delete, interfere with, or disable the normal operation of the software; provided, however, that code included in the software that prohibits use outside of the license scope purchased for the software will not be deemed to be disabling code, and (b) "warranty commencement date" means the date upon which Customer first uses the software to process actual data in the operation of Customer's business (e.g., to register a patient, to produce a bill, to record a treatment or diagnosis or to process or view a medical image). The warranty period for any software or component furnished to correct a warranty failure will be the unexpired term of the warranty applicable to the repaired or replaced software.

2.1.3. Except for the right to license warranty above, the above warranties do not cover equipment or third-party software delivered with the GE Healthcare software. Third-party software is identified with a separate part number on the quotation (i) delivered to Customer in the third-party manufacturer/supplier's packaging and with its labeling, or (ii) for which GE Healthcare expressly indicates (either in the quotation or in the product documentation) that the software or equipment is provided with the third-party manufacturer/supplier's warranty in lieu of a GE Healthcare warranty. Such products are covered by the third-party manufacturer/supplier's warranties, to the extent available.

2.2. No Other Warranties. NO OTHER EXPRESS OR IMPLIED WARRANTIES, INCLUDING IMPLIED WARRANTIES OF NON-INFRINGEMENT, MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, QUIET ENJOYMENT, SYSTEM INTEGRATION AND DATA ACCURACY, WILL APPLY.

2.3. Sole and Exclusive Remedies for Breach of Warranties. The remedies set forth below are Customer's sole and exclusive remedies and GE Healthcare's sole and exclusive liability for warranty claims. These exclusive remedies shall not have failed of their essential purpose (as that term is used in the Uniform Commercial Code) as long as GE Healthcare remains willing to repair or replace defective warranted products or re-perform any non-conforming services for no charge, as applicable, within a commercially reasonable time after being notified of Customer's warranty claim.

2.3.1. If there is any breach of a warranty contained in Section 2.1.1, GE Healthcare will promptly re-perform any non-conforming services for no charge as long as Customer provides reasonably prompt written notice to GE Healthcare.

2.3.2. If there is a breach of warranty contained in Section 2.1.2(i) GE Healthcare will indemnify Customer in accordance with Section 3.3 of the General Terms and Conditions to included as part of this Agreement.

2.3.3. If there is any breach of a warranty contained in Section 2.1.2(ii) – (iv) and Customer promptly notifies GE Healthcare of Customer's warranty claim during the warranty period and makes the software available for service, GE Healthcare will, at its option, with respect to the GE Healthcare software, either correct the non-conformity or replace the applicable software. Unless agreed otherwise, warranty service will be performed without charge from 8:00 a.m. to 5:00 p.m. (local site time), Monday-Friday, excluding GE Healthcare holidays, and outside those hours at GE Healthcare's then prevailing service rates and subject to the availability of personnel. For certain licensed software, GE Healthcare will perform warranty service only at an authorized service center or, in some instances, via a secure, remote connection to a GE Healthcare online center.

2.4. Limitations. GE Healthcare shall not have any obligation to Customer hereunder if the warranty claim results from or arises out of: (i) the use of the software in combination with any software, tools, hardware, equipment, supplies, accessories or any other materials or services not furnished by GE Healthcare or recommended in writing by GE Healthcare; (ii) the use of the software in a manner or environment, or for any purpose, for which GE Healthcare did not design or license it, or in violation of GE Healthcare's written recommendations or instructions on use; (iii) any alteration, modification or enhancement of the software by Customer or any third party not authorized or approved in writing by GE Healthcare (iv) inadequate back-up or virus protection or any other cause external to the software or beyond GE Healthcare's reasonable control. In addition, the warranties set forth above do not cover the software to the extent it is used in any country other than the country to which GE Healthcare ships the licensed software (unless GE Healthcare expressly agrees otherwise in writing). GE Healthcare does not guarantee that the software will operate without error or interruption.

GE Healthcare

Warranty Statement (United States)

1. **Warranted Products.** These warranties cover the purchase and use of the following GE Healthcare products:

- Magnetic Resonance
- Computed Tomography
- Mammography
- Positron Emission Tomography (including scanners, cyclotrons & chemistry labs)
- Nuclear
- X-ray
- Surgical Navigation Systems
- Cardiology
- Ultrasound
- Bone Mineral Densitometry
- Physiological Monitoring
- Small Animal Imaging
- C-Arms
- Advantage Workstation and Server
- Anesthesia Delivery
- Respiratory Care
- Gold Seal
- Phototherapy and other infant care accessories
- Microenvironments, including Giraffe®, Care Plus®, Ohio® Infant Warmer Systems and Panda™ Baby Warmers

2. **GE Healthcare Warranties.**

2.1 Scope. This warranty statement incorporates GE Healthcare's General Terms and Conditions and GE Healthcare's Product Terms and Conditions. GE Healthcare warrants that its services will be performed by trained individuals in a professional, workman-like manner. GE Healthcare will promptly re-perform any non-conforming services for no charge as long as Customer provides reasonably prompt written notice to GE Healthcare. The foregoing service remedy, together with any remedy provided herein, are Customer's sole and exclusive remedies (and GE Healthcare's sole and exclusive liability) for warranty claims. These exclusive remedies shall not have failed of their essential purpose (as that term is used in the Uniform Commercial Code) as long as GE Healthcare remains willing to repair or replace defective warranted products or re-perform any non-conforming services for no charge, as applicable, within a commercially reasonable time after being notified of Customer's warranty claim. NO OTHER EXPRESS OR IMPLIED WARRANTIES, INCLUDING IMPLIED WARRANTIES OF NON-INFRINGEMENT, MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, QUIET ENJOYMENT, SYSTEM INTEGRATION AND DATA ACCURACY, WILL APPLY.

2.2 Term Usage. "Warranted Product" is a collective term which includes both the above-listed manufactured equipment and licensed software, with the exception of Healthcare IT Products, purchased by and/or licensed to (as applicable) Customer under the relevant GE Healthcare Quotation. Where an item of equipment has software code embedded in it, the code will only be considered licensed software under this warranty statement if the applicable GE Healthcare Quotation provides a separate part number for that software.

2.3 Equipment Warranty. Except as indicated otherwise below, GE Healthcare warrants the equipment will be free from defects in title and that for 1 year from the Warranty Commencement Date (as defined below) (i) the equipment will be free from defects in material and workmanship under normal use and service and (ii) except for equipment manufactured in compliance with Customer's designs or specifications, the equipment will perform substantially in accordance with GE Healthcare's written technical specifications for the equipment (as such specifications exist on the date the equipment is shipped) (the "Specifications"). This warranty covers both parts and labor and is available only to end-users that purchase the equipment from GE Healthcare or its authorized distributors. Customers purchasing through an authorized distributor must contact GE Healthcare promptly following such purchase to enable this warranty.

2.4 Software Warranty. Except as indicated otherwise below, GE Healthcare warrants for 90 days from the Warranty Commencement Date that (i) the licensed software will perform substantially in accordance with the applicable Documentation (as defined herein), (ii) it has not inserted any Disabling Code (as defined herein) into the licensed software and (iii) it will use reasonable commercial efforts consistent with industry standards to scan for and remove any software viruses before installation of the applicable Warranted Product. Except as indicated otherwise below, GE Healthcare warrants that it has the right to license or sublicense the licensed software to Customer for the purposes and subject to the terms and conditions set forth in GE Healthcare's General Terms and Conditions. As used in this warranty statement, (i) "Disabling Code" means computer code that is designed to delete, interfere with, or disable the normal operation of the Warranted Product; provided, however, that code included in the licensed software that prevents use outside of the license scope purchased for the software will not be deemed to be Disabling Code and (ii) "Documentation" means the GE Healthcare user manuals, on-line help functions, technical specifications and user instructions regarding the operation, installation and use of the software as made available by GE Healthcare to Customer.

2.5 Pre-owned Equipment. GE Healthcare's Gold Seal Preferred Products (certain pre-owned GE Healthcare equipment) and GE Healthcare's certified pre-owned Bone Mineral Densitometry Products are provided with GE Healthcare's standard warranties carrying the same duration as the new equipment warranty, but in no event exceeding 1 year (unless otherwise provided in writing by GE Healthcare). Except as expressly provided in this paragraph or in the applicable GE Healthcare Quotation, used and/or pre-owned equipment is not warranted by GE Healthcare.

2.6 Healthcare IT and X-Ray Tubes. GE Healthcare X-ray and Image Intensifier Tubes, Maxiray X-ray Tubes and GE Healthcare IT Products are covered by a separate warranty statement provided in an applicable GE Healthcare Quotation.

2.7 Third-Party Software and Equipment. This warranty statement does not cover Third-Party Software and Equipment (as defined herein) delivered with the Warranted Products (commonly identified by NL or NW series numbers in GE Healthcare's Quotation). "Third-Party Software and Equipment" means any non-GE Healthcare software or equipment (i) delivered to Customer in the third-party manufacturer/supplier's packaging and with its labeling or (ii) for which GE Healthcare expressly indicates (either in the GE Healthcare Quotation or in the product documentation) that the software or equipment is provided with the third-party manufacturer/supplier's warranty in lieu of a GE Healthcare warranty. Such products are covered by the third-party manufacturer/supplier's warranties, to the extent available. Anesthesia monitor mounting solutions Third-Party Software and Equipment purchased directly from GE Healthcare will not be treated as Third-Party Software or Equipment.

3. **Warranty Commencement.** Unless expressly provided otherwise in this warranty statement or the applicable GE Healthcare Quotation, the warranty period begins (the "Warranty Commencement Date") on the earlier of: (i) if GE Healthcare installs the Warranted Product, 5 days after GE Healthcare notifies Customer that it has completed assembly and the Warranted Product is operating substantially in accordance with GE Healthcare's Specifications; (ii) if GE Healthcare does not install the Warranted Product, 5 days after delivery of the Warranted Product to Customer; (iii) the date Customer first uses the Warranted Product for patient use; or (iv) if GE Healthcare is contractually required to install the Warranted Product, the 30th day following shipment to the end-user Customer if installation is delayed for reasons beyond GE Healthcare's reasonable control. The warranty period for any Warranted Product or component furnished to correct a warranty failure will be the unexpired term of the warranty applicable to the repaired or replaced Warranted Product. The warranty period for Vital Signs, Inc. Products begins on the date such products are shipped to Customer.

4. **Remedies.** If Customer promptly notifies GE Healthcare of Customer's warranty claim during the warranty period and makes the Warranted Product available for service, GE Healthcare will, at its option (i) with respect to equipment, either repair, adjust or replace (with new or exchange replacement parts) the non-conforming Warranted Product or components of the Warranted Product and (ii) with respect to GE Healthcare's licensed software, either correct the non-conformity or replace the applicable licensed software. Warranty service will be performed without charge from 8:00 a.m. to 5:00 p.m. (local site time), Monday-Friday, excluding GE Healthcare holidays, and outside those hours at GE Healthcare's then prevailing service rates and subject to the availability of personnel. For certain Warranted Products, GE Healthcare will perform warranty service only at an authorized service center or, in some instances, via a secure, remote connection to a GE Healthcare online center. With respect to GE Healthcare's warranty for the services it provides to Customer, Customer's exclusive remedy is set forth in Section 2.1 above.

Warranty claims for the Warranted Products should be directed through GE CARES at 1-800-437-1171. Warranty claims for accessories and supplies items should be directed through 1-800-558-5102.

5. **Limitations.** GE Healthcare shall not have any obligation to Customer hereunder if the warranty claim results from or arises out of: (i) the use of the Warranted Product in combination with any software, tools, hardware, equipment, supplies, accessories or any other materials or services not furnished by GE Healthcare or recommended in writing by GE Healthcare; (ii) the use of the Warranted Product in a manner or environment, or for any purpose, for which GE Healthcare did not design or license it, or in violation of GE Healthcare's recommendations or instructions on use; or (iii) any alteration, modification or enhancement of the Warranted Product by Customer or any third party not authorized or approved in writing by GE Healthcare. In addition, this warranty does not cover the Warranted Product to the extent it is used in any country other than the country to which GE Healthcare ships the Warranted Product (unless GE Healthcare expressly agrees otherwise in writing). GE Healthcare does not guarantee that licensed software will operate without error or interruption.

In addition, these warranties do not cover: (i) any defect or deficiency (including failure to conform to Specifications and/or Documentation, as applicable) that results, in whole or in part, from any improper storage or handling, failure to maintain the Warranted Products in the manner described in any applicable instructions or specifications, inadequate back-up or virus protection or any cause external to the Warranted Products or beyond GE Healthcare's reasonable control, including, but not limited to, power failure and failure to keep Customer's site clean and free of dust, sand and other particles or debris; (ii) the payment or reimbursement of any facility costs arising from repair or replacement of the Warranted Products or parts; (iii) any adjustment, such as alignment, calibration, or other normal preventative maintenance required of Customer; (iv) expendable supply items; (v) stockpiling of replacement parts; (vi) any failure of the Warranted Products to use or correctly process dates; and (vii) products not listed in GE Healthcare's Accessories and/or Supplies catalogs at the time of sale, and all service manuals are provided AS IS. For network and antenna installations not provided by GE Healthcare or its authorized agent(s), network and antenna system troubleshooting will be billable at GE Healthcare's standard service rates.

For MR systems, these warranties do not cover (i) any defect or deficiency that results, in whole or in part, from failure of any water chiller system supplied by Customer, (ii) service to any water chiller systems supplied by Customer and (iii) for MR systems with LHe/LN or shield cooler configured superconducting magnets (except for MR Systems with LCC magnets), any cryogen supply, cryogenic service or service to the magnet, cryostat, coldhead, shield cooler compressor or superconductive or resistive shim coils unless the need for such supply or service is caused by a defect in material or workmanship covered by these warranties (GE Healthcare's MR Magnet Maintenance and Cryogen Service Agreement is available to provide supplemental coverage during the warranty period). For Proteus XR/a, Definium and Precision 500D x-ray systems, these warranties do not cover collimator bulbs.

6. **Exceptions to GE Healthcare Standard Warranties Described Above.**

CT Partial System Equipment Upgrades*: Six (6) months
MR Partial System Equipment Upgrades*: Six (6) months
X-ray Partial System Equipment Upgrades*; High Voltage Rectifiers and TV Camera Pick-Up Tubes: Six (6) months
PET Partial System Equipment Upgrades* (Scanners, Cyclotrons and Chemistry Labs): Six (6) months
Nuclear Partial System Equipment Upgrades*: Six (6) months
GE OEC New or Exchange Service/Maintenance Parts: Ninety (90) days
HealthNet Lan, Advantage Review — Remote Products: Ninety (90) days

GE Ultrasound Exchange Probes and Transducers, Ultrasound Water Path attachment Kit: Ninety (90) days
GE Ultrasound Service Replacement Parts: Thirty (30) days
LOGIQBook and Other Handheld/Compact Ultrasound Products: Standard warranty includes (i) repair services at GE Healthcare service facilities, (ii) three (3) business day turnaround repair time for systems shipped via overnight delivery (where available), measured from the date of shipment (GE Healthcare is not responsible for delays in overnight shipment), (iii) seventy-two (72) hour loaner systems or probe replacement service via Fed Ex (shipping charges included), (iv) technical support via telephone from 7:00 am to 7:00 pm Central Time, Monday-Friday, excluding GE Healthcare holidays, (iv) field support/service is available for an additional charge and (v) preventative maintenance for an additional charge. For an additional charge, GE Healthcare will also provide the following enhanced warranty features as part of the system warranty: coverage for system damage due to accidental dropping or mishandling, with a maximum of two (2) replacement systems during the term of the warranty.
Ultrasound Partial System Equipment Upgrades*: Ninety (90) days (Customer will not be credited the value of this warranty against pre-existing warranties or service agreements).
Dash, Solar 8000M, 8000i & Tram: Additional two (2) years of parts only coverage, excluding displays (United States only)
DINAMAP ProCare Vital Signs Monitors: Two (2) years
DINAMAP Pro 100-400V2 Series Monitors: Three (3) years
Enterprise Access: One (1) year parts, ninety (90) days labor
MAC 1600: Three (3) years
MAC 1200: Three (3) years (United States only)
Batteries: Ninety (90) days, except (i) for LOGIQBook batteries, which are warranted for twelve (12) months and (ii) for Nickel cadmium or lead acid batteries for X-ray and mammography systems (which will carry a sixty (60)-month warranty prorated as shown below). For Nickel cadmium or lead acid batteries for X-ray and mammography systems, warranty service will be performed without charge from 8:00 a.m. to 5:00 p.m. (local site time), Monday-Friday, excluding GE Healthcare holidays, and outside those hours at GE Healthcare's then prevailing service rates and subject to the availability of personnel only during the first twelve (12) months of the sixty (60)-month warranty period. For X-ray and mammography systems, if nickel cadmium or lead acid batteries need replacement during their applicable warranty period, Customer will pay the price of the replacement battery in effect on its delivery date less a Pro Rata Credit Allowance (as defined herein). The Pro Rata Credit Allowance for batteries that fail less than twelve (12) months after the warranty begins is one hundred percent (100%). The Pro Rata Credit Allowance for batteries that fail more than twelve (12) months after the warranty begins is:

1 - (# of Mos. After Warranty Commencement /60) x 100%

For the purpose of Pro Rata Credit Allowance, a fraction of a month less than fifteen (15) days will be disregarded, and a fraction of a month equal to or greater than fifteen (15) days will be regarded as a full month.
Care Plus® Incubator: Three (3) years parts, one (1) year labor
Ohio® Infant Warmer Systems and Panda™ Warmers: Lifetime parts warranty on heater cal rod
BiliBlanket® Plus High Output Phototherapy System: Two (2) years on Light Box and eighteen (18) months on Fiberoptic Pad
Microenvironment and Phototherapy expendable components, this includes but is not limited to patient probes, probe covers and light bulbs: Thirty (30) days
GE OEC refurbished c-arms: Twelve (12) months after installation
Oximeters: Three (3) years from installation, or thirty-nine (39) months from GE Healthcare invoice, whichever occurs sooner
Tec 7 Vaporizers: Three (3) years
Tec 6 Plus Vaporizers: Two (2) years
X-ray and Image Intensifier Tubes and Maxiray X-ray Tubes: See GE Healthcare Warranty Statement X-Ray an Image Intensifier Tubes
Accessories and Supplies: GE Healthcare's catalog and/or website includes a "Service/Warranty Code" which identifies the installation, warranty, applications and post-warranty service, if any, provided for each accessory and supply product. Following are the warranty periods for accessories and supplies:

Service/Warranty Code T	100 Years
Service/Warranty Code V	25 Years
Service/Warranty Codes X	15 Years
Service/Warranty Codes F	3 Years
Service/Warranty Codes D, J, N, O, R or Z	2 Years
Service/Warranty Codes A, B, C, E, G, L, P, Q, S or Y	1 Year
Service/Warranty Code H	6 Months
Service/Warranty Code K and all Vital Signs, Inc. products	3 Months
Service/Warranty Code M	1 Month
Service/Warranty Code W	Out of Box Failure Only

*** NOTE: For partial system equipment upgrades, the warranty applies only to the upgraded components**

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GE Healthcare

Warranty Codes For Accessories And Supplies

Service / Warranty Codes. If Customer promptly notifies GE Healthcare of its warranty claim and makes the Product available for service, GE Healthcare will provide the warranty service indicated in the applicable Service/Warranty Code description. The terms and conditions of GE Healthcare's Warranty Statement(s) apply to all warranty claims. Basic Service Premise for Products – GE Healthcare Field Engineers will take the first call for service and either provide direct support or arrange for support from the manufacturer or its dealers as indicated by the individual Service/Warranty Code. If the Service/Warranty Code calls for Product return for repair or in-warranty exchange, Customer must return the Product as GE Healthcare directs. GE Healthcare provides warranty service from 8:00 AM to 5:00 PM local time Monday-Friday EXCLUDING GE HEALTHCARE HOLIDAYS. If a Service/Warranty Code provides for warranty service to be performed on Customer's site, such service is available outside the above hours at GE Healthcare's prevailing service rates and subject to the availability of personnel.

A **GE Healthcare directly, or through a sub-contractor, provides the following:**

Installation; parts; on-site warranty service to repair, adjust or replace (at GE Healthcare's option and using new or exchange replacement parts) non-conforming products or parts; applications training in some cases (with additional charge); and post-warranty service, at prevailing hourly billed service ("HBS") rates and, in some cases, under GE Healthcare service contracts.

B **GE Healthcare directly provides the following through GE Healthcare's Global Parts Operation (GPO):**

New or exchange replacement parts at no charge to correct non-conforming products or parts during the warranty period; new or exchange replacement parts at GE Healthcare's normal prices for post-warranty repairs. ***Note:*** *Installation, applications training and on-site service is the Customer's responsibility. However, GE Healthcare's Field Engineers may be available at prevailing HBS rates. Contact GE CARES for availability.*

C **GE Healthcare arranges for the third-party Product Manufacturer or its dealers to provide the following:**

Installation (in some cases with an additional charge); parts; on-site warranty service to repair, adjust, or replace (at the manufacturer's or dealer's option and using new or exchange replacement parts) non-conforming products or parts; applications training in some cases (some with additional charge); and post-warranty service at prevailing service rates.

D **GE Healthcare refers to the Product Manufacturer warranty, which provides the following:**

Basic functional troubleshooting (no technical labor) with supplier phone support and repair or replacement (at the manufacturer's or dealer's option) of defective products or parts. ***Note:*** *The battery for Service/Warranty Code D has a 1-year warranty. For detailed warranty information, please refer to the Product Manufacturer's warranty certificate.*

E **GE Healthcare directly, or through a sub-contractor, provides:**

Installation (in some cases with an additional charge); basic functional troubleshooting (no technical labor) with supplier phone support; and coordination of unit exchange or loaner program for in-factory service.

GE Healthcare arranges for the third-party Product Manufacturer or its dealers to provide in-factory service:

At no charge during the warranty period and at manufacturers or dealer's prevailing service rates outside of the warranty period. Products must be returned to the manufacturer or dealer, at GE Healthcare's expense during warranty and Customer's expense after warranty, for repair.

F **GE Healthcare refers to the Product Manufacturer warranty, which provides the following:**

Basic functional troubleshooting (no technical labor) with supplier phone support and replacement of non-conforming products or parts, which Customer returns to the manufacturer or dealer during the warranty period. ***Note:*** *For detailed warranty information, please refer to the Product Manufacturer's warranty certificate.*

G, J, O and Q **GE Healthcare refers to the Product Manufacturer warranty, which provides the following:**

Start up and commissioning, basic functional troubleshooting (no technical labor) with supplier phone support 24/7; and warranty service to repair, adjust, or replace (at the manufacturer's or dealer's option) non-conforming products or parts (excluding installation, time and material). ***Note:*** *The UPS battery for Service/Warranty Code G has a 9-year pro-rated warranty to cover non-conforming material. Start up and commissioning for Service/Warranty Code O applies only to 10 KVA and above. The UPS battery for Service/Warranty Codes O and Q has a 1-year warranty to replace the product. For detailed warranty information, please refer to the Product Manufacturer's warranty certificate. Warranty service for Service/Warranty Codes G and O is provided On-site. For detailed warranty information, please refer to the Product Manufacturer's warranty certificate.*

H, K, L and M GE Healthcare directly provides the following:

Exchange of non-conforming products, which Customer returns to GE Healthcare during the warranty period. **Note:** *Installation, parts, applications training, and on-site service is the Customer's responsibility.*

N, R and S GE Healthcare refers to the Product Manufacturer warranty, which provides the following:

Installation; Preventative Maintenance; and parts and labor. **Note:** *Post-warranty service, at manufacturer's prevailing HBS rates, and in some cases, under GE Healthcare service contracts. The battery for Service/Warranty Code R has a 1-year warranty. For detailed warranty information, please refer to the Product Manufacturer's warranty certificate.*

P GE Healthcare directly provides the following:

Replacement of non-conforming components. **Note:** *Installation, parts, applications training, and on-site service is the Customer's responsibility.*

T, V and X GE Healthcare directly provides the following:

Replacement of Product only; GE Healthcare will not replace patient records; and product is warranted only for image legibility. **Note:** *Installation, parts, applications training, and on-site service is the Customer's responsibility.*

W GE Healthcare directly provides the following:

Replacement of Product only for Out of Box failure. **Note:** *Installation, parts, applications training, and on-site service is the Customer's responsibility.*

Y and Z GE Healthcare refers to the Product Manufacturer warranty, which provides the following:

Basic functional troubleshooting (no technical labor) with supplier phone support and replacement of non-conforming components **Note:** *All electrical components (excluding the UPS) for Service/Warranty Code Z have a 1-year warranty. For detailed warranty information, please refer to the Product Manufacturer's warranty certificate.*

GE Healthcare

QUOTATION

Quotation Number: P7-C91678 V 1

Piedmont Medical Center Hospital
222 S Herlong Ave
Rock Hill SC 29732

Attn: Gina Carey
Director of Radiology
222 S Herlong Ave
Rock Hill SC 29732

Date: 08-20-2010

Qty	Catalog No.	Description	Ext Sell Price
1		**Discovery MR750 3.0T**	
1	S7500AT	Discovery MR750 16 Channel Fixed Site MR System with iROC (In Room Operator Console)	$991,818.00

S7500AT comprises a state of the art MR750 16 channel MRI system inclusive of the iROC (In Room Operator Console).

The MR750 3.0T system incorporates several new technologies designed to improve image quality, MR exam workflow and efficiency, and exam consistency. Included in this collector are the technologies that drive the MR750 system including:

OpTix Technology: GE's exclusive optical RF technology improves signal detection efficiency with 165 dB of dynamic range while reducing electrical noise. By locating the digital receiver electronics inside the magnet room close to the origin of the MR signal, interference from noise sources is reduced improving image quality and SNR. Scalability is another key benefit of the OpTix technology. The use of fiber optic cables for data transmission reduces the cabling footprint over conventional BNC designs and enables high channel count systems without requiring additional space. With 72 coil connection ports available within the system, the OpTix technology can seamlessly route signals from any port to the receivers with a dynamic switching RF hub. Additionally, the OpTix technology enables multi-channel broadband receive for advanced multi-nuclear studies.

Volume Reconstruction Engine 2.0 (VRE 2.0): The backbone of any high-channel count system is the reconstruction architecture. The MR750 utilizes the latest dual-core 2.6 GHz processing technology with the VRE2.0 recon architecture. With its expansive 32 GB of memory, acquisition to-disk technology, and 5400 2D FFT/s frame rate, the VRE 2.0 delivers the processing power to reconstruct 32-channels of high-resolution 3D volumetric data.

In-Room Operator Console (iROC): By consolidating all controls into one place, the In-Room Operator Console (iROC) provides real time feedback to the operator to improve exam room efficiency. With a high-resolution, 12.1 inch color LCD display located just above the MR750 gantry, coil-connection, patient set-up, cardiac and respiratory waveforms makes exam preparation a breeze. The iROC provides feedback on:

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- Display of Patient name, ID, and study description.
- Display and entry of patient weight.
- Display and entry of patient orientation / position.
- AutoStart initiates automatic scan start.
- Cardiac & Respiratory waveform display.
- Coil connection status.

MR750 Power Electronic Cabinet: The performance of the MR750 system is derived from a set of water-cooled power electronics housed within a single cabinet.

EXtreme Gradient Driver (XGD): The eXtreme Gradient Driver (XGD) provides the power and duty-cycle to support 50 mT/m peak amplitude at a slew-rate of 200 mT/m/s on all 3-axes simultaneously. By incorporating a water cooled power-electronics architecture, this system supports continuous peak gradient performance with 100% duty cycle.

RF Amplifier: To drive the MR750 RF body coil, the system utilizes a GE exclusive water cooled, solid-state 35kW RF amplifier design. The solid-state design improves amplifier reliability and performance regardless of patient load. In addition, the amplifier support a 100W continuous-wave output mode for advanced proton-decoupling and spin-labeling research.

Included with S7500AT is the MR750 Site Collector Kit. Optimally designed for patient safety, patient comfort, and efficient workflow, the external features of the MR750 also provide an aesthetically pleasing look and feel

that can reduce patient anxiety. The wide open flare of the covers increase the effective bore size and can reduce patient anxiety when entering the scan room or magnet bore. With patient-optimized lighting and air conditioning, the system can be ideally set for each individual, increasing their control of the environment.

Included within S7500AT are:

Wide Screen flat panel monitor.

Scantools Pulse Sequences.

BrainSTAT software for time course analysis: The BrainSTAT post-processing application automatically generates parametric maps for neuro Blood Flow, Blood Volume, Mean Transit Time, and Time to Peak signal intensity. A Gamma Variant fitting algorithm is used to automatically estimate the arterial input function, then calculate the quantitative values for the four parametric maps. The maps may be saved in DICOM format and fused with high-resolution

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		anatomic datasets for improved visualization of tissue and anatomy	
		Fluoro Triggered MRA allows the user to visualize the arrival of a contrast agent then commence the 3D CE-MRA acquisition.	
		2D FIESTA imaging for rapid imaging with T2/T1 contrast. This sequence may be gated for high CNR images of the heart.	
		3D FIESTA imaging allows thin slice imaging with T2/T1 contrast.	
		FIESTA-C: Phase cycled FIESTA to demonstrate high CNR imaging between fluid and tissues. Especially interesting for cranial nerve imaging.	
		3D FIESTA imaging with fat sat is advanced software designed for imaging of the coronary arteries. The software acquires 3D images using FIESTA (Fast Imaging Employing STeady state Acquisition). Fat suppression is applied to accentuate the coronary arteries. The use of VAST (VAriable Sampling in Time) technology greatly shortens breath-holding requirements or allows for higher spatial resolution.	
		iDrive Pro Plus: A real time interface for MR imaging.	
		Connect Pro for DICOM Worklist management: ConnectPro enables the DICOM worklist server class for the Signa operators' console, making it easy to query your HIS/RIS by name, or scheduled date, and to download patient demographics directly to the scanner. The data is automatically loaded into the Express Exam Modality Worklist for simple filtering, editing and prescription of protocols for exam preparation.	
		TRICKS for Multiphase CE-MRA imaging: TRICKS (Time Resolved Imaging of Contrast KineticS) provides high-resolution multi-phase 3D volumes of any anatomy for fast accurate visualization of the vasculature. With segmented temporal sampling and complex data recombination, TRICKS can accelerate 3D dynamic vascular imaging without compromising spatial detail. TRICKS also uses elliptic centric data collection for optimized contrast resolution and auto-subtraction for optimized background suppression. The result is time course imaging that does not require timing or triggering, provides high temporal and high spatial resolution, and enables the extraction of optimum phases of data. As a result, TRICKS enables reliable, high quality vascular imaging.	
		TRICKS is compatible with surface coils and supports parallel imaging even higher temporal resolution.	
		PROPELLER is a revolutionary acquisition and reconstruction technique that dramatically reduces the impact of patient motion on image quality. Artifacts	

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		from gross movement, cardiac, and respiratory cycles can be eliminated with PROPELLER. As the name suggests, multiple blades of data are acquired at increasing angles throughout the sequence until the entire dataset has been completed. A unique reconstruction algorithm then combines these independent blades of data to form the resulting image. This method of acquisition and reconstruction creates images with unusually high contrast-to-noise ratio as well as makes the sequence insensitive to motion artifacts on T2 and T2 FLAIR sequences and insensitive to susceptibility artifacts on DWI sequences. The result is high quality T2 and T2 FLAIR images of the brain and spine even when the patient fails to remain still, and high quality DWI images in the presence of dental work or surgical hardware. Images can be acquired in any orientation. IDEAL imaging option: Generate consistent tissue contrast and reduce the number of series in an exam with IDEAL. The IDEAL acquisition and reconstruction methods can generate water-only, fat-only, in-phase and out-of-phase data sets for clear tissue differentiation in a single series. In addition, susceptibility artifacts common to MR imaging such as incomplete or inaccurate fat saturation, and chemical shift can be eliminated as well. The IDEAL application acquires multiple echoes and uses unique reconstruction routines to generate the four image contrasts and correct for errors due to tissue susceptibility. IDEAL is ideally suited for imaging anatomical regions such as the brachial plexus, neck, spine, chest, foot, ankle, and axilla where inhomogeneous magnetic fields may yield failures with traditional fat saturation techniques. IDEAL is compatible with Fast Spin Echo, 3D Gradient Echo and parallel imaging. For fast multi-phase imaging of the abdomen and pelvis, fat and water separation techniques are employed with LAVA. This efficient LAVA-Flex acquisition uses 2D ARC parallel imaging to eliminate artifacts from breath hold misregistration and incorrect FOV placement. LAVA-Flex is included in the Express Exam Scantools and is standard with the MR750 system. For fast multi-phase imaging of the breast, fat and water separation is compatible with VIBRANT. The efficient VIBRANT-Flex acquisition uses 2D ARC parallel imaging to gain higher acceleration factors over ASSET parallel imaging, reduces artifacts from breath hold misregistration, and eliminates artifacts due to incorrect FOV prescription. CUBE for 3D FSE imaging: Exclusive to GE, the Cube technology can eliminate multiple independent two-dimensional datasets with a single three-dimensional volume (or cube) of high-resolution data to provide better	

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		image quality in shorter exam times. Compared to traditional 3D fast spin echo acquisitions, Cube uses a combination of optimized echo train pulses to: reduce SAR, extend the duration of the acquisition echo train, and reduce the echo spacing. The system automatically adjusts the echo train flip angle amplitude to provide optimize tissue contrast based on the specific tissue T1 and T2 characteristics and prescription parameters. To further reduce exam time and improve image quality, Cube is compatible with ARC self-calibrating parallel imaging, included with all MR750 systems.	
		Isotropic Cube datasets are easily reformatted from a single acquisition into any plane without gaps, and with the same resolution as the original plane for improved anatomical review and tissue visualization.	
		High resolution Cube data can be acquired with T2, T2 FLAIR, or Proton density weighted tissue contrasts for neuro and musculoskeletal imaging.	
		COSMIC (Coherent Oscillatory State acquisition for Manipulation of Image Contrast): COSMIC	
		is a 3D imaging technique specifically tailored for cervical spine evaluation. The unique fluid-weighted contrast yields improved visualization of the cervical nerve roots and intervertebral disks. The high-resolution images are easily reformatted for better tissue visualization from any orientation.	
		The 3D MERGE (Multi-Echo Recombined Gradient Echo) sequence has been optimized to generate clear tissue contrast in the cervical spine. By acquiring and summing multiple gradient-echoes at various echo-times, MERGE improves gray-white matter contrast within the cord and provides excellent visualization of the neuroforaminal canals. The high in-plane resolution and thin slices enable excellent image reformats for better tissue visualization from all angles.	
		Diffusion Tensor imaging (DTI) creates contrast based on the degree of diffusion anisotropy in cerebral tissues such as white matter. The DTI method expands Echo planar imaging capability to include diffusion imaging sequence using motion sensing gradient pulses along 6 to 150 orientations in order to generate tensor component images. With the MR750 Express Workflow, fractional anisotropy (FA) and Volume Ratio Anisotropy (VRA) maps may be automatically created after image acquisition without any user intervention.	
		With the DTI data, the separate FiberTrak post-processing utility generates eigenvector information from the diffusion tensor acquisition and processed datasets.	

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		Using a robust and efficient seeding process, three-dimensional renderings of the diffusion along white matter tracts are generated.	
		FiberTrak: White matter tracts and tissues with high fractional anisotropy are easily displayed and visualized in the 3D Volume Viewer with FiberTrak. This host computer post processing tool expands the capability of Diffusion Tensor imaging by generation of 2D color orientation maps, 2D eigenvector maps, and 3D tractography maps from the diffusion tensor image data. The resulting datasets may be easily saved and archived for later use.	
		Autovoice can be combined with all pulse sequences within MR Echo allowing automated voice commands in over seven differing languages.	
		VIBRANT for Breast Imaging: VIBRANT (Volume Imaged BReast AssessmeNT) is a fast, high-resolution T1 weighted imaging sequence and application optimized for evaluation of breast tissue. VIBRANT uses GE exclusive technology and parallel imaging acceleration to quickly acquire multi-phase data without compromising spatial resolution. This 3D gradient echo technique, optimized for sagittal or axial acquisitions uses an optimized inversion pulse and dual-shimming technology that yields enhanced image contrast and robust, uniform, bilateral fat suppression. Auto-subtraction of the first dataset is also available to further background suppression. For enhanced speed, VIBRANT is compatible with both ASSET and ARC parallel imaging with acceleration factors up to four. As a result, VIBRANT enables reliable, high quality breast imaging.	
		For improved tissue contrast, VIBRANT is compatible with fat and water separation imaging. The VIBRANT-Flex acquisition will provide a water-only, fat-only, in-phase and out of phase data sets in a single acquisition and produce images with significantly reduced chemical shift and susceptibility artifacts. This is critical for evaluation of the axilla and chest wall. The IDEAL feature must be purchased separately.	
		FUNCTOOL Fusion: To better visualize tissue and contrast, multiple images from separate	
		acquisitions can be overlaid on one another. With the Signa MR750 workflow, high-resolution anatomical images can be automatically fused with functional data or parametric maps for improved visualization. The independent imaging series are registered with rotation, translation, and large geometry correction to ensure accurate fusion. High-resolution 2D and 3D data sets, reformatted images, computed parametric maps, and spectroscopy maps may be fused with appropriate anatomical references.	

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		R2* Tool: Generate quantitative relaxation maps with the R2 Star (R2*) analysis tools in Functool. With the Express Exam workflow, this feature can automatically generate R2* maps (in units of Hz) and T2* maps (in units of milliseconds) after the multi-echo data has been acquired. The user can have complete control of analysis and may use either the default values to initiate the calculation, or specify specific starting parameter to generate the parametric maps. Input variables for edit include, but are not limited to: number of initial images/echoes to be skipped, lower and upper threshold levels, use of a two-parameter or three-parameter fitting model, confidence level.	
		The parametric maps may be saved in DICOM format and may overlay high resolution 3D images with Functool Fusion for better tissue visualization. No separate option is necessary to acquire the data; it is included in Express Exam Scantools.	
		QuickStep is an automated multi-station acquisition for the evaluation of the vascular tree. This unique application automatically prescribes, acquires, and combines images from multiple stations for fast acquisition and exam completion. To complete the entire exam completion. To complete the entire exam in as little as 6 minutes, the system will automatically acquire mask datasets from multiple stations without any user intervention. Secondary images are then acquired at the same independent table positions. The system will automatically subtract the mask images from the secondary dataset and combine the resulting images from the multiple stations into one series The user only needs to complete a review and approval of the data prior to insertion of images into the database.	
		StarMap Acquisition enables the acquisition of multiple gradient echo images at each 2D slice at a range of echo-times. The resultant images can be processed using FuncTool to provide T2* maps within the the anatomy of interest.	
		Included is a single channel transmit receive head coil.	
1	M7000MB	Discovery MR750 3.0T Magnet, Gradient and RF Body Coil	$607,500.00
		The MR750 is equipped with GE's 3rd generation 3.0T magnet, ultra-strong gradients 50 mT/m and 200T/m/s slew rate with a 60 cm bore, and a high-performance RF body coil for superb performance and image quality.	
		GE's 3rd Generation Magnet Design: With GE's exclusive 18 superconducting higher-order shim coils, active shielding technology, and stainless steel foundation, the MR750 system can be installed almost anywhere. The	

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		superconducting shim technology minimizes the need for onsite passive shimming, easily accommodates a wide-range of siting environments, and can be adjusted to compensate for environmental changes that occur over time. The magnets high-homogeneity delivers excellent fat-saturation away from isocenter and ensures image quality over a full 48 cm field-of-view. Coupled with its zero-boil off technology and remote magnet monitoring technology, the MR750 3.0T magnet is designed to provide years of worry-free, reliable, low cost operation. High-Performance Whole-Body Gradients: The MR750 incorporates the latest in MR gradient technology with the eXtreme Resonance Module (XRM). XRM gradients deliver 50 mT/m peak amplitude and 200 T/m/s maximum slew-rate on each axis simultaneously with unmatched fidelity, accuracy, and reproducibility. The gradients are water-cooled and equipped with integrated thermo-electric cooling panels to provide 100% duty-cycle and excellent stability for advanced studies such as fMRI. Acoustic noise is minimized using a passive acoustic barrier material that reduces acoustic transmission by an average of 6dB for enhanced patient comfort without compromising imaging performance.	
1	M7000BS	Discovery MR Express Patient Table Unique to GE, the fully detachable Express patient table incorporates the Liberty 2.0 Docking System to improve safety, exam efficiency, and patient comfort over fixed table solutions. Easily docked and undocked by a single operator, the patient table is simple to move in and out of the exam room for patient transport and preparation. These become vital features in those instances where multiple patient transfers can negatively impact patient care or when emergency evacuation is required; the table can be undocked and removed from the scan room in under 30 seconds with just one technologist. In time-sensitive situations there is no need to remove or disconnect surface coils as the system can automatically disconnect the coils for you. With an added second table (a separate purchasable option), the next patient can be positioned outside the magnet room while the current patient is undergoing an examination, thus minimizing the time between scans. Express Patient Table Comfort: The Express detachable table can reduce patients' anxiety and provide patient personal discretion by preparing them for the exam outside the scan room. Reduced patient table transfers for inpatients or trauma patients can improve overall patient care. The Express .	$46,980.00

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		patient table offers optional head- or feet first imaging. Additionally, feet-first positioning facilitates run-off studies and set up for claustrophobic patients. Ergonomics: With one hand and with one simple motion, the integrated arm boards and IV pole can be optimally positioned to support the patient for injections or transportation. This unique capability of the Discovery Express patient table also makes it ideally suited for multi-station exams with no scan room intervention, such as peripheral vascular (run-off) imaging. • Patient table drive: Automated, power driven vertical & longitudinal • Longitudinal speed: 30 cm/sec (fast) and 0.5 cm/sec (slow) • Total cradle length: 211 cm • Positioning accuracy: +/- 0.5 cm • Maximum patient weight for scanning: 227 kg (500 lbs) • Maximum weight for patient guardrails: 227kg (500 lbs) The Discovery MR Express Patient table is compatible with all configurations of MR750 systems.	
1	M7000ML	MR750 Dock & 16 Channel Switch Collector The MR750 Dock and 16 Channel Switch collector provides the interface between the magnet and the 16 Ch Express Patient Table. Also included is the RF signal switching hardware that routes the input signals to the respective OpTix receivers.	$102,600.00
1	M7000WM	MR450/MR750 Preinstallation Collector The Preinstallation Collector delivers to the site in advance of the magnet and main electronic components. This facilitates the later delivery and installation of supporting electronics. The following are the main components in the Preinstallation collector: • Heat exchange cabinet for distribution of chilled water. • Primary Penetration wall panel for support of the penetration cabinet. • Secondary Penetration wall panel for support of gradient filters, helium cables, and chilled air and water. • Helium cryocooler hose kit.	$56,160.00
1	M7000WL	MR450/MR750 Main Disconnect Panel The Main Disconnect Panel safeguards the MR system's critical electrical components, by providing complete power distribution and emergency-off control.	$6,480.00

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Qty	Catalog No.	Description	Ext Sell Price
1	M7000BN	MR750 Cable Configuration A, Short ER, Short SR To accommodate various electronic and scan room configurations and sizes, the MR750 has preset lengths of cables and connector kits to speed system installation. This catalog is for sites with a relatively short distance 10 meters between the penetration wall and the rear of the MR scanner, and approximately 10 meters between the penetration wall and cabinets in the electronics room. Refer to the pre-installation manual for exact cable lengths and configurations. This cable collection is compatible with fixed and relocatable building configurations.	$27,540.00
1	M1060MA	Vibroacoustic Damping Kit Material in the Vibroacoustic Damping Kit can significantly attenuate the transmission of gradient-generated acoustic noise through the building structure to nearby areas, including adjacent rooms and floors above or below the MR suite. If this kit is applied during the installation of a new magnet, no additional service charges are necessary. However, installation of the Vibroacoustic Damping kit under an existing magnet requires special steps. The steps to prepare the site and steps to install, such as modifications to the RF screen room, and other magnet rigging, modifications to the RF screen room, and other finishing work, are not covered in the pricing.	$7,938.00
1	M7000GL	Cabinet Dollies Provided to install the System Cabinets. Dollies remain the property of GE to be returned after cabinets are in place at customer site.	Incl.
1	M7000DA	iROC - In Room Operator Console Control: English English version of the Scan Control Interface for the host computer and MR450/MR750 MR magnet. This hardware interface includes the ergonomically designed keyboard, two-way communication and voice command module between the host workspace and scanner, activation buttons for patient table control, acquisition interface to initiate the scanner, and emergency stop switch. English version of the dual control panels for the In Room Operator Console. The control panels include backlighting for easy visualization in darkened rooms, automated button highlights that signal which button to press for simplified workflow and ease of use, and a trackball with mouse buttons for interaction with the Operator Console and patient setup screens.	$3,510.00
1	M3335CA	Calibration Kit Phantom Holder Cart	$1,620.00

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1	M3335CC	3.0T Calibration Kit This 3.0T calibration kit contains a large volume shim phantom, a daily quality assurance phantom, an echo-planar calibration phantom, and associated loader shells.	$9,180.00
1	M1000MW	Operator's Console Table Wide table designed specifically for the color LCD monitor and keyboard.	$162.00
1	M7000AP	3.0T 16-Channel Head/Neck/Spine Array-GE Coils The 3.0T Head/Neck/Spine (HNS) Array delivers convenience without compromise. Compatible with 16 or 32-Channel MR750 systems, this 29-element coil serves as a high-resolution brain coil, high-density neuro-vascular array, and a multi-element spine coil in one convenient package. Designed to accommodate multi-dimensional parallel imaging in any scan plane, this coil yields unprecedented imaging speed and superior image quality, thanks in large part to a unique element arrangement that focuses the signal over the anatomy of interest.	$75,600.00
1	M3335LN	3.0T 8-Channel Torso Array - GE Coils The 8-channel Torso Array coil generates outstanding, high-resolution images of the thorax, abdomen, MRCP, and pelvis, including the prostate. ASSET-optimized, it offers extended coverage in each direction - 35 cm S/I, 34 cm R/L, and 30 cm A/P.	$21,600.00
1	M3340CC	3.0T 8-Channel Shoulder Coil The 3T compatible 8-channel shoulder coil has excellent lateral coverage and improved SNR over the lower channel count designs. The semi flexible coil was designed to improve patient comfort with the goal of minimizing motion during the exams. Parallel imaging is supported to reduce acquisition times using this coil.	$35,100.00
1	M3335LB	3.0T 8-Channel Knee Array - Invivo The Knee Array is designed for high-definition MR knee imaging on 3.0T HD, HDx and Signa MR750 systems. This 8-element transmit/receive coil employs unique hybrid technology, using separate coils for transmit and receive functions. Designed uniquely for GE, it delivers more SNR than the standard extremity coil. And it's compatible with PURE for uniform signal intensity and ASSET for accelerated imaging speed.	$27,000.00

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Qty	Catalog No.	Description	Ext Sell Price
1	M3340CA	3.0T 8-Channel Wrist Coil The 8-Channel Wrist Array generates high definition MR wrist images on 3T HDx and Signa MR750 systems. The one-piece, ovoid, hinged design is optimal for small-FOV imaging and provides 12-cm S/I coverage. The coil can be positioned overhead or at the patient's side, vertically or horizontally. The coil is optimized for parallel imaging to improve acquisition times.	$35,100.00
1	M1385AF	3.0T General Purpose Flex Coil for EXCITE, HD and HDx 3T94 systems, and New HDx G3 and Signa MR750 systems. This extraordinarily versatile coil delivers uniform signal intensity over a wide range of studies, including hip, shoulder, brachial plexus, large-knee, ankle, thigh, elbow and soft-tissue neck. It's also excellent for dynamic joint imaging. With its "optimal imaging volume" design, it streamlines imaging of even highly irregular areas of interest.	$5,454.00
1	M7000C	3.0T GP Flex Coil Adaptor for MR750 This adaptor provides the necessary interface between the general-purpose flex coil and the MR750 system.	$810.00
1	M7000FB	Performed Procedure Step Performed Procedure Step (PPS) is an important automated connectivity capability - and a key step towards a film-less and paperless environment. Used in conjunction with the GE PACS broker, it automatically notifies the HIS/RIS and PACS systems of procedure status - in effect, closing the loop on the information gathered from patient arrival through billing. The results: Improved patient care and enhanced productivity.	$2,700.00
1	S7502TZ	MR Accessories Kit The Accessories Kit combines a physician's chair, a complete set of positioning pads, and a set of Velcro security straps. The Physician's Chair has padded arms for comfort and comes in a charcoal gray color that blends with any environment. The MR Accessories Kit contains a complete set of coated positioning pads in a lightweight tote case that can be a permanent fixture in an MR suite or can be easily carried from room to room. The following pads are included: 1 knee rest, 1 knee coil insert, 1 extremity rest, segment table pads, 4 body wedges, 4 rectangle stack pads, and 2 rectangle elbow pads. The Velcro Security Straps include one 14 inch wide set and one 6 inch wide	$2,160.00

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Qty	Catalog No.	Description	Ext Sell Price
		set.	
1	E8823JB	MR Dielectric Pad Set-Includes 1 Neck Pad and 1 Abdomen Pad These soft and flexible dielectric pads are used to suppress shading artifacts that can sometimes be encountered at higher 3.0T field strengths, and especially when imaging in the cervical spine and abdomen and pelvis. Covered with a patient friendly outer cover, the neck pad is placed inside the coil, and under the patient's neck, while the abdomen pad is placed over the patient's abdomen or pelvis and under the front portion of the torso array coil.	$840.00
1	W0106MR	TiP Discovery and Optima Family Training 10 Days Onsite Plus 10 Hrs TVA The TiP Training Choices program is designed for CURRENT GE customers WITHOUT HDx experience who purchase a Discovery or Optima system. Training is delivered onsite at the customer's facility and instructs students in start-up operation of the system and introduces participants to the system design, workflow, new options and clinical applications included. Extended TVA support ensures learners maintain performance over the long term. This training program must be scheduled and completed within 36 months after the date of product delivery.	$19,800.00
1		**NonProducts**	
1		MR system rigging	$9,500.00
		Quote Summary:	
		Total Quote Net Selling Price	**$2,097,152.00**
		(Quoted prices do not reflect state and local taxes if applicable)	

If you would like to place an order for this equipment, a formal contract document will be prepared for your consideration. This quote is for budgetary use only; only a GE contract can become a binding order.

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Piedmont Medical Center Hospital
222 S Herlong Ave
Rock Hill SC 29732

Attn: Gina Carey
Director of Radiology
222 S Herlong Ave
Rock Hill SC 29732

Date: 08-20-2010

Qty	Catalog No.	Description	Ext Sell Price
1		**LightSpeed VCT XTe**	
1	S7864TB	The LightSpeed VCT XTe is a premium clinical volume CT system capable of coronary CTA at 3-6 mSv* dose with no loss in image quality. This revolution in CT scanning is enabled by the industry leading 40mm V-Res detector, Volara XT Data Acquisition System, 800mA Performix Pro tube and Generator, Real-time Table/Gantry control systems. Built on the legacy of LightSpeed VCT this systems unique technologies deliver true clinical performance This is a premium LightSpeed VCT configuration that includes Xtream HD. Clinical Capabilities: • Complete a low dose coronary CTA study in as few as 5 heart beats at doses as low as 3-6 mSv* with improved IQ with SnapShot(TM) Pulse. • Complete a helical acquisition coronary CTA study in 4-5 heart beats with GE's exclusive 5-Beat Cardiac (TM). • In an acute care setting, perform an exam to detect coronary artery disease, pulmonary embolus and aortic dissection in one exam with GE's exclusive Triple RuleOut (TM). • Scan 1700 mm with 0.625mm slices in 12.5 seconds...fine detail and extremely fast coverage speed for trauma. • Perform a dynamic neuro CTA and CTP study with 80mm of shuttle coverage with up to 24% less dose with VolumeShuttle(Optional). • Complete a high resolution chest exam in 1.4 seconds...reducing motion. • Scan a chest/abdomen/pelvis in 3.4 seconds with sub-mm resolution. Key Features: Excellent Image Quality: • Exclusive V-Res (TM) Detector technology providing 40mm (64 rows) of 0.625mm acquisition in all scan modes for optimized MPR and 3D imaging. • Faster coverage speed of 137.5mm/sec with sub-mm resolution. • Diode technology providing true 64 channel acquisition and a platform for future growth. • Enhanced features for coronary & angiography including: ECG waveform display on the console, cardiac optimized bowtie filters for dose reduction & cardiac specific image filters. • Full 360 degree rotation in 0.4, 0.5, 0.6, 0.7, 0.8, 0.9, 1 seconds, ensuring	$1,363,500.00

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Qty	Catalog No.	Description	Ext Sell Price

short breath holds, more comfortable exams and flexibility to customize protocols for unique patients needs with minimal coverage impact (0.35, 0.375, 0.40, 0.425, 0.475 and 0.50 are only available for cardiac applications).

- Routine thin slice scanning, as thin as 0.625mm optimizing lesion detection and facilitating the use of thinner images for sagittal, coronal, oblique, and volume image presentation and review
- Highly efficient compact geometry design delivering optimum performance of the x-ray tube and generator
- Image decomposition to:
  - Retrospective thin images from data sets where thicker images were initially reconstructed
  - Facilitates more detailed image analysis.
  - Improves 3D and reformat visualization.
- Neuro3D Filter provides users the capability to filter angiographic data using specially designed and optimized 3D filter to achieve up to 36% dose savings while maintaining image quality or achieve up to 20% image quality (noise) improvement at the same dose.
- The R-Peak Editor allows user to retrospectively modify trigger points identifying R-peaks on ECG trace as displayed on the console. The capability may improve successful cardiac acquisition rate by enabling users to perform the modification in the cases where there is irregular heartbeat or suboptimal triggers.

Fast Easy Simultaneous Workflow:

- Xtream(TM)HD Workflow Platform, the next evolution of GE's workflow platform built to help you maximize productivity
  - Delivers up to 35 images per second images per second (ips) reconstruction
  - Upto 16 ips network transfer rates
  - Direct Multiplanar Reformats (DMPR) that enables the move from 2D review to prospective 3D review of sagittal, coronal and oblique planes automatically
  - Data Export and Interchange that allow you easily share images with referring physicians and patients
- Includes a complete set of clinically proven protocols and the ability to customize your own for total of 8,460 prgrammable protocols
- Remote tilt from the operator console to increase exam speed.

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- Built-in breathing lights with a countdown timer, so the patient does not have to guess how much longer to hold their breath.
- In room start button mounted on gantry with countdown display, facilitates single technologist operation and improved departmental productivity.
- GE software allows you to automate or build every task into the protocols to increase throughput.
- 250,000 uncompressed 512 image files storage capacity, and 2880 scan seconds of scan data storage capacity

Dose Management Leadership:

- OptiDose management features: new bowtie filters optimized for coronary angiography and pediatric body exams, full 3D dose modulation, color coding for kids, tracking collimator hardware and software for x-ray beam tracking, optional ECG dose modulation, to name a few of GE's dose optimization features, all based on the ALARA priniciple
- 3D Dose modulation Before the scan, clinicians can select the desired Noise/IQ: CT then tailored automatically exposure parameters, patient to patient and real-time x-y-z during each scan, resulting in up to 30% dose reduction
- Tracking collimator hardware and software for x-ray beam tracking to minimize patient dose.
- Filtration of the x-ray beam is optimized independently for body and head applications
- DLP (dose length product), and dose efficiency display during scan prescription provides patient dose information to the operator

Adaptive Statistical Iterative Recon (ASIR) provides users with a new and innovative image reconstruction technology to reduce unwanted noise in diagnostic images, allowing users to improve image quality at up to 40% less dose.

The Xtream HD Reconstruction breaks through existing limits on speed, image quality and flexibility to provide an optimized volumetric workflow solution from acquisition to final report and has the capability to deliver up to 35 full fidelity images per second (ips) reconstruction and 35ips network transfer rates.

Clinical Benefits:

- Cardiac CT allows ECG gated acquisitions of the heart in SnapShot mode

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		• Coronary artery calcification imaging with retrospective and prospective gating-option • CTA runoffs • More thin slices faster; routine use of thin slices without compromising IQ, coverage, or throughput • Full organ coverage in arterial phase • Longer helical scans • Multi-phase organ studies • Improved multi-planar reformats with isotropic microvoxel imaging • Faster scanning with outstanding image quality and GE's proprietary cross beam and hyperplane reconstruction algorithms • System designed for optimization of z-axis resolution and dose with 0.625 mm slice thickness System components: Gantry: Advanced slip ring design continuously rotates the generator, Performix tube, Matrix II detector and Volara digital data acquisition system around the patient. • Aperture: 70 cm • Maximum SFOV: 50 cm • Rotational speeds: 360 degrees in 0.35, 0.375,0.4,0.425,0.45,0.475,0.5,0.6,0.7, 0.8, 0.9, 1.0 seconds. • Tilt: +/- 30 degrees, speed: 1 degree/second • Remote tilt from operator's console • Integrated breathing lights & countdown timer • Integrated start scan button with countdown timer to indicate when x-ray will turn on Laser Alignment Lights: • Defined internal and external scan planes to +/- 1 mm accuracy • Operate over full range of gantry tilt • Coronal light remains perpendicular to axial light as gantry tilts making visual readout easy from tableside or the operator console. Table: Cantilever design for easy access,and stability • Vertical range: 43 cm to 99.1 cm • Vertical scannable range: 78.5cm to 99.1 cm • Horizontal range: 1700mm, (2000mm option)	

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- Horizontal Pitches: 0.5:1, 0.9:1, 1.375:1, and Cardiac pitches 0.16:1 to 0.24:1 for 0.35 second scanning
- Horizontal speed: up to 175 mm/sec
- Table automatically re-centers on scan plane with changes in vertical position
- Table load capacity:
  - 227kg (500 lb) +/-0.25mm positional accuracy

X-ray Tube: Performix metal-ceramic tube unit offers a optimized design for exams requiring a large number of scans without tube cooling.

- Performix tube with 8.0 MHU of storage and capability of 100 kw operation provides increased helical performance with greater patient throughput and virtually no tube cooling. Advanced technology in the tube includes a metal ceramic frame and high speed bearing for long life at sub-second scanning, a high efficiency motor to accelerate the anode and efficient cooling for high throughput and superior helical performance.
- Wide range of technique (10 ma to 800 ma, in 5 ma increments) gives technologist and physician flexibility to tailor protocols to specific patient needs, while optimizing patient dose, and providing the power needed to perform a broad spectrum examinations.
- Heat storage capacity: 8.0 MHU
- Heat dissipation:
  - Anode (Max) >2,100 KHU/min
  - Casing (cont) 648 KHU/min
- Dual Focal Spots:
  - Small Focal Spot: 0.7 (W) x 0.6 (L) Nominal Value; (IEC 336/93)
  - Large Focal Spot: 0.9 (W) x 0.9 (L) Nominal Value; (IEC 336/93)
- Maximum power: 100 kW @ 140 kVp
- Beam collimated to 56 degree fan angle.

High Voltage Generator: High Frequency on-board generator allows for continuous operation during scan.

- 100 kW Output Power
- kVp: 80, 100, 120, 140 kVP
- mA: 10 to 800 mA, 5 mA Increments.

Maximum mA for Each kVp Selection:

- 675mA @ 80kVp

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Qty	Catalog No.	Description	Ext Sell Price
		• 770mA @ 100kVp • 800mA @ 120kVp • 715mA @ 140kVp V-Res Detector: The V-Res detector was designed for high performance imaging. The LightSpeed VCT XTe delivers up to 64 slices per rotation, and 182 slices per second in cardiac mode. The V-Res detector benefits are: • Solid 40mm coverage per rotation • Solid Image Quality from the use of GE's exclusive patented detector material • 64 detector rows Volara Digital DAS (Data Acquisition System): The Volara digital DAS dramatically reduces noise and improves image quality, especially in low dose exams, large patient, or areas of the anatomy that are difficult to image such as shoulder and hips • 2,450Hz maximum sample rate • Effective analog to digital conversion range greater than 2,000,000:1 IVY 3150 Cardiac Trigger Monitor: Synchronizes output for R-Wave Synchronization Applications features Automatic Operation, ECG and Heart Rate Display, P-Lock Algorithm, Trigger Mark, Chart Recorder, ECG Data Storage, ECG Notch Filter, System Interlock, and Universal Power Supply. Designed exclusively to work with GE CT Scanners. Xtream HD Operator Console: • 803GB of total system storage • 250,000 uncompressed 512 image files storage capacity, and 2880 scan seconds of scan data storage capacity • 9 GB DVD/CD-R for data interchange (not recommended as a long term archive) Image Networking: Exams can be selected and moved between the LightSpeed VCT XTe CT Scanner System and any imaging system supporting DICOM protocol for network send, receive and pull/query. • Standard Auto-configuring Ethernet • Direct Network Connection • Supports 1GB or 10/100/1000 BaseT • Supported Protocols - DICOM Network	

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- Advantage Net
- InSite Point-to-Point
- TCP/IP (for System Administration)

DICOM Conformance Standards:

- DICOM Storage Service Class
- Service Class User (SCU) for image send
- Service Class Provider (SCP) for receive
- DICOM Query/Retrieve Service Class
- DICOM MOD Media Service Class
- DICOM Storage Commitment Class Push
- DICOM Modality Worklist (incl: Performed Procedure Step) (through ConnectPro option)
- DICOM Print

InSite Broadband includes: Hardware essential for systems to be connected to highspeed internet. Enables customer to access services designed to: improve quality, enhance performance, increase productivity, reduce costs, reduce downtime, expand imaging capabilities, and increase privacy and security of data transmissions

The LightSpeed VCT XTe workflow platform is designed to deliver high performance in each of these tasks:

- SmartTools Simplifies Scan Setup and Includes All Reconstructions, Filming, Archiving, Transferring Prospectively Reducing Exam Time by Up to 40%.
- Xtream(TM)HD, the next evolution of GE's workflow platform built on the LINUX operating system delivers up to 35 fps reconstruction of full fidelity images and the fastest network transfer rates of up to 16 ips.
- Data Export and Interchange allow you to easily share images with referring physicians and patients
- Direct MPR that enables the move from 2D review to 3D image review of axial, sagittal, coronal and oblique planes automatically
- Exam Split delivers the capability to split a series of patient images into separate groups for networking
- Exam Rx desktop environment provides the clinical tools necessary fast, efficient control of patient studies. Exam Rx tools include patient scheduling and data entry, exam protocol selection, protocol viewing and editing, scan data acquisition, image reconstruction, image display

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Qty	Catalog No	Description	Ext Sell Price

and routine analysis, AutoTransfer, AutoStore, and AutoFilm

- ImageWorks is a desktop environment designed to take advantage of the LightSpeed VCT XT CT Scanner System advanced computer systems. Standard features include archive, network and manual film control, as well as some advanced image processing such as Direct multi-planar reformatting (DMPR), multi-projection volume rendering (MPVR) and display. The ImageWorks

  desktop also provides a gateway for DICOM 3.0 image transactions,either through a local area network, or via DICOM-formatted media.
- VariViewer is an interactive axial review mode that can change the slice thickness reconstruction instantaneously
- Neuro 3D Filter provides users capability to filter angiographic data using specially designed and optimized 3D filter to achieve up to 36% dose savings while maintaining image quality or achieve up to 20% image quality (noise) improvement at the same dose.

Scan Modes: The LightSpeed VCT XTe scanner system can perform virtually any clinical application due to its wide variety of scan modes. Helical scan mode offers continuous 360 degree scanning with table incrementation and no interscan delay. Axial scan mode allows for up to 64 contiguous axial planes to be acquired simultaneously.

Scan Enhancements:

- Anatomical programmer: a ten region anatomical selector allows quick and easy access to user programmable protocols. Separate selector for adult and pediatric exams with greater than 8460 protocol storage available.
- Protocols include preset scan time, kVp, mA, scan mode, image thickness and spacing, table speed, scan FOV, display FOV and center, recon algorithm, and special image acquisition and processing options like DMPR
- Any scan parameters may be edited for each scan or all scans - either before or during an exam. The number of scans may also be easily changed.
- AutoScan.Automates table movement and start of each scan.
- Auto-Voice· 3 preset (English) and 17 user defined messages automatically deliver patient breathing instructions, especially useful for multiple helical scanning.
- Trauma Patient: Allows patient scans and image display/analysis

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Qty	Catalog No.	Description	Ext Sell Price
		without entering patient data before scanning. • Reconstruction Algorithms: Soft Tissue, Standard, Detail, Bone, Bone Plus, Lung, and Edge. ASIR & Volume Helical Shuttle are licensed for use with a GE X-ray tube. Use of a third party x-ray tube will require the purchase of an additional license for these features. Warranty The published Company warranty in effect on the date of shipment shall apply. The Company reserves the right to make changes. All specifications are subject to change. Regulatory compliance:This product is designed to comply with applicable standards under the radiation control for Health and Safety Act of 1968. Laser alignment devices contained within this product are appropriately labeled according to the requirements of the Center for Devices and Radiological Health. Siting Considerations: See the Pre-Installation manual for details of the siting requirements for LightSpeed VCT. This product is a CT-compliant device which satisfies regulations regarding Electro-Magnetic Compatibility (EMC) and Electro-Magnetic Interference (EMI), pursuant to IEC-601.	
1	B7877EN	English Keyboard (Black) for CT systems	Incl.
1	B7864GA	Standard length cable set for VCT and VCT Select systems	Incl.
1	B7864GS	The VT 1700 table for LightSpeed VCT or LightSpeed RT16 systems enables Volume scanning. Key features of the VT 1700 table include: 500 lb weight capacity, 1700 mm scannable range, 175 mm/sec travel time, real-time Z-axis position feedback between gantry and table.	Incl.
1	S7800PE	The Advanced Neuro package includes: VesselIQ Xpress & AutoBone Xpress VesselIQ Xpress provides provides an optimized non-invasive application to analyze vascular anatomy and pathology and aid in determining treatment plans from a set of CTA images. The software supports the physician in: • Assessment of aneurysms • Automatic tools for segmentation • Vessel sizing • Semi-automated segmentation of thrombus • Dedicated anatomy based protocols	$64,800.00

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Qty	Catalog No.	Description	Ext Sell Price
		• Ability to compare exams	
		Dynamic Shuttle	
		Dynamic Shuttle is a software package that provides the user with the ability to produce datasets that can capture the kinetic behavior of contrast medium in the anatomy being imaged. The images can be viewed in a dynamic form as a 3D volume over time.	
		Perfusion 4 Neuro	
		CT Perfusion 4 Neuro is an image analysis software package that allows the evaluation of dynamic CT data following an injection of a compact bolus of contrast material, generating information with regards to changes in image intensity over time. The software provides a quick and reliable assessment of the type and extent of cerebral perfusion disturbances by providing qualitative and quantitative information on various perfusion related parameters, which may be related to acute stroke, brain tumor angiogenesis and treatment thereof.	
		VolumeShuttle	
		VolumeShuttle innovatively provides the 80-mm of Z-coverage necessary for accurate dynamic neuro angiographic and perfusion studies with a single contract injection. GE's exclusive real-time scan control, system architecture, and fast, smooth table acceleration and deceleration enable the patient to be effortlessly shuttled back and forth between two adjacent axial locations, with minimal inter-scan delay.	
		The GE LightSpeed VCT system uniquely designed to make it all possible - as a result of these key scanner attributes:	
		• The 40-mm high resolution V-Res detector with micro voxel technology	
		• Real-time system controls to precisely control table movement and X-ray control.	
		This technology works by scanning axially in one location and the moving the patient to an adjacent position in @1 second. Another axial acquisition is performed, followed by a shuttle back to the previous position. This cycle continues for the duration of the exam...up to 40 seconds. Each cycle of two acquisitions is approximately 3 seconds.	
		NOTE: All software are Non-transferable to other hardware and are Non-returnable.	
1	M81521FF	AW VolumeShare 4 with Two Flat Panel Monitors and 4 GB of RAM	$75,600.00

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Qty	Catalog No.	Description	Ext Sell Price
		AW VolumeShare 4 is a multi modality image review, comparison and post processing workstation built with simplicity and power at its core. Powerful software is optimized to take advantage of state of the art 64 bit technology to ensure leading edge performance. AW VolumeShare 4 features include: Hardware: • HP XW8600 Workstation with Intel 5482 Quad Core Xeon 3.2 GHz CPU w/ 12MB Shared L2 Cache / 1600 MHz FSB • 4GB DDR-2 800 ECC DIMM • 146GB SAS 15,000rpm Hard Disk for OS and Apps. • 292GB: SAS 15,000rpm Hard Disks for Image Data • 2 x 19" NEC monitors Software: • Fast access to information you need through optional RIS integration & priors post-fetch • Efficient workflow through dynamic load, end review and Key Image Notes features • Optional productivity package to pre-process exams and allow up to 8 simultaneous sessions • 1-click auto contour in Volume Viewer on CT and MR exams with ability to quickly compare previous contours • Customized MR Volume Viewer protocols based on PSD name, image weight, scan plane and specific MR parameters • Customized PET Volume Viewer protocols • Dedicated MR cardiac viewer for single and multiple Cine review • Support for external DICOM USB media and preference management tool to exchange preferences across users	
1	M81531VM	AW VolumeShare 4 Software Only Upgrade with Purchase of a Advanced Application	Incl.
1	M81521PN	AW VolumeShare4 Productivity Package with 12GB of Additional RAM. Requires HP xw8600 Hardware AW VolumeShare4 with Productivity Package Represents: • More Capacity to Load Multiple Large Dataset with at least 12GB of RAM.	$12,600.00

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Quotation Number: P7-C91677 V 1

Qty	Catalog No.	Description	Ext Sell Price
		• Instantaneous Display of Exams with AutoLaunch. • Instantaneous Access to the Segmented Vessel Volume with Preprocessing. Productivity Package makes full use of the 64 bit Technology as well as the Dual Screen xw8600 Hardware of the AW workstation. It Runs 12 to 16 GB of RAM giving the Ability to Load simultaneously up to 15,300 Images. AutoLaunch Loads Automatically Multiple Cases as soon as they are Transferred to the AW. A Single Click in the AutoLaunch Window Raises Instantly in the Case in Volume Viewer. Interaction with the Data is Immediately Possible as they are Preloaded and Ready to Use. AutoLaunch is compatible with CT, MR and PET Single Volume Protocols of Volume Viewer. One-Touch Links provide the Ability to Automatically Launch the best Protocol for each Exam based upon DICOM Image Acquisition Elements. An Intuitive User Interface in the Protocol Launcher provided an Easy Configuration of One Touch Links by Clicking the Hand Icon. When combined with Optional AutoBone Xpress, the Productivity Package will also Provide the Automatic Preprocessing of the Bone Removal. Raising CTA Exams Located in the AutoLaunch Window will give Instantaneous Access to the Vessel Volume Resulting from the 0-Click Bone Removal. There is No More Waiting Time between the Exam Selection and the Ability to interact in 3D with the Segmented Vascular Volume.	
1	B79821SV	CardIQ Xpress 2.0 Elite for AW VolumeShare2 or higher. CardIQ Xpress 2.0 Elite is an integrated post processing image analysis software dedicated for the application of cardiovascular imaging on GE's Advantage Workstation (VolumeShare2 or higher with the productivity package). The CardIQ Xpress 2.0 software option can be used to effectively display, reformat and analyze 2D or 3D cardiac CT images for qualitative or quantitative assessment of heart anatomy and coronary artery vessels from single or multiple cardiac phase image data sets. CardIQ Xpress 2.0 is launched via it's own link or from Volume Viewer applications. It provides the user with both single and multiple cardiac phase analysis protocols. The operator has a variety of different 2D, 3D or reformatted protocols to choose from to perform analysis and measurements. They include: display of coronary vessel tree, angiographic view, 2D and 3D rendering of single or multiple coronary artery vessels or grafts, automatic reformation of cross	$55,000.00

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Qty	Catalog No.	Description	Ext Sell Price
		sectional cardiac images into planes along short or long axis of the heart, one-touch cath views for 3D or reformatted images, 3D angiographic view phase registration, plaque density measurements and color HU mapping of the plaque, IVUS-like views, 3D ejection fraction, 4D aortic and Mitral valve views, relative perfusion, transparency views and beating heart images from single or multiple cardiac phase image data sets.	
		The CardIQ Xpress 2.0 tool can be applied to standard axial CT images. These images can be acquired on GE's LightSpeed multi-slice CT scanners using the cardiac CT SnapShot Pulse, Segment, Burst or Burst Plus imaging acquisition option.	
		Clinical Benefits: Cardiovascular CT imaging using multislice CT technology is a new and exciting clinical application which may make significant impacts to cardiovascular disease management as a non-invasive imaging technique. Multislice detector CT, which has been quickly adopted by the clinical community, has the advantage of being easy-to-use, reliable and accessible, as compared to other invasive or non-invasive cardiac imaging techniques. One of the critical components for an effective cardiac CT application is a fully integrated post processing and analysis tool tailored for cardiac imaging. The CardIQ Xpress 2.0 Elite option is designed to provide an easy-to-use and time-effective means for cariovascular image manipulation. Clinical applications include: imaging of cardiac morphology, coronary artery imaging and assessment of relative perfusion, bypass graft patency, post intervention follow-up and functional assessment.	
		CardIQ Xpress 2.0 Elite simplifies user workflow by: • Pre-processing the images & models for quick review of the exam • Loading images into the auto launch area for real-time review of multiple exams • Stream-lining protocol selection • Easy switching form one protocol to the other without exiting the application • Single click one-touch cath views • Batch movie output within cardiac reformat • User defined layouts within vessel analysis for simplified viewing and filming • Multi-phase load to single phase review	
		The CardIQ Xpress 2.0 Elite option allows the user to: • As the exam is networked to the AW Pre-processing of the data occurs	

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Qty	Catalog No.	Description	Ext Sell Price
		• Automatically loads images into auto launch for real-time review • Extract, render and display 2D/3D coronary vascular tree images with automatic vessel tracking with single click of a protocol • Automatically render data for streamlined reading to include: 3D rendered heart, angiographic view, tree VR, and ejection fraction. • Color enhanced relative perfusion defect pattern recognition for detection of ischemic heart disease • Reformat standard axial CT images of single or multiple cardiac phases automatically into short, long and two chamber long axis of the heart for easy review • 2D reformat review with predefined views to reveiw all coronary vessels • Perform functional evaluation of the heart and cine capabilities for multiphase beating heart images with one easy click • Select protocols within the reveiw step area allowing user to select a different protocol without exiting the application • Automatically track, extract and display coronary artery vessels using coronary vessel analysis tools from a single or multiple cardiac phase image data sets with manual tracking option • One step label to instantly change a vessel name • Various measurements of coronary artery vessels to include stenosis, density and length of stenotic area • PlaqID assigns customizable color maps to HU values for improved visualization of plaque pathology • Pre-defined VR IVUS-like views for virtually determining the different compositions of the plaque • One touch angiographic view protocol display coronary vessel tree and myocardium with automatic removal of heart chambers for cath comparative view • Heart transparency model allowing for full visualization of coronaries in relations to the heart chambers with the ability to fade out the chambers of the heart • 4D aortic valve and mitral valve views with one touch • Automatic extraction of the left ventricle with automatic selection of ES and ED for ejection fraction & volume measurements • Oblique reformat views in the standard cath angles to provide an easy analysis of the coronary vessels • Load multi-phase images, review the data and decide which phase or	

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Qty	Catalog No.	Description	Ext Sell Price
		phases will be reveiwed for further processing by dropping the non-essential phases • One touch protocols are available for performing 3D analysis of the heart quickly with pre-defined presets to view the cardiac vessels and chambers. Available with single or multi-phase data sets • Phase registration - ability to register images from different cardiac phases into a unique data set. The data set can then be saved as a 3D object and/or used for further analysis System requirements: • AW Workstation with VolumeShare2 or higher running 8400 hardware or higher • Productiving Package for Auto Launch and Preprocessing on hp8400 or higher with 12GB RAM • 2 monitor configuration • Color landscape monitor	
1	B79971JH	SmartScore 4.0 Software Kit Only for AW 4.2P and Higher. B79971JH SmartScore 4.0 is for the Advantage Windows Workstation. New features include: Mass score, automatic highlighting of the calcium, new mouse modes & improvements to patient report. Images from GE LightSpeed, BrightSpeed or Xi product lines with either prospective or retrospective gating data can be used with the SmartScore software.	$35,000.00
1	E8007NG	Medrad Stellant D Dual-Flow Ceiling Mount Injection System with Short Post. Requires E8007NZ Mounting Plate be added to the order....E	$38,000.00
1	E8007PJ	OCS III MOUNTING PLATE	$520.00
1	E8007PT	Medrad Stellant P3T Cardiac Protocol Option P3T Cardiac computes custom injection protocols as well as scan timing for each patient, enabling personalized care and patient safety while maintaining efficient workflow. • Utilizes the power of DualFlow technology (simultaneous injection of contrast and saline) to obtain functional cardiac data • Enables more consistent images across varied patients, studies and technologists • Eliminates the need to estimate injection protocols for complicated studies	$4,240.00

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Qty	Catalog No.	Description	Ext Sell Price
1	E4502AE	CT Main Disconnect Panel - 125 Amp with Auto Restart FEATURES/BENEFITS • Custom panel serves as the main power disconnect between the CT system and the facility 400-480V power source Panel provides short circuit, overload, undervoltage release, automatic restart, and emergency shut down for the CT system • Reduces installation time and cost by providing a single-point power connection eliminating the need to mount and wire a number of individual components • Standardized design and testing assures high product quality and system reliability • On systems where the optional 12.5 kVA partial system UPS is ordered, the Main Disconnect Panel also provides mandated emergency power off control via a UPS output disconnect function included in the panel design • Provides a standardized platform for future UPS or other GE engineered modifications or upgrades SPECIFICATIONS • Dimensions (H x W): 30.24 in. x 19.78 in. • Enclosure Depth: 7.05 in. • Handle Depth: 10.3 in. • Weight: 110 lbs. • UL, cUL and CE labeled • Panel disconnect provides OSHA lockout/tagout provisions • Surface or semi-flush mounting • Partial system UPS sold separately (E4502F) COMPATIBILITY • CT LS Pro 16, LS Pro 32, RT Systems, LS VCT, CT 750HD NOTES: • Customer is responsible for rigging and arranging for installation with a certified electrician • ITEM IS NON-RETURNABLE AND NON-REFUNDABLE	$7,736.80
1	E8016AZ	Slicker - CT HD750 and VCT w/GT 1700 Table (2 Piece Set)	$336.00

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Quotation Number: P7-C91677 V 1

Qty	Catalog No.	Description	Ext Sell Price
		FEATURES/BENEFITS • Two-piece, sealed slicker cushion set has comfort pads enclosed inside the slicker cover and extender cover • Durable, clear PVC plastic cover facilitates faster, more thorough cleanup of blood and fluids • Increase system uptime by protecting table from spills and particulate contaminants • Thermo-sealed seams and flaps prevent contaminate buildup in hard to clean areas COMPATIBILITY • VCT with GT 1700 Table, CT HD750	
1	E8016BA	Footswitch Slicker for CT HD750 and VCT Systems The footswitch slicker for CT VCT 2000 and 1700 systems is made of durable, clear PVC plastic that protects the footswitch and facilitates faster, more thorough cleanup of contamination caused by blood and other body fluids. Cover is held securely in place with Velcro...H	$40.00
1	B7877CA	Interpreting the Heart: A Visual Guide Using CardIQ (TM) Xpress Educational Toolkit Interpreting the Heart: A Visual Guide Using CardIQ (TM) Xpress is a product intended for radiologists and cardiologists who want to learn how to interpret cardiac CT angiography images using the CardIQ software on the AW workstation. Based on the criteria established by the Society of Cardiac Computed Tomography (SCCT), these 50 cardiac CTA cases can be used towards Level 1 and Level 2 Cardiac CT credentials. This guide contains 50 cardiac CTA case studies, packaged in 2 binders. The first binder consists of 30 cardiac CTA case studies, which have a correlating cardiac catheterization exam. All 30 cases have multiphase image data to evaluate coronary function; 25 of these cases have non-contrast image data to obtain a calcium score. The second binder contains 20 cardiac CTA case studies without cardiac catheterization correlation. All case studies include cardiac CTA impressions as well as a detailed description of findings under each reference image by an expert interpreter.	$2,500.00

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Qty	Catalog No.	Description	Ext Sell Price
		All cases can be loaded and reviewed on your Advantage Workstation (TM). Other features include: • Blank reporting forms for note-taking during case reviews for both cardiac CTA and cardiac catheterization cases • Blank log sheet for SCCT credentialing This product is available for sale with VCT, VCT XT and HD scanners.	
1	W0100CT	6 Day CT TiP Onsite System Training CT Onsite Training for a new CT system • One 4 day onsite visit to coincide with system start-up. • One 2 day onsite follow-up visit 6-8 weeks post system start up. During the first visit, the applications specialist will work with the medical and technical staff on system operation and patient procedures. The training produces the best results when a dedicated core group of 2-4 CT technologists complete the session with a modified patient schedule. It is suggested that key physicians are available to participate in the protocol implementation and image quality review sessions. By the end of this visit, the core group should be able to perform the routine patient procedures. The 2 day revisit is suggested after the staff has run the system for 6-8 weeks, however this is flexible based on the site needs. The training will focus on the intermediate and advanced functions of the system or special needs of the customer. The training produces the best results when the same dedicated core group of 2-4 CT technologists from the initial visit complete the session with a modified patient schedule. This training program must be scheduled and completed within 12 months after the date of product delivery.	$10,400.00
1	W0600CT	2 Days TiP Onsite Training Advantage Windows Workstation--CT One 2 day TiP onsite visit for CT Advantage Windows Workstation training. Includes T&L expenses. Days provided consecutively. This training program must be scheduled and completed within 12 months after the date of product delivery.	$3,600.00
1	W0021HC	TiP HQ Class LightSpeed VCT - Full Service 3.5 day CT course held in the Milwaukee area. Includes travel and modest living expenses.	$3,800.00

PO Box 414, Milwaukee, WI 53201-0404
General Electric Company
General Electric Company, GE Medical Systems

GE Healthcare

QUOTATION

Quotation Number: P7-C91677 V 1

Qty	Catalog No.	Description	Ext Sell Price
		This course is designed to introduce the technologist to the CT LightSpeed VCT system.	
		This training program must be scheduled and completed within 12 months after the date of product delivery.	
		Quote Summary:	
		Total Quote Net Selling Price	**$1,677,672.80**
		(Quoted prices do not reflect state and local taxes if applicable)	

If you would like to place an order for this equipment, a formal contract document will be prepared for your consideration. This quote is for budgetary use only; only a GE contract can become a binding order.

19/19

PO Box 414, Milwaukee, WI 53201-0404
General Electric Company
General Electric Company, GE Medical Systems

D

ATTACHMENT D

SPACE PROGRAM (REVISED)

SPACE PROGRAM SUMMARY

Function/Space	No. of Beds	Net to Gross	DGSF	% DGSF	DGSF/ Bed	Comments
Nursing Services	100 Total Beds		74,292			
ICU Unit 1	10	1.45	8,756	5%	876	
Medical/ Surgical Unit 2	18	1.50	12,928	8%	718	Post Partum Combined w/Med Surg
Medical/Surgical/Post Partum Unit 3	36	1.50	21,846	13%	607	1:6 nursing
Medical/Surgical Unit 4	36	1.50	21,846	13%	607	1:6 nursing
Labor and Delivery (LDR)	3	1.30	7,428	4%	2,476	1 C-Section
Nursery	13	1.10	1,488	1%	114	13 bassinets;1 isolation
					44%	
Diagnostic & Treatment Services			49,576			
Central Sterile Supply		1.10	2,462	1%		
PAT / Laboratory / Morgue /		1.10	3,992	2%		
Pharmacy		1.15	2,692	2%		
Non-invasive Cardiology / P.Func		1.35	3,160	2%		6 Procedure Rooms
Rehab Services		1.10	0	0%		
Diagnostic Imaging / Radiology		1.25	12,388	7%		1 R/F, 1 Rad., 1 Mammo, 2 U/S, 1 Nuc Med, 1 CT, 1 MRI, 1 IR Lab, 1 Bone,
Respiratory Therapy		1.10	975	1%		
Surgery/Endo/Cath/PACU/Recovery		1.5	23,907	14%		4 O.R.'s; 2 Endo; 1 Cath; 17 PACU; 23 Same Day/Recovery
					29%	
Ambulatory Services			11,471			
Emergency Department		1.45	11,471	7%	#DIV/0!	2 Trauma; 4 Fast Track, 1 Psych, 2 OB/GYN, 7 Gen.Treatment
			0	0%		
Nurse Pre Admit		1.15	0	0.0%		
					7%	
Administrative Services			17,715			
Administrative Services (includes Accounting, Administration, Human Resources)		1.25	4,074	2%		
Admissions/Business Office		1.25	2,819	2%		
				0%		
Education		1.2	2,801	2%		
Family Service Center			0	0%		
Lobby /Entry		1.1	1,903	1%		
Medical Staff Services (Medical Records, Med Staff Lounge/Library, Marketing & Physician Liaison, Nursing Support Svc, Case Mgmt, RM/QA)		1.25	3,944	2%		
Religious Services / Chapel		1.1	583	0.3%		
Volunteers/Gift Shop		1.1	1,591	1%		

Pied.Supp.CON.0163

JOINT-B-PMC-001.0169

RECORD 002353

SPACE PROGRAM SUMMARY

Function/Space	No. of Beds	Net to Gross	DGSF	% DGSF	DGSF/ Bed	Comments
					10%	
Support Services			17,414			
Bio Medical Services		1.15	662	0.4%		
Dietary - Food & Nutrition		1.25	8,649	5.1%		
Environmental Services		1.15	1,306	0.8%		
HIS (Hospital Information Systems)		1.1	876	0.5%		
Maintenance & Engineering/Staff Lockers		1.1	2,724	1.6%		
Materials Management/Linen Holding		1.1	3,196	1.9%		Laundry is outsourced
					10%	
Total DGSF			170,468	100%		
BLDG circulation factor		0.18	30,684			general hospital circulation; vertical +horiz circ.
Sub Total=			201,152			
Central Energy Plant			8,291			Budgeted for Central Plant
MEP factor		0.035	7,040			for shafts, electrical closets, mech rm, etc.
Sub Total=			216,483			
Exterior wall/Stacking factor		0.025	5,412			
Sub Total=			221,895			
Total Programmed BGSF			221,895			
			1.30			
Total GSF / Bed			2,219			

Pied.Supp.CON.0164

JOINT-B-PMC-001.0170

RECORD 002354

E

ATTACHMENT E

PROJECT TIMELINE (REVISED)

Piedmont Medical Center
Fort Mill Medical Center
Fort Mill Medical Center Proposal to Construct 100-Bed Hospital

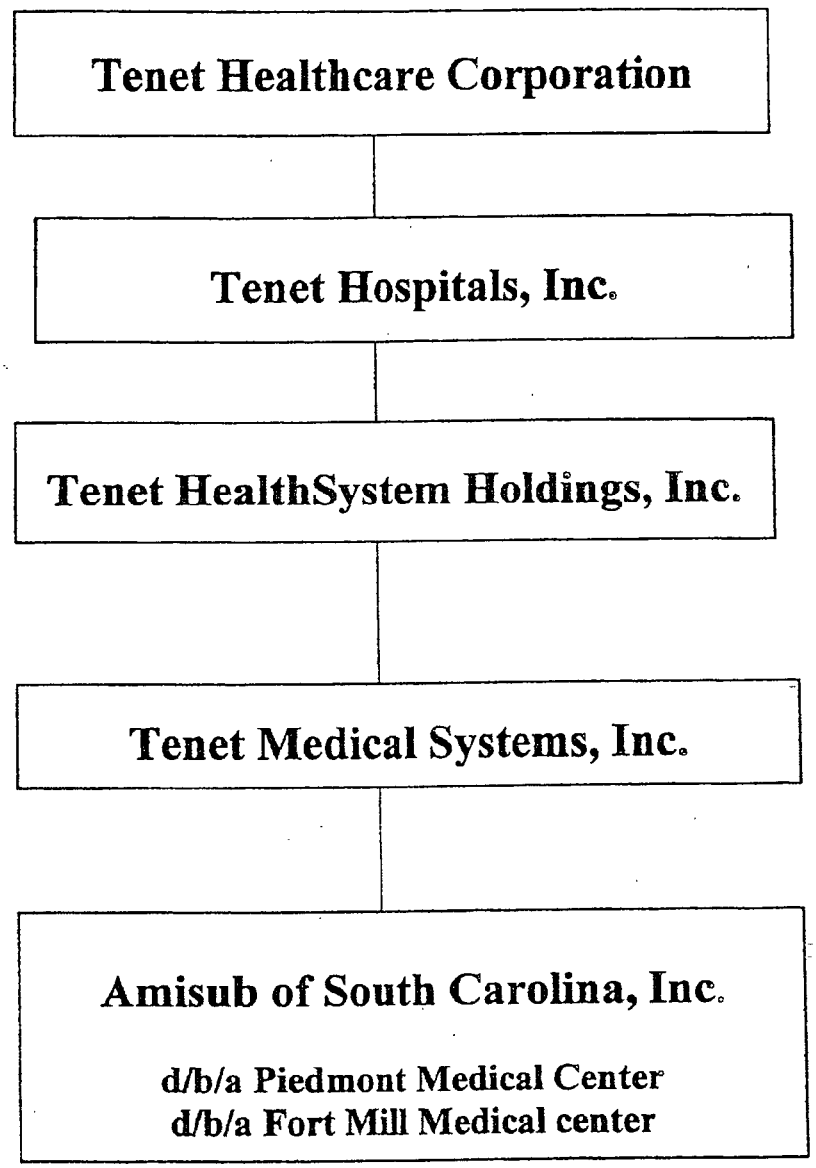
Project Timeline

Phase	Anticipated Date (Month/Year)
Drawings submitted to City/State	April 2013
Agency Reviews Complete	June 2013
Construction Start	July 2013
Construction complete	May 2015
Occupancy	July 2015

ATTACHMENT F

ORGANIZATIONAL CHART

CURRENT STRUCTURE



ATTACHMENT G

POPULATION PROJECTION COMPARISON (REVISED)

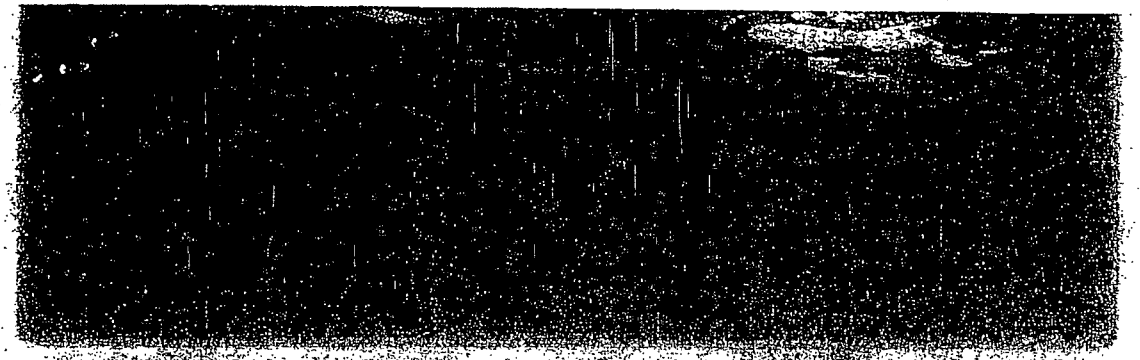
Fort Mill CON
Population Source Comparison - SC ORS and Claritas

County	SC ORS July 1, 2010 Projection	SC ORS July 1, 2015 Projection	Claritas 2010 Projection	Claritas 2015 Projection
Chester	33,020	33,830	32,497	31,723
Lancaster	74,800	77,150	78,833	87,231
York	218,990	235,930	229,473	262,113

Source: South Carolina ORS, August 2010; Claritas, Inc., August 2010.

ATTACHMENT H

ARTICLES ON GROWTH AND DEVELOPMENT IN FORT MILL



ANDY BURRIS/SPECIAL TO THE FORT MILL TIMES

The 2,000-acre Regent Park is being sold off to several developers by its Malaysian owners. The area, formerly the famous Heritage USA religious theme park run by Jim and Tammy Faye Bakker, as seen above, will add more residential as well as commercial development to northern Fort Mill Township.

Owners break up, sell former resort

Mac Banks
mbanks@fortmilltimes.com

FORT MILL TOWNSHIP — Owners of the MUI Regent Park have sold off shares of 2,000 homes within Fort Mill Township, as Malaysian owners break up and sell off the property to developers.

Several developers from Rock Hill, Fort Mill and Charlotte say they want to turn the former religious resort of Heritage USA and open space into a major new residential and commercial area in northern Fort Mill Township.

Owners of the 2,000-acre Regent Park, Malaysian United Industries (MUI) say they are no longer in a position to develop it. MUI bought the land in the early 1990s after the PTL religious theme park known as Heritage USA was shuttered following the downfall of its leaders, Jim and Tammy Faye Bakker.

MUI dissolved its team of developers about three years ago, and about a year and a half ago began selling off the land in pieces. About 600 acres were sold just last year.

It was easier to break up the property to sell it, rather than trying to find one buyer for all of the land, said Regent Park's general manager Payton Ding.

"We will be here until everything is sold," Ding said. "There is a lot of demand for property here."

Who's buying the land?

The area is being developed by several companies. One of those is Kuester Real Estate Services of Fort Mill.

Falson Kuester, president of Kuester Real Estate Services, originally helped to develop Heritage USA for the Bakkers. He sold 1,200 acres to the Bakkers to establish their ministry here in the 1970s and 1980s.

"It is a large body of land that commands a lot of attention," Kuester said. "It has been quite satisfying to us. We have captured the momentum that exists there today. The momentum is so big now, I can see a bright and active future."

West of the railroad tracks that split the property in half, as many as 800 homes could be built on 500 acres.

This area has already been partially developed with subdivisions and the Regent Park Golf Course, but much of it remains untouched.

Other developers of the western side of Regent Park include Cornerstone Development of Rock Hill, which bought two tracts that will include 350 lots on 43 acres and 38 lots on 19 additional acres.

Cornerstone also plans to build another subdivision in this area that will include 300 homes on 85 acres.

See **RESORT—12A**

Yes, I want to subscribe!
Print your name, address and phone number in the shaded area below. Mail it to us with $21 to receive a local one-year subscription.
YES

Frattarolis work for cure for their son

Jonathan Allen
jallen@fortmilltimes.com

Anthony's mother Beth Frattaroli said. They also had to learn how to read

District work on high sch

Mac Banks
mbanks@fortmilltimes.c

FORT MILL TOWNSHIP District officials aren't wa ting to work on the district's and second high school.

This week district offici ting together more detaile schools, which voters overw building in a $62.55 millio last week. District staff and ting together a detailed con a process to reassign middl students, and curricula for

Jim Britton, project mar Management Group, the gr district's building program, liminary work has already

The site plan for the new n will be located behind Spri School, is nearly complete, l ter plan for the middle sch about the same time as Spri was built.

"The middle school desig as the high school design,"

So Britton is concentratin er a detailed layout for the high school.

Attorney cited for violation

Mac Banks
mbanks@fortmilltimes.com

INDIAN LAND—All-terrain vehicle thefts are on the rise in the Panhandle.

Between mid-December and last week, 13 ATVs have been stolen in the Indian Land area, according to the Lancaster County Sheriff's Department.

"I think there is a connection given the location of the thefts," said Lt. Christy Rogers.

The thefts occurred within a three-to-four-mile radius of Man-O-War Drive and Henry Harris Road.

Rogers said deputies believe more than one person is stealing the ATVs, but the thieves could be working together. Rogers said she doesn't believe the work is that of teenagers.

"I think it is adults," she said. "They seem fairly organized."

Rogers said the thefts have happened at different times of the day, and the thieves went to great lengths to steal the ATVs by cutting through chains and padlocks.

"They are very gutsy," she said. "The homeowners have made a lot of efforts to secure their property."

Terry Everidge's ATV was stolen from a locked building in her backyard. According to Everidge, the thieves pushed out the building's air conditioning unit and crawled through the hole in the wall to get to the ATV.

"It really takes a real lowlife to take them," Everidge said.

Everidge said her husband, who has muscular dystrophy, uses the ATV to move around the yard. In a letter in last week's *Fort Mill Times*, she criticized the thieves responsible.

"It was a necessity for us," she said. "It wasn't for recreation. I can't afford to replace it."

Rogers said she has scant advice for Indian Land residents concerned about their own vehicles, because most of stolen ATVs were properly secured.

Rogers said any tips from residents would help them in their investigation.

"We are definitely looking for help from the community," she said.

Rogers said residents should look for any suspicious traffic in their neighborhoods. If they see something unusual, be sure to get vehicle's description and tag number, then call the Lancaster County Sheriff's Department at (803) 283-4186.

RESORT: *Commercial, residential areas planned on site*

from page 1A

Lennar Corp. also has plans for two sections of Regent Park. One section would contain 122 homes on 67.5 acres, and the other would have 89 homes on 21 acres.

Crown Homes, which is already located in Regent Park, has plans for 60 homes on 12 acres.

Ryan Homes has plans for 185 townhomes on 37 acres near the entrance of Regent Park, off Hwy. 21 Business.

KMW Homes, part of Kuester Real Estate Services, in combination with NuSouth Builders has plans for 33 homes on 21 acres. KMW Homes also has plans for a subdivision called Woburn at Regent Park. It would contain 45 homes on 23 acres.

Olson Development has plans for 50 townhomes and a commercial area on a 22-acre site. The commercial area will have 60,000 square feet of retail space, including a grocery store and three outparcels, and it will be called Town Square at Regent Park. Construction should begin this fall on the retail section, said developer Kent Olson.

"We think this is a fantastic site," Olson said. "Regent Park is experiencing a real explosive expansion of roof tops. The people of Regent Park deserve a grocery store."

A shopping center has also been proposed for the corner of Flint Hill Road and Hwy. 21.

More homes could be on the horizon, besides these. Ding said MUI is talking with U.S. Land Investments of Charlotte about buying nearly 900 acres.

According to published reports, those 900 acres could mean an additional 1,500 houses and townhomes, as well as a mixed-use development.

No deal has been reached yet, Ding said.

But what about the older section of Heritage USA, the section that still contains the old theme park, water slides, grand ballroom and half-built high-rise hotel?

That's the area east of the railroad tracks, about 1,000 acres total, which straddle the border between North and South Carolina and stretch across York, Lancaster and Mecklenburg counties.

Ding said MUI is still looking for a buyer, or buyers, for that land.

"We would like to sell to one party, but we are open to any proposal," he said, and added that it would cost from $20,000 to $80,000 an acre.

Kuester said that in his opinion a lot of what remains from the old religious resort must be removed before it's suitable for redevelopment.

"The towers have to come down in my opinion," he said. "The only thing that has some structural integrity is the hotel, but that would take some TLC."

The announcements of Regent Park's growth are getting mixed reviews from local leaders.

"It will accelerate the growth," said Fort Mill School District Assistant Superintendent Chuck Epps. "In the long term, it is just more stress on all the services – schools, roads, the county."

And average enrollment growth of 500 students per year could rise as high as 800 students per year, Epps added.

"We will probably see the number on the top end of that figure," he said.

Because Regent Park is already zoned for residential and mixed-use developments, it does not need to be rezoned and approved by the York County Council.

The county's land-use plan, its present plan as well as the proposed plan going before the county council next month, already expects the area to be developed.

The developers' plans fit in with those standards, said county planning and zoning director Eric Greenway.

However, the York County Planning Commission will review plats for the proposed new subdivisions and commercial areas. Plans are in various stages of completion, and will come before the planning commission individually from each developer.

VIOLATIONS:

from page 1A

In 2001, the Macks received permission from the Fort Mill Historic Review Board to fix up the house. They stripped the house of its front and back porches, and its exterior siding. About a year ago, they boarded up the windows.

Hunter said he has talked repeatedly with the Macks about fixing up the house so it no longer violates town building codes, but nothing has been done to the property since last spring.

"They have got major problems they are going to have to correct," he said.

The Macks said the renovation has been more expensive and difficult than they had expected. Bayles Mack said they have spent about $100,000 on repairs to the house already. He said they hope to rent out the house as office space.

"We either have to continue doing it or we will tear it down," he said. "The cheapest thing to do would be to tear it down, but I would hate to see it go."

Barry Mack said he plans to begin outside renovations in April or May – putting on a new roof and installing siding. Then, they can start renovating the interior, including putting in a bathroom.

Bayles Mack said they plan to abide by a schedule once they set it with town officials.

"As long as we keep with a schedule and have a plan that will be all that is necessary," Bayles Mack said. "My hope is that we will finish it this year."

The Macks have 30 days to reply to the violations, either complying with Fort Mill building codes or appealing the violations to the Fort Mill Board of Zoning Appeals. They could face fines of $250 a day for each violation if they do not comply, Hunter said.

YMCA: *Branch to be named after Weston*

from page 1A

The YMCA raised $7 million for this and two other YMCA projects and also borrowed $9 mil-

lly, not long before Weston died. The YMCA is named for Weston, a local war hero who fought in World War II, Korea and Viet-

A&M University for 13 years.

Bell said he knows Weston would be honored with the groundbreaking and the YMCA

The Herald
Monday • September 20, 2004

EDUCATION • 2B
BUSINESS • 4B
TELEVISION • 5B
CLASSIFIEDS • 6B-8B

LOCAL

heraldonline.com

Bracing for the boom

Sun City to bring mixed blessing of growth to rural Lancaster County

By Jason Cato
The Herald

INDIAN LAND — The new Food Lion on U.S. 521 in the Lancaster County panhandle is just a sign of commerce to come, or so County Manager Chap Hurst hopes.

The thousands of new homes approved to be built in the area — and the people who will fill them — ought to help ensure his wish comes true.

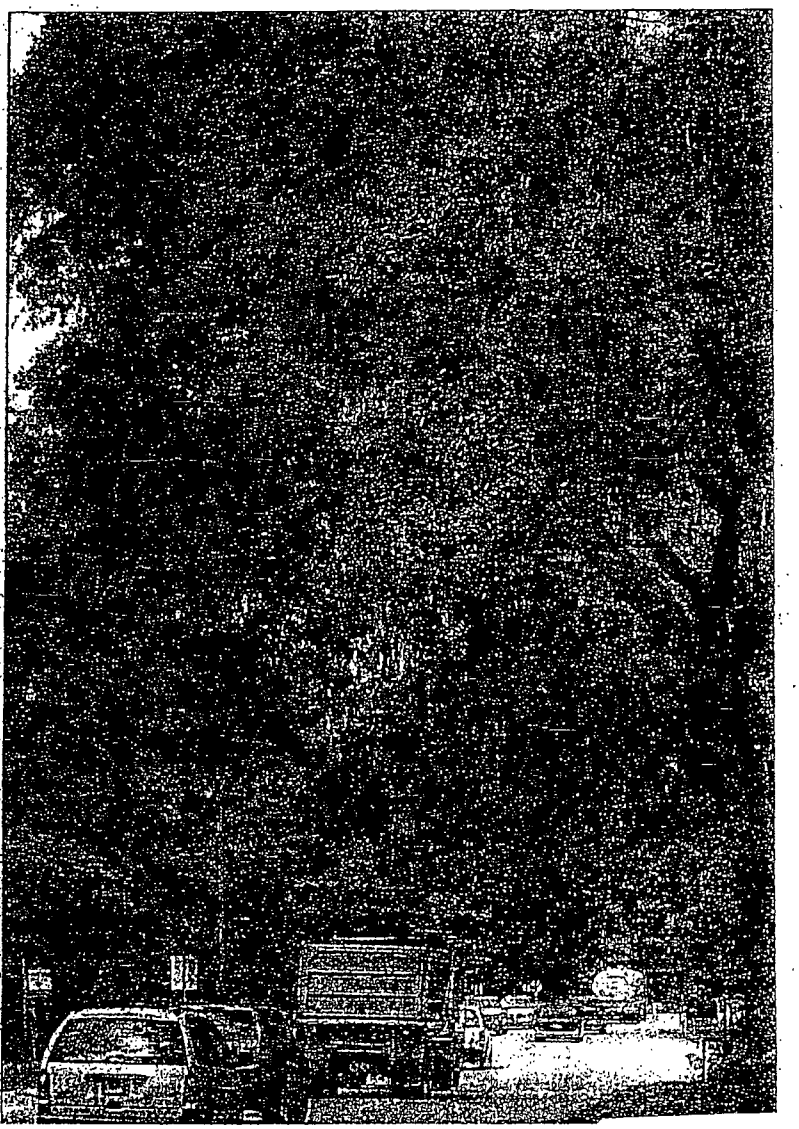
Expected to come along with the homes are businesses needed to support a community — grocery stores, gas stations, medical offices, dry cleaners and restaurants. And Lancaster County officials are counting on Sun City Carolina Lakes to be the magnet that begins to draw them in, just as Sun City Hilton Head has done in southern Beaufort County.

"Basically, they created a city with their business impact," said Hurst, who has spent a lot of time on Hilton Head Island. "I'm hoping that is what happens here. I think this will draw growth further into Lancaster County, and that's what we need."

Carolina Lakes, the retirement community Del Webb plans to build on U.S. 521, will start out similar to how the development near Bluffton started.

"Many Sun Cities started out away from everything. Then the community

When Del Webb located the community on U.S. 278 about 13 miles west of Hilton Head in 1995, little was



Ken Hull, general manager of Sun City Hilton Head

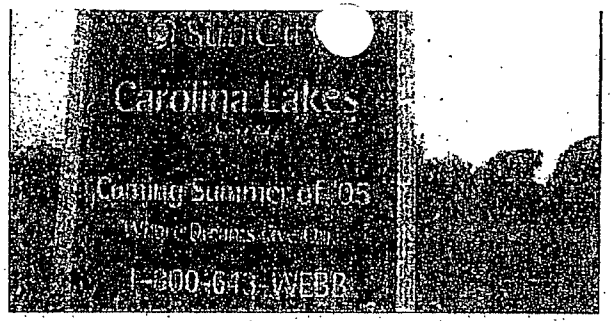
other developments, a Wal-Mart, car dealerships, medical offices and more. The University of South Carolina at Beaufort is building a campus next door to Sun City Hilton Head, and the Technical College of the Lowcountry has plans for a new campus across the street.

"Many Sun Cities started out away from everything," said Ken Hull, general manager of Sun City Hilton Head. "Then the community starts to grow, and services come to meet the demand. It is an effect that occurs when we arrive. There's a synergy that is created, but there has to be an attraction. Just because Sun City is there doesn't mean other builders are going to come without demand."

That demand is coming because Sun City will not be alone in the panhandle area around Indian Land. The Lancaster County Council has approved plans for 12,000 homes, more than half as many as now exist in the entire county, for the wedge of land that reaches to the North Carolina state line. The 2,200-home St. Katherine will be built about two miles farther down U.S. 521 from Sun City and will help pull businesses to Lancaster County rather than Pineville, N.C., Hurst said.

"When you put those two together, you're looking at a city much larger than Lancaster," Hurst said.

[redacted]



to Sun City Hilton Head. At left, a sign advertises Sun City Carolina Lakes on U.S. 521 in Lancaster County.

Photos by Andy Burriss The Herald

incentive to commercial growth into the panhandle.

But growth concerns Hurst. Officials in Beaufort County said areas facing anywhere near the amount of growth they've seen in the past decade had better be prepared.

Some around Bluffton have even coined a new motto for the town: "It could be worse."

Lancaster County doesn't want the same, Hurst said.

"Sometimes you have growth that just feeds on itself," he said. "I've seen what other communities have gone through."

To prepare, Lancaster County officials have devised a master plan and are working with experts from the Strom Thurmond Institute at Clemson University to help determine what the county can handle and when. The formula aims to gauge the effects growth will have on the county's services, economy and quality of life.

"Hopefully, it will help us address each of the new developments that come in," Hurst said.

Unprecedented growth

When Sun City was built near Bluffton in the mid-1990s, it became the other end of the magnet to Hilton Head's tourist center, said Anthony Criscitiello, Beaufort County's planning director.

"When Sun City materialized in 1993, it essentially kicked off rapid growth in southern Beaufort County," Criscitiello said. "That's a fact."

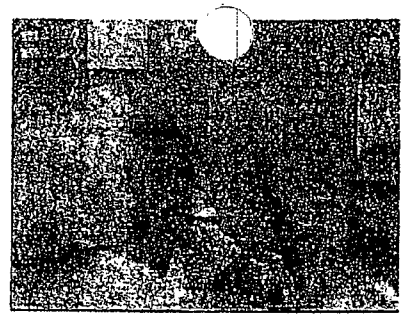
That growth begin to fill in more than 10 miles between Hilton Head and Bluffton, up to that point a quiet village along the pristine May River. When the growth began, Bluffton covered about 1 square mile. Today, through annexations, it's about 50 square miles and ranks as the fifth largest municipality in the state in land size.

"Growth in that area has been profound," Criscitiello said.

Though all of Beaufort County has grown by more than 40 percent over the past decade, making it the fastest growing county in South Carolina, Bluffton's population has grown by nearly 165 percent during the same time. Bluffton now has more than 10,000 addresses, according to the Hilton Head Island-Bluffton Chamber of Commerce.

There are numerous new housing developments in the greater Bluffton area. One

See SUN CITY • 2B



Jessica Williams, 10, raises her hand to pa fifth-grade class recently at Jefferson Ele The word of the month, respect, is featur in the background.

R-e-s-p-e-c-t a lesson in li for elementa

By Toya Graham
The Herald

Edith H

YORK — Move over writing, reading and rithmetic. Students at Jefferson Elementary School are getting lessons in two more r's — respect and responsibility.

Students hone their character skills one word at a time, one month at a time — starting with this month's word, respect.

"It tells you how to treat other people," said fifth-grader Brian Overcash, 10. "Treat others the way you want to be treated."

Edith Hartis, school guidance counselor, said the word of the month program teaches students how to get along with and relate to other people. A similar program is in place at Cotton Belt Elementary School.

"It's a character-b[illegible]ding program because it teac[illegible]e skills," Hartis said of the 4-year-old program. "The goal is to help students

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Company sells bonds to build on its success

By Tim Hartis
The Herald

The Rock Hill Hosiery Building Compa[illegible] nounced a 3 percent interes[illegible]ment on bonds for the first six months. [redacted]

building enlarged.

75 years ago (1929)

■ A.A. Hurley of Chester mourned the death of his daughter, Mrs. Virginia

college. Elizabeth W. Biggers and Mary Jane Burnett were two of 25 RHHS grads attending Winthrop.

50 years ago ([illegible])

■ U.S. Army Gen. Mark Clark,

25 years ago (1979)

■ Eastern U.S. Clogging Champion John Faust, 14, of Richburg practiced for the world competition set for Fontana Village, N.C., in October.

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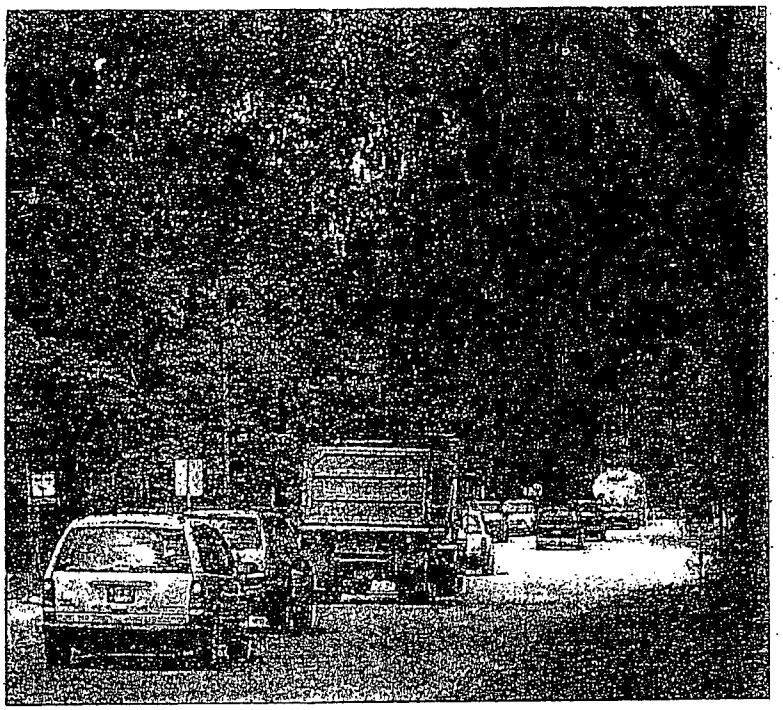

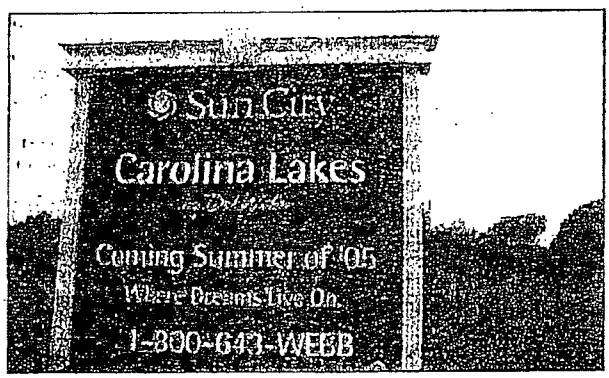

Rush hour traffic backs up in Bluffton, home to Sun City Hilton Head. At left, a sign advertises Sun City Carolina Lakes on U.S. 521 in Lancaster County.

Photos by Andy Burriss The Herald

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Some around Bluffton have even coined a new motto for the town: "It could be worse."

Lancaster County doesn't want the same, Hurst said.

"Sometimes you have growth that just feeds on itself," he said. "I've seen what other communities have gone through."

To prepare, Lancaster County officials have devised a master plan and are working with experts from the Strom Thurmond Institute at Clemson University to help determine what the county can handle and when. The formula aims to gauge the effects growth will have on the county's services, economy and quality of life.

"Hopefully, it will help us address each of the new developments that come in," Hurst said.

Unprecedented growth

When Sun City was built near Bluffton in

the magnet to Hilton Head's tourist center, said Anthony Criscitiello, Beaufort County's planning director.

"When Sun City materialized in 1993, it essentially kicked off rapid growth in southern Beaufort County," Criscitiello said. "That's a fact."

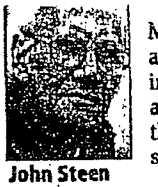
That growth begin to fill in more than 10 miles between Hilton Head and Bluffton, up to that point a quiet village along the pristine May River. When the growth began, Bluffton covered about 1 square mile. Today, through annexations, it's about 50 square miles and ranks as the fifth largest municipality in the state in land size.

"Growth in that area has been profound," Criscitiello said.

Though all of Beaufort County has grown by more than 40 percent over the past decade, making it the fastest growing county in South Carolina, Bluffton's population has grown by nearly 165 percent during the same time. Bluffton now has more than 10,000 addresses, according to the Hilton Head Island-Bluffton Chamber of Commerce.

There are numerous new housing devel-

April to a life. He suffered a stroke three days later and had been in a local nursing home prior to his death. Steen was the retired owner and operator of Steen's Garage and Auto Sales in Lesslie for 30 years. He died Tuesday at age 75.



John Steen

The property was checked Thursday by the man's son, Warren said. After the funeral Saturday, the family discovered some power tools, a hydraulic lift, a log-splitter and chainsaw were missing from the shed. The thieves left a box of Christmas ornaments untouched, younger daughter Brenda Steen said.

"They took things they could pawn and get money for," she said.

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Jessica Williams, 10, raises her hand to part fifth-grade class recently at Jefferson Elem The word of the month, respect, is feature in the background.

R-e-s-p-e-c-t a lesson in li for elementa

By Toya Graham
The Herald

YORK — Move over writing, reading and 'rithmetic. Students at Jefferson Elementary School are getting lessons in two more r's — respect and responsibility.

Students hone their character skills one word at a time, one month at a time — starting with this month's word, respect.

Edith H

ing its d

Pled.Supp.CON.0176

Hood's Homework Heroes for the week are: Matthew Nguyen, Holly Curdt and Francisco Cordova.

Crowders Creek

The following students are at the red level in the Accelerated Reader ... Lindsey Medler, Gabrielle Bryant, Brianna Bryant, Arthur Hale, Thomas Honeyman, Alyssa Boner and Hannah Rayfield.

Kirk McSwain received the bronze medal and Reilly Burleson received the silver medal in the Accelerated Reader program.

Fort Mill

Students of the month are: Tree-Frog team — Rebecca Helms and Michael Hill; Dragon team — Kelly Jebo and Benjamin Kilburn; and Cougar team — Rachel Acuna.

Eighth grade "drivers" of the month for appropriate behavior, positive attitude and academic success are: Chevrolets — David Frick, Tony Hall, Kelsey Marshall and Kristi Tolvinsley; Fords — Ashley Brown, Garrett Bruce, Jessica Frasure and Quinn Sittloh; Pontiacs — Erin Allison and Kayla Mullis.

Band students who are marching this fall with the defending state 4A championship Fort Mill High School band are: Tommy Werner, Rachel Martenson, Rachel Blackman and Chase Crosby.

Harold C. Johnson

The fall book fair will be today through the Media Center.

...ily night will be 4 to 6:30 p.m. Thursday.

Rawlinson Road

The school is having a book drive for September. Collection bins for new and used books will be in the front office.

Additional parent meetings for the Outer Banks, N.C., trip have been scheduled for 7:45 a.m. and 11:45 a.m. Tuesday. The meetings will be in Room A209. Attendance is mandatory in order for your child to go on the trip.

HIGH

Rock Hill

Charlotte Bishop

Nathan Rouse

Ch... Bishop and Nathan Rouse have ... chosen to compete for the ...ferit Scholarships. They entered the ...petition last year as juniors and were chosen to be semi-finalists this year.

COLLEGES

been recalled by the Food and Drug Administration after reports of negative side effects in treated dogs, in-

the U.S. Fish and Wildlife Service.

The Clemson University autopsy report did not pinpoint a cause

could have killed the wolf, but the company maintains few dogs have bad reactions to the medicine.

Sun City

from 1B

touts itself as "Bluffton's New Traditional Neighborhood" and is filled with Charleston-style homes. A half dozen others line the same new road that links U.S. 276 and S.C. 46, the two main routes through and around Bluffton.

Bluffton Village, a new multifaceted development, is within blocks of the town's historic center. It's a mixed-use development with a palmetto lined brick lane, an oversized, antique-looking clock, gas-style street lamps and upscale apartments that place residents at the doorsteps of new businesses. The development also houses a new post office. A library is on the way.

Other commercial centers in the heart of Bluffton sport names like Magnolia Village, Towne Center Distinctive Shoppes and Services, The Prominade and Legacy Commons.

"And the area is not built out, even now," Criscitiello said.

But that growth has put tremendous pressure on the area's infrastructure, including its roads, police, fire protection and schools.

Congested roads

By far, road congestion is the most often heard gripe about growth in southern Beaufort County.

Larry Toomer, 45, grew up on Hilton Head Island and attended schools in Bluffton. In those days, the drive could be made in about 10 minutes.

"Now, in the middle of the night, you could probably still make it in 10 to 12 minutes," said Toomer, who owns of the Bluffton Oyster Co. along with his wife, Tina.

More often, though, the same trip will take an hour and a half, he said. A few cars backed up at a four-way stop used to be a traffic jam in historic Bluffton. Now cars, construction trucks and tractor-trailers back up for blocks under the moss-draped oak branches that hang over Bluffton streets.

As frustrating as that is, the Toomers said increased business eases the pain. Along with the traffic, sales at the riverside seafood market have tripled in the past few years.

"Everybody makes more money," said Tina Toomer, who also serves on the Bluffton planning commission. "It's definitely been good for our business. So I don't have any qualms about the growth — except for the roads."

Lancaster County prepares

Hurst said he's aware of the straining influence growth can have on traffic, but he thinks Beaufort County has done a good job of dealing with traffic on U.S. 278 — even if locals there don't agree.

And he's worried about more than roads. Hurst is concerned about the effect growth will have on the county's ability to provide services.

"Every department in this county will be impacted by this growth," he said.

Even with a commercial boom, Hurst said the economic impact of the growth will not be felt for at least five years. To help offset that, Sun City has agreed to give the county $100,000 for the next two years to allow it to begin getting prepared for what will be needed — including sheriff's office substations and extra planning department staff.

Sun City and the county may establish a special tax district where Carolina Lakes residents will pay an annual fee to pay for more firefighters and emergency medical service employees to serve not only their community but all residents in the panhandle.

In addition, Sun City officials have set aside two acres and $1.5 million to build a branch of the Lancaster County public library.

"I just wish some of the other developers would do the same thing. Everyone needs to pay for their own share," said Jon Hardy, head of the local Del Webb business group. "As growth comes, we all need to look for opportunities to give back to the community."

This relationship and approach to growth is a model Hurst said will be applied to future development in the county, especially in the panhandle area.

"We're trying not to burden the people who were already there. It's not fair to burden them to pay for new services required by new residents," Hurst said. "We don't mind growth, but we want people to pay for what they're bringing with them. And they're going to have to do it. That's why we're creating this model."

Jason Caio • 329-4071
jcaio@heraldonline.com

Respect

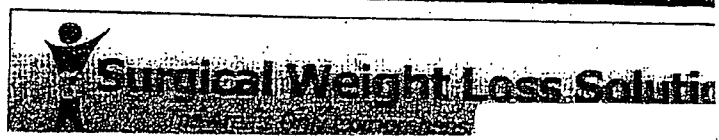
from 1B

abused and abandoned children. The labels are used to purchase computers, encyclopedias and passenger vans.

The students will collect pennies for a future service project to benefit PATH, a York-area charitable relief group. Both service projects help students at Jefferson learn kindness, respect, responsibility

ter traits when they enter school, they'll have them when they leave," she said.

Toya Graham • 329-4062
tgraham@heraldonline.com



Herald editor Terry Plumb's column will return next week.

Viewpoint

James Warrell, opinion page editor, 329-4081
jwarrell@heraldonline.com

Sunday, April 18, 2004

THE CHANGING LANDSCAPE

York County Comprehensive Plan maps development until 2025

The comprehensive plan is an updated guide for how York County should grow in the next 20 years. It was presented to the York County Council last week and will be discussed in a series of workshops before the council takes a vote on it in late summer or early fall. The proposal has nine key elements: population, housing, economic development, natural resources, open space, cultural resources, community facilities and services, transportation and land use. Each element offers goals and strategies for achieving those aims. Most of the suggestions in the plan — managing population growth, preserving open space and natural resources, and boosting mass transit options — are based on local folks' input. The council has the final sy on the blueprint and none of the recommendations are written in stone. If approved, the plan will be enforced through zoning laws — a set of regulations that govern where and under what conditions homes and businesses can be built. It will take two or three years to update the existing rules. Residents will have the opportunity to sound off on the proposal in a series of forums scheduled in May and June.

POPULATION

and 2003, according to U.S. Census data. As of July 1, 2003, the area had 178,070 residents. The population boom is expected to continue over the next 20 years, but some areas of the county are not experiencing positive growth and a high quality of life. Planners believe an estimated 178,408

LAND USE

Summary:
A guide for where the county should pinpoint future development, based on community feedback. Residents have said they were concerned about the way the area has

Summary:
An inventory and analysis of York County's residents. It's one of the core elements of the guide because it provides the framework for the plan. Growth trends also determine when and where schools, recreational outlets and other in-demand facilities should be built. York County was the second-fastest growing county in South Carolina between 2000 and 2003, according to U.S. Census data. As of July 1, 2003, the area had 178,070 residents. The population boom is expected to continue over the next 20 years, but some areas of the county are not experiencing positive growth and a high quality of life. Planners believe an estimated 278,698 people will call the area home by 2025.

Here's a snapshot of population traits:

- Fort Mill is the fastest growing area in York County, while Rock Hill holds the No. 2 spot. The increase is due to the in-migration of new residents who work in Charlotte as well as Gaston and Richland counties.
- Whites account for 77.2 percent of the population, while non-whites make up 20.5 percent. By 2025, the county's population is expected to be 74.9 percent white and 32.2 percent non-white.
- Roughly 47.9 percent of the population was comprised of males; females, 51.7 percent. Those numbers aren't expected to shift much by 2025, holding steady at 49.7 percent and 51.2 percent, respectively.

Goal: Prepare for the needs of a diverse and changing population.

How?:

- Continue monitoring and updating population trends to get a handle on the area's changing demographics. Many of the county's agencies and departments do this by requiring updated population breakdowns.

Summary:
A guide for where the county should pinpoint future development, based on community feedback. Residents have said they were concerned about the way the area has changed, particularly in the parts of the county closest to Charlotte. Other have expressed worries about traffic congestion and the impact of sprawl on their quality of life. Those in the more rural communities have asked that rural characteristics be preserved.

Here's a quick view at some land-use element:

- Future development should be located in the urban eastern section, which includes Rock Hill, Fort Mill, York, Clover and Tega Cay. Roads, water, sewer and other public services are readily available in these areas. This type of growth helps avoid sprawl, which happens when subdivisions spring up in rural areas without access to such services.
- Encourage compact developments, where houses, stores and other businesses are built close together, allowing people to be less dependent on cars.

Some of the six goals include:

Goal 1: Manage growth to achieve quality, compact development that provides a balance of uses and densities at appropriate locations, is consistent with available public services and discourages sprawl and other undesirable development patterns.

Goal 2: Raise the bar for development quality to retain scenic beauty and unique character.

Goal 3: Guide the largest proportion of growth into designated urban areas.

How?:

- Develop standard to retain open space within new developments.
- Direct higher density development within existing urban boundaries.
- Improve standards for commercial development in suburban areas.

CULTURAL RESOURCES

Summary:
Provides an inventory of York County's cultural resources, including Historic Brattonsville, the Catawba Indian Reservation, Kings Mountain's State Park and historic buildings and how to preserve them.

Here's a brief look at some of the county's historic places:

- The Bethel community is one of the oldest in York County.
- Kings Mountain State Park, considered one of the most significant natural resources in the county, is located in the Clover area. The park preserves the battlefield where Patriot forces defeated British forces in 1780, a battle that many consider to be the turning point of the Revolutionary War.
- Fort Mill is home to a historic downtown district as well as the Unity Presbyterian Church Historic Complex.

Goal: Protect cultural resources in the county through the National Register of Historic Places nominations as well as federal and state preservation programs.

How?:

- Continue to nominate eligible properties to the National Register of Historic Places.
- Participate in federal and state programs that encourage the preservation and protection of cultural resources in York County.

NATURAL RESOURCES

Summary: Provides suggestions for protecting streams, creeks and rivers used for generating power and recreation; animals and plant life; and other natural characteristics of the area. There are also recommendations for improving air and water quality.

Here's a look at the county's natural resource characteristics:

- The climate has been an asset for attracting industry and people from northern areas in the country.
- Soil conditions vary from favorable to highly undesirable for development and are scattered throughout the county.
- Two major watersheds, the Catawba River and Broad River basins, divide York County, with the Catawba surrounding the bulk of the area. Municipal and industrial discharge; agriculture, construction and stormwater runoff impact the health of the river.
- A minimum of 2.5 percent of the county's land area is needed to maintain the plant and animal population and species mix that exists within the county.

Goal 1: Protect and preserve natural, wildlife habitat and agricultural and timber lands areas.

- Work to boost public education and involvement in stormwater pollution prevention and rehabilitation.

park preserves the battlefield where Patriot forces defeated British forces in 1780, a battle that

grams that encourage the preservation and protection of cultural resources in York County.

agriculture, construction and stormwater runoff impact the health of the river.

- A minimum of 2.5 percent of the county's land area is needed to maintain the plant and animal population and species mix that exists within the county.

Goal 1: Protect and preserve natural, wildlife habitat and agricultural and timber lands areas.

Goal 2: Regulate stormwater discharge in York County's urban areas to meet federal standards.

How?:

- Ensure zonings protect environmental areas.
- Promote federal low-impact development and best management practice regulations by developers, farmers, timber companies and any other group whose activities may disturb the land.

TRANSPORTATION

Summary: Offers a vast list of transportation strategies that will help York County achieve its goals for managed growth, quality development and community character. The strategies are designed to promote a system that enhances the community and ties in with proposed land use patterns.

Following is a snapshot of the county's transportation outlook:

- The existing network of roads provides good accessibility to Charlotte, Columbia and the rest of the region.
- A 1-cent sales tax program for road improvements has helped to provide money needed to upgrade several county roads.
- The 82-X Rock Hill Express, operated by the Charlotte Area Transit Service, provides bus service for Charlotte commuters who live in Rock Hill and Fort Mill.

Goal 1: Develop and maintain a roadway network that safely accommodates traffic at acceptable levels of service, while supporting sound growth and economic development.

Goal 2: Provide a diverse transportation system that has convenient transit, including buses and rail lines, and pedestrian, bicycle and other alternatives to personal vehicles.

Goal 3: Develop and apply financial resources and growth management tools that will prevent over-congested roads, reduce air pollution and ease the burden on taxpayers to pay for roadway upgrades resulting from growth.

How?:

- Discourage corridor development patterns that cause traffic congestion.
- Develop a pedestrian and bicycle network.
- Manage growth so that is reduces air pollution including ozone, carbon minoxide and other pollutants.

COMMUNITY FACILITIES

Summary: Offers criteria for where, when, and how to provide water and sewer, libraries, fire stations and recreational outlets that support the recommendations in the land-use element. It also provides a framework for reducing the burden on the county's financial resources, improving customer service and enhancing quality of life.

Here are some of the highlights of the community facilities in the area:

- York County is served by a comprehensive water system and is also divided into separate water districts.
- The county's library system consists of a main branch in Rock Hill and four other branches in Clover, Fort Mill, Lake Wylie and York.
- York County government has offices established in more than 30 different buildings of varying size located throughout the county.

Some of the 14 goals include:

Goal 1: Correct existing space deficiencies, consolidate some office locations and reduce costs related to providing operations.

Goal 2: Consider long-term options to expand recreation opportunities for all county residents.

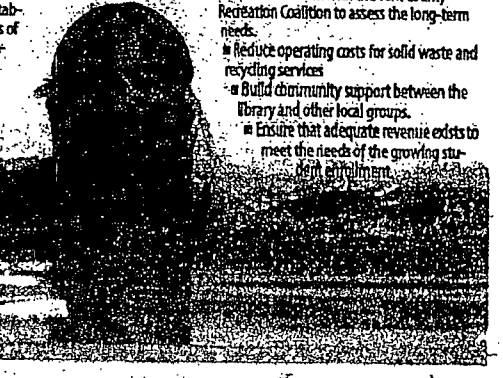
Goal 3: Expand convenience centers in more densely developed sections of the county.

Goal 4: Move forward with plans for existing library expansion and build a new one.

Goal 5: Make sure adequate land is reserved throughout the county for school expansion or new schools that are consistent with future land use patterns.

How?:

- Follow the facilities master plan.
- Continue to work with the York County Recreation Coalition to assess the long-term needs.
- Reduce operating costs for solid waste and recycling services
- Build community support between the library and other local groups.
- Ensure that adequate revenue exists to meet the needs of the growing student enrollment.



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Real Estate

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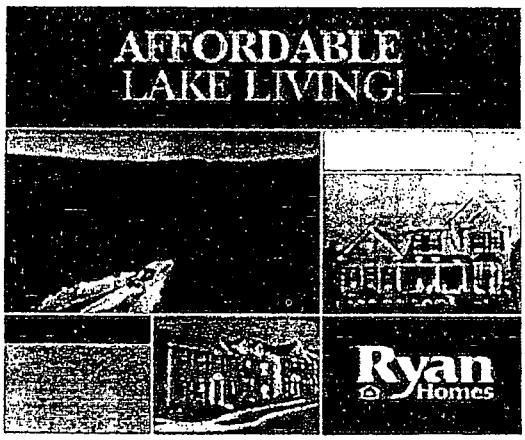
Posted on Wed, Aug. 04, 2004

COMING TO LANCASTER COUNTY

Sun City coming to upstate S.C.

Lancaster County backs 3,600-home community

HEATHER VOGELL
Staff Writer



IMAGES

Sun City is coming.

The Lancaster County Council approved the 3,600-home S.C. retirement community this week with only minor changes and no opposition from neighbors.

Over the next decade, the age-restricted development will grow into its own small-city in Lancaster County's panhandle just down U.S. 521 from Ballantyne, officials with developer Del Webb say.

Along with thousands of homes, a public golf course and new shopping centers will spring up on what's now farmland, they say.

It could become the largest retirement community in the area and rank among the region's biggest housing developments overall. Del Webb wants to cash in on surging demand from baby boomers in the Charlotte region.

Retirees are expected to buy more than 85,970 homes in western North Carolina by 2010, according to a real estate consultant's study. Demand for such homes in the Charlotte area alone could rise by 55 percent over the decade, the study found.

Del Webb hopes South Carolina's lower taxes will draw many south of the state line.

"There is a tremendous need for this project in this town," said Jon Hardy, president of Del Webb's local business unit.

Dubbed "Sun City Carolina Lakes," the development will resemble other Sun Cities in Western states such as Arizona and California, and in South Carolina near Hilton Head Island.

Commission
• Home & Business Service Directory

Buyers of Sun City townhouses and single-family homes will need to be 55 and older, or part of a couple with one member that age. The community will offer social activities and other amenities for what Del Webb calls "active adults." Typically, Sun City developments have clubhouses and billiard rooms, tennis courts and organized events such as concerts or dances.

Homes will likely sell for between $150,000 and $350,000, Hardy said. Del Webb plans to break ground by May 1 and begin selling homes by next July or August, he said. The development will be built off U.S. 521 near Van Wyck Road.

The cost of building everything planned in Sun City -- from homes to retail -- could approach $1 billion, Hardy said. Del Webb hopes to employ Lancaster residents and buy some materials from local businesses, he said.

By the end of the decade it takes to build the development in full, Lancaster County will have reaped roughly $23 million in new tax revenue, according to estimates.

"We welcome you to Lancaster County," councilman Fred Thomas told developers at Monday's council meeting.

In June, county planning staff members recommended the county deny the project because of concerns that Lancaster couldn't afford to pay for county services for all the new residents.

But the council found another solution: Sun City homeowners will be charged higher property taxes than other residents.

This week, the council gave preliminary approval to a $75 special tax to pay for fire and emergency medical services staff for the Sun City area. Fire departments there now are volunteer.

The county also plans to create another special tax of $350 to $450 annually to pay for costs related to roads and water and sewer service, Hardy and County Administrator Chap Hurst said. Residents will also pay regular county taxes.

In addition, Del Webb has pledged to donate $200,000 in cash to the rural county to ease the burden of a rapid influx of newcomers.

Hardy said that although Del Webb has the green light to build 3,600 units, it will likely only be able to fit about 3,200 on the 1,200 acres it plans to develop. Assuming there will be a mix of single homeowners and couples, the development could eventually house roughly 4,800. About 62,000 people live in the county now.

In comparison, Baxter Village near Fort Mill has 500 homes, with another 825 planned. The planned Palisades community on the Mecklenburg County side of Lake Wylie will include 2,000 homes on 1,500 acres. And Highland Creek in northeast Charlotte is expected to grow to 4,200 homes.

Sun City Carolina Lakes

What did Lancaster County approve?

Plans include 3,000 single-family homes, 400 townhouses and 200 attached

Who can buy homes there?

People who are 55 and older, or part of a couple with one member over 55.

What will they cost?

Probably between $150,000 and $350,000

When will they be available?

Del Webb plans to start selling homes by July or August 2005

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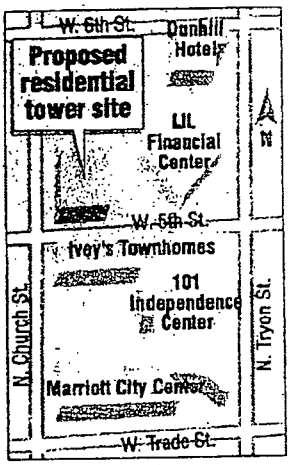
JOURNAL

VOLUME 19 NUMBER 23 SEPTEMBER 3, 2004

Condo tower for North Cl

Atlanta developer will build 35-story project n



J. LEE HOWARD
SENIOR STAFF WRITER

An Atlanta-based multifamily development company is drawing plans for a 35-story condominium tower at Church and Fifth streets.

The Novare Group Inc. confirms it has the 0.8-acre parcel under contract for construction of a 390-unit residential tower with prices ranging from $170,000 to $260,000 per unit. A development cost has not been disclosed.

"Charlotte is a city that we have been interested in for some time," says John Long, Novare chief investment officer. "It is a dynamic metropolitan area with a vibrant economy and an energetic city center, and we are excited to be a part of its growth."

Bank of America Corp. owns the property, which is nestled behind the IJL Financial Center and across Church Street from the historic Settlers Cemetery.

The site, which is used as a surface parking lot, is valued for tax purposes at almost $3.5 million.

Plans also call for construction of an eight-story parking deck that would e
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Clear Springs expanding vision

York County officials concerned about residential impact

KEN ELKINS
STAFF WRITER

[redacted]

[redacted] ompany executives say.

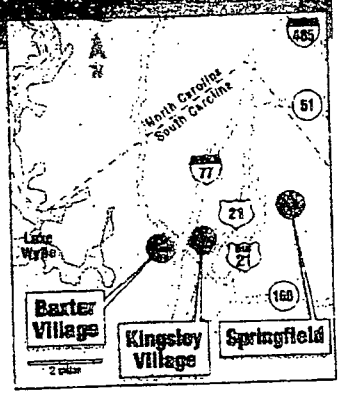
Plans call for construction to start by early 2006.

Springfield north, planned near U.S. Highway 21 Business, would contain 700 homes, 500,000 square feet of commercial and 500,000 square feet of industrial space on 1,110 acres.

Kingsley Village — to be developed adjacent to the Kingsley Park office development on the east side of Interstate 77 at S.C.

photo KEN ELKINS

About 500 of an eventual 625 homes have been built in the first Clear Springs mixed-use project, Baxter, where a commercial district, above, is also under development.



CLEAR SPRINGS, PAGE 49

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RECORD 002378

CLEAR SPRINGS: Fort Mill projects would total $1 billion in investment

FROM PAGE 1

Highway 160, across I-77 from Baxter — would have 424 homes and up to 3 million square feet of commercial development on 640 acres.

Such growth has long been envisioned for the overall Clear Springs project — a 6,000-acre series of villages virtually encircling Fort Mill on land controlled by the Close family.

However, as the development company began enlisting the help of York County officials this week, the response was less than enthusiastic.

In particular, some York County Council members are questioning Clear Springs' request for creating a special tax district to cover the cost of infrastructure for the proposed new villages.

"This was not the tool that we should apply to residential growth," says council member Buddy Motz. "If we set a precedent, we would have to have it available to other residential developers."

"If you want commercial to happen, you have to assist it with residential development. It's part and parcel of the whole thing."

Don Killoran
Clear Springs Development Co.

Under a special tax district, local governments in South Carolina can levy an additional property tax that applies only to a designated area. Revenue generated by the tax is designated for a particular purpose, such as infrastructure improvements.

During a work session Tuesday, Motz and other council members said they need

Baxter is on the west side of I-77 at S.C. 160.

Other Clear Springs developments include Bradley Park, a 530-acre industrial tract on the south side of Fort Mill that includes a massive US Foodservice Inc. distribution center, and Kingsley Park, a 75-acre business park that's home to a Weyerhaeuser Co. regional headquarters.

The 2,300-acre Anne Springs Close Greenway also is considered part of the overall Clear Springs development.

In addition, plans call for eventual development of Springfield south, which isn't included in Clear Springs' tax-district request, on land adjacent to Springfield Golf Club, off U.S. 21 Business.

photo DIEDRA LAIRD/KRT

The next major Clear Springs projects will have larger commercial components than the Village of Baxter community, above.

BE FIRST TO CHOOSE YOUR VIEW.

the wh... thing.

Don Killoren

Clear Springs Development Co.

Revenue generated by the tax is designated for a particular purpose, such as infrastructure improvements.

During a work session Tuesday, Motz and other council members said they need more details on the development proposal before approving a tax.

Such funding arrangements are intended for commercial and industrial projects, Motz says. "We would be lowering the bar to include residential."

Also, council members expressed concern that too many homes are being built in the northeastern part of the county, where schools are quickly becoming overcrowded.

Clear Springs is seeking the special tax designation to pay for about $50 million in infrastructure at the two village sites. Without such funds for roads, sidewalks, water service and sewer lines, development of the villages will be slow, says Don Killoren, Clear Springs chairman and chief executive.

"We wanted to make sure we were moving in a direction that council would approve," Killoren says of the session with County Council members.

The villages' residential components are crucial to attracting commercial growth, he contends.

"If you want commercial to happen, you have to assist it with residential development," Killoren says. "It's part and parcel of the whole thing."

The Close family, which holds controlling interest in Fort Mill-based Springs Industries Inc., launched the overall Clear Springs project in 1997. About 500 of an eventual 825 homes have been built in the first mixed-use project, Baxter, where a commercial district is also under development.

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The Herald
Wednesday • May 26, 2004

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BUSINES

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IN BRIEF

Staff and wire reports

York Tech to offer maintenance program

York Technical College announced Tuesday it will offer a new associate degree program in industrial maintenance.

There is a shortage of qualified professionals in this field, and the demand is expected to grow in the coming years, according to a statement from the college.

The industrial maintenance program is available to day and evening students. Coursework will be split between the classroom and lab. After completing a core curriculum, students will move into one of the following concentrations: HVAC (heating, ventilation and air conditioning), industrial electricity, industrial maintenance, machine tool or welding.

For information, call the York Tech admissions office at 327-8008.

Chamber starting move to new headquarters

The York County Regional Chamber of Commerce will start moving into its new headquarters in downtown Rock Hill this week.

As a result, chamber staff won't have access to e-mail on Thursday and Friday. They can still be reached by phone at 324-7500.

The chamber's first day at its new location will be Tuesday.

Chamber officials have been in temporary offices in the Bank of America building on East Main Street more than a year. The new headquarters are at 116-118 E. Main St., site of the former OK Pawn Shop and other businesses. The historic building has been undergoing renovations since fall 2002.

Founders credit union reports strong growth

During the 53rd annual meeting of Founders Federal Credit Union this month, Founders officials reported that despite a slow economy, the company had strong growth in loans and shares.

During 2003, Founders saw asset growth of $39 million and added more than 7,300 new members. Joe McCain, Chairman of the Board of

GOLD HILL COMMONS

$200M plan nears c

If approved, 277-acre site would bring housing, retail

By Caroline Brustad Fossi
The Herald

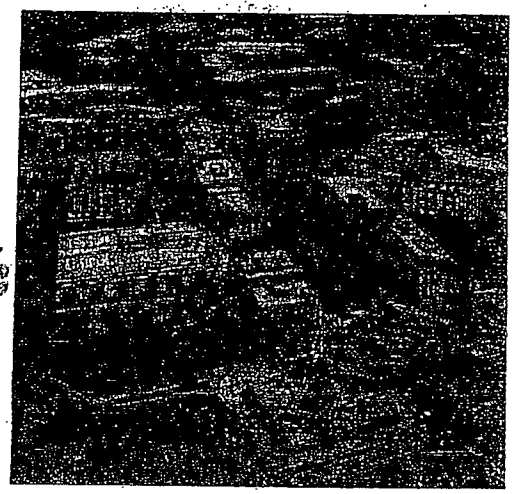
Almost seven months after announcing plans for Gold Hill Commons — a $200 million business and housing complex near Knights Stadium in Fort Mill — a Charlotte development firm says construction will soon be under way.

Corinthian Properties plans to start with two 57,000-square-foot "flex" buildings on the site's southern edge, visible from Interstate 77, company President Shawn Helda told members of the York County Economic Development board during a meeting in Rock Hill on Tuesday. Plans will be submitted to York County next week. Once approved, construction could start as early as July and will take about six months to complete.

The buildings could be used for offices, light manufacturing or distribution. Several businesses have already expressed interest in the space, Helda said, including a national mortgage company that may move its support operations there, bringing about 300 employees.

The next stage of the development will be eight smaller office buildings, each less than 10,000 square feet.

It will take about 10 years for the entire 277-acre development to take shape, Helda said. In addition to office, manufacturing and distribution space, future plans include a 325-unit apartment complex, loft-style apartments or townhouses above retail or office space, shops, restaurants, a hotel and a movie theater.



This rendering shows plans for Gold Hill Commons, a 277-acre busine near Knights Stadium in Fort Mill. The baseball field is at right.

The community's town center will be a gathering place, with architecture reminiscent of European villages, or of U.S. cities like Charleston or Savannah, Ga., Helda said. Plans also call for natural areas and a trail that will link to nearby greenways.

Northern bypass a key

A key to the development's success, Helda said, will be the completion of a northern bypass around Fort Mill, which will offer a second entrance to the development's northern edge. The main entrance to the development off Gold Hill Road is Deerfield Road, which leads to the Knights minor-league baseball stadium.

> *"The land around Knights Castle ... has excellent commercial potential."*
>
> Mark Farris,
> York County economic development director

The bypass is being built through "Pennies for Progress," York County's 1-cent sales tax program for road improvements. Part of the bypass has already been built. Construction on the second part, stretching from Steele Road to Gold Hill Road, should start this fall and be completed in less than two years, said Randy Bellmann, a consultant overseeing the program.

Krispy Kreme earnings anyt

By Paul Nowell
The Associated Press

CHARLOTTE — The chief executive officer of Krispy Kreme Doughnuts remains adamant that the low-carb diet craze and not rapid expansion is to blame for the company's first quarterly loss since going public in 2000.

"In 30 years in this business, I've never ever seen anything that rivals what has oc-

the company was using the low-carb theory as a cover for its mistakes.

The Winston-Salem, N.C.-based company said Tuesday it lost $24.4 million, or 38 cents per share, in its first quarter after taking a charge for shutting down its Montana Mills Bread Co. chain — which it plans to sell — and other restructuring costs.

Krispy Kreme, which has seen its share price plummet 37 percent since warning May

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Krispy Kreme e
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BUSINESS

heraldonline.com

Caroline Brustad Fossi
Business editor
329-4082
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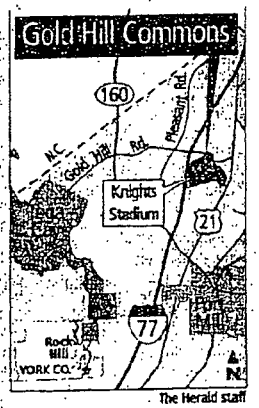
M plan nears construction

Special to The Herald

This rendering shows plans for Gold Hill Commons, a 277-acre business and housing development near Knights Stadium in Fort Mill. The baseball field is at right.



The Herald staff

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"The land around Knights Castle ... has excellent commercial potential."

Mark Farris, York County economic development director

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One meeting attendee asked how Gold Hill Commons would be affected if the Knights relocate to Charlotte — a move team officials say could come in about five years. Helda said his company would consider buying or leasing the stadium land for possible use as a year-round entertainment venue for concerts and other activities.

The rural, wooded land around Knights Stadium has been owned by Jennings family since the Depression era. Kathryn Jennings and her brother, David, took possession of the property around the stadium in 1996. They jointly own the land through a partnership called Jennings Enterprises.

The family spent many years looking for a suitable developer, said Fort Mill attorney Bayles Mack, who introduced Helda and Kathryn Jennings at the meeting. "They want it to be done right."

Helda was drawn to the property because of its natural beauty, and its location off I-77 near Rock Hill, Charlotte and fast-growing Fort Mill. The area's quality of life and schools also are plusses, he said.

Mark Farris, York County's economic development director, said Gold Hill Commons could bring jobs, as well as much-needed business development to Fort Mill. The area needs retail, commercial and industrial growth to balance booming residential growth, he said. Homeowners pay lower taxes than businesses but require more government and school services.

"The land around Knights Castle is one of the few larger tracts of property left along I-77 in the Fort Mill area that has excellent commercial-development potential," Farris said.

Caroline Brustad Fossi • 329-4082
cbrustad@heraldonline.com

Kreme earnings anything but hot now

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Krispy Kreme, which has seen its share price plummet 37 percent since warning May

expansion plans for the year. It estimates opening about 100 new stores systemwide, which is about 20 less than previously planned.

Krispy Kreme earned $13.1 million, or 22 cents a share, in the same quarter last year.

Excluding the nonrecurring charges, earnings were 23 cents a share, which matched the average analyst estimate compiled by re-

lion and systemwide same-store sales increased 4 percent.

Speaking during a conference call to industry analysts, Livengood was asked by BB&T Capital Market's Andrew Wolfe if the low-fat diet fad in the early 1990s also had a negative impact on Krispy Kreme's bottom line.

Not even close, he said. "This is not an excuse. It's what it is. What is important now

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York County

Executive Summary

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Why York County?

It's easy to see that York County capitalizes on its geography offering the advantages of a South Carolina location and business climate with adjacent access to the largest metropolitan area in the two Carolinas – Charlotte USA. York County is an integral part of the Charlotte region, located a few miles south of the City of Charlotte across the border of North and South Carolina. The region offers a unique balance of business strength, accessibility and quality of life. It's what attracts so many companies and, most importantly, keeps them going strong.

CHARLOTTE USA

The diversity and strength of the business community continually supports growth even during challenging economic times. In the past several years, York County has averaged $200 million in industry and business development and 1,700 new jobs annually. In 2001, reported investment totaled $653 million and 3,800 new jobs. Home to the 2nd largest financial center in the nation, the region also boasts a strong distribution and manufacturing presence.

When selecting a location for business operation, accessibility is key. No wonder so many national and international companies have turned to the Charlotte region as a place to call home, including eight Fortune 500 headquarters. York County is midway between New York and Miami providing access to over 50% of the nation's population and industry base.

Serving 23 million passengers a year, the Charlotte/Douglas International Airport is the 6th largest major airline hub in the nation offering over 500 flights daily including non-stop flights to London and Frankfurt.

Interstate 77 runs through the eastern portion of York County and Interstate 85 runs near the northwestern part of the county all joined together by an excellent network of US and state highways. Positioned at the heart of the largest, most consolidated rail system in the Carolinas, York County puts coastal shipping centers within easy reach of the region's inland port.

As part of the Charlotte region, York County offers an unparalleled quality of life including excellent schools, national cultural events, and first class entertainment facilities blending the advantages of a major metropolitan city and a small town atmosphere. Outdoor activities include boating, hiking and playing on some of the nation's most outstanding golf courses. With teams in the NFL, IHL and triple-A baseball as well as the reputation as a major NASCAR headquarters, the region continues to be recognized as a national sports market. A short drive to the Blue Ridge Mountains or the famed Carolina beaches, York County also offers easy access to a variety of destinations.

So, why York County? The best of all worlds is offered here. Quality of life, excellent business climate, and accessibility are just the beginning. South Carolina incentives make the move to York County a smart one. Our reasonable cost of operation and productive labor force make staying in business here even smarter.

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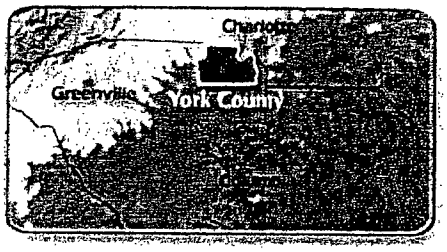
Location

Situated in the heart of the Carolina Piedmont, just across the South Carolina line from dynamic metro Charlotte, York County brings together the grace and charm of life in a small community with the opportunities and advantages of the big city. There are nine municipalities within York County: Clover, Fort Mill, Hickory Grove, McConnells, Rock Hill, Sharon, Smyrna, Tega Cay and York. The City of Rock Hill is the commercial and financial center, while the City of York is the county seat.



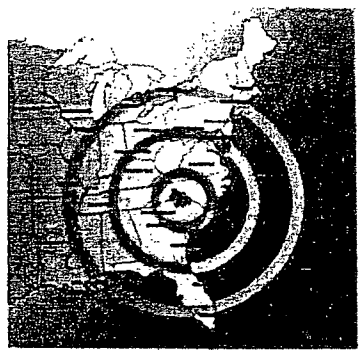
York County is 685 square miles of gently rolling landscape located in the Piedmont area of Carolina 75 miles north of Columbia and just Southwest of Charlotte, NC. Elevations in York County range from 500 feet to about 1,200 feet above sea level. The majority of soil conditions provide excellent building and development foundations.

Accessibility

York County has an advantageous location - 57% of the U.S. population and 62% of U.S. industry are within 650 miles.

Population Comparison in a 650-Mile Radius

City	% of U.S. Population
York County/ Charlotte Region	57%
Atlanta	44%
New York	40%



- More than 130 million people can be reached in only 2 hours by air and one day by car or truck from the Charlotte Region
- Major transportation & distribution center

Flight/Driving Times

City	Miles	Kilometers	Driving Time	Flight Time
Atlanta, GA	243	391	3:57	1:15
Chicago, IL	765	1231	12:13	2:00
Orlando, FL	524	843	8:13	1:30
New York, NY	646	1039	0:27	1:50
Memphis, TN	620	998	9:22	1:40
Washington, DC	400	644	6:24	1:15

Charlotte Douglas International Airport

The Charlotte/Douglas International Airport is ranked among the nation's top airports and serves commercial, cargo, corporate, private, military and trucking operations. The Airport is midway between I-85 and I-77, a convenient location with quick entrances and exits easily accessible from York County. US Airways operates its largest hub at Charlotte/Douglas offering a wide variety of destinations. With Charlotte/Douglas International Airport serving Charlotte, you can reach most business destinations with direct or one-stop flights.

- Over 500 flights daily
- 146 cities served by non-stop & single plane service
- Over 23 million passengers in 2003
- Over 1.3 million international passengers in 2003
- 2003 Rankings: 13th nationwide in total operations
  17th in total passengers

International Service

(Non-stop flights)

- Antigua
- Aruba
- Belize
- Bermuda
- Cancun, Mexico
- Cozumel, Mexico
- Frankfurt, Germany
- Freeport, Grand Bahamas
- Grand Cayman Islands
- La Romana, Dominican Rep.
- London, England
- Mexico City, Mexico
- Montreal, Canada
- Montego Bay, Jamaica
- Munich, Germany
- Nassau, Bahamas
- Providenciales, Turks & Caicos
- Punta Cana, Dominican Republic
- San Jose, Costa Rica
- San Juan, Puerto Rico
- St. Maarten, Netherland Antilles
- St. Kitts
- St. Thomas, U.S. Virgin Islands
- Toronto, Canada

Beginning February 12, 2005

- Liberia, Costa Rica
- Barbados

Airlines

Mainline Carriers:

- American Airlines
- Air Canada
- ATA
- Continental Airlines
- Delta Air Lines
- Lufthansa Airlines
- Northwest Airlines
- United Airlines
- US Airways
- Independence Air

Regional Carriers:

- American Eagle
- American Connection
- Continental Express
- Delta Connection
- Northwest Jetlink
- United Express
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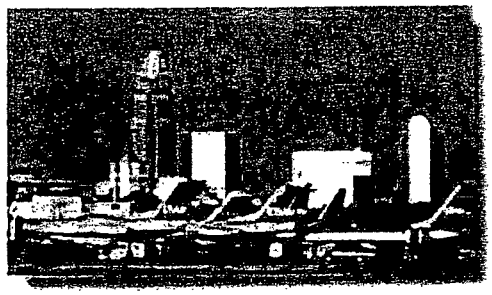

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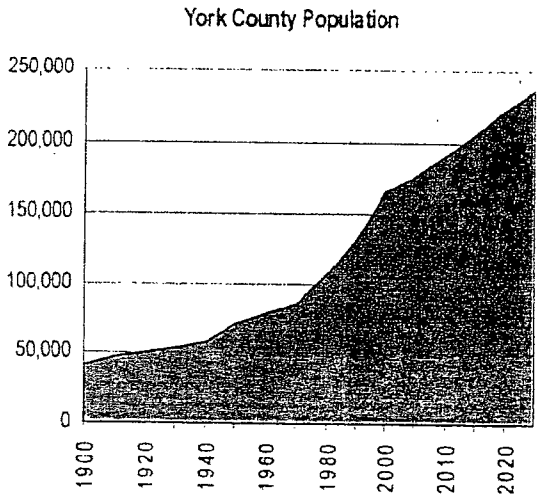
York County Demographics



York County Population

Population, 2004 estimate	182,193
Population percent change, 2003-2004	2.5%
Persons per square mile, 2004	261.9
Population, 2000	164,614
Population, percent change, 1990 to 2000	25.2%

Age Distribution (2004 estimate)

Persons 15 to 19 years old	7.1%
Persons 20 to 64 years old	62.0%
Persons 65 years old and over	10.8%

Household Income (2000)

Median household income	$44,539
Median family income	$51,815
Per capita income	$20,536

Ethnicity (2004 estimate)

White persons	77.0%
Black or African American persons	19.4%
American Indian/Alaska Native persons	0.8%
Asian persons	0.9%
Persons of Hispanic or Latino origin	2.5%

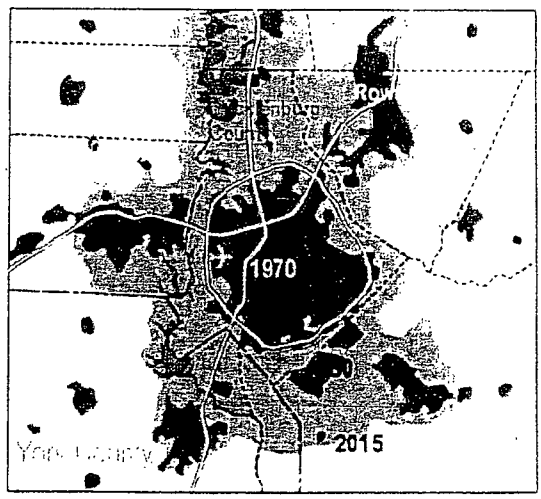
Source: DemographicsNow using U.S. Census

Regional Urban Growth

Estimated for 2015

Regional Population

County	2004 (estimate)	2015 (projected)
York	182,193	198,200
Alexander	35,156	42,748
Anson	25,140	27,561
Cabarrus	146,248	185,714
Catawba	148,471	177,372
Chester	33,833	37,700
Chesterfield	43,366	43,500
Cleveland	98,808	111,687
Gaston	193,911	210,707
Iredell	136,650	169,988
Lancaster	62,895	62,300
Lincoln	68,354	84,282
Mecklenburg(Charlotte)	769,746	998,022
Rowan	135,024	161,924
Stanly	59,068	67,337
Union	152,765	189,355
Charlotte Region	**2,291,628**	**2,768,397**



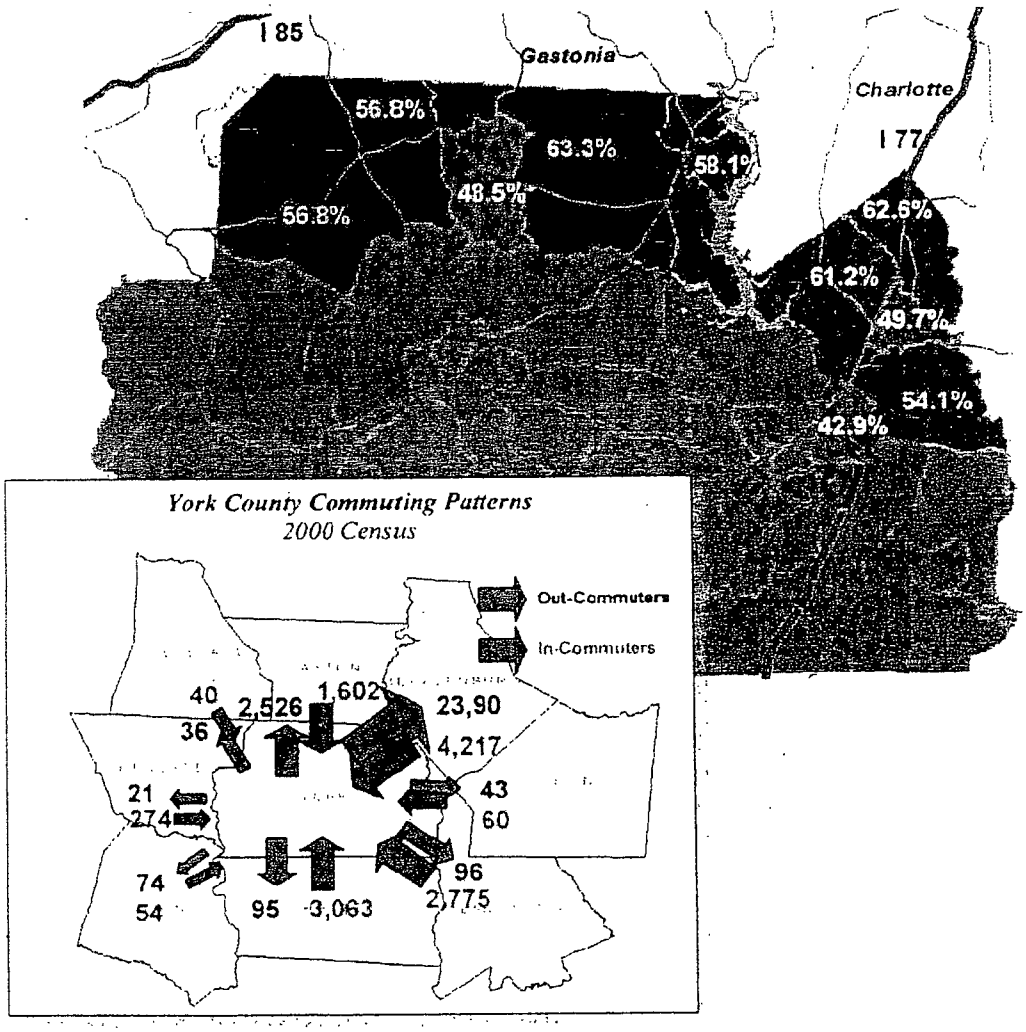
Source: US Census Bureau, South Carolina Office of Research & Statistics, North Carolina State Demographer, DemographicsNow

Commuting Patterns

- A total of 40% of York County's workforce over the age of 16 commute to a work place outside of the county up from 38% in 1990.
- Nearly 24,000 or 30% travel to Charlotte/Mecklenburg County alone compared to 25% in 1990.
- The northern portion of York County tends to produce the most out-commuters as Census tracts bordering North Carolina listed 50% or more of the workforce commuting outside the county.

High Volume of Out-Commuters In York County

Percent of Workforce (Ages 16+) Commuting out of York County



Sources: 2000 Census, 1990 Census

Labor Force

York County offers a productive workforce with increasingly diversified skills. Approximately 40% of the county's workforce commutes many miles to jobs throughout the region. New businesses locating in York County find good availability in the labor supply, especially with people who desire a job closer to home. In a recent survey of companies in the labor shed area, our workforce received high marks for productivity and most companies judged absenteeism and turnover to be low.

South Carolina is a "right to work" state and has a low unionization rate of 4.2%. The state continues to hold the slot for lowest or second lowest union rate in the United States during the last decade. South Carolina also has one of the lowest work stoppage rates in the country over the last 30 years. York County has not held a union election in the last five years.

Annual Average 2004 Labor Force

	Total Labor Force	Unemployed	Unemployment Rate
York County	96,804	7,511	7.8%
Charlotte Region	1,216,063	61,832	5.1%

Registered Applicants

In the past year, nearly 8,000 people registered with the South Carolina Employment Security Commission in York County as searching for employment opportunities. Of these, approximately 2,000 had skills in manufacturing occupations, 2,000 in administrative and sales occupations, 1,600 in distribution occupations and over 1,000 in professional and managerial occupations.

Underemployment

Studies have shown that firms that expand or grow in York County draw from those who are already employed. A recent survey found that many people expressed an interest in changing jobs, creating a pool of desirable candidates for new employment opportunities. These underemployed workers were surveyed in York, Chester, Lancaster and southern Mecklenburg counties constituting the Catawba Labor Shed area. This pool of workers possesses the skills, experience and education that seem to qualify them for job upgrades. In addition to underemployed workers, the study found that 5,700 people, approximately 76% female, are not actively seeking work would accept a good job if offered.

• Number of ***underemployed*** workers	49,400
• Number of ***unemployed*** persons who are seeking work	14,300
• Number of persons who are not working, but are contemplating ***re-entering the workforce***	5,700
• **Total number of workers available for employers**	**69,400**

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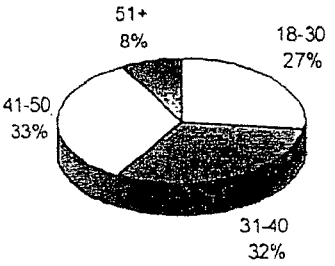
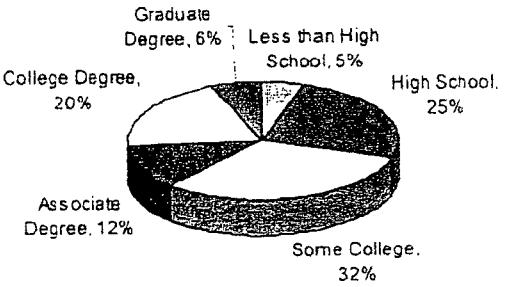
Underemployment
Continued

Age Distribution of Underemployed Workers



Education of Underemployed Workers



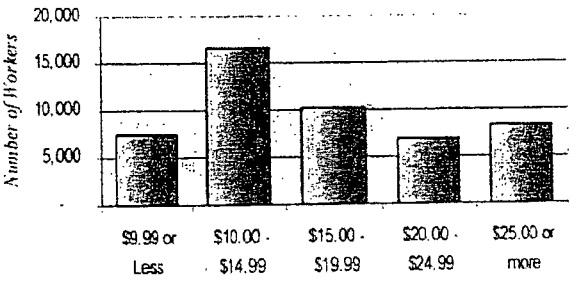
Employment Skills of Underemployed Workers*

	Number of Persons	Percentage
Office/Data/Word Processing	31,100	63%
Computer Use	42,000	85%
Computer Programmer	11,900	24%
Warehouse/Materials Handling	25,700	52%
Manufacturing Production/Assembly/Fabrication	24,200	49%
Machining/Welding/Other Industrial Machines	13,800	28%
Telecommunications	14,300	29%
Technician/Quality Assurance	16,800	34%
Maintenance/Installation/Repair	13,300	27%
Electronics/Engineering	8,400	17%

** Individuals polled may have skills in more than one job classification*

Wage Expectations of Underemployed Workers*

Desired Wage Rates of Underemployed Workers



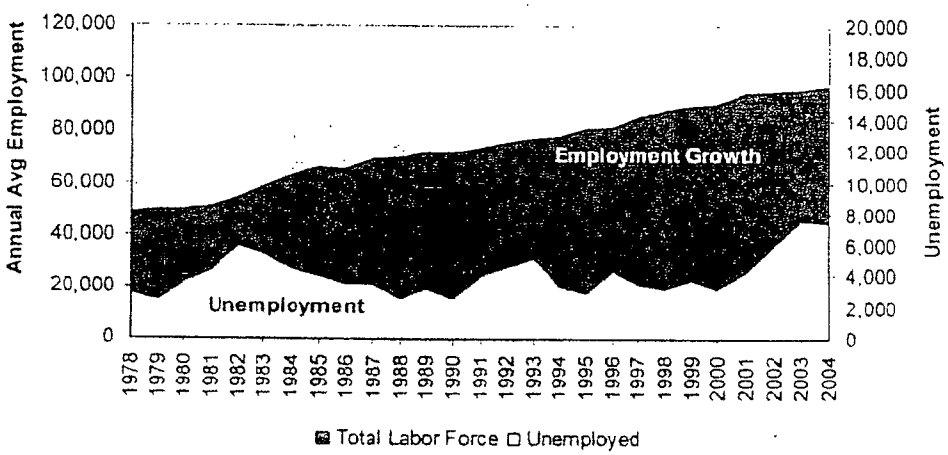
Underemployed workers might also be termed upgraders with the skills, experience and education to justify desired pay rates ranging from $7.00 to $25.00 an hour. The pay required to hire people among these underemployed workers is consistent with that required in more that two hundred locations surveyed nation-wide. The upper end of the pay range for this group, a rate of $22.05 an hour or more would be required in order to change jobs. At the lower end of the pay required to change jobs, 25% of those surveyed would take a new job for $11.24 an hour. Those not actively seeking work would re-enter the workforce if offered a good job with a median rate of $12.00.

Sources: South Carolina Employment Security Commission, "The Catawba Region Workforce Report" by The Pathfinder 2002s

Current Employment

York County April 2005	Total Labor Force	Employed	Unemployed	Unemployment Rate
	97,780	91,120	6,660	6.8

York County Employment Trends



Labor Participation

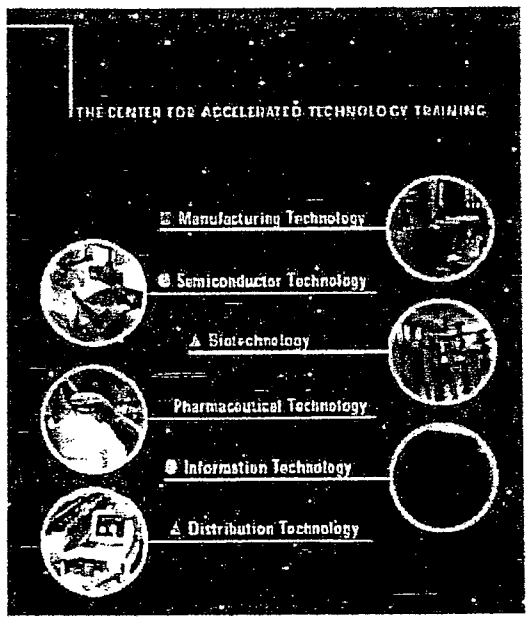
	15-mile Radius of Rock Hill	30-mile Radius of Rock Hill	York County
Labor Force Participation Rate	53.9%	51.9%	55.5 %
	The average South Carolina and US participation rate are both 50%.		
Distribution by Age (2001)			
18 - 24	11.7 %	11.0 %	12.1 %
25 - 44	32.5%	33.9%	31.9%
45 - 54	10.9%	10.7%	11.0%
55 - 64	10.6%	17.2%	8.5%
Distribution by Sex (2001)			
Male	47.9 %	47.7 %	48.0 %
Female	52.1%	52.3%	52.0%
Education (Age 16-69)			
High School Graduates	72.3 %	65.4 %	73.9 %
1-3 Years of College	26.1%	20.2	28.3
College Graduates	12.8%	16.0%	11.6%
Post Graduates	5.5%	5.9%	5.3%

Sources: South Carolina Employment Security Commission, South Carolina Dept. of Commerce, "The Catawba Region Workforce Report" by Pathfinders, 2002

Center for Accelerated Technology Training

The Center for Accelerated Technology Training is a program of the South Carolina Technical College System designed to provide tailor-made training to new and expanding industries in South Carolina.

The college system was founded on the premise that the state would be better served by providing a way to train its citizens and employ them in South Carolina with jobs that the state helped to create. When the concept of technical education was being proposed, many of South Carolina's young people were leaving the state to pursue higher paying jobs in other geographic regions. There was a profound need to be more proactive in recruiting business and industry into the state, in training citizens for the jobs that those industries would create and in maintaining a commitment to that training should businesses want to expand and grow within our state.



The Center for Accelerated Technology Training keeps as its main purpose to offer trained employees to a company when the doors are first opened for operation. Since 1961, 198,026 people have been trained for new jobs in 1,596 companies. The Center for Accelerated Technology Training program has been highlighted on NBC Nightly News, "America Close Up" with Tom Brokaw, ABC News with Peter Jennings, and in the Wall Street Journal.

How the Center for Accelerated Technology Training Operates

Project Management, Development and Implementation
South Carolina is one of the few states in the nation that provides project management staff for the duration of the training project. Most customers find this to be an invaluable asset when in a startup or expansion status. The Center for Accelerated Technology Training's staff has been in the training business for over forty years and brings to each project a level of professionalism and experience that only enhances the overall effort.

Process Analysis
Our project team will visit one of your facilities similar to that which will be built in South Carolina. We will observe processes, review documentation, equipment and analyze skill levels. This visit allows us to not only better understand your processes but also to actually observe employees performing job tasks, talk with your experts and become familiar with the work place environment.

Project Schedule
The Center for Accelerated Technology Training Team will identify all time frames for curriculum and training material development, site preparation, instructor selection and, if necessary, instructor training. All activities will be scheduled to meet your projected hire dates.

Applicants
The Center for Accelerated Technology Training will ensure that quality applicants are recruited through a variety of methods for every training program. We work very closely with the South Carolina Employment Security Commission and their local Job Service offices to recruit and test applicants. Through the interviewing process, the company selects all applicants for training.

Trainees
Trainees attend any pre-employment training classes on their own time without pay. The project staff also monitors on the job training and all trainees are expected to meet the established goals of the training even though they are on the company payroll. Successful completion of a pre employment training program carries no obligation on the part of the trainee to accept any offer of employment nor does the company guarantee an offer.

Curricula
Training content is determined and materials are designed in coordination with your company to teach the specialized skills demanded by your process. The Center for Accelerated Technology Training has curriculum development staff as well as a Media Production Unit and a training library that provide a host of materials and resources.

Training Site
The Center for Accelerated Technology Training commits to provide a suitable training site if one is not available at the company facility. Often training is conducted at the local Technical College in the area or a site provided by the community. The training facility will be upfitted as necessary by the Center's Support Unit.

Instructors
The Center for Accelerated Technology Training will secure and train qualified instructors for both pre-employment and on the job training. Sources for these instructors are your company, your vendors, local technical college personnel, local industry personnel and others as appropriate.

York Technical College

In York County, York Technical College offers CATT programs and a comprehensive Continuing Education program where citizens can continually upgrade their skills. In October, 2004, York Technical College's Institute for Manufacturing Productivity was awarded the Community Economic Development Best Practice Award at the annual Community College Leadership Congress of the Association of Community College Trustees held in New Orleans.

For more information contact:

Larry Lindsey, Area Director
452 S. Anderson Road
Rock Hill, SC 29730-3395
Phone: 803-327-8054
www.sctechsystem.com

Many companies that can locate anywhere in the world chose York County as the best of all worlds. Why? Commitment to promoting business growth and expansion, low start up costs, availability of skilled labor, and excellent return on investment.

Major Private Employers

Employment	Company	City	Product
1500	Wells Fargo Home Mortgage	Fort Mill	Home Mortgage
1150	Bowater Coated and Specialty Papers Division	Catawba	Coated & uncoated paper
1071	Duke Power-Catawba Nuclear Station	York	Nuclear Power
852	Ross Distribution	Fort Mill	Distribution
800	Stacy's	York	Plants
780	U. S. Foodservice, Inc.	Fort Mill	Distribute food
673	Leiner Health Products	Fort Mill	Vitamins and nutritional supplements
570	INA Bearing Company, Inc.	Fort Mill	Needle & roller bearings
517	Muzak	Fort Mill	Audio Architecture
500	Black & Decker	Fort Mill	Distribution
490	Tyco Electronics	Rock Hill	Computer Connectors
405	Springs Industries, Inc. - Executive Office	Fort Mill	Corporate headquarters
360	Champion Laboratories, Inc.	York	Auto oil filters
350	ArvinMeritor	York	On-highway brakes, components & axles
350	United American Video Corporation	Fort Mill	Manufacture video tapes
315	Northern Tool and Equipment, Inc.	Fort Mill	Distribution of tools
310	American Eagle Wheel Corp.	York	Aluminum Wheels
300	Pharr-Yarns-Clover Division	Clover	Carpet yarn
285	West Marine	Rock Hill	Boating Supplies

Updated 4th Quarter 2004

Fortune 500 Firms

The Charlotte Region is home to two of the Fortune 20: Bank of America and Duke Energy. Six additional Fortune 500 firms are headquartered and over 300 Fortune 500 companies have a presence in the region.

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Tax & Business Incentives Overview

York County & South Carolina

South Carolina's philosophy is to offer a fair, stable and reasonable tax structure that allows businesses to grow and prosper. Conservative fiscal management and taxation policies create a climate that encourages growth while maintaining a balanced budget. York County and South Carolina have various incentive programs that add to the positive business climate. These incentives are designed mainly to limit tax liability in the most significant state and local applications such as corporate and personal income tax, sales tax and local property tax.

- In South Carolina, only local government levies property taxes.
- There is no tax, state or local, on inventories or intangibles in South Carolina.
- ***York County has the ability to negotiate local property taxes from a 10.5% down to a 6% assessment or a 43% reduction.***

Corporate & Personal Income Tax

Corporate Income Tax

South Carolina has the lowest corporate income tax rate in the Southeast and one of the lowest in the nation. South Carolina income tax is imposed upon South Carolina taxable income of domestic and foreign corporations. South Carolina collects at a 5% corporate income tax rate.

- Partnerships are not subject to South Carolina corporate income taxes.
- Corporate Income Tax Exemptions - insurance companies, certain non-profit corporations organized for the purpose of providing water supply and/or sewage disposal, banks, building and loan associations and certain electric cooperatives
- "S" corporations are exempt to the extent it is exempt from federal corporate income tax.

South Carolina Jobs Tax Credits - Corporate Income Tax application

Corporate Income Tax levied in South Carolina is 5% and is based on a tripartite formula of sales, payroll and asset with sales in SC double-weighted. Compared to North Carolina's 7% corporate income tax rate, there is an immediate savings when compared to SC. In addition, SC allows qualified and eligible companies a Jobs Tax Credit in the amount of $2,500 per job in York County and $3,500 per job in a Multi-County Industrial Park. The minimum number of jobs created is 10 net new jobs in one year. The credit is per job, per year for five years and is applied towards the corporate income tax in SC and cannot equal more than 50% of any one year's liability although there is a 15 year carry forward for unused credits.

Enterprise Program (Jobs Development Credits) - Personal Income Tax application

Personal income is tiered in SC based on earned income however most employees at the $30,000 annual salary range would be subject to a 7% assessment. For qualified companies, upon successful application and approval, the SC Coordinating Council for Economic Development establishes a Revitalization Agreement for Jobs Development Credits. This program allows eligible companies to retain a portion of the personal withholding amount between 2 to 5 percent of wages to the employees and use these accrued funds for fixed capital investments, e.g. land and building, leasehold improvements, expansions and other non-personal investment. Machinery and equipment (FF&E) purchases are specifically excluded from eligible

expenditures. The program allows an eligible company to accrue JDC's for a period of 10 years and also is qualified based on the development status of the particular county.

Corporate Headquarters Credits
A corporation establishing a corporate headquarters in South Carolina, or adding to an existing corporate headquarters, is entitled to a credit against corporate income and license taxes.

The credit is equal to 20% of the (a) qualifying real property costs incurred in the design, preparation and development of either establishing or expanding a corporate headquarters, and (b) direct construction or direct lease costs for the first five years of operations for the headquarters. In order to quality for the credit, the headquarters or expansion must result in the creation of forty (40) new headquarters function jobs or research and development related functions and services, twenty (20) of which are executive, administrative or professional jobs. The qualifying real property costs involved must be at least $50,000.

Local Property Tax

Real and personal property used in business are subject to property tax levied by local governments. Although property tax is collected locally, the South Carolina Department of Revenue (DOR) generally oversees property tax collections to ensure equitable and uniform assessment throughout the state. The Department of Revenue appraises manufacturing and distribution facilities. There is no state or local tax on intangibles or inventories.

The calculation of property taxes involves the following three elements:

1. **Valuation**

2. **Assessment Ratio**: The assessment ratio, established in the State Constitution to ensure stability, is 10.5% for manufacturing property (in the absence of a fee-in-lieu agreement) and 6% for commercial real property. Commercial personal property is assessed at 10.5%. The valuation is multiplies by this ratio to produce the "assessed value" of a particular piece of property. Taxes are levied based upon this assessed value.

3. **Millage**: Each taxing jurisdiction determines on an annual basis the number of mills required to apply to the total assessed value of property subject to taxation within its jurisdiction in order to raise the money it needs to operate for the next year. (Each jurisdiction also takes other sources of revenue into account in making this determination.) The 2004 average York County millage rate is 260 mills.

4. **Exemptions:** Inventories and intangible property are exempt from property taxation.

Incentive programs for local property tax reduce property tax liability by property tax abatement *or* Fee-in-lieu of property taxes.

Tax Abatement

Any manufacturing company that invests in land, building, and machinery and equipment, with a sum of $50,000 or greater, is eligible to abate the county operating tax for York County, currently at 57.9 mills. A distribution company may be eligible for abatement if the project creates 75 or more new jobs. The abatement stands for five (5) years and does not affect the depredation value of the property. The abatement must be filed, in the same tax year as the purchase was made, to the Department of Revenue.

Fee-in-Lieu of Taxes

For eligible and qualified companies, York County is potentially able to provide as much as a 43% property tax reduction for a 20-year period through the Fee-in-Lieu of Taxes program. Assuming a minimum net-taxable investment of $10 million, York County may be willing to reduce applicable real and personal tax assessment rates from 10.5%(for manufacturing) to 6% for a twenty year period. Another benefit to this program is the elimination of any annual property tax increases since rates would be locked for five year increments during the 20-year agreement.

Sales & Use Tax

Sales Tax - Manufacturer's Exemption

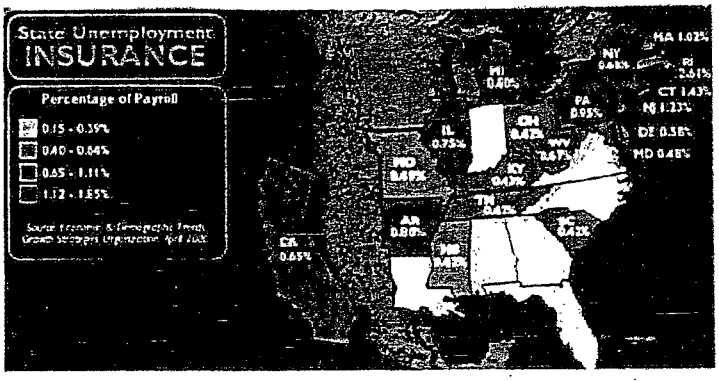
South Carolina imposes a sales and use tax of 5%, the proceeds of which are used exclusively to fund the public school system. The sales tax applies to all retail sale, lease and rental of tangible personal property. SC exempts any applicable sales tax for purchases that are an integral part of the manufacturing process including raw materials, machinery and equipment for manufacturing, electricity used for manufacturing, packaging materials and other products as allowed by law. York County has leveraged a 1% additional tax, recently renewed by county voters, to improve roads throughout the county. York County's sales tax rate is 6%.

Unemployment & Workers Compensation

Unemployment Taxes

Firms employing one or more persons for 20 weeks in a calendar year or having a payroll of $1.500 in a given quarter are required to pay contributions into the trust fund based on the first $7.000 paid by the employer.

The rate is 2.64 % for a period of 12 months until a company is eligible for an experience rate. The South Carolina Employment Security Commission computes a new rate based on the experience of the employer. Contributions are computed and returned quarterly. Under the experience rating, an employer may have a contribution rate ranging from a maximum of 5.40 % to a minimum of .54 %.



This is based on three factors:

- most recent taxable annual payroll
- contributions made to the trust fund
- and benefits charged against his account for unemployment insurance paid to former or current employees.
- *The average experience rate is 1.4 %.*

For additional information, visit the South Carolina Employment Security Commission Web site at www.sces.org.

Workers Compensation

A firm with four or more employees is subject to the provisions of the Workmen's Compensation Law that is administered by the South Carolina Industrial Commission. A recent mandate reduced the tax on workers' compensation insurance premiums and self-insurer expenses from 4.5 percent to 3.5 percent to 2.5 percent. Even before these changes, South Carolina had the tenth lowest average workers' compensation in the nation and the third lowest in the Southeast.

Workers Compensation	
Average Cost for All Manufacturing per $100 Payroll	$2.83
Maximum Weekly Benefit (1999)	$483.47
Days of Waiting Period	7

Workers' Compensation Comparative Costs, 2000

Rank	State	Amount
1	Florida	1.72
2	California	1.564
9	Alabama	1.299
9	New York	1.299
16	Georgia	1.069
19	Tennessee	1.003

Rank	State	Amount
20	New Jersey	0.997
24	Kentucky	0.925
25	Pennsylvania	0.894
38	North Carolina	0.713
39	South Carolina	0.692
	U.S. average	**1.0**

Source: South Carolina Employment Security Commission, Actuarial & Technical Solutions Inc. Wadley-Donovan Group, Ltd

Cultural Amenities

While access to Charlotte is immediate, the advantage of York County's location is distinct. York County is home to two of the best attractions in South Carolina – Paramount's Carowinds theme park and Historic Brattonsville. Several Brattonsville locations were used as sets for the filming of the major motion picture *The Patriot* starring Mel Gibson.

The region's cultural lineup also includes nationally recognized museums, symphony, opera, theater and dance companies. The Blumenthal Performing Arts Center is home to the Charlotte Symphony Orchestra, Opera Carolina, Charlotte Repertory Theatre, Charlotte Choral Society, Charlotte Oratorio Singers, and the NC Dance Theater.

The Discovery Place, a "hands-on" science museum, contains an OMNIMAX theatre and the Kelly Space Voyager Planetarium. The Mint Museum of Art hosts internationally renowned artists. The Museum of York County also provides art, history & natural history exhibits.

Recreational Opportunities

With a mild year-round climate, recreation opportunities abound. Outdoor activities include boating, hiking and playing on some of the nation's most outstanding golf courses. Lake Wylie and the Catawba River provide ample opportunity for water sports in York County. The Anne Close Springs Greenway offers 26 miles of hiking, horseback and bicycle trials weaving through over 2,000 acres in Fort Mill. A short drive to the Blue Ridge Mountains or the famed Carolina beaches. York County also offers easy access to a variety of destinations.

With teams in the NFL, IHL and triple-A baseball as well as the reputation as a major NASCAR headquarters, the region continues to be recognized as a national sports market. York County is home to the Knights Stadium, Charlotte's triple-A affiliate to the Chicago White Sox.

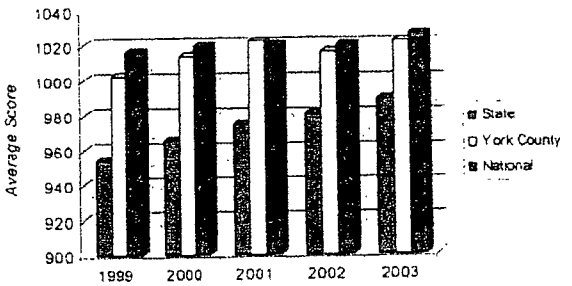
Lifestyles

York County's location provides a wide range of housing options from lakeside living to rural settings. Plentiful shopping, dining, entertainment, medical service options make York County an ideal location. From home cooking to trendy, restaurants offer foods from all over. Shopping opportunities include the nation-wide retailers and upscale boutiques. York County also has a wide range of medical services available, with specialists in most branches.

York County Schools

At the start of the 21st Century, the challenges of global economic competition create an ever growing emphasis on the improvement of our educational system. And in South Carolina, this issue takes center stage. We are one of the five states leading the nation in systematic reform of education. The York County public school system ranks among the top districts within the state, with average SAT scores of 1022 (for 2003) compared with the national average of 1026 and a state average of 989. York County schools consist of four school districts and seven private schools.

SAT Score Trends



Public Schools

	District #1 York	District # 2 Clover	District #3 Rock Hill	District #4 Fort Mill
Superintendent	Dr Katie Brochu	Bill R. Jenkins	Dr. Randy Bridges	TEC Dowling
Phone	803-684-9916	803-222-7191	803-981-1000	803-548-2527
Number of Schools	7	8	21	8
Elementary/Middle/High	4/2/1	6/1/1	15/4/2	5/2/1
Total Enrollment	**4,979**	**4,811**	**15,272**	**5,857**

Private Schools

School	Grades offered	Enroll-ment	City	Denomination	Phone
Ann Barron Child Dev Ctr	K	10	Rock Hill	Presbyterian	803-327-9549
Blessed Hope Baptist	K-12	183	York	Baptist	803-689-9819
Catawba Baptist Child Dev Ctr	K	15	Rock Hill	Baptist	803-324-1194
L. Springs Recreation Complex	K	15	Fort Mill	N/A	803-547-1035
Saint Anne School	K-8	333	Rock Hill	Catholic	803-324-4814
Trinity Christian School	K-12	373	Rock Hill	Nondenominational	803-366-3121
Westminster/Catawba School	K-12	761	Rock Hill	Presbyterian	803-366-1810

Comparative SAT Scores

District	District #1 York	District # 2 Clover	District #3 Rock Hill	District #4 Fort Mill	County Totals/ Avg	South Carolina Avg
Total # of Seniors	298	268	820	327	1,713	38,698
# Taking SAT 2002	112	121	460	214	907	22,521
# Taking SAT 2003	119	132	447	249	947	22,831
% Tested 2003	40	49	55	76	55	59
Total Score 2002	970	1009	1019	1066	1016	981
Total Score 2003	994	1010	1025	1059	1022	989
Avg Verbal Score	489	490	507	522	502	493
Avg Math Score	505	520	518	537	520	496

Sources: York County Schools, South Carolina State Department of Education

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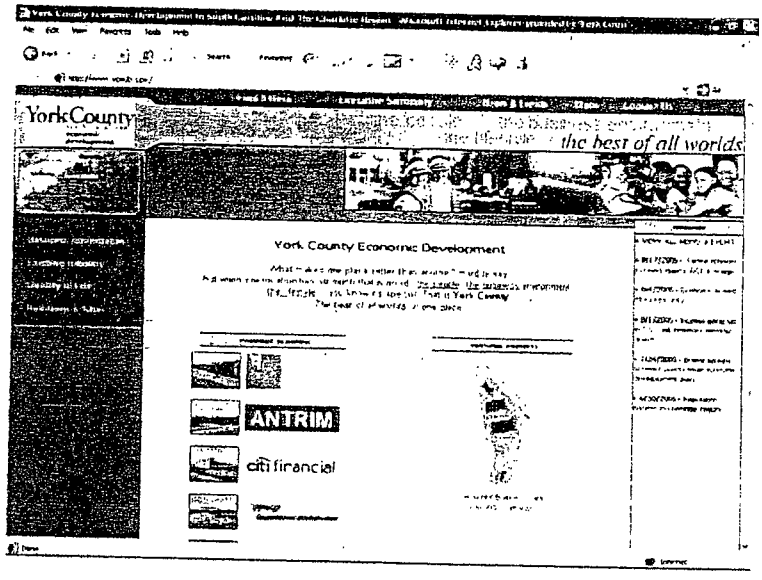
Contact

Services offered by the York County Economic Development Board

The York County Economic Development Board provides a variety of information and free services designed to help businesses locate or expand commercial operations in York County. We assist companies with almost every facet of capital investment and job creation including traditional economic development arenas such as site or building selection and development, but also assistance with financing, labor resources, jobs training, permitting and other aspects of a company's location or expansion decision. Our goal is to be the point of contact for York County in not only the initial stages of a project, but also provide assistance years later in the efforts to grow and expand business.

Our Web Site

Check our Web site for additional information on York County, SC.

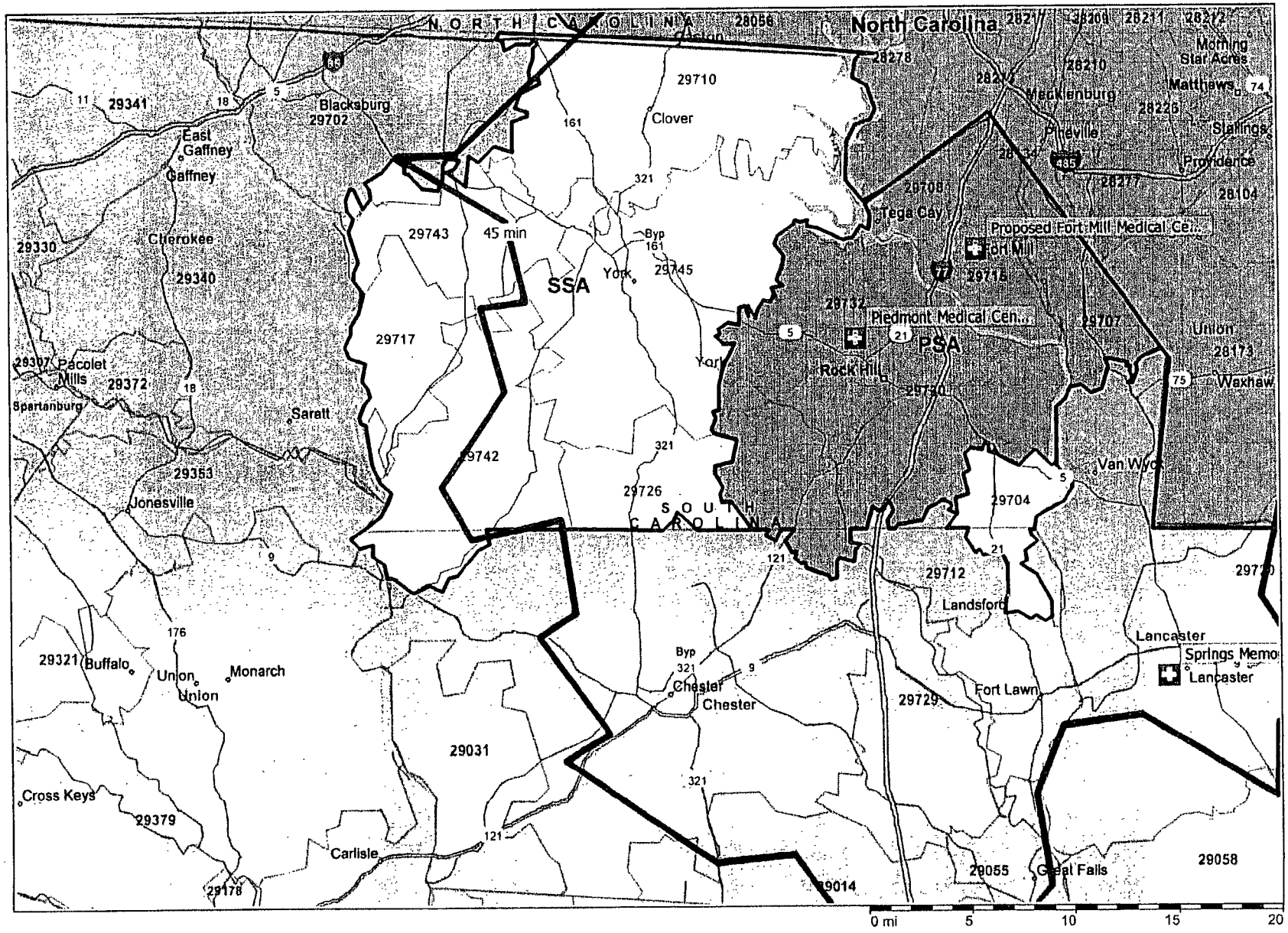


York County Economic Development Board
1830 Second Baxter Crossing
Fort Mill, SC 29708
Phone: (803) 802-4300
Fax: (803) 802-4299
www.yceedb.com

Mark Farris, Director
Teresa Curtice, Existing Industry Coordinator
Barbara Mayes, Economic Development Assistant
Kevin Thomas, Marketing Specialist

ATTACHMENT I

45-MINUTE DRIVE TIME CONTOUR MAP AND SERVICE AREA MAP
(REVISED)



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ATTACHMENT J

EVIDENCE OF FINANCING

September 28, 2010

Ms. Beverly Brandt
Director, Bureau of Health Facilities and Services Development
Division of Planning and Certification of Need
Department of Health and Environmental Control
1777 St. Julian Place, Suite 201
Columbia, SC 29204

Re: Certificate of Need Application by Amisub of South Carolina, Inc. – 100 Bed Hospital – Fort Mill, SC

Dear Ms. Brandt:

This letter certifies that Tenet Healthcare Corporation, the parent corporation of Amisub of South Carolina Inc., makes the commitment to provide the necessary funding for the development of this project, which is estimated at approximately $147 million.

Tenet Healthcare Corporation intends to finance the 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. As of June 30, 2010, Tenet Healthcare Corporation had $711 million in cash and cash equivalents.

In addition to its capital expenditure commitment, Tenet Healthcare Corporation also hereby commits to provide funding for working capital as necessary for the project.

Sincerely,

John Holland
Senior Vice President, Operations
Tenet Healthcare Corporation

Tenet Healthcare Corporation • Headquarters Office
1445 Ross Ave, Suite 1400 • Dallas, TX 75202 • Tel 469.893.2000 • Fax 469.893.8600 • www.tenethealth.com

ATTACHMENT K

FINANCIAL PROJECTIONS AND ASSUMPTIONS (REVISED)

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		43%	53%	62%	64%	66%
Admissions		4,449	5,404	6,317	6,499	6,686
Adjusted Admissions		8,089	9,960	11,801	12,303	12,825
Inpatient Days		15,857	19,343	22,652	23,304	23,976
Adjusted Patient Days		28,830	35,651	42,316	44,118	45,987
ADC		43.4	53.0	62.1	63.8	65.7
Adjusted ADC		79.0	97.7	115.9	120.9	126.0
ALOS		3.6	3.6	3.6	3.6	3.6
FTEs Worked		275	337	398	411	418
FTEs Paid		317	389	459	473	482
Gross Patient Revenues						
Inpatient Revenue		$86,290,890	$109,471,506	$133,326,707	$142,653,177	$152,632,052
Outpatient Revenue		$70,594,577	$92,295,427	$115,740,914	$127,403,552	$140,131,487
Total Gross Patient Revenue		$156,885,467	$201,766,932	$249,067,621	$270,056,729	$292,763,538
Deductions from Revenue						
Indigent/Charity		$4,706,564	$6,053,008	$7,472,029	$8,101,702	$8,782,906
Other		$77,146,996	$102,121,759	$129,265,608	$143,320,928	$158,710,474
Total Deductions		$81,853,560	$108,174,767	$136,737,637	$151,422,630	$167,493,380
Other Revenue		$227,444	$236,542	$246,004	$255,844	$266,077
Net Revenue		$75,259,351	$93,828,707	$112,575,988	$118,889,942	$125,536,235
Operating Expenses						
Salaries, Wages, and Benefits		$26,087,909	$32,955,152	$40,066,970	$42,547,274	$44,653,843
Supplies		$10,650,668	$13,177,124	$15,746,292	$16,696,798	$17,703,737
Med & Clinical Fees		$1,479,760	$1,812,919	$2,151,716	$2,278,149	$2,412,022
Other Prof Fees		$1,654,512	$1,787,430	$1,922,668	$1,988,547	$2,057,359
Other Fees & Services		$6,132,614	$6,921,302	$7,723,513	$8,060,966	$8,415,942
Utilities and Phones		$865,407	$917,222	$959,186	$992,052	$1,026,381
Repairs/Maint/Equip Rent		$2,080,369	$2,297,707	$2,518,798	$2,617,453	$2,720,924
Other Ctrl Expenses		$2,038,419	$2,251,375	$2,468,007	$2,564,673	$2,666,058
Prov for Bad Debt		$7,173,050	$9,003,566	$10,873,542	$11,554,961	$12,276,475
Total Controllable Expenses		$58,162,708	$71,123,796	$84,430,693	$89,300,875	$93,932,740
Non-Controllable Expenses		$8,135,551	$9,395,617	$9,698,107	$9,915,110	$10,137,591
Total Expenses	$2,173,992	$66,298,259	$80,519,413	$94,128,799	$99,215,984	$104,070,330
EBITDA	**($2,173,992)**	$8,961,092	$13,309,295	$18,447,188	$19,673,958	$21,465,905
Depreciation and Amortization		$7,358,824	$7,458,824	$7,558,824	$7,858,824	$8,108,824
EBIT	**($2,173,992)**	$1,602,268	$5,850,471	$10,888,365	$11,815,134	$13,357,081
Interest Expense		$10,391,282	$9,982,514	$9,546,174	$9,073,617	$8,561,839
Pretax Income	**($2,173,992)**	($8,789,013)	($4,132,043)	$1,342,191	$2,741,517	$4,795,242
Income Taxes at 38.25%	($831,552)	($3,361,798)	($1,580,507)	$513,388	$1,048,630	$1,834,180
Net Income	**($1,342,440)**	($5,427,215)	($2,551,536)	$828,803	$1,692,887	$2,961,062

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 percent 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. OB and General Acute services were weighted accordingly. Gross Revenues were inflated by 4 percent per year based on current trends for medical care services.

An assumption for charity care represents 3 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	$156,885,467	$201,766,932	$249,067,621	$270,056,729	$292,763,538
Charity/Indigent	$4,706,564	$6,053,008	$7,472,029	$8,101,702	$8,782,906
% 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 percent per year.

Supplies

Supplies were based on Piedmont Medical Center's actual experience volume adjusted, with 5 percent of supplies assumed to be fixed and 95 percent variable. Inflation was assumed at 2 percent per year.

Bad Debt

Bad debt was assumed at 9.5 percent 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 percent 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 3 million dollars. Of the remaining NCE, 60 percent was assumed to be fixed and 40 percent variable. Inflation was assumed at 2 percent per year.

Taxes
An effective tax rate of 38.25 percent was assumed.

Cost of Capital
A cost of capital expense was imputed for the project based on an interest rate of 8 percent payable over 15 years.

Piedmont Medical Center
Income Statement

	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	104,349	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	$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

Piedmont Medical Center
Financial Forecast Assumptions

Summary
In general, financial assumptions were gathered from 2004 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.

ATTACHMENT L

PIEDMONT MEDICAL CENTER MEDICAL STAFF ROSTER (REVISED)

Piedmont Medical Center		Medical Staff					
Name	Title	Practice	Address	Phone	Fax	Category	Specialty
Abrams, Mark J.	MD	Charlotte Eye, Ear, Nose & Throat	200 S. Herlong Ave., Ste. A, Rock Hill, SC 29732	328-1864	328-1865	Active	Otolarynology
Adams, Robert J.	MD	Piedmont Medical Center Stroke Program	222 S Herlong Ave, Rock Hill, SC 29732	329-1234		Consulting	Telemedicine
Adamson, Tim E.	MD	Carolina Neurosurgery & Spine	225 Baldwin Avenue, Charlotte, NC 28204	704-373-0212	704-335-8448	Courtesy	Neurosurgery
Adelman, Dean B.	DO	Fort Mill Family Practice	1690 Hwy 160 West, Fort Mill, SC 29715	547-7541	548-0122	Courtesy	FP
Adeola, Tolulola	MD	Schumacher Group Hospital Medicine Division	222 S Herlong Avenue, Rock Hill, SC 29732	909-5937	323-2856	Active	IM
Adlakha, Arun	MD	Carolina Pulmonary Physicians	124 Glenwood Drive, Rock Hill, SC 29732	324-5280	328-0270	Active	Pulmonary Medicine
Afulukwe, Ifediora	MD	Heath Springs Medical Center	209 S College Street, Heath Springs, SC 29058	803/273-4018	803-273-4023	Courtesy	IM
Agor, Longinus	MD	Schumacher Hospitalist	222 South Herlong Avenue, Rock Hill, SC 29732	803-909-5937	803-323-2856	Active	IM
Alleyne,II, William F.	MD	Carolina Pulmonary Physicians	124 Glenwood Drive , Rock Hill, SC 29732	324-5280	328-0270	Active	Pulmonary Medicine
Allinger, James A.	MD	Anesthesia Associates	222 S. Herlong Avenue,Rock Hill, SC 29732	329-6711	329-5120	Active	Anesthesia
Aluko, Gbenga	MD	Schumacher Group Hospital Medicine Division	222 S Herlong Avenue, Rock Hill, SC 29732	909-5937	323-2856	Active	IM
Amato, Victor M.	MD	Catawba Gastroenterology	1380 Ebenezer Road, Rock Hill, SC 29732	366-7550	366-7595	Active	GI
Amin, Vimalkumar P.	MD	Catawba Gastroenterology	1380 Ebenezer Road, Rock Hill, SC 29732	366-7550	366-7595	Active	GI
Anderson, Bryan	MD	Rock Hill Eye Clinic	1565 Ebenezer Road, Rock Hill, SC 29732	328-0168	325-8473	Active	Ophthalmology
Anderson, Chris A.	MD	Apollo MD	222 S Herlong Avenue, Rock Hill, SC 29732	329-6849		Active	EM
Antezana, James N.	MD	Weston Med/Surg Center	2131 Ayrsley Town Blvd,Ste 400, Charlotte, NC 28273	980-297-7400	980-297-7744	Courtesy	Vascular Surgery
Asher, Anthony L.	MD	Carolina Neurosurgery & Spine	225 Baldwin Avenue, Charlotte, NC 28204	704-373-0212	704-335-8448	Courtesy	Neurosurgery
Aya-ay, Jerome	MD	Piedmont West	1190 Filbert Hwy, York, SC 29745	628-0004	682-6004	Courtesy	FP
Ayodele, Ayotunde	MD	York Pediatrics	1538 Healthcare Drive, Rock Hill, SC 29732	980-6610	980-6162	Active	Pediatrics
Badalyan, Rupal	MD	North Central Family Medical	1131 Saluda Street, Rock Hill, SC 29731	325-7744	325-1117	Active	FP
Bailey, Luna	MD	Ear, Nose, Throat & Audiology Assoc	744 Arden Lane, Ste 200, Rock Hill, SC 29732	328-3686	328-9889	Active	Otolarynology
Baker, Robert W.	MD	Anesthesia Associates	222 S. Herlong Avenue,Rock Hill, SC 29732	329-6711	329-5120	Active	Anesthesia
Baki, Talal T.	MD	Carolina Cardiology Associates	196 Cardiology Dr., Rock Hill, SC 29732	324-5135	324-8161	Active	Cardiology
Bale, C. Stephen	MD	Piedmont GYN/OB	200 S. Herlong Avenue, Ste. F, Rock Hill, SC 29732	324-7606	324-3908	Courtesy	OB/GYN
Barr, Stephen J.	DO	Apollo MD	222 S Herlong Avenue, Rock Hill, SC 29732	329-6849		Active	EM
Barrett, Rhonda V.	MD	Rock Hill Eye Clinic	1565 Ebenezer Road, Rock Hill, SC 29732	328-0168	325-8473	Active	Ophthalmology
Baxter, Felicia	MD	Pediatric Hospitalist	222 South Herlong Avenue; Rock Hill, SC 29732	323-2963		Active	Pediatrics
Bedrick, James	MD	Mecklenburg Eye Associates	2015 Randolph Road, Ste 108, Charlotte, NC 28207	704-334-2020	704-334-6073	Courtesy	Ophthalmology
Bellanfonte, Lisa	MD	Medical Associates of Fort Mill	1698 Highway 160 Ste 140, Fort Mill, SC 29708	802-5181	802-5114	Courtesy	IM
Bensky, Andrew S.	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd , Ste. 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Consulting	Pediatric Cardiology
Benson, Christopher A.	MD	Rock Hill GYN/OB	1721-05 Ebenezer Rd., Ste 145, Rock Hill, SC 29732	328-2401	328-1030	Active	OB/GYN
Bergman, James L.	MD	Fort Mill Family Practice	1690 Hwy 160 West, Fort Mill, SC 29715	547-7541	548-0122	Courtesy	FP
Bernard,Jr, Joe	MD	Carolina Neurosurgery & Spine	225 Baldwin Avenue, Charlotte, NC 28204	704-373-0212	704-335-8448	Courtesy	Neurosurgery
Bhaskaran, Dharmendra	MD	Internal Medicine Group	225 S Herlong Ave, Ste 230, Rock Hill, SC 29732	366-3900	366-1213	Active	IM
Bhoothapuri, Ramesh	MD	Nephrology Associates	1436 Riverchase Blvd, Rock Hill, SC 29732	329-2636	329-2184	Active	Nephrology
Billman, Mark A.	DMD, MD	The Center for Oral & Maxillofacial Surgery	372 S.Herlong Ave., Rock Hill, SC 29732	324-1160	324-2456	Active	Oral Surgery
Binder, Christian	MD	Virtual Radiologic Professionals	11995 Singletree Lane, Ste 500, Eden Prairie, MN 55344	952-595-1299	952-935-2757	Consulting	Telemedicine
Bixenman, William	MD	Nephrology Associates	1436 Riverchase Blvd, Rock Hill, SC 29732	329-2636	329-2184	Active	Nephrology
Black, Kristin	MD	New Day Family Health Services	820 W. Meeting Street, Lancaster, SC 29720	704/853-5079	704-853-5269	Courtesy	FP
Blackwell, Derrick	DO	Piedmont Family Practice at Tega Cay	773 Stockbridge Drive, Fort Mill, SC 29708	547-5447	802-9138	Active	FP
Blotnick, Charles A.	MD	Mecklenburg Eye Associates	2015 Randolph Road., Ste. 108 Charlotte, NC 28207	704/334-2020	704-334-6073	Courtesy	Ophthalmology

Boden, Thomas M.	MD	Virtual Radiologic Professionals, LLC	11995 Singletree Lane, Ste 500, Eden Prairie, MN 55344	952-595-1299	952-935-2757	Consulting	Telemedicine
Borhanian, Kamran	MD	Palmetto Surgery	1578-01 Constitution Blvd., Rock Hill, SC 29732	324-5858	324-5585	Active	General Surgery
Bott, Stephen J.	MD	Digestive Disease Associates	170 Amendment Avenue, Rock Hill, SC 29732	324-7607	324-4097	Active	GI
Bragdon,Jr., William H	MD	(Psychiatry)	222 S Herlong Avenue, Rock Hill, SC 29732	329-6861		Courtesy	Psychiatry
Browning, Jared C.	MD	Virtual Radiologic Professionals, LLC	11995 Singletree Lane, Ste 500, Eden Prairie, MN 55344	952-595-1299	952-935-2757	Consulting	Telemedicine
Bulczack, Darius	MD	Virtual Radiologic Professionals, LLC	11995 Singletree Lane, Ste 500, Eden Prairie, MN 55344	952-595-1299	952-935-2757	Consulting	Telemedicine
Bullard, Graham W.	MD	Southeast Pain Care	POB 36351, Charlotte, NC 28236	704-377-5772	704-377-3389	Courtesy	Pain Management
Burack, David	MD	Carolina Center for Rheumatology	744 Arden Lane, Ste 225, Rock Hill, SC 29732	329-1660	329-4118	Consulting	Rheumatology
Burri, Stuart H.	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704-333-7376	704-333-7386	Consulting	Radiation Oncology
Butler, Jerome M.	MD	Southeast Radiation Oncology	200 Queens Road, Suite 400; Charlotte, NC 28204	366-5186	704-333-7386	Consulting	Radiation Oncology
Campbell, Margaret F.	MD	Schumacher Group Hospital Medicine Division	222 S Herlong Avenue, Rock Hill, SC 29732	909-5937	323-2856	Active	IM
Carlisle, Joseph E.	DMD	The Center for Oral & Maxillofacial Surgery	372 S.Herlong Ave., Rock Hill, SC 29732	324-1160	324-2456	Courtesy	Oral Surgery
Carter, Rhonda G.	DDS	The Center for Oral & Maxillofacial Surgery	372 S.Herlong Ave., Rock Hill, SC 29732	324-1160	324-2456	Active	Oral Surgery
Cedarholm, John C.	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Courtesy	Cardiology
Chalela, Julio	MD	Piedmont Medical Center Stroke Program	222 S Herlong Ave, Rock Hill, SC 29732	329-1234		Consulting	Telemedicine
Chang, John K.	MD	Virtual Radiologic Professionals, LLC	11995 Singletree Lane, Ste 500, Eden Prairie, MN 55344	952-595-1299	952-935-2757	Consulting	Telemedicine
Charles, Craig J.	MD	Piedmont Infectious Diseases	222 S. Herlong Avenue, Rock Hill, SC 29732	367-0527 - Beeper	325-2984	Active	Infectious Diseases
Chen, Tammy T.	MD	Piedmont Behavioral Medicine Associates	200 S Herlong Avenue, Rock Hill, SC 2973	323-2775	323-2776	Active	Psychiatry
Chimowitz, Marc	MD	Piedmont Medical Center Stroke Program	222 S Herlong Ave, Rock Hill, SC 29732	329-1234		Consulting	Telemedicine
Choudhury, Anju	MD	Cornerstone Clinic	1462 Constitution Blvd., Rock Hill, SC 29732	909-4040	909-4044	Courtesy	IM
Ciminelli, Mark A.	MD	Carolina Heart Specialists	370 S Herlong Ave, Ste 200, Rock Hill, SC 29732	366-8300	327-4805	Active	Cardiology
Clark, Tameta R.	MD	Southeast Pain Care	POB 36351, Charlotte, NC 28236	704-377-5772	704-377-3389	Courtesy	Pain Management
Cobb, Mariel, L.	MD	Virtual Radiologic Professionals, LLC	11995 Singletree Lane, Ste 500, Eden Prairie, MN 55344	952-595-1299	952-935-2757	Consulting	Telemedicine
Collins, Susan	DMD	Collins and Batson Dental	1251 Ebenezer Road, Rock Hill, SC 29732	324-3277		Courtesy	Dentistry
Coric, Domagoj	MD	Carolina Neurosurgery & Spine	225 Baldwin Avenue, Charlotte, NC 28204	704-373-0212	704-335-8448	Courtesy	Neurosurgery
Cowan, David E.	MD		1 Medical Pk Dr., Bldg #1, Chester, SC 29706	385-3516	803-581-5472	Active Emertius	Urology
Cowan, Michael A.	MD	Carolina Neurosurgery & Spine	175 Amendment Avenue Ste 104, Rock Hill, SC 29732	325-1618	980-8418	Active	Neurosurgery
Cox, J. Thomas	MD	Pediatrix Medical Group	222 S. Herlong Avenue, Rock Hill, SC 29732	909-2041	909-2138	Courtesy	Neonatology
Cox, Jeffrey N.	MD	Carolina Sleep Medicine	175 Amendment Ave., Ste. 103, Rock Hill, SC 29732	366-1255	366-1316	Consulting	Sleep
Crabtree, Christopher	DPM	Alpine Podiatry	430 S. Herlong Avenue, Rock Hill, SC 29732	327-2217	327-2272	Active	Podiatry
Crain, Corey K.	MD	Surgical Specalists of the Carolinas	1721-07 Ebenezer Road, Ste. 175, Rock Hill, SC 29732	324-5256	328-0440	Active	General Surgery
Crawford, Charles H.	DMD		1236 Ebenezer Rd., Rock Hill, SC 29732	324-7540	324-4128	Active	Pediatric Dentistry
Crawford, Chris	MD	Carolina Plastic Surgery & Laser Center	1721 Ebenezer Rd., Ste. 205, Rock Hill, SC 29732	328-1919	328-1818	Active	Plastic Surgery
Creagh, Jr., Charles	MD	Carolina Pulmonary Physicians	124 Glenwood Drive, Rock Hill, SC 29732	324-5280	328-0270	Active Emertius	Pulmonary Medicine
Crimaldi, Anthony J.	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Consulting	Radiation Oncology
Crotwell, Henry	MD	Family Medicine Associates	826 E. Liberty St., York, SC 29745	684-3738	684-3808	Courtesy	FP
Culp, Jr., William L.	DMD		1236 Ebenezer Rd.Ste 100, RH, SC 29732	324-2921	324-2491	Courtesy	Dentistry
Das, Sushil	MD	Primary Medical Associates	1787 Ebenezer Road, Rock Hill, SC 29732	324-7777	324-8787	Active	IM
Davidson, Larry S.	MD	Carolina Neurosurgery & Spine	110 Lake Concord Road, NE Concord, NC 28025	704-831-2800	704-792-2674	Courtesy	Neurosurgery
Demchak, Susan	MD	Piedmont GYN/OB	200 S. Herlong Avenue Ste F, Rock Hill, SC 29732	324-7698	324-3908	Courtesy	OB/GYN
Denenberg, Michael B.	MD	Southeast Pulmonary & Critical Care	154 Amendment Ave., Ste. 103, Rock Hill, SC 29732	980-5864	980-5817	Active	Pulmonary Medicine
Deshmukh, Vinay	MD	Carolina Neurosurgery & Spine	225 Baldwin Avenue, Charlotte, NC 28204	704-373-0212	704-335-8448	Courtesy	Neurosurgery
Dickey, III, Hugh B	DMD		1204 Ebenezer Rd., Rock Hill, SC 29732	329-2126	329-0707	Courtesy	Dentistry
DiOrio, Christopher A.	DO	Apollo MD	222 S Herlong Avenue, Rock Hill, SC 29732	329-6849		Active	EM

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Dodge, Terry L.	MD	Chest Anesthesia	1 Medical Pk Dr., Bldg #1, Chester, SC 29706	581-3151		Courtesy	Anesthesiology
Doline, Robert	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Consulting	Radiation Oncology
Douglas, Thomas D.	MD	Carolina Urology Center	1780 Medical Park Dr., Rock Hill, SC 29732	327-1116	327-6872	Active	Urology
Dwivedi, Tarunendu	MD		1721 Ebenezer Road, Ste 265, Rock Hill, SC 29732	329-7778	329-7843	Courtesy	Psychiatry
Dyer, E. Hunter	MD	Carolina Neurosurgery & Spine	225 Baldwin Avenue, Charlotte, NC 28204	704-373-0212	704-335-8448	Courtesy	Neurosurgery
Edgerton, T. Arthur	MD	Catawba Cardiothoracic Surgery	200 S. Herlong Ave., Ste.E-1, Rock Hill, SC 29732	324-1950	324-1933	Active	Cardiovascular Surgery
Edwards, Nathaniel C.	MD	Sanger Heart and Vascular Institute	197 Piedmont Blvd. Suite 111, Rock Hill, SC 29732	327-3456	327-4320	Active	Cardiology
Ekunsanmi, Bamidele	MD	Premier Clinics	1609 Constitution Blvd., Rock Hill, SC 29732	326-3000	326-3003	Active	IM
Eller, Chad R.	MD	Apollo MD	222 South Herlong Avenue, Rock Hill, SC 29732	329-6849		Active	EM
Erb, Brian	MD	Nephrology Associates	1436 Riverchase Blvd, Rock Hill, SC 29732	329-2636	329-2184	Active	Nephrology
Espinal, Alex R.	MD	Palmetto Surgery	1578-01 Constitution Blvd., Rock Hill, SC 29732	324-5858	324-5585	Active	General Surgery
Evans, William M.	MD	Southeast Pain Care	POB 36351 Charlotte, NC 28236	704-377-5772	704-377-3389	Courtesy	Pain Management
Ezeihuaku, Christopher	MD	Schumacher Group Hospital Medicine Division	222 S Herlong Avenue, Rock Hill, SC 29732	909-5937	323-2856	Active	IM
Ezell, Terry H.	MD	Carolina Urology Center	1780 Medical Park Dr., Rock Hill, SC 29732	327-1116	327-6872	Active	Urology
Farr, Arman K.	MD	Retina Institute of the Carolinas	724 Arden Lane Suite 220, Rock Hill, SC 29732	323-2020	323-2024	Active	Ophthalmology
Fassler, John E.	MD	Nephrology Associates	1436 Riverchase Blvd, Rock Hill, SC 29732	329-2636	329-2184	Active	Nephrology
Fedor, John M.	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Courtesy	Cardiology
Finger, III, Frederick E.	MD	Carolina Neurosurgery & Spine	225 Baldwin Avenue, Charlotte, NC 28204	704-373-0212	704-335-8448	Courtesy	Neurosurgery
Fleischer, Thomas	MD	Carolina Orthopedic Surgery	134 Professional Park Dr., Rock Hill, SC 29732	329-3130	329-4533	Active	Orthopedic
Foral, Jonathan M	MD	Virtual Radiologic Professionals, LLC	11995 Singletree Lane, Ste 500, Eden Prairie, MN 55344	952-595-1299	952-935-2757	Consulting	Telemedicine
Forrester, Douglas	MD	Anesthesia Associates	222 S. Herlong Avenue, Rock Hill, SC 29732	329-6711	329-5120	Active	Anesthesia
Frank, Theodore	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Courtesy	Cardiology
Fraser, III, Robert W	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333/7376	704-333-7386	Consulting	Radiation Oncology
Fritz, Jonathan P.	MD	Rock Hill Eye Clinic	1565 Ebenezer Road, Rock Hill, SC 29732	328-0168	325-8473	Active	Ophthalmology
Gamage, Anoma S.	MD	Piedmont East	760 Addison Avenue, Rock Hill, SC 29730	329-1930	329-2549	Courtesy	FP
Gant, Dean A.	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333/7376	704-333-7386	Consulting	Radiation Oncology
Garretson, Bret	MD	Digestive Disease Associates	170 Amendment Avenue, Rock Hill, SC 29732	324-7607	324-4097	Active	GI
Gazzuolo, Debra	MD	Carolina Medical Consultants	311 Glenwood Dr, Rock Hill, SC 29732	366-7175	366-0529	Courtesy	IM
Gilbert, Richard L.	MD	Southeast Pain Care	POB 36351, Charlotte, NC 28236	704-377-5772	704-377-3389	Courtesy	Pain Management
Gilleland, Geoffrey T.	MD	Rock Hill Radiology	218 S. Herlong Avenue, Rock Hill, SC 29732	327-2828	985-4775	Active	Radiology
Gingerich, Troy	MD	Southeast Pain Care	POB 36351 Charlotte, NC 28236	704-377-5772	704-377-3389	Courtesy	Pain Management
Girard, Donna J.	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Consulting	Radiation Oncology
Gor, Asutosh	MD	Carolina Blood & Cancer Care	1583 Health Care Drive., Rock Hill, SC 29732	329-7772	329-9821	Active	Oncology
Goradia, Dhawal	MD	Virtual Radiologic Professionals, LLC	11995 Singletree Lane, Ste 500, Eden Prairie, MN 55344	952-595-1299	952-935-2757	Consulting	Telemedicine
Graham, Lafonda	MD	North Central Family Medical	1131 Saluda Street, Rock Hill, SC 29731	325-7744	325-1117	Active	FP
Green, Donnielle L.	DO	Schumacher Group Hospital Medicine Division	222 S Herlong Avenue, Rock Hill, SC 29732	909-5937	323-2856	Active	IM
Grewal, Sandeep S	MD	Ace Medical Group	744 Arden Lane, Ste 100, Rock Hill, SC 29732	325-2236	325-2234	Active	IM
Gunter, R. Glenn	MD	Rock Hill Family Practice	1435 Ebenezer Road, Rock Hill 29732	328-3828	328-3879	Courtesy	FP
Haake, Michael R.	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704-333-7376	704-333-7386	Consulting	Radiation Oncology
Haber, Robert H.	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Courtesy	Cardiology
Hart, Craig F	MD	York Pathology Associates	222 S Herlong Avenue, Rock Hill, SC 29732	329-6845	327-7598	Active	Pathology
Hart, Darlington I.	MD	Cornerstone Clinic	1462 Constitution Blvd., Rock Hill, SC 29732	909-4040	909-4044	Courtesy	IM
Hayden, Geoffrey E.	MD	Apollo MD	222 S Herlong Avenue, Rock Hill, SC 29732	329-6849		Active	EM
Hayes, Angela N.	MD	Piedmont Medical Center Stroke Program	222 S Herlong Ave, Rock Hill, SC 29732	329-1234		Consulting	Telemedicine

Hayes, Terry F.	MD	Piedmont West	1190 Filbert Hwy, York, SC 29745	628-0004	682-6004	Courtesy	EM
Haynie, Justin F.	MD	Sanger Heart and Vascular Institute	197 Piedmont Blvd. Suite 111, Rock Hill, SC 29732	327-3456	327-4320	Active	Cardiology
Heafner, Michael	MD	Carolina Neurosurgery & Spine	225 Baldwin Avenue, Charlotte, NC 28204	704-373-0212	704-335-8448	Courtesy	Neurosurgery
Heil, Thomas	DO	Southeast Pain Care	POB 36351 Charlotte, NC 28236	704-377-5772	704-377-3389	Courtesy	Pain Management
Heinig, Michael F.	MD	Carolina Orthopedic Surgery	134 Professional Park Dr., Rock Hill, SC 29732	329-3130	329-4533	Active	Orthopedics
Henegar, Martin	MD	Carolina Neurosurgery & Spine	225 Baldwin Avenue, Charlotte, NC 28204	704-373-0212	704-335-8448	Courtesy	Neurosurgery
Herlong, Rene	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Consulting	Pediatric Cardiology
Herndon, Jr., William M.	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Courtesy	Cardiology
Herring, Katrina	MD	Piedmont Family Practice	200 South Herlong Ave, Suite G; Rock Hill, SC 29732	325-1770	325-1790	Courtesy	Family Practice
Hicklin, III, Harry E.	MD	Sanger Heart and Vascular Institute	197 Piedmont Blvd. Suite 111, Rock Hill, SC 29732	327-3456	327-4320	Active	Cardiology
Hicklin, Jonathan C.	MD	Rock Hill Eye Clinic	1565 Ebenezer Road, Rock Hill, SC 29732	328-0168	325-8473	Active	Ophthalmology
Hilton, Ansley L.	MD	Rock Hill GYN/OB	1721-05 Ebenezer Road, Rock Hill, SC 29732	328-2401	328-1030	Active	OB/GYN
Hoitink, John	MD	Carolina Medical Consultants	311 Glenwood Dr., Rock Hill,SC 29732	366-7175	366-0529	Courtesy	IM
Holmstedt, Christine A.	DO	MUSC Stroke Program	19 Hagwood Avenue #501 Charleston, SC 29425			Consulting	Telemedicine
Holman,Jr, David	MD	Family Medicine Associates	826 E. Liberty St., York, SC 29745	684-3738	684-3808	Courtesy	FP
Holtzman, Ronald	MD	Pediatrix Medical Group	222 S Herlong Avenue, Rock Hill, SC 29732	909-2041	909-2138	Courtesy	Neonatology
Hooten, Mark T.	MD	Anesthesia Associates	222 S. Herlong Avenue, Rock Hill, SC 29732	329-6711	329-5120	Active	Anesthesia
Hsu, Rhea	MD	Carolina Medical Consultants	311 Glenwood Dr., Rock Hill,SC 29732	366-7175	366-0529	Courtesy	IM
Hubbard, James D.	DO	Carolina OB/GYN	360 S. Herlong Ave, Rock Hill, SC 29732	366-4171	366-6890	Active	OB/GYN
Hurt, Christopher	MD	Virtual Radiological	11995 Singletree Lane, Ste 500; Eden Prairie, MN 55344	952-595-1150	952-935-2757	Consulting	TeleRadiology
Iuliano, Stephen	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Charlotte, NC 28203	704-373-1503	704-373-2624	Courtesy	Cardiology
Jacuch, Edward C.	DO	Piedmont Medical Center Stroke Program	222 South Herlong Avenue, Rock Hill, SC 29732	329-1234		Consulting	Tele-Medicine
James,III, W. Scott	MD	Carolina Orthopedic Surgery	134 Professional Park Dr., Rock Hill, SC 29732	329-3130	329-4533	Active	Orthopedics
Jamison, Cynthia R.	MD	New Day Family Health Services	820 W. Meeting Street, Lancaster, SC 29720	803-285-5441	803-2857509	Courtesy	FP
Jarrell, S. Taylor	MD	Carolina Neurosurgery & Spine	175 Amendment Avenue Ste 104, Rock Hill, SC 29732	325-1618	980-8418	Active	Neurosurgery
Jauch, Edward	MD	Piedmont Medical Center Stroke Program	222 S Herlong Ave, Rock Hill, SC 29732	329-1234		Consulting	Telemedicine
Jegede, Aderonke	MD	Schumacher Group Hospital Medicine Division	222 South Herlong Avenue; Rock Hill, SC 29732	909-5937	323-2856	Active	IM
Jenkins, M. Dave	MD	Carolina Medical Consultants	311 Glenwood Dr., Rock Hill,SC 29732	366-7175	366-5029	Courtesy	IM
Jenkins,Jr., E. Earl	MD	York Pathology Associates	222 S. Herlong Avenue, Rock Hill, SC 29732	329-6845	327-7598	Active	Pathology
Jewell, James L.	MD	Jewell Family Practice	1147 Ebenezer Road, Rock Hill, SC 29732	329-6648	985-4134	Courtesy	FP
John, Trent	MD	Tri-County Pediatrics	165 Amendment Avenue, Ste 102, Rock Hill, SC 29732	329-2700	329-2788	Courtesy	Pediatrics
Johnson, Eric G.	MD	Piedmont Family Practice at Rock Hill	200 S Herlong Avenue, Ste G, Rock Hill, SC 29732	325-1770	325-1790	Courtesy	FP
Johnson, Samuel A.	MD	Schumacher Group Hospital Medicine Division	222 S Herlong Avenue, Rock Hill, SC 29732	909-5937	323-2856	Active	IM
Johnson, Thomas	MD	Sanger Heart and Vascular Institute	197 Piedmont Blvd, Suite 111, Rock Hill, SC 29732	327-3456	327-4320	Active	Cardiology
Jones, Christopher T.	MD	Central Carolina ENT	1565 Ebenezer Road, Rock Hill, SC 29732	327-4000	366-9829	Active	Otolarynology
Josiah-Howze, Dara	MD	The Olive Tree Wellness	111 Claebourne Street, Fort Mill, SC 29715	802-1307	802-1303	Active	Psychiatry
Kedar, Rajesh H.	MD	Metrolina Medical Associates	2670 Mills Park Drive, Rock Hill, SC 29732	985-3939	985-3929	Active	IM
Kelly, Timothy J.	MD	Central Carolina ENT	1565 Ebenezer Road, Rock Hill, SC 29732	327-4000	366-9829	Active	Otolarynology
Kessler, Chad S.	MD	Charlotte Eye, Ear, Nose & Throat	200 S Herlong Avenue, Ste A, Rock Hill, SC 29732	328-1864	328-1865	Active	Otolarynology
Kim, Eugene J.	MD	Piedmont Pulmonary, LLC	222 S Herlong Avenue, Rock Hill, SC 29732	323-2945		Active	Critical Care
Kim, Paul K.	MD	Carolina Neurosurgery & Spine	225 Baldwin Avenue, Charlotte, NC 28204	704-373-0212	704-335-8448	Courtesy	Neurosurgery
Konefal, John B.	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Consulting	Radiation Oncology
Kowalchuk, Glen J.	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Courtesy	Cardiology
Lankford, Scott P.	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Consulting	Radiation Oncology

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Lazaridis, Christos	MD	Piedmont Medical Center Stroke Program	222 S Herlong Ave, Rock Hill, SC 29732	329-1234		Consulting	Telemedicine
LeBliss, Mary	MD	Schumacher Hospitalist	222 S Herlong Avenue, Rock Hill, SC 29732	909-5937	323-2856	Active	Internal Medicine
Lee, John W.	MD	Apollo MD	222 S Herlong Avenue, Rock Hill, SC 29732	329-6849		Active	EM
Lee, Jr., James E.	MD	Ascension Behavioral Healthcare	452 Lakeshore Parkway Ste 105, Rock Hill, SC 29732	329-1915	329-1918	Active	Psychiatry
Lehman, Jr., William L.	MD	Carolina Orthopedic Surgery	134 Professional Park Dr., Rock Hill, SC 29732	329-3130	329-4533	Active	Orthopedics
Leonard, Bruce A.	MD	Rock Hill Radiology	218 S. Herlong Avenue, Rock Hill, SC 29732	327-2828	985-4775	Active	Radiology
LeRoy, Jr., Albert G.	MD	Carolina Urology Center	1780 Medical Park Dr., Rock Hill, SC 29732	327-1116	327-6872	Active	Urology
Lesslie, Robert D.	MD	Riverview Medical	1393 Celanese Rd., Rock Hill, SC 29732	329-3103	325-2232	Courtesy	EM
Liang, Mark J.	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Consulting	Radiation Oncology
Liu, Jonathan J.	MD	Lewisville Medical Center	3248 Edgeland Road, Richburg, SC 29729	789-6111		Courtesy	FP
Livingston, Wilbur D. Jr.	MD	Carolina Urology Center	1780 Medical Park Dr., Rock Hill, SC 29732	327-1116	327-6872	Active	Urology
Lubega, Margaret	MD	First Pediatric Care Center	2644 Court Drive, Gastonia, NC 28054	704/868-3664	704-868-3665	Courtesy	FP
Lupo, Susan E.	MD	Anesthesia Associates	222 S. Herlong Avenue, Rock Hill, SC 29732	329-6711	329-5120	Active	Anesthesia
Maduro, Lissette	MD	North Central Family Medical	1131 Saluda Street, Rock Hill, SC 29731	325-7744	325-1117	Active	FP
Magura, Christian E.	MD	Carolina Urology Center	1780 Medical Park Dr., Rock Hill, SC 29732	327-1116	327-6872	Active	Urology
Mandell, Howard	MD	Metrolina Neurological	200 South Herlong Avenue, Suite H, Rock Hill, SC 29732	366-6135	366-3439	Active	Neurology
Marashi, Amir H.	MD	South Charlotte Oral & Facial Surgery	10035 Park Cedar Drive, Suite 300, Charlotte, NC 28210	704/542-9600	704-542-9651	Courtesy	Max/Facial Surgery
Marfo, Magdalene	MD	Schumacher Group Hospital Medicine Division	222 S Herlong Avenue, Rock Hill, SC 29732	909-5937	323-2856	Active	IM
Margalit, Gal	MD	Piedmont East	760 Addison Avenue, Rock Hill, SC 29730	329-1930	329-2549	Courtesy	EM
Marion, III, Malcolm L	MD	Rock Hill Family Practice	1435 Ebenezer Road, Rock Hill 29732	328-3828	328-3879	Courtesy	FP
Matthews, Jr.,Curtis J.	MD	Carolina Urology Center	1780 Medical Park Dr., Rock Hill, SC 29732	327-1116	327-6872	Active	Urology
Matthews, Mark R.	MD	Rock Hill Radiology	218 S. Herlong Avenue, Rock Hill, SC 29732	327-2828	985-4775	Active	Radiology
Maynard, James L.	MD	York Pathology Associates	222 S. Herlong Avenue, Rock Hill, SC 29732	329-6845	327-7598	Active	Pathology
McBean, Mary R.	MD	Family Medicine Associates	826 E. Liberty St., York, SC 29745	684-3738	684-3808	Courtesy	FP
McCall T. Bradley	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Consulting	Radiation Oncology
McCammon, Robert J.	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Consulting	Radiation Oncology
McCarthy, Jr., William G.	MD	Carolina Orthopedic Surgery	134 Professional Park Dr., Rock Hill, SC 29732	329-3130	329-4533	Active	Orthopedics
McClelland, R. Craig	MD	Rock Hill GYN/OB	1721-05 Ebenezer Rd., Ste 145, Rock Hill, SC 29732	328-2401	328-1030	Active	OB/GYN
McGinnis, L. Scott	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Consulting	Radiation Oncology
McKinney, Jr., Edward D.	MD	Rock Hill Radiology	218 S Herlong Avenue, Rock Hill, SC 29732	327-2828	985-4775	Active	Radiology
McLanahan, C. Scott	MD	Carolina Neurosurgery & Spine	225 Baldwin Avenue, Charlotte, NC 28204	704-373-0212	704-335-8448	Courtesy	Neurosurgery
McMahon, Sandra	MD	Medical Associates of Rock Hill	2450 India Hook Road, Ste B, Rock Hill, SC 29732	328-0181	328-0553	Courtesy	IM
McMeekin, Hayne D.	MD	Saluda Center	2400 W Main Street, Rock Hill, SC 29732	327-6103	325-5443	Courtesy	Psychiatry
McQueen,III, Donald	MD	Carolina Orthopedic Surgery	134 Professional Park Dr., Rock Hill, SC 29732	329-3130	329-4533	Active	Orthopedics
Meakin, Charles J.	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Consulting	Radiation Oncology
Mercado, Sonia	MD	Pediatrix Medical Group	222 S. Herlong Avenue, Rock Hill, SC 29732	909-2041	909-2138	Active	Neonatology
Mika, Brian	MD	Piedmont Behavioral Medicine	200 S. Herlong Avenue Ste C; Rock Hill, SC 29732	323-2775	323-2776	Active	Psychaitry
Miller, Fred	MD	Medical Associates of Rock Hill	2450 India Hook Road, Ste B, Rock Hill, SC 29732	328-0181	328-0553	Courtesy	IM
Miller, Gregory A.	MD	Rock Hill GYN/OB	1721-05 Ebenezer Rd., Ste 145, Rock Hill, SC 29732	328-2401	328-1030	Active	OB/GYN
Miller, Joshua S.	MD	Southeast Pain Care	POB 36351, Charlotte, NC 28236	704-377-5772	704-377-3389	Courtesy	Pain Management
Mishra, Shashank	MD	Edgewater Medical Center	1162-A Fort Mill Highway, Fort Mill, SC 29707	396-7900	396-2963	Courtesy	FP
Mitro, Gregory C.	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Consulting	Radiation Oncology
Mobley, David	MD	Baxter Urgent Care	502 Sixth Baxter Crossing Fort Mill, SC 29708	396-8100	396-8040	Courtesy	Family Practice
Modi, Ankita	MD	Tri-County Pediatrics	165 Amendment Avenue, Ste 102, Rock Hill, SC 29732	329-2700	329-2788	Courtesy	Pediatrics

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Muniz, Felix R.	MD	Southeast Pain Care	POB 36351, Charlotte, NC 28236	704-377-5772	704-377-3389	Courtesy	Pain Management
Murphree, Timothy	MD	Piedmont Rehabilitation Medicine	1795 Frank Gaston Blvd., Rock Hill, SC 29732	326-3688	326-3687	Consulting	Physical Medicine
Muscialowski, Jr., Richard S.	MD	Sanger Heart and Vascular Institute	704 Gold Hill Road, Ste 115, Fort Mill, SC 29715	835-0400	835-0404	Active	Cardiology
Naidu, Sashi	MD	Carolina Blood & Cancer Care	1583 Health Care Drive, Rock Hill, SC 29732	329-7772	329-9821	Active	Oncology
Nair, Jyothi	MD	Tri-County Pediatrics	165 Amendment Avenue, Ste 102, Rock Hill, SC 29732	329-2700	329-2788	Courtesy	Pediatrics
Nandurkar, Sanjay	MD	Piedmont Interventional Spine and Pain Center	834 W Meeting Street, Ste A, Lancaster, SC 29720	803-289-7246	803285-1522	Courtesy	Pain Management
Nathwani, Niyati	MD	Carolina Blood & Cancer Care	1583 Health Care Drive, Rock Hill, SC 29732	329-7772	329-9821	Active	Oncology
Naylor, Irvin	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Courtesy	Cardiology
Nelson, David G.	MD	Carolina Eyecare Center	410 S Herlong Avenue Ste 101, Rock Hill,SC 29732	985-3937	980-2672	Courtesy	Ophthalmology
New, Myo M.	MD	Ace Medical Group	744 Arden Lane, Ste 100, Rock Hill, SC 29732	325-2236	325-2234	Active	IM
Nguyen, Victoria	DO	Virtual Radiological	11995 Singletree Lane, Ste 500; Eden Prairie, MN 55344	952-595-1150	952-935-2757	Consulting	TeleRadiology
Nicholson, Douglas	DO	Nephrology Associates	1436 Riverchase Blvd, Rock Hill, SC 29732	329-2636	329-2184	Active	Nephrology
Nix, David	MD	Carolina Cancer Specialist	225 South Herlong Avenue Suite 201; Rock Hill, SC 29732	329-9088	329-9075	Active	Oncology
Nunnery, Kenneth E.	MD	Fort Mill Family Practice	1690 Hwy 160 West, Fort Mill, SC 29715	547-7541	548-0122	Courtesy	FP
Oberer, Daniel M.	MD	Carolina Neurosurgery & Spine	225 Baldwin Avenue, Charlotte, NC 28204	704-373-0212	704-335-8448	Courtesy	Neurosurgery
Oehme, Stephen F.	MD	Rock Hill Family Practice	1435 Ebenezer Road, Rock Hill SC 29732	328-3828	328-3879	Courtesy	FP
Olson, Thomas H.	DPM	Piedmont Podiatry	724 Arden Lane, Ste 200, Rock Hill, SC 29732	366-9440	366-7704	Active	Podiatry
Omoigui, Nowamagbe	MD	Cardiovascular Care Group, PA	114 Gateway Corporate Blvd, Columbia, SC 29203	803-227-3540	803-227-3548	Courtesy	Cardiology
Onafowokan, Joel	MD	Schumacher Group Hospital Medicine Division	222 S Herlong Avenue, Rock Hill, SC 29732	909-5937	323-2856	Active	IM
Onwukwe, Augustine	MD	Schumacher Group Hospital Medicine Division	222 S Herlong Avenue, Rock Hill, SC 29732	909-5937	323-2856	Active	IM
Park, Richard I.	MD	Southeast Pain Care	POB 36351, Charlotte, NC 28236	704-377-5772	704-377-3389	Courtesy	Pain Management
Parsons, Gregory S.	MD	Central Carolina ENT	1565 Ebenezer Rd., Ste 110, Rock Hill, SC 29732	327-4000	366-9829	Active	Otolarynology
Partyka, Catherine	MD	Pediatrix Medical Group	222 S Herlong Avenue, Rock Hill, SC 29732	909-2041	909-2138	Courtesy	Neonatology
Patel, Jitendra	MD	Schumacher Hospitalist	222 South Herlong Avenue; Rock Hill, SC 29732	909-5937	323-2856	Active	Internal Medicine
Patel, Kashyap B.	MD	Carolina Blood & Cancer Care	1583 Health Care Drive, Rock Hill, SC 29732	329-7772	329-9821	Active	Oncology
Patel, Nirav H.	MD	Digestive Disease Associates	170 Amendment Avenue, Rock Hill, SC 29732	324-7607	324-4097	Active	GI
Patel, Raj M.	MD	Sunshine Pediatrics	724 Arden Lane, Ste 100, Rock Hill, SC 29732	980-7337	980-2229	Active	Pediatrics
Patel, Shilpesh	MD	Patel Medical Clinic, P.A.	223 S. Herlong Avenue, Suite 100, Rock Hill, SC 29732	980-7400	980-3611	Courtesy	IM
Patel, Shilpesh	MD	Patel Medical Clinic	PO Box 36730; Rock Hill, SC 29732	980-7400	980-3611	Courtesy	Internal Medicine
Patel, Taral N.	MD	Carolina Heart Specialists	370 S Herlong Ave, Ste 200, Rock Hill, SC 29732	366-8300	327-4805	Active	Cardiology
Patel, Vasant B.	MD	Carolina Cardiology Associates	196 Cardiology Dr., Rock Hill, SC 29732	324-5135	324-8161	Active	Cardiology
Paukovitz, Catherine A	DPM	Alpine Podiatry	430 S. Herlong Avenue, Rock Hill, SC 29732	327-2217	327-2217	Active	Podiatry
Paxtor, Carlos G.	MD	Sunshine Pediatrics	724 Arden Lane, Ste 100, Rock Hill, SC 29732	980-7337	980-2229	Active	Pediatrics
Pennington, Larry H.	MD	Digestive Disease Associates	170 Amendment Avenue, Rock Hill, SC 29732	324-7607	324-4097	Active	GI
Percival, Brandon	DPM	Carolina Podiatry Group	1190 Highway 9 Bypass West, Lancaster, SC 29721	285-1411	803-283-9920	Courtesy	Podiatry
Perez, Luis M.	MD	Children's Urology of the Carolinas	1718 E. 4th Street, Suite 302, Charlotte, NC 28204	704/376-5636	704-376-5933	Courtesy	Pediatric Urology
Peterson, Eric	MD	Nephrology Associates	1436 Riverchase Blvd, Rock Hill, SC 29732	329-2636	329-2184	Active	Nephrology
Pietro, Paul	MD	Women's First, LLC	121 Main Street; Chester, SC 29706	803-581-5030		Courtesy	OB/GYN
Pillai, Mohan	MD	Summit Plastic and Hand Surgery	1700 1st Baxter Crossing, Suite 202, Fort Mill, SC 29708	802-2488	802-3352	Active	Plastic Surgery
Plunkett, Steven R.	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Consulting	Radiation Oncology
Podiask, Stephen	MD	Southeast Pain Care	POB 36351, Charlotte, NC 28236	704-377-5772	704-377-3389	Courtesy	Pain Management
Porter, Mark A.	MD	Metrolina Neurological	200 South Herlong Avenue, Suite H, Rock Hill, SC 29732	366-6135	366-3439	Active	Neurology
Powell,Jr,E.Neal	MD	Carolina Orthopedic Surgery	134 Professional Park Dr., Rock Hill, SC 29732	329-3130	329-4533	Active	Orthopedics
Ramesh, Kumari	MD	Internal Medicine Group	225 S Herlong Ave, Ste 230, Rock Hill, SC 29732	366-3900	366-1213	Active	IM

Ramos, Robert T.	MD	Apollo MD	222 S Herlong Avenue, Rock Hill, SC 29732	329-6849	985-4538	Active	EM
Randall, Jr., Robert D.	MD	MEC Surgical	1665 Herlong Court, Ste A, Rock Hill, SC 29732	329-8500	329-8511	Active	General Surgery
Rao, Raviprasad	MD	Pediatrix Medical Group	222 S Herlong Ave, Rock Hill, SC 29732	980-2041	909-2138	Courtesy	Neonatology
Raymond, Glenn	MD	Carolina OB/GYN	360 S. Herlong Ave., Rock Hill, SC 29732	366-4171	366-6890	Active	OB/GYN
Redding, Mark	MD	Carolina Neurosurgery & Spine	110 Lake Concord Road, NE Concord, NC 28025	704-831-2800	704-792-2674	Courtesy	Neurosurgery
Reinhardt, Jr., James E.	MD	Rock Hill Radiology	218 S. Herlong Avenue, Rock Hill, SC 29732	327-2828	985-4775	Active	Radiology
Rentz, Jr., James N.	MD	Carolina Orthopedic Surgery	134 Professional Park Dr., Rock Hill, SC 29732	329-3130	329-4533	Active	Orthopedics
Reuter, Robert	MD	Rock Hill Radiology	218 S. Herlong Avenue, Rock Hill, SC 29732	327-2828	985-4775	Active	Radiology
Revell, Jr. Walter	MD	Surgical Specalists of the Carolinas	1721-07 Ebenezer Road, Ste. 175, Rock Hill, SC 29732	324-5256	328-0440	Active	General Surgery
Revell, William S.	MD	Piedmont GYN/OB	200 S. Herlong Avenue, Ste. F, Rock Hill, SC 29732	324-7606	324-3908	Courtesy	OB/GYN
Richardson, Scott	MD	Digestive Disease Associates	170 Amendment Avenue, Rock Hill, SC 29732	324-7607	324-4097	Active	GI
Richter, Richard L.	MD	Anesthesia Associates	222 S. Herlong Avenue, Rock Hill, SC 29732	329-6711	329-5120	Active	Anesthesia
Rinaldi, Michael	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste. 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Courtesy	Cardiology
Riopel, Donald A.	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste. 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Consulting	Pediatric Cardiology
Risser, Marjorie J.	DMD	The Center for Oral& Maxillofacial Surgery	372 S.Herlong Ave., Rock Hill, SC 29732	324-1160	324-2456	Active	Oral Surgery
Robbins, Amy	MD	Hospice Community Care	PO Box 993, Rock Hill, SC 29731	329-4663		Courtesy	Pain Management
Robinson, Joe C.	MD	Rock Hill GYN/OB	1721-05 Ebenezer Rd., Ste 145, Rock Hill, SC 29732	328-2401	328-1030	Active	OB/GYN
Rodrique, Randolph L.	MD	Digestive Disease Associates	170 Amendment Avenue, Rock Hill, SC 29732	324-7607	324-4097	Active	GI
Roof, Kevin S.	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Consulting	Radiation Oncology
Rose, Geoffrey	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Courtesy	Cardiology
Rowland, Barbara L.	MD	Rock Hill GYN/OB	1721-05 Ebenezer Rd., Ste 145, Rock Hill, SC 29732	328-2401	328-1030	Active	OB/GYN
Ryder-Cook, Allan S.	MD	Metrolina Neurological	200 South Herlong Avenue, Suite H, Rock Hill, SC 29732	366-6135	366-3439	Active	Neurology
Samaan, Maged G.	MD	Piedmont Pulmonary, LLC	222 S Herlong Avenue, Rock Hill, SC 29732	323-2945		Active	Critical Care
Samiy, Nasi	MD	Retina Institute of the Carolinas	724 Arden Lane Suite 220, Rock Hill, SC 29732	323-2020	323-2024	Active	Ophthalmology
Sample, Jerry J.	MD	Shiland Family Medicine	2633 Celanese Rd., Rock Hill, SC 29732	329-5131	366-6600	Courtesy	FP
Schreiner, Virginia C.	MD	Virtual Radiologic Professionals, LLC	11995 Singletree Lane, Ste 500, Eden Prairie, MN 55344	952-595-1299	952-935-2757	Consulting	Telemedicine
Schroeder, Christopher W.	MD	Surgical Specalists of the Carolinas	1721-07 Ebenezer Road, Ste. 175, Rock Hill, SC 29732	324-5256	328-0440	Active	General Surgery
Schwartz, Matthew A.	MD	Carolina Orthopedic Surgery	134 Professional Park Dr., Rock Hill, SC 29732	329-3130	329-4533	Active	Orthopedics
Scott, Shirley K.	MD	Carolina Breast Center	154 Amendment Ave., Ste 104, Rock Hill, SC 29732	329-8990	329-8991	Courtesy	General Surgery
Seymore, Cathy H.	MD	Southeast Radiology Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Consulting	Radiation Oncology
Seymore, R. Jeffrey	MD	Hospice Community Care	PO Box 993, Rock Hill, SC 29731	329-4663		Consulting	Pain Management
Shah, Deepak B.	MD	Carolina Heart Specialists	370 S Herlong Ave, Ste 200, Rock Hill, SC 29732	366-8300	327-4805	Active	Cardiology
Shah, Gaurang C.	MD	Tri-County Pediatrics	165 Amendment Avenue, Ste 102, Rock Hill, SC 29732	329-2700	329-2788	Courtesy	Pediatrics
Shah, J. K	MD	Carolina Cardiology Associates	196 Cardiology Dr., Rock Hill, SC 29732	324-5135	324-8161	Active	Cardiology
Shah, Jagdish V.	MD	Catawba Mental Health	166 Dotson Street, Rock Hill, SC 29732	327-2012	327-4198	Courtesy	Psychiatry
Shah, Vipal B.	MD	Carolina Heart Specialists	370 S Herlong Ave, Ste 200, Rock Hill, SC 29732	366-8300	327-4805	Active	Cardiology
Sharma, Deovyaas	MD	Internal Medicine Group	225 S Herlong Ave, Ste 230, Rock Hill, SC 29732	366-3900	366-1213	Active	IM
Shepherd, Jaime M.	MD	Virtual Radiologic Professionals, LLC	11995 Singletree Lane, Ste 500, Eden Prairie, MN 55344	952-595-1299	952-935-2757	Consulting	Telemedicine
Shuler, Donald W.	MD	Family Medicine Associates	826 E. Liberty St., York, SC 29745	684-3738	684-3808	Courtesy	FP
Simpson, Jr., Thomas H.	DMD, MD	The Center for Oral & Maxillofacial Surgery	372 S.Herlong Ave., Rock Hill, SC 29732	324-1160	324-2456	Active	Oral Surgery
Sinclair, Pamela	MD	Carolina Cancer Specialist	225 S. Herlong Avenue, Suite 201, Rock Hill, SC 29732	329-9088	329-9075	Active	Oncology
Singh, Pradeep	MD	Carolina Cardiology Associates	196 Cardiology Dr., Rock Hill, SC 29732	324-5135	324-8161	Active	Cardiology
Singhi, Sushil	MD	Carolina Cardiology Associates	196 Cardiology Dr., Rock Hill, SC 29732	324-5135	324-8161	Active	Cardiology
Sink, Bryan	MD	Piedmont West	1190 Filbert Hwy, York, SC 29745	628-0004	628-6004	Courtesy	EM

Sliz, Nicholas	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Consulting	Pediatric Cardiology
Slota, Paul A.	MD	Carolina Heart Specialists	370 S Herlong Ave, Ste 200, Rock Hill, SC 29732	366-8300	327-4805	Active	Cardiology
Smith, Jr., Richard T.	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste. 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Consulting	Pediatric Cardiology
Smith, Mark D.	MD	Carolina Neurosurgery & Spine	225 Baldwin Avenue, Charlotte, NC 28204	325-1618	980-8418	Courtesy	Neurosurgery
Snyder, Howard F.	MD	Rock Hill Radiology	218 S. Herlong Avenue, Rock Hill, SC 29732	327-2828	985-4775	Active	Radiology
Soderstrom, Lawrence P.	MD	Rock Hill Radiology	218 S. Herlong Avenue, Rock Hill, SC 29732	327-2828	985-4775	Active	Radiology
Sohner, Mark	MD	Piedmont Internal Medicine at Baxter Village	502 Sixth Baxter Crossing, Suite A, Fort Mill, SC 29708	802-2424	802-3767	Courtesy	IM
Stangas, Peter A.	MD	Rock Hill Radiology.	218 S. Herlong Avenue, Rock Hill, SC 29732	327-2828	985-4775	Active	Radiology
Starr, Carter L.	MD	Apollo MD	222 S Herlong Avenue, Rock Hill, SC 29732	329-6849		Active	EM
Start, Robert J.	MD	Anesthesia Associates	222 S. Herlong Avenue, Rock Hill, SC 29732	329-6711	329-5120	Active	Anesthesia
Stern, Herbert J.	MD	Stern Cardiology	4324 Quail View Road; Charlotte, NC 28224	980-355-1959		Consulting	Pediatric Cardiology
Stuver, David B.	MD	Baxter Urgent Care	502 Sixth Baxter Crossing, Fort Mill, SC 29708	396-8100	396-8040	Courtesy	IM
Sullivan, Robert J.	MD	Southeast Pain	POB36351, Charlotte, NC 28236	704-377-5772	704-378-0695	Courtesy	Pain Management
Sundararaman, Michael	MD	Apollo MD	222 S Herlong Avenue, Rock Hill, SC 29732	329-6849		Active	EM
Sweet, Robert Michael	MD	Cosmetic & Reconstructive Associates	311 Pendleton St., Rock Hill, SC 29730	817-7749	817-7750	Active	Plastic Surgery
Symanski, John	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Courtesy	Cardiology
Tafari, Gashaw T.	MD	North Central Family Medical	1131 Saluda Street, Rock Hill, SC 29731	325-7744	325-1117	Active	Pediatrics
Taormina, Martin V.	MD	Carolina Vascular Surgery	1721 Ebenezer Rd., Ste 115, Rock Hill, SC 29732	985-4000	985-4006	Active	Vascular Surgery
Taylor, Deborah J.	MD	Schumacher Group Hospital Medicine Division	222 S Herlong Avenue, Rock Hill, SC 29732	909-5937	323-2856	Active	FP
Taylor, III, R. Norman	MD	Rock Hill GYN/OB	1721-05 Ebenezer Rd., Ste 145, Rock Hill, SC 29732	328-2401	328-1030	Active	OB/GYN
Thakkar, Vipul V.	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704-333-7376	704-333-7386	Consulting	Radiation Oncology
Thekdi, Ashish	MD	Catawba Gastroenterology	1380 Ebenezer Road, Ste E; Rock Hill, SC 29732	803-286-9963	366-7595	Active	Gastroenterology
Thies, Steven	MD	Charlotte Surgical Group	1918 Randolph Road, Ste 130, Charlotte, NC 28207	704-364-8100	704-365-2073	Courtesy	General Surgery
Thomas, Aydrian	MD	Piedmont Internal Medicine and FP at York	1795 DeVinney Road, York, SC 29745	818-5995	818-5985	Courtesy	FP
Thomas, Jr., Robert E.	MD	York Pathology Associates	222 S. Herlong Avenue, Rock Hill, SC 29732	329-6845	327-7598	Active	Pathology
Thomley, Alan M.	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Courtesy	Cardiology
Thorp, James W.	MD	Pediatrix Medical Group	222 S. Herlong Avenue, Rock Hill, SC 29732	909-2041	909-2138	Active	Neonatology
Timony, Tracy	MD	MD-VIP	430 S. Herlong Avenue, Suite 102; Rock Hill, SC 29732	324-8004		Courtesy	IM
Trautman, Thomas G.	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Consulting	Radiation Oncology
Tucker, Charles L.	MD	Retina Institute of the Carolinas	724 Arden Lane Suite 220, Rock Hill, SC 29732	323-2020	323-2024	Active	Ophthalmology
Turan, Tanya N.	MD	Piedmont Medical Center Stroke Program	222 S Herlong Ave, Rock Hill, SC 29732	329-1234		Consulting	Telemedicine
Tuttle, Nicholas H.	MD	Rock Hill Family Practice	1435 Ebenezer Road, Rock Hill 29732	328-3828	328-3879	Courtesy	FP
Valite, Delfin F.	MD	Advance Behavioral Medicine	POB 36624, Rock Hill, SC 29732	327-4357	324-4357	Courtesy	Psychiatry
Van Der Veer, Craig	MD	Carolina Neurosurgery & Spine	225 Baldwin Avenue, Charlotte, NC 28204	704-373-0212	704-335-8448	Courtesy	Neurosurgery
Vemuri, Sameer	MD	Carolina Neurosurgery & Spine	175 Amendment Avenue Ste 104, Rock Hill, SC 29732	325-1618	980-8418	Courtesy	Physical Medicine
Villamor, Randolph	MD	Carolina Medical Consultants	311 Glenwood Dr., Rock Hill, SC 29732	366-7175	366-0529	Courtesy	IM
Villamor, Shelaila	DO	North Central Family Medical	1131 Saluda Street, Rock Hill, SC 29730	325-7744	325-1117	Courtesy	FP
Villaret, Douglas	MD	Charlotte Eye, Ear, Nose, & Throat	200 S Herlong Ave, Ste A, Rock Hill, SC 29732	328-1864	328-1865	Active	Otolarynology
Vujicic, Ratko	MD	V Pain Clinic	197 Piedmont Blvd, Ste 214, Rock Hill, SC 29732	909-3600	909-3800	Courtesy	Pain Management
Wagner, Brett	MD	ApolloMD	222 South Herlong Avenue, Rock Hill, SC 29732	329-6849		Active	EM
Walker, Brian A.	DO	Edgewater Medical Center	1162-A Fort Mill Highway, Fort Mill, SC 29707	396-7900	396-2963	Courtesy	FP
Warden, Jeffrey	MD	Apollo MD	222 S Herlong Avenue, Rock Hill, SC 29732	329-6849		Active	EM
Warlick, Jr., William	MD	Southeast Radiation Oncology	200 Queens Rd.,Ste.400, Charlotte, NC 28204	704/333-7376	704-333-7386	Courtesy	Radiation Oncology
Weber, Karl	MD	Medical Associates of Rock Hill	2450 India Hook Road, Ste B, Rock Hill, SC 29732	328-0181	328-0553	Courtesy	IM

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Wells, David	MD	Pediatrix Medical Group	222 S Herlong Avenue, Rock Hill, SC 29732	909-2041	909-2041	Courtesy	Neonatology
Welsh, James D.	MD	Carolina Blood & Cancer Care	1583 Health Care Drive, Rock Hill, SC 29732	329-7772	329-9821	Active	Oncology
White, George H.	MD	Rock Hill Family Practice	1435 Ebenezer Road, Rock Hill 29732	328-3828	328-3879	Courtesy	FP
Wilder, Brian	MD	Southeast Pain Care	POB 36351, Charlotte, NC 28236	704-377-5772	704-377-3389	Courtesy	Pain Management
Wiley, Kelvin J.	MD	Schumacher Group Hospital Medicine Division	222 S Herlong Avenue, Rock Hill, SC 29732	909-5937	323-2856	Active	FP
Williams, Andrea	MD	Ear, Nose Throat & Audiology Assoc	744 Arden Lane, Ste 200, Rock Hill, SC 29732	328-3686	328-9889	Courtesy	Otolarynology
Wilson, B. Hadley	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Courtesy	Cardiology
Wilson, Brian C.	MD	Piedmont ENT	197 South Herlong Avenue, Rock Hill, SC 29732	366-9000	366-9200	Active	Otolarynology
Wilson, James	MD	Carolina Center for Rheumatology	744 Arden Lane, Ste 225, Rock Hill, SC 29732	329-1660	329-4118	Consulting	Rheumatology
Woodburn, Donald W.	MD	Schumacher Group Hospital Medicine Division	222 S Herlong Avenue, Rock Hill, SC 29732	909-5937	323-2856	Active	IM
Wooten, Sally M.	MD	Piedmont Pulmonary, LLC	222 S Herlong Avenue, Rock Hill, SC 29732	323-2945		Active	Critical Care
Woziak, Robert	MD	Lancaster Endocrinology	410 S. Herlong Avenue, Ste 106, Rock Hill, SC 29732	329-3899	329-4377	Active	Endocrinology
Wright, David K.	MD	Carolina Urology Center	1780 Medical Park Dr., Rock Hill, SC 29732	327-1116	327-6872	Active	Urology
Yearta, G. Marshall	MD	Fort Mill Family Practice	1690 Hwy 160 West, Fort Mill, SC 29715	547-7541	548-0122	Courtesy	FP
Yousefian, Mehrdad	MD	Lewisville Medical Center	3248 Edgeland Road, Richburg, SC 29729	789-6111		Courtesy	IM
Zhang, Quanwei	MD	Metrolina Neurological	200 South Herlong Avenue, Suite H, Rock Hill, SC 29732	366-6135	366-3439	Active	Neurology
Zimmern, Samuel H.	MD	Sanger Heart and Vascular Institute	1001 Blythe Blvd., Ste 300, Charlotte, NC 28203	704-373-1503	704-373-2624	Courtesy	Cardiology
9/28/2010							

ATTACHMENT M

LETTER FROM YORK COUNTY MEDICAL SOCIETY

CAROLINA CARDIOLOGY ASSOCIATES

Diagnostic and Interventional Cardiology

Jay K. Shah, M.D., F.A.C.C., F.S.C.A.I.
Pradeep Singh, M.D., M.P.H., F.A.C.C.
Sushil K. Singhi, M.D., F.A.C.C., F.A.C.P., F.A.H.A.
Vasant B. Patel, M.D., F.A.C.C.
Talal Baki, M.D., F.A.C.C., F.S.C.A.I.
Michelle Christian, PA-C
Kristin Whitmer, MPAS, PA-C
Richard Boulware, PA-C

September 24, 2010

South Carolina Department of Health and Environmental Control
Attn: CON Director Beverly Brandt
P. O. Box 8594
Columbia, SC 29202-8594

RE: York County Medical Society

Dear Ms. Brandt:

I have received requests from the parties applying to build a hospital in Fort Mill, SC and I want to emphasize that the medical community is supportive of a hospital being built in Fort Mill.

As you know, the York County Medical Society's membership has for many years been comprised of members of the York County medical community, some of which are retired physicians, specialists that do not have interaction with a hospital due to the nature of their practice and many who are employed by one of the applicants being considered to build the Fort Mill hospital. It is inherit conflicts created by these relationships that make it impossible for the medical society to represent that it has an objective position on behalf of any particular applicant and thus the medical society is not taking a position in support of any hospital applicant.

While we know that the residents of York County have had and continue to have choices among the three area hospitals, having one located in the Fort Mill area will improve ease of access and we will continue to urge the development of such a facility.

Again, thank you for your interest.

Sincerely,

Sushil K. Singhi, M.D.

Sushil K. Singhi, M.D., F.A.C.C., F.A.C.P., F.A.H.A.
President, York County Medical Society

SKS:sdc

803/324-5135
Fax 803/324-8161

196 Cardiology Drive
Rock Hill, SC 29732

803/285-9700
Fax 803/285-9713

834 West Meeting Street
Medical Arts Bldg. 4, Suite H
Lancaster, SC 29720

803/802-0090
Fax 803/802-0089

1658 West Hwy. 160
Fort Mill, SC 29715

Pled.Supp.CON.0229

JOINT-B-PMC-001.0244

RECORD 002428

ATTACHMENT N

SAMPLE QUALITY AND PATIENT SAFETY POLICIES

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Piedmont Medical Center	Administrative Policies and Procedures	No. 1.1004
	SUBJECT: **Patient Identification and Safety via Armband Use**	Page **1 of 5**
		Original Date: 1/92
		Revised Date: 9/95, 9/99, 7/02, 1/03, 7/03, 12/15
		Approved: Charles Miller

1.1004 Patient Identification and Safety via Armband Use

1.1004.1 Policy Statement(s):

It is the policy of Piedmont Medical Center to ensure that all patients are properly identified prior to provision of any care, treatment, or service. **Exception:** Patients unable to provide identifying information experiencing conditions requiring emergency care will receive treatment prior to identification, if such care and treatment is necessary to stabilize the patient's condition (example: unidentified patient arriving comatose to the Emergency Department).

1.1004.2 Responsibility:

- Physician
- Registered Pharmacist
- Occupational Therapist
- Speech Therapist
- Laboratory Technologist
- Registered Nurse (RN)
- Registered Dietitian
- Resource Management
- Financial Counselor
- Other members of the Healthcare team
- Licensed Practical Nurse (LPN)
- Respiratory Therapist
- Physical Therapist
- Radiologic Technologist

1.1004.3 Definitions:

A. Allergy means a Hypersensitivity induced by exposure to a particular antigen (allergen) resulting in a harmful immunologic reaction on subsequent exposures.

B. Do Not Resuscitate (DNR) means a physician's order which states that in the event of a respiratory or cardiac arrest, cardiopulmonary resuscitative measures will not be initiated.

C. Elopement Precautions means specific measures to ensure that a patient with cognitive impairment (including safety judgment) does not leave the department without staff knowledge.

D. Identifier means a piece of information unique to the patient (i.e., patient's name, date of birth, medical record number, etc.)

E. Principles of Identification means a system for positive identification of all hospital patients which fulfills four (4) basic functions:

1. Provides positive identification of patients in all areas of the hospital from time of admission or acceptance for treatment
2. Provides a positive method of linking patients to their medical records and treatment
3. Minimizes the possibility that identifying data is lost or transferred from one patient to another
4. Improves the accuracy of patient identification

F. Stop A Fall Precautions means specific measures to ensure that patients identified as being at risk for falls and injuries do not sustain injury.

1.1004.4 Equipment/Supplies:

Appropriately colored and/or numbered armband(s)

1.1004.5 Procedure:

1. Primary Adult and Pediatric Patient Armband

   A. Proper identification of the patient is obtained by asking the patient his/her full name.

   B. If the patient is confused or unable to verify their identity for any reason, initial identification must be confirmed by the person accompanying the patient to the unit/department.
      1) If an unresponsive patient is brought to the Emergency Department by a police officer or an emergency medical services (EMS) personnel, and there is no identification present, ask the police officer or EMS personnel to identify his patient, if possible.
      2) If that is not possible, then a temporary name (i.e., John or Jane Doe) is assigned to the patient and an Emergency Department number or a medical record number. These identifiers are then used to identify the patient.

   C. After properly identifying the patient, the hospital armband is applied.
      1) This tamperproof, nontransferable identification band is prepared and affixed to the patient in the Admitting Office, Emergency Room or Patient Care Unit.
      2) This armband is then used to verify patient identification prior to treatments and/or procedures as well as medication administration.
      3) Outpatient departments not utilizing armbands will have department specific policies for proper patient identification.

2. Primary Newborn Patient Armband

   A. Newborns have appropriately colored (pink for female or blue for male) arm and leg bands applied immediately after delivery, prior to separation from his/her parents.

   B. The matching numbered armband is applied to the mother and a designated adult prior to separation from the newborn(s).

   C. The numbers on all four (4) arm or leg bands are the same.

3. The responsible care provider verifies that the patient's identification bracelet is in place and the following two identifiers are checked prior to carrying out any procedure:

A. Patient's name (adult or pediatric patient) or mother's last name (newborn)

B. Patient's date of birth

Note: If the patient's date of birth is not available, the second identifier becomes the patient's medical record number.

4. Whenever possible, staff should also verbally assess the patient to assure proper identification, asking the patient's name and date of birth, then matching the verbal confirmation to the written information on the identification band.

5. Patient identification must be confirmed using the two-identifier system prior to conducting any healthcare procedures. These procedures include, but ate not limited to: medication administration, obtaining lab specimens, performing a treatment, performing a diagnostic test, (i.e., a diagnostic radiographic study), distributing a diet tray, and sending patients to another department.

   A. If the patient's identity cannot be verified due to an illegible or missing identification band, no procedure may be conducted.

   B. Defective or missing bands shall be replaced immediately with new identification bands. In the case of a newborn, all four (4) numbered bands are replaced in the presence of a parent.

   C. Verification that the patient's identification band is present and legible is a routine component of the patient assessment process and is performed by each healthcare provider.

   D. The patient wears the identification band until after he/she is discharged from the hospital. If the patient expires, the identification band remains in place.

6. Once certain risks to patient safety have been identified, the following armbands are applied:

   A. Allergies: Cranberry

   B. Blood Bank: Green and white striped (looped through the primary armband, so that it can be salvaged if it needs to be moved due to edema or procedures).

   C. Elopement Precautions: Purple

   D. Stop A Fall Precautions: Orange

7. Do Not Resuscitate (DNR) Patient Identification System:

A. Upon notification of a patient's DNR status (verified by the patient's physician), a second arm band which is solid blue in color (indicating the DNR status) is affixed to the patient's wrist.

B. Verification of the physician's order for the DNR status with application of the solid blue armband with the patient name (written with a permanent black marker), is done by a registered nurse.

C. A blue dot shall be placed on the outside cover of the patient's chart (near the addressograph label) dated with the most current review date.

D. A blue dot shall be placed on the telemetry monitors by the nursing station to denote DNR status.

E. If the DNR order is rescinded, the blue DNR identification bans is immediately removed from the patient.

8. Selective Therapeutic Effort
   A. Upon notification of a patient's Selective Therapeutic status, a patient's Easy ID label shall be applied to a blue and white patient identification bracelet and the bracelet placed on the patient's arm by an RN.

1.1004.7 Documentation:

Armband placement is documented in the nursing notes.

1.1004.7 Cross Reference(s):

Blood/Blood Products Transfusion Policy
Patient Care Management
Fall Prevention (Stop A Fall Program)
Transfusion of Blood and Blood Products Policy

1.1004.8 Attachment(s):

N/A

1.1004.9 Reference(s):

JCAHO (2002). Hospital Accreditation Standards. (Standard Tx.3.6). Oakbrook Terrace, Illinois: JCAHO Office of Publications.

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		8-6
Piedmont Medical Center	**Policies and Procedures**	Page 1 of 3
	SUBJECT: Communication and Verification of Critical Values	Original Date: 12/03
		Revised:
		Reviewed:

Policy Statement(s):

Critical value test results are communicated to the physician or other licensed independent practitioner. Accuracy of this communication is verified as described in the following procedure.

Responsibility:

Nurses
Laboratory personnel
Respiratory Therapists
Imaging personnel
Physicians or other licensed independent practitioners (LIP)

Definition(s):

Critical or Panic Values – Abnormal test results which could cause ill effects to the patient. These values have been identified by the medical staff of Piedmont Medical Center.
RAV – Read back and verified or repeated and verified.

Equipment/Supplies:

N/A

Procedure:

1. Laboratory Values

   A. Panic values are called to the nursing unit or procedural area where patient is located.

   B. The nurse repeats and verifies the test result with laboratory personnel if this is via phone.

   C. The nurse contacts the appropriate LIP and communicates the test result.

   D. The LIP repeats and verifies the results to ensure accuracy.

2. Imaging Test Results

   A. The Radiologist determines if the finding is a critical value.

   B. The Radiologist calls the ordering LIP at his discretion to notify of critical findings.

   C. Other critical findings are reported to the nursing unit or procedural area where the patient is located.

D. The nurse who receives this call repeats and verifies the findings to ensure accuracy.

E. The nurse is responsible for notification of the LIP if not done by the Radiologist. Before the call ends, the nurse repeats the findings to verify that the LIP understood the information.

3. Surgical/Procedural Areas

A. As critical values are reported to the nurse, they are conveyed to the appropriate LIP and verified for accuracy.

4. Respiratory Therapy/Cardiopulmonary

A. The respiratory therapist notifies the nurse and/or the physician of critical values. If the nurse needs to speak to the physician anyway, the nurse may elect to notify the doctor of the critical value.

B. When echocardiography reveals a finding that may be detrimental, the technician notifies the physician. If the patient is an outpatient, discharge is deferred until the physician evaluates the situation.

C. In the vascular lab, the physician is notified for any deep venous thrombosis or carotid stenosis. If the patient is an outpatient, discharge is deferred until the physician evaluates the situation.

D. During electroencephalogram, the finding of active seizures is communicated to the physician as a critical value.

Documentation:

1. Critical values are documented by the nurse in the appropriate section of the nursing record.

2. Verification and read back of values is abbreviated by "RAV".

3. Critical values are recorded in the appropriate part of the chart, i.e., lab values appear with all lab results, imaging results appear in the Radiology section of the chart.

Cross Reference(s):

Reading X-Rays in the Emergency Department
Call Report on STAT or Portables
Call Reports
Critical Panic Ranges

Attachment(s):

N/A

Reference(s):

Joint Commission on Accreditation of Healthcare Organizations. (2003). 2004 National Patient Safety Goals: Goal #2. http://www.jcaho.org/accredited+organizations/patient+safety/04+npsg/04_npsg.htm. Downloaded 9/26/03.

Verification of Verbal or Telephone Orders

Doctor

Nurse

- Avoid verbal orders as much as possible!
- All verbal orders should be written down and then read it back verbatim to the practitioner who initiated it.
- The practitioner should then verbally confirm that the order is correct.
- The nurse then must document that he/she has verified the verbal order with their initials.

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How can we improve communication throughout the organization?

- Create a documentation tool on which all staff can document important issues concerning care or follow-up.
- Educate staff to encourage successful methods of communication (appropriate & skillful listening and negotiating techniques).
- Maintain a non punitive environment, that supports the reporting and analysis of errors.

Standardized Abbreviations Throughout The Organization!

- **Goal:** To improve safety and communication through appropriate use of abbreviations.
- **Why:** To reduce the risk of medication errors associated with:
  - Bad handwriting or typo
  - Signs
  - Greek letters
  - Latin terms
  - More then one meaning

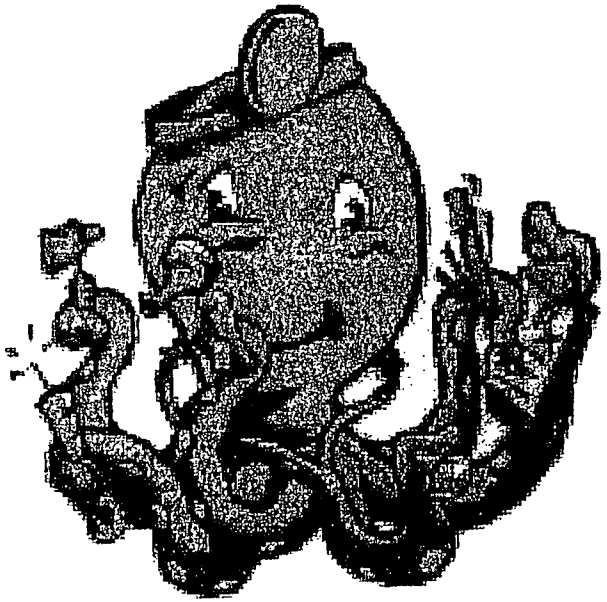
Pharmacist

Acceptable Abbreviations

Unacceptable Abbreviation	Correct Abbreviation or Wording	Unacceptable Abbreviation	Correct Abbreviation or Wording
µ g	Microgram	U or u	Unit
o.d. or OD	Daily	IU	Units
TIW or tiw	Three times a week	cc	mL
Per os	PO, By Mouth Or Orally	x3d	For three days.
q.d. or QD	Daily or Every Day	BT (bedtime)	Hs (hour of sleep)
Qn or qhs	Nightly	ss	One-half or 1/2
q6PM	6PM Nightly	< and >	Greater and Less than
q.o.d. or QOD	Every Other Day	/ (slash mark)	per
Sub q or SC	Subcut or Subcutaneous	1.0 mg / .5 mg	1 mg / 0.5mg

If we are busy or not!!!!

- **STOP** and **verify** all verbal orders!
- Use only **APPROVED** abbreviations!
- Keep lines of **COMMUNICATION** open between all staff members!!!
- Remember, we are **ALL** important members of the healthcare team!



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Piedmont Medical Center	Policies and Procedures	Page 1 of 11
	SUBJECT: Medication Administration	Original Date: 1970
		Revised: 10/95, 10/96, 5/97, 7/97, 9/99,2/00,7/00, 11/02, 4/03
		Reviewed: 5/02

Policy Statement(s):

1. Individuals order and/or administer medications as defined in their scope of practice.
2. Medications are administered to patients in accordance with the five rights of medication administration.
3. Medications are be maintained in a secure manner.
4. All newly ordered medications are to be reviewed with a pharmacist prior to administration except in the case of an emergency.
5. Dangerous abbreviations are avoided when medications are ordered. (See attached list).
6. The hospital does not dispense drugs to patients to take home on discharge, unless the drugs are prescribed in continuity with hospital care and only on written orders of a physician. Medications partially used as ointments, creams, sprays and liquids may be taken home if sent to the Pharmacy with a physician's prescription for re-labeling.

Responsibility:

Healthcare providers licensed to administer or dispense medications.

Definition(s):

1. The Five Rights of Medication Administration:

   Right Patient
   Right Medication
   Right Dose
   Right Time/Date
   Right Route/Method

2. Licensed Independent Practitioner – Any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual's license and individually granted clinical privileges.
3. Secured – Stored in a locked cart, cabinet or bin.

Equipment/Supplies:

Medication Administration Record
Pill crusher

Syringes, needles, filter straws
Diluent
Physician's Order Sheet

Procedure:

1. Orders

   A. Orders shall be written legibly and dated and timed on the order sheet. If the order is confusing or illegible, the order is clarified with the ordering physician prior to dispensing or administration of the drug.

   B. Changes in the level of care, (i.e. transfers to or from a critical care unit), require new medication orders.

   C. For orders "Continue Home Medications", the nurse asks the patient for the name, dose, frequency of each medication, verifies this information with the physician and then writes each medication as directed as an order on the physician's order form.

   D. For orders "Resume Medications", the nurse verifies the name, dosage and frequency of each medication with the physician and then writes each medication as directed as an order on the physician's order form.

2. Routine – Times of Administration

   A. All routine medications are delivered to the patient care area within 3 hours of receipt of a physician's written/verbal order.

   General Guidelines

   A. The initial dose of a prescribed medication is given at the closest scheduled administration time unless otherwise ordered (as in the case of "Now" or "Stat" orders).

   B. Administer medications within one hour before or after the scheduled time of administration.
      1) Routine administration times:

AC	0730 1130 1630
PC	1000 1400 1800
Daily	0900 or 1000
AM	0900
Bedtime	2100
BID	0900 1700
TID	0900 1300 1700

QID 0900 1300 1700 2100
Q4H 0100 0500 0900 1300 1700 2100
Q3H 0300 0600 0900 1200 1500 1800 2100 0000
Q8H 0600 1400 2200
Q6H 0600 1200 1800 0000
Q12H 0900 2100

C. If two medications are scheduled at the same frequency of administration, place medications on opposite schedules, i.e. one on Schedule A and one on Schedule B.
   1) IV Piggyback – Administration times shall be as follows unless otherwise ordered:

Schedule A

Q4H 0200 0600 1000 1400 1800 2200
Q6H 0600 1200 1800 2400
Q8H 0600 1400 2200
Q12H 0900 2100
Q24H 0900

Schedule B

Q4 H 0100 0500 0900 1300 1700 2100
Q6H 0300 0900 1500 2100
Q8H 0200 1000 1800
Q12H 0600 1800 or 1200 2400
Q24H 2100

D. Behavioral Medical Units medication administration times vary. See Unit Specialty Manual.

3. Special Circumstances

A. Admission
   1) All large volume intravenous fluids without additives are initiated within two hours of admission using unit based stock fluid.
   2) For new admissions, the nurse administers daily or q AM medications that have not been started in the Emergency Department up until 1500 unless the physician orders otherwise.

B. NOW or STAT Orders
   1) NOW and STAT medications are obtained from the Pyxis, if available. If unavailable from the Pyxis, they are obtained from Pharmacy.
   2) A STAT medication is given within a maximum of thirty minutes from receipt of the written/verbal physician order.
   3) A NOW medication shall be given within a maximum of one hour from receipt of the physician

order.

4) When order written on MD order sheet and not yet transcribed to the MAR and it is a NOW or STAT medication, the RN is to sign on order sheet next to medication ordered with RN initials and time of administration of the drug.

C. Hold Orders

1) Whenever a physician orders "Hold (medication name)" with a specific time limit, (i.e. Hold 9 am dose of Lasix tomorrow), the medication is held for that specific time ordered and resumed as previously scheduled/ordered.
2) Whenever a physician orders "HOLD (medication name)" without a specific time frame, this is interpreted the same as an order to discontinue the medication.
3) Whenever a medication is ordered to be held for a specific level or parameter, the parameter shall be documented on the MAR next to the time held and the nurse's initials.

D. Pre-Op/Pre-Procedure

1) Preoperative orders shall automatically cancel all PO medication orders after midnight prior to surgery unless otherwise specified by the physician. All other medications shall be discontinued automatically at the time of surgery.
   NOTE: This applies to patients NPO for surgery and not to patients NPO for diagnostic testing such as Imaging, Endoscopy, or Cardiac Cath. Specific pre-procedural orders for administration/holding of medications are followed.
2) For "On Call to OR" medications, when the OR calls for a patient to be given his pre-op medication, this is a STAT order requiring the pre-op medication to be given immediately.
3) The nurse administers daily or q AM medications that have been held for testing or other reasons up until 1500 unless otherwise ordered.
4) All medications are ordered by the physician following surgical procedures. Surgery cancels all previous medication orders.

E. Discontinuing Medications

1) All medications are discontinued and must be reordered post operatively.
2) Medications are discontinued and must be reordered upon any change in the level of care – (example: transfer to or from a critical care area).
3) Controlled substance orders are reordered every 10 days, or they will be discontinued by Pharmacy.

F. Emergencies

ACLS protocol drugs are administered in the event of a cardiac/pulmonary arrest in the absence of a physician as approved by the Medical Executive Committee. The administration of these drugs is directed by an ACLS credentialed registered nurse until the arrival of a physician.

G. Range Orders

1) When a range order is written with certain dosage and frequency range (Ex A: 2-4mg every

4 – 6 hours, Ex B: 1-2 tablets every 6 – 8 hours), it shall be interpreted as follows unless specified by the physician:

a. Begin with giving the lower dose (For above examples: 2mg for Ex A and one tablet for Ex B). If symptomatic relief is not obtained or condition not improved, then the next dose should be increased to higher dose (e.g. 4mg for Ex A, two tablets for Ex B).
b. Start with longer time interval (For above examples: every 6 hours for Ex A and every 8 hours for Ex B). If symptoms appear before the next dose, the dosing interval can be decreased to shorter intervals.

2) PRN orders shall be written to include the symptom or indication for use (e.g. PRN pain, PRN fever) unless there is only one possible use for the medication. PRN orders are only administered if the symptom or indication is present.

H. Discharge

A. Upon discharge all medications are returned to the Pharmacy by the Pharmacist or Pharmacy Technician, or Pharmacy staff courier using computer discharge summary sheets.

B. All unused medications are credited to the patient.

C. All partially used medications are destroyed.

D. Partially used medications (creams, ointments, eye medications, inhalers, liquid-reconstituted antibiotics only) may be sent home with the patient upon written order of the physician.

No controlled substances shall be sent home with the patient.

1) The Pharmacy shall be given a prescription and the partially used medication to be re-labeled.
2) The Retail Pharmacy fills any other discharge prescriptions given them by their physician, per the patient's request. The patient must pay for these prescriptions. They cannot be added to the patient's bill.
3) The Pharmacist labels the medication according to law.
4) The properly labeled medication is returned to the floor, patient or family member.
5) The RN or LPN may then give the medication to the patient to take home.
6) No refills are allowed on these prescriptions.
7) Under no circumstances is a nurse allowed to give a patient an unlabeled drug to take home.

E. Each drug released to a patient on discharge shall be recorded in the discharge notes in the patient's medical record.

4. Storage of Medications

A. Medications shall not be kept at the patient bedside. Exception: Metered dose inhalers with a physician order.

B. Medications are stored in individual, labeled patient cassettes or bins in a secured location/medication cart.

C. The medication cart/preparation area is secured at all times.

D. If a keyed medication cabinet is utilized, the key is in the possession of the medication nurse, charge nurse or other authorized personnel at all times.

E. Medications are delivered by the Pharmacy.

F. Discontinued medications and any medication left at the time of discharge are returned to the Pharmacy.

G. Each nursing unit is responsible for stocking each medication cart with medication preparation supplies, cleaning the cart and emptying the trash.

5. Medication Preparation

A. Distractions are limited during medication preparation.

B. Medications are only prepared for one (1) patient at a time.

C. Medications remain in the unit dose packaging until administration.

D. A physician's order is obtained if unscored tablets or capsules must be divided in order to obtain the correct dose.

E. Medications are crushed in the original packaging or in an approved pill crusher if necessary. Enteric coated medications are not crushed.

F. If a medication must be given via an enteric feeding tube, the nurse notifies the pharmacist and requests a liquid form of the drug if available.

G. Medications are not removed from the unit dose packaging until at the bedside. If medications are removed from the unit dose packaging, they shall be wasted if not immediately administered.

Liquid Medication

H. Note the condition of liquid medicine. If there is sediment in a bottle which does not give directions to shake before using, it shall be wasted and refilled promptly.

I. Hold container at eye level.

J. Wipe the mouth of the bottle prior to replacing the lid.

Injections

Sterile water/sterile saline is used as a diluent for parenteral injections unless a specific diluent is indicated for the medication.

6. Medication Administration

A. Medication Administration Records (MARs) are brought into the patient's room as part of the verification process. Exception: Patient in isolation.

B. The nurse visually checks the patient's armband for name and birthdate to confirm identity prior to medication administration.

C. When giving medications, the name of the drug and dosage is checked two (2) times: when the medication is taken from the drawer and when it is placed into the cup. The medication shall be compared with the Medication Administration Record.

D. If there is a question related to the medication, dosage, time, patient or route, the nurse reviews the original order for verification prior to administration.

E. The nurse observes the patent take medications. Medications are not left at the patient's bedside to be taken later.

F. The nurse administers medications to only one patient at a time.

G. If a patient is noted to be unable to protect his airway, the nurse holds the oral medication(s) and contacts the physician for an alternate route.

H. The needleless IV system is utilized at all times. Use of sharps is limited to IM/SQ injections. Medications are removed from vials using the approved needle less transfer system.

I. Needles are not recapped. All sharps are disposed of in the biohazard sharps container closest to the point of medication administration.

J. If medications are administered via an enteral feeding tube, the tube is flushed with at least 30 cc of water before and after giving the drug.

7. Administration of Selected Medications

A. Digoxin, beta blockers, calcium blockers

These medications are not held without a physician's order unless the patient is experiencing symptomatic bradycardia, (i.e., light headed, dizzy and unable to walk without pre-syncopal episodes). The medication is then held and the physician notified immediately if any of the above symptoms occur.

B. Isosorbide Mononitrate (ISMO)
ISMO is given in two (2) oral doses daily 7 hours apart. Administration times are at 0900 and 1600.

C. Warfarin (Coumadin)
1) The initial Coumadin dose will be determined by the physician.
2) PT/INR is ordered daily per protocol.
3) The Coumadin dose is ordered daily by the physician based on the PT/INR result.
4) The PT/INR result is recorded daily by the RN on the MAR in the Coumadin dose section prior to the dose being administered.
5) Coumadin is given daily at 1700.
6) The RN holds the Coumadin dose and immediately notifies the physician whenever the INR result is greater than 3.0 unless a target range has been ordered by the physician.
7) Whenever the physician discontinues Coumadin therapy, repeating lab work for PT/INR is discontinued automatically.

Note: The physician may elect a predetermined daily dose of Coumadin. In the event, the PT/INR protocol will be followed based on the physicians written daily dose.

D. Oral hypoglycemic Agents
These agents are given at 0730 and 1630.

E. Promethazine HCl (Phenergan)
Phenergan may be given undiluted, slow IV Push via central line. If given peripherally, it is diluted in a minimum of 10 ml normal saline and given at a rate not to exceed 1 ml/min.

F. IV Potassium Chloride Administration
1) Concentration (Maximum recommended dilutions)

KCl Delivery	Large Volume Dilution	Small Volume Dilution
Peripheral Line	40 mEq/liter	10 mEq/100 ml
Central Line	80 mEq/liter	40 mEq/100 ml
Central Line w/Entry Into Heart	60 mEq/liter	6 mEq/100 ml

2) Rate (Maximum mEq/hour)
High infusion rates may result in high intra-cardiac K+ concentrations, causing increased danger of arrhythmias.