THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM DARLINGTON COUNTY
Court of Common Pleas

CIVIL ACTION NO: 2010-CP-16-0332
TRACKING NO: 2011-197671

Pee Dee Health Care, P.A.,.....Appellant,

v.

Estate of Hugh S. Thompson, ...Respondent.

SUPPLEMENTAL RECORD ON APPEAL

Counsel of Record for Appellant:

Tony R. Megna, Esquire
Matthews and Megna, LLC
3400 West Avenue
Columbia. SC 29203
(803) 254-3676

Counsel of Record for Respondent:

Rene Josey, Esquire
PO Box 5478
Florence, SC 29501

And

Jay James, Esquire
PO Box 507
Darlington, SC 29540

RECEIVED
JAN 24 2013
SC Court of Appeals

Index to Supplemental Record on Appeal as required by this Court's order dated January 8, 2013.

EXHIBIT 1

IN SUPPLEMENTAL RECORD ON APPEAL

(ORDER OF COURT DATED JANUARY 8, 2013)

Received 1/10/13

The South Carolina Court of Appeals

Pee Dee Health Care, P. A., Appellant,

v.

Estate of Hugh S. Thompson, Respondent.

Appellate Case No. 2011-197671

RECEIVED
JAN 24 2013
SC Court of Appeals

ORDER

After careful consideration, Respondent's motion to dismiss is denied. However, within twenty days, Appellant shall serve and file a supplemental record on appeal that includes the three matters Respondent alleges were omitted from the record on appeal. The missing items include: (1) Exhibits to the Return to the Motion to Disqualify, (2) Exhibits to Pee Dee Health Care's Return to Motion to Disqualify, and (3) Exhibits to the Motion to Disqualify.

Furthermore, Appellant's motion for extraordinary relief is denied.

FOR THE COURT

Columbia, South Carolina

FILED
1/8/13 AS

cc:
John J. James, II
Jon Rene Josey
Tony Ray Megna

EXHIBIT 2

IN SUPPLEMENTAL RECORD ON APPEAL

(Original Exhibit HH of Plaintiff's Response to Motion to Disqualify)

HH

Dear Tony,

I have been awfully rushed since I got back from Columbia (late last night). Sorry I haven't found all the documents you need. I will get the rest of them together as soon as possible, and if necessary, bring them up to you in Columbia.
You will find two "private agreements" with the Board: the earlier dated one (which has probably been superseded by the one executed this year) was the result of the settlement in Federal Court I referred to.
I've got literally a box full of documents concerning the arduous struggle with the Board. Any of them I can make available to you if you need them.
I think the current "private agreement" is the index document now. I'm sure I'll be talking to you again soon, and I'll try to locate everything before I do.

Thanks,

Hugh Thompson

copied/sent 9-15

EXHIBIT 3

IN SUPPLEMENTAL RECORD ON APPEAL

(Original Exhibit V of Pee Dee Health Care's Motion to Disqualify)

Medical University of South Carolina

On the nomination of the Faculty

of the

College of Medicine

has conferred upon

Hugh Smith Thompson, Jr.

the degree of

Doctor of Medicine

In testimony whereof this Diploma has been issued at Charleston

in the State of South Carolina this seventeenth day of March in the year of our Lord one thousand nine hundred and seventy-three.

Chairman, Board of Trustees

President

Dean, College of Medicine

Ex. 5, 4 J

Medical College of South Carolina

On the nomination of the Faculty

of the

School of Pharmacy

has conferred upon

Hugh Smith Thompson, Jr.

the degree of

Bachelor of Science in Pharmacy

In testimony whereof this Diploma has been issued at Charleston, in the State of South Carolina, this first day of June in the year of our Lord one thousand nine hundred and sixty-seven.

Edwin Schachte, Jr.
Chairman, Board of Trustees

AUGET LABORANDO

William McCord
President
William H. Golod

FOWLER RURAL MEDICAL CLINIC
DON H. FOWLER, M.D.
P.O. BOX 875 210 E. DOZIER ST.
MARION, S.C. 29571-0875
(843) 423-4044
FAX (843) 423-3489

June 30, 1998

Mr. Tom Fuller, Administrator
Marion County Medical Center
Marion, S.C. 29571

RE: Hugh Thompson, M.D.

Dear Tom:

Please find attached a letter from Hugh Thompson, M.D. explaining his current situation. Dr. Thompson began working at Fowler Rural Medical Clinic in May of this year. Our agreement is that he continue his CME in Family Practice and works in the clinic under my supervision until such time we both feel comfortable requesting hospital priviledges.

I would like for him to perform History and Physicals and dictate Discharge Summaries in the near future. We have requested the approval of the Medical Board for these priviledges and are awaiting their answer.

I will be happy to keep you abreast of any developments. As you know I desperately need this help and have been very pleased with his performance over the last six weeks. He is knowledgable, personable and eager to learn more about the practice of Family Medicine.

I am asking for your patience in this matter and apologize for any confusion or inconvenience this may have caused.

Sincerely,

Don H. Fowler, M.D.

Don H. Fowler, M.D.

cc: Medical Staff

Duke University

Duke University Medical Center

this is to certify that

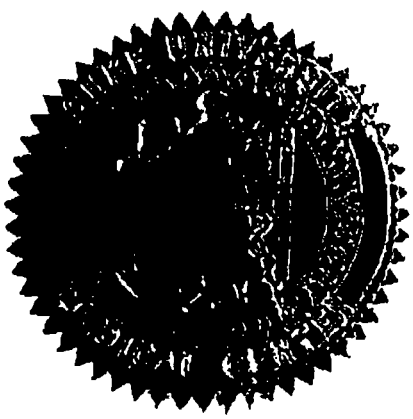
Hugh Smith Thompson, M.D.

Has Completed Creditably Postgraduate Training
in the Duke University Medical Center
and Affiliated Hospitals

Department of Anesthesiology
Resident 10·1·74 ~ 9·30·76

October 1, 1976

Durham, North Carolina



Ernest W. Busse
Director, Medical Education

Stuart M. Lessoma
Hospital Director

Merel H. Harmel
Chairman of Department

National Board of Medical Examiners

of the

United States of America

Hugh Smith Thompson, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a

Diplomate of the National Board of Medical Examiners

Attest

J. Myers
Chairman of the Board

John A. Hubbard
President of the Board

Philadelphia, Pa.
July 1, 1974

Certificate No. 120029

SC Department of Labor, Licensing and Regulation
Board of Medical Examiners
1999-2000

REGISTRATION CERTIFICATE

PHYSICIAN

EXPIRES 12/31/2000

ALL PHYSICIANS LICENSED BY THIS BOARD ARE REQUIRED TO REREGISTER ANNUALLY. APPLICATIONS ARE MAILED BY MAY 1st EACH YEAR. THIS IS TO CERTIFY THAT THE PHYSICIAN NAMED BELOW HAS REGISTERED WITH THE BOARD.

DR. HUGH S. THOMPSON

CERTIFICATE & LICENSE NUMBER 7087

REPORT CHANGES AS REQUIRED

Administrator

P.O. Box 11329 • Columbia, SC 29211-1329

American Medical Association

Physicians dedicated to the health of America

July – December 1999

☐ Yes, I want to apply for my AMA membership and confirm my commitment to the Principles of Medical Ethics.

☐ Please send me state/county medical society membership information.

Hugh Thompson MD
115 N Ervin St
Darlington SC 29532

Half Year Membership Application

1999 Dues	210.00

(If payment has already been made, please disregard this notice.)

Payment method: ☐ Check made payable to AMA
☐ MasterCard ☐ VISA ☐ AMEX ☐ OPTIMA

Please check credit payment method below (select one option):
☐ Credit card single payment
☐ Credit card single payment with automatic renewal
☐ Credit card installment payments with automatic renewal
See back for credit payment information.
☐ Multi-Year Regular Physician Membership
Pay for 4 years – get the 5th year free (Physicians Only)
☐ Yearly payment with automatic renewal
☐ Monthly payment with automatic renewal

Credit Card No.

Signature Required Exp. Date

Daytime Phone

04501731311 80 99 18102A 12610

Address Verification

To help ensure your benefits reach you in a timely fashion, please verify your address.

Hugh Thompson MD
04501731311

Declined
6/23/99

Please print clearly your corrected or preferred mailing address below.

Name

Address

City State Zip

Telephone Fax

e-mail

Is this your: ☐ Home ☐ Office ☐ Other

Return this application in the enclosed postage-paid envelope or mail to:
Membership Processing, American Medical Association, P.O. Box [illegible], Chicago, IL [illegible]

Membership Qualification Questions

(Not applicable to medical students.)

Hugh Thompson MD
04501731311 80 99 18102A 12610
Darlington SC 29532

Members of the AMA abide by the Principles of Medical Ethics. To assist us in upholding these standards, please provide the answers to the following questions. Then sign and date this application and return it in the postage-paid envelope.

Yes No
☐ ☐ 1. Have you been convicted of fraud or a felony within the last five years?
☐ ☐ 2. Has any action, in any jurisdiction, been taken regarding your license to practice medicine within the last five years or extending to within the last five years? This includes actions involving revocation, suspension, limitation, probation, or any other sanctions or conditions imposed upon a license.
☐ ☐ 3. Have you been the subject of any disciplinary action by any medical society or hospital staff within the last five years?

If you answered yes to any of these questions, please attach full information.

The foregoing information is true and complete, and I endorse the Principles of Medical Ethics (see back).

Signature Date

Your AMA membership (except for fully retired members) includes benefit of membership subscriptions to *Journal of the American Medical Association* ([illegible] per year) and *American Medical News* ([illegible] per year). $10.00 of member dues are allocated for each publication. These subscriptions are a benefit of membership and are not deductible from the annual AMA membership dues. *Allow 4-6 weeks to receive your first issue.*

6/8/99

To: Jean
Fr: Mark

HUGH S. THOMPSON
111 N ERVIN ST
DARLINGTON, SC 29532

3347

DATE 6/8/99

PAY TO THE ORDER OF Pamplin Memorial Education Fund $ 175.00

One hundred seventy five and 00/100 DOLLARS

DARLINGTON COUNTY BANK

For 1999 Calgeria file CME

:053201886: 0101555906# 3347

CME 36 credit hours

Dr. Thompson

Dept Dev.
DMC

10

CW 7

BEFORE THE STATE BOARD OF MEDICAL EXAMINERS OF SOUTH CAROLINA

In the Matter of: Hugh S. Thompson, M.D., Licensee.	**PRIVATE AGREEMENT**

WHEREAS, Licensee has advised the Board of a commitment to a life of sobriety and willingness to submit at Licensee's expense to such tests and other conditions as the Board may desire, from time to time, to assure it of Licensee's continued compliance with that commitment.

THEREFORE, IT IS UNDERSTOOD AND AGREED THAT:

1. This Agreement is not a disciplinary action under S.C. Code Ann. §40-47-200 (Supp. 1996), but instead is a reasonable accommodation designed to protect the public and assist Licensee in a continuing recovery effort. Licensee hereby consents to the monitoring of Licensee's treatment and practice of medicine. Licensee specifically consents and does hereby agree to comply with the following terms and conditions, which shall continue in effect until further Order of the Board:

(a) Licensee shall completely abstain from the consumption of mood-altering substances, including alcohol, except as prescribed by a duly licensed practitioner for a documented legitimate medical purpose. All use of such substances is to be reported by Licensee to the Board or its designee within 48 hours of initiation. All such medical treatment and prescribing shall be reported directly to the Board in writing by the treating practitioner within ten (10) days after the date of treatment. Licensee must inform the treating practitioner of this responsibility and ensure timely compliance. Failure to inform the treating practitioner of this responsibility shall be considered a violation of this Agreement.

(b) Licensee shall be subject to periodic, unannounced blood and urine alcohol and/or drug analysis as desired by the Board, the purpose being to ensure that the Licensee remains drug and/or alcohol-free. The cost of such blood and urine alcohol and/or drug analyses and reports will be borne by Licensee, which costs shall be paid within thirty (30) days after the date of the invoice therefor. Failure to make timely payment of such costs, to provide a specimen upon request, or to remain alcohol and/or drug-free shall be considered a violation of this Agreement.

(c) Licensee must have a written contract with and be an active participant in the activities of an aftercare program approved in advance in writing by the Board including, but not limited to, the Physicians Advocacy and Assistance Committee of the South Carolina Medical Association, or a successor program approved as such

by the Board (hereinafter the Program). Such contract shall specify the required frequency of attendance at support groups, or other such activities as the Program shall deem appropriate, including, but not limited to:

(1) Monitoring and aftercare activities of the Program;
(2) Alcoholics Anonymous (AA) or Narcotics Anonymous (NA);
(3) Caduceus support groups or its equivalent approved by the Board;
(4) Such additional therapeutic activities as deemed appropriate and necessary by the Program when incorporated into the contract.

Licensee shall submit or arrange for the submission of quarterly written reports documenting Licensee's regular participation in such therapeutic activities deemed appropriate by the Program, and documenting Licensee's full compliance with the terms of the contract with the Program and this Agreement. Said reports shall be submitted on or before the first day of April, and every third month thereafter.

(d) Within thirty (30) days of the date of this Agreement, Licensee must provide to the Board a letter signed by an appropriate representative of the Program mentioned above verifying that Licensee has signed a written contract with and become an active participant in the activities of the Program, as required above. Compliance with this paragraph shall not be deemed satisfied until said written verification is received by the Board. Failure to comply with this requirement within the prescribed time shall automatically result in the immediate temporary suspension of Licensee's license to practice until such time as full compliance has been made by Licensee.

(e) Licensee shall appear and report to the Board as requested by the Board.

(f) Licensee shall promptly advise this Board in writing of any changes in address, practice, hospital privileges, professional status, or compliance with this Agreement. Correspondence and copies of reports and notices mentioned herein shall be directed to:

LLR-Board of Medical Examiners
P. O. Box 11289
Columbia, SC 29211-1289

2. It is understood and agreed that by executing this Agreement, Licensee specifically consents to execute and to deliver to the Board, within ten (10) days of request, an authorization for the release to the Board of any and all records, reports, or other information concerning Licensee by any and all persons or entities involved, notwithstanding any privilege provided by federal or state law. Failure to comply with this requirement within the prescribed time shall automatically result in the immediate temporary suspension of Licensee's license to practice until such time as full compliance has been made by Licensee.

3. It is further understood and agreed that this Agreement is not to be considered a public document under the South Carolina Freedom of Information Act and shall remain private. However, a copy of this Agreement may be provided by the Board upon written request by any other federal or state licensing or regulatory authority.

4. It is further understood that, because of its private nature, this Agreement does not require Licensee to disclose its existence to others, except federal or state licensing or regulatory authorities.

5. It is further understood and agreed that each provision of this Agreement shall be subject to review by the Board. Licensee shall cooperate with the Board, its attorneys, investigators, and other representatives in the investigation of Licensee's practice and compliance with the provisions of this Agreement. Licensee may be required to furnish the Board with additional information as may be deemed necessary by the Board or its representatives. In addition to such requests, the Board in its discretion may require Licensee to submit further documentation regarding Licensee's practice, and it is Licensee's responsibility to fully comply with all such requests in a timely fashion. Failure to satisfactorily comply with such requests will be deemed a violation of this Agreement.

6. It is further understood and agreed that in the event that public action is subsequently taken by the Board as a result of violation of the terms and conditions provided herein, then this Agreement shall become disclosable as a public document under the South Carolina Freedom of Information Act.

7. It is further understood and agreed that if Physician fails to abide by any of the aforementioned terms and conditions, or if it should be indicated from reliable reports submitted to the Board that Physician is otherwise unable to practice medicine with reasonable skill and safety to patients, then Physician's license may be immediately temporarily suspended until further Order of the Board following hearing into the matter of the failure. It is understood and agreed that by executing this Agreement, Physician specifically consents to waive the procedural requirements of S.C. Code Ann. §40-47-200 and Regulation 81-12.5. It is understood and agreed that by executing this Agreement, Physician specifically consents to consideration by the Board of any appropriate sanction under §40-47-200 after the hearing required by this paragraph.

8. It is further understood and agreed that this Agreement does not satisfy, prejudice, or stay any disciplinary action currently pending before the Board or which may be filed in the future.

AND IT IS SO AGREED.

STATE BOARD OF MEDICAL EXAMINERS

Effective:_____
Date

BY:_____
BEN C. PENDARVIS, JR., M.D.
President of the Board

I AGREE:

_____
LICENSEE

_____
Date

_____
WITNESS OR ATTORNEY

_____
Date

Membership # 111 120

South Carolina Medical Malpractice
PATIENTS' COMPENSATION FUND
Post Office Box 210738
Columbia, SC 29221-0738
(803) 731-1687

CERTIFICATE OF MEMBERSHIP

Hugh S. Thompson, M.D.	SC 7087
NAME	**LICENSE NUMBER**
Fowler Rural Medical Clinic 210 E. Dozier St. Marion, SC. 29571	(843)423-4044
WORK ADDRESS	**TELEPHONE**
111 N. Ervin St. - Darlington, S.C. 29532	(843)393-3609
HOME ADDRESS	**TELEPHONE**

J.U.A.	Jo be Determined	5-18-98 - 5-18-99	100,000 / 300,000.
BASIC INSURANCE	**BASIC POLICY #**	**BASIC POLICY DATES**	**BASIC LIMITS**
Occurance	$8560.00	-0-	Family Practice
TYPE OF POLICY Occurrence/Claims	**BASIC INS PREM**	**PCF MEMBERSHIP FEE**	**TYPE PRACTICE**

I hereby agree to assist and cooperate with the PCF in all matters connected with my membership in the PCF.

I furthermore understand and agree that my membership in the PCF is contingent on my having in force basic malpractice insurance coverage with limits not less than $100,000 per claim and $300,000 annual aggregate for all claims, unless I have been certified by the PCF as a self-insured.

I furthermore understand and agree that my membership, along with all benefits provided to me by the PCF, will be suspended during the entire period of time that I do not have the required basic malpractice insurance coverage in force, unless I have been certified by the PCF as a self-insured.

I furthermore understand and agree that the PCF has no obligation and will make no payments for the defense or settlement of claims or judgements for incidents which occur during the suspension period.

WITNESS: Ruth R Brady _____ Hugh S Thompson MD
Notary Public Member

(PCF Use Only)

The PCF membership of _____

is hereby certified for the period of _____ to _____. Said membership is subject to the above conditions.

_____ _____
Date Administrator

Please return this form to the above address, a copy will be sent to you after processing.

Medical University of South Carolina

Teaching Hospitals

Charleston, South Carolina

This is to Certify that

Hugh Smith Thompson, M.D.

has completed the following training

SURGERY INTERN
for the period July 1, 1973–June 30, 1974

at these Hospitals and during such service has conducted himself creditably.

Dated at Charleston, South Carolina this 1st day of July , 1974

Dean, College of Medicine

Department Chairman

The Alpha Omega Alpha Honor Medical Society

FOUNDED BY WILLIAM W. ROOT

ΑΩΑ 1902

Be it known that

Hugh S. Thompson

has been elected to membership at

The Medical College of South Carolina

Anno Domini 1973

John Z. Bowers *President*

James A Campbell *Secretary-Treasurer*

Fellow-in-Anesthesiology

THE AMERICAN COLLEGE OF ANESTHESIOLOGISTS

OF

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC.

This is to certify that

Hugh Smith Thompson, M.D.

a duly licensed Physician, having complied with all the requirements of

THE AMERICAN COLLEGE OF ANESTHESIOLOGISTS,

and having demonstrated to its satisfaction an adequate preparation and experience together with special knowledge of the art and science of Anesthesiology, and being proficient in the practice of this specialty is hereby admitted as a

Fellow of The American College of Anesthesiologists

BY EXAMINATION

John S. Hallaz M.D.
President, A.S.A.

Richard T. Ward M.D.
Chairman, A.C.A.

8283

Eugene C. Noyes M.D.
Secretary, A.C.A.

The American Board of Anesthesiology

Hereby certifies that

Hugh Smith Thompson

a licensed Graduate of Medicine, having complied with all the requirements of this Board, is qualified to serve as a consultant in Anesthesiology.

Given this third day of October, 1980

THE AMERICAN BOARD OF ANESTHESIOLOGY, INC.

Robert L. Eastin, M.D.
President

Orval B Brandford M D
Vice-President

E L Eder M D
Secretary-Treasurer

AMERICAN BOARD OF MEDICAL SPECIALTIES EXCELLENCE

Certificate No. 9785

Fowler Rural Medical Clinic
Don H. Fowler, M.D.
P.O. Box 875
Marion, S.C. 29571-0875
(843)423-4044
FAX (843)423-3489

August 20, 1998

Mr. Aaron Kozloski, Executive Director
S.C. Board of Medical Examiners
P.O. Box 11289
Columbia, S.C. 29211-1289

Dear Mr. Kozloski:

I am writing to confirm to my satisfaction with the performance of Hugh S. Thompson, M.D. Doctor Thompson has, at my request, petitioned the Board to allow him to do histories, physical examinations and discharge summaries on the hospitalized patients of this clinic.
Doctor Thompson has performed his duties in a prudent and professional manner. He has demonstrated basic clinical competence and continues in his enthusiasm to increase his knowledge and skills in Family Practice. He has shown good judgment in being prompt to request consultation in patient care problems with which he feels he needs the input of experience.
From the standpoints of hastening his integration into this practice, as an educational tool, and as a great help to this practice, I feel it is entirely appropriate for him to undertake these duties. I would very much appreciate the Board's granting him this request.

Sincerely,

Don H. Fowler, M.D.

CC: Hugh S. Thompson, M.D.

BEFORE THE STATE BOARD OF MEDICAL EXAMINERS OF SOUTH CAROLINA

In the Matter of: Hugh S. Thompson, M.D., Medical License #7087, Licensee.	**PRIVATE AGREEMENT**

WHEREAS, Licensee has advised the Board of a commitment to a life of sobriety and willingness to submit at Licensee's expense to such tests and other conditions as the Board may desire, from time to time, to assure it of Licensee's continued compliance with that commitment.

THEREFORE, IT IS UNDERSTOOD AND AGREED THAT:

1. This Agreement is not a disciplinary action under S.C. Code Ann. §40-47-200 (Supp. 1996), but instead is a reasonable accommodation designed to protect the public and assist Licensee in a continuing recovery effort. Licensee hereby consents to the monitoring of Licensee's treatment and practice of medicine. Licensee specifically consents and does hereby agree to comply with the following terms and conditions, which shall continue in effect until further Order of the Board:

(a) Licensee shall completely abstain from the consumption of mood-altering substances, including alcohol, except as prescribed by a duly licensed practitioner for a documented legitimate medical purpose. All use of such substances is to be reported by Licensee to the Board or its designee within 48 hours of initiation. All such medical treatment and prescribing shall be reported directly to the Board in writing by the treating practitioner within ten (10) days after the date of treatment. Licensee must inform the treating practitioner of this responsibility and ensure timely compliance. Failure to inform the treating practitioner of this responsibility shall be considered a violation of this Agreement.

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the South Carolina Medical Association, or a successor program approved as such by the Board (hereinafter the Program). Such contract shall specify the required frequency of attendance at support groups, or other such activities as the Program shall deem appropriate, including, but not limited to:

(1) Monitoring and aftercare activities of the Program;
(2) Alcoholics Anonymous (AA) or Narcotics Anonymous (NA);
(3) Caduceus support groups or its equivalent approved by the Board;
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(d) Within thirty (30) days of the date of this Agreement, Licensee must provide to the Board a letter signed by an appropriate representative of the Program mentioned above verifying that Licensee has signed a written contract with and become an active participant in the activities of the Program, as required above. Compliance with this paragraph shall not be deemed satisfied until said written verification is received by the Board. Failure to comply with this requirement within the prescribed time shall automatically result in the immediate temporary suspension of Licensee's license to practice until such time as full compliance has been made by Licensee.

(e) Licensee shall appear and report to the Board as requested by the Board.

(f) Licensee shall promptly advise this Board in writing of any changes in address, practice, hospital privileges, professional status, or compliance with this Agreement. Correspondence and copies of reports and notices mentioned herein shall be directed to:

LLR-Board of Medical Examiners
P. O. Box 11289
Columbia, SC 29211-1289

2. It is understood and agreed that by executing this Agreement, Licensee specifically consents to execute and to deliver to the Board, within ten (10) days of request, an authorization for the release to the Board of any and all records, reports, or other information concerning Licensee by any and all persons or entities involved, notwithstanding any privilege provided by federal or state law. Failure to comply with this requirement within the prescribed time shall automatically result in the immediate temporary suspension of Licensee's license to practice until such time as full compliance has been made by Licensee.

3. It is further understood and agreed that this Agreement is not to be considered a public document under the South Carolina Freedom of Information Act and shall remain private. However, a copy of this Agreement may be provided by the Board upon written request by any other federal or state licensing or regulatory authority.

4. It is further understood that, because of its private nature, this Agreement does not require Licensee to disclose its existence to others, except federal or state licensing or regulatory authorities.

5. It is further understood and agreed that each provision of this Agreement shall be subject to review by the Board. Licensee shall cooperate with the Board, its attorneys, investigators, and other representatives in the investigation of Licensee's practice and compliance with the provisions of this Agreement. Licensee may be required to furnish the Board with additional information as may be deemed necessary by the Board or its representatives. In addition to such requests, the Board in its discretion may require Licensee to submit further documentation regarding Licensee's practice, and it is Licensee's responsibility to fully comply with all such requests in a timely fashion. Failure to satisfactorily comply with such requests will be deemed a violation of this Agreement.

6. It is further understood and agreed that in the event that public action is subsequently taken by the Board as a result of violation of the terms and conditions provided herein, then this Agreement shall become disclosable as a public document under the South Carolina Freedom of Information Act.

7. It is further understood and agreed that if Physician fails to abide by any of the aforementioned terms and conditions, or if it should be indicated from reliable reports submitted to the Board that Physician is otherwise unable to practice medicine with reasonable skill and safety to patients, then Physician's license may be immediately temporarily suspended until further Order of the Board following hearing into the matter of the failure. It is understood and agreed that by executing this Agreement, Physician specifically consents to waive the procedural requirements of S.C. Code Ann. §40-47-200 and Regulation 81-12.5. It is understood and agreed that by executing this Agreement, Physician specifically consents to consideration by the Board of any appropriate sanction under §40-47-200 after the hearing required by this paragraph.

8. It is further understood and agreed that this Agreement does not satisfy, prejudice, or stay any disciplinary action currently pending before the Board or which may be filed in the future.

AND IT IS SO AGREED.

Effective: 4-9-98 ~~4/8/98~~
Date

STATE BOARD OF MEDICAL EXAMINERS

BY: Hartwell Z. Hildebrand
HARTWELL Z. HILDEBRAND, M.D.
President of the Board

I AGREE:

[signature], M.D. 4/8/98
LICENSEE Date

Karen Y. Newton 4/8/98
WITNESS OR ATTORNEY Date

SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION
BEFORE THE BOARD OF MEDICAL EXAMINERS

In the Matter of:	)	
	)	
HUGH SMITH THOMPSON, M.D.	)	
	)	FINAL ORDER
Medical License #7087,	)	
	)	
Respondent.	)	
	)	

STATEMENT OF THE CASE

On or about June 7, 1993, the Executive Director of the Board of Medical Examiners (the Board) served and filed a Notice and Complaint against Hugh Smith Thompson, M.D. (Respondent), who is a physician duly licensed by the Board to practice medicine in South Carolina. On or about November 8, 1993, a Notice and Amended Complaint was served and filed against Respondent. On or about January 12, 1994, after proper notice, a hearing was held before a panel of members of the Medical Disciplinary Commission pursuant to S.C. Code Ann. §40-47-200 (Supp. 1993) and Regulations No. 81-15 and 81-16. Following Receipt of the Hearing Panel's Report, a Final Order Hearing was noticed and held on Wednesday, May 18, 1994, at the Board's Office located at the Koger Center, 101 Executive Center Drive, Suite 120, Columbia, South Carolina. Respondent appeared with counsel, Celeste T. Jones, Esquire. The State was represented by associate counsel Clifford O. Koon, Jr., Esquire, and Deputy General Counsel Richard P. Wilson.

The Board hereinbelow makes specific findings of fact regarding the issues involved in this matter. The findings are specifically based on the Board's review of the exhibits admitted into evidence and the testimony presented.

FINDINGS OF FACT

The Board finds:

1. Respondent is a physician duly licensed by the Board to practice medicine in South Carolina. He currently resides in Darlington, South Carolina. Respondent previously practiced anesthesiology in Florence, South Carolina, until he ceased active practice on or about April 30, 1992.

2. Respondent's case concerns the prescribing of quantities of various controlled substances and other dangerous drugs including Tylox, Lortab, Vicodin, Darvocet-N 100, Tagamet, and Darvon over an approximately 26 month period to an alleged patient outside a bona fide physician-patient relationship and without documented medical justification or need.

3. Respondent testified that he and Patient A were close personal friends who dated each other during the period under review. Respondent further testified that he had seen her socially 6 to 10 times prior to November 28, 1990, when she first requested pain medication from him. Although she lived in Columbia, she approached Respondent in Darlington allegedly because of her trust in him from their personal relationship and her concern for strict confidentiality due to her job situation which was sensitive to any allegation of personal drug abuse. Respondent further admitted that he was aware at that time of her history of substance abuse. Respondent stated that he nevertheless agreed to her request because of their close personal relationship and because he believed she was genuinely in pain.

4. Their arrangement was for her usually to telephone Respondent in Darlington and he, in turn, would telephone his authorization for drugs to a pharmacy in Columbia for her to

pick up. Respondent also admitted that sometimes at their social meetings she would tell him about her pain and then he would call-in a prescription for her, as requested.

5. Prescription documents found at a Columbia pharmacy reveal that between November 28, 1990, and January 6, 1993, Respondent called-in approximately 45 prescriptions for Patient A, principally for Schedule III narcotic analgesics, such as Lortab and Vicodin.

6. Respondent admitted that he never saw Patient A in a medical setting and never did a full history and physical examination of her. Respondent did not produce any medical record concerning the care he allegedly rendered to her and kept virtually no record of the drugs he prescribed for her.[1] Among other things, Respondent did no appropriate workups, kept no progress notes, and had no treatment plan to justify the medical need and purpose for the drugs he prescribed for her.

7. In response to a question from the Panel, Respondent admitted that he did not think of himself as a member of her treatment team. Therefore, Respondent apparently never advised other physicians, who were known by him to be actively treating Patient A for her medical problems, that he was supplying her with additional drugs which could mask some of the symptoms and causes they were attempting to treat.

---

[1] Respondent's record of the care he rendered during the approximately 26 month period under review consists of only seven (7) very brief references to quantities of Vicodin ES he prescribed during the last three months. The remaining documents in Respondent's record were portions of hospital records she had provided concerning some of her surgeries at various times during the period under review which documented her history of chronic pain. Those hospital records contain no reference to Respondent as a referring physician, consultant, or anesthesiologist. Additional hospital records concerning Patient A subsequently obtained for the Panel Hearing also are devoid of any reference to Respondent.

8. Respondent also appeared and testified under oath before the Board. Respondent admitted, among other things, that he had no "conventional" physician-patient relationship with Patient A. Respondent testified that the only physical examinations conducted by him were done "informally" in her home with someone else present. Respondent asserted that he once had medical records concerning Patient A's care, but that they must have been lost. However, it was conceded that there are no medical records in this record to support Respondent's position. Respondent further admitted that he knew of the prohibition of State law against prescribing controlled substances for family and close personal friends, and that he had become uncomfortable doing so in this case. However, Respondent testified that he continued prescribing to Patient A because of their personal relationship. Respondent further admitted that, although the physician is supposed to be in control, sometimes he was not. The record reveals that Respondent's only involvement was to supply Patient A with the drugs she requested.

9. Accordingly, the Board finds that there is no evidence of a bona fide physician-patient relationship between Respondent and Patient A. The Board further finds that Respondent's prescribing to Patient A was not in the usual course of professional practice and was below the professional standard of care in similar situations.

CONCLUSIONS OF LAW

The Board concludes that Respondent has violated S.C. Code Ann. §§40-47-200(7), (8), (11) and (12) (1986); Regulation No. 81-60(A), (D), (F), and (G) (1986); Regulations No. 81-

60(C), (D), and (E) (Supp.1992) of the Rules and Regulations of the Board; and S.C. Code Ann. §§44-53-360 (c) and (h) (1986).

SANCTION

In enforcing the Medical Practice Act, the Board is mindful that its ultimate purpose is to protect the public and maintain the integrity of the profession in the State. In fashioning an appropriate sanction, this Board has meticulously weighed the public interest and the need for services of qualified medical doctors against the countervailing concern that society be protected from professional misconduct.

Respondent's misconduct involves the unlawful and inappropriate prescribing of controlled substances outside a bona fide physician-patient relationship and not in the usual course of his practice. In addition to raising serious questions regarding his professional competence, Respondent's misconduct threatened the public health and subverted the laws governing the use of controlled substances.

Accordingly, the Board finds it is in the public interest to impose the following sanction.

THEREFORE, IT IS ORDERED THAT:

1. Respondent's license to practice medicine in this State is hereby suspended for an indefinite period. Said suspension shall be stayed and Respondent's license reinstated in a probationary status only after Respondent has satisfied the following specified precondition for reinstatement:

(a) Respondent shall pay a fine of Five Thousand and No/100 ($5,000.00) Dollars. Said fine shall not be deemed paid until received by the Board.

2. Thereafter, Respondent's license shall be reinstated in a probationary status for an indefinite period of time upon the following terms and conditions of probation, which shall remain in effect until further Order of the Board:

(a) Within thirty (30) days of the date of this Final Order, Respondent shall enter into a Consent Order or Agreement with the Bureau of Drug Control, South Carolina Department of Health and Environmental Control (the Department), restricting his Controlled Substances Registration in all schedules to institutional use only. This restriction is designed and intended to prohibit Respondent from prescribing controlled substances outside a hospital or clinic licensed by the Department. Compliance shall not be deemed complete until a copy of said Consent Order or Agreement is received by the Board. Failure to comply with this requirement within the prescribed time shall automatically result in the immediate temporary suspension of Respondent's license to practice medicine until such time as full compliance has been made by Respondent.

(b) Respondent shall use triplicate copies of prescriptions for all controlled substances written by him. One copy shall be delivered to the patient; one copy shall be placed in the patient's hospital or clinic record; and one copy shall be maintained by Respondent in a readily retrievable manner for inspection by representatives of the Board or other appropriate authorities. The last copy shall be delivered by Respondent to the Board upon request at such times as the Board may desire.

3. Failure by Respondent to abide by any of the aforementioned conditions of probation during said period shall warrant the immediate revocation of probation and the immediate imposition of the aforementioned indefinite suspension of his license to practice medicine in this State pending hearing into the matter and until further Order of the Board.

4. Respondent shall cooperate with the Board, its attorneys, investigators, and other employees in the investigation of Respondent's practice and compliance with the provisions of this Final Order. It is Respondent's responsibility to demonstrate compliance with each and every provision of this Final Order. Respondent may be required to furnish the Board with additional information as may be deemed necessary by the Board or its representatives. In addition to such requests the Board, in its discretion, may require Respondent to submit further documentation regarding Respondent's practice, and it is Respondent's responsibility to fully comply with all such requests in a timely fashion. Failure to satisfactorily comply with such requests will be deemed a violation of this Final Order.

5. This Final Order shall take effect immediately upon receipt by Respondent or his counsel.

AND IT IS SO ORDERED.

SOUTH CAROLINA DEPARTMENT OF LABOR,
LICENSING AND REGULATION
BOARD OF MEDICAL EXAMINERS

BY: _____
STEPHEN I. SCHABEL, M.D.
President of the Board

May 31, 1994.

(c) Respondent's medical records (office, hospital, and surgical activity) shall be subject to periodic review by Board representatives. The cost of such reviews shall be borne by Respondent.

(d) Respondent shall appear and report to the Board as requested by the Board.

(e) Within one (1) year of the date of this Final Order, Respondent must attend and document completion of the Clinical, Legal, and Ethical Issues in Prescribing Abusable Drugs program offered by the Florida Medical Association and the University of South Florida, or an equivalent course approved in advance by the Board. Respondent must file written proof of compliance with the Board within fifteen (15) days after completing this requirement. Failure to comply with this requirement shall automatically result in the immediate temporary suspension of Respondent's license to practice medicine until such time as full compliance has been made by Respondent.

(f) Respondent shall comply with the terms of this Final Order and all State and Federal statutes and regulations concerning the practice of medicine.

(g) Respondent shall promptly advise this Board in writing of any changes in address, practice, hospital privileges, professional status, or compliance with this Final Order. Correspondence and copies of reports and notices mentioned herein shall be directed to:

South Carolina Department of Labor,
Licensing & Regulation
Board of Medical Examiners
P. O. Box 212269
Columbia, SC 29221-2269

State of South Carolina

Department of Health and Human Services

David M. Beasley
Governor

July 14, 1998

Gwen Power
Director

CERTIFIED MAIL

Hugh S. Thompson, M.D.
111 N. Ervin Street
Darlington, SC 29532

RE: Reinstatement in the South Carolina Medicaid Program

Dear Dr. Thompson:

Based on the action taken by the South Carolina Department of Labor, Licensing and Regulation - Board of Medical Examiners, you are being reinstated in the South Carolina Medicaid Program. This action is retroactive to April 14, 1998, the date of the Reinstatement issued by the Board.

Sincerely,

Gwen Power
Director

GP:cm

cc: Ms. Carolyn G. Jordan, Chief
Bureau of Medicaid Program Assessment

Ms. Darlynn Thomas, Chief
Bureau of Health Services

Department Head, Program Development
Bureau of Community Services

Office of the Director
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 253-6100 • Fax (803) 253-4137

FROM :

FAX NO. :

Mar. 04 1999 11:55AM P1

ATTN
SUSAN

Tom Marchant
ASSOCIATES

Real Estate • Land Development
LICENSED IN NORTH & SOUTH CAROLINA

803-698-4184

3.4.99

TO: HUGH THOMPSON
FROM: TOM MARCHANT

CONTRACT ON LOT # 262

PLEASE SIGN/INITIAL WHERE NOTED
BY ↘ & RETURN.

SEE YOU TONIGHT.

Yo

Phone: 864/250-1800 Fax: 864/250-1808 Pager: 864/413-0040

FROM :   FAX NO. :   Mar. 04 1999 11:55AM P2

CONTRACT FOR SALE OF LAND OR LOT

DATE: A Contract to purchase is offered this 22 day of Feb, 1999 by HUGH THOMPSON, Purchaser

to MICHAEL K. ARMSTRONG, Seller

AGREEMENT AND DESCRIPTION: Purchaser agrees to buy and Seller agrees to sell all that lot or parcel of land, with the buildings and improvements thereon, if any, located in [illegible] County, South Carolina, and being described as follows: LOT [illegible] [illegible]

PRICE: The sales price is 14,000

(1) $ 500 Earnest money held in trust by TOM MARCHANT ASSOCIATES
(2) $ [illegible] Additional cash at closing
(3) $ [illegible] Loan Amount to be obtained by Purchaser
(4) $ 14,000 Sales Price

CONVEYANCE AND CLOSING DATE: Seller agrees to convey by marketable title and deliver a proper general warranty deed with all stamps affixed thereto, free of encumbrances, except subject to all reservations, easements, rights-of-way, and restrictive covenants of record or on the premises (provided they do not make the title unmarketable) and to all governmental statutes, ordinances, rules and regulations. The deed shall be prepared in the name(s) of HUGH THOMPSON [illegible] and delivered by Seller [illegible]. Closing [illegible] or standard [illegible] closing, and such action should on or before [illegible]

POSSESSION: Possession of said premises will be given Purchaser on or before AT CLOSING

EARNEST MONEY: If any contingency of the Contract cannot be satisfied through no fault of Purchaser, or if a binding Contract is not accepted by all parties, the earnest money will be returned to Purchaser after the deposit of funds has cleared the account of the broker holding the funds. All such monies [illegible] funds shall be deposited on or before the next banking day. [illegible]

ADJUSTMENTS: [illegible]

DEFAULT: [illegible]

[illegible]

GOOD FUNDS AT CLOSING: [illegible]

DISCLAIMER BY BROKERS AND AGENTS: THE PARTIES ACKNOWLEDGE THAT THE LISTING AND SELLING BROKERS AND THEIR AGENTS: [illegible]

[illegible]

REMARKS: [illegible]

ADDENDUM ATTACHED YES ✓ NO ____ IF YES, NUMBER OF ADDENDUMS [illegible]

If Purchaser and Seller both initial this sentence, each agrees that receipt of a signed document by telecopy (FAX) will be the same as receipt of an original signed contract. Seller ____ Purchaser ____

THIS IS A LEGALLY BINDING CONTRACT. PURCHASER AND SELLER SHOULD SEEK LEGAL ADVICE IF THE CONTENTS ARE NOT UNDERSTOOD. BOTH PURCHASER AND SELLER ACKNOWLEDGE THE RECEIPT OF A COPY OF THIS CONTRACT [illegible]

Witness to Purchaser	Date	Purchaser	SS#
Witness to Purchaser	Date	Purchaser	SS#
Witness to Seller	Date	Seller	SS#
Witness to Seller	Date	Seller	SS#

Listing Office ____ Listing Agent [signature] Phone # 864/250-1800

Selling Office ____ Selling Agent [signature] Phone # 864/250-1800

TOM MARCHANT ASSOCIATES
BOX 816 / GREENVILLE, SOUTH CAROLINA 29602 / 864-271-9222
CLIFF RIDGE 864 / 836-4004   DIGITAL PAGER 864 / 413-0040

DISCLOSURE AND CONSENT TO DUAL AGENCY

Brokerage Company TOM MARCHANT ASSOCIATES
(Print or type)

Licensee TOM MARCHANT
(Print or type)

Seller MICHAEL K. ARMSTRONG
(Print or type)

Buyer HUGH S. THOMPSON
(Print or type)

Property Location LOT # 262 CLIFF RIDGE DR.
(Print or type)
CLIFF RIDGE AT CAESAR'S HEAD, S.C.

LICENSEE/COMPANY DISCLOSURE: *PRIOR TO MAKING THIS REQUEST FOR CONSENT TO ACT AS A DUAL AGENT REPRESENTING BOTH SELLER/CLIENT AND BUYER/CLIENT IN THE SAME REAL ESTATE TRANSACTION INVOLVING THE ABOVE-STATED LOCATION, UNDERSIGNED LICENSEE/COMPANY HAS SEPARATELY INFORMED BOTH SELLER/CLIENT AND BUYER/CLIENT ABOUT THE LIMITED DUTIES OF A DUAL AGENT; AND HAS ADVISED THAT THE DUAL AGENT MAY NOT BE AN ADVOCATE FOR EITHER PARTY AND MAY NOT DISCLOSE TO ONE PARTY ANY INFORMATION GAINED FROM THE OTHER PARTY IF THE INFORMATION CONCERNS: WILLINGNESS OR ABILITY OF SELLER TO ACCEPT LESS THAN THE ASKING PRICE; WILLINGNESS OR ABILITY OF BUYER TO PAY MORE THAN THE OFFERED PRICE; CONFIDENTIAL NEGOTIATING STRATEGY NOT DISCLOSED IN AN OFFER AS TERMS OF A SALE; MOTIVATION OF SELLER FOR SELLING OR MOTIVATION OF BUYER FOR BUYING.*

SELLER OR BUYER ACKNOWLEDGMENT AND CONSENT: *SELLER OR BUYER BY SIGNING BELOW ACKNOWLEDGES THAT HE OR SHE HAS BEEN INFORMED BY LICENSEE/COMPANY ABOUT DUAL AGENCY AND THE LIMITED DUTIES OF A DUAL AGENT. SELLER OR BUYER HEREBY AGREES TO MODIFY ANY PRIOR AGENCY DISCLOSURE ACKNOWLEDGMENTS AND AGENCY REPRESENTATION AGREEMENTS WITH LICENSEE/COMPANY TO THE EXTENT THAT SELLER OR BUYER DOES VOLUNTARILY GIVE CONSENT FOR LICENSEE/COMPANY TO ACT AS A DUAL AGENT REPRESENTING BOTH SELLER AND BUYER ONLY IN THE REAL ESTATE TRANSACTION IN WHICH* MICHAEL K. ARMSTRONG
(Name of Seller)

IS THE SELLER AND HUGH S. THOMPSON
(Name of Buyer)

IS THE BUYER OF PROPERTY AT THE ABOVE-STATED LOCATION. SELLER OR BUYER FURTHER ACKNOWLEDGES RECEIPT OF A SIGNED COPY OF THIS FORM.

SIGNATURES

(Date) (Seller or Buyer)

(Date) (Seller or Buyer)

2.28.99 (Licensee)
(Date)

This form is promulgated by the South Carolina Department of Labor, Licensing and Regulation, Real Estate Commission for mandatory use by real estate licensees. It may be reproduced but may not be modified or altered in any way.

The American Board of Anesthesiology

Hereby certifies that

Hugh Smith Thompson

a licensed Graduate of Medicine, having complied with all the requirements of this Board, is qualified to serve as a consultant in Anesthesiology.

Given this third day of October, 1980

President

Vice-President

Secretary-Treasurer

Certificate No. **9785**

The American Board of Anesthesiology

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Given this third day of October, 1980

THE AMERICAN BOARD OF ANESTHESIOLOGY, INC.

Robert L. Eckenhoff, M.D.
President

Orval B Brownford M.D
Vice-President

E L Lebher M.D
Secretary-Treasurer

AMERICAN BOARD OF MEDICAL SPECIALTIES
EXCELLENCE
SPIRITUSQUE

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Orval B Brownford M.D
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E L Eger M.D
Secretary-Treasurer

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37

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Robert K. Enders, M.D.
President

Orval B Brownford M.D
Vice-President

E L Eckenhoff MD
Secretary-Treasurer

AMERICAN BOARD OF MEDICAL SPECIALTIES
EXCELLENCE
OPTIMUM SUAE

Certificate No. 9785

Fellow-in-Anesthesiology

THE AMERICAN COLLEGE OF ANESTHESIOLOGISTS

OF

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC.

This is to certify that

Hugh Smith Thompson, M.D.

a duly licensed Physician, having complied with all the requirements of

THE AMERICAN COLLEGE OF ANESTHESIOLOGISTS,

and having demonstrated to its satisfaction an adequate preparation and experience together with special knowledge of the art and science of Anesthesiology, and being proficient in the practice of this specialty is hereby admitted as a

Fellow of The American College of Anesthesiologists

BY EXAMINATION

John S. Hatley M.D.
President, A.S.A.

Richard T. Ward M.D.

8283

Eugene C. Noyel M.D.
Secretary, A.C.A.

39

Fellow-in-Anesthesiology

THE AMERICAN COLLEGE OF ANESTHESIOLOGISTS

OF

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC.

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Chairman, A.C.A.

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BY EXAMINATION

John S. Hatton M.D.
President, A.S.A.

Richard T. Ward M.D.

8283

Eugene C. Noyes M.D.
Secretary, A.C.A.

41

Fellow-in-Anesthesiology

THE AMERICAN COLLEGE OF ANESTHESIOLOGISTS

OF

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BY EXAMINATION

John S. Hatton M.D.
President, A.S.A.

Richard T. Ward M.D.

8283

Eugene C. Boyd M.D.
Secretary, A.C.A.

EXHIBIT 4

IN SUPPLEMENTAL RECORD ON APPEAL

(Original Exhibit B to Respondent's Motion to Disqualify)

Lake City Community Hospital
258 N. Ron McNair Boulevard
Lake City, SC 29560
843-374-2036

March 31, 2008

Palmetto GBA, Provider Enrollment
2300 Springdale Drive
Camden, SC 29020

Re: Lower Florence County Hospital
Provider Based #42-0066
CCN# 42-3433

To Whom It May Concern:

The enclosed CMS-855A application is for the purpose of changing our ownership interest and/or managing control information for both organizations and individuals for each of our Rural Health Clinics owned by Lower Florence County Hospital. The following sections were completed for:

Pee Dee Health Care
201 Cashua Street
Darlington, SC 29532
Provider Number-42-3433

Section 1- Changing Medicare information for provider 42333 NP# 1134301625
Section 1B-Ownership Interest and/or Managing Control Information (Organizations)
Ownership Interest and/or Managing Control Information (Individuals)
Section 3-No Adverse legal actions/convictions
Section 5-Ownership Interest-Organizations
Section 6-Ownership Interest-Individuals
Section 13- Contact Person
Section 15- Certification Statement
*attachment: provider based attestation statement

If you should have any questions please contact me at 803-799-1700.

Sincerely yours,

Cheri Reed

Cheri L. Reed, Senior Director, Human Resources & Compliance

DEFENDANT'S EXHIBIT B

DM

MEDICARE ENROLLMENT APPLICATION

INSTITUTIONAL PROVIDERS

CMS-855A

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 41 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

SECTION 1: BASIC INFORMATION

A. Check one box and complete the required sections

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
❑ You are a **new enrollee** in Medicare	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all** sections except **2F, 2G,** and **2H**
❑ You are enrolling with another fee-for-service contractor's jurisdiction ❑ You are **reactivating** your Medicare enrollment	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all** sections except **2F, 2G,** and **2H**
❑ You are **voluntarily terminating** your Medicare enrollment	Effective Date of Termination: Medicare Identification Number that is terminating *(if issued)*: NPI *(if issued)*:	**Complete sections: 1, 2B1, 13,** and either **15** or **16**
❑ There has been a **Change of Ownership (CHOW)** of the Medicare-enrolled provider You are the: ❑ Seller/Former Owner ❑ Buyer/New Owner	Medicare Identification Number *(if issued)*: NPI: Tax Identification Number:	**Seller/Former Owner: 1A, 2F, 13,** and either **15** or **16** **Buyer/New Owner: Complete all** sections except **2G** and **2H**
❑ Your organization has taken part in an **Acquisition** or **Merger** You are the: ❑ Seller/Former Owner ❑ Buyer/New Owner	Medicare Identification Number of the Seller/Former Owner *(if issued)*: NPI: Tax Identification Number:	**Seller/Former Owner: 1A, 2G, 13,** and either **15** or **16** **Buyer/New Owner: 1A, 2G, 4, 13,** and either **15** (if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this provider.
❑ Your organization has **Consolidated** with another organization You are the: ❑ Former organization ❑ New organization	Medicare Identification Number of the Seller/Former Owner *(if issued)*: NPI: Tax Identification Number:	**Former Organizations: 1A, 2H, 13,** and either **15** or **16** **New Organization: Complete all** sections except **2F** and **2G**
☑ You are **changing** your Medicare information	Medicare Identification Number *(if issued)*: 423433 NPI: 1134301625	**Go to Section 1B**
❑ You are **revalidating** your Medicare enrollment	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all sections except 2F, 2G, and 2H**

SECTION 1: BASIC INFORMATION (Continued)

B. Check all that apply and complete the required sections:

	REQUIRED SECTIONS
☐ Identifying Information	1, 2 (complete only those sections that are changing), 3, 13, and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Adverse Legal Actions/Convictions	1, 2B1, 3, 13, and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Practice Location Information, Payment Address & Medical Record Storage Information	1, 2B1, 3, 4 (complete only those sections that are changing), 13, and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☑ Ownership Interest and/or Managing Control Information (Organizations)	1, 2B1, 3, 5, 13, and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☑ Ownership Interest and/or Managing Control Information (Individuals)	1, 2B1, 3, 6, 13, and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Chain Home Office Information	1, 2B1, 3, 7, 13, and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Billing Agency Information	1, 2B1, 3, 8 (complete only those sections that are changing), 13, and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Special Requirements for Home Health Agencies	1, 2B1, 3, 12, 13, and either 15 (if you are the authorized official) or 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Authorized Official(s)	1, 2B1, 3, 6, 13, and 15.
☐ Delegated Official(s) (Optional)	1, 2B1, 3, 6, 13, 15, and 16.

SECTION 3: ADVERSE LEGAL ACTIONS/CONVICTIONS (Continued)

ADVERSE LEGAL HISTORY

1. Has your organization, under any current or former name or business identity, ever had an adverse action listed on page 13 of this application imposed against it?

☐ YES–Continue Below ☑ NO–Skip to Section 4

2. If yes, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

TRUE COPY ATTESTED

CMS-855A (02/08)

14

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) (Continued)

A: ORGANIZATION WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

☐ Not Applicable

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☑ ADD	☐ DELETE
DATE (mm/dd/yyyy)		03/26/2007	

Check all that apply:

☑ 5 Percent or More Ownership Interest ☐ Partner ☑ Managing Control

Legal Business Name as reported to the Internal Revenue Service
Mid-Carolina Hospital Group,LLC

"Doing Business As" Name *(if applicable)*

Address Line 1 *(Street Name and Number)*
3400 West Avenue

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4
Columbia	SC	29203-6901

Tax Identification Number *(Required)*
20-8694144

Medicare Identification Number(s) *(If issued)*	NPI *(If issued)*
na	na

TRUE CERTIFIED COPY,
CLERK OF COURT

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) (Continued)

B. ADVERSE LEGAL HISTORY

If reporting a change to existing information, check "Change," provide the effective date of the change, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date:_____

1. Has this organization in Section 5A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against it?

☐ YES – Continue Below ☑ NO – Skip to Section 6

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution.

Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action	Date	Taken By	Resolution

TRUE CERTIFIED COPY

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☑ ADD	☐ DELETE
DATE (mm/dd/yyyy)		03/26/2007	

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Tony	R.	Megna	JD
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
251-86-3766	04/23/1955	na	na

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☑ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☑ Managing Employee (W-2)
- ☑ Director/Officer
- ☐ Contracted Managing Employee
- ☐ Other _____

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date: _____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

CLERK OF COURT
CLEARFIELD COUNTY, PA.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☑ ADD	☐ DELETE
DATE (mm/dd/yyyy)		03/26/2007	

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Benjamin	W.	Lamb	MD
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(If issued)*	**NPI** *(If issued)*
250-67-0144	03/08/1973	H47550	1003918775

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☑ Managing Employee (W-2)
- ☑ Director/Officer
- ☐ Contracted Managing Employee
- ☑ Other Less than 5% direct/indirect owner

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date:_____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☑ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)	03/26/2007		

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Clarence	W.	Bowman	II
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
556-68-4052	07/05/1947	na	na

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☑ Managing Employee (W-2)
- ☐ Director/Officer
- ☐ Contracted Managing Employee
- ☐ Other _____

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date: _____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

TRUE CERTIFIED COPY
CLERK OF COURT/RMC
DARLINGTON COUNTY, S.C.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☑ ADD	☐ DELETE
DATE (mm/dd/yyyy)		03/26/2007	

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Ernest	M.	Atkinson	MD
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
251-08-1543	04/06/1963	F35708	1144314254

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☑ Managing Employee (W-2)
- ☑ Director/Officer
- ☐ Contracted Managing Employee
- ☑ Other Less than 5% direct/indirect owner

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date: _____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

CM5-855A (02/08)

CLERK OF COURT
DARLINGTON COUNTY, S.C.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☑ ADD	☐ DELETE
DATE (mm/dd/yyyy)		03/26/2007	

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Katie	S.	Noyes	
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
266-11-2617	09/08/1954	na	na

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☑ Managing Employee (W-2)
- ☑ Director/Officer
- ☐ Contracted Managing Employee
- ☑ Other less than 5% direct/indirect ownership

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date:_____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

CLERK OF COURT
DARLING, LOUISIANA

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☑ ADD	☐ DELETE
DATE (mm/dd/yyyy)		03/26/2007	

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Josiah	S.	Matthews	MD
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
250-48-4927	06/04/1931	C60908	1114008100

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☑ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☑ Managing Employee (W-2)
- ☑ Director/Officer
- ☐ Contracted Managing Employee
- ☐ Other _____

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date:_____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

TRUE CERTIFIED COPY

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☑ ADD	☐ DELETE
DATE (mm/dd/yyyy)		03/26/2007	

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Sabrina	G.	Obrien	MD
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
400-17-7358	09/28/1966	G37386	1699807013

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☐ Managing Employee (W-2)
- ☐ Director/Officer
- ☑ Contracted Managing Employee
- ☐ Other Less than 5% direct/indirect owner

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date: _____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☑ ADD	☐ DELETE
DATE (mm/dd/yyyy)		03/26/2007	

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Priscilla	L	Welch	MD
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
247-13-6210	06/13/1957	D17709	1841203895

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☑ Managing Employee (W-2)
- ☑ Director/Officer
- ☐ Contracted Managing Employee
- ☑ Other Less than 5% direct/indirect owner

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date:_____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

TRUE CERTIFIED COPY
CLERK OF CIRCUIT COURT
BURLINGTON COUNTY

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☑ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)	03/26/2007		

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Albert	D.	Mims	MD
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
248-98-6044	09/27/1952	B91946	1609993934

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☑ Managing Employee (W-2)
- ☑ Director/Officer
- ☐ Contracted Managing Employee
- ☑ Other Less than 5% direct/indirect owner

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date: _____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☑ ADD	☐ DELETE
DATE (mm/dd/yyyy)		03/26/2007	

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
David	W.	Moon	MD
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(If issued)*	**NPI** *(If issued)*
249-82-1045	01/01/1954	D05567	1417053133

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☑ Managing Employee (W-2)
- ☑ Director/Officer
- ☐ Contracted Managing Employee
- ☑ Other Less than 5% direct/indirect owner

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date: _____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

TRUE CERTIFIED COPY
Scott
CLERK
DARL

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☑ ADD	☐ DELETE
DATE (mm/dd/yyyy)		03/26/2007	

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Bonnie	L.	Crickman	MD
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
325-54-0466	01/31/1958	B92449	1740260736

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☑ Managing Employee (W-2)
- ☑ Director/Officer
- ☐ Contracted Managing Employee
- ☑ Other Less than 5% owner

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date: _____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

THIS CE

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☑ ADD	☐ DELETE
DATE (mm/dd/yyyy)		03/26/2007	

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Kristopher	R.	Crawford	MD
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
311-76-3358	11/12/1969	H68426	1124034195

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☐ Managing Employee (W-2)
- ☐ Director/Officer
- ☑ Contracted Managing Employee
- ☐ Other _____

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date: _____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

TRUE CERTIFIED COPY

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☑ ADD	☐ DELETE
DATE (mm/dd/yyyy)		03/26/2007	

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Alexander	H.	Cohen	MD
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
248-80-9983	10/16/1954	D47053	1912[illegible]958

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☑ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☑ Managing Employee (W-2)
- ☑ Director/Officer
- ☐ Contracted Managing Employee
- ☐ Other _____

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date: _____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

TRUE CERTIFIED COPY

CLERK

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☑ ADD	☐ DELETE
DATE (mm/dd/yyyy)		03/26/2007	

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Warren	M.	Matthews	
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
249-13-5821	02/27/1960	na	na

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☑ Managing Employee (W-2)
- ☑ Director/Officer
- ☐ Contracted Managing Employee
- ☑ Other less than 5% direct/indirect ownership

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date: _____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☑ ADD	☐ DELETE
DATE (mm/dd/yyyy)		03/26/2007	

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
John	R.	Watkins	
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
248-84-2972	06/21/1948	na	na

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☑ Managing Employee (W-2)
- ☐ Director/Officer
- ☐ Contracted Managing Employee
- ☑ Other less than 5% direct/indirect owner

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date:_____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

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SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☐ ADD	☑ DELETE
DATE (mm/dd/yyyy)			04/01/2008

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Benjamin	R.	Matthews	
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(If issued)*	**NPI** *(If issued)*
247-11-8180	04/17/1957	na	na

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☑ Managing Employee (W-2)
- ☐ Director/Officer
- ☐ Contracted Managing Employee
- ☑ Other less than 5% direct/indirect owner

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date: _____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

THIS CERTIFIED COPY

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☐ ADD	☑ DELETE
DATE (mm/dd/yyyy)			10/31/2007

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Lawernce "Woody"	W.	Turner	
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
250-98-2618	08/09/1967	na	na

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

☐ 5 Percent or Greater Direct/Indirect Owner
☐ Partner
☑ Managing Employee (W-2)
☐ Director/Officer
☐ Contracted Managing Employee
☐ Other _____

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date: _____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

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CLERK OF CIRCUIT COURT
DARLINGTON COUNTY, S.C.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	❑ CHANGE	❑ ADD	DELETE
DATE (mm/dd/yyyy)			03/26/2007

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
James	H.	Clark	MD
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
250-76-6903	05/17/1943		

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ❑ 5 Percent or Greater Direct/Indirect Owner
- ❑ Partner
- ❑ Managing Employee (W-2)
- ❑ Director/Officer
- ❑ Contracted Managing Employee
- ❑ Other _____

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

❑ Change ❑ Effective Date:_____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

❑ YES -Continue Below ❑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	❑ CHANGE	❑ ADD	❑ DELETE
DATE (mm/dd/yyyy)			03/26/2007

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Joseph	C.	Landrum	MD
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
260-72-2661	11/19/1945	F78704	

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ❑ 5 Percent or Greater Direct/Indirect Owner
- ❑ Partner
- ❑ Managing Employee (W-2)
- ❑ Director/Officer
- ❑ Contracted Managing Employee
- ❑ Other _____

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

❑ Change ❑ Effective Date:_____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

❑ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

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SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	☐ CHANGE	☐ ADD	☒ DELETE
DATE (mm/dd/yyyy)			03/26/2007

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Morris		Brown	MD
Social Security Number *(Required)*	**Date of Birth** *(mm/dd/yyyy)*	**Medicare Identification Number** *(if issued)*	**NPI** *(if issued)*
226-21-9193	05/24/1965	F78704	

2. What is the above individual's relationship with the provider in Section 2B1? *(Check all that apply.)*

- ☐ 5 Percent or Greater Direct/Indirect Owner
- ☐ Partner
- ☐ Managing Employee (W-2)
- ☐ Director/Officer
- ☐ Contracted Managing Employee
- ☐ Other _____

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date: _____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 1 of this application imposed against him/her?

☐ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

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ATTEST
CLERK OF CIRCUIT COURT

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual in Section 6B.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	❑ CHANGE	❑ ADD	❑ DELETE
DATE (mm/dd/yyyy)			03/26/2007

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Joseph	D.	Bushardt	MD
Social Security Number (Required)	Date of Birth (mm/dd/yyyy)	Medicare Identification Number (if issued)	NPI (if issued)
251-86-8100	06/20/1947		

2. What is the above individual's relationship with the provider in Section 2B1? (Check all that apply.)

❑ 5 Percent or Greater Direct/Indirect Owner
❑ Partner
❑ Managing Employee (W-2)
❑ Director/Officer
❑ Contracted Managing Employee
❑ Other _____

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

❑ Change ❑ Effective Date:_____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had an adverse legal action listed on page 13 of this application imposed against him/her?

❑ YES–Continue Below ☑ NO–Skip to Section 7

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution

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CLERK OF COURT

SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the fee-for-service contractor will contact the individual shown below. If the contact person is an authorized or delegated official, check the appropriate box below and skip to the section indicated.

- ❑ Contact an Authorized Official listed in Section 15
- ❑ Contact a Delegated Official listed in Section 16

First Name	Middle Initial	Last Name
Cheri	L	Reed

Telephone Number	Fax Number *(if applicable)*
803 799-1700	803 254 3679

Address Line 1 *(Street Name and Number)*
3400 West Ave

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4
Columbia	SC	29203-6901

E-mail Address
Corporate@pahc.com

SECTION 15: CERTIFICATION STATEMENT (Continued)

B. 1ST AUTHORIZED OFFICIAL SIGNATURE

I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact immediately.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Tony	R	Megna	

Telephone Number	Title/Position
803 799-1700	CEO

Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)	Date Signed (mm/dd/yyyy)
	4/5/08

C. 2ND AUTHORIZED OFFICIAL SIGNATURE

I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact immediately.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)

Telephone Number	Title/Position

Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)	Date Signed (mm/dd/yyyy)

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

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Jean B. Singer
CLERK OF COURT
DARLINGTON COUNTY S.C.

PROVIDER-BASESD ATTESTATION STATEMEMENT FOR LAKE CITY COMMUNITY HOSPITAL 258 RON MCNAIR BOULEVARD LAKE CITY, SOUTH CAROLINA 29560-2462		
A	Main Provider's Medicare Provider Number:	42-0066
B	Main Providers Name	Lake City Community Hospital
C	Main Provider's Address:	258 Ron McNair Blvd, Lake City, South Carolina 29560
D	Application Contact name and Phone Number:	Katie Noyes 803-254-3676 Pete Bowman 843-374-6120
E	Facility / Organization name:	No. Lake City Community Hospital is the only hospital involved in these transactions. However, the RHCs are off-campus.
F	Facility / Organization's exact address	258 Ron McNair Blvd, Lake City, South Carolina 29560
G	Facility / Organization's Medicare Provider Number, if there is one	42-3433.
H	Is the facility part of a multi-campus hospital?	No. Lake City Community Hospital is the only hospital involved in these transactions. However, the RHCs are off-campus.
I	Is the facility a Federally Qualified Health Center [FQHC]? If so, and if the FQHC meets the criteria at section 413.65(n), it need not attest to its provider-based status. The provider-based rules do not apply to other FQHCs that do not meet the criteria at	No

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DARLINGTON, SC

	section 413.65(n) and an attestation should not be submitted.	
J	The facility/organization became provider-based with the main provider on the following date:	N/A
K	Please indicate if this attestation is adding deleting, or changing previous information—if yes, please make certain to include the effective date.	This attestation changes previous information in Block D and G above effective March 26, 2007.
L	Indicate whether the facility/organization is "on campus" or "off campus" (per § 413.65(a)(2)) with the main provider: 1. _____ On campus of the main provider (located within 250 yards from the main provider building) OR 2. __X__ Off campus of the main provider (located 250 yards or greater from the main provider building, but subject to § 413.65(e)(3))	Off Campus
M	**I certify that I have carefully read the attached sections of the Federal provider-based regulations, before signing this attestation, and that the facility/organization complies with the following requirements to be provider-based to the main provider (initial ONE selection only):** 1. **No.** The facility/organization is "on campus" per 42 C.F.R. §413.65(a)(2) and is in compliance with the following provider-based requirements (shown in the following attached pages) in §413.65(d) and §413.65(g), other than those in §413.65(g)(7). If the facility/organization is operated as a joint venture, I certify that the requirements under §413.65(f) have been met. I am aware of, and will comply with, the requirement to maintain documentation of the basis for these attestations (for each regulatory requirement) and to make that documentation available to the Centers for Medicare & Medicaid Services (CMS) and to CMS contractors upon request.	

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MARION COUNTY S.C.

	OR **I certify that I have carefully read the attached sections of the Federal provider-based regulations, before signing this attestation, and that the facility/organization complies with the following requirements to be provider-based to the main provider (initial ONE selection only):** 1. **No.** The facility/organization is "on campus" per 42 C.F.R. §413.65(a)(2) and is in compliance with the following provider-based requirements (shown in the following attached pages) in §413.65(d) and §413.65(g), other than those in §413.65(g)(7). If the facility/organization is operated as a joint venture, I certify that the requirements under §413.65(f) have been met. I am aware of, and will comply with, the requirement to maintain documentation of the basis for these attestations (for each regulatory requirement) and to make that documentation available to the Centers for Medicare & Medicaid Services (CMS) and to CMS contractors upon request. OR 2. **YES.** The facility/organization is "off campus" per 42 C.F.R. §413.65(a)(2) and is in compliance with the following provider-based requirements (shown in the following attached pages) in §413.65(d) and §413.65(e) and §413.65(g). If the facility/organization is operated under a management contract/agreement, I certify that the requirements of §413.65(h) have been met. Furthermore, I am submitting along with this attestation to the Centers for Medicare & Medicaid Services (CMS), the documentation showing the basis for these attestations (for each regulatory requirement).

I attest the facility/organization complies with the following requirements to be provider-based to the main provider [please indicate Yes or No for each requirement]:

1	The department of the provider, the remote location of a hospital, or the satellite facility and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of the provider, the remote location of a hospital, or the satellite facility, or in States where State law does not permit licensure of the provider and the prospective department of the provider, the remote location of a hospital, or the satellite facility under a single license. If the provider and	Yes Please find attached a copy of the Hospital license.

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CLERK OF COURT, TMC
DARLINGTON COUNTY, S.C.

	facility/organization are located in a state having a health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers, the commission or agency has not found that the facility/organization is not part of the provider.	
2	The clinical services of the facility or organization seeking provider-based status and the main provider are integrated.	Yes. All RHCs perform the same services.
2a	Professional staff of the facility or organization have clinical privileges at the main provider.	Yes
2b	The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.	Yes
2c	The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the chief medical officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the chief medical officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.	Yes
2d	Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking	Yes

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DARLINGTON COUNTY, SC

	provider-based status and the main provider.	
2e	Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.	Yes, they are cross-referenced through use of a database system. Electronic medical records are being implemented which will allow access to records at all locations.
2f	Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.	Yes, all patients have access. Subject to their desire and ability to travel to the main provider. The Darlington RHC site has historically offered ancillary services that are similar to those services offered at the main provider [other than in-patient services.]
3	The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of a facility or organization that is a hospital department are reported in a cost center of the provider, costs of a provider-based facility or organization other than a hospital department are reported in the appropriate cost center or cost centers of the main provider, and the financial status of any provider-based facility or organization is incorporated and readily identified in the main provider's trial balance.	Yes
4	The facility or organization seeking status as a department of a provider, a remote location of a hospital, or a satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.	Yes.

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DARLINGTON COUNTY, SC

5	In the case of a hospital outpatient department or a hospital-based entity **(if the facility is not a hospital outpatient department or a hospital-based entity, please record "NA" for "not applicable" and skip to requirements under number 6),** the facility or organization fulfills the obligation of:	
5a	Hospital outpatient departments located either on or off the campus of the hospital that is the main provider comply with the anti-dumping rules in §§489.20(l), (m), (q), and (r) and §489.24 of chapter IV of Title 42.	N/A. This attestation is made on behalf of a RHC. However, as matter of internal policy, the RHCs always provide patients with the services they are able to provide, and comply with the intent of the anti-dumping rules in §§489.20(l), (m), (q), and (r) and §489.24 of chapter IV of Title 42.
5b	Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) are billed with the correct site-of-service so that appropriate physician and practitioner payment amounts can be determined under the rules of Part 414 of chapter IV of Title 42.	N/A. This attestation is made on behalf of a RHC. However, each RHC service is billed under the corresponding RHC number that is providing the service.
5c	Hospital outpatient departments comply with all the terms of the hospital's provider agreement.	Yes. This attestation is made on behalf of a RHC.
5d	Physicians who work in hospital outpatient departments or hospital-based entities comply with the non-discrimination provisions in §489.10(b) of chapter IV of Title 42.	Yes. This attestation is made on behalf of a RHC.
5e	Hospital outpatient departments (other than RHCs) treat all Medicare patients, for billing purposes, as hospital outpatients. The departments do not treat some Medicare patients as hospital outpatients and others as physician office patients.	Yes. However, this attestation is made on behalf of a RHC.
5f	In the case of a patient admitted to the hospital as an inpatient after receiving treatment in the hospital outpatient department or hospital-based entity, payments for services in the hospital	Yes. This attestation is made on behalf of a RHC.

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	outpatient department or hospital-based entity are subject to the payment window provisions applicable to PPS hospitals and to hospitals and units excluded from PPS set forth at §412.2(c)(5) of chapter IV of Title 42 and at § 413.40(c)(2) of chapter IV of Title 42, respectively. **(Note: If the potential main provider is a CAH, enter "NA" for this item).**	
5g	**(Note: This requirement only applies to off campus facilities).** When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, and the treatment is not required to be provided by the antidumping rules in §489.24 of chapter IV of Title 42, the hospital provides written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary's potential financial liability (that is, that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability).	This attestation is made on behalf of a RHC.
5.g.1	The notice is one that the beneficiary can read and understand.	N/A. This attestation is made on behalf of a RHC.
5.g.2	If the exact type and extent of care needed is not known, the hospital furnishes a written notice to the patient that explains that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based.	N/A. This attestation is made on behalf of a RHC.
5.g.3	The hospital furnishes an estimate based on typical or average charges for visits to the facility, but states that the patient's actual liability will depend upon the actual services furnished by the hospital.	N/A. This attestation is made on behalf of a RHC.
5.g.4	If the beneficiary is unconscious, under great duress, or for any other reason is	N/A. This attestation is made on behalf of a RHC.

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Scott B. Surgeon
CLERK OF COURT/DEPUTY
DARLINGTON COUNTY, S.C.

	unable to read a written notice and understand and act on his or her own rights, the notice is provided before the delivery of services, to the beneficiary's authorized representative.	
5.g.5	In cases where a hospital outpatient department provides examination or treatment that is required to be provided by the antidumping rules at § 489.24 of chapter IV of Title 42, the notice is given as soon as possible after the existence of an emergency condition has been ruled out or the emergency condition has been stabilized.	N/A. This attestation is made on behalf of a RHC.
5h	Hospital outpatient departments meet applicable hospital health and safety rules for Medicare-participating hospitals in part 482 of this chapter.	N/A. This attestation is made on behalf of a RHC.

For off campus facilities, please complete the following:

In addition to the above requirements (numbers 1-5h), I attest that the facility/organization complies with the following requirements to be provider-based to the main provider as an off campus facility (please indicate Yes or No for each requirement):

6	The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:	
6a	The business enterprise that constitutes the facility or organization is 100 percent owned by the provider.	Yes.
6b	The main provider and the facility or organization seeking status as a department of the provider, a remote location of a hospital, or a satellite facility have the same governing body.	Yes. The Hospital Executive Managment Committee is the governing authority for all Hospital operations.
6c	The facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status is subject to common bylaws and operating decisions of the governing body of	Yes

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Scott B. Sugar
CLERK OF COURT, ORANGE COUNTY, FLORIDA

	the provider where it is based.	
6d	The main provider has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the facility or organization.	Yes. The Hospital Executive Managment Committee is the governing authority for all Hospital operations.
7	The reporting relationship between the facility or organization seeking provider-based status and the main provider has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its existing departments, as evidenced by compliance with all of the following requirements:	
7a	The facility or organization is under the direct supervision of the main provider.	Yes. The RHC reports directly to the Hospital Executive Managment Committee. The Hospital Executive Managment Committee is the governing authority for all Hospital operations.
7b	The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability. The facility or organization director or individual responsible for daily operations at the entity--	Yes. The RHC reports directly to the Hospital Executive Managment Committee. The Hospital Executive Managment Committee is the governing authority for all Hospital operations.
7.b.1	Maintains a reporting relationship with a manager at the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and its existing departments; and	Yes. The RHC reports directly to the Hospital Executive Managment Committee. The Hospital Executive Managment Committee is the governing authority for all Hospital operations.
7.b.2	Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.	Yes. The RHC reports directly to the Hospital Executive Managment Committee. The Hospital Executive Managment Committee is the

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CLERK OF COURT, ARLINGTON COUNTY, VA

		governing authority for all Hospital operations.
7c	The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are (1) contracted out under the same contract agreement; or (2) handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.	Yes. The operations for billing are being integrated. Currently, billing and administrative services are accomplished by both hospital employees and by contract, with the contract of the facility or organization being managed by the main provider. All contracts are approved and managed by the Executive Managment Committee as the governing authority for all Hospital operations.
8	The facility or organization is located within a 35-mile radius of the campus of the potential main provider, except when the requirements in paragraph 8a of this section are met (please check below in the appropriate location if you qualify for the exemption):	Yes.
8a	The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under §412.106 of chapter IV of Title 42) greater than 11.75 percent or is described in §412.106(c)(2) of chapter IV of Title 42 implementing section 1886(e)(5)(F)(i)(II) of the Act and is:	
8.a.1	Owned or operated by a unit of State or local government;	
8.a.2	A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or	Answers to 8a-c: The main provider is operating the

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CLERK OF COURT
DARLINGTON

8.a.3	A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).	entity as an RHC that is otherwise qualified as a provider-based entity because Lake City community Hospital is located in a rural area as defined in § 412.62(f)(1)(iii) of chapter IV of Title 42, and has fewer than 50 beds as determined under §412.105(b) of chapter IV of Title 42, is not subject to the criteria in 8a and 8b above.
8b	The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the attestation for provider-based status is filed with CMS, and for each subsequent 12-month period:	
8.b.1	At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;	
8.b.2	At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or	
8.b.3	If the facility or organization is unable to meet the criteria in (1) or (2) directly above because it was not in operation during all of the 12-month period described paragraph 8b, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in paragraph 8b, accounted for at least 75	

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	percent of the patients served by the main provider.	
8c	If the facility or organization is attempting to qualify for provider-based status under this section, then the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, in adjacent States.	
Note: An RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area as defined in § 412.62(f)(1)(iii) of chapter IV of Title 42, and has fewer than 50 beds as determined under §412.105(b) of chapter IV of Title 42, is not subject to the criteria in 8a and 8b above.		
9	The facility or organization that is not located on the campus of the potential main provider and otherwise meets the requirements of 1-8 above, but is operated under management contract, meets all of the following criteria **(please respond to 9a - 9d if the facility is operated under a management contract; otherwise record "NA" for "not applicable")**:	Yes
9a	The main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility or organization who are directly involved in the delivery of patient care, except for management staff and staff who furnish patient care services of a type that would be paid for by Medicare under a fee schedule established by regulations at Part 414 of chapter IV of Title 42. Other than staff that may be paid under such a Medicare fee schedule, the main provider does not utilize the services of "leased" employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing or similar agreement) that are directly involved in the delivery of patient care.	Yes

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DANE COUNTY, WISCONSIN

9b	The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph 7c above.	Yes
9c	The main provider has significant control over the operations of the facility or organization as determined under criteria in paragraph 7b above.	Yes
9d	The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.	Yes. All Agreements are held by the Hospital Executive Managment Committee.
For facilities/organizations operated as joint ventures requesting provider-based determinations: In addition to the above requirements (numbers 1-5h for on campus facilities), I attest that the facility/organization complies with the following requirements to be provider-based to the main provider:		
10	The facility or organization being attested to as provider-based is a joint venture that fulfills the following requirements:	
10a	The facility is partially owned by at least one provider;	Lake City Community Hospital is the only hospital involved in these transactions.
10b	The facility is located on the main campus of a provider who is a partial owner;	Lake City Community Hospital is the only hospital involved in these transactions.
10c	The facility is provider-based to that one provider whose campus on which the facility organization is located; and	Lake City Community Hospital is the only hospital involved in these transactions.
10d	The facility or organization meets all the requirements applicable to all provider-based facilities and organizations in paragraphs 1-5 of this attestation.	Lake City Community Hospital is the only hospital involved in these transactions.
I certify that the responses in this attestation and information in the documents are accurate, complete, and current as of this date. I acknowledge that the regulations must be continually adhered to. Any material change in the relationship between the facility/organization and the main provider, such as a change of ownership or entry into a		

	paragraphs 1-5 of this attestation.	

I certify that the responses in this attestation and information in the documents are accurate, complete, and current as of this date. I acknowledge that the regulations must be continually adhered to. Any material change in the relationship between the facility/organization and the main provider, such as a change of ownership or entry into a new or different management contract, may be reported to CMS. (NOTE: ORIGINAL ink signature must be submitted)

Signature of Officer or Administrator or authorized person	Clarence W. Bowman, II
Printed Name of Officer or Administrator or authorized person	Clarence W. Bowman, II
Title of authorized person acting on behalf of the provider	CEO, Lake City Community Hospital
Direct telephone number	843-374-2026
Date	4-5-07

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statement or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years or both. (18 U.S.C. § 1001).

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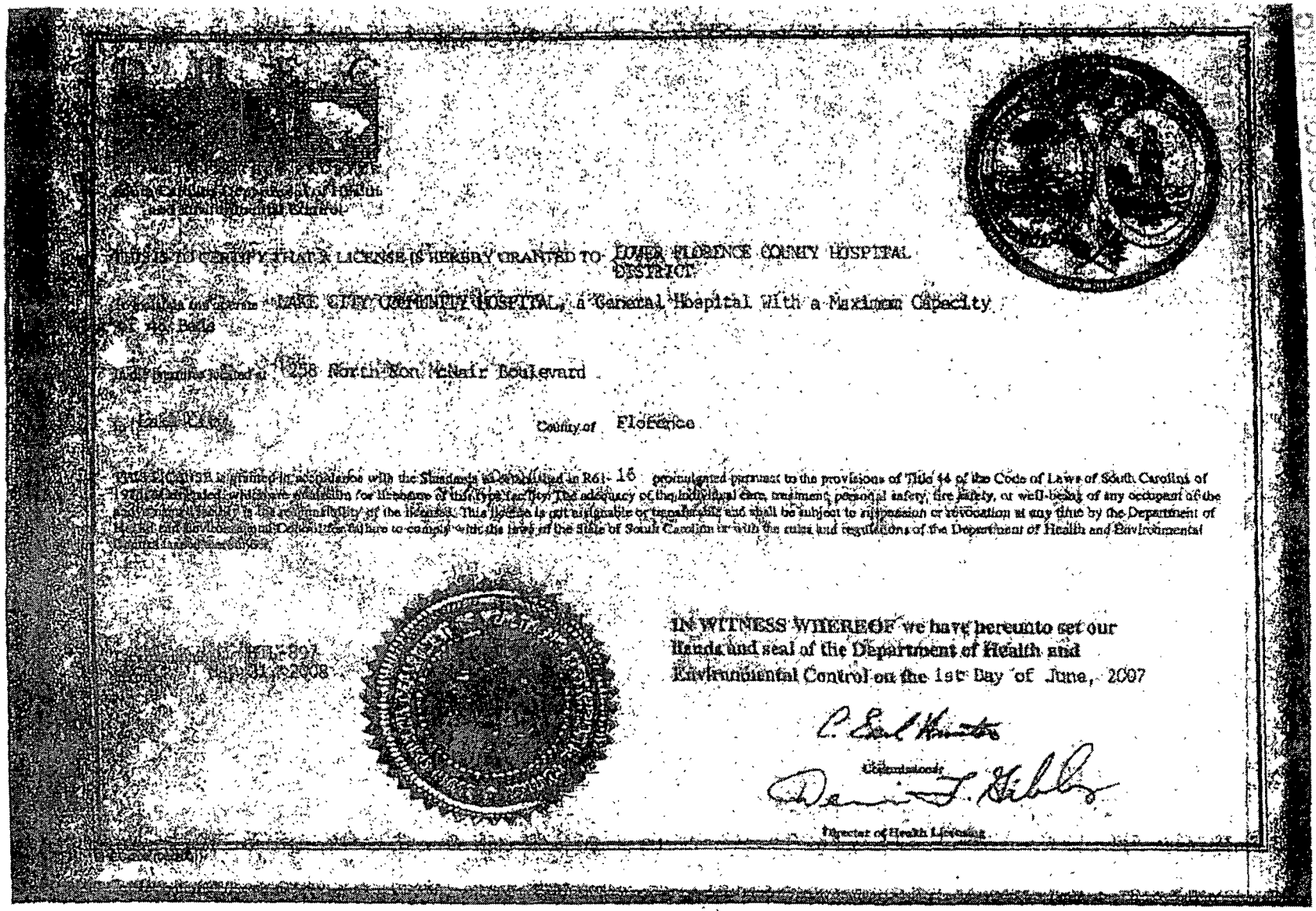


THIS IS TO CERTIFY THAT A LICENSE IS HEREBY GRANTED TO LOWER FLORENCE COUNTY HOSPITAL DISTRICT

to operate the facility known as LAKE CITY COMMUNITY HOSPITAL, a General Hospital With a Maximum Capacity of 49 Beds

located at 1258 North Non Connair Boulevard

in the City of Lake City County of Florence

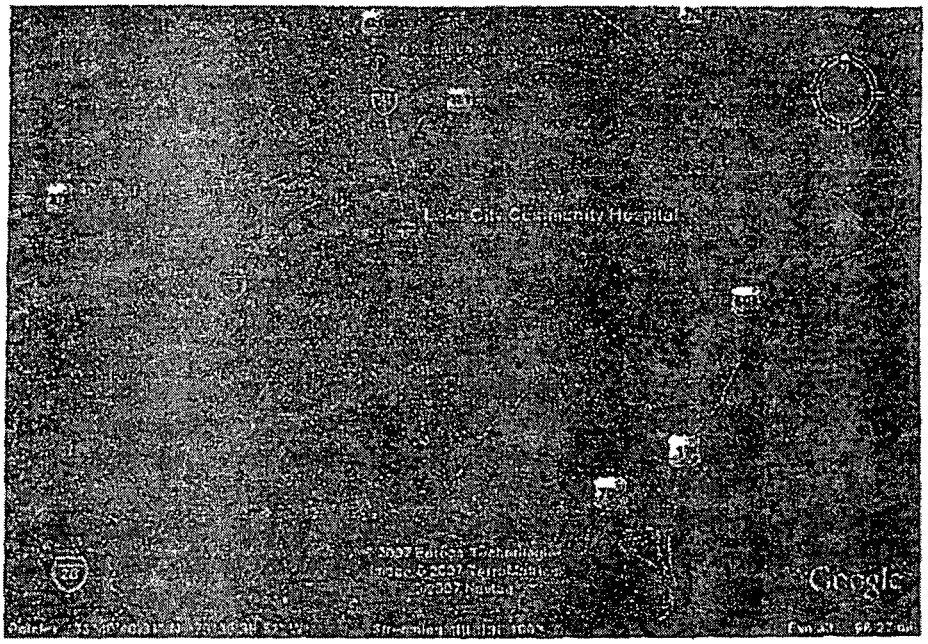
This license is granted in accordance with the Standards established in R61-16 promulgated pursuant to the provisions of Title 44 of the Code of Laws of South Carolina of 1976, as amended, which are applicable for licensure of this type facility. The adequacy of the individual care, treatment, personal safety, fire safety, or well-being of any occupant of the facility is the responsibility of the licensee. This license is not assignable or transferable and shall be subject to suspension or revocation at any time by the Department of Health and Environmental Control found to fail to comply with the laws of the State of South Carolina or with the rules and regulations of the Department of Health and Environmental Control governing the facility.

Expires: 5-31-2008

IN WITNESS WHEREOF we have hereunto set our Hands and seal of the Department of Health and Environmental Control on the 1st Day of June, 2007

Commissioner

Director of Health Licensing



35 mile straight-line distance from

Lake City Community Hospital
258 Ron McNair Boulevard, Lake City, SC 29560

extending through

Darlington Medical Center
201 Cashua Street, Darlington, SC 29532

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CLERK OF COUNCIL
DARLINGTON COUNTY, S.C.

FedEx Express US Airbill 8565 8372 9070

0215

1 From (Package and Payment Info)
Date 4/5/08 Sender's FedEx Account Number 1378-3963-6
Sender's Name PEE DEE HEALTH CARE, PA Phone (803) 799-1700
Company PEE DEE HEALTHCARE
Address 3400 WEST AVE
City COLUMBIA State SC ZIP 29203-6901

2 Your Internal Billing Reference

3 To
Recipient's Name Palmetto GBA Phone ( )
Company Palmetto GBA Provider Enrollment
Recipient's Address 2300 Springdale Dr
We cannot deliver to P.O. Boxes or P.O. ZIP codes.
Address
To request a package be held at a specific FedEx location, enter FedEx Ship Center or Hold at Location address.
City Camden State SC ZIP 29020

0327943354

4a Express Package Service — Packages up to 150 lbs.
- FedEx Priority Overnight
- FedEx Standard Overnight ✓
- FedEx First Overnight
- FedEx 2Day
- FedEx Express Saver

4b Express Freight Service — Packages over 150 lbs.
- FedEx 1Day Freight
- FedEx 2Day Freight
- FedEx 3Day Freight

5 Packaging
- FedEx Envelope
- FedEx PAK
- FedEx Box ✓
- FedEx Tube
- Other

6 Special Handling
- SATURDAY Delivery NOT Available for
- HOLD Weekday at FedEx Location
- HOLD Saturday at FedEx Location
- No
- Yes
- Yes
- Dry Ice
- Cargo Aircraft Only

7 Payment Bill to
- Sender ✓
- Recipient
- Third Party
- Credit Card
- Cash/Check

Total Packages 1 Total Weight Total Declared Value* $ .00

8 Residential Delivery Signature Options
- No Signature Required
- Direct Signature
- Indirect Signature

519

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CERTIFICATE OF COUNSEL – RULE 210(g), SCACR

Counsel for Appellant certifies to the best of his knowledge, information, and belief that the record contains all material proposed to be included by the parties and does not contain any material irrelevant to this appeal.

Tony R. Megna
Counsel for Appellant
3400 West Avenue
Columbia, SC 29203
(803) 799-1700

Dated: 1/22/13

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM DARLINGTON COUNTY
Court of Common Pleas

CIVIL ACTION NO: 2010-CP-16-0332
TRACKING NO: 2011197671

Pee Dee Health Care, P.A.,.....Appellant,

v.

Estate of Hugh S. Thompson, ...Respondent.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on the 24 day of Jan., 2013, a copy of the Supplemental Record on Appeal in the above referenced matter has been served upon each of the following, by depositing a copy of same in the United States Mail, with first class postage annexed thereto as follows:

Jay James, Esquire
PO Box 507
Darlington, SC 29540

Rene Josey, Esquire
PO Box 5478
Florence, SC 29502

Harriet L. Hobbs

RECEIVED
JAN 24 2013
SC Court of Appeals