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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

The Honorable Ralph King Anderson, III
Chief Administrative Law Judge

APPELLATE CASE No. 2020-001323
ADMINISTRATIVE LAW COURT CASE NO.: 18-ALJ-07-0358-CC
ADMINISTRATIVE LAW COURT CASE NO.: 18-ALJ-07-0360-CC
ADMINISTRATIVE LAW COURT CASE NO.: 18-ALJ-07-0366-CC

CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper
Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper
St. Francis Berkeley Hospital and Roper Mount Pleasant Hospital.....Respondent,

v.

South Carolina Department of Health and Environmental Control and
Medical University Hospital Authority, d/b/a MUHA Community Hospital,.....Respondents,

AND

Walterboro Community Hospital, Inc., d/b/a Colleton Medical Center,.....Appellant,

v.

South Carolina Department of Health and Environmental Control and
Medical University Hospital Authority, d/b/a MUHA Community Hospital,.....Respondents,

AND

Trident Medical Center, LLC d/b/a Trident Medical Center
and Summerville Medical Center,.....Appellants,

v.

South Carolina Department of Health and Environmental Control and
Medical University Hospital Authority, d/b/a MUHA Community Hospital,.....Respondents.

**RETURN OF APPELLANTS TRIDENT MEDICAL CENTER AND WALTERBORO
COMMUNITY HOSPITAL TO MEDICAL UNIVERSITY HOSPITAL AUTHORITY'S
MOTION TO SUPPLEMENT BRIEFS AND RECORD ON APPEAL**

The Respondent Medical University Hospital Authority d/b/a MUHA Community Hospital (MUHA) moved the Court on August 8, 2022, to open the appellate record in this case in order to supplement the briefs of the parties and the Record on Appeal (Motion to Supplement) with material that MUHA asserts can be used to argue judicial estoppel against the Appellant Trident Medical Center, LLC d/b/a Trident Medical Center and Summerville Medical Center (Trident). MUHA's Motion to Supplement with material not presented to the Administrative Law Court (ALC) is contrary to this Court's own rules and the standard of review applicable to this case. Further, no grounds exist for MUHA to argue judicial estoppel in this case for the reasons set forth below. Therefore, Appellants oppose MUHA's Motion to Supplement and urge the Court to dismiss it.

I. BACKGROUND

This case arises from a decision by the Respondent South Carolina Department of Health and Environmental Control (Department) to grant a Certificate of Need (CON) to MUHA to establish a \$325 million, 128-bed community hospital in Berkeley County. The Department's review of MUHA's proposed hospital was conducted under the CON program for health care facilities and services as established by the State Certification of Need and Health Facility Licensure Act (CON Act) and the regulations promulgated thereunder (CON Regulations). *See* S.C. Code Ann. §§ 44-7-110, *et seq.* (2018 and Supp. 2019) and 3 S.C. Code Ann. Regs. 61-15 (Supp. 2019).

In considering whether to grant or deny a CON application, the Department and the ALC must evaluate an application using the project review criteria found in the CON Regulations and the standards set forth in the South Carolina Health Plan (State Health Plan) in effect at the time the application is filed. S.C. Code Ann. § 44-7-225 (2018). The CON Act requires the Department

to publish a State Health Plan at least every other year and each version of the State Health Plan must contain at a minimum (1) an inventory of existing health care facilities, beds, specified health services, and equipment; (2) projections of need for additional health care facilities, beds, health services, and equipment; (3) standards for distribution of health care facilities, beds, specified health services, and equipment, including scope of services to be provided, utilization, and occupancy rates, travel time, regionalization, other factors relating to proper placement of services, and proper planning of health care facilities; and (4) a determination of which project review criteria are most important in evaluating CON applications for each type of facility, service, and equipment, including a finding as to whether the benefits of improved accessibility to each type of facility, service, and equipment may outweigh the adverse effects caused by the duplication of any existing facility, service, or equipment. S.C. Code Ann. §§ 44-7-180(B) and (C) (2018). Under the CON Regulations, the Department cannot approve a project unless it complies with the State Health Plan.¹ *See* 3 S.C. Code Ann. Regs. 61-15 § 307(1) (Supp. 2019).

In its CON application, MUHA sought to establish its proposed hospital under Standard 5 of the 2017-2018 State Health Plan (2017-2018 Plan), which allows a facility with a bed need to use such need to create a new hospital at a different site within the same service area, subject to certain conditions. (R. pp. 005360–005361). Under the 2017-2018 Plan, MUHA had a stated need for 147 additional beds at MUSC Medical Center in downtown Charleston. (R. p. 004337; R. p.

¹ The CON Regulations provide that the Department “may not issue a Certificate of Need unless an application is in compliance with the South Carolina Health Plan as described in this regulation, project review criteria, and other regulations which must be identified by the Department. The Department may refuse to issue a Certificate of Need even if an application is in compliance with the South Carolina Health Plan but is inconsistent with project review criteria or departmental regulations.” 3 S.C. Code Ann. Regs. 61-15 § 307(1) (Supp. 2019); *see also* S.C. Code Ann. § 44-7-210(B) (2018).

005377). MUHA sought to move 128 of the 147 beds needed at MUSC Medical Center in order to create a new hospital in Berkeley County.

On July 23, 2018, the Department approved MUHA's proposed hospital. (**R. pp. 005323–005327**). Trident, the Respondent Walterboro Community Hospital, Inc., d/b/a Colleton Medical Center (CMC), and the former Respondent CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper St. Francis Berkeley Hospital and Roper Mount Pleasant Hospital (Roper) challenged the Department's decision before the Board of the Department and before the ALC. Following a contested case hearing on the merits and the consideration of requests by the parties to alter or amend its initial order, the ALC issued its Final Amended Order on September 4, 2020, approving MUHA's CON application. (R. pp. 000004–000074).

Trident, CMC, and Roper timely filed their Notices of Appeal of the ALC's Order and, after some preliminary motions and Roper's withdrawal from the case,² the parties filed their final briefs on April 29, 2021. The Record on Appeal was filed with the Court on April 14, 2021.

Now, one year and four months later, MUHA seeks to open and supplement the Record on Appeal and to engage in further briefing in this case. MUHA bases its Motion to Supplement on its assertion that Trident has taken an inconsistent factual position in a CON application filed with the Department after the issuance of the ALC's Final Amended Order was issued and after the final briefs and Record on Appeal were filed in this case. In its Motion to Supplement, MUHA claims that Trident's alleged inconsistent factual positions give rise to MUHA being able to assert

² On October 23, 2020, Roper and MUHA filed a Notice of Agreed Dismissal with the Court pursuant to which Roper withdrew its appeal in this matter.

judicial estoppel against Trident on the issue of need for MUHA's proposed hospital. As set forth below, MUHA's arguments in support of its Motion to Supplement are without merit.

II. ARGUMENT

A. Motion to Supplement

MUHA seeks the permission of the Court to supplement the briefs and Record on Appeal with new arguments and materials related to the December 7, 2021 CON Application of Trident Medical Center, LLC d/b/a Summerville Medical Center (SMC) to add 50 acute care hospital beds to its existing hospital in Dorchester County, South Carolina. The material that MUHA wishes to include in the Record on Appeal is attached to its Motion to Supplement as an Appendix and consists of the following documents:

- The May 31, 2022 decision of the Department approving the November 2021 CON application of Roper St. Francis Hospital-Berkeley, Inc. d/b/a Roper St. Francis Berkeley Hospital (Roper Berkeley) for the addition of 124,691 square feet of new construction to add 50 new acute care beds;
- The June 27, 2022 decision of the Department approving the December 7, 2021 CON application of SMC for the addition of 56,943 square feet of new construction to add 50 new acute care beds;
- The December 7, 2021 CON Application of SMC to add 50 acute care beds to its existing hospital in Dorchester County; and
- The November 2021 CON Application of Roper Berkeley to add 50 acute care beds to its existing hospital in Berkeley County.

(Motion to Supplement, Appx. pp. 1-133).

The ALC issued its Final Amended Order, which gives rise to this appeal, on September 4, 2020. (R. pp. 000004–000074). Thus, all of the documents that MUHA seeks to add to the Record on Appeal did not come into existence until more than one year after the ALC made its final decision in this case.

Rule 209(c), SCACR, provides that a party's Designation of Matter to be Included in the Record on Appeal "may only propose to include portions of the transcript, pleadings, orders, exhibits, or other materials which may be properly included in the Record on Appeal." This limitation on what a party properly may propose to include in the Record on Appeal cites to Rule 210(c), SCACR, which provides in relevant part, "The Record shall not ... include matter which was not presented to the lower court or tribunal."

The appellate courts in South Carolina have interpreted the prohibition against including matter not considered below as grounds for denying efforts to supplement the record to include new material. *See Williamsburg Rural Water & Sewer Co. v Williamsburg Cty. Water & Sewer Auth.*, 367 S.C. 566, 571, 627 S.E.2d 690, 693 (2006) ("Nothing in the appellate court rules permits a party to unilaterally add after-created evidence to the record."); *Henning v. Kaye*, 307 S.C. 436, 438, 415 S.E.2d 794, 794-795 (1992) ("Appellant is reminded that the Record on Appeal shall not contain any matter not presented to the trial court."); *Norris v. Ferre*, 315 S.C. 179, 183, 432 S.E.2d 491, 493 (Ct.App. 2005) (Motion to supplement record with deposition testimony from an unrelated action denied under Rule 209(c), SCACR).

The material that MUHA seeks to add to the Record on Appeal was never presented to the ALC because the CON applications and Department decisions in question were not in existence at the time the ALC was considering the issues in this case. Under the rules of this Court, MUHA's Motion to Supplement must be denied.

Furthermore, S.C. Code Ann. § 1-23-610(B), which governs the Court's judicial review of contested case decisions by the ALC, provides that, "[t]he review of the administrative law judge's order must be confined to the record." In its Motion to Supplement, MUHA proposes to present to the Court evidence which has never been proffered to the ALC, for which a foundation has never

been laid, and which has not been testified to by a competent witness. Under the applicable standard of review, at a minimum, any evidence being considered by this Court must in the first instance be presented to the trier of fact. Therefore, Appellants contend that consideration of such evidence by this Court could only come after remand to the ALC, and such remand is not warranted in this case.

B. Judicial Estoppel

If the Court finds that its rules do not prohibit supplementation of the Record on Appeal in this case, MUHA's Motion to Supplement must still be denied because no grounds exist for the assertion of judicial estoppel against Trident. In the absence of such grounds, MUHA's Motion to Supplement lacks justification.

Judicial estoppel is an equitable concept that prevents a litigant from asserting a factual position inconsistent with, or in conflict with, one the litigant has previously asserted in the same or a related proceeding. *Cothran v. Brown*, 357 S.C. 210, 215, 592 S.E.2d 629, 631 (2004). In *Cothran*, the Supreme Court established the elements that must be met to apply the doctrine of judicial estoppel:

We now adopt the following elements necessary for the doctrine to apply: (1) two inconsistent positions taken by the same party or parties in privity with one another; (2) the positions must be taken in the same or related proceedings involving the same party or parties in privity with each other; (3) the party taking the position must have been successful in maintaining that position and have received some benefit; (4) the inconsistency must be part of an intentional effort to mislead the court; and (5) the two positions must be totally inconsistent.

Id. at 215-216, 592 S.E.2d at 632. As discussed below, MUHA's arguments fail to satisfy any of the material elements necessary for the doctrine of judicial estoppel to apply.

1. Totally Inconsistent Factual Positions (Elements 1 and 5)

MUHA contends that Trident should be judicially estopped from arguing that no need exists for MUHA's hospital because of an allegedly inconsistent factual position taken by SMC in

its recent CON application to add 50 beds to its existing hospital, which is located approximately 11 miles from the site of MUHA's proposed hospital. (Motion to Supplement, p. 2). In its Motion to Supplement, MUHA summarizes its argument as follows:

In seeking and obtaining its 50-bed CON, Trident necessarily and successfully took the factual position that there was a need for MUHA's 128 hospital beds, and that these 128 beds did not satisfy all of the need in the area. Manifestly, if there is a need for 50 beds in addition to the 128-bed hospital, then there was and is a need for the 128-bed hospital. Trident, however, seeks to take the opposite factual position before this Court. This Court should decline to hear Trident any further on the question of need for MUHA's 128-bed hospital.

(Motion to Supplement, p. 5).

Nowhere in its December 7, 2021 50-bed CON application does SMC discuss or even mention MUHA's proposed 128-bed hospital. (*See* Motion to Supplement, Appx. pp. 13-63). Consequently, the Department's June 27, 2022 decision granting SMC's request to add 50 beds is also silent as to MUHA or its proposed hospital. (*See* Motion to Supplement, Appx. pp. 7-10). Thus, MUHA's assertion that SMC "necessarily and successfully took the factual position that there was a need for MUHA's 128 hospital beds, and that these 128 beds did not satisfy all of the needs in the area" is false. (*See* Motion to Supplement, p. 5).

As a variation of its argument, MUHA also asserts,

When Trident submitted its certified application, it knew about MUHA's hospital only 11.2 miles away. More importantly, Trident necessarily included those 128 beds when it contended that nevertheless there was a need for 50 additional hospital beds in the same area. In other words, as a predicate to its request for 50 additional beds, Trident necessarily abandoned its claim that there was no need for MUHA's 128 beds.

(Motion to Supplement, p. 4). This argument appears to concede that SMC made no overt factual statements in its CON application regarding MUHA's proposed hospital. Instead, MUHA argues that SMC's actions in applying for its own new beds amount to a concession by Trident of a central issue of its appeal in this case. Upon closer analysis, this argument also fails.

MUHA's CON application to build a \$325 million, 128-bed community hospital in Berkeley County was based on Standard 5 of the 2017-2018 Plan, which provides:

A facility may apply to create a new additional hospital at a different site ***within the same service area*** through the transfer of existing licensed beds, the projected bed need for the facility, or a combination of both existing beds and projected bed need. The facility is not required to have a projected need for additional beds in order to create a new additional hospital. There is no required minimum number of beds in order to approve the CON application. ***The applicant must justify, through patient origin and other data, the need for a new hospital at the chosen site and the potential adverse impact a new hospital at the chosen site could have on the existing hospitals in the service area.***

(See Ex. A, p. EX_A-009-010) (emphasis added).³

Under the 2017-2018 Plan, the applicable service area for addressing the need for MUHA's 128-bed proposed hospital was the so-called "Tri-County Service Area," which consisted of Charleston, Berkeley and Dorchester Counties. (Ex. A, p. EX_A-026). The 2017-2018 Plan indicated that MUHA had a need for 147 additional beds at MUSC Medical Center, located in downtown Charleston. (*Id.*). Using Standard 5 of the 2017-2018 Plan, MUHA sought to move 128 of the 147 beds needed in downtown Charleston to Berkeley County in order to create a new hospital. (R. pp. 004364-004265).

SMC, which is located in Summerville in Dorchester County, and Trident Medical Center, which is located in Charleston County, were considered to be existing hospitals in the Tri-County Service Area under the 2017-2018 Plan. As such, Trident opposed MUHA's proposed 128-bed hospital on numerous grounds, including whether MUHA could demonstrate a need for its new hospital under Standard 5. As summarized in Trident's final brief, Trident argued:

[U]nder the plain language of Standard 5, in order to justify the Proposed Hospital, MUHA was required to demonstrate more than its institutional need for 147 new hospital beds as reflected in the Plan (which need is not disputed) and its capacity constraints at MUSC Medical Center. Appellants contended that Standard 5 clearly

³ For ease of reference and purposes of this Return only, Trident attaches the relevant sections of the two different State Health Plans placed in issue by MUHA, but not provided by it to this Court.

and unequivocally requires that MUHA demonstrate that a need for the Proposed Hospital's services actually exists in the geographic area where the hospital is to be located. In other words, in this case, MUHA proposes a new 128-bed community hospital providing only non-tertiary services when there are numerous hospital facilities with a total of 456 existing acute care beds already offering these same non-tertiary services within a ten-mile radius of the location of the Proposed Hospital. (R. p. 002648:20–002649:1).

(Brief of Appellants, p. 21).

In contrast to the issues raised by MUHA's 128-bed application under Standard 5 of the 2017-2018 Plan, Standard 5 was never an issue before the Department in considering and approving SMC's 50-bed CON application in 2022. This is because SMC's application was filed under the 2020 State Health Plan (2020 Plan), which went into effect in June 12, 2020. (Ex. B, pp. EX_B-001-022). The 2020 Plan contains different standards and different geographic service areas from the 2017-2018 Plan that controls this case.

In the 2020 State Health Plan, for purposes of determining hospital bed need, the Department abolished the former Tri-County Service Area and created new service areas for each of Charleston County, Berkeley County, and Dorchester County. Under the 2020 Plan, SMC is the only hospital located in the Dorchester County Service Area. (Ex. B, p. EX_B-021). Thus, the need for hospital beds in Dorchester County is calculated under Standard 4 of the 2020 Plan with reference only to SMC's bed need.⁴

As the sole hospital in Dorchester County, SMC's 50-bed CON application was based entirely on its stated institutional need for 7 additional hospital beds, increased to 50 beds under the 2020 Plan as being more economically feasible.⁵ (See Motion to Supplement, Appx. 21; Ex.

⁴ Standard 4 of the 2020 Plan provides that, "The bed need for each service area is the combined bed need for all individual hospitals in the service area." (Ex. B., EX_B-004).

⁵ Standard 6 of the 2020 Plan provides in relevant part that, "If the number of beds needed is less than 50, then up to a total of 50 beds could be approved for any entity at any location within the service area." (Ex. B, EX_B-004-005).

B, EX_B-004). SMC does not discuss MUHA's 128-bed proposed hospital in Berkeley County because that proposed hospital is not relevant to the need for additional hospital beds at SMC's existing hospital in the Dorchester County service area under the 2020 Plan. Consequently, the Department's decision to approve SMC's 50-bed addition also does not discuss or consider MUHA's 128-bed proposed hospital. (Motion to Supplement, Appx. pp. 7-10).

SMC's 50-bed CON application is neither legally nor factually related or relevant to MUHA's 128-bed proposed hospital. Therefore, contrary to MUHA's assertions, SMC did not "necessarily" consider MUHA's proposed 128 beds in requesting additional beds of its own; nor did SMC "necessarily" concede that MUHA's proposed beds were needed. Under the doctrine of judicial estoppel, therefore, SMC cannot be said to have taken two "totally inconsistent factual positions" as to the need for MUHA's project.⁶

2. Same Party or Parties in Privity (Elements 1 and 2)

Part of the material that MUHA seeks to place in the Record on Appeal is a November 2021 CON application filed by Roper Berkeley to add 50 beds to its existing hospital in Berkeley County and the Department's decision approving that application. (*See* Motion to Supplement, Appx. pp. 1-4 and 64-133). Trident was not a party to Roper Berkeley's 50-bed CON nor is it in privity with Roper Berkeley. Roper Berkeley is a separate corporate entity that has no legal relationship whatsoever to Trident. (R. pp. 001582:10-001583:17). Thus, factual positions taken by Roper Berkeley in its 50-bed CON application are not relevant to MUHA's attempt to assert judicial estoppel against Trident.

⁶ MUHA also claims that Trident has conceded the so-called "ten mile radius" issue in SMC's CON application. This argument also fails under Trident's arguments above concerning the legal and factual differences between SMC's CON application and MUHA's proposed hospital. Thus, MUHA cannot demonstrate that judicial estoppel is applicable to this issue, and its Motion to Supplement in that respect must be denied. (Motion to Supplement, p. 5).

Furthermore, Roper is no longer a party to this appeal because, as MUHA itself observes in its Motion to Supplement, on October 23, 2020, “Roper and MUHA submitted a “Notice of Agreed Dismissal” of Roper’s appeal based on their settlement agreement.” (Motion to Supplement, p. 3). To the extent that MUHA attempts to supplement the Record on Appeal with material related to Roper Berkeley’s November 2021 CON application, the Motion to Supplement must be denied.

Finally, it is unclear from MUHA’s Motion whether MUHA is seeking to assert judicial estoppel against the Appellant CMC. Although CMC and Trident are owned by the same ultimate parent corporation, CMC is a legally separate corporate entity from Trident, as is evidenced by the caption of this matter identifying CMC as the appellant Walterboro Community Hospital, Inc., d/b/a Colleton Medical Center. (*See also* R. p. 002385:4-22). Further, CMC had no involvement in the SMC 50-bed CON application. (See Motion to Supplement, Appx. pp. 13-63). Therefore, CMC is not a party in privity with Trident for purposes of judicial estoppel, and, to the extent that MUHA attempts to assert judicial estoppel against CMC, its Motion to Supplement must be denied.

3. Same or Related Proceedings (Element 2)

As discussed above, SMC’s December 2021 CON application to add 50 beds to its existing hospital in Dorchester County was filed under the 2020 State Health Plan. That Plan contains materially different standards and different geographic service areas than the 2017-2018 Plan, under which MUHA filed and which is applicable to this case. Thus, MUHA’s attempts to demonstrate that Trident’s alleged inconsistent factual statements were made by it in the “same or related proceedings” must fail. *See, e.g., Wright v. Craft*, 372 S.C. 1, 39, 640 S.E.2d 486, 506 (Ct.App. 2006)(Refusing to apply judicial estoppel because statements made by buyer in car loan

application did not occur in a proceeding related to buyer's Unfair Trade Practice claims against seller of car.). Therefore, MUHA cannot assert judicial estoppel against Trident in this case and its Motion to Supplement must be denied.

4. Intentional Effort to Mislead the Court (Element 4)

For the many reasons discussed above, MUHA has failed to show that Trident has taken inconsistent factual positions with regard to the need for MUHA's Hospital. Further, MUHA has made no other showing that Trident has attempted to mislead the Court on any other issue. Consequently, the doctrine of judicial estoppel is not applicable in this matter.⁷

CONCLUSION

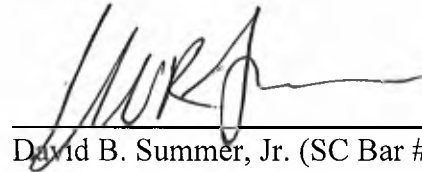
Rules 209(c) and 210(c), SCACR, prohibit MUHA from supplementing the Record on Appeal with evidence not presented to or considered by the ALC in making its decision in this case. Thus, under the Court's own rules, MUHA's Motion to Supplement must be denied.

Furthermore, MUHA's Motion to Supplement lacks any legal justification because MUHA does not meet the elements required to assert judicial estoppel against Trident. As set forth above, Trident/SMC's CON application for 50 new beds in Dorchester County under the 2020 State Health Plan is factually and legally different from MUHA's application, which was filed under a different Plan with different standards and different geographic service areas. In the absence of a colorable claim of judicial estoppel, MUHA's Motion to Supplement lacks justification and must be denied.

⁷ Element 3 of the doctrine of judicial estoppel, that the party being estopped benefited from its inconsistent factual position, is also not met. Although SMC's 50-bed application was approved, which was a benefit to SMC, as demonstrated above, the approval was not the result of SMC's taking a "totally inconsistent" factual position to the one taken before this Court regarding MUHA's proposed hospital.

Therefore, Appellants respectfully request that this Court deny MUHA's Motion to Supplement the Briefs and Record on Appeal.

Respectfully submitted,



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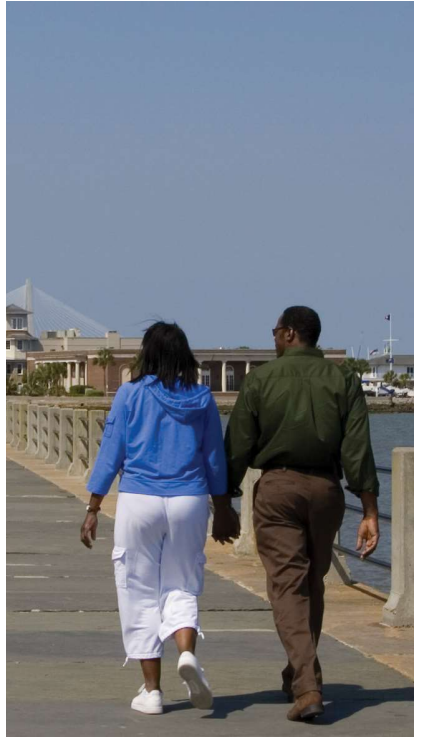
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August 29, 2022
Columbia, South Carolina

EXHIBIT A

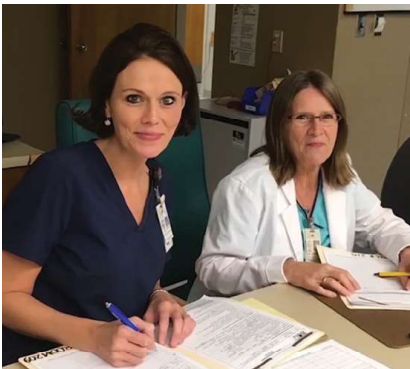
**2017-2018 State Health Plan
Chapter 3 Hospitals**

Plan Enacted June 9, 2017



2017–2018 South Carolina Health Plan

Enacted June 9, 2017



- (2) The population data set forth in this Plan was received from the South Carolina Revenue and Fiscal Affairs Office in April of 2017. The material includes population projections that are subject to the following conditions:

These projections offer only one scenario of future population change using the most current data available. The overall accuracy of the projections depends on the extent to which future events unfold in a manner that reflects previous trends observed within each group. The model cannot account for unprecedented events that may significantly alter an area's demographic composition in the future. The possible events include large factory openings or closings, changes in technology, public health crises, environmental events, or other conditions that could have an effect on migration, birth rates, or death rates. This means that population projections are likely to be more accurate in the immediate future than in distant years into the future. The projections will be updated regularly as new data becomes available and future events unfold. Annual county population estimates released by the Census Bureau will be monitored along with birth and death data released each year, and adjustments will be made to the projected population results as appropriate.

CHAPTER 2

INVENTORY REGIONS AND SERVICE AREAS

INVENTORY REGIONS

This Plan has adopted the [Department's regions](#) for the purpose of inventorying [Health Care Facilities](#) and [Health Services](#) as designated and enumerated below:

<u>Region</u>	<u>Counties</u>
I - Upstate	Abbeville, Anderson, Cherokee, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Spartanburg, and Union
II - Midlands	Aiken, Barnwell, Chester, Edgefield, Fairfield, Kershaw, Lancaster, Lexington, Newberry, Richland, Saluda and York
III - Pee Dee	Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter and Williamsburg
IV - Lowcountry	Allendale, Bamberg, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper and Orangeburg

NEED FOR HEALTH CARE FACILITIES AND HEALTH SERVICES

This Plan calculates the need for certain Health Care Facilities and Health Services throughout South Carolina based on certain formula and criteria set forth in detail in this Plan. For example:

- The need for hospital beds is based on the utilization of individual facilities.
- The need for acute psychiatric services, alcohol and drug abuse services, comprehensive rehabilitation services, and residential treatment centers for children and adolescents is based on various service areas and utilization methodologies specified in this Plan.
- The need for most health services (e.g., cardiac catheterization, open heart surgery) is based upon the service standard, which is a combination of utilization criteria and travel time requirements.
- The need for long-term care and skilled nursing service is projected by county.

SERVICE AREAS

In addition to inventory regions, this Plan designates service areas for certain Health Care Facilities and Health Services. These service areas may be comprised of one or more counties. Service areas may cross inventory regions. The need for a service is analyzed by assessment of existing resources and need in the relevant service area, along with other factors set forth in this Plan, applicable statutes and regulations.

TRANSFER BETWEEN AFFILIATED FACILITIES

Given the ever-changing nature of the health care delivery system, affiliated facilities may want to transfer or exchange specific technologies or licensed beds in order to better meet an identified need. [Affiliated facilities](#) are two or more health care facilities, whether inpatient or outpatient, owned, leased, or who have a formal legal relationship with a central organization and whose relationship has been established for reasons other than for transferring beds, equipment or services. In certain instances such a transfer or exchange of acute services could be accomplished in a cost-effective manner and result in a more efficient allocation of health care resources. This transfer or exchange of services applies to both inpatient and outpatient services. *A Certificate of Need is required to transfer or exchange beds, services, and/or equipment.* In order to evaluate a proposal for the transfer or exchange of any health care technology reviewed under the Certificate of Need program, the following criteria must be applied to it:

1. A transfer or exchange of beds, services, and/or equipment may be approved only if there is no overall increase in the number or amount of such beds and/or services.
2. A transfer or exchange initiated under this Chapter may only occur within the service area(s) established in this Plan.
3. The facility receiving the beds, services, and/or equipment must demonstrate the need for the additional capacity based on historical and/or projected utilization patterns.
4. The applicants must explain the impact of transferring the beds, services, and/or equipment on the health care delivery system of the county and/or service area from which it is to be taken; any negative impact must be detailed, along with the perceived benefits of the proposal.
5. The facility giving up beds, services, and/or equipment may not use the loss of such beds, services, and/or equipment as justification for a subsequent request to establish or re-establish such beds, services, and/or equipment.
6. A written contract or agreement between the governing bodies of the affiliated

facilities approving the transfer or exchange of beds, services, and/or equipment must be included in the Certificate of Need process.

7. Each facility giving up beds, services, and/or equipment must acknowledge in writing that this exchange is permanent; any further transfers would be subject to this same process.

ESTIMATED STATE CIVILIAN POPULATION

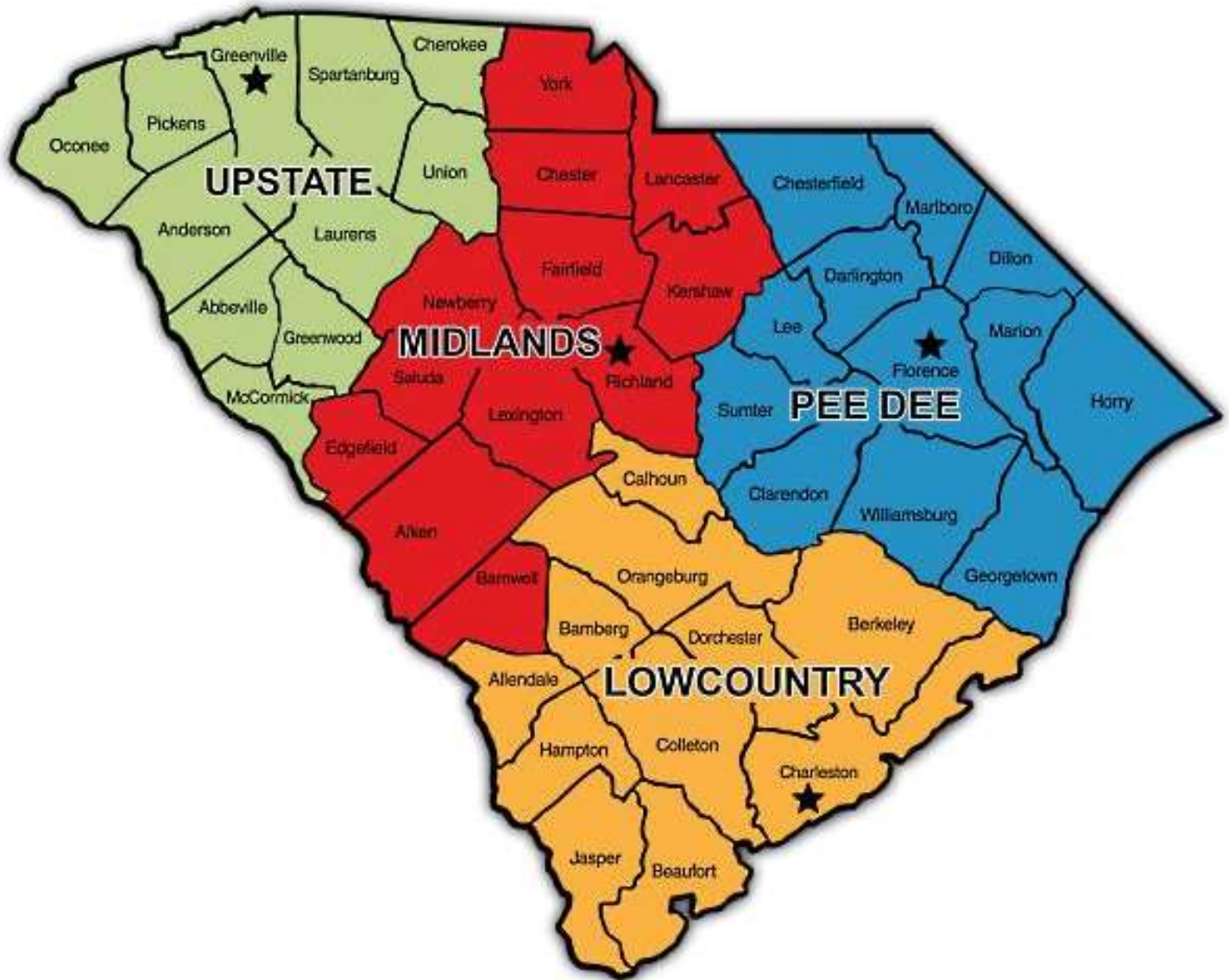
Where these projections were required for calculations, this Plan has been developed using the estimated civilian population of 4,896,146 for 2015 and projected population of 5,288,470 for 2022. All population data (county, planning area, and statewide) were provided by the South Carolina Revenue and Fiscal Affairs Office, Health and Demographics Section, in April 2017.

INVENTORY DATES

Only those facilities reviewed under the Certificate of Need program are included in the inventory. The cut-off date for inclusion of information in this Plan was April 13, 2017. Inventory and utilization data set forth in this Plan is derived from the 2015 Joint Annual Reports (JARs). The period of time in which the individual data was collected is set forth by the reporting entity in its individual JAR submission.

DHEC REGIONS MAP

(Chapter 2)



CHAPTER 3

GENERAL HOSPITALS

GENERAL HOSPITALS

Relevant Definitions

[“Hospital”](#) means a facility organized and administered to provide overnight medical, surgical, or nursing care of illness, injury, or infirmity and may provide obstetrical care, and in which all diagnoses, treatment, or care is administered by or under the direction of persons currently licensed to practice medicine, surgery, or osteopathy.

Hospital may include residential treatment facilities for children and adolescents in need of mental health treatment which are physically a part of a licensed psychiatric hospital. This definition does not include facilities which are licensed by the Department of Social Services.

[“Hospital Bed”](#) means a bed for an adult or child patient. Bassinets for the newborn in a maternity unit nursery, beds in labor rooms, recovery rooms, and other beds used exclusively for emergency purposes are not included in this definition.

Bed Capacity

For existing beds, capacity is considered bed space designated exclusively for inpatient care, including space originally designed or remodeled for inpatient beds, even though temporarily not used for such purposes. The number of beds counted in any patient room is the maximum number for which adequate square footage is provided, except that single beds in single rooms have been counted even if the room contained inadequate square footage.

Inventory and Bed Need

All licensed general hospitals, including Federal facilities, are listed in the inventory. Patient days and admissions are as reported by the hospital in its JAR. The number of patient days utilized for the general hospital bed need calculations does not include days of care rendered in licensed psychiatric units, substance abuse units, or comprehensive rehabilitation units of hospitals. These days of care are shown in the corresponding inventories for each type of service. In addition, the days of care provided in Long-Term Care hospitals are not included in the general bed need calculations.

Total capacity by survey refers to a total designed capacity or maximum number of beds that may be accommodated as determined by an on-site survey. This capacity may exceed the

number of beds actually set up and in use. It may also differ from the licensed capacity, which is based on State laws and regulations. Beds have been classified as conforming and nonconforming, according to standards of plant evaluation.

Variable Occupancy Rate

The General Acute Hospital bed need methodology uses the following variable occupancy rate factors:

0 - 174 bed hospitals → 65%
175 - 349 bed hospitals → 70%
350+ bed hospital → 75%

The population and associated utilization are broken down by age groups. The use rates and projected average daily census are made for the age cohorts of 0-17, 18-64, and 65 and over, in recognition that different population groups have different hospital utilization rates.

Where the term “hospital bed need” is used, these figures are based upon utilization data for the general acute hospitals. This term does not suggest that facilities cannot operate at higher occupancy rates than used in the calculations without adding additional beds.

Availability

Bamberg, Barnwell, Lee, Marlboro, McCormick and Saluda counties no longer have local hospitals. Calhoun County is served by the Regional Medical Center of Orangeburg and Calhoun Counties. The need for general hospital beds is determined through the consideration of current utilization and projected population growth with the goal of having beds available within approximately thirty (30) minutes’ travel time for the majority of the residents of the State.

CERTIFICATE OF NEED PROJECTION AND STANDARDS

1. Calculations of hospital bed need are made for individual hospitals and totaled by county to determine the overall bed need for that service area, which is the county for CON purposes.
2. For individual hospitals, the methodology for calculating bed need is as follows:
 - a. Determine the current facility use rate by dividing the current utilization by the current population in each of the three age cohorts.
 - b. Multiply the current facility use rate by age cohort by the projected population for seven years in the future by age cohort (in thousands) and divide by 365 to

obtain a projected average daily census by age cohort.

- c. Divide the sum of the age cohort projected facility average daily census by the variable occupancy (.65/.70/.75) to determine the number of beds needed to meet the hospital's need.
 - d. The number of additional beds needed or excess beds for the hospital is obtained by subtracting the number of existing beds from the bed need.
 - e. The totals for each hospital in a county or service area are summed to determine whether there is an overall projected surplus or need for additional beds.
3. If a service area indicates a surplus of beds, then no additional beds will be approved unless an individual hospital in the service area indicates a need for additional beds. Should an individual hospital indicate a need for additional beds, then a maximum of the actual projected bed need or up to 50 additional beds may be approved for that hospital to allow for the construction of an economical unit at either the existing hospital site or another site, if the existing hospital is relocating or has relocated in whole or in part to that site. The hospital requesting the addition must document the need for additional beds beyond those indicated as needed by the methodology stated above, based on historical and projected utilization, as well as projected population growth or other factors demonstrating the need for the proposed beds. Additional beds will only be approved for the specific hospital indicating a need.
 4. If there is a need for additional hospital beds in the service area, then any entity may apply to add these beds within the service area, and any entity may be awarded the Certificate of Need for these beds. If the number of beds needed is less than 50, then up to a total of 50 beds could be approved for any entity at any location within the service area. An applicant requesting additional beds beyond those indicated as needed by the methodology stated above must document the need for additional beds based on historical and projected utilization, projected population growth that has not been considered in this Plan or other factors demonstrating the need for the proposed beds. It is up to the applicant to document the need and the potential negative impact on the existing facilities.
 5. A facility may apply to create a new additional hospital at a different site within the same service area through the transfer of existing licensed beds, the projected bed need for the facility, or a combination of both existing beds and projected bed need. The facility is not required to have a projected need for additional beds in order to create a new additional hospital. There is no required minimum number of beds in order to approve the CON application. The applicant must justify, through patient origin and other data, the need for a new hospital at the chosen site and the potential

adverse impact a new hospital at the chosen site could have on the existing hospitals in the service area.

6. No additional hospital will be approved unless it is a general hospital and will provide:
 - a. A 24-hour emergency services department that meets the requirements to be a Level III emergency service as defined in the *Emergency Services* section of [Regulation 61-16](#);
 - b. Inpatient medical services to both surgical and non-surgical patients; and
 - c. Medical and surgical services on a daily basis within at least six of the major diagnostic categories as recognized by Centers for Medicare and Medicaid Services (CMS). Any applicant for a new hospital must provide a written commitment that the facility will accept Medicare and Medicaid patients and that unreimbursed services for indigent and charity patients are provided at a percentage that meets or exceeds other hospitals in the service area. The CMS Diagnostic Categories Chart is located in Chapter XIII of this Plan.
7. Due to the low utilization and the low capital cost of converting hospital-based nursing home, psychiatric, rehabilitation and/or substance abuse beds to general acute care hospital beds, the following policies may apply:
 - a. Hospitals that have licensed nursing home beds within the hospital may be allowed to convert nursing home beds to general acute care hospital beds only within the hospital, provided the hospital can document an actual need for additional general acute care beds. Need will be based on actual utilization, using current information. *A Certificate of Need is required for this conversion.*
 - b. Existing acute care hospitals that have inpatient psychiatric, rehabilitation, or substance abuse beds may be allowed to convert such beds to acute care hospital beds, regardless of the projected need for general acute care hospital beds. *A Certificate of Need is required for this conversion.*
8. In some areas of South Carolina, a considerable influx of tourists is not counted in the permanent population. If an individual hospital in these areas can document and demonstrate the need for additional beds due to non-resident (tourist) population and seasonal utilization fluctuations due to this population, then, based on further analysis, the Department may approve some additional beds at the existing hospital.
9. Should the deletion of services at a federal facility result in an immediate impact on the utilization of a hospital, then the Department may approve a request for additional beds at the affected hospital. The affected hospital must document the

increase in demand and explain why additional beds are needed to accommodate patients previously served at the federal facility.

10. Changes in the delivery system due to health care reform have resulted in the consolidation of facilities and the establishment of provider networks. These consolidations and agreements may lead to situations where affiliated hospitals may wish to transfer beds between themselves in order to serve their patients in a more efficient manner. *A proposal to transfer or exchange hospital beds requires a Certificate of Need* and must comply with the provisions outlined in Chapter II, Transfer between Affiliated Facilities.
11. Factors to be considered regarding modernization of facilities include:
 - a. Functional arrangement of the facility as it relates to efficient handling of patients and related workloads.
 - b. The ability to update medical technology within the existing plant.
 - c. Existence of The Joint Commission (TJC) or other accreditation body deficiencies or “grandfathered” licensure deficiencies.
 - d. Cost efficiency of the existing physical plant versus plant revision, etc.
 - e. Private rooms are now considered the industry standard.
12. Each modernization proposal must be evaluated on the basis of merit, cost efficiency, and impact on healthcare delivery within the service area.

The Hospital Bed Need Chart is located at the end of this Chapter.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

1. Compliance with the Need Outlined in this Section of this Plan;
2. Community Need Documentation;
3. Distribution (Accessibility);
4. Acceptability;
5. Record of the Applicant;
6. Cost Containment; and
7. Adverse Effects on Other Facilities.

General hospital beds are typically located within approximately thirty (30) minutes' travel time for the majority of the residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

LONG-TERM ACUTE CARE HOSPITALS

Long-Term Acute Care Hospitals (LTACHs) are hospitals with an average Medicare inpatient length of stay of greater than 25 days, including all covered and non-covered days of stay of Medicare patients. They provide treatment to patients with complex medical conditions, such as strokes, cardiac care, ventilator dependency, wound care and post-surgical care.

A LTACH may be either a freestanding facility or may occupy space in another hospital ("hospital-within-a-hospital"). Hospitals must meet additional federal criteria in order to qualify as a LTACH under the "hospital-within-a-hospital" model:

1. The new LTACH must have a governing body, which is distinct and separate from the governing body of the host hospital, and the new body cannot be under the control of the host hospital or any third entity that controls both hospitals.
2. The LTACH must have a separate Chief Executive Officer through whom all administrative authority flows, who is not employed by, or under contract with, the host hospital or any third entity that controls both hospitals.
3. The LTACH must have a separate Chief Medical Officer who reports directly to the governing body and is responsible for all medical staff activities. The Chief Medical Officer cannot be under contract with the host hospital or any third entity that controls both hospitals.
4. The LTACH must have a separate medical staff which reports directly to the governing body, and adopt bylaws governing medical care, including granting privileges to individual practitioners.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. An application for a LTACH must be in compliance with the relevant standards in [Regulation 61-16](#) (*Minimum Standards for Licensing Hospitals and Institutional General Infirmaries*).
2. Although LTACH beds are not considered to be a separate category for licensing purposes, they will be inventoried separately from general acute care hospital beds for planning purposes.

3. The utilization of LTACHs is not included in the bed need for general acute care hospital beds. No bed need will be calculated for LTACH beds. An applicant must document the need for LTACH beds based on the utilization of existing LTACH beds.
4. A hospital that has leased general beds to a LTACH shall be entitled to regain these beds once the lease is terminated. No entity other than the hospital (or its successor) that initially leased the general acute beds to the LTACH shall be entitled to the beds upon termination of the lease. *A Certificate of Need application is required:*
 - a. A hospital may be allowed to convert these former LTACH beds to general acute hospital beds regardless of the projected need for general acute beds;
 - b. A hospital may be allowed to convert these former LTACH beds to psychiatric, inpatient treatment facility, rehabilitation, or other specialty beds only if there is a bed need projected for this proposed other category of licensed beds.
5. A hospital which seeks to be designated as a LTACH, and has been awarded a CON for that purpose, must be certified as a LTACH by CMS within 24 months of accepting its first patient, or the CON issued to that hospital for that purpose shall be revoked. The entity that has had its CON revoked shall not have the authority to operate as a general acute care hospital.
6. A hospital that desires to be designated as a Pediatric LTACH must restrict admissions to patients under the age of 21 who require long-term medical care. Should the facility attempt to provide care that is inconsistent with this requirement or patient demand or other economic conditions require the facility to close, the Certificate of Need issued to that hospital for that purpose shall be revoked.

The Long-Term Acute Care Hospitals Chart is located at the end of this Chapter.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

1. Compliance with the Need Outlined in this Section of this Plan;
2. Community Need Documentation;
3. Distribution (Accessibility);
4. Record of the Applicant.

Long-Term Acute Care Hospital beds are located within approximately sixty (60) minutes' travel time for the majority of the residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating

Certificate of Need applications for these beds.

CRITICAL ACCESS HOSPITALS (CAH)

The South Carolina Department of Health and Human Services administers programs through the Medicaid program to assist struggling rural hospitals. One such program designates rural hospitals as Critical Access Hospitals (CAH) who are then eligible for more favorable Medicaid reimbursement methodology.

A CAH is intended to provide essential health services to rural communities. Converting a struggling rural hospital to a CAH can allow a community to maintain local health access that would otherwise be lost. CAHs are subject to review by the Independent Payment Advisory Board (IPAB), whereas other hospitals are not currently subject to IPAB review.

The impact of the Critical Access Hospital Program in South Carolina is a financial one, allowing cost-based reimbursement from Medicare for a facility choosing to participate. The designation as a CAH does not require a change in the licensing of an existing hospital. However, a hospital may be required to de-license a number of beds in order to meet the 25-bed requirement.

The designation of a hospital as a Critical Access Hospital *does not require Certificate of Need review* because it does not change the licensing category of the facility. However, an exemption from Certificate of Need review is required for a hospital to reduce its number of licensed beds in order to meet the criteria for a CAH. *Should a hospital later desire to revert to a general acute hospital, a Certificate of Need is required*, but the facility may be permitted to increase the number of licensed hospital beds up to the prior number of beds without regard or affect to the current bed need shown in the service area.

The Critical Access Hospitals Chart is located at the end of this Chapter.

PERINATAL REGIONS

The Perinatal Regions referred to in the Obstetrical Services and Neonatal Services sections below are distinct from the Department's Regions defined in Chapter II of this Plan, and are identified by the name of its designated Regional Perinatal Center.

Perinatal Region

Counties

I - Greenville Memorial

Abbeville, Anderson, Edgefield, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Saluda

II - Spartanburg Regional

Cherokee, Chester, Spartanburg, Union

III - Palmetto Health Richland	Aiken, Allendale, Bamberg, Barnwell, Calhoun, Clarendon, Fairfield, Kershaw, Lancaster, Lee, Lexington, Newberry, Orangeburg, Richland, Sumter, York
IV - McLeod Regional	Chesterfield, Darlington, Dillon, Florence, Horry, Marion, Marlboro, Williamsburg
V - MUSC Medical	Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Georgetown

PERINATAL SERVICE LEVELS

Because the cost of high-risk obstetrical and neonatal services is so great, it is not desirable or cost-effective for all hospitals in the State to provide the higher levels of care. Over the years, a regionalized approach to perinatal care has been implemented in South Carolina to address the need for high quality, risk-appropriate, cost-effective perinatal health care. Regionalization provides a coordinated system of perinatal care for a well-defined population group. Each hospital providing perinatal services is designated by the Department's Division of Health Licensing as a Level I, II, III, or IV Perinatal Hospital, or a Regional Perinatal Center (RPC). Each Level I, II, III and IV hospital maintains a relationship with its designated RPC for consultation, transport and continuing education. Patients are transferred to the appropriate RPC when medically appropriate, if beds are available. True regionalization for the optimization of perinatal care includes a stated goal of back-transporting infants when they no longer require the highest level of care. Convalescing infants benefit from a community-based program closer to home that promotes parent education and family bonding to facilitate a safe and timely discharge. In this way, quality care is provided to mothers and newborn infants, and specially trained perinatal personnel and intensive care facilities can be used efficiently and cost-effectively.

The complete descriptions of the five levels of perinatal services described briefly below are outlined in the Section of [Regulation 61-16](#) entitled *Designation of Inpatient Perinatal Care Services*.

[Basic Perinatal Center with Well Newborn Nursery \(Level I\)](#). Level I hospitals provide services for normal uncomplicated pregnancies. A full list of the requirements for a Level I Basic Perinatal Center with Well Newborn Nursery can be found at Regulation 61-16, Section 1306.A. *Certificate of Need review is not required to establish a Level I program.*

[Specialty Perinatal Center with Special Care Nursery \(Level II\)](#). In addition to the requirements of Regulation 61-16, Section 1306.A, Level II hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. A full list of the requirements for a Level II Specialty Perinatal Center can be found at Regulation 61-16, Section 1306.B. *Certificate of Need review is not required to establish a Level II program.*

[Subspecialty Perinatal Center with Neonatal Intensive Care Unit \(Level III\)](#). In addition to the requirements of Regulation 61-16, Sections 1306.A and 1306.B, Level III hospitals provide all aspects of perinatal care, including intensive care and a range of continuously available, subspecialty consultation as recommended in the most recent edition of the *Guidelines for Perinatal Care* (GPC) by the American Academy of Pediatrics (AAP) and The American College of Obstetricians and Gynecologists. A full list of the requirements for a Level III Subspecialty Perinatal Center with Neonatal Intensive Care Unit can be found at Regulation 61-16, Section 1306.C. Neonatal transport may only be performed by Regional Perinatal Centers. *Certificate of Need Review is required to establish a Level III program.*

[Regional Perinatal Center with Neonatal Intensive Care Unit \(RPC\)](#). In addition to the requirements of Regulation 61-16, Sections 1306.A through 1306.C, RPCs provide consultative, outreach, and support services to other hospitals in the region. A full list of the requirements for a Regional Perinatal Center can be found at Regulation 61-16, Section 1306.D. No more than one Regional Perinatal Center will be approved in each perinatal region. *Certificate of Need Review is required to establish a RPC.*

[Complex Neonatal Intensive Care Unit \(Level IV\)](#). In addition to the requirements of Regulation 61-16, Sections 1306.A through 1306.C, Level IV hospitals shall include additional capabilities and considerable experience in the care of the most complex and critically ill newborn infants and have pediatric medical and surgical specialty consultants available 24 hours a day. A full list of the requirements for a Complex Neonatal Intensive Care Unit can be found at Regulation 61-16, Section 1306.E. A Level IV hospital need not act as a Regional Perinatal Center (RPC). *Certificate of Need Review is required to establish a Level IV program.*

The Perinatal-Capable Facilities Chart is located at the end of this Chapter.

OBSTETRICAL SERVICES

Advances in obstetrical and newborn intensive care offer the promise of lower perinatal mortality and improvement in the quality of life for survivors. The high cost of intensive care and the limited availability of skilled personnel have created the requirement for a more efficient method of resource allocation.

Maternal, fetal, and neonatal mortality and morbidity rates can be significantly reduced if patients at high risk are identified early in the pregnancy and optimum techniques for the care of both the mother and infant are applied. High-risk deliveries are a small percent of total annual deliveries, but these patients require a high degree of specialized care. In 2015, 81.7% of all Very Low Birthweight (VLB) babies were born in either a Level III center or a Regional Perinatal Center, whereas the Healthy People 2020 national objective was 83.7%.

Infant mortality is defined as the death of babies from birth until their first birthday. South Carolina's infant mortality rate for 2015 was 7.0 infant deaths per 1,000 live births versus the national rate of 5.82 infant deaths per 1,000 births in 2014.

Neonatal mortality is the death rate for infants up to 28 days old. For 2015, South Carolina's neonatal mortality rate for all races was 4.6 neonatal deaths per 1,000 live births, while the Healthy People 2020 national objective was 4.1 neonatal deaths per 1,000 live births.

The need for obstetrical beds will be evaluated based on information supplied by the Joint Annual Report of Hospitals and other sources. Those facilities experiencing low utilization and in close proximity to one another should consider consolidating services, where appropriate.

The OB Utilization and Births Chart is located at the end of this Chapter.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following project review criteria are considered the most important in evaluating Certificate of Need applications for an obstetrical service:

1. Compliance with the Need Outlined in this Section of this Plan;
2. Distribution (Accessibility);
3. Acceptability;
4. Record of the Applicant; and
5. Adverse Effects on Other Facilities.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

NEONATAL SERVICES

Neonatal services are highly specialized and are only required by a very small percentage of infants. The need for these services is affected by the incidence of high-risk deliveries, the percentage of live births requiring neonatal services, and the average length of stay. The limited need for these services requires that they be planned for on a regional basis, fostering the location of these specialized units in hospitals that have the necessary staff, equipment, and consultative services and facilities. Referral networks facilitate the transfer of infants requiring this level of services from other facilities.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. The projected need for neonatal intensive care bassinets is calculated on a regional basis:
 - a. For each region take the average number of births from 2013-2015 and the average population of women age 15-44 for 2013-2015 to generate an average birth rate.
 - b. Multiply the average birth rate against the projected 2019 population of women age 15-44 to project the number of births in 2019.
 - c. Generate the projected number of intensive care bassinets needed in a region by applying a constant of 3.25 bassinets per 1,000 live births to the projected birth rate and subtracting the existing bassinets from this total.
 - d. Any Level III, Level IV, or RPC neonatal unit may request additional intensive care bassinets beyond those indicated as needed by the methodology above. The Level III, Level IV, or RPC neonatal unit requesting the addition must document the need for additional intensive care bassinets based on historical and projected utilization, projected population growth, routine swing of intermediate care bassinets into the intensive care setting, or other factors demonstrating the need for the proposed bassinets.
2. Only Level III, Level IV, and RPCs neonatal units have intensive care bassinets.

The Intensive and Intermediate Bassinets Chart, Utilization of Neonatal Special Care Units Chart and NICU Bed Need Chart are located at the end of this Chapter.

The addition of neonatal intermediate care bassinets does not require Certificate of Need review.

In some areas the number of intensive care bassinets should be increased. The intermediate care bassinets should be better utilized in Level II facilities so babies can be transferred back closer to their home community, potentially alleviating the high utilization of the current intensive/intermediate care bassinets in RPC facilities in some areas of the State. To improve the availability of the existing RPC neonatal intensive care bassinets, utilization of the back transport concept should be supported. This component of regionalized care involves the transfer of infants who no longer require neonatal intensive care to facilities with intermediate or continuing care bassinets appropriate to the individual baby's care needs. If more back transfers to the Level II facilities occurred, then some of the overcrowding problems of the existing RPC units would be alleviated.

It should be noted that some RPC, Level III, and Level IV facilities with intensive care bassinets may at times have intermediate type infants in intensive care bassinets and vice versa as the patient load changes within the unit. RPCs may use intermediate and intensive care bassinets interchangeably as the level of care required by the neonate varies.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following criteria are considered the most important in evaluating Certificate of Need applications for a neonatal service:

1. Compliance with the Need Outlined in this Section of this Plan;
2. Distribution (Accessibility);
3. Acceptability
4. Record of the Applicant; and
5. Adverse Effects on Other Facilities.

Because neonatal services are planned and located regionally due to the small percentage of infants requiring neonatal services, this service is available within approximately 30 minutes' travel time for the majority of the population. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

CMS DIAGNOSTIC CATEGORIES

(Chapter 3)

MDC 1:	Diseases and disorders of the nervous system
MDC 2:	Diseases and disorders of the eye
MDC 3:	Diseases and disorders of the ear, nose, mouth and throat
MDC 4:	Diseases and disorders of the respiratory system
MDC 5:	Diseases and disorders of the circulatory system
MDC 6:	Diseases and disorders of the digestive system
MDC 7:	Diseases and disorders of the hepatobiliary system and pancreas
MDC 8:	Diseases and disorders of the musculoskeletal system and
MDC 9:	Diseases and disorders of the skin, subcutaneous tissue and breast
MDC 10:	Endocrine, nutritional and metabolic diseases and disorders
MDC 11:	Diseases and disorders of the kidney and urinary tract
MDC 12:	Diseases and disorders of the male reproductive system
MDC 13:	Diseases and disorders of the female reproductive system
MDC 14:	Pregnancy, childbirth and the puerperium
MDC 15:	Newborns/other neonates with conditions originating in the
MDC 16:	Diseases and disorders of the blood and blood-forming organs and immunological disorders
MDC 17:	Myeloproliferative diseases and disorders and poorly differentiated
MDC 18:	Infectious and parasitic diseases
MDC 19:	Mental diseases and disorders
MDC20:	Alcohol/drug use and alcohol/drug-induced organic mental
MDC 21:	Injury, poisoning and toxic effects of drugs
MDC 22:	Burns
MDC 23:	Factors influencing health status and other contact with health
MDC 24:	Multiple significant traumas
MDC 25:	Human immunodeficiency virus infections

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
Region I										
Abbeville Area Medical Center	<18	5332	4930	15	0					
	18-64	14627	13270	451	1					
	+65	4973	5860	1621	5					
TOTAL		24932	24060	2087	6	65%	10	25	-15	22.87%
Abbeville County Total							10	25	-15	
AnMed Health Medical Center	<18	45054	44870	4586	13					
	18-64	115809	118750	32824	92					
	+65	33829	40780	41805	138					
TOTAL		194,692	204,400	79,215	243	75%	324	423	-99	51.31%
AnMed Health Women's and Children's Hospital	<18	45054	44870	787	2					
	18-64	115809	118750	5432	15					
	+65	33829	40780	1086	4					
TOTAL		194,692	204,400	7,305	21	65%	33	72	-39	27.80%
Anderson County Total							357	495	-138	
Mary Black Health System - Gaffney (Gaffney Medical Center) 1	<18	13378	13070		0					
	18-64	34082	33600		0					
	+65	8734	10260		0					
TOTAL		56,194	56,930	9,107	25	65%	39	125	-86	19.96%
Cherokee County Total							39	125	-86	
Greenville Memorial Medical Center	<18	115082	122900	43222	126					
	18-64	305057	332480	75796	226					
	+65	71724	95000	53186	193					
TOTAL		491,863	550,380	172,204	546	75%	728	746	-18	63.24%
Greer Memorial Hospital (GHS)	<18	115082	122900	134	0					
	18-64	305057	332480	6264	19					
	+65	71724	95000	4592	17					
TOTAL		491,863	550,380	10,990	36	65%	56	82	-26	36.72%
Hillcrest Memorial Hospital (GHS)	<18	115082	122900	6	0					
	18-64	305057	332480	3661	11					
	+65	71724	95000	2543	9					
TOTAL		491,863	550,380	6,210	20	65%	32	43	-11	39.57%
Patewood Memorial Hospital (GHS)	<18	115082	122900	1	0					
	18-64	305057	332480	1090	3					
	+65	71724	95000	1265	5					
TOTAL		491,863	550,380	2,356	8	65%	13	72	-59	8.96%
Saint Francis - Downtown & Saint Francis - Millennium	<18	115082	122900	47	0					
	18-64	305057	332480	21508	64					
	+65	71724	95000	32636	118					
TOTAL		491,863	550,380	54,191	183	70%	262	226	36	65.69%
Saint Francis - Eastside	<18	115082	122900	87	0					
	18-64	305057	332480	10701	32					
	+65	71724	95000	6827	25					
TOTAL		491,863	550,380	17,615	57	65%	88	93	-5	51.89%
Greenville County Total							1,179	1,262	-83	
Self Regional Healthcare	<18	16127	15820	707	2					
	18-64	41616	39630	26134	68					
	+65	12095	14010	27362	87					
TOTAL		69,838	69,460	54,203	157	70%	225	326	-101	45.55%
Greenwood County Total							225	326	-101	
Laurens County Memorial Hospital (GHS) 1	<18	14781	14280	551	1					
	18-64	40410	38640	4703	12					
	+65	11432	13340	5500	18					
TOTAL		66,623	66,260	10,754	31	65%	49	76	-27	38.77%

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
Laurens County Total							49	76	-27	
Oconee Memorial Hospital (GHS)	<18	15209	14540	1132	3					
	18-64	43859	42760	9468	25					
	+65	16645	19800	14267	46					
TOTAL		75,713	77,100	24,867	75	65%	116	169	-53	40.31%
Oconee County Total							116	169	-53	
Baptist Easley Hospital (Palmetto Baptist Medical Center - Easley)	<18	23855	26370		0					
	18-64	78931	75000	6819	18					
	+65	18905	22760	8403	28					
TOTAL		121,691	124,130	15,222	45	65%	70	109	-39	38.26%
AnMed Health Cannon 1 (Cannon Memorial Hospital)	<18	23855	26370		0					
	18-64	78931	75000		0					
	+65	18905	22760		0					
TOTAL		121,691	124,130	2,983	8	65%	13	55	-42	14.86%
Pickens County Total							83	164	-81	
Mary Black Health System - Spartanburg (Mary Black Memorial Hospital)	<18	69835	71550	262	1					
	18-64	181834	187240	11468	32					
	+65	45633	56090	10472	35					
TOTAL		297,302	314,880	22,202	68	65%	106	174	-68	34.96%
Spartanburg Medical Center	<18	69835	71550	2135	6					
	18-64	181834	187240	75692	214					
	+65	45633	56090	64463	217					
TOTAL		297,302	314,880	142,290	437	75%	583	484	99	80.54%
Pelham Medical Center (Village Hospital)	<18	69835	71550	0	0					
	18-64	181834	187240	4263	12					
	+65	45633	56090	5116	17					
TOTAL		297,302	314,880	9,379	29	65%	46	48	-2	53.53%
Spartanburg County Total							735	706	29	
Union Medical Center 1	<18	5990	5340		0					
	18-64	16480	14740		0					
	+65	5307	5960		0					
TOTAL		27,777	26,040	6,034	15	65%	24	143	-119	11.56%
Union County Total							24	143	-119	
Region II										
Aiken Regional Medical Center 3	<18	36383	35570	426	1					
	18-64	99461	99060	18141	50					
	+65	29985	37980	21129	73					
TOTAL		165,829	172,610	39,696	124	70%	178	197	-19	55.21%
Aiken County Total								197	-19	
Southern Palmetto Hospital 4 (Barnwell County Hospital)	<18	5,554	5,370							
	18-64	13,140	11,830							
	+65	3,425	3,980							
TOTAL		22,119	21,180			65%	25	0	25	0.00%
Barnwell County Total							25	0	25	
Chester Regional Medical Center	<18	7397	6880	77	0					
	18-64	19340	17480	1572	4					
	+65	5530	6510	1541	5					
TOTAL		32,267	30,870	3,190	9	65%	14	82	-68	10.66%
Chester County Total							14	82	-68	
Edgefield County Hospital	<18	5036	4250	1	0					
	18-64	17084	15940	123	0					
	+65	4394	5410	392	1					

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
TOTAL		26,514	25,600	516	2	65%	3	25	-22	5.65%
Edgefield County Total								3	25	-22
Fairfield Memorial Hospital	<18	4634	3830	3	0					
	18-64	13900	12110	119	0					
	+65	4213	5090	222	1					
TOTAL		22,747	21,030	344	1	65%	2	25	-23	3.77%
Fairfield County Total								2	25	-23
Kershaw Health 2 (Kershaw County Medical Center)	<18	14,867	14,640		0					
	18-64	37,676	37,800		0					
	+65	9,973	12,590		0					
TOTAL		62,516	65,030	19,001	54	65%	84	121	-37	43.02%
Kershaw County Total								84	121	-37
Springs Memorial Hospital 1	<18	18749	19580		0					
	18-64	50359	55790		0					
	+65	16734	24810		0					
TOTAL		85,842	100,180	24,205	77	70%	111	199	-88	33.32%
Lancaster County Total								111	199	-88
Lexington Medical Center 5	<18	66209	66910	223	1					
	18-64	174401	185810	64183	187					
	+65	41223	55370	60486	223					
TOTAL		281,833	308,090	124,892	411	75%	548	485	63	70.55%
Lexington County Total								548	485	63
Newberry County Memorial Hospital	<18	8378	8210	113	0					
	18-64	22648	21850	3004	8					
	+65	6986	8460	4244	14					
TOTAL		38,012	38,520	7,361	22	65%	35	90	-55	22.41%
Newberry County Total								35	90	-55
Palmetto Health Baptist Parkridge	<18	88453	96860	1255	4					
	18-64	271087	281250	7215	21					
	+65	47511	63010	7186	26					
TOTAL		407,051	441,120	15,656	50	65%	78	76	2	56.44%
Palmetto Health Baptist	<18	88453	96860	13536	41					
	18-64	271087	281250	30251	86					
	+65	47511	63010	26425	96					
TOTAL		407,051	441,120	70,212	223	70%	319	287	32	67.02%
Palmetto Health Richland	<18	88453	96860	37913	114					
	18-64	271087	281250	81421	231					
	+65	47511	63010	48509	176					
TOTAL		407,051	441,120	167,843	521	75%	696	579	117	79.42%
Providence Health (Providence Hospital)	<18	88453	96860	11	0					
	18-64	271087	281250	15827	45					
	+65	47511	63010	24080	87					
TOTAL		407,051	441,120	39,918	133	70%	190	258	-68	42.39%
Providence Health Northeast	<18	88453	96860	18	0					
	18-64	271087	281250	2193	6					
	+65	47511	63010	3116	11					
TOTAL		407,051	441,120	5,327	18	65%	28	74	-46	19.72%
Richland County Total								1,311	1,274	37
Piedmont Medical Center 6	<18	61836	65930	1060	3					
	18-64	155706	175120	29476	91					
	+65	33653	47100	26179	100					
TOTAL		251,195	288,150	56,715	194	70%	278	268	10	57.98%
Fort Mill Medical Center 6								100		

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
York County Total								278	368	-90
Region III										
McLeod Health Cheraw (Chesterfield General Hospital)	<18	10586	9690	19	0					
	18-64	27903	26100	842	2					
	+65	7528	8850	769	2					
	TOTAL	46,017	44,640	1,630	5	65%	8	59	-51	7.57%
Chesterfield County Total								8	59	-51
McLeod Health Clarendon (Clarendon Memorial Hospital)	<18	6891	6010	69	0					
	18-64	19893	17660	4605	11					
	+65	6991	8140	5419	17					
	TOTAL	33,775	31,810	10,093	29	65%	45	81	-36	34.14%
Clarendon County Total								45	81	-36
Carolina Pines Regional Medical Center	<18	15405	14200	1822	5					
	18-64	40608	37730	6867	17					
	+65	11535	13620	6839	22					
	TOTAL	67,548	65,550	15,528	44	65%	69	116	-47	36.67%
McLeod Medical Center - Darlington	<18	15405	14200	0	0					
	18-64	40608	37730	217	1					
	+65	11535	13620	328	1					
	TOTAL	67,548	65,550	545	2	65%	3	49	-46	3.05%
Darlington County Total								72	165	-93
McLeod Medical Center - Dillon	<18	8060	7530	525	1					
	18-64	18348	16750	4634	12					
	+65	4826	5680	3265	11					
	TOTAL	31,234	29,960	8,424	23	65%	37	79	-42	29.21%
Dillon County Total								37	79	-42
Carolinas Hospital System 1	<18	33464	32770		0					
	18-64	83923	81910		0					
	+65	21513	25870		0					
	TOTAL	138,900	140,550	54320	151	70%	216	310	-94	48.01%
Women's Center - Carolinas Hospital System 1	<18	33464	32770		0					
	18-64	83923	81910		0					
	+65	21513	25870		0					
	TOTAL	138,900	140,550	2,491	7	65%	11	20	-9	34.12%
Lake City Community Hospital 1	<18	33464	32770		0					
	18-64	83923	81910		0					
	+65	21513	25870		0					
	TOTAL	138,900	140,550	4,007	11	65%	18	48	-30	22.87%
McLeod Regional Medical Center - Pee Dee 7	<18	33464	32770	3938	11					
	18-64	83923	81910	67808	181					
	+65	21513	25870	59492	196					
	TOTAL	138,900	140,550	131,238	388	75%	518	461	57	77.99%
Florence County Total								763	839	-76
Tidelands Georgetown Memorial Hospital	<18	12107	10870	189	0					
	18-64	33924	32090	7950	21					
	+65	15267	19350	8661	30					
	TOTAL	61,298	62,310	16,800	51	65%	79	131	-52	35.14%
Tidelands Waccamaw Community Hospital	<18	12107	10870	225	1					
	18-64	33924	32090	10013	26					
	+65	15267	19350	17628	61					
	TOTAL	61,298	62,310	27,866	88	65%	135	124	11	61.57%
Georgetown County Total								214	255	-41

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
Conway Hospital	<18	58904	63740	3612	11					
	18-64	184214	205840	15761	48					
	+65	66081	105690	13463	59					
	TOTAL	309,199	375,270	32,836	118	70%	169	210	-41	42.84%
Grand Strand Medical Center 8	<18	58904	63740	1174	3					
	18-64	184214	205840	38020	116					
	+65	66081	105690	43033	189					
	TOTAL	309,199	375,270	82,227	308	70%	441	325	116	69.32%
McLeod Loris (Loris Community Hospital) 9	<18	58904	63740	219	1					
	18-64	184214	205840	4230	13					
	+65	66081	105690	4762	21					
	TOTAL	309,199	375,270	9,211	34	65%	54	50	4	50.47%
McLeod Seacoast (Seacoast Medical Center) 9	<18	58904	63740	31	0					
	18-64	184214	205840	3138	10					
	+65	66081	105690	6088	27					
	TOTAL	309,199	375,270	9,257	36	65%	56	105	-49	24.15%
Horry County Total							664	585	79	
Carolinas Hospital System - Marion (Marion County Medical Center)	<18	7473	6870	3229	8					
	18-64	18657	16570	3230	8					
	+65	5617	6320	3328	10					
	TOTAL	31,747	29,760	9,787	26	65%	41	124	-83	21.62%
Marion County Total							41	124	-83	
Marlboro Park Hospital 4	<18	5,766	5,100							
	18-64	18,097	16,530							
	+65	4,140	4,730							
	TOTAL	28,003	26,360			65%	25	0	25	0.00%
Marlboro County Total							25	0	25	
Palmetto Health Tuomey	<18	26388	25270		0					
	18-64	64991	62120	26055	68					
	+65	16101	19360	25033	82					
	TOTAL	107,480	106,750	51,088	151	70%	216	283	-67	49.46%
Sumter County Total							216	283	-67	
Williamsburg Regional Hospital 1	<18	7,271	6,300		0					
	18-64	20,162	17,270	1,956	5					
	+65	5,634	6,690	2,995	10					
	TOTAL	33,067	30,260	4,951	14	65%	23	25	-2	54.26%
Williamsburg County Total							23	25	-2	
Region IV										
Allendale County Hospital 1	<18	1795	1360	0	0					
	18-64	6004	4970	314	1					
	+65	1634	1900	353	1					
	TOTAL	9,433	8,230	667	2	65%	3	25	-22	7.31%
Allendale County Total							3	25	-22	
Beaufort Memorial Hospital 1	<18	35395	36880		0					
	18-64	99620	106450		0					
	+65	44574	61540		0					
	TOTAL	179,589	204,870	39,898	125	65%	192	169	23	64.68%
Hilton Head Hospital	<18	35395	36880	117	0					
	18-64	99620	106450	7558	22					
	+65	44574	61540	14803	56					
	TOTAL	179,589	204,870	22,478	78	65%	121	93	28	66.22%
Beaufort County Total							313	262	51	

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
Trident Medical Center & Berkeley Medical Center 1, 10	<18	166114	180030		0					
	18-64	476343	535390		0					
	+65	102069	146830		0					
	TOTAL	744,526	862,250	71,955	228	70%	327	296	31	66.60%
Summerville Medical Center 11	<18	166114	180030	2028	6					
	18-64	476343	535390	11593	36					
	+65	102069	146830	8513	34					
	TOTAL	744,526	862,250	22,134	75	65%	116	124	-8	48.90%
MUSC Medical Center 12	<18	166114	180030	28399	84					
	18-64	476343	535390	105594	325					
	+65	102069	146830	48814	192					
	TOTAL	744,526	862,250	182,807	602	75%	803	656	147	76.35%
Mount Pleasant Hospital	<18	166114	180030	8	0					
	18-64	476343	535390	2645	8					
	+65	102069	146830	2400	9					
	TOTAL	744,526	862,250	5,053	18	65%	28	85	-57	16.29%
Roper Hospital 13	<18	166114	180030	13	0					
	18-64	476343	535390	22148	68					
	+65	102069	146830	34258	135					
	TOTAL	744,526	862,250	56,419	203	70%	291	316	-25	48.92%
Bon Secours - Saint Francis Xavier Hospital	<18	166114	180030	92	0					
	18-64	476343	535390	19206	59					
	+65	102069	146830	12379	49					
	TOTAL	744,526	862,250	31,677	108	70%	155	204	-49	42.54%
East Cooper Medical Center	<18	166114	180030	19	0					
	18-64	476343	535390	8607	27					
	+65	102069	146830	5979	24					
	TOTAL	744,526	862,250	14,605	50	65%	78	130	-52	30.78%
Berkeley / Charleston / Dorchester County Total							1,798	1,811	-13	
Colleton Medical Center	<18	8550	7680	825	2					
	18-64	21940	19620	8934	22					
	+65	7241	8630	9478	31					
	TOTAL	37,731	35,930	19,237	55	65%	85	116	-31	45.43%
Colleton County Total							85	116	-31	
Hampton Regional Medical Center	<18	4447	3830	10	0					
	18-64	12266	10850	1033	3					
	+65	3336	3910	1512	5					
	TOTAL	20,049	18,590	2,555	7	65%	12	32	-20	21.88%
Hampton County Total							12	32	-20	
Coastal Carolina Medical Center	<18	5922	5660	20	0					
	18-64	17158	18410	3921	12					
	+65	4744	9900	4804	27					
	TOTAL	27,824	33,970	8,745	39	65%	61	41	20	58.44%
Jasper County Total							61	41	20	
Regional Medical Center of Orangeburg & Calhoun Counties 1	<18	23030	21720		0					
	18-64	62137	54260		0					
	+65	18822	21980		0					
	TOTAL	103,989	97,960	44,741	115	70%	165	247	-82	49.63%
Orangeburg / Calhoun County Total							165	247	-82	

* This chart does not count beds already counted in the charts for psychiatric beds, rehabilitation beds, and substance abuse beds. The patient days associated with these beds have been deducted from the reported total number of patient days.

1 Age cohorts not adequately reported.

2 Facility did not submit 2015 JAR.

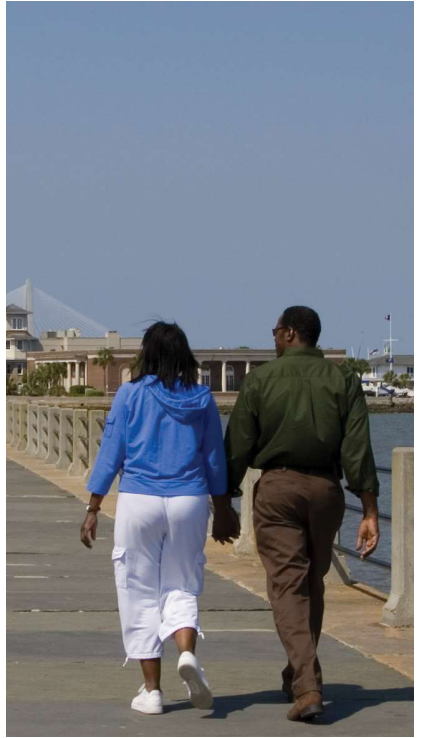
GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
3 SC-16-17 issued 3/2/2017 for the addition of 14 acute care beds.										
4 Facility is closed. Bed need is based minimally on CAH bed count limit.										
5 SC-16-08 issued 3/2/2016 for addition of 71 acute care beds, some of which have been liscenced.										
6 Pending resolution of an appeal, Piedmont proposes constructing a 100-bed hospital in Fort Mill using a combination of new and transferred hospital beds.										
7 SC-16-42 issued 8/11/2016 for addition of 8 acute care beds.										
8 SC-16-17 issued 5/12/2016 for the addition of 24 acute care beds.										
9 SC-15-29 issued 8/18/2015 for transfer of 55 acute care beds from McLeod Loris to McLeod Loris Seacoast for a total of 50 beds at McLeod Loris and 105 beds at McLeod Seacoast.										
10 SC-16-19 issued 5/26/2016 for the construction of a new 50 bed acute care hospital.										
11 SC-14-07 issued 10/27/2014 for addition of 30 acute care beds.										
12 CON SC-15-15 issued 6/30/15 for the addition of 52 acute hospital beds, some of which have been liscenced.										
13 SC-16-01 issued 1/6/2016 for construction of a new acute care hospital by transfer of 50 beds from Roper Hospital to the new hospital.										

EXHIBIT B

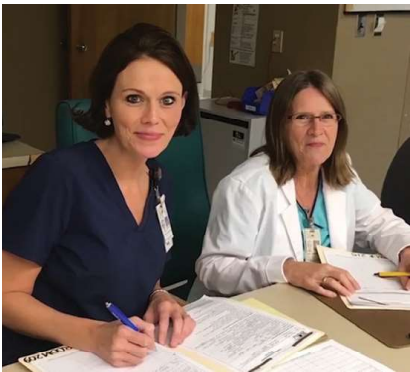
2020 State Health Plan Chapter 3 Hospitals

Chapter 3 Enacted June 12, 2020



2020 South Carolina Health Plan

Enacted March 13, 2020 for all but Chapter 3, which was enacted June 12, 2020



CHAPTER 3

GENERAL HOSPITALS

GENERAL HOSPITALS

Relevant Definitions

"Hospital" means a facility organized and administered to provide overnight medical, surgical, or nursing care of illness, injury, or infirmity and may provide obstetrical care, and in which all diagnoses, treatment, or care is administered by or under the direction of persons currently licensed to practice medicine, surgery, or osteopathy.

Hospital may include residential treatment facilities for children and adolescents in need of mental health treatment which are physically a part of a licensed psychiatric hospital. This definition does not include facilities which are licensed by the Department of Social Services.

"Hospital Bed" means a bed for an adult or child patient. Bassinets for the newborn in a maternity unit nursery, beds in labor rooms, recovery rooms, and other beds used exclusively for emergency purposes are not included in this definition.

Bed Capacity

For existing beds, capacity is considered bed space designated exclusively for inpatient care, including space originally designed or remodeled for inpatient beds, even though temporarily not used for such purposes. The number of beds counted in any patient room is the maximum number for which adequate square footage is provided, except that single beds in single rooms have been counted even if the room contained inadequate square footage.

Inventory and Bed Need

All licensed general hospitals, including Federal facilities, and CON-approved general hospitals are listed in the inventory. Patient days and admissions are as reported by the hospital in its JAR. The number of patient days utilized for the general hospital bed need calculations does not include days of care rendered in licensed psychiatric units, substance abuse units, or comprehensive rehabilitation units of hospitals. These days of care are shown in the corresponding inventories for each type of service. In addition, the days of care provided in Long-Term Care hospitals are not included in the general bed need calculations.

Total capacity by survey refers to a total designed capacity or maximum number of beds that may be accommodated as determined by an on-site survey. This capacity may exceed the

number of beds actually set up and in use. It may also differ from the licensed capacity, which is based on State laws and regulations. Beds have been classified as conforming and nonconforming, according to standards of plant evaluation.

Variable Occupancy Rate

The General Acute Hospital bed need methodology uses the following variable occupancy rate factors:

0 - 174 bed hospitals → 65%
175 - 349 bed hospitals → 70%
350+ bed hospital → 75%

The population and associated utilization are broken down by age groups. The use rates and projected average daily census are made for the age cohorts of 0-17, 18-64, and 65 and over, in recognition that different population groups have different hospital utilization rates.

Where the term “hospital bed need” is used, these figures are based upon utilization data for the general acute hospitals. This term does not suggest that facilities cannot operate at higher occupancy rates than used in the calculations without adding additional beds.

Availability

The need for general hospital beds is determined through the consideration of current utilization and projected population growth with the goal of having beds available within approximately 30 minutes’ travel time for the majority of the residents of the State.

CERTIFICATE OF NEED PROJECTION AND STANDARDS

1. Calculations of hospital bed need are made for individual hospitals and for service areas.
2. For individual hospitals, the methodology for calculating bed need is as follows:
 - a. Determine the current facility use rate by dividing the 2018 patient days by the 2018 population in each of the three age cohorts.
 - b. Multiply the current facility use rate for each age cohort by the projected population by age cohort and divide by 365 to obtain a projected average daily census (ADC) by age cohort.
 - c. Divide the sum of the age cohort projected ADC by the variable occupancy factor (.65/.70/.75) to determine the hospital's bed need.

- d. The number of additional beds needed or excess beds for the hospital is obtained by subtracting the number of existing and approved beds from the hospital's bed need.
3. The methodology for calculating the statewide utilization bed need for a service area is as follows:
 - a. Divide the statewide total patient days by 365 to determine the statewide average daily census.
 - b. Divide the statewide average daily census by the statewide occupancy factor (.75) to determine the total statewide bed need.
 - c. Divide the statewide bed need by the 2018 statewide population to generate a bed-per-population (BPP) multiplier.
 - d. For each service area, multiply the projected population by the BPP multiplier to determine the service area bed need, then subtract the total number of existing and approved beds to determine the statewide utilization bed need for the service area.
4. The bed need for each service area is the combined bed need for all individual hospitals in the service area. The bed need for service areas with no hospital, or for service areas in which no hospital has reported any utilization data on the most recent JAR, is the statewide utilization bed need.
5. If a service area indicates a surplus of beds, then no additional beds will be approved unless an individual hospital in the service area indicates a need for additional beds. Should an individual hospital indicate a need for additional beds, then a maximum of the actual projected bed need or up to 50 additional beds may be approved for that hospital to allow for the construction of an economical unit at either the existing hospital site or another site, if the existing hospital is relocating or has relocated in whole or in part to that site. The hospital requesting the addition must document the need for additional beds beyond those indicated as needed by the methodology stated above, based on historical and projected utilization, as well as projected population growth or other factors demonstrating the need for the proposed beds. Additional beds will only be approved for the specific hospital indicating a need.
6. If there is a need for additional hospital beds in the service area, then any entity may apply to add these beds within the service area, and any entity may be awarded the Certificate of Need for these beds. If the number of beds needed is less than 50, then up to a total of 50 beds could be approved for any entity at any

location within the service area. An applicant requesting additional beds beyond those indicated as needed by the methodology stated above must document the need for additional beds based on historical and projected utilization, projected population growth that has not been considered in this Plan or other factors demonstrating the need for the proposed beds. It is up to the applicant to document the need and the potential negative impact on the existing facilities.

7. A facility may apply to create a new additional hospital at a different site within the same service area through the transfer of existing licensed beds, the projected bed need for the facility, or a combination of both existing beds and projected bed need. The facility is not required to have a projected need for additional beds in order to create a new additional hospital. There is no required minimum number of beds in order to approve the CON application. The applicant must justify, through patient origin and other data, the need for a new hospital at the chosen site and the potential adverse impact a new hospital at the chosen site could have on the existing hospitals in the service area.
8. No additional hospital will be approved unless it is a general hospital and will provide:
 - a. A 24-hour emergency services department that meets the requirements to be a Level III emergency service as defined in the *Emergency Services* section of [Regulation 61-16](#);
 - b. Inpatient medical services to both surgical and non-surgical patients; and
 - c. Medical and surgical services on a daily basis within at least six of the major diagnostic categories as recognized by Centers for Medicare and Medicaid Services (CMS). Any applicant for a new hospital must provide a written commitment that the facility will accept Medicare and Medicaid patients and that unreimbursed services for indigent and charity patients are provided at a percentage that meets or exceeds other hospitals in the service area. The CMS Diagnostic Categories Chart is located at the end of this Chapter.
9. Due to the low utilization and the low capital cost of converting hospital-based nursing home, psychiatric, rehabilitation and/or substance abuse beds to general acute care hospital beds, the following policies may apply:
 - a. Hospitals that have licensed nursing home beds within the hospital may be allowed to convert nursing home beds to general acute care hospital beds only within the hospital, provided the hospital can document an actual need for additional general acute care beds. Need will be based on actual utilization, using current information. *A Certificate of Need is required for this conversion.*

- b. Existing acute care hospitals that have inpatient psychiatric, rehabilitation, or substance abuse beds may be allowed to convert such beds to acute care hospital beds, regardless of the projected need for general acute care hospital beds. *A Certificate of Need is required for this conversion.*
- 10. In some areas of South Carolina, a considerable influx of tourists is not counted in the permanent population. If an individual hospital in these areas can document and demonstrate the need for additional beds due to non-resident (tourist) population and seasonal utilization fluctuations due to this population, then, based on further analysis, the Department may approve some additional beds at the existing hospital.
- 11. Should the deletion of services at a federal facility result in an immediate impact on the utilization of a hospital, then the Department may approve a request for additional beds at the affected hospital. The affected hospital must document the increase in demand and explain why additional beds are needed to accommodate patients previously served at the federal facility.
- 12. Changes in the delivery system due to health care reform have resulted in the consolidation of facilities and the establishment of provider networks. These consolidations and agreements may lead to situations where affiliated hospitals may wish to transfer beds between themselves in order to serve their patients in a more efficient manner. *A proposal to transfer or exchange hospital beds requires a Certificate of Need* and must comply with the provisions outlined in Chapter 2, Transfer between Affiliated Facilities.
- 13. Factors to be considered regarding modernization of facilities include:
 - a. Functional arrangement of the facility as it relates to efficient handling of patients and related workloads.
 - b. The ability to update medical technology within the existing plant.
 - c. Existence of The Joint Commission (TJC) or other accreditation body deficiencies or "grandfathered" licensure deficiencies.
 - d. Cost efficiency of the existing physical plant versus plant revision, etc.
 - e. Private rooms are now considered the industry standard.
- 14. Each modernization proposal must be evaluated on the basis of merit, cost efficiency, and impact on healthcare delivery within the service area.

The Hospital Bed Need Chart is located at the end of this Chapter.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

1. Compliance with the Need Outlined in this Section of this Plan;
2. Community Need Documentation;
3. Distribution (Accessibility);
4. Acceptability;
5. Ability to Complete the Project; and
6. Adverse Effects on Other Facilities.

General hospital beds are typically located within approximately thirty (30) minutes' travel time for the majority of the residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

LONG-TERM ACUTE CARE HOSPITALS

Long-Term Acute Care Hospitals (LTACHs) are hospitals with an average Medicare inpatient length of stay of greater than 25 days, including all covered and non-covered days of stay of Medicare patients. They provide treatment to patients with complex medical conditions, such as strokes, cardiac care, ventilator dependency, wound care and post-surgical care.

A LTACH may be either a freestanding facility or may occupy space in another hospital ("hospital-within-a-hospital"). Hospitals must meet additional federal criteria in order to qualify as a LTACH under the "hospital-within-a-hospital" model:

1. The new LTACH must have a governing body, which is distinct and separate from the governing body of the host hospital, and the new body cannot be under the control of the host hospital or any third entity that controls both hospitals.
2. The LTACH must have a separate Chief Executive Officer through whom all administrative authority flows, who is not employed by, or under contract with, the host hospital or any third entity that controls both hospitals.
3. The LTACH must have a separate Chief Medical Officer who reports directly to the governing body and is responsible for all medical staff activities. The Chief Medical Officer cannot be under contract with the host hospital or any third entity that controls both hospitals.

4. The LTACH must have a separate medical staff which reports directly to the governing body, and adopt bylaws governing medical care, including granting privileges to individual practitioners.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. An application for a LTACH must be in compliance with the relevant standards in [Regulation 61-16](#) (*Minimum Standards for Licensing Hospitals and Institutional General Infirmaries*).
2. Although LTACH beds are not considered to be a separate category for licensing purposes, they will be inventoried separately from general acute care hospital beds for planning purposes.
3. The utilization of LTACHs is not included in the bed need for general acute care hospital beds. No bed need will be calculated for LTACH beds. An applicant must document the need for LTACH beds based on the utilization of existing LTACH beds.
4. A hospital that has leased general beds to a LTACH shall be entitled to regain these beds once the lease is terminated. No entity other than the hospital (or its successor) that initially leased the general acute beds to the LTACH shall be entitled to the beds upon termination of the lease. *A Certificate of Need application is required:*
 - a. A hospital may be allowed to convert these former LTACH beds to general acute hospital beds regardless of the projected need for general acute beds;
 - b. A hospital may be allowed to convert these former LTACH beds to psychiatric, inpatient treatment facility, rehabilitation, or other specialty beds only if there is a bed need projected for this proposed other category of licensed beds.
5. A hospital which seeks to be designated as a LTACH, and has been awarded a CON for that purpose, must be certified as a LTACH by CMS within 24 months of accepting its first patient, or the CON issued to that hospital for that purpose shall be revoked. The entity that has had its CON revoked shall not have the authority to operate as a general acute care hospital.
6. A hospital that desires to be designated as a Pediatric LTACH must restrict admissions to patients under the age of 21 who require long-term medical care. Should the facility attempt to provide care that is inconsistent with this requirement or patient demand or other economic conditions require the facility to close, the Certificate of Need issued to that hospital for that purpose shall be revoked.

The Long-Term Acute Care Hospitals Chart is located at the end of this Chapter.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

1. Compliance with the Need Outlined in this Section of this Plan;
2. Community Need Documentation;
3. Distribution (Accessibility);
4. Record of the Applicant.

Long-Term Acute Care Hospital beds are located within approximately 60 minutes' travel time for the majority of the residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

CRITICAL ACCESS HOSPITALS (CAH)

The South Carolina Department of Health and Human Services administers programs through the Medicaid program to assist struggling rural hospitals. One such program designates rural hospitals as Critical Access Hospitals (CAH) who are then eligible for more favorable Medicaid reimbursement methodology.

A CAH is intended to provide essential health services to rural communities. Converting a struggling rural hospital to a CAH can allow a community to maintain local health access that would otherwise be lost. CAHs are subject to review by the Independent Payment Advisory Board (IPAB), whereas other hospitals are not currently subject to IPAB review.

The impact of the Critical Access Hospital Program in South Carolina is a financial one, allowing cost-based reimbursement from Medicare for a facility choosing to participate. The designation as a CAH does not require a change in the licensing of an existing hospital. However, a hospital may be required to de-license a number of beds in order to meet the 25-bed requirement.

The designation of a hospital as a Critical Access Hospital *does not require Certificate of Need review* because it does not change the licensing category of the facility. However, an exemption from Certificate of Need review is required for a hospital to reduce its number of licensed beds in order to meet the criteria for a CAH. *Should a hospital later desire to revert to a general acute hospital, a Certificate of Need is required*, but the facility may be permitted to increase the number of licensed hospital beds up to the prior number of beds without regard or affect to the current bed need shown in the service area.

The Critical Access Hospitals Chart is located at the end of this Chapter.

PERINATAL REGIONS

The Perinatal Regions referred to in the Obstetrical Services and Neonatal Services sections below are distinct from the Department's Regions defined in Chapter 2 of this Plan, and are identified by the name of its designated Regional Perinatal Center.

Perinatal Region

Counties

I - Greenville Memorial

Abbeville, Anderson, Edgefield, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Saluda

II - Spartanburg Regional

Cherokee, Chester, Spartanburg, Union

III - Palmetto Health Richland

Aiken, Allendale, Bamberg, Barnwell, Calhoun, Clarendon, Fairfield, Kershaw, Lancaster, Lee, Lexington, Newberry, Orangeburg, Richland, Sumter, York

IV - McLeod Regional

Chesterfield, Darlington, Dillon, Florence, Horry, Marion, Marlboro, Williamsburg

V - MUSC Medical

Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Georgetown

PERINATAL SERVICE LEVELS

Because the cost of high-risk obstetrical and neonatal services is so great, it is not desirable or cost-effective for all hospitals in the State to provide the higher levels of care. Over the years, a regionalized approach to perinatal care has been implemented in South Carolina to address the need for high quality, risk-appropriate, cost-effective perinatal health care. Regionalization provides a coordinated system of perinatal care for a well-defined population group. Each hospital providing perinatal services is designated by the Department's Division of Health Licensing as a Level I, II, III, or IV Perinatal Hospital, or a Regional Perinatal Center (RPC). Each Level I, II, III and IV hospital maintains a relationship with its designated RPC for consultation, transport and continuing education. Patients are transferred to the appropriate RPC when medically appropriate, if beds are available. True regionalization for the optimization of perinatal care includes a stated goal of back-transporting infants when they no longer require the highest level of care. Convalescing infants benefit from a community-based program closer to home that promotes parent education and family bonding to facilitate a safe and timely discharge. In this way, quality

care is provided to mothers and newborn infants, and specially trained perinatal personnel and intensive care facilities can be used efficiently and cost-effectively.

The complete descriptions of the five levels of perinatal services described briefly below are outlined in the Section of [Regulation 61-16](#) entitled *Designation of Inpatient Perinatal Care Services*.

[Basic Perinatal Center with Well Newborn Nursery \(Level I\)](#). Level I hospitals provide services for normal uncomplicated pregnancies. A full list of the requirements for a Level I Basic Perinatal Center with Well Newborn Nursery can be found at Regulation 61-16, Section 1306.A. *Certificate of Need review is not required to establish a Level I program.*

[Specialty Perinatal Center with Special Care Nursery \(Level II\)](#). In addition to the requirements of Regulation 61-16, Section 1306.A, Level II hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. A full list of the requirements for a Level II Specialty Perinatal Center can be found at Regulation 61-16, Section 1306.B. *Certificate of Need review is not required to establish a Level II program.*

[Subspecialty Perinatal Center with Neonatal Intensive Care Unit \(Level III\)](#). In addition to the requirements of Regulation 61-16, Sections 1306.A and 1306.B, Level III hospitals provide all aspects of perinatal care, including intensive care and a range of continuously available, subspecialty consultation as recommended in the most recent edition of the *Guidelines for Perinatal Care* (GPC) by the American Academy of Pediatrics (AAP) and The American College of Obstetricians and Gynecologists. A full list of the requirements for a Level III Subspecialty Perinatal Center with Neonatal Intensive Care Unit can be found at Regulation 61-16, Section 1306.C. Neonatal transport may only be performed by Regional Perinatal Centers. *Certificate of Need Review is required to establish a Level III program.*

[Regional Perinatal Center with Neonatal Intensive Care Unit \(RPC\)](#). In addition to the requirements of Regulation 61-16, Sections 1306.A through 1306.C, RPCs provide consultative, outreach, and support services to other hospitals in the region. A full list of the requirements for a Regional Perinatal Center can be found at Regulation 61-16, Section 1306.D. No more than one Regional Perinatal Center will be approved in each perinatal region. *Certificate of Need Review is required to establish a RPC.*

[Complex Neonatal Intensive Care Unit \(Level IV\)](#). In addition to the requirements of Regulation 61-16, Sections 1306.A through 1306.C, Level IV hospitals shall include additional capabilities and considerable experience in the care of the most complex and critically ill newborn infants and have pediatric medical and surgical specialty consultants available 24 hours a day. A full list of the requirements for a Complex Neonatal Intensive Care Unit can be found at Regulation 61-16, Section 1306.E. A Level IV hospital need not act as a Regional Perinatal Center (RPC). *Certificate of Need Review is required to establish a Level IV program.*

The Perinatal-Capable Facilities Chart is located at the end of this Chapter.

OBSTETRICAL SERVICES

Advances in obstetrical and newborn intensive care offer the promise of lower perinatal mortality and improvement in the quality of life for survivors. The high cost of intensive care and the limited availability of skilled personnel have created the requirement for a more efficient method of resource allocation.

Maternal, fetal, and neonatal mortality and morbidity rates can be significantly reduced if patients at high risk are identified early in the pregnancy and optimum techniques for the care of both the mother and infant are applied. High-risk deliveries are a small percent of total annual deliveries, but these patients require a high degree of specialized care. In 2017, 76% of all Very Low Birthweight (VLB) babies were born in either a Level III center or a Regional Perinatal Center, whereas the Healthy People 2020 national objective was 83.7%.

Infant mortality is defined as the death of babies from birth until their first birthday. South Carolina's infant mortality rate for 2017 was 6.5 infant deaths per 1,000 live births versus the national rate of 5.79 infant deaths per 1,000 births in 2017.

Neonatal mortality is the death rate for infants up to 28 days old. For 2016, South Carolina's neonatal mortality rate for all races was 4.4 neonatal deaths per 1,000 live births, while the Healthy People 2020 national objective was 4.1 neonatal deaths per 1,000 live births.

The need for obstetrical beds will be evaluated based on information supplied by the Joint Annual Report of Hospitals and other sources. Those facilities experiencing low utilization and in close proximity to one another should consider consolidating services, where appropriate.

The OB Utilization and Births Chart is located at the end of this Chapter.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following project review criteria are considered the most important in evaluating Certificate of Need applications for an obstetrical service:

1. Compliance with the Need Outlined in this Section of this Plan;
2. Distribution (Accessibility);
3. Acceptability;
4. Record of the Applicant; and
5. Adverse Effects on Other Facilities.

The benefits of improved accessibility will be equally weighed with the adverse effects of

duplication in evaluating Certificate of Need applications for this service.

NEONATAL SERVICES

Neonatal services are highly specialized and are only required by a very small percentage of infants. The need for these services is affected by the incidence of high-risk deliveries, the percentage of live births requiring neonatal services, and the average length of stay. The limited need for these services requires that they be planned for on a regional basis, fostering the location of these specialized units in hospitals that have the necessary staff, equipment, and consultative services and facilities. Referral networks facilitate the transfer of infants requiring this level of services from other facilities.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. The projected need for neonatal intensive care bassinets is calculated on a regional basis:
 - a. For each region take the average number of births from 2016-2018 and the average population of women age 15-44 for 2016-2018 to generate an average birth rate.
 - b. Multiply the average birth rate against the projected 2023 population of women age 15-44 to project the number of births in 2023.
 - c. Generate the projected number of intensive care bassinets needed in a region by applying a constant of 3.25 bassinets per 1,000 live births to the projected birth rate and subtracting the existing bassinets from this total.
 - d. Any Level III, Level IV, or RPC neonatal unit may request additional intensive care bassinets beyond those indicated as needed by the methodology above. The Level III, Level IV, or RPC neonatal unit requesting the addition must document the need for additional intensive care bassinets based on historical and projected utilization, projected population growth, routine swing of intermediate care bassinets into the intensive care setting, or other factors demonstrating the need for the proposed bassinets.
 - e. In the absence of a projected need for Level III Intensive Care bassinets in a Perinatal Region as set forth in this Chapter, an existing Level II facility can be approved for a Certificate of Need to become a Subspecialty Perinatal Center and establish up to eight (8) neonatal intensive care bassinets (NICU beds), provided the applicant can demonstrate, during the 12 month period immediately prior to the month in which the CON application is submitted to the Department, a minimum of 1,500 births and 2,500 intermediate patient days at its facility.

2. Only Level III, Level IV, and RPCs neonatal units have intensive care bassinets.

The Intensive and Intermediate Bassinets Chart, Utilization of Neonatal Special Care Units Chart and NICU Bed Need Chart are located at the end of this Chapter.

The addition of neonatal intermediate care bassinets does not require Certificate of Need review.

In some areas the number of intensive care bassinets should be increased. The intermediate care bassinets should be better utilized in Level II facilities so babies can be transferred back closer to their home community, potentially alleviating the high utilization of the current intensive/intermediate care bassinets in RPC facilities in some areas of the State. To improve the availability of the existing RPC neonatal intensive care bassinets, utilization of the back transport concept should be supported. This component of regionalized care involves the transfer of infants who no longer require neonatal intensive care to facilities with intermediate or continuing care bassinets appropriate to the individual baby's care needs. If more back transfers to the Level II facilities occurred, then some of the overcrowding problems of the existing RPC units would be alleviated.

It should be noted that some RPC, Level III, and Level IV facilities with intensive care bassinets may at times have intermediate type infants in intensive care bassinets and vice versa as the patient load changes within the unit. RPCs may use intermediate and intensive care bassinets interchangeably as the level of care required by the neonate varies.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following criteria are considered the most important in evaluating Certificate of Need applications for a neonatal service:

1. Compliance with the Need Outlined in this Section of this Plan;
2. Distribution (Accessibility);
3. Record of the Applicant; and
4. Adverse Effects on Other Facilities.

Because neonatal services are planned and located regionally due to the small percentage of infants requiring neonatal services, this service is available within approximately 30 minutes' travel time for the majority of the population. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

CMS DIAGNOSTIC CATEGORIES (Chapter 3)

MDC 1:	Diseases and disorders of the nervous system
MDC 2:	Diseases and disorders of the eye
MDC 3:	Diseases and disorders of the ear, nose, mouth and throat
MDC 4:	Diseases and disorders of the respiratory system
MDC 5:	Diseases and disorders of the circulatory system
MDC 6:	Diseases and disorders of the digestive system
MDC 7:	Diseases and disorders of the hepatobiliary system and pancreas
MDC 8:	Diseases and disorders of the musculoskeletal system and
MDC 9:	Diseases and disorders of the skin, subcutaneous tissue and breast
MDC 10:	Endocrine, nutritional and metabolic diseases and disorders
MDC 11:	Diseases and disorders of the kidney and urinary tract
MDC 12:	Diseases and disorders of the male reproductive system
MDC 13:	Diseases and disorders of the female reproductive system
MDC 14:	Pregnancy, childbirth and the puerperium
MDC 15:	Newborns/other neonates with conditions originating in the
MDC 16:	Diseases and disorders of the blood and blood-forming organs and immunological disorders
MDC 17:	Myeloproliferative diseases and disorders and poorly differentiated
MDC 18:	Infectious and parasitic diseases
MDC 19:	Mental diseases and disorders
MDC20:	Alcohol/drug use and alcohol/drug-induced organic mental
MDC 21:	Injury, poisoning and toxic effects of drugs
MDC 22:	Burns
MDC 23:	Factors influencing health status and other contact with health
MDC 24:	Multiple significant traumas
MDC 25:	Human immunodeficiency virus infections

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2018 Pop	2024 Pop	2018 Pt Days	Proj ADC	Var. Rate Factor	Bed Need	Licensed / Approved Beds	Staffed / Approved Beds	Add/ Excess Use	2018 % Occup. Rate	Statewide Bed Need	Add/ Excess State	Bed Need
Region I														
Abbeville Area Medical Center	<18	4,924	4,525	2	0									
	18-64	14,274	13,330	521	1									
	+65	5,343	5,955	980	3									
TOTAL		24541	23810	1,503	4	65%	7	25	25	-18	16.47%			
Abbeville County Total							7	25	25	-18		39	14	-18
AnMed Health Medical Center	<18	45,852	47,155	33	0									
	18-64	118,445	123,580	33,751	96									
	+65	36,185	41,940	43,794	139									
TOTAL		200,482	212,675	77,578	236	75%	315	423	274	-108	50.25%			
AnMed Health Women's and Children's Hospital	<18	45,852	47,155	1,145	3									
	18-64	118,445	123,580	3,567	10									
	+65	36,185	41,940	758	2									
TOTAL		200,482	212,675	5,470	16	65%	25	72	50	-47	20.81%			
Anderson County Total							340	495	324	-155		344	-151	-155
Cherokee Medical Center	<18	13,140	12,925	43	0									
(Formerly - Mary Black Health System - Gaffney (Gaffney Medical Center))	18-64	34,340	34,005	2,809	8									
	+65	9,598	10,925	3,744	12									
TOTAL		57,078	57,855	6,596	18	65%	29	125	80	-96	14.46%			
Cherokee County Total							29	125	80	-96		94	-31	-96
Prisma Health Greenville Memorial Hospital	<18	118,364	124,015	21,895	63									
(Formerly - Greenville Memorial Medical Center)	18-64	314,713	338,430	90,060	265									
	+65	81,136	102,040	54,766	189									
TOTAL		514,213	564,485	166,721	517	75%	690	746	648	-56	61.23%			
Prisma Health Greer Memorial Hospital	<18	118,364	124,015	77	0									
(Formerly - Greer Memorial Hospital (GHS))	18-64	314,713	338,430	5,495	16									
	+65	81,136	102,040	3,000	10									
TOTAL		514,213	564,485	8,572	27	65%	42	82	70	-40	28.64%			
Prisma Health Hillcrest Hospital	<18	118,364	124,015	2	0									
(Formerly - Hillcrest Memorial Hospital (GHS))	18-64	314,713	338,430	2,158	6									
	+65	81,136	102,040	1,719	6									
TOTAL		514,213	564,485	3,879	12	65%	19	43	43	-24	24.71%			
Prisma Health Patewood Hospital	<18	118,364	124,015	4	0									
(Formerly - Patewood Memorial Hospital (GHS))	18-64	314,713	338,430	4,837	14									
	+65	81,136	102,040	1,724	6									
TOTAL		514,213	564,485	6,565	20	65%	32	72	72	-40	24.98%			
Saint Francis - Downtown & Saint Francis -Millennium	<18	118,364	124,015	6	0									
	18-64	314,713	338,430	24,861	73									
	+65	81,136	102,040	37,833	130									
TOTAL		514,213	564,485	62,700	204	70%	291	226	226	65	76.01%			
Saint Francis - Eastside	<18	118,364	124,015	41	0									
	18-64	314,713	338,430	11,088	33									
	+65	81,136	102,040	7,505	26									
TOTAL		514,213	564,485	18,634	59	65%	91	93	93	-2	54.89%			
Greenville County Total							1,165	1,262	1,152	-97		911	-351	-97
Self Regional Healthcare	<18	15,969	15,910	747	2									
	18-64	41,677	40,455	21,408	57									
	+65	13,095	15,000	24,747	78									
TOTAL		70,741	71,365	46,902	137	70%	196	326	272	-130	39.42%			
Greenwood County Total							196	326	272	-130		116	-210	-130

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2018 Pop	2024 Pop	2018 Pt Days	Proj ADC	Var. Rate Factor	Bed Need	Licensed / Approved Beds	Staffed / Approved Beds	Add/ Excess Use	2018 % Occup. Rate	Statewide Bed Need	Add/ Excess State	Bed Need
Prisma Health Laurens County Hospital (Formerly - Laurens County Memorial Hospital (GHS))	<18 18-64 +65 TOTAL	14,592 39,992 12,410 66,994	14,320 38,920 14,155 67,395	69 4,296 3,464 7,829	0 11 11 22									
Laurens County Total						65%	35	76	57	-41	28.22%	109	33	-41
Prisma Health Oconee Memorial Hospital (Formerly - Oconee Memorial Hospital (GHS))	<18 18-64 +65 TOTAL	15,615 44,563 18,196 78,374	15,430 45,100 21,430 81,960	120 8,179 12,054 20,353	0 23 39 62									
Oconee County Total						65%	96	169	132	-73	33.00%	133	-36	-73
Prisma Health Baptist Easley Hospital (Formerly - Baptist Easley Hospital)	<18 18-64 +65 TOTAL	23,712 80,565 20,660 124,937	27,310 78,605 24,245 130,160		0 17 26 43									
AnMed Health Cannon 1	<18 18-64 +65 TOTAL	23,712 80,565 20,660 124,937	27,310 78,605 24,245 130,160	NR NR NR 2,543	0 0 0 7									
Pickens County Total						65%	12	55	26	-43	12.67%	211	47	-85
Spartanburg Medical Center - Mary Black Campus (Formerly - Mary Black Health System - Spartanburg)	<18 18-64 +65 TOTAL	72,501 190,575 50,812 313,888	76,455 206,135 60,460 343,050	49 10,666 9,488 20,203	0 32 31 63									
Spartanburg Medical Center	<18 18-64 +65 TOTAL	72,501 190,575 50,812 313,888	76,455 206,135 60,460 343,050	1,968 69,524 64,513 136,005	6 206 210 422									
Pelham Medical Center (Village Hospital)	<18 18-64 +65 TOTAL	72,501 190,575 50,812 313,888	76,455 206,135 60,460 343,050	0 4,503 5,460 9,963	0 13 18 31									
Spartanburg County Total						65%	48	48	48	0	56.87%	554	-152	2
Union Medical Center 11	<18 18-64 +65 TOTAL	5,816 16,040 5,554 27,410	5,535 14,855 6,125 26,515	0 1,410 1,010 2,420	0 4 3 7									
Union County Total						65%	11	85	50	-74	7.80%	43	-42	-74
Region II														
Aiken Regional Medical Center 2	<18 18-64 +65 TOTAL	36,849 99,651 32,901 169,401	36,340 98,920 39,645 174,905	242 19,469 20,462 40,173	1 53 68 121									
Aiken County Total						70%	174	197	197	-23	55.87%	283	86	-23
MUSC Health Chester Medical Center (Formerly - Chester Regional Medical Center)	<18 18-64 +65 TOTAL	7,244 18,952 6,055 32,251	6,735 17,955 6,750 31,440	56 1,317 1,432 2,805	0 3 4 8									
Chester County Total						65%	13	82	36	-69	9.37%	51	-31	-69
Edgefield County Healthcare (Formerly - Edgefield County Hospital)	<18 18-64 +65 TOTAL	4,894 17,084 5,074 27,052	4,600 16,790 5,955 27,345	0 112 414 526	0 0 1 2									
Edgefield County Total						65%	3	25	25	-22	5.76%	45	20	-22

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2018 Pop	2024 Pop	2018 Pt Days	Proj ADC	Var. Rate Factor	Bed Need	Licensed / Approved Beds	Staffed / Approved Beds	Add/ Excess Use	2018 % Occup. Rate	Statewide Bed Need	Add/ Excess State	Bed Need
Kershaw Health	<18	15,167	15,165	92	0									
	18-64	38,397	39,450	6,557	18									
	+65	12,028	14,215	9,632	31									
	TOTAL	65,592	68,830	16,281	47	65%	73	99	90	-26	45.06%			
Kershaw County Total							73	99	90	-26		112	13	-26
MUSC Health Lancaster Medical Center (Formerly - Springs Memorial Hospital)	<18	20,786	24,280	64	0									
	18-64	54,535	64,045	13,394	43									
	+65	20,059	27,320	7,702	29									
	TOTAL	95,380	115,645	21,160	70	70%	101	199	146	-98	29.13%			
Lancaster County Total							101	199	146	-98		187	-12	-98
Lexington Medical Center 3	<18	68,294	69,590	172	0									
	18-64	180,157	192,385	63,378	185									
	+65	46,581	58,685	69,742	241									
	TOTAL	295,032	320,660	133,292	427	75%	569	557	436	12	65.56%			
Lexington County Total							569	557	436	12		518	-39	12
Newberry County Memorial Hospital	<18	8,404	8,790	103	0									
	18-64	22,564	21,975	2,484	7									
	+65	7,552	8,710	3,919	12									
	TOTAL	38,520	39,475	6,506	19	65%	30	90	54	-60	19.81%			
Newberry County Total							30	90	54	-60		64	-26	-60
Prisma Health Baptist Parkridge (Formerly - Palmetto Health Baptist Parkridge)	<18	88,630	95,805	1,605	5									
	18-64	273,156	272,800	9,686	27									
	+65	52,790	64,710	8,800	30									
	TOTAL	414,576	433,315	20,091	61	65%	94	76	76	18	72.43%			
Prisma Health Baptist (Formerly - Palmetto Health Baptist)	<18	88,630	95,805	12,558	37									
	18-64	273,156	272,800	38,897	106									
	+65	52,790	64,710	25,911	87									
	TOTAL	414,576	433,315	77,366	231	70%	330	287	292	43	73.85%			
Prisma Health Richland (Formerly - Palmetto Health Richland)	<18	88,630	95,805	40,639	120									
	18-64	273,156	272,800	85,869	235									
	+65	52,790	64,710	58,840	198									
	TOTAL	414,576	433,315	185,348	553	75%	738	579	573	159	87.70%			
Providence Health (Providence Hospital)	<18	88,630	95,805	0	0									
	18-64	273,156	272,800	13,365	37									
	+65	52,790	64,710	21,391	72									
	TOTAL	414,576	433,315	34,756	108	70%	155	258	173	-103	36.91%			
Providence Health - Northeast	<18	88,630	95,805	1	0									
	18-64	273,156	272,800	3,438	9									
	+65	52,790	64,710	3,628	12									
	TOTAL	414,576	433,315	7,067	22	65%	34	74	43	-40	26.16%			
Richland County Total							1,351	1,274	1,157	77		700	-574	77
Piedmont Medical Center 4	<18	66,495	73,945	2,102	6									
	18-64	168,387	195,210	33,773	107									
	+65	39,236	52,200	30,419	111									
	TOTAL	274,118	321,355	66,294	225	70%	321	268	250	53	67.77%			
Fort Mill Medical Center 4	<18	66,495	73,945	--	--									
	18-64	168,387	195,210	--	--									
	+65	39,236	52,200	--	--									
	TOTAL	274,118	321,355	0	0	70%		64	64	-100	0			
York County Total							321	332	314	-34		519	187	-34
Region III														
McLeod Health Cheraw	<18	10,032	9,515	120	0									
	18-64	27,327	25,850	3,450	9									
	+65	8,395	9,555	5,175	16									
	TOTAL	45,754	44,920	8,745	25	65%	40	59	40	-19	40.61%			
Chesterfield County Total							40	59	40	-19		73	14	-19

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2018 Pop	2024 Pop	2018 Pt Days	Proj ADC	Var. Rate Factor	Bed Need	Licensed / Approved Beds	Staffed / Approved Beds	Add/ Excess Use	2018 % Occup. Rate	Statewide Bed Need	Add/ Excess State	Bed Need
McLeod Health Clarendon	<18	6,479	5,735	28	0									
	18-64	19,307	17,775	3,717	9									
	+65	7,914	8,970	3,013	9									
	TOTAL	33,700	32,480	6,758	19	65%	29	81	49	-52	22.86%			
Clarendon County Total							29	81	49	-52		53	-28	-52
Carolina Pines Regional Medical Center	<18	14,817	14,000	283	1									
	18-64	39,307	36,715	7,323	19									
	+65	12,678	14,390	6,571	20									
	TOTAL	66,802	65,105	14,177	40	65%	62	116	80	-54	33.48%			
McLeod Medical Center - Darlington 1	<18	14,817	14,000	NR	0									
	18-64	39,307	36,715	NR	0									
	+65	12,678	14,390	NR	0									
	TOTAL	66,802	65,105	158	0	65%	1	49	22	-48	0.88%			
Darlington County Total							63	165	102	-102		106	-59	-102
McLeod Medical Center Dillon	<18	7,743	7,070	471	1									
	18-64	17,756	16,775	4,028	10									
	+65	5,100	5,685	3,026	9									
	TOTAL	30,599	29,530	7,525	21	65%	33	79	34	-46	26.10%			
Dillon County Total							33	79	34	-46		48	-31	-46
MUSC Health Florence Medical Center (Formerly - Carolinas Hospital System)	<18	32,590	30,760	576	1									
	18-64	82,098	79,205	28,786	76									
	+65	23,471	26,810	26,522	83									
	TOTAL	138,159	136,775	55,884	152	70%	217	310	310	-93	49.39%			
MUSC Health Florence Women's Pavillion (Formerly - Women's Center - Carolinas Hospital System) 5	<18	32,590	30,760	NR	0									
	18-64	82,098	79,205	NR	0									
	+65	23,471	26,810	NR	0									
	TOTAL	138,159	136,775	0	0	65%	0	20	0	-20	0.00%			
Lake City Community Hospital 1	<18	32,590	30,760	NR	0									
	18-64	82,098	79,205	NR	0									
	+65	23,471	26,810	NR	0									
	TOTAL	138,159	136,775	1,899	5	65%	8	48	26	-40	10.84%			
McLeod Regional Medical Center of the Pee Dee	<18	32,590	30,760	3,275	8									
	18-64	82,098	79,205	64,226	170									
	+65	23,471	26,810	61,292	192									
	TOTAL	138,159	136,775	128,793	370	75%	494	517	440	-23	68.25%			
Florence County Total							719	895	776	-176		221	-674	-176
Tidelands Georgetown Memorial Hospital	<18	11,438	10,510	107	0									
	18-64	33,521	32,350	6,402	17									
	+65	17,290	20,810	8,556	28									
	TOTAL	62,249	63,670	15,065	45	65%	70	131	131	-61	31.51%			
Tidelands Waccamaw Community Hospital	<18	11,438	10,510	150	0									
	18-64	33,521	32,350	8,102	21									
	+65	17,290	20,810	15,881	52									
	TOTAL	62,249	63,670	24,133	74	65%	115	124	124	-9	53.32%			
Georgetown County Total							185	255	255	-70		103	-152	-70

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2018 Pop	2024 Pop	2018 Pt Days	Proj ADC	Var. Rate Factor	Bed Need	Licensed / Approved Beds	Staffed / Approved Beds	Add/ Excess Use	2018 % Occup. Rate	Statewide Bed Need	Add/ Excess State	Bed Need
Conway Hospital	<18	61,715	66,785	345	1									
	18-64	200,001	230,755	17,632	56									
	+65	82,431	126,340	15,823	66									
	TOTAL	344,147	423,880	33,800	123	70%	177	210	172	-33	44.10%			
Grand Strand Medical Center	<18	61,715	66,785	1,022	3									
	18-64	200,001	230,755	36,549	116									
	+65	82,431	126,340	59,313	249									
	TOTAL	344,147	423,880	96,884	368	70%	526	325	325	201	81.67%			
McLeod Loris	<18	61,715	66,785	22	0									
	18-64	200,001	230,755	4,858	15									
	+65	82,431	126,340	5,919	25									
	TOTAL	344,147	423,880	10,799	40	65%	62	50	50	12	59.17%			
McLeod Seacoast	<18	61,715	66,785	7	0									
	18-64	200,001	230,755	4,116	13									
	+65	82,431	126,340	9,135	38									
	TOTAL	344,147	423,880	13,258	51	65%	80	105	105	-25	34.59%			
Horry County Total								845	690	652	155	685	-5	155
MUSC Health Marion Medical Center (Formerly - Carolinas Hospital System - Marion)	<18	7,082	6,410	2,094	5									
	18-64	17,795	16,365	2,096	5									
	+65	6,162	6,790	2,157	7									
	TOTAL	31,039	29,565	6,347	17	65%	27	124	129	-97	14.02%			
Marion County Total								27	124	129	-97	48	-76	-97
Prisma Health Tuomey Hospital (Formerly - Palmetto Health Tuomey)	<18	25,354	23,975	0	0									
	18-64	63,642	59,870	23,044	59									
	+65	17,516	20,230	22,103	70									
	TOTAL	106,512	104,075	45,147	129	70%	185	283	197	-98	43.71%			
Sumter County Total								185	283	197	-98	168	-115	-98
Williamsburg Regional Hospital 5	<18	6,340	5,400	NR	0									
	18-64	17,825	15,255	NR	0									
	+65	6,441	7,085	NR	0									
	TOTAL	30,606	27,740	0	0	65%	0	25		-25	0.00%			
Williamsburg County Total								0	25	0	-25	45	20	20
Region IV														
Allendale County Hospital	<18	1,680	1,415		0									
	18-64	5,433	4,530	159	0									
	+65	1,790	1,860	262	1									
	TOTAL	8,903	7,805	421	1	65%	2	25	25	-23	4.61%			
Allendale County Total								2	25	25	-23	13	-12	-23
Beaufort Memorial Hospital	<18	35,023	35,605	500	1									
	18-64	102,250	108,570	15,659	46									
	+65	51,442	66,180	16,454	58									
	TOTAL	188,715	210,355	32,613	100	65%	154	169	169	-15	52.87%			
Hilton Head Hospital	<18	35,023	35,605	51	0									
	18-64	102,250	108,570	6,598	19									
	+65	51,442	66,180	15,551	55									
	TOTAL	188,715	210,355	22,200	74	65%	115	93	93	22	65.40%			
South Of Broad Hospital 6	<18	35,023	35,605		0									
	18-64	102,250	108,570		0									
	+65	51,442	66,180		0									
	TOTAL	188,715	210,355		0	65%	0	20		-20				
Beaufort County Total								269	282	262	-13	340	58	-13

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2018 Pop	2024 Pop	2018 Pt Days	Proj ADC	Var. Rate Factor	Bed Need	Licensed / Approved Beds	Staffed / Approved Beds	Add/ Excess Use	2018 % Occup. Rate	Statewide Bed Need	Add/ Excess State	Bed Need
Berkeley Medical Center 7	<18	52,749	57,815		0									
	18-64	137,932	155,715		0									
	+65	30,410	41,980		0									
	TOTAL	221,091	255,510	0	0	65%	0	50	50	-50	0.00%			
Roper St. Francis- Berkeley	<18	52,749	57,815	0	0									
	18-64	137,932	155,715	0	0									
	+65	30,410	41,980	0	0									
	TOTAL	221,091	255,510	0	0	65%	0	50	50	-50	0.00%			
MUHA Community Hospital 8	<18	52,749	57,815	0	0									
	18-64	137,932	155,715	0	0									
	+65	30,410	41,980	0	0									
	TOTAL	221,091	255,510	0	0	65%	0	128	128	-128	0.00%			
Berkeley County Total							0	228	100	-228		413	185	185
Bon Secours - Saint Francis Xavier Hospital 12	<18	79,933	84,155	51	0									
	18-64	259,351	274,190	18,412	53									
	+65	66,621	86,385	13,324	47									
	TOTAL	405,905	444,730	31,787	101	70%	145	201	149	-56	43.33%			
East Cooper Medical Center	<18	79,933	84,155	11	0									
	18-64	259,351	274,190	8,125	24									
	+65	66,621	86,385	5,928	21									
	TOTAL	405,905	444,730	14,064	45	65%	69	130	130	-61	29.64%			
Mount Pleasant Hospital	<18	79,933	84,155	12	0									
	18-64	259,351	274,190	3,522	10									
	+65	66,621	86,385	4,648	17									
	TOTAL	405,905	444,730	8,182	27	65%	42	85	73	-43	26.37%			
MUSC Medical Center 9 & 10	<18	79,933	84,155	25,196	73									
	18-64	259,351	274,190	104,894	304									
	+65	66,621	86,385	59,153	210									
	TOTAL	405,905	444,730	189,243	587	75%	783	685	656	98	75.69%			
Roper Hospital	<18	79,933	84,155	2	0									
	18-64	259,351	274,190	21,801	63									
	+65	66,621	86,385	32,573	116									
	TOTAL	405,905	444,730	54,376	179	70%	256	266	241	-10	56.01%			
Trident Medical Center 13	<18	79,933	84,155	1,355	4									
	18-64	259,351	274,190	45,955	133									
	+65	66,621	86,385	37,386	133									
	TOTAL	405,905	444,730	84,696	270	70%	386	282	296	104	82.29%			
Charleston County Total							1,681	1649	1545	32		718	-931	32
Colleton Medical Center	<18	8,390	8,070	636	2									
	18-64	21,675	20,855	5,964	16									
	+65	7,595	8,480	7,439	23									
	TOTAL	37,660	37,405	14,039	41	65%	64	116	112	-52	33.16%			
Colleton County Total							64	116	112	-52		61	-55	-52
Summerville Medical Center	<18	39,214	40,080	3,025	8									
	18-64	98,799	108,745	14,598	44									
	+65	22,634	30,285	8,753	32									
	TOTAL	160,647	179,110	26,376	85	65%	131	124	124	7	58.28%			
Dorchester County Total							131	124	124	7		290	166	7
Hampton Regional Medical Center	<18	4,116	3,645	0	0									
	18-64	11,672	10,470	1,037	3									
	+65	3,563	3,890	1,328	4									
	TOTAL	19,351	18,005	2,365	7	65%	11	32	14	-21	20.25%			
Hampton County Total							11	32	14	-21		30	-2	-21
Coastal Carolina Hospital (Formerly - Coastal Carolina Medical Center)	<18	5,889	5,755	25	0									
	18-64	17,472	17,905	4,142	12									
	+65	5,610	9,015	5,244	23									
	TOTAL	28,971	32,675	9,411	35	65%	54	41	35	13	62.89%			
Jasper County Total							54	41	35	13		53	12	13
Regional Medical Center of Orangeburg & Calhoun Counties 1	<18	19,044	17,735	NR	0									
	18-64	50,776	45,250	NR	0									
	+65	17,114	18,830	NR	0									
	TOTAL	86,934	81,815	54,931	142	70%	203	247	209	-44	60.93%			
Orangeburg County Total							203	247	209	-44		133	-114	-44

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2018 Pop	2024 Pop	2018 Pt Days	Proj ADC	Var. Rate Factor	Bed Need	Licensed / Approved Beds	Staffed / Approved Beds	Add/ Excess Use	2018 % Occup. Rate	Statewide Bed Need	Add/ Excess State	Bed Need
Bamberg		14,275	12,830									21	21	21
Barnwell		21,112	19,740									32	32	32
Fairfield**		22,402	21,230									35	35	35
Lee		17,142	15,650									26	26	26
McCormick		9,410	8,675									14	14	14
Marlboro		26,398	24,410									40	40	40
Saluda		20,544	20,865									34	34	34
Calhoun		14,520	13,795									23	23	23
Counties Without General Hospitals														
Statewide Total		5,084,127	5,474,585	2,244,741				11,688				0,0016137		
Beds Per Population Multiplier		0,0016136												

* This chart does not count beds already counted in the charts for psychiatric beds, rehabilitation beds, and substance abuse beds. The patient days associated with these beds have been deducted from the reported total number of patient days.

** E-19-02 issued for the permanent closure of Fairfield Memorial Hospital effective December 2018. Fairfield Memorial removed from inventory.

1 Age cohorts not adequately reported.

2 SC-17-12 issued 3/2/2017 for the addition of 14 acute care beds.

3 CON SC-19-19 issued 3/12/2019 for the addition of 72 acute hospital beds. Not yet complete.

4 SC-19-74 issued 5/30/2019 for construction of a 100-bed hospital in Fort Mill using a combination of new and transferred hospital beds. Piedmont Medical Center's licensed bed count remains 268 and the Fort Mill Medical Center bed count remains 64 until such time as the Fort Mill Medical Center Project is complete. Upon final completion of the project, Fort Mill Medical Center will have 100 general beds and Piedmont Medical Center's licensed bed count will be reduced by the 36 beds transferred to Fort Mill.

5 Facility did not submit 2018 JAR.

6 Staff decision approving a 20-bed acute care hospital in Beaufort County. On appeal.

7 SC-16-19 issued 5/26/2016 for the construction of a new 50 bed acute care hospital.

8 Staff decision approving a 128-bed acute care hospital in Berkeley County. On appeal.

9 CON SC-15-26 issued 6/30/15 for the addition of 52 acute hospital beds, four (4) of which have been licensed.

10 CON SC-20-01 issued 1/8/2020 for the addition of 29 general beds, not yet complete.

11 E-19-38 Issued on 11/19/2019 for the decrease in licensed bed capacity by 58 general acute care beds resulting in a licensed bed capacity of 85 general acute care beds.

12 E-19-03 Issued on 02/14/2019 for the decrease in licensed bed capacity by 3 general hospital beds resulting in a licensed bed capacity of 201 general hospital beds.

13 E-19-18 Issued on 03/22/2019 for the decrease in licensed bed capacity by 14 general hospital beds resulting in a licensed bed capacity of 282 general hospital beds.

RECEIVED
Aug 29 2022
SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

The Honorable Ralph King Anderson, III
Chief Administrative Law Judge

APPELLATE CASE NO. 2020-001323

ADMINISTRATIVE LAW COURT CASE No.: 18-ALJ-07-0358-CC
ADMINISTRATIVE LAW COURT CASE No.: 18-ALJ-07-0360-CC
ADMINISTRATIVE LAW COURT CASE No.: 18-ALJ-07-0366-CC

CareAlliance Health Services, d/b/a Roper St. Francis Healthcare,
Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc.,
Roper St. Francis Berkeley Hospital and Roper Mount Pleasant
Hospital,.....Appellant-Respondent,

v.

South Carolina Department of Health and Environmental Control and
Medical University Hospital Authority, d/b/a MUHA Community Hospital,.....Respondents,

AND

Walterboro Community Hospital, Inc., d/b/a Colleton Medical Center,.....Appellant,

v.

South Carolina Department of Health and Environmental Control and
Medical University Hospital Authority, d/b/a MUHA Community Hospital,.....Respondents,

AND

Trident Medical Center, LLC d/b/a Trident Medical Center
and Summerville Medical Center,.....Appellant,

v.

South Carolina Department of Health and Environmental Control and
Medical University Hospital Authority, d/b/a MUHA Community Hospital,.....Respondents.

PROOF OF SERVICE

The undersigned hereby certifies that on August 29, 2022, s/he has caused a copy of the **Return of Appellants Trident Medical Center and Walterboro Community Hospital to Medical University Hospital Authority's Motion to Supplement Briefs and Record on Appeal** to be served upon all parties of record by electronic mail, addressed as follows:

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Xavier Hospital, Inc., Roper St. Francis
Berkeley Hospital and Roper
Mount Pleasant Hospital*

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Raleigh, NC
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August 29, 2022

VIA HAND DELIVERY AND E-MAIL(ctappfilings@sccourts.org)

The Honorable Jenny Abbott Kitchings
Clerk, South Carolina Court of Appeals
1220 Senate Street
Columbia, SC 29201

RECEIVED
Aug 29 2022
SC Court of Appeals

Re: CareAlliance Health Services, et al., vs. South Carolina DHEC, et al., AND Walterboro Community Hospital, Inc. d/b/a Colleton Medical Center v. South Carolina DHEC, et al. AND

Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center vs. SC DHEC, et al.

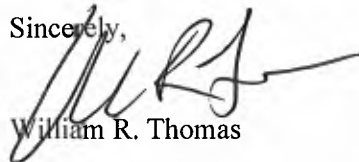
Appellate Case No. 2020-001323

Dear Ms. Kitchings:

Enclosed please find Return of Appellants Trident Medical Center and Walterboro Community Hospital to Medical University Hospital Authority's Motion to Supplement Briefs and Record on Appeal in the above-referenced cases.

With best regards, I am

Sincerely,



William R. Thomas

WRT/jcp
Enclosure

cc: Vito M. Wicevic, Esquire (via email)
Rupinderjit S. Grewal, Esquire (via email)
Jennifer J. Hollingsworth, Esquire (via email)
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